



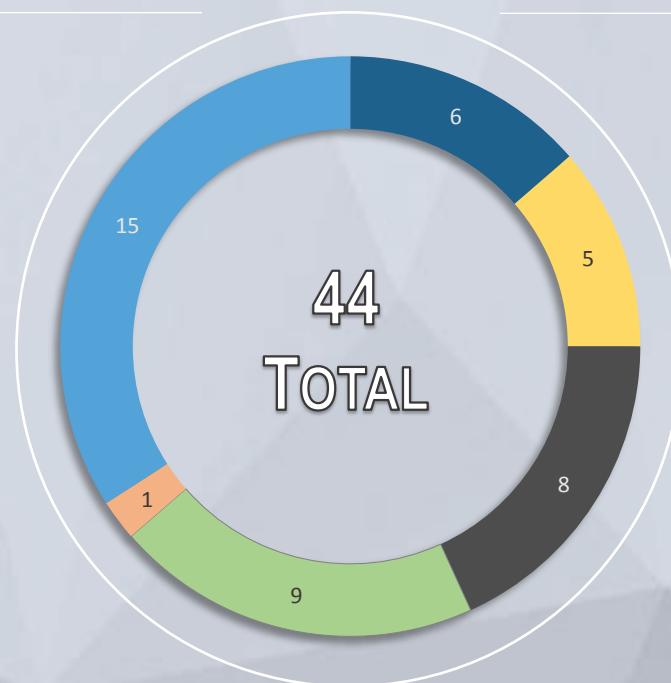
STATE AUDITOR'S OFFICE

AUDIT HIGHLIGHTS

2015-2016

This document includes reports at Article II agencies issued between January 2015 to December 2016. The State Auditor's Office is available as a resource to the Legislature on any of our reports.

Audit Coverage* for Article II: Health and Human Services



■ Department Of Aging and Disability Services

■ Department of Assistive and Rehabilitative Services

■ Department of Family and Protective Services

■ Department of State Health Services

■ Texas Civil Commitment Office

■ Health and Human Services Commision

*This graph represents the number of audit engagements at Article II agencies. An audit report may contain multiple agencies.



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ISSUE RATINGS

began March 28, 2016

Auditors use professional judgement to rate the audit findings identified in certain audit reports. For each report, the issue ratings are summarized in the report chapters/subchapters. Auditors determine the ratings based on the degree of risk or effect of the findings in relation to the audit objective(s).

LOW

The audit identified strengths that support the audited entity's ability to administer the program(s)/function(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

MEDIUM

Issues identified present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.

HIGH

Issues identified present risks or effects that if not addressed could substantially affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern(s) and reduce risks to the audited entity.

PRIORITY

Issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern(s) and reduce risks to the audited entity.

In determining the ratings of audit findings, auditors consider 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 issues. Auditors also identify and consider other factors when appropriate.

*The SAO rates findings only for performance audits.



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ARTICLE II: HEALTH AND HUMAN SERVICES

REPORT TITLE	REPORT NUMBER	RELEASE DATE	ISSUE RATINGS
Department of Aging and Disability Services			
A Report on Analysis of Quality Assurance Team Projects	16-026	5/10/2016	
State of Texas Financial Portion of the Statewide Single Audit Report for the Year Ended August 31, 2015	16-555	3/14/2016	
State of Texas Federal Portion of the Statewide Single Audit Report for the Fiscal Year Ended August 31, 2015	16-317	2/29/2016	
An Audit Report on Capital Budgets at Health and Human Services Agencies	15-044	8/28/2015	
State of Texas Financial Portion of the Statewide Single Audit Report for the Year Ended August 31, 2014	15-555	2/27/2015	
State of Texas Federal Portion of the Statewide Single Audit Report for the Fiscal Year Ended August 31, 2014	15-313	2/27/2015	



ARTICLE II: HEALTH AND HUMAN SERVICES

REPORT TITLE	REPORT NUMBER	RELEASE DATE	ISSUE RATINGS
Department of Assistive and Rehabilitative Services (agency abolished effective September 1, 2016)	16-555	3/14/2016	
State of Texas Financial Portion of the Statewide Single Audit Report for the Year Ended August 31, 2015			
State of Texas Federal Portion of the Statewide Single Audit Report for the Fiscal Year Ended August 31, 2015	16-317	2/29/2016	
An Audit Report on Capital Budgets at Health and Human Services Agencies	15-044	8/28/2015	
State of Texas Financial Portion of the Statewide Single Audit Report for the Year Ended August 31, 2014	15-555	2/27/2015	
State of Texas Federal Portion of the Statewide Single Audit Report for the Fiscal Year Ended August 31, 2014	15-313	2/27/2015	



ARTICLE II: HEALTH AND HUMAN SERVICES

REPORT TITLE	REPORT NUMBER	RELEASE DATE	ISSUE RATINGS
Department of Family and Protective Services			
An Audit Report on On-site Financial Audits of Selected Residential Foster Care Contractors	17-011	10/31/2016	● ● ● ●
A Report on Analysis of Quality Assurance Team Projects	16-026	5/10/2016	
State of Texas Financial Portion of the Statewide Single Audit Report for the Year Ended August 31, 2015	16-555	3/14/2016	
State of Texas Federal Portion of the Statewide Single Audit Report for the Fiscal Year Ended August 31, 2015	16-317	2/29/2016	
An Audit Report on Capital Budgets at Health and Human Services Agencies	15-044	8/28/2015	
A Report on On-site Financial Audits of Selected Residential Foster Care Contractors	15-043	8/27/2015	
State of Texas Financial Portion of the Statewide Single Audit Report for the Year Ended August 31, 2014	15-555	2/27/2015	
State of Texas Federal Portion of the Statewide Single Audit Report for the Fiscal Year Ended August 31, 2014	15-313	2/27/2015	



ARTICLE II: HEALTH AND HUMAN SERVICES

REPORT TITLE	REPORT NUMBER	RELEASE DATE	ISSUE RATINGS
Department of State Health Services			
An Audit Report on a Selected Contract at the Department of State Health Services	16-031	6/28/2016	● ● ● ●
A Report on Analysis of Quality Assurance Team Projects	16-026	5/10/2016	
An Audit Report on Selected Agencies' Use of Department of Information Resources Information Technology Staffing Services Contracts	16-020	3/29/2016	● ● ● ●
State of Texas Financial Portion of the Statewide Single Audit Report for the Year Ended August 31, 2015	16-555	3/14/2016	
State of Texas Federal Portion of the Statewide Single Audit Report for the Fiscal Year Ended August 31, 2015	16-317	2/29/2016	
An Audit Report on Capital Budgets at Health and Human Services Agencies	15-044	8/28/2015	
An Audit Report on Procurement for Terrell State Hospital Operations at the Health and Human Services Commission and the Department of State Health Services	15-030	3/25/2015	
State of Texas Financial Portion of the Statewide Single Audit Report for the Year Ended August 31, 2014	15-555	2/27/2015	
State of Texas Federal Portion of the Statewide Single Audit Report for the Fiscal Year Ended August 31, 2014	15-313	2/27/2015	



ARTICLE II: HEALTH AND HUMAN SERVICES

REPORT TITLE	REPORT NUMBER	RELEASE DATE	ISSUE RATINGS
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Texas Civil Commitment Office
(formerly the Office of Violent Sex Offender Management)

An Audit Report on the Office of Violent Sex Offender Management [15-018](#) 1/26/2015



ARTICLE II: HEALTH AND HUMAN SERVICES

REPORT TITLE	REPORT NUMBER	RELEASE DATE	ISSUE RATINGS
Health and Human Services Commission			
An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission	17-007	10/13/2016	● ● ● ●
An Audit Report on Human Resources Contract Management at the Health and Human Services Commission	17-004	10/10/2016	● ● ● ●
A Report on Health and Human Services Commission Contracts	17-005	10/4/2016	
An Audit Report on a Selected Contract at the Department of State Health Services	16-031	6/28/2016	● ● ● ●
A Report on Analysis of Quality Assurance Team Projects	16-026	5/10/2016	
An Audit Report on Selected Agencies' Use of Department of Information Resources Information Technology Staffing Services Contracts	16-020	3/29/2016	● ● ● ●
State of Texas Financial Portion of the Statewide Single Audit Report for the Year Ended August 31, 2015	16-555	3/14/2016	
State of Texas Federal Portion of the Statewide Single Audit Report for the Fiscal Year Ended August 31, 2015	16-317	2/29/2016	
A Report on Health and Human Services Commission Contracts	16-006	10/15/2015	
An Audit Report on Capital Budgets at Health and Human Services Agencies	15-044	8/28/2015	
An Investigative Report on the Health and Human Services Commission's and the Office of Inspector General's Procurement of Services and Commodities from 21CT, Inc.	15-031	4/2/2015	
An Audit Report on Procurement for Terrell State Hospital Operations at the Health and Human Services Commission and the Department of State Health Services	15-030	3/25/2015	
State of Texas Financial Portion of the Statewide Single Audit Report for the Year Ended August 31, 2014	15-555	2/27/2015	
State of Texas Federal Portion of the Statewide Single Audit Report for the Fiscal Year Ended August 31, 2014	15-313	2/27/2015	
A Report on Recent Contracting Audits	15-019	1/23/2015	





Medicaid Managed Care Related Audits at the Health and Human Services Commission

The State Auditor's Office (Office) has issued the following recent reports related to Medicaid managed care at the Health and Human Services Commission (Commission):

- *An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission* (Report 17-007, October 2016).
 - The objective of this audit was to determine whether the Commission and the Office of Inspector General administer selected Medicaid managed care contract management processes and related controls in accordance with contract terms, applicable laws, regulations, and agency policies and procedures.
 - This audit focused on how well the Commission used different types of audits to verify information reported to it from Medicaid managed care organizations (MCOs). Audits of MCOs are performed by contracted audit firms and by the Office of Inspector General.



Medicaid Managed Care Related Audits at the Health and Human Services Commission

- *An Audit Report on HealthSpring Life and Health Insurance Company, Inc., a Medicaid STAR+PLUS Managed Care Organization (Report 17-025, February 2017).*
 - The objective of this audit was to determine whether selected financial processes and related controls at an MCO are designed and operating to help ensure (1) the accuracy and completeness of data that the MCO reports to the Commission and (2) compliance with applicable requirements.
 - This audit covered HealthSpring Life and Health Insurance Company, Inc.'s (HealthSpring) contracts with the Commission for STAR+PLUS and its financial statistical reports and reported medical and pharmacy claims for fiscal year 2015.



Medicaid Managed Care Related Audits at the Health and Human Services Commission

Overall Conclusion - October 2016 Report:

- *An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission* (Report 17-007, October 2016).
 - The Commission should develop and implement an overall strategy for planning, managing, and coordinating audit resources that it uses to verify the accuracy and reliability of program and financial information that MCOs report to it.
 - The lack of an overall strategy has resulted in gaps in audit coverage of MCOs, lack of consistent follow-up on audit findings, inconsistent application of procedures, and duplication of effort.
 - The Commission paid a total of \$35.7 billion to MCOs for Medicaid managed care between fiscal years 2013 and 2015.



Medicaid Managed Care Related Audits at the Health and Human Services Commission

Key Findings - October 2016 Report:

- The Commission should improve its processes for performance audits of MCOs (see text box for information on performance audits).
 - The Commission's contracted audit firms conducted performance audits of 11 of the 23 MCOs with active contracts covering fiscal years 2011 and 2015. However, the Commission did not document why it selected those MCOs to be audited.
 - For performance audits covering fiscal year 2011 through May 2016, the Commission did not verify or track whether MCOs corrected findings for 11 (92 percent) of 12 performance audits conducted.
 - For those 12 performance audits, only 1 MCO received a corrective action plan from the Commission that required the MCO to address the audit findings.

Performance Audits

Performance audits provide assurance regarding the effectiveness of MCOs' internal controls and address fraud, waste, and abuse as part of the audit scope. The objectives of those audits are based on the risks identified at each MCO. The Commission approves the scope and objectives for each performance audit.



Medicaid Managed Care Related Audits at the Health and Human Services Commission

Key Findings - October 2016 Report (continued):

- The Commission should enhance its use of agreed-upon procedures (AUP) engagements to ensure that financial risks are consistently addressed and identified issues are corrected (see text box for information on AUP engagements).
 - The Commission uses AUP engagements to verify financial statistical reports that MCOs submit to validate whether MCOs owe the Commission money under the State's Medicaid experience rebate requirements.
 - Both audit firms had the same objective of validating MCOs' financial statistical reports that the Commission uses to verify the amount of experience rebates that MCOs owed; however, the Commission approved different procedures for each audit firm to identify possible systemic errors in the MCOs' financial reports. The Commission did not consistently require each audit firm to expand audit tests to determine whether identified errors were systemic within an MCO's operations and could materially affect the accuracy of financial statistical reports.
 - The Commission does not have a process to issue corrective action plans to correct performance or noncompliance issues identified in AUP engagements.

Agreed-upon Procedures (AUP)

AUP engagements may be narrower in scope than performance audits and unless requested, auditors may not provide assurance regarding the effectiveness of MCOs' internal controls or address fraud, waste, and abuse. The auditor reports only on the findings related to the procedures that the Commission agreed upon.



Medicaid Managed Care Related Audits at the Health and Human Services Commission

Key Findings - October 2016 Report (continued):

- The Commission should obtain greater assurance about the effectiveness of MCOs' pharmacy benefit managers' (PBM) internal controls and compliance with state requirements.
 - MCOs paid \$235.2 million to PBMs from March 2012 through August 2015 to administer \$7.4 billion in prescription benefits. However, the Commission has performed only one performance audit of MCOs' PBMs since 2012, and the scope of that audit was limited to two months.
 - The Commission's oversight of the MCOs' PBMs relies on a combination of monitoring self-reported information from MCOs and limited verification of selected portions of that self-reported information through annual AUP engagements performed by contracted audit firms.
 - The Commission did not issue any corrective action plans to MCOs to require them to correct performance or noncompliance issues related to PBMs identified in AUP engagements.



Medicaid Managed Care Related Audits at the Health and Human Services Commission

Key Findings – October 2016 Report (continued):

- The Commission should improve coordination of audit activities.
 - Six of the eight MCO performance audits that the Office of Inspector General performed between fiscal years 2011 and 2015 included reviews of an MCO's financial statistical reports that had been previously reviewed in an AUP engagement contracted by the Commission's Medicaid CHIP Division.
- The Commission did not collect all costs for audit-related services.
 - The Commission did not collect \$2,022,025 (41 percent) of the \$4,950,664 in costs that MCOs were required to reimburse to the Commission for fiscal years 2011 through 2015.
 - In addition, the Commission did not request reimbursement from MCOs for \$1,176,428 (58 percent) of the \$2,022,025 uncollected amount.



Medicaid Managed Care Related Audits at the Health and Human Services Commission

Overall Conclusion – February 2017 Report:

- *An Audit Report on HealthSpring Life and Health Insurance Company, Inc., a Medicaid STAR+PLUS Managed Care Organization (Report 17-025, February 2017).*
 - From September 1, 2014, through August 31, 2015, payments to HealthSpring from the Commission totaled \$713.7 million. Approximately \$601.3 million of that amount paid for medical claims and prescription drug claims for 62,828 people enrolled in STAR+PLUS.
 - HealthSpring accurately reported to the Commission the medical claims and prescription drug claims paid in fiscal year 2015. Approximately 84.3 percent of the payments that HealthSpring received were spent on medical claims and prescription drug claims.



Medicaid Managed Care Related Audits at the Health and Human Services Commission

Overall Conclusion – February 2017 Report (continued):

- HealthSpring reported to the Commission certain administrative expenses for fiscal year 2015 that included approximately \$3.8 million in unallowable costs and \$34.0 million in questioned costs. Those costs affect the accuracy of the experience rebate amounts that HealthSpring is required to pay the Commission. For fiscal year 2015, HealthSpring paid an experience rebate of approximately \$12.5 million.

- HealthSpring had weaknesses in the controls over its processes for documenting reasons for post-payment adjustments to medical claims and for ensuring medical claims were paid within 30 days of receipt of a “clean claim” as required.



Medicaid Managed Care Related Audits at the Health and Human Services Commission

Key Findings – February 2017 Report:

- HealthSpring included unallowable costs in the bonuses it reported on its financial statistical reports, and it did not prepare required certifications and personnel activity reports.
 - HealthSpring reported bonuses totaling \$786,457 in unallowable costs that were paid to staff employed by its affiliate companies.
 - Auditors identified \$33,679,703 in questioned costs for salaries and for other medical expenses that HealthSpring reported on its financial statistical reports for fiscal year 2015. HealthSpring did not perform required certifications and prepare personnel activity reports to show that affiliate companies' salaries that it used to calculate the reported amounts were for staff who worked on STAR+PLUS-related activities.



Medicaid Managed Care Related Audits at the Health and Human Services Commission

Key Findings – February 2017 Report (continued):

- HealthSpring did not develop a written allocation methodology as required, and it overstated its reported allocated corporate costs on its financial statistical reports.
 - The allocated corporate costs HealthSpring reported to the Commission for fiscal year 2015 included \$2,881,358 in unallowable costs:
 - Advertising expenses, charitable donations, non-STAR+PLUS affiliate expenses, employee events, gifts, bonuses, and stock options, totaling \$2,736,870, were indirect costs that did not provide a direct benefit to STAR+PLUS.
 - Allocated corporate costs for severance pay, totaling \$144,488, were accrual amounts and not actual expenses that HealthSpring incurred.



Medicaid Managed Care Related Audits at the Health and Human Services Commission

Key Findings – February 2017 Report (continued):

- Auditors identified \$163,997 in unallowable costs and \$359,912 in questioned costs related to legal and professional services costs.
- HealthSpring did not report accurate and complete information about its affiliate companies.
- HealthSpring did not consistently document the reasons for post-payment adjustments that it made to paid medical claims.
- HealthSpring did not ensure that it paid all medical claims within 30 days of receipt of a “clean claim” as required.



Medicaid Managed Care Related Audits at the Health and Human Services Commission

Issue Ratings:

Auditors rated the audit findings in *An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission* (Report 17-007, October 2016) as noted below.

Summary of Chapters/Subchapters and Related Issue Ratings State Auditor's Office Report No. 17-007, October 2016		
Chapter/ Subchapter	Title	Issue Rating ^a
1-A	The Commission Should Improve Its Processes for Performance Audits of MCOs	Priority
1-B	The Commission Should Enhance Its Use of Agreed-upon Procedures Engagements to Ensure That Financial Risks Are Consistently Addressed and Identified Issues Are Corrected	High
1-C	The Commission Should Obtain Greater Assurance About the Effectiveness of MCOs' Pharmacy Benefit Managers' Internal Controls and Compliance with State Requirements	Priority
1-D	The Commission Should Improve Coordination of Audit Activities	High
2-A	The Commission Did Not Collect All Costs for Audit-related Services	Medium
2-B	The Commission Generally Collected Experience Rebates in a Timely Manner; However, It Should Improve Certain Collection Activities	Low
3	The Commission Should Use Information That Its External Quality Review Organization Contractor Provides to Strengthen Its Monitoring of MCO Performance	Low
4	The Commission Should Strengthen Its Security and Processing Controls Over Certain Information Technology Systems	Medium

^a Auditors used professional judgement and rated the audit findings identified in the report. The issue ratings were determined based on the degree of risk or effect of the findings in relation to the audit objective.



Medicaid Managed Care Related Audits at the Health and Human Services Commission

Issue Ratings (continued):

Auditors rated the audit findings in *An Audit Report on HealthSpring Life and Health Insurance Company, Inc., a Medicaid STAR+PLUS Managed Care Organization* (Report 17-025, February 2017) as noted below.

Summary of Subchapters and Related Issue Ratings State Auditor's Office Report No. 17-025, February 2017		
Subchapter	Title	Issue Rating ^a
1-A	HealthSpring Accurately Reported the Medical Claims and Prescription Drug Claims That It Paid in Fiscal Year 2015	Low
1-B	HealthSpring Included Unallowable Costs in the Bonuses It Reported on Its Financial Statistical Reports, and It Did Not Prepare Required Certifications and Personnel Activity Reports	High
1-C	HealthSpring Did Not Develop a Written Allocation Methodology as Required, and It Overstated Its Reported Allocated Corporate Costs on Its Financial Statistical Reports	High
1-D	HealthSpring Did Not Consistently Maintain Documentation to Show That Certain Legal and Professional Services Costs Were Applicable to STAR+PLUS and Incurred During the Reporting Period	Medium
1-E	HealthSpring Did Not Report Accurate and Complete Information About Its Affiliate Companies	Medium
2-A	HealthSpring Did Not Consistently Document the Reasons for Post-payment Adjustments That It Made to Paid Medical Claims	High
2-B	HealthSpring Did Not Ensure That It Paid All Medical Claims Within 30 Days of Receipt of a Clean Claim as Required	Medium

^a Auditors used professional judgement and rated the audit findings identified in the report. The issue ratings were determined based on the degree of risk or effect of the findings in relation to the audit objective.



An Audit Report on

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

October 2016

Report No. 17-007



An Audit Report on

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

SAO Report No. 17-007
October 2016

Overall Conclusion

The Health and Human Services Commission (Commission) should develop and implement an overall strategy for planning, managing, and coordinating audit resources that it uses to verify the accuracy and reliability of program and financial information that managed care organizations (MCOs) report to it. The lack of an overall strategy has resulted in gaps in audit coverage of MCOs, lack of consistent follow-up on audit findings, inconsistent application of procedures, and duplication of effort.

The Commission paid a total of \$35.7 billion to MCOs for Medicaid managed care between **fiscal years 2013 and 2015**. The Commission's need for a well-defined strategy for managing audit resources in an effective and efficient manner is increasingly important due to the continued expansion of Medicaid managed care programs in areas such as behavioral health services, prescription drug benefits, and nursing facilities.

The Commission contracts with two audit firms for periodic performance audits and annual agreed-upon procedures (AUP) engagements of MCOs. The Commission uses those audit activities as a key component to verify the accuracy and reliability of information that it uses to monitor MCO compliance with Medicaid managed care contract requirements (see text box for definitions of AUP engagements and performance audits). The Office of Inspector General also conducts performance audits of MCOs.

The audit activities performed by contracted audit firms and the Office of Inspector General

Background Information

The 72nd Legislature established a Medicaid managed care pilot program. In a managed care program, a managed care organization (MCO) is paid for each client enrolled. In managed care, clients receive health care services through a network of doctors, hospitals, and other health care providers that have contracted with the MCO. The Health and Human Services Commission (Commission) continues to expand Medicaid managed care. In fiscal year 2013, 80 percent of the **State's** Medicaid population was enrolled in managed care.

As of February 2015, Texas Medicaid managed care programs included State of Texas Access Reform (STAR), STAR+PLUS, NorthSTAR, STAR Health, and **Children's Medicaid Dental Services**.

Sources: *Texas Medicaid and CHIP in Perspective*, Tenth Edition, Health and Human Services Commission, February 2015, and data from the Uniform Statewide Accounting System.

Audit-related Activities for MCOs

Agreed-upon Procedures (AUP) Engagements - The Commission uses AUP engagements to verify financial statistical reports that MCOs submit to validate whether MCOs owe the Commission money under the **State's Medicaid rebate requirements**. In an AUP engagement, the auditor reports only on the findings related to the procedures that the Commission approved.

Performance Audits - Performance audits are greater in scope than AUP engagements. They provide **assurance regarding the effectiveness of MCOs'** internal controls and should address fraud, waste, and abuse as part of the audit scope. The objectives of those audits are based on the risks identified at each MCO. The Commission approves the scope and objectives for each performance audit. Examples of performance audits that the Commission had its contracted audit firms conduct in fiscal years 2011 through 2015 included **coverage of MCOs'** subcontractor monitoring, claims processing, and complaints tracking. Those performance audit reports included reviews of internal controls, and some audits had findings related to subcontractor monitoring, claims processing, and complaints tracking.

Sources: The Commission and generally accepted governmental auditing standards.

varied in frequency and methodology. The Commission has not comprehensively defined how those different audit approaches address the risks associated with Medicaid managed care, and it does not use results of those audit activities to **monitor MCOs' performance**.

The weaknesses in the Commission's **use of audit resources** are discussed in more detail below.

The Commission lacks a documented audit selection process, and there are gaps in **the Commission's** performance audit coverage.

The Commission lacks a documented process to show how it determines which MCOs to audit. Although the Commission paid contracted audit firms a total of \$1,337,525 to assess the risks of each MCO in fiscal years 2011, 2013, and 2015, it did not document how those risk assessments were used to select which MCOs to audit. The risk assessments identified risk areas for all of the MCOs reviewed. However, the Commission did not audit 12 (52 percent) of the 23 MCOs that provided Medicaid services from fiscal year 2011 through fiscal year 2015.

In addition, since fiscal year 2012 the Commission has not conducted performance **audits of the services that MCOs' pharmacy benefit manager contractors** provide. Pharmacy benefit manager contractors administer the prescription drug benefits of MCOs. From March 2012 to August 2015, MCOs reported they paid \$235,199,287 to pharmacy benefit manager contractors to administer \$7.4 billion in prescription benefits.

The Commission did not sufficiently follow up on issues identified from performance audits and AUP engagements.

The Commission did not follow up on issues identified in 11 of 12 performance audits conducted, and it did not issue any corrective action plans related to issues identified in the AUP engagements.

The Commission did not ensure that procedures for identifying issues at MCOs were consistent between the two contracted audit firms.

When performing AUP engagements for the Commission, both contracted audit firms have the same objective of **validating MCOs' financial statistical reports** that the Commission uses to verify the amount of "experience rebates"¹ that MCOs owe. **However, the Commission's requirements for the audit firms to expand** certain tests were different for each of the two firms. The Commission did not require each audit firm to expand those tests to determine whether identified errors were systemic within an **MCO's operations and could materially** affect the accuracy of financial statistical reports.

¹ "Experience rebates" are a portion of an MCO's net income before taxes that is returned to the State in accordance with statute and the uniform managed care contract terms.

The Commission's **Medicaid** CHIP division and the Office of Inspector General did not coordinate audit coverage to minimize duplication of effort.

The Office of Inspector General conducted performance audits on the financial statistical reports of 6 of the 8 MCOs that had been previously evaluated by contracted audit firms during AUP engagements. The Commission paid those contracted audit firms a total of \$236,415 to evaluate those financial statistical reports.

The Commission did not collect all costs for audit-related services.

The Commission did not collect \$2,022,025 (41 percent) of the \$4,950,664 in costs that it incurred for fiscal years 2011 through 2015 for audit-related services for which MCOs were required to reimburse the Commission.

The Commission generally collected rebates from MCOs as required.

The Commission collected \$787,077,260 (99.6 percent) of the \$789,862,545 in experience rebates that MCOs were contractually required to pay the Commission for fiscal years 2011 through 2014. However, it did not resolve in a timely manner the experience rebates that certain MCOs disputed. Specifically, the Commission did not collect \$3,458,395 in required rebates from 3 MCOs for fiscal years 2011, 2012, and 2013 as a result of unresolved disputes.

The Commission should use information from its External Quality Review Organization to strengthen its monitoring of **MCOs' performance**.

The Commission's Health Plan Management unit indicated that it did not receive detailed information available from the Commission's External Quality Review Organization. The Health Plan Management unit could use that detailed information to strengthen its monitoring efforts. Specifically, the detailed information includes performance information on MCOs from Medicaid client surveys, such as ratings on **access to urgent care or Medicaid clients' ratings of their health plans**.

The Commission should strengthen controls over certain information technology systems.

The Commission did not establish adequate information technology controls to ensure that its reconciliations of daily deposits were documented, access to its systems was appropriate, and changes to the systems were documented.

Table 1 presents a summary of the findings in this report and the related issue rating. (See Appendix 2 for more information about the issue rating classifications and descriptions.)

Table 1

Summary of Chapters/Subchapters and Related Issue Ratings		
Chapter/ Subchapter	Title	Issue Rating ^a
1-A	The Commission Should Improve Its Processes for Performance Audits of MCOs	Priority
1-B	The Commission Should Enhance Its Use of Agreed-upon Procedures Engagements to Ensure That Financial Risks Are Consistently Addressed and Identified Issues Are Corrected	High
1-C	The Commission Should Obtain Greater Assurance About the Effectiveness of MCOs' Pharmacy Benefit Managers' Internal Controls and Compliance with State Requirements	Priority
1-D	The Commission Should Improve Coordination of Audit Activities	High
2-A	The Commission Did Not Collect All Costs for Audit-related Services	Medium
2-B	The Commission Collected Experience Rebates in a Timely Manner; However, It Should Improve Certain Collection Activities	Low
3	The Commission Should Use Information That Its External Quality Review Organization Contractor Provides to Strengthen Its Monitoring of MCO Performance	Low
4	The Commission Should Strengthen Its Security and Processing Controls Over Certain Information Technology Systems	Medium

^a A chapter or subchapter is rated Priority if the issues identified present risks or effects that if not addressed could critically affect the **audited entity's ability to effectively administer the program(s)/function(s) audited**. **Immediate action is required** to address the noted concern and reduce risks to the audited entity.

A chapter or subchapter is rated High if the issues identified present risks or effects that if not addressed could substantially affect the **audited entity's ability to effectively administer the program(s)/function(s) audited**. **Prompt action is essential to address** the noted concern and reduce risks to the audited entity.

A chapter or subchapter is rated Medium if the issues identified present risks or effects that if not addressed could moderately affect the **audited entity's ability to effectively administer program(s)/function(s) audited**. **Action is needed to address the noted concern** and reduce risks to a more desirable level.

A chapter or subchapter is rated Low if the **audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited** or the issues identified do not present significant risks or effects that would negatively affect the **audited entity's ability to effectively administer the program(s)/function(s) audited**.

Auditors communicated other, less significant issues in writing to Commission management.

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

At the end of each chapter in this report, auditors made recommendations to address the issues identified during this audit. The Commission generally agreed **with the recommendations in this report. The Commission's management's** responses are presented in Appendix 6.

Audit Objective and Scope

The objective of this audit was to determine whether the Commission and the Office of Inspector General administer selected Medicaid managed care contract management processes and related controls in accordance with contract terms, applicable laws, regulations, and agency policies and procedures.

The scope of this audit covered the Commission's Medicaid managed care contracted audit activities from fiscal year 2011 through fiscal year 2015, performance audits conducted by the Office of Inspector General from fiscal year 2011 through fiscal year **2015, and the Commission's External Quality Review** Organization contract for fiscal years 2014 and 2015.

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Detailed Results

Chapter 1

The Commission Should Improve Its Use of Audit Activities to Monitor MCOs

The Health and Human Services Commission (Commission) contracts with external auditors to perform periodic performance audits and annual agreed-upon procedures (AUP) engagements of Medicaid managed care organizations (MCOs). In addition, the Office of Inspector General conducts performance audits of MCOs. However, the Commission should develop and implement an overall strategy for planning, managing, and coordinating its audit-related resources for verifying information that MCOs report to it. The lack of an overall strategy for auditing MCOs has resulted in gaps in audit coverage, lack of consistent follow-up on audit findings, inconsistent application of procedures, and duplication of effort.

Chapter 1-A

The Commission Should Improve Its Processes for Performance Audits of MCOs

Chapter 1-A
Rating:
Priority²

The Commission uses performance audits to obtain assurance about MCOs' internal controls and compliance. However, the Commission lacks a documented process to determine which MCOs should receive a performance audit and what the scope and objectives of each performance audit should be. While the Commission's contracted audit firms conducted performance audits of 11 MCOs covering fiscal years 2011 and 2015, the Commission did not document why it selected those MCOs to be audited.

The Commission paid contracted audit firms \$1,337,525 to perform risk assessments of MCOs in fiscal years 2011, 2013, and 2015. According to the Commission, it discussed those risk assessments, which identified risk areas for all of the MCOs reviewed, with the contracted audit firms. However, the Commission did not document how it used those risk assessments to determine which MCOs to audit. For example, the Commission did not have documentation showing why it had not audited the MCO that one contracted audit firm identified as the highest risk and recommended be audited.

² The risks related to the issues discussed in Chapter 1-A are rated as Priority because they present risks or results 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.

Without a documented process to determine which MCOs pose the highest risk, the Commission cannot ensure that MCOs that present the greatest risks to Medicaid managed care receive audit coverage. Of the 23 MCOs with active contracts with the Commission from fiscal year 2011 through fiscal year 2015, 12 (52 percent) had not received a performance audit during that time. According to Texas Government Code, Section 531.02412 (a), “the Commission shall make every effort to ensure the integrity of Medicaid. To ensure that integrity, the Commission shall perform risk assessments of every element of the program and audit those elements of the program that are determined to present the greatest risks.” Performance audits are used to provide the Commission with assurance about whether a MCO’s internal controls are operating effectively.

The Commission did not verify that MCOs corrected performance audit findings.

The Commission does not have a documented process for how it should follow up on performance audit findings. For performance audits covering fiscal year 2011 through May 2016, the Commission did not verify or track whether MCOs corrected findings for 11 (92 percent) of 12 performance audits conducted.³ The Commission asserted that it follows up verbally on the status of performance audit findings and recommendations. However, it did not document any follow up, and it also did not require its contracted audit firms to perform follow-up on performance audits.

In addition, the Commission does not have a documented process for determining when a corrective action plan should be issued in response to performance audit findings. For the 12 performance audits discussed above, only 1 MCO received a corrective action plan from the Commission that required the MCO to address the audit findings. For the one performance audit for which the Commission issued a corrective action plan, the findings included issues with subcontractor monitoring. However, three other performance audits for which the Commission did not issue corrective action plans also included findings with subcontractor monitoring. The Commission did not have documentation showing why corrective action plans were not issued for those other audits. Examples of other findings in the 11 performance audits for which the Commission did not issue corrective action plans included problems with MCOs’ claims processing and complaints procedures.

If the Commission does not adequately document its follow-up activities or if it does not consistently issue corrective action plans, it cannot fully ensure the integrity of Medicaid, as required by Texas Government Code, and

³ Eleven of 23 MCOs active from fiscal year 2011 through fiscal year 2015 received performance audits during that time. However, 12 individual performance audits were conducted; and one MCO (Seton Health Plan) received two separate performance audits.

findings at MCOs may not be resolved, which may present greater risks to Medicaid patients and to the State.

Performance audits met certain requirements.

All 12 performance audits conducted by the Commission's contracted audit firms indicated that internal controls and fraud, waste, and abuse at MCOs were considered, as required by generally accepted governmental auditing standards.

Recommendations

The Commission should:

- Document the process it uses to select MCOs to audit.
- Prioritize the highest risk MCOs to audit.
- Include previous audit coverage as a risk factor in selecting MCOs to audit.
- Establish a process to document its follow-up on performance audit findings and verify the implementation of audit recommendations.
- Establish and implement policies and procedures to (1) determine when a corrective action plan should be issued and (2) follow up on MCO implementation of corrective action plans.

Chapter 1-B

The Commission Should Enhance Its Use of Agreed-upon Procedures Engagements to Ensure That Financial Risks Are Consistently Addressed and Identified Issues Are Corrected

Chapter 1-B
Rating:
High⁴

For fiscal years 2011 through 2013, the Commission used agreed-upon procedures (AUP) engagements to ensure that the annual financial statistical reports MCOs submitted to the Commission complied with contractual reporting requirements (see text box for more information on financial statistical reports). The Commission used those reports to determine the amount of experience rebates that MCOs were required to pay to the Commission (see text box for information about experience rebates). However, opportunities exist for the Commission to enhance its use of AUP engagements to identify MCOs' performance and compliance issues and to ensure that the issues identified in AUP engagements are corrected.

To identify systemic issues, the Commission should ensure that certain procedures are performed in a consistent manner by each contracted audit firm.

AUP engagements include procedure steps to verify that certain financial items such as medical claims, pharmacy claims, and administrative expenses are appropriate, accurate, and reported in compliance with applicable requirements. When performing AUP engagements for the Commission during fiscal years 2011 through 2013, both contracted audit firms had the same objective of validating MCOs' financial statistical reports that the Commission uses to verify the amount of experience rebates that MCOs owed. However, the Commission approved different procedures for each contracted audit firm. For example, of the AUP engagements that the State Auditor's Office reviewed:

- The Commission approved different procedures to identify possible systemic errors in the MCOs' financial reports for the two audit firms with which the Commission contracted to perform AUP engagements in fiscal year 2013. The procedures the Commission approved for one contracted audit firm, which evaluated 11 MCOs, required the audit firm to discuss

Financial Statistical Reports

The Commission receives financial statistical reports from MCOs on a quarterly and annual basis as required by the Commission's contracts with the MCOs. Those reports are the primary statements of financial results submitted by MCOs to the Commission. The Commission uses the reports to analyze the MCO's membership, revenues, expenses, and net income by service area and program.

Source: The Commission.

Experience Rebates

Texas Government Code, Section 533.014, requires the Commission to adopt rules that ensure MCOs share profits they earn through the Medicaid managed care program. The Commission has incorporated profit-sharing provisions into its contracts with MCOs that require MCOs to share certain percentages of their net income before taxes with the Commission (see Appendix 4 for more information on how experience rebates are calculated.)

The General Appropriations Act (83rd Legislature), Rider 13, page II-91, requires that experience rebates the Commission receives from MCOs be spent on funding services for Medicaid.

⁴ The risks related to the issues discussed in Chapter 1-B are rated as High because they 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.

with the Commission whether to perform additional tests to determine whether testing errors identified in medical claims, pharmacy claims, and administrative expenses were systemic. For the other contracted audit firm, which evaluated 10 MCOs, the Commission directed the audit firm to expand its testing if identified errors indicated potential systemic problems. However, those expanded testing procedures applied only to issues associated with unallowable administrative expenses. In addition, that audit firm was not required to discuss with the Commission the decision to expand its testing to determine whether issues were systemic.

- The Commission did not require one contracted audit firm to expand its testing to determine the materiality of the total unallowable expenses that audit firm identified. Based on that audit firm's testing of a sample of 75 administrative expenses for fiscal year 2012, that audit firm reported concerns that an MCO reported unallowable expenses that could materially affect the accuracy of its financial statistical report. The audit firm calculated that the identified errors represented \$18,351 of the MCO's reported administrative expenses, which totaled \$6,242,240.

The Commission did not issue any corrective action plans related to AUP engagements.

The Commission does not have a process to issue corrective action plans to correct performance or noncompliance issues identified in AUP engagements. In the AUP engagements, the contracted audit firms identified payment inaccuracies with medical claims, pharmacy claims, and administrative expenses reported on MCOs' financial statistical reports. In addition, some AUP engagements also identified performance and noncompliance issues with Medicaid program requirements and other contract requirements, such as processing errors with medical claims (for example, late payments and failure to pay interest charges) or inappropriately charging processing fees to pharmacies.

The Commission's use of AUP engagement findings was limited to recalculating experience rebates based on the identified errors. The Commission asserted that, if a finding results in additional experience rebates, it also will assess the MCO an interest charge on the additional amount owed.

Recommendations

The Commission should:

- Ensure that financial risks identified in AUP engagements are adequately and consistently addressed.
- Establish policies and procedures for determining when a corrective action plan should be issued for AUP engagements.

Chapter 1-C

The Commission Should Obtain Greater Assurance About the Effectiveness of MCOs' Pharmacy Benefit Managers' Internal Controls and Compliance with State Requirements

Chapter 1-C
Rating:
Priority⁵

Transfer of Managing Managed Care Pharmacy Benefits from the Commission to MCOs

Effective March 2012, most Medicaid clients and all **Children's Health Insurance Program** (CHIP) clients began obtaining their prescription drug benefits through an MCO, as required by Senate Bill 7 (82nd Legislature, First Called Session). Outpatient prescription drugs are a benefit of each of the following Medicaid managed care programs: State of Texas Access Reform (STAR), STAR+PLUS, and STAR Health.

Each MCO has its own participating pharmacy network comprising pharmacies contracted with the Commission to allow local pharmacies to dispense medications to managed care members. The MCO contracts with a pharmacy benefit manager (PBM) to process prescription claims, and the PBM contracts and works with pharmacies that dispense medications to Medicaid managed care members.

MCOs and PBMs are required by state law to adhere to the Commission's Vendor Drug Program's list of preferred and non-preferred prescription medications for Medicaid formularies until August 31, 2018.

Source: *Texas Medicaid and CHIP in Perspective*, Tenth Edition, Health and Human Services Commission, February 2015.

The Commission's oversight of the MCOs' pharmacy benefit managers (PBMs) relies on a combination of monitoring self-reported information from MCOs and limited verification of selected portions of that self-reported

information through annual AUP engagements performed by contracted audit firms. The Commission has not conducted a performance audit of PBM contractors since fiscal year 2012. As a result, it has limited assurance about the effectiveness of PBMs' internal controls and compliance with Commission requirements. In addition, the Commission has not verified whether PBMs have corrected findings from the one performance audit conducted on MCO's PBMs since MCOs became responsible for managing pharmacy benefits in 2012 (see text box for more information). The Commission also relies on MCOs' management assertions that the findings identified in AUP engagements have been addressed. MCOs paid \$235,199,287 to PBMs from March 2012 through August 2015 to administer \$7.4 billion in prescription benefits (see Appendix 5 for more information).

The Commission receives self-reported information from MCOs each quarter, and the Commission asserted that it relies on that information and the results from AUP engagements to determine whether PBMs comply with pharmacy benefit requirements. However, as discussed in Chapter 1-B, the Commission's use of AUP engagements primarily focuses on validating financial statistical reports that the Commission uses to verify the amount of experience rebates that MCOs owed.

The AUP engagement procedures that covered PBM activity during fiscal year 2013⁶ did not include PBM compliance with requirements in areas such as pharmacy network adequacy or drug utilization.

The limited procedures that the Commission has approved for AUP engagements related to PBMs indicate the need for greater assurance about

⁵ The risks related to the issues discussed in Chapter 1-C are rated as Priority because they present risks or results 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.

⁶ The AUP engagements covering fiscal year 2013 financial statistical reports were the most recently completed AUP engagements as of February 2016.

PBM internal controls and compliance with state requirements. For example:

- The contracted audit firms identified seven MCOs whose PBMs charged pharmacy transactions fees for processing pharmacy claims, which is not allowed by the Commission's contract with the MCOs.
- AUP engagements completed on 11 MCOs during fiscal year 2013 determined that there was not a complete audit trail of claims the PBM paid to pharmacies and the contracted auditor was unable to verify the accuracy of pharmacy expenses.

The Commission did not issue any corrective action plans to MCOs to require them to correct performance or noncompliance issues related to PBMs identified in AUP engagements.

The Commission has **performed only one performance audit of MCOs' PBMs**, and the scope of that audit was limited to two months.

Since MCOs became responsible for managing pharmacy benefits in March 2012, the Commission has performed only one performance audit of MCOs' PBMs (the cost for that audit was \$120,785). While that performance audit included three PBMs that subcontracted with five MCOs, the scope was March 2012 through April 2012, which were the first two months after MCOs became responsible for managing Medicaid pharmacy benefits.

That 2012 performance audit concluded that PBMs were complying with certain transparency standards and that a test sample of pharmacy claims payments were accurate. However, that audit also determined that PBMs were not complying with the Commission's preferred drug list and prior authorization requirements. The Commission did not perform any follow-up audits or independently verify that those PBMs had taken corrective action to ensure compliance with the requirements identified.

Recommendations

The Commission should:

- Conduct periodic audits of MCOs' PBM contractors or require MCOs to conduct periodic audits of their PBM contractors.
- Develop, document, and implement a monitoring process to ensure that MCOs satisfactorily correct and resolve findings reported in performance audits and AUP engagements of PBM contractors.

Chapter 1-D
The Commission Should Improve Coordination of Audit Activities

Chapter 1-D
Rating:
High⁷

The Commission should ensure that its Medicaid Children's Health Insurance Program (CHIP) Division and its Office of Inspector General coordinate audit activities involving MCOs to minimize duplication of effort. Specifically, 6 (75 percent) of the 8 MCO performance audits that the Office of Inspector

Texas Government Code,
Sections 531.102(w) and
531.1025

Effective September 1, 2015, Texas Government Code, Sections 531.102(w) and 531.1025, required that the Office of Inspector General coordinate all audit and oversight activities relating to providers, including the development of audit plans, risk assessments, and findings, with the Commission to minimize the duplication of activities.

General performed between fiscal years 2011 and 2015 included reviews of an MCO's financial statistical reports that had been previously reviewed in an AUP engagement contracted by the Commission's Medicaid CHIP Division. Texas Government Code, Sections 531.102(w) and 531.1025, require the Commission to coordinate all audit activities to minimize duplication of effort (see text box). The Commission paid the contracted audit firms \$236,415 for those six AUP engagements.

For those six audits, the Office of Inspector General reviewed the same financial statistical reports for the same time periods as the contracted audit firms. The Office of Inspector General reported inaccuracies in the MCOs' financial reports, including experience rebate adjustments for three MCOs that totaled \$303,895. While the Office of Inspector General and the contracted audit firms identified similar types of findings, the financial effects identified by each report were different. In addition, the Office of Inspector General's audit reports were released after the AUP engagements were completed.

Table 2 on the next page shows the six audits for which the Commission's contracted audit firms and the Office of Inspector General reviewed the same financial statistical reports for the same time periods.

⁷ The risks related to the issues discussed in Chapter 1-D are rated as High because they 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.

Table 2

Six MCO Audits the Office of Inspector General Performed That Also Had a Contracted AUP Engagement				
MCO Audited	Office of Inspector General Report Release Date	Contracted Audit Firm Report Release Date	Time Between Reports Released	Audit Scope
Amerigroup Texas, Inc.	August 28, 2015	March 31, 2015	150 days	March 1, 2012, through August 31, 2013
Community Health Choice	December 21, 2015	December 2, 2014	384 days	March 1, 2012, through August 31, 2013
Cook Children's Health Plan	August 3, 2015	January 11, 2013	934 days	September 1, 2010, through August 31, 2011
Driscoll Health Plan	November 25, 2013	November 27, 2012	363 days	September 1, 2010, through August 31, 2011
Molina Healthcare of Texas, Inc.	March 4, 2015	February 5, 2013	757 days	September 1, 2010, through August 31, 2011
Parkland Community Health Plan	November 17, 2014	January 4, 2013	682 days	September 1, 2010, through August 31, 2011

Source: Office of Inspector General.

Improved coordination between the Office of Inspector General and the Medicaid CHIP Division could help to ensure the efficient use of the Commission's resources.

Recommendation

The Commission should improve the coordination of audit activities between its Medicaid CHIP Division and the Office of Inspector General to minimize duplication of audit coverage of MCOs.

The Commission Should Improve Its Processes for Collecting Reimbursements of Costs Related to Its Contracted Audit Services and Collecting Experience Rebates

The Commission should improve its process for collecting reimbursements from MCOs for contracted audit services. Those services are performed to determine MCOs' compliance with certain state and contract requirements for the Medicaid managed care program, including certain financial reporting requirements that help ensure the accuracy and completeness of experience rebates MCOs may owe the Commission.

In addition, the Commission should improve its processes for collecting experience rebates. The Commission collected \$787,077,260 in experience rebates that MCOs owed to it. However, opportunities exist for the Commission to improve its collection process to ensure that all experience rebates that MCOs owe are collected and deposited in the Commission's Medicaid program accounts in a timely manner.

Chapter 2-A

The Commission Did Not Collect All Costs for Audit-related Services

Chapter 2-A
Rating:
Medium⁸

The Commission did not consistently collect reimbursements for all of its costs from MCOs for contracted audit firms' audit-related services conducted on MCOs' operations and financial reports. Specifically, the Commission did not collect \$2,022,025 (41 percent) of the \$4,950,664 in costs that MCOs were required to reimburse to the Commission for fiscal years 2011 through 2015. In addition, the Commission did not request reimbursement from MCOs for \$1,176,428 (58 percent) of the \$2,022,025 uncollected amount (see Table 3 on the next page).

⁸ The risks related to the issues discussed in Chapter 2-A are 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.

Table 3

Reimbursements for Audit-related Costs as of May 2016 ^a					
Contracted Service	The Commission's Total Cost	Amount the Commission Collected	Amount Outstanding as of May 2016		Outstanding Amount (Percent of the Commission's Total Cost)
			Billed	Not Billed	
Risk Assessment	\$ 1,337,525	\$ 328,280	\$114,334	\$ 894,911 ^b	75%
Performance Audit	1,401,652	711,209	427,901	262,542 ^c	49%
AUP Engagement	2,211,487	1,889,150	303,362	18,975 ^d	15%
Totals	\$4,950,664	\$2,928,639	\$845,597	\$1,176,428	41%

^a Amounts presented for risk assessments and performance audits include amounts due for contracted audit firms' services on both Medicaid and CHIP programs. The audit services for those contracted audits cannot be separated by Medicaid- and CHIP-related programs. However, AUP engagement totals in Table 3 represent amounts only for Medicaid-related engagements.

^b Amount includes \$441,490 for 16 risk assessments covering fiscal years 2010 and 2011 for which the contracted audit firms invoiced the Commission in May 2011 and August 2011; \$237,567 for 10 risk assessments covering fiscal year 2013 for which one contracted audit firm invoiced the Commission in December 2013; and \$215,854 for 11 risk assessments covering fiscal year 2015 for which one contracted audit firm invoiced the Commission in October and November 2015.

^c Amount includes \$147,538 for one performance audit covering fiscal years 2011 and 2012 for which one contracted audit firm invoiced the Commission in March 2013, and one performance audit for \$115,004 covering fiscal years 2012 and 2013 for which one contracted audit firm invoiced the Commission in May 2013.

^d Amount is for one AUP engagement covering fiscal year 2013 for which the contracted audit firm invoiced the Commission in June 2015.

Source: Invoices and payment documentation provided by the Commission.

The Commission's contract with MCOs specifies that each MCO agrees to pay for all reasonable costs the Commission incurs to perform an examination, review, or audit of the MCO's books relating to the contract.

Recommendation

The Commission should develop, document, and implement billing processes within its Medicaid/CHIP Division to ensure that MCOs reimburse the Commission for audit-related services as required.

Chapter 2-B

The Commission Collected Experience Rebates in a Timely Manner; However, It Should Improve Certain Collection Activities

Chapter 2-B

Rating:

Low ⁹

The Commission collected \$787,077,260 (99.6 percent) of the \$789,862,545 in experience rebates that MCOs owed the Commission for fiscal years 2011 through 2014. Opportunities exist for the Commission to strengthen its collection process to ensure that:

- All experience rebates that the Commission collects are deposited in Medicaid and CHIP program accounts¹⁰ in a timely manner.
- All MCOs' disputes of experience rebates owed to the Commission are followed up on and resolved in a timely manner.

The Commission should ensure that it consistently transfers experience rebates that were deposited into its suspense fund to Medicaid and CHIP program accounts in a timely manner.

Suspense Fund

A suspense fund is established to separately account for certain receipts pending their distribution or disposal.

Source: Office of the Comptroller of Public Accounts.

The Commission did not ensure that it accurately and completely transferred all experience rebates deposited in its suspense fund to Medicaid and CHIP program accounts in a timely manner (see text box for more information about a suspense fund). As of February 29, 2016, the Commission had 30 experience rebates that totaled \$153,057,379 deposited in its suspense fund. Eight of those 30 experience rebates had been held in the suspense fund for at least 179 days. Those eight experience rebates totaled \$27,617,250; one of those rebates, totaling \$273,681¹¹, had been in suspense for 420 days.

The Commission does not have a documented process to follow up on and resolve experience rebates disputed by MCOs.

The Commission does not have a documented process to follow up on and resolve experience rebates disputed by MCOs. For example, the Commission did not resolve or collect \$3,458,395¹² in experience rebates from 3 MCOs during fiscal years 2011 through 2013.

⁹ The risks related to the issues discussed in Chapter 2-B are 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.

¹⁰ For MCOs that provide services under CHIP, payments for experience rebates included amounts for the Medicaid and CHIP programs. Auditors determined that payments for experience rebates in the suspense fund are approximately 90 percent for the Medicaid program and 10 percent for the CHIP program.

¹¹ The \$273,681 amount in suspense was a partial amount of an experience rebate payment that totaled \$45,310,794. The Commission was unable to explain why the full amount of the experience rebate had not been transferred from its suspense fund to the appropriate Medicaid and CHIP accounts.

¹² This amount is not the difference between the total amount assessed and the total amount collected because it does not include refunds that the Commission may pay MCOs pending the completion of financial examinations. As of May 2016, the refunds paid for fiscal years 2011 through 2014 totaled \$111,529.

Recommendations

The Commission should develop, document, and implement monitoring processes within its Medicaid/CHIP Division to ensure that:

- It identifies experience rebates deposited in the Commission's suspense account and transfers those rebates to the appropriate Medicaid and CHIP program accounts in a timely manner.
- It follows up on and resolves in a timely manner experience rebates disputed by MCOs.

Chapter 3

The Commission Should Use Information That Its External Quality Review Organization Contractor Provides to Strengthen Its Monitoring of MCO Performance

Chapter 3
Rating:
Low¹³

External Quality Review Organization (EQRO)

The Commission's EQRO contractor is the Institute for Child Health Policy with the University of Florida. Federal law requires state Medicaid programs to contract with an EQRO to help evaluate Medicaid managed care programs.

The EQRO assesses care provided by MCOs by conducting ongoing evaluations of the quality of care provided primarily using MCO administrative data, including claims data. The EQRO also reviews MCO documents and provider medical records; conducts interviews with MCO administrators; and conducts surveys of Texas Medicaid and CHIP members, caregivers of members, and providers.

Sources: *Texas Medicaid and CHIP in Perspective*, Tenth Edition, February 2015; and the Commission.

The Commission's Health Plan Management unit is responsible for monitoring activities of MCOs. The Health Plan Management unit asserted that it receives and reviews a summary report of member surveys from the Commission's External Quality Review Organization (EQRO) contractor (see text box for more information about the EQRO). The Commission reviewed and approved all invoices, totaling \$2.6 million, that auditors tested for certain deliverables provided by the EQRO contractor during fiscal years 2014 and 2015.

However, the Health Plan Management unit did not document how it used reports from the EQRO in monitoring MCOs. In addition, the Health Plan Management unit indicated that it did not receive more detailed information about member surveys that the contractor provides to the Commission. That Health Plan Management unit could use that detailed information to strengthen its monitoring efforts. Specifically, the detailed information includes performance information on MCOs from Medicaid client surveys, such as ratings on access to urgent care or Medicaid clients' ratings of their health plans. The Commission does not have a process to track summary performance information the Health Plan Management unit receives, and it does not have a process to communicate the detailed performance information to the Health Plan Management unit.

The Commission's request for proposals for the EQRO contract stated that part of the Commission's desired mission was to improve the health of Texans by monitoring consumer satisfaction, monitoring the quality of care provided to consumers, and measuring the performance of MCOs participating in Texas Medicaid programs. If the Commission does not use the results from the member surveys that its EQRO contractor provides and document the results of its monitoring, there is an increased risk that MCOs will not address Medicaid clients' concerns.

The Commission also does not use the validation results of paid claims data from the EQRO contractor to monitor MCO performance. In the validation process, the EQRO contractor matches paid claims data with medical records

¹³ The risks related to the issues discussed in Chapter 3 are rated as Low because the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

it obtains from providers and reports on discrepancies in the data. The Commission could use the validation results to help monitor MCO performance by considering the amount of discrepancies as a risk factor in its monitoring of MCOs. The *State of Texas Contract Management Guide* states that monitoring a contractor's performance to ensure that the contractor is performing all duties required and that all developing problems are addressed is a key function of proper contract administration.

Recommendation

The Commission should use member survey results, including detailed data, and the validation results of paid claims data, to enhance its monitoring of MCOs and document how it uses that information in its monitoring efforts.

The Commission Should Strengthen Its Security and Processing Controls Over Certain Information Technology Systems

Chapter 4
Rating:
Medium¹⁴

Auditors reviewed the Commission's Accounts Receivable Tracking System (ARTS), which the Commission uses to track experience rebates and payments collected from MCOs. Auditors reviewed controls over user access, password security, change management, and data processing for ARTS. The Commission did not establish controls to ensure that data recorded in ARTS matches data in the Health and Human Services Accounting System (HHSAS) and the Uniform Statewide Accounting System (USAS). Auditors also identified weaknesses in the Commission's change management process for ARTS.

In addition, the Commission should strengthen its user access controls for ARTS and certain network folders that the Commission uses to manage experience rebate collections. To minimize security risks, auditors communicated details about the user access weaknesses for ARTS and network folders directly to Commission management.

The Commission should ensure that it documents its reconciliations of deposits recorded in ARTS to deposit records in HHSAS and USAS.

The Commission did not document its reconciliations to show that it verified that daily deposits recorded in ARTS were processed accurately and completely in HHSAS and USAS. The Commission asserted that its accounts receivable staff (1) generated daily reports showing the previous day's transactions processed in ARTS, HHSAS, and USAS and (2) performed a reconciliation. However, it did not have a process to document those reconciliations. As a result, the Commission could not provide documentation to support its assertion that reconciliations were performed. Without documenting the daily reconciliations among ARTS, HHSAS, and USAS, the Commission cannot ensure that reconciliations are performed consistently and that errors detected during reconciliations are corrected.

The Commission should ensure that its information technology contractor documents programming changes made to ARTS and that Commission management authorizes those changes.

The Commission did not maintain proper documentation of programming changes to ARTS. The Commission did not maintain a comprehensive list of requested, reviewed, and approved changes to ARTS. Specifically, when the information technology contractor made programming changes to ARTS, the

¹⁴ The risks related to the issues discussed in Chapter 4 are rated as Medium because they present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.

Commission did not ensure that the information technology contractor (1) documented a description of the user testing of the changes, including the results of that testing, and (2) obtained the Commission's documented authorization to make the changes. Without maintaining a complete list of changes, there is an increased risk that unauthorized changes may be made in the system.

Recommendations

The Commission should:

- Strengthen user access controls for ARTS and certain network folders that the Commission uses to manage experience rebate collections.
- Require its accounts receivable staff to document daily reconciliations of deposits recorded in ARTS to the transactions processed in HHSAS and USAS.
- Develop, document, and implement a process to ensure that all programming changes to ARTS and the authorization and testing of those changes are formally documented.

Appendices

Appendix 1

Objective, Scope, and Methodology

Objective

The objective of this audit was to determine whether the Health and Human Services Commission (Commission) and the Office of Inspector General administer selected Medicaid managed care contract management processes and related controls in accordance with contract terms, applicable laws, regulations, and agency policies and procedures.

Scope

The scope of this audit covered the Commission's Medicaid managed care contracted audit activities from fiscal year 2011 through fiscal year 2015, performance audits conducted by the Office of Inspector General from fiscal year 2011 through fiscal year 2015, and the Commission's External Quality Review Organization (EQRO) contract for fiscal years 2014 and 2015.

Methodology

The audit methodology included reviewing results of contracted audit activities of managed care organizations (MCO), as well as performance information from the Commission's EQRO contractor.

Audit work included collecting and reviewing the Commission's agreed-upon procedures (AUP) engagements and performance audits related to MCOs, the Commission's payments to the contracted audit firms for audit services, the Commission's reimbursements from MCOs for audit services, and support for certain deliverables from the EQRO contract.

Data Reliability and Completeness

Accounts Receivable Tracking System (ARTS). Auditors tested receipt of experience rebates in ARTS. Auditors also tested general controls, including access, change management, and password settings. Auditors determined that ARTS data was of undetermined reliability because of weaknesses in user access and change management controls.

The Commission's spreadsheets for calculating and tracking experience rebates. Auditors tested calculations in the experience rebate spreadsheet templates. Auditors also tested general controls such as password configuration and user access. Auditors determined that the spreadsheets were of undetermined reliability due to issues identified related to user access.

Sampling Methodology

Auditors selected a nonstatistical random sample of 16 reimbursements to test the accuracy and completeness of reimbursements for contracted audit-related services recorded in ARTS. The sampled items were generally not representative of the population and, therefore, it would not be appropriate to project those test results to the population.

Information collected and reviewed included the following:

- The Commission's AUP reports related to MCOs.
- The Commission's engagement letters with contracted audit firms.
- Reports from the Commission's performance audits of MCOs.
- Risk assessments prepared by external audit firms.
- Invoices from audit firms for contracted audit services.
- Proof of payment to the Commission for contracted audit services.
- Experience rebate calculations and payments.
- The Commission's contract with the EQRO.
- MCO report cards and member surveys.
- Invoices and proof of payment to the EQRO.
- The EQRO's methodology for validation of paid claims data.
- Office of Inspector General performance audit reports.
- User access lists to the ARTS database.
- User access lists to network folders for experience rebate spreadsheets.

Procedures and tests conducted included the following:

- Interviewed Commission and Office of Inspector General staff.
- Interviewed staff at the Commission's contracted audit firms.
- Reviewed Commission policies and procedures.
- Reviewed results of the Commission's performance audits of MCOs.
- Reviewed results of the AUP engagements of MCOs.
- Reviewed audit procedures and risk assessments for the Commission's performance audits of MCOs.
- Reviewed reimbursements from MCOs to the Commission for contracted audit services.
- Verified experience rebate and recovery calculations and reviewed payment information the Commission received from MCOs.
- Performed analysis of AUP engagement procedures and verified whether the Commission approved the procedures.
- Reviewed the Commission's performance audit of its pharmacy benefit manager.
- Reviewed the Commission's contract with the EQRO and deliverables related to claims data verification, member surveys, and MCO report cards.
- Reviewed invoices and proof of payment to the EQRO.
- Tested user access to the ARTS database.
- Tested user access to network folders for experience rebate spreadsheets.
- Tested change management and password security in the ARTS database.
- Reviewed data processing controls in ARTS.

Criteria used included the following:

- Texas Government Code, Sections 531.02412 and 531.102.
- Title 1, Texas Administrative Code, Chapter 202.
- The Office of the Comptroller of Public Accounts' *Reporting Requirements for Fiscal 2016 Annual Financial Reports of State Agencies and Universities, Agency Funds*.
- The Commission's *Uniform Managed Care Terms and Conditions*.
- *State of Texas Contract Management Guide*, version 1.10.
- *Government Auditing Standards*, 2011 Revision, U.S. Government Accountability Office.

Project Information

Audit fieldwork was conducted from December 2015 through August 2016. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

- Kristyn Hirsch Scoggins, CGAP (Project Manager)
- Willie J. Hicks, MBA, CGAP (Assistant Project Manager)
- Salem Chuah, CPA
- Katherine M. Curtsinger
- Allison Fries
- Steven M. Summers, CPA, CISA, CFE
- Dennis Ray Bushnell, CPA (Quality Control Reviewer)
- John Young, MPAff (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 4 provides a description of the issue ratings presented in this report.

Table 4

Summary of Issue Ratings	
Issue Rating	Description of Rating
Low	The audit identified strengths that support the audited entity's ability to administer the program(s)/function(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.
Medium	Issues identified present risks or effects that if not addressed could <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.

The Commission's Payments to MCOs

The Health and Human Services Commission (Commission) paid a total of \$35,723,212,549 to managed care organizations (MCOs) from fiscal year 2013 through fiscal year 2015 for Medicaid expenses. Table 5 lists the MCOs, including dental maintenance organizations, that received payment during that time period.

Table 5

Amounts the Commission Paid to MCOs		
Fiscal Year 2013 through Fiscal Year 2015		
Aetna Health, Inc.	\$	635,458,500
Amerigroup Insurance Company		2,552,115,297
Health Care Service Corporation (doing business as Blue Cross Blue Shield of Texas)		162,857,308
CHRISTUS Health Plan		73,048,721
Community First Health Plans, Inc.		749,846,561
Community Health Choice		1,913,732,756
Cook Children's Health Plan		725,096,743
DentaQuest USA Insurance Company		1,937,303,895
Driscoll Health Plan		1,078,466,054
El Paso First Health Plans, Inc.		404,027,241
CignaHealthSpring		1,178,919,816
MCNA Dental Insurance Company (doing business as MCNA Dental)		1,540,821,212
Molina Healthcare of Texas		3,973,096,009
Parkland Community Health Plan, Inc.		1,406,110,463
Scott & White Health Plan		359,384,365
Sendero Health Plans, Inc.		101,011,319
Seton Health Plan		105,022,017
SHA, LLC (doing business as FirstCare)		869,706,793
Superior HealthPlan ^a		12,025,719,599
Texas Children's Health Plan, Inc.		2,144,891,875
UnitedHealthcare		1,786,576,005
	Total	\$ 35,723,212,549

^a Includes payments to Bankers Life Insurance of Wisconsin and Superior Health Plan, Inc. According to the Centene Corporation Web site and the U.S. Securities and Exchange Commission Web site, Bankers Reserve Life Insurance Company of Wisconsin and Superior HealthPlan are subsidiaries of Centene Corporation.

Sources: Uniform Statewide Accounting System and MCO or company Web sites.

Calculating Experience Rebates

The Health and Human Services Commission (Commission) included in its contracts with managed care organizations (MCOs) the requirements for calculating experience rebates in Texas Government Code, Section 533.014. (See Chapter 1-B for more information on that statute.)

According to the Commission's contracts with MCOs, an MCO must pay an experience rebate to the Commission if the MCO's net income before taxes exceeds a certain percentage, as defined by the Commission, of the total revenue a MCO receives each fiscal period. The experience rebate is calculated in accordance with a tiered rebate method that the Commission defines (see Table 6). The tiers are based on the consolidated net income before taxes for all of the MCO's Medicaid program and Children's Health Insurance Program service areas that are included in the scope of the contract, as reported on the MCO's financial statistical reports (which the Commission should review and confirm).

Table 6

Tiers for Experience Rebates		
Pre-tax Income as a Percent of Revenues	MCO Share	The Commission's Share
Less than or equal to 3 percent	100 percent	0 percent
Greater than 3 percent and less than or equal to 5 percent	80 percent	20 percent
Greater than 5 percent and less than or equal to 7 percent	60 percent	40 percent
Greater than 7 percent and less than or equal to 9 percent	40 percent	60 percent
Greater than 9 percent and less than or equal to 12 percent	20 percent	80 percent
Greater than 12 percent	0 percent	100 percent

Source: The Commission's *Uniform Managed Care Terms and Conditions*.

Pharmacy Benefit Managers' Financial Information

Table 7 shows the financial activity that all managed care organizations (MCOs) reported to the Health and Human Services Commission (Commission) for managing pharmacy benefit managers from March 2012 through August 2015.

Table 7

Financial Information for Pharmacy Benefit Managers Reported by All MCOs	
March 2012 through August 2015	
Type of Financial Activity	Total
Pharmacy premiums that MCOs received from the Commission	\$8,102,949,089
Prescription expenses	\$7,413,793,743
Administrative expense - pharmacy benefit manager contractors	\$235,199,287

Source: The Commission.

The Commission's Management's Response

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HHSC Management Responses

Overall Conclusion

The Health and Human Services Commission (Commission) should develop and implement an overall strategy for planning, managing, and coordinating audit resources that it uses to verify the accuracy and reliability of program and financial information that managed care organizations (MCOs) report to it. The lack of an overall strategy has resulted in gaps in audit coverage of MCOs, lack of consistent follow-up on audit findings, inconsistent application of procedures, and duplication of effort.

Overall Management Comments

The Commission operates under a collaborative approach in which several areas within the Medicaid and CHIP Services Department as well as the HHSC Inspector General, oversee specified Medicaid managed care contract requirements.

The Commission has designated resources for major contract monitoring requirements such as: Health Plan Management who is responsible for overall operations; Financial Reporting and Audit Coordination for financial reporting; Operations Coordination for encounter data; Program Support and Utilization Management for long term care utilization; Vendor Drug for prescription benefits; Contract Compliance and Support for assessment of actual remedies; as well as the Inspector General for special investigation units of the MCOS.

While Health Plan Management serves as the centralized unit responsible for managing the MCO day-to-day operational aspects of the Medicaid and CHIP managed care programs, the knowledge and expertise of subject matter experts within the Health and Human Services System (HHS System) are essential for successful operation of the Medicaid and CHIP programs.

A holistic assessment of performance monitoring takes place on a routine basis. Specific contractual requirements are assigned to the various units based on area of expertise. The responsible area monitors MCO performance, conducts analysis, and recommends remedies, including liquidated damages and corrective action. On a quarterly basis, the appropriate areas conduct an overall assessment of each MCO based on performance for the specified timeframe and information is presented to Medicaid/CHIP executive management before execution of recommendations.

Chapter 1 - Audit Activities used to Monitor MCOs

Chapter 1-A - Performance Audits of MCOs

Recommendations

The Commission should:

- Document the process it uses to select MCOs to audit.
- Prioritize the highest risk MCOs to audit.
- Include previous audit coverage as a risk factor.

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- Establish a process to document its follow-up on performance audit findings and verify the implementation of audit recommendations.
- Establish and implement policies and procedures to (1) determine when a corrective action plan should be issued and (2) follow-up on MCO implementation of corrective action plans.

HHSC Management Response

The Commission is in agreement with the finding and associated recommendations and offer the following response.

Health Plan Management developed a desk manual with established standard operating procedures to provide defined processes and to ensure consistency across MCOs. Since the implementation of the revised desk manual in 2015, Health Plan Management continues to add new standard operating procedures in an effort to proactively provide consistent documented guidance while maintaining existing processes. Health Plan Management initiated the development of a process to guide the prioritization of MCO risk and audit activity as well as a documented process for follow-up on performance audit findings from initiation of remedies through implementation of audit recommendations.

Health Plan Management established procedures to routinely review data reported by the MCO, data produced by the Commission, and audit findings in order to provide cross-analysis of information for determining and prioritizing risk. Quarterly Reporting elements are reviewed quarterly to identify non-compliance with defined performance standards and corrective action. HPM will develop procedures to utilize risk assessments conducted to identify MCO(s) with the highest risk in order to prioritize performance audits.

Health Plan Management operates a robust process for managing complaints and/or inquiries received from Medicaid contracted providers, other state agencies, government officials, and the Medicaid and CHIP Department. This process provides direct insight of trends and possible non-compliance which could require prompt corrective action throughout the Medicaid managed care programs

MCO claims processing performance is monitored and assessed quarterly for non-compliance requiring corrective action and helps identify risks by service type (i.e. acute care, behavioral health, dental, long term care, pharmacy, and vision). This separation of claims by types of service allows for identification of specific potential areas of concern that might be obscured if all claims were monitored together.

The Medicaid managed care contracts specifically provide the Commission the ability to conduct additional readiness reviews and monitoring efforts on MCOs as determined necessary. To enhance the process the Commission plans to complete the following:

- Document processes utilized for the performance audit selection of MCOs.
- Establish a process to include prioritization by MCO risk level using data and information gathered through agency monitoring of MCOs.

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HHSC Management Responses

- Establish a process to include consideration of risks from previous audit findings.
- Develop standard operating procedures to document follow-up monitoring efforts for performance audit findings to include verification of implementation of audit recommendations.
- Develop standard operating procedures to include Corrective Action Plan (CAP) issuance determination and monitoring efforts.

Implementation Date:

July 2017

Responsible Person:

Director of MCD Health Plan Management

Chapter 1-B - Agreed Upon Procedure Engagements

Recommendations

The Commission should:

- Ensure that financial risks identified in AUP engagements are adequately and consistently addressed.
- Establish policies and procedures for determining when a corrective action plan should be issued for AUP engagements.

HHSC Management Response - Consistency

The Commission is in agreement with the finding and associated recommendations and offer the following response.

HHSC is committed to achieving effective and consistent identification of any financial risks which may exist within the MCOs participating in the Medicaid and CHIP programs. HHSC has required the audit firms to align the Agreed Upon Procedures (AUPs) between firms to provide a more consistent evaluation of the MCOs (completed for FY 2014 AUPs and planned for FY 2015 AUPs). The Commission has discussed with the audit firms planned actions when errors are identified in either the claims or administrative sample selections (expanding testing, noting the availability of MCO data, and/or administrative penalties and possible termination of the contract, etc.).

HHSC plans to implement a consolidated Financial Statistical Report for SFY 2016 to allow the audit firms to efficiently test expense captions using a statistically valid sample so that error rates can be extrapolated to the entire population, thus eliminating the need to perform expanded testing in most circumstances. This process will completely align sampling procedures for all MCOs and among the audit firms.

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Audit of Medicaid Managed Care Contract Processes at the Health and Human Services Commission
HHSC Management Responses

Implementation Date:

December 2016

Responsible Person:

Director of MCD Financial Reporting and Audit Coordination

HHSC Management Response- Corrective Action Plans

HHSC agrees that formal CAPs can be effective in improving contractor performance. However they are not necessarily required to address all findings identified by the audit firms through the AUP engagements. HHSC's contractor monitoring includes a two-step follow-up process in the existing engagements that is intended to ensure findings are addressed by the MCOs. This process starts with requiring each MCO to provide management responses to the findings detailed in the AUP reports. These management responses become part of the reports and are intended to outline the MCOs' agreement or disagreement with the findings, and how the MCO will correct any deficiencies in controls and processes to address the issue. The audit firms are responsible for providing auditor follow-up comments to these management responses if the MCO does not sufficiently address the finding to ensure the proper action is taken to resolve the issue. The second step in the follow-up process is an AUP procedure, which states "Obtain copies of the MCOs 2013 FSR attestation reports and review the MCO management responses to identify the corrective actions that were to be implemented. Through inquiry of the MCO management, determine the nature, timing, and extent of efforts to remediate the cause of prior year recommendations. Document whether such efforts were consistent with the management response provided in the prior year report." This procedure step is applied at the start of the next year's AUP engagement and is intended to follow-up on the MCOs actions to fully address the prior year's AUP findings.

MCOs might have repeat findings over multiple fiscal years, and while this is reasonable for a second year since the AUP reports are not issued until close to or after the next year's 334-day FSRs are submitted, many findings are repeated beyond the second year. Going forward, HHSC will issue CAPs to ensure that repeat findings do not occur.

In order to ensure that findings are fully addressed and corrected HHSC will issue CAPs when appropriate.

HHSC will collaborate with its audit contractors and MCD Contract Compliance and Support at the end of each audit cycle and will pay special attention to findings which are repetitive in nature or are demonstrative of a pattern of non-compliance. HHSC will also evaluate findings with respect to recent MCO Risk Assessments that have been conducted to determine if the finding falls into a category or function that has been identified as high risk. HHSC will also consider the MCO's demonstrated performance in preparing and submitting quarterly financial deliverables.

STATE AUDITOR'S OFFICE (SAO)
Audit of Medicaid Managed Care Contract Processes at the Health and Human Services Commission
HHSC Management Responses

HHSC will develop a plan for monitoring ongoing MCO progress in implementing each CAP. In addition AUP procedure step #1 will be revised to require the audit firm to follow-up and report on the progress the MCO has made on implementing the formal CAP submitted in response to the prior year's report.

Implementation Date:

September 2017 for FY 2015 AUP assignments

Responsible Person:

*Director of MCD Financial Reporting and Audit Coordination
Deputy Director of MCD Contract and Performance Management*

Chapter 1-C - MCO Pharmacy Benefits Manager Internal Control and Compliance

Recommendations

The Commission should:

- Conduct periodic audits of MCOs' pharmacy benefit manager contractors or require MCOs to conduct periodic audits of their pharmacy benefit manager contractors.
- Develop, document, and implement a monitoring process to ensure that MCOs satisfactorily correct and resolve findings reported in performance audits and AUPs of pharmacy benefit manager contractors.

HHSC Management Response - AUPs

The Commission is in agreement with the finding and associated recommendations and offer the following response.

On a quarterly basis, Health Plan Management reviews reports with the health plans regarding compliance with requirements. These reviews include separate pharmacy items such as changes in pharmacy network, pharmacy member appeals and complaints made both to the MCO and HHSC, pharmacy claims adjudication timeliness, and reconciliation of pharmacy encounters to the Financial Statistical Reports (FSRs). In addition, pharmacy is included in the overall analysis of member and provider hotline compliance with requirements. However, we agree with the SAO's observation that the Pharmacy Benefit Manager (PBM) data reviewed by HPM is self-reported and not currently validated.

FSR AUPs include testing for the sampled claims' adherence to the Preferred Drug List requirements and prior authorizations, as well as proper reporting of paid claims on the FSR. Testing procedures also include pharmacy claim payments pricing term's adherence to executed pharmacy contracts. We agree that the audit firms' FSR work doesn't address other areas of operational compliance.

STATE AUDITOR'S OFFICE (SAO)
Audit of Medicaid Managed Care Contract Processes at the Health and Human Services Commission
HHSC Management Responses

HHSC does not consider the audit firms finding relating to the transaction fees in SFY 2013 to be an issue of noncompliance. HHSC disallowed the practice in SFY 2014 and requested the audit firms to determine whether transaction fees were utilized by the PBMs prior to the disallowance of the practice. The audit firms did not find any cases in SFY 2014 where PBM transaction fees were paid.

To address the risk of inaccurate reporting, the audit firms have been engaged to perform data validation of 12 quarterly self-prepared reports for all MCOs. These reports include pharmacy self-reported data. The data validation work will coincide with the SFY 2015 FSR AUP work.

Implementation Date:

*AUP assignment for FY 2015 commences November 2017
Performance audit of MCO self-reported data issued August 2017*

Responsible Person:

*Director of MCD Financial Reporting and Audit Coordination
Director of MCD Health Plan Management*

HHSC Management Response – Performance Audits

HHSC Management Response-1

The IG has included an audit of Managed Care Pharmacy Benefit Manager Compliance in its Fiscal Year 2017 Audit Plan. The IG plans to initiate the audit within the next six months, and will coordinate the timing, selection of one or more pharmacy benefit managers to audit, and preliminary scope and objectives of the audit with MCD before the audit is initiated.

Implementation Date:

March 2017

Responsible Person:

Deputy Inspector General for Audit

HHSC Management Response-2

Medicaid and CHIP Services Department will consider the overall risk to the Medicaid Program of PBM performance in determining the frequency of Performance Audits. In making this determination they will use: results of internal monitoring efforts; PBM performance as indicated by member complaint logs; results of annual MCO AUPs and results of IG audits.

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Audit of Medicaid Managed Care Contract Processes at the Health and Human Services Commission
HHSC Management Responses

Implementation Date:

August 2017

Responsible Person:

Director of MCD Health Plan Management

HHSC Management Response – Monitoring

Currently, the Commission utilizes encounter data and self-reported information from MCOs to conduct quarterly reviews in order to determine compliance with pharmacy benefit contract requirements. This includes the reviewing of quarterly reports to monitor compliance with the Preferred Drug List, changes in pharmacy networks, pharmacy member appeals and complaints, pharmacy claims adjudication timeliness, and reconciliation of pharmacy encounters to Financial Status Reports.

To strengthen the oversight process HHSC will:

- *Conduct periodic onsite reviews of MCOs' PBM.*
- *Develop, document, and implement a monitoring process to ensure MCOs perform audits on the PBMs and that reported findings are corrected and resolved.*
- *Develop, document, and implement a monitoring process to ensure that MCOs satisfactorily correct and resolve findings reported in performance audits and agreed upon procedure engagements of PBM contractors.*

Implementation Date:

March 2017

Responsible Person:

Deputy Director of MCD Operations

Chapter 1-D - Coordination of Audit Activities

Recommendation

The Commission should improve the coordination of audit activities between its Medicaid CHIP Division and the Office of Inspector General to eliminate duplication of audit coverage of MCOs.

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HHSC Management Responses

HHSC Management Response

The Commission is in agreement with the finding and associated recommendation and offer the following response.

HHSC is completing a series of steps planned to establish policy and guidelines to ensure appropriate communication and collaboration on the planning and performance of managed care organization audits.

Texas Administrative Code Sections 371.37 and 353.6 were adopted on July 14, 2016. These rules assigned authority to the HHSC Executive Commissioner to establish policy outlining the roles and responsibilities of divisions, departments, and offices of HHSC in coordinating and performing audits of participating managed care organizations.

HHSC has prepared a draft circular titled "Coordination of Managed Care Organization Audits." The circular establishes the Executive Commissioner's policies for coordination of audits of managed care organizations, and defines roles in, jurisdiction over, and frequency of audits of managed care organizations participating in Medicaid conducted by various divisions of HHSC, including the Medicaid and CHIP Services Department (MCD) and the Inspector General (IG). The draft circular is currently in the review and approval process.

In addition, processes and practices are fully established and performed that ensure coordination between MCD and the IG occurs frequently and regularly. These processes and practices include:

- *Coordination between IG and MCD in the development and periodic revision of proposed managed care organization audits included in the IG Audit Plan.*
- *Quarterly briefings by the IG Audit Division to the Medicaid and CHIP Director and applicable MCD senior staff on the status of active managed care organization audits.*
- *Participation by MCD in the planning process of IG managed care organization audits, including providing input to IG on the timing of audits, applicable risks, and proposed audit scope and objectives.*
- *Participation by MCD in key managed care organization audit meetings, including entrance conferences, status updates, and exit conferences.*
- *MCD review of proposed IG audit findings and recommendations, and draft audit reports.*

Implementation Date:

January 2017 - Approval of Managed Care Organization Audit Coordination Circular

STATE AUDITOR'S OFFICE (SAO)
Audit of Medicaid Managed Care Contract Processes at the Health and Human Services Commission
HHSC Management Responses

Responsible Person:

*Deputy Inspector General for Audit
Director of MCD Financial Reporting and Audit Coordination*

Chapter 2 - Collecting Contracted Audit Services Costs and Experience Rebates

Chapter 2-A - Ensure MCOs reimburse for all Audit Related Services

Recommendation

The Commission should develop, document, and implement billing processes within its Medicaid and CHIP Services Department to ensure that MCOs reimburse the Commission for audit-related services as required.

HHSC Management Response

HHSC has initiated billing MCOs for risk assessments, reviews, and audits conducted by external auditors including assessments, reviews and audits utilized for broader compliance and performance testing.

HHSC will review the language in the managed care contracts and clarify the requirement that MCOs will pay for costs incurred by HHSC for external audits necessary for oversight of participating MCOs, if clarification is necessary.

Implementation Date:

September 2017

Responsible Person:

*Deputy Director of MCD Contract and Performance Management
Director of MCD Financial Reporting and Audit Coordination*

Chapter 2-B - Improve Certain Experience Rebate Collection Activities

Recommendations

The Commission should develop, document, and implement monitoring processes within its Medicaid and CHIP Services Department to ensure that:

- It identifies Experience Rebates deposited in the Commission's suspense account and transfers those rebates to the appropriate Medicaid and CHIP program accounts in a timely manner.
- It follows-up on and resolves Experience Rebates disputed by MCOs in a timely manner.

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Audit of Medicaid Managed Care Contract Processes at the Health and Human Services Commission
HHSC Management Responses

HHSC Management Response -1

The Commission is in agreement with the finding and associated recommendations and offer the following response.

Experience Rebates are calculated at least three times before they are finalized. MCOs submit 90-day FSRs on December 31st for the prior fiscal year. At the same time the MCOs submit a check for any Experience Rebate that might be due. They submit the 334-day FSR on August 31st of the following year. This delayed submission allows for claims runout. The Experience Rebate is recalculated using the 334-day FSR and MCOs will submit a check for any additional Experience Rebate that might be due. In addition MCOs are assessed 12% interest compounded daily beginning on the due date of the 90-day FSR on any additional Experience Rebate due. Findings from HHSC's contract auditor's AUP engagements might affect an MCO's net income and, therefore, the amount of Experience Rebate due from the MCO. The MCOs are assessed an interest penalty on any adjusted Experience Rebate amounts. This can occur up to two years after the close of the fiscal year.

Some MCOs attempt to minimize their exposure to the amount of interest charged. There have been cases where MCOs have submitted checks after the close of the fiscal year, but prior to the completion of the AUPs, for any potential findings that would increase Experience Rebate due. In some cases, some or all of these amounts are ultimately refunded to the MCOs as overpayments of the Experience Rebate. Since these amounts represent estimates by the MCOs and are subject to potential refund they are not allocated to a Program by HHSC. Therefore, they remain in a suspense account until the final AUPs are completed.

In general the Accounts Receivable (AR) department receives the check for processing and after initial entry, the check is deposited into AR's suspense account. The check is recorded on an internal form and sent to Medicaid and CHIP Services Department (MCD) Finance to await coding instructions to process and allocate the funds appropriately. Once MCD Finance validates the MCO's self-reported Financial Statistical Reports (FSRs) against known data, such as HHSC's membership and capitation reports, the experience rebate calculation is completed using the UMCC methodology. The calculation is then reviewed and approved by the Director Financial Reporting and Audit Coordination for MCD. Once approved, the allocation is sent to AR's Accounts Receivable Tracking System (ARTS), usually based on the Document Locator Number (DLN) or check number provided via the internal form sent originally.

AR will implement a process whereby MCD Finance is contacted monthly via email inquiring about any and all outstanding funds related to Medicaid and Chip Programs. This will provide a paper trail and an account of proactively trying to clear the AR suspense account.

Implementation Date:

Implemented September 1, 2016

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Audit of Medicaid Managed Care Contract Processes at the Health and Human Services Commission
HHSC Management Responses

Responsible Person:

*Accounts Receivable Supervisor
Accounts Receivable Detail/Initial Team Lead*

HHSC Management Response-2

In a very few cases MCOs have used the Experience Rebate as a method to offset amounts they believe are owed to them by HHSC.

Demand letters will be issued for all outstanding Experience Rebates due.

Implementation Date:

October 2016

Responsible Person:

*Director of MCD Financial Reporting and Audit Coordination
Deputy Director of MCD Contract and Performance Management*

Chapter 3 - Better Utilize External Quality Review Organization Contractor Information

Recommendation

The Commission should use member survey results, including detailed data, and the validation results of paid claims data to enhance its monitoring of MCOs and document how it uses that information in its monitoring efforts.

HHSC Management Response

The Commission will revise its policies and processes to enhance its monitoring of MCO performance. In its assessment of MCO performance, the Commission will consider information from its external quality review organization (EQRO), including member survey results and validation of paid claims.

Implementation Date:

July 2017

Responsible Person:

*Deputy Medicaid Director for Quality and Program Improvement
Director of MCD Health Plan Management*

Chapter 4 - Strengthen IT Security and Processing Controls

STATE AUDITOR'S OFFICE (SAO)
Audit of Medicaid Managed Care Contract Processes at the Health and Human Services Commission
HHSC Management Responses

Recommendations

The Commission should:

- Strengthen user access controls for ARTS and certain network folders the Commission uses to manage experience rebate collections.
- Require its accounts receivable staff to document daily reconciliations of deposits recorded in ARTS to the transactions processed in HHSAS and USAS.
- Develop, document, and implement a process to ensure that all programming changes to ARTS and the authorization and testing of those changes are formally documented.

HHSC Management Response

The Commission is currently in the process of migrating to a single platform with full functionality available. This will allow security classes to be simplified (including keyword feature, manager approvals, etc.) and user authorization to be handled in one place. This will also allow the system to make use of user identification. Upon completion of maintenance changes (estimated to be effective September 1, 2017) ARTS will no longer require password management through itself and changes to HHSC security policies will be handled outside of the ARTS department.

Effective July 2016 all daily reconciliations are now being initiated and dated upon completion. The reconciliation process and segregation of duties occurs from the initial entry. Warrants/checks are entered into ARTS (which interfaces with HHSAS) via the scan process and initial entry whereby a DLN (Document Locator Number) is assigned. The detail entry area determines where the funds should be allocated via the service codes and groups them accordingly by receipt category. Upon completion of the checks being allocated to the appropriate service codes, the checks are surrendered to the voucher processing area where comptroller document numbers are assigned to keep track of deposits. Reconciliation between HHSAS and USAS are performed the following day after the overnight batch processes have occurred.

Change management process currently in place that requires the approval of either the AR Supervisor or AR Manager, before any maintenance, and/or system enhancements are performed. The current process consist of approvals via email, however a more formal automated change management process is planned for implementation by December 15, 2016.

Implementation Date:

September 1, 2017

Responsible Person:

*Accounts Receivable Manager
HHSC IT Enterprise Contract Manager*

Copies of this report have been distributed to the following:

Legislative Audit Committee

The Honorable Dan Patrick, Lieutenant Governor, Joint Chair

The Honorable Joe Straus III, Speaker of the House, Joint Chair

The Honorable Jane Nelson, Senate Finance Committee

The Honorable Robert Nichols, Member, Texas Senate

The Honorable John Otto, House Appropriations Committee

The Honorable Dennis Bonnen, House Ways and Means Committee

Office of the Governor

The Honorable Greg Abbott, Governor

Health and Human Services Commission

Mr. Charles Smith, Executive Commissioner



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An Audit Report on

Human Resources Contract Management at the Health and Human Services Commission

October 2016

Report No. 17-004



An Audit Report on

Human Resources Contract Management at the Health and Human Services Commission

SAO Report No. 17-004
October 2016

Overall Conclusion

The Health and Human Services Commission (Commission) has outsourced the majority of its human resources functions. However, the Commission did not adequately monitor and enforce the human resource requirements in its \$56.9 million human resources and payroll services agreement (contract) with NorthgateArinso.¹ As a result, there were weaknesses in classification of employees and compliance with human resources and information technology contract requirements.

The Commission did not ensure that the contractor adequately performed some critical human resources tasks required by the contract, including:

- Ensuring the proper classification of employees.
- Ensuring that the contractor is complying with human resources contract requirements.

In addition, the Commission did not:

- Develop a comprehensive monitoring plan and risk assessment for the contract.
- Adequately document the activities it performed to monitor **the contractor's** compliance with the human resources contract requirements.
- Adequately monitor **the contractor's compliance with** significant information technology contract requirements.

The Commission **adequately monitored the contractor's compliance with payroll-related requirements**. It also adequately reviewed contractor invoices and generally complied with requirements for contract planning, procurement, and formation.

Background Information

The Health and Human Services Commission (Commission) contracted with NorthgateArinso for human resources and **payroll services**. **The contract's term is** May 1, 2013, through April 30, 2018, with two one-year options to extend. The initial cost of the contract was not to exceed \$56.9 million. As of February 29, 2016, the health and human services (HHS) agencies reported that there were 53,736 full-time equivalent (FTE) positions for which the contractor was responsible for providing services.

The mission of the contract, as stated in the request for proposals, is to provide efficiently delivered, high-quality human resources: payroll; and time, labor, and leave services that support the mission of the HHS agencies. Those services include:

- Recruitment and hiring.
- Compensation management.
- Performance management.
- Benefits management.

Sources: The Commission's contract with NorthgateArinso and the State Auditor's Office's Full-time Equivalent (FTE) State Employee System.

¹ The contractor is also referred to as HHS Employee Service Center.

Table 1 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.)

Table 1

Summary of Chapters/Subchapters and Related Issue Ratings		
Chapter/ Subchapter	Title	Issue Rating ^a
1	The Commission Lacked Sufficient Processes to Ensure That Employees Were Properly Classified	Priority
2-A	The Commission Lacked a Comprehensive Monitoring Plan and Risk Assessment to Direct Its Monitoring of the Contract	Priority
2-B	The Commission Did Not Sufficiently Monitor to Ensure That the Contractor Complied with the Human Resources Contract Requirements	Priority
2-C	The Commission Did Not Adequately Monitor Significant Information Technology Contract Requirements	High
2-D	The Commission Provided Adequate Oversight of the Payroll and Time, Labor, and Leave Services the Contractor Performed	Low
2-E	The Commission Adequately Reviewed Contractor Invoices; However, It Did Not Always Accurately Charge the Payments to the Correct Contract	Medium
3	The Commission Generally Complied with State Requirements for Contract Planning, Procurement, and Formation	Low

^a A subchapter is rated Priority if the issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern and reduce risks to the audited entity.

A subchapter is rated High if the issues identified present risks or effects that if not addressed could substantially affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern and reduce risks to the audited entity.

A subchapter is rated Medium if the issues identified present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.

A subchapter is rated Low if the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

Auditors communicated other, less significant issues in writing to the Commission.

Key Points

The Commission had significant weaknesses in its processes for ensuring proper classification of employees.

Auditors determined that a significant number of employees at and job postings for **the State's health and human services agencies**² (HHS agencies) were not properly classified according to the State's Position Classification Plan. Specifically:

- Based on a list of 5,484 HHS agency managers and supervisors on January 15, 2016, 760 (13.9 percent) were misclassified with entry-level titles and other nonsupervisory titles.
- An **audit conducted by the State Auditor's Office's State Classification Team** determined that 356 (57.7 percent) of 617 program specialist employees at the Department of Aging and Disability Services were not classified correctly (see *A Classification Compliance Audit Report on Program Specialist and Program Supervisor Positions at the Department of Aging and Disability Services, State Auditor's Office Report No. 16-705*, August 2016).
- Of the 149 job postings tested, 40 (26.8 percent) appeared to be incorrectly classified based on the duties described in the job description compared to **information in the State's Position Classification Plan**.

Correct job classifications are essential in preventing underpaying or overpaying employees. Improper job classification can also lead to unqualified managers and supervisors. In addition, it may contribute to employee turnover.

The Commission did not adequately monitor to ensure that the contractor complied with certain contract requirements.

The Commission did not ensure that the contractor complied with the following contract requirements, which contributed to misclassifications of job positions, possible misclassifications of job postings, and inaccurate job postings:

- Assist managers with the development and revision of job descriptions.
- Maintain a repository of job descriptions and make that repository readily available to HHS agency employees.
- Review job postings to verify accuracy, completeness, and compliance with Commission policies and procedures.

² The contract included critical human resources functions for Commission employees and employees at the Department of Family and Protective Services, Department of Assistive and Rehabilitative Services, Department of Aging and Disability Services, and Department of State Health Services (collectively referred to as "HHS agencies" in this report).

- Monitor the application selection process to ensure that minimum qualification criteria are met, and that selection summary documents are properly submitted.
- Maintain selection packets.
- Perform an annual classification review, including the review of Fair Labor Standards Act (FLSA) designations for all HHS agency positions.

The Commission did not have a comprehensive monitoring plan or perform risk assessments to direct its monitoring of the contract.

The Commission did not have a comprehensive monitoring plan and a supporting risk assessment in place to help focus its monitoring of the contractor to determine whether the contractor provided the required services. A monitoring plan and risk assessment should identify the contract requirements to be monitored, how the requirements will be monitored, and who will perform the monitoring.

The Commission should improve its documentation of its monitoring activities.

The Commission did not adequately document its interactions with the contractor. **The lack of documentation associated with the Commission's monitoring makes it difficult for the Commission to hold the contractor accountable for providing the services required in the contract.**

The Commission did not ensure that the contractor complied with significant information technology contract requirements.

The Commission should improve its monitoring of the information technology-related requirements in the contract. Neither the Commission nor the contractor **had an adequate process to periodically review user access to the Commission's** human resources system or to ERS Online, which contains confidential employee data, and ensure that user accounts are disabled when users leave employment. In addition, the Commission did not adequately ensure that the contractor complied **with information security best practices and the Commission's security protocols** and standards as required by the contract.

The Commission monitored the contractor's compliance with payroll-related requirements; reviewed invoices; and generally complied with contract planning, procurement, and formation requirements.

The Commission's Payroll, Time, Labor, and Leave Department developed a process to adequately monitor contractor performance in those areas. The monitoring was performed by subject matter experts. The Commission also adequately reviewed contractor invoices; however, it did not always accurately charge the payments to the correct contract. In addition, the Commission generally complied with applicable statutes and *State of Texas Contract Management Guide* requirements for contract planning, procurement, and formation for the contract.

Summary of Management's Response

At the end of each chapter in this report, auditors made recommendations to address the issues identified during this audit. The Commission generally 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 administered certain contract management functions for selected contracts in accordance with applicable requirements.

The scope of this audit covered the Commission's human resources and payroll services agreement with NorthgateArinso, effective on May 1, 2013. That contract covered services for the Commission, as well as the Department of Aging and Disability Services, the Department of Assistive and Rehabilitative Services, the Department of Family and Protective Services, and the Department of State Health Services.

Auditors reviewed contract planning, procurement, formation, and monitoring activities through February 29, 2016.

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Detailed Results

Chapter 1

The Commission Lacked Sufficient Processes to Ensure That Employees Were Properly Classified

Chapter 1
Rating:
Priority³

The Health and Human Services Commission (Commission) did not have sufficient processes to ensure that employees were properly classified, including enforcing certain requirements in its \$56.9 million human resources and payroll services agreement (contract) with NorthgateArinso⁴ (contractor).

The Commission designed a model in which managers at the State's health and human services agencies⁵ (HHS agencies) and the contractor have shared responsibility for ensuring that (1) employees are properly classified, (2) employees have the proper Fair Labor Standards Act (FLSA)⁶ status as an exempt or non-exempt employee, and (3) job postings are accurate. The Commission's Human Resources Department's role in the designed model is limited to functions such as employee relations, policy interpretation, workforce planning, and Centralized Accounting and Payroll/Personnel System (CAPPs) testing and security. The Commission has not required the contractor to comply with certain contract requirements that would help ensure that HHS agency employees are properly classified and job postings are accurate. For HHS agency managers and supervisors, the human resources-related job duties are in addition to their regular job duties. The Commission has not ensured that training or guidance are available to help HHS agency managers and supervisors to perform classification duties, perform the FLSA status reviews, and accurately post a job position.

³ The risk related to the issues discussed in Chapter 1 is rated as Priority because they present risks or results 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.

⁴ The contractor is also referred to as HHS Employee Service Center.

⁵ The contract provided critical human resources services for Commission employees and for employees at the Department of Family and Protective Services, Department of Assistive and Rehabilitative Services, Department of Aging and Disability Services, and Department of State Health Services (collectively referred to as "HHS agencies" in this report).

⁶ The FLSA requires that most employees in the United States be paid at least the federal minimum wage for all hours worked and overtime pay at time-and-one-half the regular rate of pay for all hours worked more than 40 hours in a workweek. However, employees with certain job duties and salaries are exempt from both the minimum wage and overtime pay requirements.

Incorrectly Classified Job Positions

The Commission had a significant number of the job positions that were not correctly classified according to the State's Position Classification Plan. Specifically:

- Based on a list of 5,484 HHS agency managers and supervisors on January 15, 2016, 760 (13.9 percent) of those employees were misclassified with entry-level and other nonsupervisory titles. For example, an employee classified as an Administrative Assistant I had employees directly reporting to that position and was responsible for providing annual performance evaluations. Those job duties are not appropriate for that job classification title. The State's Position Classification Plan states that an Administrative Assistant I position "works under close supervision, with minimal latitude for the use of initiative and independent judgment."
- An audit conducted by the State Auditor's Office's State Classification Team determined that 356 (57.7 percent) of 617 employees classified within program specialist and program supervisor job classification series at the Department of Aging and Disability Services were not classified correctly (see *A Classification Compliance Audit Report on Program Specialist and Program Supervisor Positions at the Department of Aging and Disability Services*, State Auditor's Office Report No. 16-705, August 2016).

Correct job classifications are essential in preventing underpaying or overpaying employees. Improper job classification can also lead to unqualified managers and supervisors. In addition, it may contribute to employee turnover.

Incorrectly Classified and Inaccurate Job Postings

The Commission had a significant number of job postings that appeared to not be (1) correctly classified according to the State's Position Classification Plan and (2) accurate (see text box for more information about the Commission's job posting process). Specifically:

- Of the 149 job postings tested, 40 (26.8 percent) appeared to be incorrectly classified based on the duties described in the job posting compared to information in the State's Position Classification Plan.

The Commission's Job-posting Process

For a job position to be posted, the hiring manager at the HHS agency creates a job requisition that includes items such as position title, FLSA status, essential job duties, and minimum qualifications. The contractor reviews and approves the job requisition, then the hiring manager's supervisor reviews and approves it. After the supervisor's approval, the job requisition is automatically posted to the HHS employment Web site and other Web sites as required.

Sources: The Commission and NorthgateArinso.

- Of the 55 job postings tested that required military crosswalk language, 28 (50.9 percent) did not contain that language as required by Texas Government Code, Section 656.002, which was effective as of September 1, 2015 (see text box for more information about military crosswalk language).
- Forty (26.7 percent) of 150 job postings tested contained information that was not entered into the correct section in the posting. For example, some postings listed the education requirements in the registrations, licensure requirements, or certifications section. A more appropriate section to list the education requirements would be in the initial screening criteria section. By not having information in the proper sections, there is an increased risk that requirements are unclear for applicants and applicant screeners.
- Of the 79 job postings for a manager or supervisor tested, 17 (21.5 percent) did not contain information regarding supervisor responsibilities, such as hiring and performing annual evaluations, reviewing the accuracy of job classifications, and determining FLSA status.

Not Adequately Enforcing All Contract Requirements

The Commission did not ensure that the contractor complied with certain contract requirements, which contributed to misclassifications of the job positions, possible misclassifications of job postings, and inaccurate job postings. Specifically:

- Contract requirement - Assist managers and supervisors with the development and revision of job descriptions. **The Commission did not require the contractor to assist HHS agency managers and supervisors in the development of job descriptions**, even though assisting them is an explicit requirement in the contract. In addition, the contractor stated to auditors that it does not assist HHS managers and supervisors in the development of job descriptions.
- Contract requirement - Maintain a repository of job descriptions and make that repository available to HHS agency employees. **As of May 2016, there was not a job description repository that contained all of the job descriptions being used within the HHS agencies that was easily accessible to employees**. HHS agency managers and supervisors can request a job description from the contractor; however, the contractor will provide it to them only with approval from the requesting person's supervisor. In addition, the

Military Crosswalk

Texas Government Code, Section 656.002, states that a state agency shall include on all forms and notices related to a state agency employment opening the military occupational specialty code for each branch of the armed forces of the United States, identified as provided by Section 654.0375, that corresponds to the employment opening if the duties of the available position correlate with a military occupational specialty.

contractor maintains job descriptions for only those positions the contractor has audited.⁷ If the position has not been audited, the HHS agency manager or supervisor must draft the job description.

- Contract requirement - Review of the job postings to verify the accuracy, completeness, and compliance with Commission policies and procedures. **The contract requires the contractor to perform those reviews.** Proper review of the job postings would help ensure that the job title and job duties in the job postings align with the State's Position Classification Plan and reduce the risk of misclassifications of newly hired employees. In addition, proper review would help ensure that all required information is included in the job posting and that the information is in the proper job posting sections.
- Contract requirement - Monitor the application selection process to ensure that minimum qualifications criteria are met, and that the selection summary documents are properly submitted. **HHS agency managers and supervisors are required to complete a selection summary document**, which explains how the selected applicant met the hiring criteria. The contractor is required to monitor to ensure that minimum qualifications criteria and licensing and certifications requirements were met, and that the selection summary document was properly submitted. However, the contractor did not ensure that the selection summary was adequately completed for 22 (17.3 percent) of the 127 job postings tested for which an applicant was hired.
- Contract requirement - Maintain selection packets in a way that makes the information retrievable by multiple search tools. **The contractor could not provide the selection packet to auditors** for 69 (54.3 percent) of the 127 job postings tested for which an applicant was hired. The contractor stated that it does not have a process to identify when selection packets are not provided or follow up when packets are not provided by the HHS agency managers or supervisors.

⁷ According to WorldatWork, a nonprofit human resources association, a job position analysis (or audit) is the systematic, formal study of the duties and responsibilities that constitute job content. The process seeks to obtain important and relevant information about the nature and level of the work performed and the specifications required for an incumbent to perform the job at a competent level.

- Contract requirement - Perform an annual classification review, including review of FLSA designations on all HHS agency positions (see text box for more information about FLSA status determinations). **An annual classification and FLSA status review would verify that each HHS agency employee's job classification and FLSA status reflect the actual job duties performed.** In addition, Texas Government Code, Section 654.0155, requires state entities to annually review individual job assignments for all positions to ensure that each position is properly classified. Instead of requiring the contractor to perform an annual classification and FLSA status review, as required by the contract, the Commission required the managers and supervisors to review the classification and FLSA status for employees directly reporting to them during the employees' annual performance evaluations. However, that process was not effective because:

- ♦ The Commission did not have a mechanism to track whether the managers and supervisors reviewed an employee's job classification and FLSA status during the annual performance evaluations.
- ♦ HHS agency managers and supervisors did not complete annual performance evaluations in a timely manner. The Commission reported that completion rates⁸ since 2013 for annual evaluations for all HHS agencies ranged from a low of 45.4 percent on August 31, 2014, to a high of 58.5 percent on August 31, 2015.

Lack of Sufficient Training and Guidance to HHS Agency Managers and Supervisors

HHS agency managers and supervisors write and approve job postings, which includes writing the job duties and essential functions and determining proper job classification and FLSA status. However, the HHS agencies did not provide those managers and supervisors with the training or guidance needed to write the job postings and perform classification and FLSA status reviews. In addition, the Commission did not offer any training courses related to job classification.

The contractor is required by the contract to provide job description training to HHS agency employees four times per year. The contractor offered the job description class six times each in the second and third years of the contract (the class was not offered during the first year), and 176 HHS agency employees attended those classes. On January 15, 2016, the Commission

Determining FLSA Status

To determine whether an employee is exempt from FLSA requirements, an agency **must verify an employee's specific job duties and salary and compare them to the U.S. Department of Labor's requirements for FLSA exemption.** Job titles do not determine exempt status.

Source: U.S. Department of Labor.

⁸ The completion rates are based on the number of performance evaluations that should have been completed within the previous 12 months.

reported that 5,484 managers and supervisors within the HHS agencies were responsible for hiring which includes writing and reviewing job postings.

Recommendations

The Commission should:

- Evaluate its model for delivering human resources services to determine whether it is working as intended and providing the desired outcomes, such as correctly classified employees. The Commission should update the model to address identified deficiencies.
- Require the contractor to perform contract requirements including, but not limited to:
 - ◆ Assisting managers and supervisors with the development and revision of job descriptions.
 - ◆ Maintaining a repository of job descriptions and making that repository readily available to HHS agency employees.
 - ◆ Performing adequate reviews of the job postings to verify whether (1) they are accurate, complete, and comply with Commission policies and procedures and (2) the job postings are properly classified according to the State's Position Classification Plan.
 - ◆ Monitoring to ensure that the selection summaries completed by HHS agency managers and supervisors are properly submitted and demonstrate how the selected applicants met the requirements in the job postings.
 - ◆ Obtaining and maintaining all selection packets after a job posting is filled.
- Require the contractor to provide an annual classification and FLSA review for all HHS agency employees as required by the contract.
- Provide HHS agency managers and supervisors with sufficient training and guidance if those managers and supervisors continue to be responsible for writing and approving job postings and conducting annual reviews of job classifications and FLSA status.

Management's Response

The Health and Human Services Commission (HHSC) is in agreement with the findings and associated recommendations and offer the following responses.

Contractor Requirements - *The contractor is required to assist managers and supervisors with the development and revision of job descriptions. The contract does not require the contractor to compose the job descriptions as a job description is typically composed by one who knows the most about what the position does, i.e., incumbents and managers. Managers utilize the Centralized Accounting and Payroll/Personnel System (CAPPS) to draft job descriptions and submit job audit requests directly to the contractor. Since the classification/job audit process is somewhat subjective, the process will need to be reviewed internally by HHS Management to develop and implement a plan for process improvement and make a decision on how best to provide the service to our employees in an efficient, timely manner -- while ensuring a consistent, equitable process. Once a decision has been made, the contract requirements, service level agreements, monitoring plans, etc. will be updated accordingly.*

The contract requirement to "maintain a repository of job descriptions and making that repository available to HHS agency employees" was contingent upon HHSC configuration of PeopleSoft 9.1 functionality to use Profile Manager. At the time of contract execution, this requirement was listed and accepted along with NorthgateArinso's clarification: "Included in NGA solution. NGA will coordinate with HHS and CPA to configure PeopleSoft 9.1 functionality using Profile Manager for the Job Description Repository based upon requested requirements" Due to funding, other project priorities, and resource restraints, the requirement has not been implemented; however removing the requirement was not considered because it would likely result in significant, additional cost to HHSC if this were treated as a future enhancement to the system. The agreed upon workaround was to provide the available job description to the manager upon request. Management will need to review and determine if additional language should be added to the scope of work document to clarify this item or if NorthgateArinso's proposal which is incorporated into the Agreement.

As recommended by SAO, additional process improvements will be incorporated into the contract monitoring plan to help ensure the contractor is conducting an adequate review of job postings and coordinating with the hiring authority to clarify, confirm, and revise information as appropriate. The current approach to contract monitoring employs traditional risk assessment and contract monitoring procedures. Contract oversight uses a risk

assessment instrument completed annually to identify and prioritize the service level agreements deem as high, medium and low risks.

Currently, the contractor collects and maintains selection packets as they are submitted to the service center by the manager/hiring authority once a selection is made. The ability for hiring authorities to scan/upload the selection packets to the contractor was explored but was not feasible at that time. Additional discussions have occurred with the contractor to determine the best course and fiscal action to take to follow up with managers/hiring authorities and/or escalate instances when selection packets are significantly delayed or not received.

Communications will be provided to managers approving job offers to emphasize that the minimal job offer requirements of the job posting must be met.

Classification and FLSA Review - Management will revisit the current annual classification and FLSA review process and develop and implement a plan to ensure annual reviews are conducted by the contractor.

Additional staff that includes subject matter experts in classification will be used to conduct monitoring activities, as recommended by SAO.

Training for Managers and Supervisors - Management will identify additional opportunities for managers and supervisors to attend training on how to write job descriptions. As a value-added service the contractor provides at least four job description trainings to HHS agency employee per year.

Implementation Date:

September 2017

Responsible Person:

Deputy Executive Commissioner of System Support Services

The Commission Did Not Adequately Monitor to Ensure That the Contractor Performed Critical Human Resources and Information Technology Tasks; However, the Commission Adequately Monitored Payroll and Time, Labor, and Leave

The Commission did not have a comprehensive monitoring plan or perform risk assessments to direct its monitoring of the contract. As a result, the Commission's monitoring of the contractor's human resources services was not sufficient to ensure that the contractor complied with the contract requirements.

The Commission also did not adequately monitor to verify that the contractor complied with significant information technology contract requirements. Auditors identified instances in which former contractor employees had active accounts to both CAPPs and ERS Online, both of which contain confidential data.

The Commission's Payroll, Time, Labor, and Leave Department adequately monitored the contractor's payroll and time, labor, and leave services provided and verified that the contractor complied with requirements in those areas. In addition, the Commission adequately reviewed contractor invoices; however, it did not always accurately charge the payments to the correct contract.

Service Level Agreements

The contract contains service level agreements, which are specific service requirements used to measure the contractor's performance or specified obligations during the course of the contract. The service level agreements include a performance standard, benchmark, and specified liquidated damages.

The Commission's Contract Oversight Unit (within the System Support Services Division) focused its monitoring on the service level agreements (see text box for information about service level agreements). However, the contract does not include service level agreements that address the quality of the services provided for the accuracy and completeness of job postings and the proper classification of employees. In addition, the Contract Oversight Unit did not adequately document (1) its interactions with the contractor as required and (2) what was monitored, how it was monitored, or the results of any of the site visits that the unit performed from May 1, 2013, through February 29, 2016.

The Contract Oversight Unit has the primary responsibility for monitoring the contract; however, it relies on subject matter experts to monitor payroll; time, labor, and leave; and information technology requirements. The Contract Oversight Unit does not consistently involve subject matter experts in monitoring the human resources services the contractor provides.

Chapter 2-A

The Commission Lacked a Comprehensive Monitoring Plan and Risk Assessment to Direct Its Monitoring of the Contract

Chapter 2-A

Rating:

Priority⁹

The Contract Oversight Unit did not have a comprehensive monitoring plan and a supporting risk assessment in place to help focus its monitoring of the contractor to determine whether the contractor provided the required services. A monitoring plan and risk assessment should identify the contract requirements to be monitored, how the requirements will be monitored, and who will perform the monitoring. A monitoring plan and risk assessment are required by the *State of Texas Contract Management Guide* and the Commission's *Contracting Processes and Procedures Manual*.

The Contract Oversight Unit's *Operations Manual* states that the Commission predetermined the risk of the services the contractor provides, and it included the service level agreements in the contract to address those risks. As a result, the Commission's monitoring of the contract has focused almost exclusively on the contract's service level agreements. Although the contract contains 20 service level agreements that pertain to human resources services (see Appendix 3), none of them measures the quality of the services provided for the accuracy and completeness of job postings and the proper classification of employees. Because the Commission did not assess any risks that were outside the scope of the service level agreements, it lacked an oversight mechanism to monitor and identify problems related to the quality of the services provided.

As discussed above, the Contract Oversight Unit did not consistently involve the Commission's Human Resources Department in the monitoring of the human resources services the contractor provided. In addition, the Human Resources Department did not have a copy of the contract and, therefore, may not be aware of all of the service requirements in the contract. Because the requirements for the human resources areas included in the contract are complex, increasing the Human Resources Department's role in monitoring contractor performance could help the Commission address the issues discussed in Chapter 1.

In addition, because it did not conduct a risk assessment, the Contract Oversight Unit did not identify contractor access to ERS Online, which allowed users to modify data and/or view confidential information for HHS agency employees, as a high-risk item needing monitoring. As a result, the Commission did not monitor to ensure that contractor employee access to

⁹ The risk related to the issues discussed in Chapter 2-A is rated as Priority because they present risks or results 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.

ERS Online was disabled when a user leaves employment. (See Chapter 2-C for more information about user access.)

Recommendations

The Commission should:

- Develop, implement, and document a comprehensive contract monitoring plan that is based on a risk assessment of all contract requirements, including those in the statement of work. That plan should:
 - ♦ Address significant areas of the contract, including human resources, payroll services, and information technology.
 - ♦ Include the subject matter experts in the monitoring of the contract, including the Commission's Human Resources Department.
- Evaluate the contract requirements and create additional service level agreements as appropriate, such as service level agreements containing metrics addressing the quality of the human resources services provided.

Management's Response

The Health and Human Services Commission (HHSC) is in agreement with the findings and associated recommendations and offer the following responses.

Contract Monitoring Plan - *The services provided under the human resources and payroll services contract expand over multiple business units and program areas within the health and human services system. Due to the size, scope, the use of manager self-service functionality, and number of resources available, the service level agreements were developed and agreed upon by all parties involved to capture those contract requirements deemed high risk, with high visibility and would require focused monitoring. The monitoring plan/checklist developed was created to ensure those critical requirements were reviewed on a regular, ongoing basis. Action will be taken to improve and enhance the monitoring plan/checklist and to incorporate relevant requirements (including those in the statement of work) and more details on how the identified requirements will be monitored, who will perform the monitoring, and the rationale for selecting items to monitor. Subject matter experts from each of the health and human services business areas (Human Resources, Information Technology, and Payroll) will be requested to assist with monitoring and reviewing data associated with the requirements of the contract.*

Contractor Requirements and Service Level Agreements - Although, there is not a service level agreement specific to measuring the quality of services provided by the vendor, Exhibit A, Article 11 of the contract describes the remedies the Commission may pursue for any areas of noncompliance with the Agreement and serves as an oversight mechanism available to address quality of services/deliverables provided under the Agreement. The Contact Oversight Unit will coordinate with the appropriate business partners as well as the General Counsel team to evaluate the contract requirements, review the current service level agreements, and determine whether additional service level metrics need to be developed.

Implementation Date:

April 2017

Responsible Person:

Deputy Executive Commissioner of System Support Services

Chapter 2-B

The Commission Did Not Sufficiently Monitor to Ensure That the Contractor Complied with the Human Resources Contract Requirements

Chapter 2-B

Rating:

Priority¹⁰

The Commission's monitoring of the human resources services that the contractor performed was not sufficient to ensure that the contractor complied with the contract requirements. As discussed in Chapter 2-A, the Commission's monitoring was primarily focused on the contract's service level agreements, which did not address key human resources functions for ensuring the accuracy of job postings and the proper classification of employees.

The Commission's Contract Oversight Unit did not document its interactions with the contractor as required by the Commission's *Contracting Process and Procedures Manual* and the Contract Oversight Unit's *Operations Manual*, which require the creation of a log of actions that provides a brief synopsis of an inspection of contractor-provided service, a meeting, or a conversation with the contractor regarding its performance.

The lack of documentation associated with the Commission's monitoring makes it difficult for the Commission to hold the contractor accountable for

¹⁰ The risk related to the issues discussed in Chapter 2-B is rated as Priority because they present risks or results 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.

providing the services required in the contract. Examples of inadequate documentation included:

- Weekly calls with the contractor. According to the Contract Oversight Unit, it conducts weekly calls with the contractor as a way to communicate on-going activities and/or projects. The results of those interactions are not documented in a log of actions as required.
- **Site visits at the contractor's location.** The Contract Oversight Unit did not create a report for any of its site visits (see next section for additional discussion about the Commission's site visit processes). The *State of Texas Contract Management Guide* and the Commission's *Contract Oversight Operations Manual* require a "report of the site visit [that] should stand by itself and serve as a record of the site monitoring work." That report should document what was monitored, how it was monitored, or the results of the site visit.

The Commission should strengthen its site monitoring processes.

The Contract Oversight Unit asserted that it performed seven site visits at the contractor from May 1, 2013, through February 29, 2016. It was able to provide auditors with some documentation that showed five of those site visits occurred. Specifically:

- For three site visits, the Contract Oversight Unit reviewed the contractor's performance for 17 individual service level agreements. Eight of the service level agreements were related to human resources. Auditors reviewed the monitoring the Contract Oversight Unit asserted it performed during the site visits for three of those human resources-related service level agreements. For those three service level agreements, the Contract Oversight Unit:
 - ♦ Did not document the justification for why those specific service level agreements were selected for review during the site visit.
 - ♦ Did not document the procedures used to review two of the service level agreements.
 - ♦ Did not validate the accuracy of the information the contractor reported in its monthly service level agreement report for those three service level agreements. For example, for one of the service level agreements, the contractor was required to monitor 275 calls per month. However, during the site visit, the Contract Oversight Unit did not perform steps to validate the numbers the contractor reported in its monthly report for calls monitored and calls that had issues.

Verifying the accuracy of the reported numbers is important because

the Commission assesses liquidated damages based on the information in the monthly reports. Based on self-reported information, the Commission assessed liquidated damages nine times between May 2013 and February 2016 when the contractor did not meet service level agreement requirements.

- ♦ Identified issues for two of the three human resources service level agreements reviewed; however, the Commission did not have any documentation showing that it communicated those issues to the contractor or that the Commission followed up on the issues.
- ♦ Did not share the results of the site visits with the Human Resources Department.
- For the fourth site visit, the Contract Oversight Unit asserted that it observed the job description training the contractor provided to HHS agencies employees; however, it did not document the results of that observation.
- For the fifth site visit, the Contract Oversight Unit, along with the Human Resources Department, discussed the job audit process with the contractor. The results of that discussion were documented.

Recommendations

The Commission should:

- Develop and implement a method to document (1) weekly calls with the contractor as required and (2) the monitoring performed during site visits. That should include, at a minimum, documenting:
 - ♦ Significant issues discussed with the contractor.
 - ♦ The rationale for selecting service level agreements to monitor.
 - ♦ What procedures were used to monitor.
 - ♦ How it validated the information that the contractor reported.
 - ♦ Issues identified, corrective action required, and resolution of identified issues.
- Develop and implement a report to document what monitoring procedures were performed during site visits and the results of site visits, and distribute those reports to the contractor and appropriate HHS agencies' business partners.

Management's Response

The Health and Human Services Commission (HHSC) is in agreement with the findings and associated recommendations and offer the following responses.

Contract Monitoring Calls and Visits Documentation - Calls and meetings with the contractor are held on a regular, ongoing basis (at least weekly). Processes have been developed and implemented to adequately document the weekly calls, which will include transcribing the notes and sharing/maintaining evidence that discussion of significant issues occurred. Site visit documentation will be revised to include written detail to capture the rationale for review of the selected items, what procedures were used to monitor, how information was validated, issues identified, corrective action required, and resolution of issues.

Contractor Monitoring Calls and Visits Results Report - A more thorough process will be developed and implemented to revise the current reporting methodology to incorporate details associated with the monitoring procedures performed and the results of the site visits. A process will be developed to share the findings with the appropriate teams.

Implementation Date:

December 2016

Responsible Person:

Deputy Executive Commissioner of System Support Services

Chapter 2-C

The Commission Did Not Adequately Monitor Significant Information Technology Contract Requirements

Chapter 2-C
Rating:
High ¹¹

The Commission is not adequately monitoring significant information technology requirements. Specifically, it did not ensure that contractor access to the Commission's human resources information system (CAPPs) and ERS Online was appropriate. In addition, while the Commission performed some monitoring of information technology related aspects of its contract, it did not adequately monitor other significant information technology requirements.

¹¹ The risk related to the issues discussed in Chapter 2-C is rated as High because they present risks or results 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.

The Commission did not adequately monitor contractor access to confidential information in CAPPS and ERS Online.

Neither the Commission nor the contractor had an adequate process in place to periodically review user access to CAPPS or ERS Online, which contains HHS agency employees' confidential data (see text box). Specifically, the Commission did not ensure that all user accounts were disabled when users left employment, as required by the Title 1, Texas Administrative Code, Section 202.24. Auditors identified instances in which former contractor employees had active accounts to both CAPPS and ERS Online with access to confidential data in the systems. Specifically:

- Two former contractor employees had access to CAPPS. When auditors brought that issue to the Commission's attention, the Commission removed the access for both accounts. Neither of the accounts was accessed after the employees' last day of employment.
- Four former contractor employees had access to confidential data in ERS Online. One of those accounts was accessed a month after the user's last day of employment. It was not possible for auditors to determine who accessed the account. When auditors brought that issue to the contractor's attention, the contractor contacted the Employees Retirement System to have the access for those four accounts removed. As discussed in Chapter 2-A, because the Commission's Contract Oversight Unit did not conduct a risk assessment, it did not identify contractor access to ERS Online as a high-risk item that needed monitoring (see Chapter 2-A for more information about user access).

Contractor Access to CAPPS and ERS Online Data

Employees of the contractor, NorthgateArinso, have access to the following systems:

- CAPPS - Contractor employees have access to update human resources, payroll, and time and labor information for HHS agency employees.
- ERS Online - Contractor employees have access to enter and/or update HHS employees' benefit information, such as benefits enrollment, qualifying life events, and personal information. This is a Web-based application.

Sources: Request for proposals and information provided by the Commission.

While the Commission performed some monitoring of information technology-related requirements in the contract, it did not adequately monitor other significant information technology-related requirements.

The Commission performed some monitoring of information technology requirements of the contract. Specifically, the Commission:

- Participated in an annual disaster recovery testing exercise. The disaster recovery testing was successful and the required changes to the related information technology were minor.
- Had a process in place to receive and review reports from the contractor about CAPPS system availability.

However, the Commission did not adequately monitor to ensure contractor compliance with information security best practices and the Commission's security protocols and standards as required by the contract. Specifically, the Commission:

- Did not monitor the contractor to verify compliance with information security best practices or with the Commission's policies and the service level agreement related to security protocols and standards, as required by the contract. In May 2015, the Commission started requiring all contractors handling confidential agency information to have a completed Security and Privacy Initial Inquiry (SPI) form on file (see text box for more information about the SPI form). However, as of May 2016, the Commission did not have an SPI in place from the contractor.
- Did not follow up on the issues identified in the contractor's 2015 Statement on Standards for Attestation Engagements (SSAE) No. 16 report, which is a third-party report on the effectiveness of the contractor's controls over its human resources system.
- Did not review other plans related to information technology that the contractor submitted at the commencement of the contract in May 2013.
- Failed to document its review of the contractor's security management plan.

SPI Form

The SPI form is the Commission's contractor security and privacy self-assessment form. The HHS System Information Security Office uses those forms as part of its contractor risk assessment process to establish risks associated with that contractor.

Source: The Commission.

Recommendations

The Commission should:

- Develop, document, and implement a process to periodically review access to CAPPS and ERS Online, and verify that the contractor requests removal of former employees' access to those systems in a timely manner.
- Develop, document, and implement a methodology to monitor the contractor's compliance with the security requirements in the contract, information security best practices, and state and agency-specific requirements. That methodology should include a process to follow up on the results of the monitoring to verify remediation of all issues identified.

Management's Response

The Health and Human Services Commission (HHSC) is in agreement with the findings and associated recommendations and offer the following responses.

Reviewing Access to CAPPS and ERS Online - Contract Oversight will coordinate with the appropriate information technology subject matter experts to (1) develop, document, and implement a process to periodically review access to CAPPS and ERS Online, and verify that the contractor requests removal of former employees in a timely manner.

NorthgateArinso (NGA) has updated the CAPPS and ERS access and removal process documents with the new HHS Portal process (for CAPPS access) and ERS process. Documents have been provided to HHS for review.

These processes will be incorporated into the contract monitoring plan as appropriate.

Contractor Monitoring of Security Requirements - Contract Oversight will coordinate with the appropriate information technology subject matter experts to develop, document, and implement a methodology to monitor the contractor's compliance with the security requirements in the contract, information security best practices, and state and agency-specific requirements.

These processes will be incorporated into the contract monitoring plan as appropriate.

Implementation Date:

December 2016

Responsible Person:

Deputy Executive Commissioner of System Support Services

Chapter 2-D

The Commission Provided Adequate Oversight of the Payroll and Time, Labor, and Leave Services the Contractor Performed

Chapter 2-D
Rating:

Low ¹²

As discussed in previous chapters, the Contract Oversight Unit had the primary responsibility for monitoring the contract; however, it relies on the Commission's Payroll, Time, Labor, and Leave Department to ensure that the contractor performed the daily required tasks in those areas. The Payroll, Time, Labor, and Leave Department developed processes to adequately monitor contractor performance. That monitoring was designed to monitor contractor compliance with applicable service level agreements and significant requirements outlined in the contract.

In addition to payroll tracking and production, the contractor is required to provide other compensation activities such as additional pay processing; overpayment prevention; and time, labor, and leave reconciliation. The Commission's Payroll, Time, Labor, and Leave Department monitoring activities included reviewing the daily contractor activities that must occur to ensure that payroll, time, labor, and leave are completed correctly and in a timely manner.

In addition, the Commission required the contractor to develop three corrective action plans when the contractor did not meet performance expectations related to payroll services. For example, in one instance, due to a processing error, 138 HHS agencies employees received paper warrant paychecks, instead of the paychecks being direct deposited into the employees' bank accounts. The Commission's Payroll, Time, Labor, and Leave Department worked with the contractor to determine the root cause of the problem and to develop a corrective action plan to prevent the problem from occurring in the future.

¹² The risk related to the issues discussed in Chapter 2-D is rated as Low because the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

Chapter 2-E

The Commission Adequately Reviewed Contractor Invoices;
However, It Did Not Always Accurately Charge the Payments to the
Correct Contract

Chapter 2-E

Rating:

Medium¹³

The Commission reviewed all 35 of the contractor invoices and made payments from May 1, 2013, through February 2016 totaling \$30.5 million. All of those payments were properly supported by the documentation, complied with the contract requirements, and were approved by authorized parties.

However, four payments totaling \$3.5 million were charged to the prior contract for human resources and payroll services. If payments are not charged to the correct contract, the Commission will not be able to accurately determine each contract's true cost.

Recommendation

The Commission should ensure that contractor payments are charged to the proper contract.

Management's Response

The Health and Human Services Commission (HHSC) is in agreement with the finding and associated recommendation and offer the following response.

Ensuring Contractor Payments are Charged to the Proper Contract - *At the beginning of a new fully executed contract, Contract Oversight will provide Procurement and Contracting Services (PCS) a requisition within five business days of a new fully executed contract. Contract Oversight will ensure any previous purchase order is closed and a new purchase order is established prior to execution of a new contract. Contract Oversight has updated its manual to include the additional step to the contract closeout and renewal procedures.*

Implementation Date:

September 30, 2016

¹³ The risk related to the issues discussed in Chapter 2-E is rated as Medium because they present risks or results 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 concerns and reduce risks to a more desirable level.

Responsible Persons:

Deputy Executive Commissioner of System Support Services

Chief Financial Officer

Chapter 3

The Commission Generally Complied with State Requirements for Contract Planning, Procurement, and Formation

Chapter 3

Rating:

Low ¹⁴

Contract Planning, Procurement, and Formation

Planning - Identify contracting objectives and contracting strategy.

Procurement - Fairly and objectively select the most qualified contractors.

Contract Formation/Rate/Price Establishment - Ensure that the contract contains provisions that hold the contractor accountable for producing desired results, including all relevant terms and conditions, and establish processes that are cost-effective and aligned with the cost of providing goods and services.

Source: *State of Texas Contract Management Guide*, version 1.10.

The Commission generally complied with applicable statutes and *State of Texas Contract Management Guide* requirements for contract planning, procurement, and formation for the contract (see text box for more information about those phases of contract management). The request for

proposals was published on April 9, 2012, with the responses due on April 30, 2012. The Commission signed the contract on March 27, 2013, with an effective date of May 1, 2013. The contract manager was a certified Texas contract manager and signed a conflict of interest form. The purchaser was a certified Texas procurement manager at the time of the procurement and signed the required annual conflict of interest form as required by the *State of Texas Contract Management Guide*.

Contract Planning. The Commission performed and completed most of the requirements for contract planning, which included identifying needs, involving the appropriate level of sponsorship, and having a communication plan. However, the Commission did not specify in the request for proposals the weight that would be applied to each evaluation criteria as required by the *State of Texas Contract Management Guide*. In addition, the Contract Advisory Team recommended that the Commission add those weights to the request for proposals. However, the Commission did not include that information in the request for proposals.

The Commission's *Contracting Processes and Procedures Manual* did not contain any requirements to include the weights for evaluation criteria in request for proposals. By not including the weights of the evaluation criteria in the request for proposals, the competitive bidding process could be circumvented because the evaluation criteria weights could be assigned after proposals are received to favor a specific vendor. The Commission finalized the evaluation tool that included the evaluation criteria and weights in July 2012.

Contract Procurement. The Commission followed requirements in applicable statutes and the *State Texas Contract Management Guide* to procure the

¹⁴ The risk related to the issues discussed in Chapter 3 is rated as Low because the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

contract. It properly advertised the solicitation, verified that vendor responses submitted required HUB subcontracting plans and disclosed conflicts of interest, evaluated the responses using the published criteria, and ensured that each evaluator used the same scoring and point scale.

Contract Formation. The contract contained all the essential clauses required by the *State of Texas Contract Management Guide*. Prior to the contract being signed, all required persons signed and dated the contract routing form indicating review and approval.

See Chapter 2-A for additional discussion about the contract not containing performance metrics for the quality of human resources services.

Recommendations

The Commission should:

- Include the evaluation criteria weights in all requests for proposals as required.
- Update its policies and procedures to require evaluation criteria weights to be included in all requests for proposals.

Management's Response

The Health and Human Services Commission (HHSC) is in agreement with the findings and associated recommendations and offer the following response.

Update Policies and Include Evaluation Criteria Weights in all RFPs - The Procurement and Contracting Services department has already been revising policies and procedures to require that evaluation criteria have weighting identified in the solicitation. The RFP template in use at HHSC also requires this, as of early Fiscal Year 2016.

Implementation Date:

September 30, 2016

Responsible Person:

Deputy Executive Commissioner of System Support Services

Deputy Executive Commissioner of Procurement and Contracting Services

Appendices

Appendix 1

Objective, Scope, and Methodology

Objective

The objective of this audit was to determine whether the Health and Human Services Commission (Commission) has administered certain contract management functions for selected contracts in accordance with applicable requirements.

Scope

The scope of this audit covered the Commission's human resources and payroll services agreement (contract) with NorthgateArinso¹⁵ effective on May 1, 2013. That contract covered services for the Commission, as well as the Department of Aging and Disability Services, the Department of Assistive and Rehabilitative Services, the Department of Family and Protective Services, and the Department of State Health Services (collectively referred to as "HHS agencies" in this report).

Auditors reviewed contract planning, procurement, formation, and monitoring activities through February 29, 2016.

Methodology

The audit methodology included gaining an understanding of the Commission's contracting processes; collecting and reviewing the contract and the related procurement documentation, financial information, and monitoring tools; conducting interviews with Commission staff; reviewing statutes, rules, Office of the Comptroller of Public Accounts requirements, and Commission policies and procedures; and performing selected tests and other procedures.

Auditors used personnel and payroll information from the Uniform Statewide Payroll/Personnel System (USPS) and relied on previous State Auditor's Office audit work to determine that data in that system was sufficiently reliable for the purposes of this audit.

Auditors also reviewed expenditure data from the Health and Human Services Administration System (HHSAS) for May 1, 2013, through February 29, 2016; data from the recruitment module (VURV) of the Centralized

¹⁵ The contractor is also referred to as HHS Employee Service Center.

Accounting and Payroll/Personnel System (CAPPS) for job postings that were opened between May 1, 2013, and February 29, 2016; manager list data from CAPPS and employee access data from CAPPS as of April 20, 2016; and ERS Online data as of April 29, 2016.

For HHSAS, auditors relied on previous audit work to determine that data was sufficiently reliable for the purposes of this audit. Auditors also compared HHSAS expenditure data to the Uniform Statewide Accounting System (USAS) and the invoices that the Commission received. Auditors used that data to test all of the Commission's payment of contractor invoices for the contract made during the audit scope.

Auditors determined that job posting data was reliable for the purposes of this audit by verifying that the data did not have blank fields, verifying that each data line was unique, and performing applicable application controls on the VURV module. Auditors used that data to pull the job posting sample that auditors tested and obtain additional data related to the job postings to verify information.

Auditors determined that the manager list data from CAPPS was reliable for the purposes of this audit by verifying that the data did not have unexplained blank or missing fields and that it contained expected values in each column. Auditors also reviewed the query language used to pull the data. Auditors used that data to determine whether the HHS agencies' managers and supervisors were properly classified based on their job titles and whether they had employees reporting directly to them.

Sampling Methodology

Auditors used professional judgment to select a sample of job postings. The sampled items were generally not representative of the population; therefore, it would not be appropriate to project the test results to the population.

Information collected and reviewed included the following:

- The Commission's contract with NorthgateArinso.
- The Commission's policies and procedures, manuals, and monitoring tools.
- The Commission's solicitation and bid documentation, evaluation criteria and documentation, and related supporting documentation.

- The Commission's contract procurement documentation, including planning documentation, approvals, and other supporting documentation.
- The Commission's contract expenditures from HHSAS and USAS.
- Employment data for all HHS agencies' employees from USPS.
- Employment data from the contractor.
- User access data from ERS Online and CAPPS.
- Commission internal audit reports.
- Prior State Auditor's Office reports.

Procedures and tests conducted included the following:

- Interviewed management and employees at the Commission and HHS agencies.
- Tested selected contract planning, procurement, formation, function, and monitoring processes for compliance with the *State of Texas Contract Management Guide*, *State of Texas Procurement Manual*, Commission policies and procedures, and applicable rules and statutes.
- Reviewed applicable conflict of interest and nondisclosure forms.
- Tested job posting data to determine whether job postings and associated documentation complied with the contract and Commission policies and procedures.
- Tested contractor access to CAPPS and ERS Online.
- Tested the Commission's monitoring of the contractor's compliance with requirements related to payroll; time, labor, and leave; human resources; and information technology.
- Tested contractor invoices and the Commission's payments to determine whether the contractor payments were supported, accurate, timely, conformed to contract requirements, and approved prior to payment.

Criteria used included the following:

- *State of Texas Contract Management Guide*, versions 1.10, 1.11, 1.12, 1.13, and 1.14.
- Contract terms for the contract, which includes the final executed contract, the request for proposals, and the contractor's proposal, as modified and agreed upon by the Commission and the contractor.
- Commission policies and procedures.
- State of Texas Procurement Manual.
- Title 1, Texas Administrative Code, Chapters 202 and 212.
- Title 34, Texas Administrative Code, Chapter 20.
- Texas Government Code, Chapters 322, 572, 2155-2158, 2161, 2251, 2252, 2254, and 2261-2263.

Project Information

Audit fieldwork was conducted from December 2015 through July 2016. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

- Becky Beachy, CIA, CGAP (Project Manager)
- Serra Tamur, MPAff, CISA, CIA (Assistant Project Manager)
- Paige Dahl
- Jennifer Fries, MS
- Richard E. Kukucka, III
- Kathy-Ann Moe, MBA
- Joy Myers, MPP
- Lara Foronda Tai, PHR, SHRM-CP

- Mary Ann Wise, CPA, CFE (Quality Control Reviewer)
- John Young, MPAff (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 of state statute(s), rules, regulations, and other requirements or criteria; and the inadequacy of the design and/or operating effectiveness of internal controls. In addition, evidence of potential fraud, waste, or abuse; significant control environment issues; and little to no corrective action for issues previously identified could increase the ratings for audit findings. Auditors also identified and considered other factors when appropriate.

Table 2 provides a description of the issue ratings presented in this report.

Table 2

Summary of Issue Ratings	
Issue Rating	Description of Rating
Low	The audit identified strengths that support the audited entity's ability to administer the program(s)/function(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.
Medium	Issues identified present risks or effects that if not addressed could <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.

Human Resources Service Level Agreements in the Contract

The Health and Human Services Commission's human resources and payroll services agreement (contract) with NorthgateArinso contains service level agreements that the request for proposals defined as "specific service requirements used to measure the Contractor's performance or specified obligations during the course of the contract." The contract contained 69 service level agreements, 20 of which were related to human resources services. None of those 20 service level agreements measured the quality of human resource services provided for the accuracy and completeness of job postings and the proper classification of employees. Table 3 lists the 20 human resources service level agreements.

Table 3

Human Resources Service Level Agreements (SLAs)				
SLA Number	Service Component	Performance Standard	Benchmark	Time Measure
2.01	Call Handling Plan	Submit, implement, and maintain a Comprehensive Plan for customer inquiry handling methods and procedures within 10 business days after the effective date of the contract.	Within 10 business days after the effective date of the contract.	One-time
2.02	Call Accuracy Monitoring Plan/ Quality Assurance	Contractor will provide accurate call information to callers, as measured by the Call Accuracy Monitoring/Quality Management Monitoring Plan. Note: "Call Accuracy Monitoring Plan" means a plan to monitor 275 calls per month.	Greater than or equal to 95 percent of monitored calls must provide completely accurate information.	Monthly
2.03	Call Abandonment Rate	Contractor will answer all calls within 20 seconds. Note: "Answer" means to respond to an inbound call by connecting the caller to a live person or to an Interactive Voice Response unit.	Greater than or equal to 97 percent.	Monthly
2.04	Forced Disconnect Percentage	Contractor will ensure that the forced disconnect percentage does not exceed 2 percent of all calls that attempt to enter the queue during the month. Note: "Forced disconnect" means calls that are prevented from entering the queue.	Less than or equal to 2 percent.	Monthly
2.05	Telephone Answer Time	Contractor will answer calls within 20 seconds after the first call ring upon caller exiting the Interactive Voice Response (IVR). Note: "Answer" means to respond to an inbound call by connecting the caller to a live person.	Greater than or equal to 80 percent.	Monthly
2.06	Service Center Responsiveness-Acknowledgments	Contractor will issue acknowledgments of requests within two business days of receiving the request. The targeted resolution date will be before the next scheduled payroll affected by the request and resolution. Note: "Acknowledgement" means a written statement delivered to the requestor indicating that the request has been received and a date provided for a targeted resolution. "Request" means an inbound call, email from a customer that includes a request, inquiry, complaint, or similar message that anticipates an appropriate response from the Contractor.	Greater than or equal to 95 percent.	Monthly

Human Resources Service Level Agreements (SLAs)				
SLA Number	Service Component	Performance Standard	Benchmark	Time Measure
2.07	Service Center Responsiveness-Responses	Contractor will provide written responses to requestors within two business days of logged case close date, unless [the Health and Human Services Commission] agrees to a longer time period. Note: If the request was pay impacting, then the written response should be delivered before the next scheduled payroll affected by the request and resolution. If the resolution does not occur in time for the next scheduled payroll, then requestor will be informed of how the pay impacting condition will be resolved before the next scheduled payroll.	Greater than or equal to 95 percent.	Monthly
2.08	Monthly Service Level Agreement Report	Contractor will provide a monthly SLA Report acceptable to [the Health and Human Services Commission] in form and substance that provides detailed information on the Contractor's performance on each SLA during the preceding date month, within 15 business days after the end of the reporting period.	100 percent.	Monthly
2.09	Required Reporting Timeliness	Contractor will submit required information or required reports by the deadline that HHSC establishes for each report. Report or data include, but are not limited to: <ul style="list-style-type: none"> ▪ EEO-4 State and Local Government Report. ▪ Veterans Employment Report. ▪ W-2 Employee Annual Earnings Statements. ▪ W-3 Transmittal of Wage and Tax Statements. ▪ [Texas Workforce Commission] (TWC) Unemployment Quarterly Reports. ▪ Texas Department of Insurance (TDI) Worker Compensation Reports. ▪ Quarterly 941 Federal Tax Reports and Required Attachments and Amendments. ▪ Annual Medicare Data Match Reports. ▪ Historically Underutilized Business (HUB). ▪ Other reports required by state or federal law or as required by Section 5.02. UTC of the contract. 	Submission of information or report by the deadline.	Per Report
2.10	Required Reporting Accuracy	Contractor will ensure accuracy of data included in all federal, state, and required reports before submitting report to [the Health and Human Services Commission] for final review. Report or data include, but are not limited to: <ul style="list-style-type: none"> ▪ EEO-4 State and Local Government Report. ▪ Veterans Employment Report. ▪ W-2 Employee Annual Earnings Statements. ▪ W-3 Transmittal of Wage and Tax Statements. ▪ [Texas Workforce Commission] (TWC) Unemployment Quarterly Reports. ▪ Texas Department of Insurance (TDI) Worker Compensation Reports. ▪ Quarterly 941 Federal Tax Reports and Required Attachments and Amendments. ▪ Annual Medicare Data Match Reports. ▪ Historically Underutilized Business (HUB). 	98 percent.	Monthly

Human Resources Service Level Agreements (SLAs)				
SLA Number	Service Component	Performance Standard	Benchmark	Time Measure
		<ul style="list-style-type: none"> Other reports required by state or federal law or as required by Section 5.02, UTC of the contract. <p>For purposes of this Performance Standard, “accuracy” refers to the degree to which a report is free of material errors. An accurate report is one that contains no material errors; an inaccurate report is one that contains one or more material errors. A “material error,” for purposes of this Performance Standard, means an error in the value, format or placement of one or more data elements within a report that may impact the usefulness or reliability of the report or impair its effectiveness in light of its intended purpose.</p>		
2.11	Turnover Report	Contractor will prepare and submit an acceptable Turnover Results Report within 45 calendar days after the completion of turnover activities.	Within 45 days after the completion of turnover activities.	One time
2.12	Key Personnel Timely Verbal Notification	Contractor will orally notify [the Health and Human Services Commission] at least two business days in advance or otherwise as soon as identified that a key personnel vacancy will occur for any reason.	Two business days in advance that a key personnel vacancy will occur.	As Required
2.13	Key Personnel Written Notification	Contractor will provide written notice of any changes of key personnel to [the Health and Human Services Commission] within 10 business days of the date on which the Contractor becomes aware of an actual or prospective change.	Within 10 business days of the date on which the Contractor becomes aware of an actual or prospective change.	As Required
2.14	Classification/FLSA Change Processing Timeliness	Contractor will process and track complete requests for classification/job audits and Fair Labor Standards Act (FLSA) changes during each month. Contractor will process all complete requests within 10 business days of receiving request and will post to the employee’s record within 2 business days. Note: “Complete request” means a classification or job audit request that contains all required data available from the manager.	Greater than or equal to 98 percent.	Monthly
2.15	90-Day Wait Processing: Retirement	[Employees Retirement System] Contribution set-up: Contractor will ensure [Employees Retirement System] Retirement Contribution set up is completed prior to next scheduled on-cycle payroll for all eligible personnel.	100 percent.	Monthly
2.16	Application Processing Timeliness	Contractor will provide hiring managers closed, completed application packages, and via [Health and Human Services Commission] approved media, within three business days of job requisition closing date.	Greater than or equal to 97 percent.	Monthly
2.17	SAO Exit Interview	Contractor will request and obtain unique ID number in the [State Auditor's Office] exit interview system and will issue to a voluntarily separated employee within five business days of Contractor ’s receipt of notice of termination from the manager.	Greater than or equal to 95 percent.	Monthly
2.18	Verifying Prior State Service	Contractor will issue a request to verify prior state employment from the designated agency within two business days after receipt of the HR0112 (Prior State Employment Form).	Greater than or equal to 97 percent.	Monthly
2.19	Verifying Prior State Service	Contractor will enter all applicable prior state service and benefits data, such as benefit	Greater than or equal to 97 percent.	Monthly

Human Resources Service Level Agreements (SLAs)				
SLA Number	Service Component	Performance Standard	Benchmark	Time Measure
		replacement pay, longevity, vacation accruals, or other service credit information, into the Centralized Accounting and Payroll/Personnel System (CAPPS) within two business days after receipt of the HR0113 (Prior State Employment Verification Form). If the on-cycle payroll has calculated prior to receipt, the information will be entered prior to the next supplemental payroll for the pay impacting entries. All other entries not affecting current payroll calculation will be entered within two business days after receipt of the prior state verification.		
2.20	Verifying Prior State Service	Contractor will issue a second request to verify prior state employment if Contractor has not received verification from the designated agency within 10 business days after the date of the initial request. The second request will be issued no later than close of business on the 12th business day from the date of the initial request, and the service center will notify the state human resources office by email upon issuing the second request.	Greater than or equal to 97 percent.	Monthly

Source: The Health and Human Services **Commission's** contract with NorthgateArinso.

Related State Auditor's Office Work

Related State Auditor's Office Work		
Number	Product Name	Release Date
16-705	A Classification Compliance Audit Report on Program Specialist and Program Supervisor Positions at the Department of Aging and Disability Services	August 2016
16-031	An Audit Report on a Selected Contract at the Department of State Health Services	June 2016
16-020	An Audit Report on Selected Agencies' Use of Department of Information Resources Information Technology Staffing Services Contracts	March 2016
16-006	A Report on Health and Human Services Commission Contracts	October 2015
15-031	An Investigative Report on the Health and Human Services Commission's and the Office of Inspector General's Procurement of Services and Commodities from 21CT, Inc.	April 2015
15-030	An Audit Report on Procurement for Terrell State Hospital Operations at the Health and Human Services Commission and the Department of State Health Services	March 2015
15-019	A Report on Recent Contracting Audits	January 2015
15-017	An Audit Report on the Telecommunications Managed Services Contract at the Health and Human Services Commission	December 2014
14-035	An Audit Report on Selected Contracts at the Health and Human Services Commission	June 2014
14-013	An Audit Report on Information and Communications Technology Cooperative Contracts at the Health and Human Services Commission	December 2013

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Human Resources Management-related Audits at the Health and Human Services Agencies

The State Auditor's Office performed two audits related to human resources management at the Health and Human Services agencies:

- *A Classification Compliance Audit Report on Program Specialist and Program Supervisor Positions at the Department of Aging and Disability Services* (Report No. 16-705, August 2016). The objective of this classification compliance audit was to determine whether the Department of Aging and Disability Services conforms to the State's Position Classification Plan in ensuring proper classification of positions.
- *An Audit Report on Human Resources Contract Management at the Health and Human Services Commission* (Report No. 17-004, October 2016). The objective of this audit was to determine whether the Health and Human Services Commission (Commission) has administered certain contract management functions for selected contracts in accordance with applicable requirements.



Human Resources Management-related Audits at the Health and Human Services Agencies

Background

- The Commission has outsourced the majority of its human resources functions to NorthgateArinso (contractor). Those functions include recruitment and hiring; compensation management; benefits management; payroll; and time, labor, and leave.
- The contract's term is May 1, 2013, through April 30, 2018. The initial cost of the contract was not to exceed \$56.9 million. As of February 29, 2016, the health and human services agencies (HHS agencies)¹ reported that there were 53,736 full-time equivalent (FTE) positions for which the contractor was responsible for providing services.

¹ The contract included critical human resources functions for Commission employees and employees at the Department of Family and Protective Services, Department of Assistive and Rehabilitative Services, Department of Aging and Disability Services, and Department of State Health Services (collectively referred to as "HHS agencies").



Human Resources Management-related Audits at the Health and Human Services Agencies

Findings Related to Proper Classification of Employees

- A significant number of employees at and job postings for the State's HHS agencies were not properly classified according to the State's Position Classification Plan:
 - Based on a list of 5,484 HHS agency managers and supervisors on January 15, 2016, 760 (13.9 percent) were misclassified with entry-level titles and other nonsupervisory titles.
 - Of the 149 job postings tested, 40 (26.8 percent) appeared to be incorrectly classified based on the duties described in the job description compared to information in the State's Position Classification Plan.
 - An audit conducted by the State Auditor's Office's State Classification Team determined that 356 (57.7 percent) of 617 program specialist and program supervisor employees at the Department of Aging and Disability Services were not classified correctly².

² See *A Classification Compliance Audit Report on Program Specialist and Program Supervisor Positions at the Department of Aging and Disability Services*, State Auditor's Office Report No. 16-705, August 2016.



Human Resources Management-related Audits at the Health and Human Services Agencies

Findings Related to Proper Classification of Employees (continued)

- The Commission's human resources office reported that the Department of Aging and Disability Services will spend \$332,445 annually to properly classify and compensate 119 of the 356 misclassified employees. There was no cost associated with addressing the classification of the remaining misclassified employees.



Human Resources Management-related Audits at the Health and Human Services Agencies

Findings Related to the Monitoring of the Contract Requirements

- The Commission did not have a comprehensive monitoring plan or perform a risk assessment to direct its monitoring of the contract. A monitoring plan and risk assessment should identify the contract requirements to be monitored, how the requirements will be monitored, and who will perform the monitoring.
- The Commission did not adequately monitor to ensure that the contractor complied with certain contract requirements, which contributed to misclassification of job positions, possible misclassifications of job postings, and inaccurate job postings. Those requirements include: (1) assisting HHS managers with the development and revision of job descriptions, (2) reviewing job postings to verify accuracy, completeness, and compliance with Commission policies and procedures, and (3) performing an annual classification review for all HHS agency positions.



Human Resources Management-related Audits at the Health and Human Services Agencies

Findings Related to the Monitoring of the Contract Requirements (continued)

- The Commission should improve its monitoring of the information technology-related requirements in the contract. Neither the Commission nor the contractor had an adequate process to periodically review user access to the Commission's human resources system or to ERS Online, which contains confidential employee data, and ensure that user accounts are disabled when users leave employment.
- The Commission adequately monitored the payroll-related requirements.



Human Resources Management-related Audits at the Health and Human Services Agencies

Issue Ratings

Auditors rated the audit findings in *A Classification Compliance Audit Report on Program Specialist and Program Supervisor Positions at the Department of Aging and Disability Services (Report No. 16-705, August 2016)* as noted below.

Summary of Chapter and Related Issue Rating ^a State Auditor's Office Report No. 16-705, August 2016		
Chapter	Title	Issue Rating
1	Analysis of Department Employees Classified in the Program Specialist and Program Supervisor Job Classification Series	Priority
^a Auditors used professional judgement and rated the audit findings identified in this report. The issue ratings were determined based on the degree of risk or effect of the findings in relation to the audit objective(s). A description of the issue ratings and other factors considered are included in Appendix 2 of the audit report.		



Human Resources Management-related Audits at the Health and Human Services Agencies

Issue Ratings (continued)

Auditors rated the audit findings in *An Audit Report on Human Resources Contract Management at the Health and Human Services Commission (Report No. 17-004, October 2016)* as noted below.

Summary of Chapters and Related Issue Ratings ^a State Auditor's Office Report No. 17-004, October 2016		
Chapter	Title	Issue Rating
1	The Commission Lacked Sufficient Processes to Ensure That Employees Were Properly Classified	Priority
2-A	The Commission Lacked a Comprehensive Monitoring Plan and Risk Assessment to Direct Its Monitoring of the Contract	Priority
2-B	The Commission Did Not Sufficiently Monitor to Ensure That the Contractor Complied with the Human Resources Contract Requirements	Priority
2-C	The Commission Did Not Adequately Monitor Significant Information Technology Contract Requirements	High
2-D	The Commission Provided Adequate Oversight of the Payroll and Time, Labor, and Leave Services the Contractor Performed	Low
2-E	The Commission Adequately Reviewed Contractor Invoices; However, It Did Not Always Accurately Charge the Payments to the Correct Contract	Medium
3	The Commission Generally Complied with State Requirements for Contract Planning, Procurement, and Formation	Low

^a Auditors used professional judgement and rated the audit findings identified in this report. The issue ratings were determined based on the degree of risk or effect of the findings in relation to the audit objective(s). A description of the issue ratings and other factors considered are included in Appendix 2 of the audit report.



A Classification Compliance Audit Report on
**Program Specialist and
Program Supervisor Positions at the
Department of Aging and Disability Services**

August 2016
Report No. 16-705



A Classification Compliance Audit Report on
**Program Specialist and
Program Supervisor Positions at the
Department of Aging and Disability Services**

SAO Report No. 16-705
August 2016

Overall Conclusion

A total of 356 (57.7 percent) of 617 employees tested at the Department of Aging and Disability Services (Department) were **misclassified in accordance with the State's Position Classification Plan**. The employees tested were classified within the program specialist and program supervisor job classification series. In previous classification compliance reviews of program specialist positions¹ at other state agencies, 924 (31.4 percent) of 2,938 employees reviewed were misclassified. The Department self-reported the classification information on which this audit focused.

Of the 356 misclassified employees, 315 (88.5 percent) were misclassified because the Department did not use a more appropriate, occupationally specific job classification series. For example, to correct one misclassification that auditors identified, the Department reclassified an employee in the program specialist job classification series to a contract specialist job classification.

The **Health and Human Services Commission's** human resources office reported that the Department will spend \$332,445 annually to properly classify and compensate 119 of the 356 misclassified employees. There was no cost associated with addressing the classification of the remaining misclassified employees. No employees will receive a decrease in salary as a result of this audit.

Responsibility for Employee Classification

NorthgateArinso (NGA) HHS Employee Service Center is a contractor that provides human resources and payroll assistance to health and human services agencies. NGA, Department supervisors, and the Health and Human Services **Commission's human resources** office share responsibility for ensuring that Department employees are classified in accordance with the **State's Position Classification Plan**, but NGA and Department supervisors have the primary responsibility for proper classification.

Source: The Health and Human Services **Commission's human resources** office.

Background Information

The **Department of Aging and Disability Services'** (Department) responsibilities include:

- Administering long-term services and support for older individuals and individuals with disabilities.
- Licensing and certifying providers of services and support for older individuals and individuals with disabilities.
- Monitoring compliance with regulatory requirements.
- **Administering the State's guardianship** program, which provides a court-appointed person (guardian) to make decisions on behalf of a person with diminished capacity.
- **Operating the State's residential facilities** for people with intellectual and developmental disabilities.

As noted in *A Summary Report on Full-time Equivalent State Employees for Fiscal Year 2015* and in *An Annual Report on Classified Employee Turnover for Fiscal Year 2015* (**State Auditor's** Office Report Nos. 16-701 and 16-702, December 2015), in fiscal year 2015, the Department:

- Had an average of 15,527.7 full-time equivalent employees, which accounted for 4.9 **percent of the State's workforce**.
- Had the highest turnover rate (32.2 percent) among state agencies with 1,000 or more employees.

Sources: The Department and the State Auditor's Office.

¹ The program supervisor job classification series was not included in previous reviews. For this audit, 355 (57.8 percent) of the 614 program specialists were misclassified, a rate that is still higher than the 31.4 percent from previous reviews of that job classification series.

Table 1 summarizes the misclassifications identified during this audit.

Table 1

Summary of Department Employees in Program Specialist and Program Supervisor Positions		
Job Classification Series	Number of Employees Tested	Number of Employees Misclassified
Program Specialist	614	355
Program Supervisor	3	1
Totals	617	356

Table 2 presents a summary of the findings in this report and the related issue rating. (See Appendix 2 for more information about the issue rating classifications and descriptions.)

Table 2

Summary of Chapters and Related Issue Ratings		
Chapter	Title	Issue Rating ^a
1	Analysis of Department Employees Classified in the Program Specialist and Program Supervisor Job Classification Series	Priority
<p>^a A chapter is rated Priority if the issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern and reduce risks to the audited entity.</p> <p>A chapter is rated High if the issues identified present risks or effects that if not addressed could substantially affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern and reduce risks to the audited entity.</p> <p>A chapter is rated Medium if the issues identified present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.</p> <p>A chapter is rated Low if the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.</p>		

Summary of Management's Response

At the end of Chapter 1 in this report, auditors made recommendations to address the issues identified during this audit. The Department agreed with the recommendations in this report.

Audit Objective and Scope

The objective of this classification compliance audit was to determine whether the Department conforms to the State's Position Classification Plan in ensuring proper classification of positions.

The scope of this audit included 617 employees within the program specialist and program supervisor job classification series at the Department as of October 1, 2015.

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Detailed Results

Chapter 1

Analysis of Department Employees Classified in the Program Specialist and Program Supervisor Job Classification Series

Chapter 1
Rating:
Priority²

A total of 356 (57.7 percent) of 617 employees at the Department of Aging and Disability Services (Department) classified in the program specialist and program supervisor job classification series³ were misclassified. See Appendix 3 for a description of program specialists and program supervisor positions.

In previous classification compliance reviews of employees classified in program specialist positions⁴ at other state agencies, 924 (31.4 percent) of 2,938 employees reviewed were misclassified (see text box for additional details).

Prior Reviews of Employees Classified as Program Specialists

In July 2009, the State Auditor's Office's State Classification Team conducted a classification compliance review focusing on program specialist positions at small and mid-sized agencies (agencies with fewer than 1,000 employees). That review determined that 82.0 percent of the employees were classified correctly (and 18.0 percent were misclassified). See *A Classification Compliance Review Report on the State's Program Specialist Positions* (State Auditor's Office Report No. 09-706, July 2009) for the results of that review.

In March 2010, the State Auditor's Office's State Classification Team conducted a classification compliance review focusing on program specialist positions at selected public safety and criminal justice agencies. That review determined that 48.1 percent of employees were classified correctly (and 51.9 percent were misclassified). See *A Classification Compliance Review Report on the State's Program Specialist Positions at Selected Public Safety and Criminal Justice Agencies* (State Auditor's Office Report No. 10-705, March 2010) for the results of that review.

In May 2011, the State Auditor's Office's State Classification Team conducted a classification compliance review focusing on program specialist positions at selected natural resources and business and economic development agencies. That review determined that 71.3 percent of employees were classified correctly (and 28.7 percent were misclassified). See *A Classification Compliance Review Report on the State's Program Specialist Positions at Selected Natural Resources Agencies and Selected Business and Economic Development Agencies* (State Auditor's Office Report No. 11-706, May 2011) for the results of that review.

² The risks related to the issues discussed in Chapter 1 are rated as priority because they 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.

³ A job classification series is a hierarchical structure of jobs arranged into job classification titles involving the work of the same nature but requiring different levels of responsibility.

⁴ The program supervisor job classification series was not included in previous reviews. For this audit, 355 (57.8 percent) of the 614 program specialists were misclassified, a rate that is still higher than the 31.4 percent from previous reviews of that position.

To address the 356 employees who were misclassified, the Health and Human Services Commission's human resources office reported that the Department chose to:

- Reclassify⁵ 315 employees into a different job classification⁶ series. For example, it reclassified a program specialist to a contract specialist.
- Reclassify 40 employees within the same job classification series but at a higher salary group.
- Change the job duties of 1 employee so the employee could remain in the current job classification and be properly classified.

Importance of Proper Classification of Employee Positions

Appropriate job classifications are important in determining salary rates that are competitive for the nature of the work performed. Misclassified positions may result in an agency underpaying or overpaying employees for the nature of work being performed.

Of the 356 misclassified employees, 315 (88.5 percent) were misclassified because the Department did not use a more appropriate and occupationally specific job classification series.

Table 3 summarizes the misclassifications identified during this audit. For additional details, see Appendix 4.

Table 3

Summary of Department Employees in Program Specialist and Program Supervisor Positions		
Job Classification Series	Number of Employees Tested	Number of Employees Misclassified
Program Specialist	614	355
Program Supervisor	3	1
Totals	617	356

The Health and Human Services Commission's human resources office reported that, as a result of reclassifications, 119 employees at the Department will receive annual salary increases ranging from \$12,386 to \$242. As a result, the Health and Human Services Commission's human resources office reported that the Department will spend \$332,445 annually to properly classify and compensate those employees. There was no cost associated with addressing the misclassifications on the remaining 237

⁵ A reclassification is the act of changing a position from one job classification to another job classification that better reflects the level or type of work being performed.

⁶ A job classification is an individual job within a job classification series. Each job classification has a corresponding salary group assignment appropriate for the type and level of work being performed.

employees. No employees will receive a reduction in salary as a result of the reclassifications.

The number of Department program specialists increased from 291 in fiscal year 2005 to 656⁷ in fiscal year 2015.⁸ Although significant increases in the number of employees within a job classification series can indicate new or expanded programs, they can also indicate an increase in misclassifications and weaknesses in internal controls for ensuring appropriate employee classification.

Some Department employees correctly classified as program specialists performed work focusing on:

- Data analysis.
- Protection of human rights.
- Transition assistance services.
- Compliance monitoring.
- Guardianship services.

The State Classification Team will review those types of positions in fiscal year 2016 during the review of the State's Position Classification Plan⁹ to determine whether it would be appropriate to recommend the addition of new job classification series, such as data analyst, to the State's Position Classification Plan.

When appropriate, adding new job classification series addresses gaps in the State's Position Classification Plan and provides agencies with new job classifications that more clearly distinguish the work that employees perform. It also helps to ensure that the State's Position Classification Plan adequately meets the needs of state agencies and properly compensates the State's employees.

⁷ Due to reasons such as employee turnover and employees being out on extended leave, not all of the Department employees in those positions in fiscal year 2015 were within the scope of this classification compliance audit.

⁸ The program supervisor job classification series was not implemented until fiscal year 2006 and, therefore, was not used in that comparison.

⁹ That review will be conducted in accordance with Texas Government Code, Chapter 654.

Recommendations

The Department should work with the Health and Human Services Commission's human resources office to:

- Complete all reclassifications, salary adjustments, and job restructuring for employees identified as misclassified during this audit and notify the employees.
- Review employees in the program specialist and program supervisor job classification series who were not within the scope of this audit to ensure that those employees are classified appropriately for their level of responsibilities and the work they perform. That review should include employees who were on extended leave during this audit or employees who were newly hired or promoted to their positions. The Department should use occupationally specific job classifications when appropriate.
- Monitor the use of program specialist and program supervisor job classification series to ensure occupationally specific job classifications are used, when appropriate. That should include closely monitoring job postings to ensure the appropriate job classification title is being used. If the Department determines that a new job classification series may be warranted, it should work with the State Auditor's Office's State Classification Team to determine whether recommendations should be made to the Legislature regarding the creation of new job classification series or additional levels in current job classification series.

Management's Response

1. Complete all reclassifications, salary adjustments, and job restructuring for employees identified as misclassified during this audit and notify the employees.

The Department of Aging and Disability Services (DADS) received the final report of positions that were identified as misclassified as a result of this audit in June 2016. The audit determinations were shared with DADS executive management and employees impacted by the reclassification of their positions. All reclassifications, salary adjustments where necessary, and job restructuring for employees will be completed with an effective date of July 1, 2016. Reclassifications are being coordinated with HHS human resources and the HHS employee service center. The reclassifications are being completed in a cost neutral manner if the employee's salary was within the new salary group. Employees whose salary was below the minimum of the new salary group will receive a salary increase as a result of reclassification into a job classification with a higher minimum salary.

2. Review employees in the program specialist and program supervisor job classification series who were not within the scope of this audit to ensure that those employees are classified appropriately for their level of responsibilities and the work they perform. That review should include employees who were on extended leave during this audit or employees who were newly hired or promoted to their positions. The Department should use occupationally specific job classifications when appropriate.

A report of all employees in the program specialist and program supervisor job classification series who were not within the scope of this audit, including employees who were on extended leave during this audit, and positions that were vacant during this audit, was provided to DADS executive management for review. After DADS Executive and Staff Operations reviewed these positions and consulted with HHS human resources, 57 employees and/or vacant positions will be reclassified in accordance with audit determinations of other positions included in the audit with an effective date of July 1, 2016.

3. Monitor the use of program specialist and program supervisor job classification series to ensure occupationally specific job classifications are used, when appropriate. That should include closely monitoring job postings to ensure the appropriate job classification title is being used. If the Department determines that a new job classification series may be warranted, it should work with the State Auditor's Office's State Classification Team to determine whether recommendations should be made to the Legislature regarding the creation of new job classification series or additional levels in current job classification series.

DADS will, in coordination with the HHS employee service center and HHS human resources, monitor the use of the program specialist and program supervisor job classification series and work to ensure occupationally specific job classifications are used when appropriate. In addition, as a result of this audit, DADS has submitted several recommendations for the creation of new job classification series, as well as a request for additional levels in other current job classification series, to HHS human resources for consideration. It is our understanding these recommendations have been reviewed and submitted to the State Auditor's Office for consideration.

Implementation Dates:

*July 1, 2016 - Reclassifications and salary adjustments
Ongoing - Creation of new job classification series and monitoring*

Responsible Persons:

*Lynn Blackmore, DADS Chief Operating Officer
Amy Tippie, DADS Director of Executive and Staff Operations
Lisa Glenn, HHS Assistant Human Resources Director
NorthgateArinso (NGA), HHS Employee Service Center*

Appendices

Appendix 1

Objective, Scope, and Methodology

Objective

The objective of this classification compliance audit was to determine whether the Department of Aging and Disability Services (Department) conforms to the State's Position Classification Plan in ensuring proper classification of positions.

Scope

The scope of this review included 617 employees within the program specialist and program supervisor job classification series as of October 1, 2015.

Methodology

The audit methodology included collecting information and documentation, reviewing and analyzing surveys completed by Department employees and verified by their supervisors, and conducting interviews with Department management.

The State Auditor's Office's State Classification Team evaluates jobs on a "whole job" basis to determine proper job classifications. The determinations are primarily based on a comparison of duties and responsibilities of the majority of work being performed against the state job description.

When determining proper classification, the State Classification Team does not focus on specific differences between one level and the next level in a job classification series (for example, Program Specialist I versus Program Specialist II). Instead, the State Classification Team considers whether an employee is appropriately classified within broad responsibility levels, such as Staff Program Specialist (Program Specialist I, Program Specialist II, and Program Specialist III positions) versus Senior Program Specialist (Program Specialist IV, Program Specialist V, Program Specialist VI, and Program Specialist VII positions).

The State Classification Team used an automated job evaluation process. The State Classification Team populated a database with information regarding the employees whose positions were tested. Staff in the Department verified the information to ensure that all positions within the

audit scope were included. Department employees were then asked to complete online surveys describing the work they perform and the percentage of time they spend performing their duties. Supervisors were asked to review and verify employees' survey responses.

Completed survey results were entered into an automated job evaluation system, which made an initial determination of whether the positions were appropriately classified. The State Classification Team reviewed all surveys to determine and validate the proper classification of positions. The State Classification Team made follow-up calls or sent clarification emails to gather additional information to determine the proper classification of positions. The Department then had the opportunity to review and address potential misclassifications.

Data Reliability and Completeness

Auditors relied on previous State Auditor's Office audit work on the Standardized Payroll Personnel Report System (SPRS) for data completeness and accuracy. Auditors determined that the data was sufficiently reliable for the purposes of this audit. Auditors determined that the data in the Classification Compliance Audit System was reliable for the purposes of this audit.

Information collected and reviewed included the following:

- Surveys completed by employees and verified by their supervisors.
- Correspondence from the Health and Human Services Commission human resources office and supervisors at the Department.

Procedures and tests conducted included the following:

- Interviewed management at the Health and Human Services Commission's human resources office and the Department regarding the classification of positions.
- Follow-up calls and emails were sent to the Department to validate proper classification of positions and to gather additional information to resolve discrepancies.

Criteria used included the following:

- Texas Government Code, Section 654.
- State job descriptions.

Project Information

Audit fieldwork was conducted from October 2015 through April 2016. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

- Sharon Schneider, CCP, PHR, SHRM-CP (Project Manager)
- Kendra Campbell, MSIS, PHR, SHRM-CP
- Kathy-Ann Moe
- Lara Tai, PHR, SHRM-CP
- Juan Sanchez, MPA, CIA, CGAP
- Dana Musgrave, MBA (Quality Control Reviewer)
- John Young, MPAff (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 4 provides a description of the issue ratings presented in this report.

Table 4

Summary of Issue Ratings	
Issue Rating	Description of Rating
Low	The audit identified strengths that support the audited entity's ability to administer the program(s)/function(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.
Medium	Issues identified present risks or effects that if not addressed could <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.

Description of Program Specialist and Program Supervisor Job Classification Series

The program specialist job classification series in the State's Position Classification Plan was designed to address limited situations in which an occupationally specific job classification did not exist. To be appropriately classified within the program specialist job classification series:

- Employees should provide consultative services and technical assistance work involving planning, developing, and implementing an agency program.
- There should be no occupationally specific job classification available within the State's Position Classification Plan that would be a good fit for the majority of work being performed. Although the program specialist job classification series covers a broad variety of duties and work, state agencies should use occupationally specific job classifications whenever possible. That helps to ensure that employees will gain the benefit of pay decisions and market reviews of positions with similar functions, experience, and skills.
- Employees should not have supervisory responsibilities.

Importance of Proper Classification of Employee Positions

Appropriate job classifications are important in determining salary rates that are competitive for the nature of the work performed. Misclassified positions may result in an agency underpaying or overpaying employees for the nature of work being performed.

The program supervisor job classification series was designed to address employees performing work similar to the program specialist job classification series but who have the additional responsibility of supervising employees working in an agency program or multiple programs.

Analysis of Misclassified Employees

Tables 5 and 6 summarize the job titles held by Department of Aging and Disability Services (Department) employees who were misclassified and how the Department addressed the misclassifications.

Table 5 summarizes the job titles of the 315 employees whom the Department stated it would reclassify into different job classification series; 98 of those reclassifications will result in salary increases totaling \$281,913 annually.

Table 5

Department Employees to Be Reclassified into Different Job Classification Series		
Job Title Prior to Audit	Job Title After Reclassification	Number of Employees To Be Reclassified
Program Specialist I	Customer Service Representative III	3
Program Specialist I	Food Service Manager IV	1
Program Specialist I	Health Specialist IV	4
Program Specialist I	Health Specialist V	1
Program Specialist I	Inspector V	1
Program Specialist I	Investigator IV	1
Program Specialist I	License and Permit Specialist IV	10
Program Specialist I	Manager I	1
Program Specialist I	Program Supervisor I	5
Program Specialist I	Program Supervisor V	1
Program Specialist I	Quality Assurance Specialist I	1
Program Specialist I	Rehabilitation Therapy Technician IV	1
Program Specialist I	Reimbursement Officer II	1
Program Specialist I	Safety Officer I	1
Program Specialist II	Administrative Assistant IV	2
Program Specialist II	Contract Specialist II	1
Program Specialist II	Contract Specialist III	2
Program Specialist II	Custodial Manager III	1
Program Specialist II	Customer Service Representative IV	1
Program Specialist II	Executive Assistant I	1
Program Specialist II	Laundry Manager III	1
Program Specialist II	License and Permit Specialist IV	8
Program Specialist II	Management Analyst I	1
Program Specialist II	Manager I	1
Program Specialist II	Program Supervisor I	2
Program Specialist II	Program Supervisor II	2

Department Employees to Be Reclassified into Different Job Classification Series		
Job Title Prior to Audit	Job Title After Reclassification	Number of Employees To Be Reclassified
Program Specialist II	Program Supervisor IV	6
Program Specialist II	Program Supervisor V	14
Program Specialist II	Protective Services Intake Specialist IV	1
Program Specialist II	Protective Services Intake Specialist V	18
Program Specialist II	Reimbursement Officer III	2
Program Specialist II	Research Specialist IV	1
Program Specialist II	Volunteer Services Coordinator IV	7
Program Specialist III	Business Analyst I	1
Program Specialist III	Contract Specialist III	1
Program Specialist III	Executive Assistant I	1
Program Specialist III	Food Service Manager IV	2
Program Specialist III	Health Specialist IV	3
Program Specialist III	Human Resources Specialist IV	2
Program Specialist III	Inspector VI	1
Program Specialist III	License and Permit Specialist IV	3
Program Specialist III	Maintenance Supervisor IV	1
Program Specialist III	Manager I	6
Program Specialist III	Program Supervisor II	1
Program Specialist III	Program Supervisor III	4
Program Specialist III	Program Supervisor IV	1
Program Specialist III	Program Supervisor V	5
Program Specialist III	Quality Assurance Specialist III	5
Program Specialist III	Systems Administrator III	1
Program Specialist III	Volunteer Services Coordinator IV	3
Program Specialist IV	Accountant III	1
Program Specialist IV	Administrative Assistant IV	1
Program Specialist IV	Contract Specialist III	3
Program Specialist IV	Contract Specialist IV	11
Program Specialist IV	Education Specialist III	7
Program Specialist IV	Education Specialist IV	1
Program Specialist IV	Health and Human Services Program Coordinator II	1
Program Specialist IV	Health Specialist IV	1
Program Specialist IV	Human Resources Specialist IV	1
Program Specialist IV	Information Specialist IV	1
Program Specialist IV	Maintenance Supervisor V	1
Program Specialist IV	Management Analyst III	1
Program Specialist IV	Manager I	31

Department Employees to Be Reclassified into Different Job Classification Series		
Job Title Prior to Audit	Job Title After Reclassification	Number of Employees To Be Reclassified
Program Specialist IV	Nurse III	1
Program Specialist IV	Ombudsman III	14
Program Specialist IV	Program Supervisor IV	1
Program Specialist IV	Program Supervisor V	4
Program Specialist IV	Project Manager I	1
Program Specialist IV	Quality Assurance Specialist III	3
Program Specialist IV	Social Worker III	1
Program Specialist IV	Systems Administrator II	1
Program Specialist IV	Training Specialist V	9
Program Specialist V	Budget Analyst IV	1
Program Specialist V	Contract Specialist IV	5
Program Specialist V	Education Specialist IV	1
Program Specialist V	Geographic Information Specialist III	1
Program Specialist V	Human Resources Specialist IV	1
Program Specialist V	Management Analyst III	2
Program Specialist V	Manager I	11
Program Specialist V	Manager II	3
Program Specialist V	Ombudsman IV	2
Program Specialist V	Program Supervisor V	7
Program Specialist V	Quality Assurance Specialist IV	9
Program Specialist V	Systems Administrator IV	2
Program Specialist V	Systems Analyst III	1
Program Specialist V	Technical Writer II	1
Program Specialist VI	Business Analyst III	4
Program Specialist VI	Contract Specialist V	2
Program Specialist VI	Data Base Administrator IV	1
Program Specialist VI	Information Specialist V	2
Program Specialist VI	Management Analyst IV	1
Program Specialist VI	Privacy Analyst II	1
Program Specialist VI	Program Supervisor II	1
Program Specialist VI	Program Supervisor III	1
Program Specialist VI	Program Supervisor VI	7
Program Specialist VI	Project Manager III	1
Program Specialist VI	Qualified Intellectual Disability Professional IV	1
Program Specialist VII	Data Base Administrator V	1
Program Specialist VII	Human Resources Specialist VI	1
Program Specialist VII	Manager IV	1

Department Employees to Be Reclassified into Different Job Classification Series		
Job Title Prior to Audit	Job Title After Reclassification	Number of Employees To Be Reclassified
Program Specialist VII	Management Analyst V	1
Program Specialist VII	Program Supervisor VII	1

Table 6 summarizes the 40 employees whom the Department stated it would reclassify within the same job classification series; 21 of those reclassifications will result in salary increases totaling \$50,532 annually.

Table 6

Department Employees To Be Reclassified Within the Same Classification Series		
Job Title Prior to Audit	Job Title After Reclassification	Number of Employees To Be Reclassified
Program Specialist I	Program Specialist IV	1
Program Specialist I	Program Specialist V	1
Program Specialist II	Program Specialist III	2
Program Specialist II	Program Specialist IV	9
Program Specialist III	Program Specialist IV	22
Program Specialist III	Program Specialist V	4
Program Supervisor IV	Program Supervisor V	1

The Department also changed the job duties of one employee classified as a Program Specialist V so that the employee could remain in the current job classification title and be appropriately classified with no changes to the employee's salary.

Copies of this report have been distributed to the following:

Legislative Audit Committee

The Honorable Dan Patrick, Lieutenant Governor, Joint Chair

The Honorable Joe Straus III, Speaker of the House, Joint Chair

The Honorable Jane Nelson, Senate Finance Committee

The Honorable Robert Nichols, Member, Texas Senate

The Honorable John Otto, House Appropriations Committee

The Honorable Dennis Bonnen, House Ways and Means Committee

Office of the Governor

The Honorable Greg Abbott, Governor

Health and Human Services Commission

Mr. Charles Smith, Executive Commissioner

Department of Aging and Disability Services

Mr. Jon Weizenbaum, Commissioner



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An Audit Report on

HealthSpring Life and Health Insurance Company, Inc., a Medicaid STAR+PLUS Managed Care Organization

February 2017

Report No. 17-025



An Audit Report on

HealthSpring Life and Health Insurance Company, Inc., a Medicaid STAR+PLUS Managed Care Organization

SAO Report No. 17-025
February 2017

Overall Conclusion

HealthSpring Life and Health Insurance Company, Inc.'s (HealthSpring) controls over its financial reporting process provided reasonable assurance that the \$601.3 million in medical claims and prescription drug claims that HealthSpring paid in fiscal year 2015 for the Medicaid STAR+PLUS managed care program (STAR+PLUS) were accurately reported on its financial statistical reports to the Health and Human Services Commission (Commission).

However, the salaries, other medical expenses, bonuses, allocated corporate costs, and professional services costs that HealthSpring reported on its financial statistical reports for fiscal year 2015 were not compliant with the Commission's contract requirements. Those costs were approximately \$53.8 million. Specifically:

- **Unallowable Costs** - Auditors identified approximately \$3.8 million in unallowable costs. HealthSpring (1) reported bonuses paid by its affiliate companies and (2) included advertising costs, charitable donations, non-STAR+PLUS affiliate company expenses, employee events expense, gifts, and stock options in its reported allocated corporate costs on its financial statistical reports. The Commission's Medicaid program requirements specify that those costs are unallowable and, therefore, should not be reported on the financial statistical reports. In addition, \$163,977 in reported professional services costs were for costs incurred in fiscal year 2014.
- **Questioned Costs** - Auditors identified approximately \$34.0 million in questioned salaries, other medical expenses (service coordinator salaries), and professional services costs. HealthSpring did not prepare certifications or personnel activity reports that the Commission requires to show that its reported salaries, approximately \$33.7 million, were for services that supported STAR+PLUS. In addition, HealthSpring could not provide

Background Information

HealthSpring Life and Health Insurance Company, Inc. (HealthSpring) provides acute care services plus long-term care services and support (LTSS) by integrating primary care, pharmacy services, and LTSS for individuals who are age 65 or older or have a disability through services delivered through Medicaid STAR+PLUS managed care program (STAR+PLUS) in three service delivery areas in Texas. Those service delivery areas are: Tarrant service delivery area, Hidalgo service delivery area, and Northeast Medicaid rural service areas (see Appendix 3 for additional information on those service delivery areas).

From September 1, 2014, through August 31, 2015, HealthSpring received payments from the Health and Human Services Commission (Commission) that totaled \$713.7 million. Approximately \$601.3 million of that amount paid for medical claims and prescription drug claims for 62,828 people enrolled in STAR+PLUS.

Source: The Commission.

documentation to show that \$359,912 in professional service costs tested were for STAR+PLUS.

The unallowable and questioned costs identified affect the accuracy of HealthSpring's calculation of net income, which the Commission uses to calculate the experience rebate¹ amounts that HealthSpring is required to pay the Commission. For fiscal year 2015, HealthSpring paid the Commission an experience rebate of approximately \$12.5 million.

In addition, HealthSpring had weaknesses in the controls over its process for documenting the reasons for post-payment adjustments to medical claims and for ensuring that medical claims are paid within 30 days of receipt of a "clean claim"² as required. The weaknesses identified in the claims payment process could affect the continued participation of HealthSpring's medical providers in STAR+PLUS.

Auditors communicated other, less significant issues to HealthSpring management and Commission management separately in writing.

Table 1 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.)

Table 1

Summary of Subchapters and Related Issue Ratings		
Subchapter	Title	Issue Rating ^a
1-A	HealthSpring Accurately Reported the Medical Claims and Prescription Drug Claims That It Paid in Fiscal Year 2015	Low
1-B	HealthSpring Included Unallowable Costs in the Bonuses It Reported on Its Financial Statistical Reports, and It Did Not Prepare Required Certifications and Personnel Activity Reports	High
1-C	HealthSpring Did Not Develop a Written Allocation Methodology as Required, and It Overstated Its Reported Allocated Corporate Costs on Its Financial Statistical Reports	High
1-D	HealthSpring Did Not Consistently Maintain Documentation to Show That Certain Legal and Professional Services Costs Were Applicable to STAR+PLUS and Incurred During the Reporting Period	Medium

¹ "Experience rebates" are a portion of a managed care organization's net income before taxes that is returned to the State in accordance with statute and the uniform managed care contract terms.

² Title 28, Texas Administrative Code, Section 21.802 (6), defines a clean claim as follows:

- For nonelectronic claims, a claim submitted by a physician or a provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy that includes required data elements and the amount paid by a health plan.
- For electronic claims, a claim submitted by a physician or a provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy using the ASC X12N 837 format and in compliance with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides, and trading partner agreements.

Summary of Subchapters and Related Issue Ratings		
Subchapter	Title	Issue Rating ^a
1-E	HealthSpring Did Not Report Accurate and Complete Information About Its Affiliate Companies	Medium
2-A	HealthSpring Did Not Consistently Document the Reasons for Post-payment Adjustments That It Made to Paid Medical Claims	High
2-B	HealthSpring Did Not Ensure That It Paid All Medical Claims Within 30 Days of Receipt of a Clean Claim as Required	Medium

^a A subchapter is rated **Priority** if the issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern and reduce risks to the audited entity.

A subchapter is rated **High** if the issues identified present risks or effects that if not addressed could substantially affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern and reduce risks to the audited entity.

A subchapter is rated **Medium** if the issues identified present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.

A subchapter is rated **Low** if the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

Summary of Management's Response

At the end of each chapter in this report, auditors made recommendations to address the issues identified during this audit. HealthSpring generally agreed with the recommendations in this report, and management's response is presented in Appendix 7.

Audit Objective and Scope

The objective of this audit was to determine whether selected financial processes and related controls at a Medicaid managed care organization (MCO) are designed and operating to help ensure (1) the accuracy and completeness of data that the MCO reports to the Commission and (2) compliance with applicable requirements.

The scope of this audit covered HealthSpring's contracts with the Commission for STAR+PLUS. It covered HealthSpring's financial statistical reports and its reported medical claims and pharmacy claims for fiscal year 2015. It also included the Commission's management of the MCO's subcontractor agreements and readiness review records for fiscal year 2015.

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Detailed Results

Chapter 1

HealthSpring Accurately Reported State Payments, Medical Claims, and Prescription Drug Claims on Its Financial Statistical Reports for Fiscal Year 2015; However, It Had Significant Weaknesses for Reporting Its Administrative Expenses

Unallowable Cost

The Commission's *Uniform Managed Care Manual* defines the cost principles that establish the allowability of various administrative expenses that an MCO can report on the financial statistical reports. A designation of "allowable" or "unallowable" does not generally govern whether the MCO can incur a cost or make a payment; allowability reflects only what is reportable on the financial statistical reports. To be allowable, expenses must conform to the requirements of the Commission's cost principles, which include being reasonable and allocable.

Questioned Cost

According to the Code of Federal Regulations, a "questioned cost" is a cost charged to MCO funds that MCO management, federal oversight entities, an independent auditor, or other audit organization authorized to conduct an audit of an MCO has questioned because of an audit or other finding. Costs may be questioned because:

- There may have been a violation of a provision of a law, regulation, contract, grant, or other agreement or document governing the use of MCO funds;
- The cost is not supported by adequate documentation; or
- The cost incurred appears unnecessary or unreasonable and does not reflect the actions a prudent person would take in the circumstances.

Sources: The Commission's *Uniform Managed Care Manual* and Title 45, Code of Federal Regulations, Section 1630.2(g).

HealthSpring Life and Health Insurance Company, Inc.'s (HealthSpring) financial reporting process provided reasonable assurance that it accurately reported certain costs on its financial statistical reports to the Health and Human Services Commission (Commission). Specifically, HealthSpring accurately reported the Medicaid STAR+PLUS (STAR+PLUS) program medical claims and the prescription drug claims that it paid for fiscal year 2015, totaling \$601,313,929, as required by its contracts with the Commission.

However, the salaries, other medical expenses, bonuses, allocated corporate costs, and professional services costs that HealthSpring reported on its financial statistical reports for fiscal year 2015, totaling \$53,808,621, may be overstated. Auditors identified weaknesses in HealthSpring's controls for reporting those costs that resulted in \$3,831,812 in unallowable costs to be reported. In addition, auditors identified \$34,039,615 in questioned costs because HealthSpring did not maintain documentation to show that the reported costs were attributable to STAR+PLUS (see text box for information about unallowable and questioned costs).

HealthSpring's overstatement of the costs listed above would affect the accuracy of HealthSpring's calculation of net income. The Commission uses the reported net income to calculate the amount of "experience rebates"³ that managed care organizations (MCOs), such as HealthSpring, are statutorily

required to pay the Commission. As of August 2016, HealthSpring paid the Commission a total of \$12,478,448 in experience rebates for fiscal year 2015. (See Appendix 6 for more information about calculating the experience rebate that HealthSpring owed for fiscal year 2015.)

³ "Experience rebates" are a portion of an MCO's net income before taxes that is returned to the State in accordance with statute and the uniform managed care contract terms. (See Appendix 5 for more information about experience rebates.)

Table 2 summarizes the identified unallowable and questioned costs.

Table 2

Unallowable and Questioned Costs That HealthSpring Reported on Its Financial Statistical Reports for Fiscal Year 2015			
Type of Administrative Expense	Reported Costs for Fiscal Year 2015	Total Unallowable Costs Identified	Total Questioned Costs Identified
Salaries	\$ 22,848,767	\$ 0	\$ 22,848,767
Bonuses	786,457	786,457	0
Other Medical Expenses ^a	11,137,962	0	10,830,936 ^b
Allocated Corporate Costs	15,355,392	2,881,358	0
Legal and Professional Services Costs	3,680,042	163,997	359,912
Totals	\$53,808,621	\$3,831,812	\$34,039,615

^a Other Medical Expenses represent salary and miscellaneous expenses related to service coordinators. A service coordinator is an employee who works with a STAR+PLUS member, the member's family, and the member's doctors and other providers to help the member get the medical and long-term care services and support they need. The coordinator must identify the member's needs and develop a plan of care.

^b The questioned costs for Other Medical Expenses represent only the salary costs portion of HealthSpring's reported Other Medical Expenses. See Chapter 1-B for information about Other Medical Expenses that auditors tested.

Source: HealthSpring and the Commission.

HealthSpring also reported inaccurate and incomplete information to the Commission about its affiliate companies that provide services supporting its administration of STAR+PLUS. The Commission uses the information that HealthSpring reports as part of its monitoring efforts to ensure the transparency and reasonableness of HealthSpring's related-party transactions.

HealthSpring Accurately Reported the Medical Claims and Prescription Drug Claims That It Paid in Fiscal Year 2015

**Chapter 1-A
Rating:**
Low ⁴

HealthSpring's financial reporting processes and controls provided reasonable assurance that the \$601,313,929 in medical claims and prescription drug claims it paid in fiscal year 2015 were accurately calculated and reported on its financial statistical reports to the Commission (see text

box for information about the required financial statistical reports). Auditors tested samples of HealthSpring's medical claims and vendor payments to its pharmacy benefit manager⁵ that were reported as paid during fiscal year 2015 (see text box for additional details on the medical claims and pharmacy claims tested). The tested medical claims and pharmacy claims were accurate, supported by documentation, and submitted for eligible STAR+PLUS members.

Paid medical claims tested were accurate, supported by documentation, and submitted by eligible providers for eligible STAR+PLUS members.

Financial Statistical Reports

The Commission receives financial statistical reports from MCOs on a quarterly and annual basis as required by the Commission's contracts with the MCOs. Those reports are the primary statements of financial results the MCOs submit to the Commission. The Commission uses the reports to analyze the MCOs' membership, revenues, expenses, and net income by service area and program.

Source: The Commission.

Medical Claims and Pharmacy Claims Tested

The samples auditors tested were selected as follows:

- **Medical Claims.** Auditors selected a random sample of 60 paid medical claims and used professional judgment to select a risk-based sample of 17 additional medical claims to test.
- **Pharmacy Claims.** Auditors selected a random sample of eight vendor payments to HealthSpring's pharmacy benefit manager and used professional judgment to select a risk-based sample of three additional vendor payments to test.

The medical claim payments tested that HealthSpring reported on its financial statistical reports for fiscal year 2015 were allowable, supported by documentation, and documented accurately in HealthSpring's claims processing system. HealthSpring reported a total of \$510,400,761 in medical claim payments for fiscal year 2015. Auditors tested a sample of 77 medical claim payments, totaling \$786,899, and verified that:

- The medical claim payment amounts matched the payment amounts shown in (1) HealthSpring's claims processing system, (2) the medical claims data that HealthSpring reported to the Commission, and (3) copies of the explanation of payment (EOP) statements that HealthSpring sent to medical providers.

⁴ The risks related to the issues discussed in Chapter 1-A are 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.

⁵ HealthSpring contracts with a pharmacy benefit manager to manage and pay pharmacy drug claims purchased through its STAR+PLUS contract. HealthSpring reimburses its pharmacy benefit manager for the pharmacy drug claims paid, and it pays a monthly management fee to the pharmacy benefit manager for the services provided. For fiscal year 2015, HealthSpring reported that it paid \$538,000 to its pharmacy benefit manager.

- Eligible providers submitted the medical claims, and those claims were for eligible STAR+PLUS members.

However, auditors identified weaknesses in HealthSpring's controls over post-payment adjustments to medical claims and for ensuring the timeliness of medical claims payments (see Chapter 2).

HealthSpring's vendor payments to its pharmacy benefit manager were accurate, supported by documentation, and for pharmacy claims for eligible STAR+PLUS members.

The pharmacy claims payments tested were accurate and supported by documentation. HealthSpring reported that it paid its pharmacy benefit manager a total of \$90,913,168 in fiscal year 2015. Auditors tested a sample of 11 payments to the pharmacy benefit manager, totaling \$18,960,236, and verified that the payment amounts matched the weekly invoices that HealthSpring received from its pharmacy benefit manager.

In addition, auditors verified that the payments for a sample of 81 pharmacy claims from HealthSpring (1) matched the payment amounts reported to the Commission and (2) were for pharmacy claims for eligible STAR+PLUS members.

Chapter 1-B

HealthSpring Included Unallowable Costs in the Bonuses It Reported on Its Financial Statistical Reports, and It Did Not Prepare Required Certifications and Personnel Activity Reports

**Chapter 1-B
Rating:**
High ⁶

HealthSpring included unallowable costs and questioned costs on its financial statistical reports for fiscal year 2015. Auditors identified \$786,457 in bonuses that HealthSpring should not have reported on its financial statistical reports for fiscal year 2015. The amount that HealthSpring reported was for bonuses that were paid to staff employed by its affiliate companies. The Commission's reporting requirements specify that bonuses paid to affiliates are unallowable costs.

In addition, auditors identified \$33,679,703 in questioned salaries and other medical expenses⁷ (see Table 3). HealthSpring did not prepare certifications

⁶ The risks related to the issues discussed in Chapter 1-B are rated as High because they present risks or results 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.

⁷ Other medical expenses represent the salaries and other costs associated with service coordinator positions. A service coordinator is an employee who works with a STAR+PLUS member, the member's family, and the member's doctors and other providers to help the member get the medical and long-term care services and support needed. The coordinator must

and personnel activity reports to show that the amounts reported for salaries and other medical expenses were for staff who worked on STAR+PLUS as required by the Commission.

Table 3

Fiscal Year 2015 Salaries, Bonuses, and Other Medical Expenses ^a		
Total Reported Costs for Fiscal Year 2015	Total Unallowable Costs Identified	Total Questioned Costs Identified ^b
\$34,773,186	\$786,457	\$33,679,703

^a Other Medical Expenses represent salary and miscellaneous expenses related to service coordinators.

^b The questioned costs include only the salary costs and the salary portion of the Other Medical Expenses HealthSpring reported.

Source: HealthSpring and the Commission.

The unallowable costs and questioned costs that auditors identified affect the Commission's calculation of the experience rebate amount that HealthSpring may owe the Commission for fiscal year 2015. (See Appendix 5 for more information about how the Commission calculates the experience rebate amounts that an MCO may owe it.)

HealthSpring erroneously reported bonuses that were paid to an affiliate company's staff on its financial statistical reports.

HealthSpring reported bonuses totaling \$786,457 on its financial statistical reports that were paid to staff employed by HealthSpring's affiliate companies (see Chapter 1-E for more information about HealthSpring's affiliate companies and Appendix 4 for information on HealthSpring's corporate structure, including its affiliate companies). While salaries for affiliate companies should be reported, the Commission's *Uniform Managed Care Manual* states that bonuses paid or payable to an affiliate are unallowable. The bonuses paid to staff employed by HealthSpring's affiliate companies should not be reported on HealthSpring's financial statistical reports.

identify the member's needs and develop a plan of care. Auditors tested only the salary costs included in the other medical expense amount that HealthSpring reported on its financial statistical reports for fiscal year 2015.

Reporting Requirements for Affiliate Salaries

The Commission's *Uniform Managed Care Manual* specifies the following reporting requirements for affiliate salaries:

- Where employees are expected to work solely on a single contract, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that contract for the period covered by the certification. These certifications will be prepared at least semi-annually and will be signed by the employee or supervisory official having firsthand knowledge of the work performed by the employee.
- Where employees work on multiple activities, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation that meets the standards in Section VI(14)(h)(5) unless a substitute system has been reviewed in advance by the Commission and will be subject to audit. Documentary support will be required where employees work on more than one activity within the MCO.

HealthSpring did not perform required certifications and prepare personnel activity reports to support the salary amounts reported on its financial statistical reports.

Auditors identified \$33,679,703 in questioned costs for salaries (totaling \$22,848,767) and for other medical expenses (totaling \$10,830,936) that HealthSpring reported on its financial statistical reports for fiscal year 2015. HealthSpring's management asserted to auditors that it did not have any staff that worked on the STAR+PLUS contracts, and that the staff who worked on the STAR+PLUS contracts were employed by its affiliate company, GulfQuest, L.P. (GulfQuest). The salary amount that HealthSpring reported on its financial statistical reports were the salary costs for staff employed by its affiliate companies. While HealthSpring correctly reported actual salary costs for staff employed by its affiliate companies on its financial statistical reports, as required, it did not perform required certifications and prepare personnel activity reports to show that affiliate companies' salaries that it used to calculate the reported amounts on its financial statistical reports were for staff who worked on STAR+PLUS-related activities (see text box for reporting requirements for affiliate company salaries).

Preparing certifications and personnel activity reports is important to help ensure that HealthSpring does not include the salary amounts or allocated salary amounts for affiliate companies' staff who may work on HealthSpring's other lines of Medicaid and Medicare health care programs located outside Texas.

Recommendations

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Discuss with the Commission how to resolve the identified questioned costs, including what adjustments should be made to the financial statistical reports for fiscal year 2015.
- Comply with the Commission's requirements that it not include bonuses paid by its affiliate companies on its financial statistical reports.
- Perform periodic certifications and prepare personnel activity reports that support the amount of time its staff or its affiliate companies' staff spend working on STAR+PLUS as required.

Chapter 1-C

HealthSpring Did Not Develop a Written Allocation Methodology as Required and It Overstated Its Reported Allocated Corporate Costs on Its Financial Statistical Reports

Chapter 1-C
Rating:
High ⁸

HealthSpring's methodology for calculating allocated corporate costs, totaling \$15,355,392, reported on its financial statistical reports for fiscal year 2015 was not in compliance with the Commission's requirements. The Commission's *Uniform Managed Care Manual* requires an MCO to ensure that:

- It develops a written allocation methodology policy.
- Costs clearly represent specifically identified operating services provided.
- Services directly benefit the Commission or its clients/customers.

However, HealthSpring did not have a written allocation methodology policy in place for fiscal year 2015 as required. In addition, its methodology for calculating allocated corporate costs included certain costs that were not allowable by the Commission. As a result, HealthSpring included \$2,881,358 in unallowable costs in the allocated corporate cost it reported (see Table 4).

Table 4

Fiscal Year 2015		
Allocated Corporate Costs		
Total Reported Costs on the Financial Statistical Reports	Total Unallowable Costs Identified	Total Questioned Costs Identified
\$15,355,392	\$2,881,358	\$0

Source: HealthSpring and the Commission.

HealthSpring did not have a written policy for calculating the allocated corporate costs reported on its financial statistical reports to the Commission.

HealthSpring's methodology for calculating its allocated corporate costs was based on spreadsheets created to calculate the allocated corporate costs that it reported on its financial statistical reports for STAR+PLUS. However, HealthSpring did not have a written policy, as required by the Commission, to help ensure that allocated corporate costs it reported were calculated correctly and that those costs were properly reviewed and approved. Having a written policy is important because HealthSpring's corporate operations manage other Medicaid and Medicare health programs throughout the

⁸ The risks related to the issues discussed in Chapter 1-C are rated as High because they present risks or results 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.

United States, including a separate contract with the Commission for the Medicaid-Medicare Plan.⁹ HealthSpring uses the costs from those programs when determining the basis for allocating costs to its STAR+PLUS contracts. Without a written allocation methodology, there is an increased risk that HealthSpring may use inconsistent methods to calculate and allocate its corporate costs among STAR+PLUS and its other health care programs. Those inconsistencies could affect the accuracy of its reported net income amount, which the Commission uses to calculate HealthSpring's experience rebates.

The allocated corporate costs that HealthSpring reported for fiscal year 2015 included unallowable costs.

The costs that HealthSpring included in its calculation for determining the allocated corporate costs to report on its financial statistical reports for fiscal year 2015 included \$2,881,358 in unallowable costs. Specifically, the reported amount included the following unallowable costs:

- Allocated corporate costs for advertising, charitable donations, non-STAR+PLUS affiliate expenses, employee events, gifts, bonuses, and stock options, totaling \$2,736,870, were indirect costs that did not provide a direct benefit to STAR+PLUS. The Commission's *Uniform Managed Care Manual* states that the expenses identified are unallowable.
- Allocated corporate costs for severance pay, totaling \$144,488, were accrual amounts and not actual expenses that HealthSpring incurred. The Commission's *Uniform Managed Care Manual* states that severance payments, but not accruals, associated with normal turnover are allowable.

HealthSpring did not maintain documentation to support the reasonableness and accuracy of internally generated financial reports and services that its corporate divisions provided.

HealthSpring did not have documentation to show the following:

- Email confirmations from managers of its corporate divisions whose staff salaries were included in the allocated corporate costs reported on the financial statistical reports for fiscal year 2015. HealthSpring stated that

⁹ According to the Commission, on May 23, 2014, the U.S. Centers for Medicare and Medicaid Services (CMS) announced that the State of Texas would partner with CMS to test a new model for providing Medicare and Medicaid enrollees with a coordinated, person-centered care experience. Texas and CMS would contract with Medicare and Medicaid plans to coordinate the delivery of and be accountable for covered Medicare and Medicaid services for participating Medicare and Medicaid enrollees. Under the demonstration, Medicare and Medicaid Plans would cover Medicare benefits in addition to the existing set of Medicaid benefits currently offered under STAR+PLUS, allowing for an integrated set of benefits for enrollees.

the email confirmations could show when staff were assigned to work on STAR+PLUS activities.

- How HealthSpring identified all of its Medicaid and Medicare health care programs for which it set the rate of allocating its corporate costs among its Medicaid and Medicare health care programs based on those programs' number of members and applicable financial information.

The Commission's *Uniform Managed Care Manual* states that for costs to be allowable, they must be adequately documented. Without adequate documentation, HealthSpring cannot show that the salaries and other information used to create the rate it used to allocate its corporate costs to STAR+PLUS is reasonable and accurate.

Recommendations

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Document its methodology for calculating allocated corporate costs for STAR+PLUS as required.
- Ensure that its methodology for calculating corporate allocation amounts align with the Commission's requirements.
- Maintain copies of emails and other documentation to support management assertions used for determining allocated corporate costs.

Chapter 1-D

HealthSpring Did Not Consistently Maintain Documentation to Show That Certain Legal and Professional Services Costs Were Applicable to STAR+PLUS and Incurred During the Reporting Period

Chapter 1-D Rating:
Medium ¹⁰

HealthSpring did not consistently maintain documentation to support the reasonableness and appropriateness of the vendor payment amounts that it used to calculate and report its legal and professional services costs, totaling \$3,680,042, on its financial statistical reports for fiscal year 2015. Auditors tested a sample of 26 vendor payments that totaled \$934,227 and identified unallowable costs and questioned costs (see Table 5).

Table 5

Fiscal Year 2015		
Legal and Professional Services		
Total Reported Costs on the Financial Statistical Reports	Total Unallowable Costs Identified	Total Questioned Costs Identified
\$3,680,042	\$163,997	\$359,912

Source: HealthSpring and the Commission.

Legal and Professional Services Costs Tested

Auditors used professional judgment to select a risk-based sample of 26 expenditures from the general ledger of one of HealthSpring's affiliate companies, GulfQuest, which manages HealthSpring's operations for STAR+PLUS. (See Chapter 1-E for more information.)

Specifically, 10 (38.5 percent) of those 26 vendor payments tested were for services provided in fiscal year 2014 but paid for in fiscal year 2015. Those 10 payment totaled \$163,997. The Commission's *Uniform Managed Care Manual* requires administrative expenses to be reported based on the date incurred rather than the date paid. It also requires prior quarters' data to be updated as needed.

In addition, 6 (23.1 percent) of the 26 vendor payments tested did not have documentation to show that the vendor payment was related to STAR+PLUS (see text box for information about the sample tested). Those 6 payments totaled \$359,912. The Commission's *Uniform Managed Care Manual* specifies that a cost is allowable only to the extent of the benefits the Commission received under the contract.

Without consistent documentation to show the appropriateness and reasonableness of the legal and professional services costs, there is an increased risk that the legal and professional services costs that HealthSpring reported on its financial statistical reports for fiscal year 2015 may be

¹⁰ The risks related to the issues discussed in Chapter 1-D are rated as Medium because they present risks or results 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(s) and reduce risks to a more desirable level.

overstated. This may affect the experience rebate amount HealthSpring may owe the Commission. (See Appendix 5 for more information for how the Commission calculates the experience rebate amount an MCO may owe.)

Recommendations

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Discuss with the Commission how to resolve the questioned costs that auditors identified, including what adjustments should be made to the financial statistical reports for fiscal year 2015.
- Maintain supporting documentation to show that a vendor payment is for services related to STAR+PLUS and that the reported amounts are accurate.
- Report vendor payments based on the dates on which the costs were incurred.

Chapter 1-E

HealthSpring Did Not Report Accurate and Complete Information About Its Affiliate Companies

Chapter 1-E
Rating:
Medium ¹¹

HealthSpring reported inaccurate information about its affiliate companies involved with the services provided for its STAR+PLUS contracts with the Commission. The Commission's contract requires that an MCO submit an annual affiliate report that provides organizational and financial information on affiliate companies involved with the services provided under managed care contracts.

In addition, HealthSpring did not provide the Commission with copies of its contracts with its affiliate companies that provide administrative services under its STAR+PLUS contracts with the Commission. The Commission's

¹¹ The risks related to the issues discussed in Chapter 1-E are rated as Medium because they present risks or results 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(s) and reduce risks to a more desirable level.

contract specifies that an MCO must submit to the Commission a copy of its contract agreements with affiliate companies.¹²

Auditors also identified payments to affiliate companies that did not have documentation to support amounts paid or were not calculated according to contract requirements.

The Commission uses the affiliate information and copies of affiliate company contracts with MCOs to support its monitoring efforts to ensure the transparency and reasonableness of an MCO's related-party transactions.

HealthSpring provided the Commission inaccurate and incomplete information on its affiliate companies involved with its STAR+PLUS contracts.

While HealthSpring submitted an affiliate report for fiscal year 2015 as required, that report included inaccurate and incomplete information on the services provided by and management fees paid to its affiliate companies. Specifically, HealthSpring's affiliate report included the following inaccurate and incomplete information:

- HealthSpring identified only one affiliate company on its affiliate report, GulfQuest. However, HealthSpring contracts with a different affiliate company, HealthSpring Management of America (HMA), for the professional services that HealthSpring described on its affiliate report. HMA has a subcontract agreement with GulfQuest to provide the actual professional services to HealthSpring. (HealthSpring's contract with HMA and HMA's subcontract with GulfQuest is discussed in more detail later in this chapter.)
- HealthSpring inaccurately reported that it paid management fees to GulfQuest that totaled \$342,000,000 in fiscal year 2015 for the professional services provided; however, auditors determined that for STAR+PLUS HealthSpring's payments totaled \$104,668,705 and those payments were paid to HMA.
- HealthSpring did not include four additional affiliate companies—Bravo Health MidAtlantic, HealthSpring USA, Newquest LLC, and Newquest of Illinois—on its affiliate report. On its financial statistical reports for fiscal year 2015, HealthSpring reported allocated corporate costs from Newquest LLC totaling \$10,878,506 and salaries and bonuses totaling \$681,531 that were related to those four companies. The Commission's contracts with HealthSpring specify that an MCO must submit a list of all

¹² Under the Commission's contract with HealthSpring for STAR+PLUS, all material subcontracts should be reported. A material subcontract is any contract, subcontract, or agreement between an MCO and another entity that meets certain criteria, including whether the other entity is an affiliate of the MCO.

affiliates and a schedule of all transactions with affiliates that will be allowable for reporting purposes. Those transactions should describe the financial terms, provide a detailed description of the services to be provided, and include an estimated amount that will be incurred by the MCO for such services.

HealthSpring did not provide the Commission a copy of its contracts with the affiliate companies that provide administrative services on its STAR+PLUS contracts.

HealthSpring did not provide the Commission a copy of the contracts that it had with its affiliate companies for STAR+PLUS. Specifically, HealthSpring did not provide the Commission copies of the following contracts:

- **HMA.** HealthSpring's contract with HMA, effective January 1, 2012, specifies that it will provide management and administrative services to HealthSpring. For STAR+PLUS, HealthSpring will pay HMA a monthly management fee based on a percentage of HealthSpring's operating revenue for the calendar year.
- **GulfQuest.** HMA subcontracted its contracted services with HealthSpring to GulfQuest. HMA's subcontract agreement with GulfQuest, executed on July 15, 2010, assigned to GulfQuest the management and administrative services that HMA was contracted to provide to HealthSpring.

Having copies of the contracts between MCOs and their affiliate companies, including applicable subcontract agreements, helps the Commission to ensure the transparency of the financial terms for the services that affiliate companies provide to MCOs.

See Appendix 4 for more information about HealthSpring's affiliate companies.

HealthSpring did not have documentation to support the accuracy and appropriateness of payments to HMA for service coordinator-related costs.

HealthSpring's payments to HMA included an amount intended to reimburse GulfQuest for service coordinator-related expenses. HealthSpring's contract with HMA specified that HealthSpring would be invoiced by HMA on a monthly basis for service coordinator-related costs and that the invoice would have sufficient detail supporting the costs. However, HealthSpring did not receive invoices as required. HealthSpring asserted that it based its reimbursement to HMA on a monthly financial report that shows the amount it owes HMA. The financial report does not show any specific information related to the reimbursement amount. It only shows the total amount owed HMA for the STAR+PLUS program and other healthcare programs HMA manages for HealthSpring. For fiscal year 2015, HealthSpring asserted that it

reimbursed HMA for service coordinator-related costs that totaled \$10,669,435. (See Chapter 1-B for more information about the service coordinator-related salaries that HealthSpring reported.)

HMA's payments to GulfQuest were calculated using a methodology that differed from the methodology required by its contract.

HMA's payments to GulfQuest were not calculated according to the payment requirements in its contract with GulfQuest. While HMA's contract with GulfQuest stated that it would pay a certain percentage of its operating revenues to GulfQuest, HMA actually paid to GulfQuest all the management fees that it received from HealthSpring for STAR+PLUS.

Recommendations

HealthSpring should:

- Report all of its affiliate companies involved in STAR+PLUS, and report accurate and complete information about those companies and costs to the Commission as required.
- Ensure that it provides the Commission copies of all of its contracts with affiliate companies, including subcontract agreements, that provide services on its STAR+PLUS contracts as required.
- Obtain and maintain documentation to support its payments to HMA for service coordinator-related expenses.
- Ensure that HMA's payments to GulfQuest are calculated and paid in accordance with contract requirements.

HealthSpring Did Not Consistently Document the Reasons for Post-payment Adjustments to Medical Claims and Pay Medical Claims Within the Required Timeframe

Because of weaknesses in HealthSpring's controls over post-payment adjustments to medical claims, it did not consistently document the reasons for its post-payment adjustments that it made to medical claims. In addition, weaknesses in HealthSpring's controls resulted in some medical claims tested not being paid within 30 days of receipt of a "clean claim" as required by HealthSpring's contracts with the Commission. (See Chapter 2-B for additional information on clean claims.)

The weaknesses identified in HealthSpring's claims payment process could affect the continued participation of HealthSpring's medical providers in STAR+PLUS.

HealthSpring Did Not Consistently Document the Reasons for Post-payment Adjustments That It Made to Paid Medical Claims

Chapter 2-A Rating:
High ¹³

Auditors tested a sample of 61 post-payment adjustments to medical claims, totaling \$52,209 that HealthSpring reported to the Commission (see text box for more information about the claims tested). The post-payment adjustments tested resulted in HealthSpring reversing the original payment

amount to a provider. For 27 (44 percent) of 61 medical claims tested, totaling \$32,067, HealthSpring did not record the reason it made the post-payment adjustment in its claims processing system. The Commission's *Uniform Managed Care Claims Manual* requires an MCO's claims system to maintain adequate audit trails and report accurate medical provider service data on paid medical claims to the Commission.

In addition, HealthSpring did not document the reason it adjusted a claim on the Explanation of Payment (EOP) for 9 (33 percent) of those 27 medical claims. An EOP notifies a medical provider about the processing status of a medical claim that HealthSpring has received. Those 9 medical claims totaled \$12,780. For the other 18 medical claims tested, the EOP included a code that indicated only that the medical claim was adjusted. The code did not provide any details about the reason the medical claim was adjusted.

¹³ The risks related to the issues discussed in Chapter 2-A are rated as High because they present risks or results that 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.

The post-payment adjustments that auditors tested were reversals of medical claim payments by HealthSpring to medical providers. In some cases a new payment may have been issued to the provider. However, due to the lack of documentation describing the reasons for post-payment adjustments, auditors were unable to always determine whether a post-payment adjustment was reasonable and whether a new payment had been paid to a medical provider. As a result, there is an increased risk that HealthSpring may have inappropriately recouped its payments to medical providers.

Recommendation

HealthSpring should develop, document, and implement a process to ensure that it records the reason for all post-payment adjustments to medical claims in its claims processing system and on the EOPs sent to medical providers.

Chapter 2-B

HealthSpring Did Not Ensure That It Paid All Medical Claims Within 30 Days of Receipt of a Clean Claim as Required

Chapter 2-B
Rating:
Medium ¹⁴

Auditors tested a sample of 77 paid medical claims that totaled \$786,889 (see text box for more information about the claims tested). HealthSpring did not process 15 (20 percent) of the 77 paid medical claims tested within 30 days of receipt of a clean claim as required (see Table 6). Those 15 claims totaled \$386,779.

Table 6

Medical Claims Tested That HealthSpring Processed Late		
Number of Days Past Due	Number of Claims	Amount
1-10 Days	6	\$148,478
11-30 Days	6	237,471
More than 30 Days	3	830
Totals	15	\$386,779

Source: HealthSpring.

Medical Claims Tested

Auditors selected a random sample of 60 paid medical claims and used professional judgment to select a risk-based sample of 17 additional paid medical claims to test. Auditors verified whether the payment amounts matched the payment amounts shown in (1) HealthSpring's claims processing system, (2) the medical claims data that HealthSpring reported to the Commission, and (3) copies of the EOP statements that HealthSpring submitted to medical providers. Auditors also determined whether the medical claims were processed in a timely manner and in compliance with the Commission's requirements.

¹⁴ The risks related to the issues discussed in Chapter 2-B are rated as Medium because they present risks or results 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(s) and reduce risks to a more desirable level.

Clean Claims

Title 28, Texas Administrative Code, Section 21.802(6), defines a **clean claim** as follows:

- For nonelectronic claims, a claim submitted by a physician or a provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy that includes required data elements and the amount paid by a health plan.
- For electronic claims, a claim submitted by a physician or a provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy using the ASC X12N 837 format and in compliance with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides, and trading partner agreements.

The Commission's *Uniform Managed Care Manual* requires that, once an MCO receives a "clean claim" (see text box for explanation of a clean claim), it is required to pay the total amount of the claim, or part of the claim, in accordance with the contract within the 30-day claim payment period. HealthSpring reported to auditors that the 15 medical claims tested were not processed within 30 days of receipt of the clean claims as a result of a staffing shortage it experienced during fiscal year 2015. However, HealthSpring paid the interest penalties on 13 (86.7 percent) of the 15 medical claims tested that were not processed within 30 days of receipt of a clean claim. HealthSpring did not pay interest for two medical claims that it processed within 3 days after the 30-day requirement.

Recommendations

HealthSpring should:

- Ensure that all medical claims are paid within the Commission's required timeframe.
- Pay interest penalties on all medical claims that are not processed within the Commission's required time frame.

Appendices

Appendix 1

Objective, Scope, and Methodology

Objective

The objective of this audit was to determine whether selected financial processes and related controls at a Medicaid managed care organization (MCO) are designed and operating to help ensure (1) the accuracy and completeness of data that the MCO reports to the Commission and (2) compliance with applicable requirements.

Scope

The scope of this audit covered HealthSpring Life and Health Insurance Company, Inc.'s (HealthSpring) contracts with the Health and Human Services Commission (Commission) for the Medicaid STAR+PLUS managed care program (STAR+PLUS). It covered HealthSpring's financial statistical reports and its reported medical claims and pharmacy claims for fiscal year 2015. It also included the Commission's management of the MCO's subcontractor agreements and readiness review records for fiscal year 2015.

Methodology

The audit methodology included selecting an MCO based on the State Auditor's Office's risk assessment of MCOs that included obtaining information and data from the Commission concerning the risks associated with MCOs.

Additionally, the audit methodology included collecting information and documentation, performing selected tests and other procedures, analyzing and evaluating results of the tests, and interviewing management and staff at HealthSpring and the Commission.

Data Reliability and Completeness

Auditors assessed the reliability of data used in the audit and determined the following:

- For medical claims and pharmacy claims data managed by HealthSpring's claims processing system, auditors reconciled claims data to claim payment totals reported on HealthSpring's financial statistical reports and to medical claims and pharmacy claims data reported to the Commission. Auditors also assessed HealthSpring's reconciliation of medical claims payment data among its claims processing system,

accounting system, and direct deposit system. Auditors determined that the data was sufficiently reliable for the purposes of this audit.

- Auditors relied on HealthSpring's external auditors' prior work on general and application controls for HealthSpring's (1) claims processing system, (2) financial accounting system, and (3) third-party vendor systems and determined that data from those three information systems was sufficiently reliable for the purposes of this audit.

Sampling Methodology

For the samples discussed below, auditors applied a nonstatistical sampling methodology primarily through random selection. In some cases, auditors used professional judgment to select sample items for testing. The sample items were not generally representative of the population; therefore, it would not be appropriate to project the test results to the population. Auditors selected the following samples:

- To test the validity, accuracy, and completeness of medical claims data and medical claims payments, auditors selected a nonstatistical, random sample of 60 medical claims and used professional judgment to select a risk-based sample of 17 additional medical claims processed during fiscal year 2015.
- To test the validity, accuracy, and completeness of pharmacy claims payments, auditors selected a nonstatistical, random sample of eight vendor payments paid to HealthSpring's pharmacy benefit manager by date and used professional judgment to select a risk-based sample of three additional vendor payments paid to HealthSpring's pharmacy benefit manager that were processed during fiscal year 2015.
- To test the validity, accuracy, and allowability of salary and bonuses reported on HealthSpring's administrative financial statistical reports for fiscal year 2015, auditors selected a nonstatistical, random sample of 90 full-time staff (excluding service coordinator positions) employed during fiscal year 2015.
- To test the validity, accuracy, and allowability of other medical expenses that HealthSpring reported on the financial statistical reports for fiscal year 2015, auditors selected a nonstatistical, random sample of 90 full-time service coordinators employed during fiscal year 2015.
- To test the validity, accuracy, and allowability of professional services that HealthSpring reported on the financial statistical reports for fiscal year 2015, auditors used professional judgment to select a risk-based sample of 26 expenditures processed during fiscal year 2015.

- To test the accuracy and allowability of allocated corporate costs that HealthSpring reported on the financial statistical reports for fiscal year 2015, auditors used professional judgment to select a risk-based sample of (1) the corporate costs for 8 health insurance markets managed by HealthSpring from September 2014 through December 2014, (2) the corporate costs for 10 health insurance markets managed by HealthSpring from January 2015 through August 2015, and (3) the allocated corporate costs related to 12 full-time employees during fiscal year 2015.
- To test the validity, accuracy, and completeness of post-payment adjustments to medical claims data, auditors selected a nonstatistical, random sample of 60 adjusted medical claims that were processed during fiscal year 2015 and used professional judgment to select a risk-based sample of 5 additional adjusted medical claims processed during fiscal year 2015.
- To test the validity and completeness of medical claims data in HealthSpring's claims processing system, auditors used professional judgment to select a risk-based sample of 60 medical claims processed during fiscal year 2015.

Information collected and reviewed included the following:

- The Commission's STAR+PLUS contracts with HealthSpring.
- The Commission's STAR+PLUS member eligibility records for HealthSpring.
- The Commission's and HealthSpring's medical claims and pharmacy claims data.
- HealthSpring's policies and procedures.
- HealthSpring's financial statistical reports for fiscal year 2015.
- HealthSpring's payroll and human resources records.
- HealthSpring's supporting documentation for calculating reported allocated corporate costs for fiscal year 2015.
- External audit reports and consultant reports on HealthSpring's claims processing system, financial accounting system, and select third-party vendor systems.
- The general ledger of GulfQuest, an affiliate company of HealthSpring, of STAR+PLUS administrative expenses for fiscal year 2015.

- HealthSpring's subcontractor agreements with its pharmacy benefit manager and affiliate companies.
- The Commission's MCO contract monitoring policies, procedures, and manuals.
- The Commission's readiness review records of HealthSpring.

Procedures and tests conducted included the following:

- Interviewed employees at HealthSpring and the Commission.
- Reconciled revenue payments reported on HealthSpring's financial statistical reports for fiscal year 2015.
- Reviewed and recalculated HealthSpring's reported allocated corporate costs on the financial statistical reports for fiscal year 2015.
- Tested to determine whether reported salaries and bonuses were accurate and supported by documentation.
- Tested to determine whether reported legal and professional costs on the financial statistical reports for fiscal year 2015 were incurred in fiscal year 2015 and applicable to STAR+PLUS.
- Tested medical claims and pharmacy claims to determine whether they were accurate, valid, supported by documentation, and submitted for eligible STAR+PLUS members.
- Reviewed the Commission's records of HealthSpring's readiness reviews and subcontractor agreements.

Criteria used included the following:

- Title 45, Code of Federal Regulations, Section 1630.2.
- Texas Government Code, Chapters 321, 531, 533, and 536.
- Title 1, Texas Administrative Code, Chapters 353 and 370.
- Title 28, Texas Administrative Code, Chapter 21.
- The General Appropriations Act (83rd Legislature).
- The Commission's Uniform Managed Care Contract for STAR+PLUS.
- The Commission's *Uniform Managed Care Manual*.

Project Information

Audit fieldwork was conducted from July 2016 and December 2016. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

- Willie J. Hicks, MBA, CGAP (Project Manager)
- Anca Pinchas, CPA, CIDA, CISA (Assistant Project Manager)
- Mary Anderson
- Salem Chuah, CPA
- Rachel Lynne Goldman, CPA
- Joseph A. Kozak, CPA, CISA
- Sarah Rajiah
- Fred Ramirez, CISA
- Michelle Rodriguez
- Dennis Ray Bushnell, CPA (Quality Control Reviewer)
- John Young, MPAff (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 7 provides a description of the issue ratings presented in this report.

Table 7

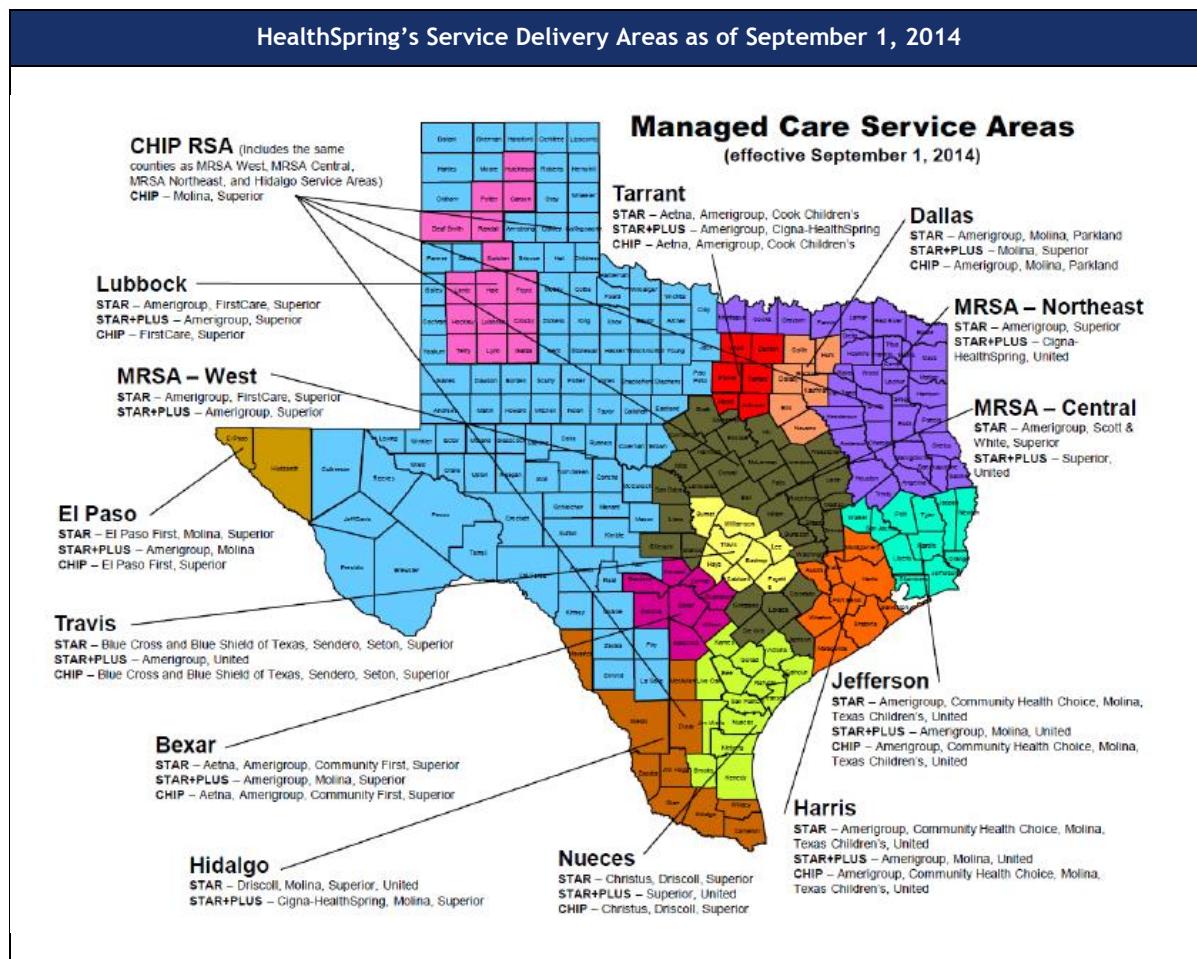
Summary of Issue Ratings	
Issue Rating	Description of Rating
Low	The audit identified strengths that support the audited entity's ability to administer the program(s)/function(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.
Medium	Issues identified present risks or effects that if not addressed could <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.

HealthSpring Life and Health Insurance Company, Inc. Service Delivery Areas

HealthSpring Life and Health Insurance Company, Inc. (HealthSpring) provides Medicaid STAR+PLUS managed care program services to three service delivery areas in Texas through its contracts with the Health and Human Services Commission. Those three service delivery areas are: (1) Tarrant (effective February 1, 2011); (2) Hidalgo (effective March 1, 2012); and (3) Northeast Medicaid Rural Service Areas (effective September 1, 2014).

Figure 1 is a regional map that shows the location of all the managed care service delivery areas, including HealthSpring's service delivery areas as of September 1, 2014.

Figure 1

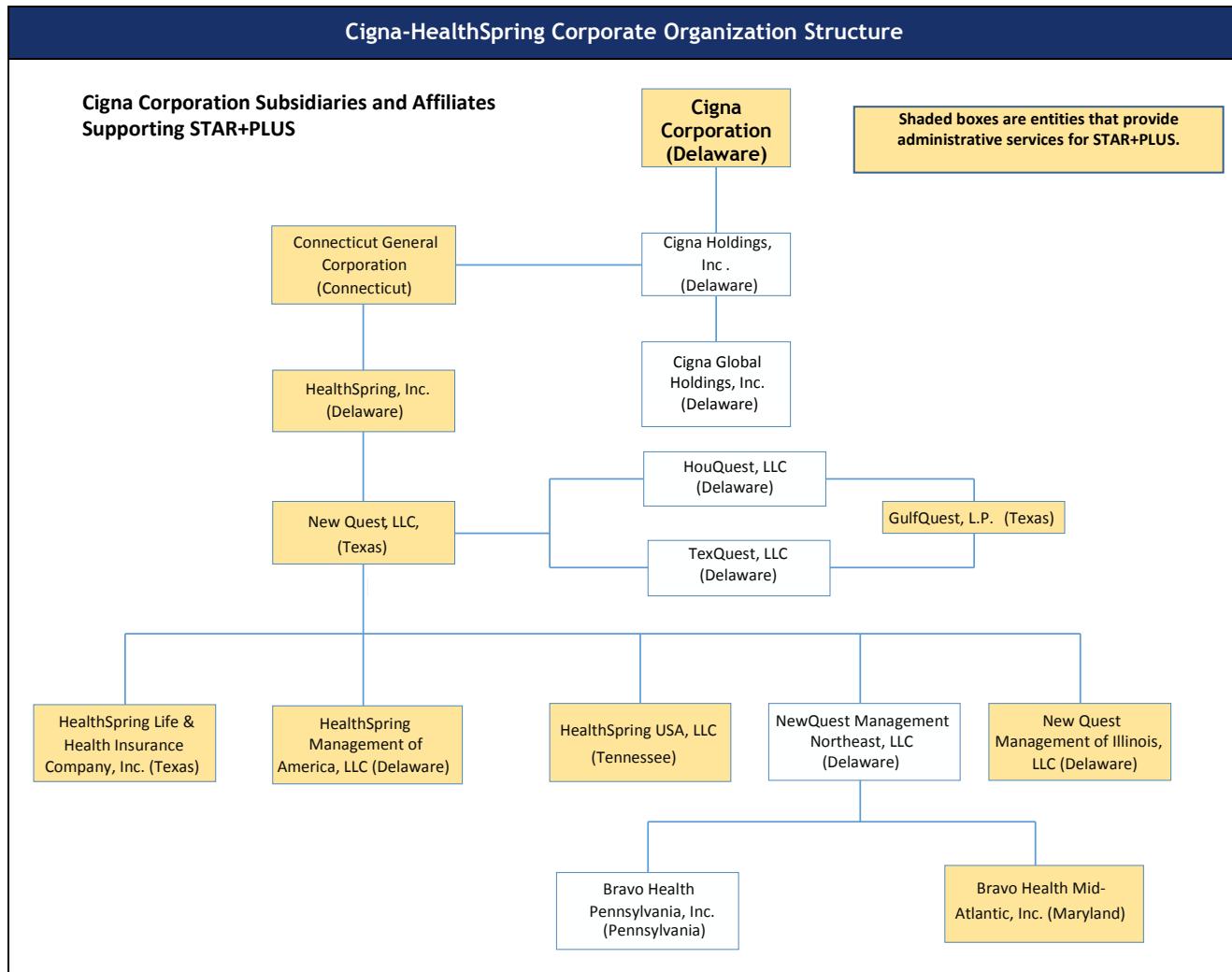


Source: *Texas Medicaid and CHIP in Perspective*, Health and Humans Services Commission, February 2015.

Cigna-HealthSpring Corporate Organization Structure

HealthSpring Life and Health Insurance Company, Inc. (HealthSpring) is a company within the Cigna Corporation. Figure 2 shows Cigna Corporation's organization chart, which includes HealthSpring and other affiliate companies that provided services during fiscal year 2015 for HealthSpring's Medicaid STAR+PLUS managed care program (STAR+PLUS) contract with the Health and Human Services Commission.

Figure 2



Source: HealthSpring.

Calculating Experience Rebates

Texas Government Code, Section 533.014, requires the Health and Human Services Commission (Commission) to adopt rules that ensure that managed care organizations (MCOs) share profits they earn through the Medicaid managed care program. Title 1, Texas Administrative Code, Section 353.3, states that each MCO participating in Medicaid managed care must pay to the State an experience rebate calculated according to the graduated rebate method described in the MCO's contract with the Commission. The Commission has incorporated profit-sharing provisions into its contracts with MCOs that require MCOs to share certain percentages of their net income before taxes with the Commission. The General Appropriations Act (83rd Legislature), Rider 13, page II-91, requires that experience rebates the Commission receives from MCOs be spent on funding services for Medicaid.

According to the Commission's contracts with MCOs, an MCO must pay an experience rebate to the Commission if the MCO's net income before taxes exceeds a certain percentage, as defined by the Commission, of the total revenue the MCO receives each fiscal period. The experience rebate is calculated in accordance with a tiered rebate method that the Commission defines (see Table 8). The tiers are based on the consolidated net income before taxes for all of the MCO's Medicaid program and Children's Health Insurance Program service areas that are included in the scope of the contract, as reported on the MCO's financial statistical reports (which the Commission reviews and confirms through annual agreed-upon procedures engagements performed by its contracted audit firms).

Table 8

Tiers for Experience Rebates		
Pre-tax Income as a Percent of Revenues	MCO's Share	Commission's Share
Less than or equal to 3 percent	100 percent	0 percent
More than 3 percent and less than or equal to 5 percent	80 percent	20 percent
More than 5 percent and less than or equal to 7 percent	60 percent	40 percent
More than 7 percent and less than or equal to 9 percent	40 percent	60 percent
More than 9 percent and less than or equal to 12 percent	20 percent	80 percent
More than 12 percent	0 percent	100 percent

Source: *Texas Health and Human Services Commission Uniform Managed Care Terms and Conditions*.

Calculating the Experience Rebate HealthSpring Owed for Fiscal Year 2015

Based on HealthSpring Life and Health Insurance Company, Inc.'s (HealthSpring) unaudited financial statistical reports for fiscal year 2015, the Health and Human Services Commission (Commission) calculated the experience rebate amount that HealthSpring owed the Commission for that fiscal period. Table 9 shows the Commission's calculation of the pre-tax net income that is subject to the tiered rebate methodology described in Appendix 5.

Table 9

Commission's Calculation of HealthSpring's Income Subject to Experience Rebate for Fiscal Year 2015	
Unaudited Pre-Tax Net Income	\$52,709,294
Admin Cap impact: Expenses reduced ^a	\$7,363,317
Cap-adjusted Pre-tax Net Income	\$60,072,611
Pre-implementation Costs ^b	(\$3,397,931)
Adjusted Income Subject to Experience Rebate	\$56,674,680

^a The admin cap is a calculated maximum amount of administrative expense dollars that can be deducted from revenues for the purposes of determining income subject to the experience rebate. While administrative expenses may be limited by the admin cap to determine experience rebates, all valid allowable expenses will continue to be reported on the financial statistical reports. The admin cap does not affect financial statistical reporting, but it may affect any associated experience rebate calculation. For fiscal year 2015, the \$7,363,317 amount was the difference between HealthSpring's admin cap of \$40,899,830 and its reported administrative expenses of \$48,263,147.

^b The pre-implementation costs in this table are related to the Commission's contract with HealthSpring for the Northeast Medicaid Rural Service Area that was effective September 1, 2014. An MCO incurs pre-implementation costs on or after the effective date of its contract but prior to the operational start date of the contract. Pre-implementation costs must be reported for each month in which the expenses were incurred and must be reported separately in financial statistical reports.

Source: The Commission.

Table 10 shows the Commission's calculation of the total experience rebate that HealthSpring owed the State for fiscal year 2015 as of November 2016.

Table 10

The Commission's Calculation of HealthSpring's Experience Rebate for Fiscal Year 2015					
Tiers - Percent of Revenue	Upper Revenue Limit	Net Income	HealthSpring's Share	The State's Share	State's Share Percentage
Less than or equal to 3 percent	\$21,522,528	\$21,522,528	\$21,522,528	\$ 0	0 percent
More than 3 percent and less than or equal to 5 percent	\$35,870,880	14,348,352	11,478,681	2,869,670	20 percent
More than 5 percent and less than or equal to 7 percent	\$50,219,231	14,348,352	8,609,011	5,739,341	40 percent
More than 7 percent and less than or equal to 9 percent	\$64,567,583	6,455,449	2,582,180	3,873,270	60 percent
More than 9 percent and less than or equal to 12 percent	\$86,090,111	0	0	0	80 percent
More than 12 percent	No Limit	0	0	0	100 percent
Totals		\$56,674,681	\$44,192,400	\$12,482,281	

Source: The Commission.

HealthSpring's Management Responses



Jay Hurt
President/Chief Executive Officer
2900 North Loop West, Suite 1300
Houston, TX 77092
Tel: 832-553-3311
Fax: 832-553-3412

February 9, 2017

Via Electronic Mail and Overnight Delivery

Willie J. Hicks, MBA, CGAP
Project Manager
State Auditor's Office
1501 N. Congress Avenue
Austin, Texas 78701

RE: Management Responses to Recommendations in Draft Audit Report

Dear Mr. Hicks,

On behalf of HealthSpring Life and Health Insurance Company, Inc. ("HealthSpring"), I am writing to respond to the recommendations set forth in the draft audit report issued on January 26, 2017 by the State Auditor's Office.

We are pleased with the recognition that HealthSpring's financial reporting processes adequately demonstrate accurate reporting of fiscal year 2015 medical claim and prescription drug claim payments. We also appreciate the opportunity to respond in accordance with Texas Government Code § 321.014(g) to certain findings and recommendations relating to other reported costs.

Chapter 1 – Financial Statistical Reports for Fiscal Year 2015

Chapter 1-A – Accurate Reporting of Medical and Prescription Drug Claims Paid

Recommendations

None.

HealthSpring Management Response

HealthSpring is in agreement with the findings.

Chapter 1-B – Reporting of Bonus Costs and Personnel Certifications

Recommendations

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Discuss with the Commission how to resolve the identified questioned costs, including what adjustments should be made to the financial statistical reports for fiscal year 2015.
- Comply with the Commission's requirements that it not include bonuses paid by its affiliate companies on its financial statistical reports.
- Perform periodic certifications and prepare personnel activity reports that support the amount of time its staff or its affiliate companies' staff spend working on STAR+PLUS as required.

HealthSpring Management Response

HealthSpring acknowledges the rationale for questioning the bonus payments. However, HealthSpring maintains that the payments are more appropriately classified as questioned costs than disallowed costs, and that such payments should be resolved during discussions with the Commission.

HealthSpring employs all of its administrative personnel through an affiliate organization, and this relationship was known to the Commission at the time the contract was awarded. Consequently, bonuses for affiliated employees are not excessive or duplicative of normal allowable employee bonuses. Rather, the affiliated employee bonuses are in lieu of any other allowable bonus costs. HealthSpring proposes to discuss the bonus payments further with the Commission and to make any adjustments that may be required after final resolution.

HealthSpring also agrees to discuss the remaining questioned costs with the Commission. HealthSpring acknowledges that it was unable to produce the requisite employee certifications. Instead of using an employee certification process, HealthSpring used an alternate allocation method to achieve the same goal. HealthSpring's process reflected an after-the-fact distribution of the actual activity of each employee and accounted for the total activity for which each employee is compensated, as the Uniform Managed Care Manual requires. HealthSpring maintains that its methodology resulted in a fair, accurate representation of the amount of time each employee spent on STAR+PLUS contracts and that the questioned costs are allowable.

In recognition of the Commission's expectation that the sponsor fulfill the aims of the Uniform Managed Care Manual through employee certifications, HealthSpring is augmenting its process for accounting for employee activity and costs on a per-contract basis by implementing a semi-

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February 9, 2017
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annual attestation process that will define clearly the percentage of time that each employee dedicates to a particular contract. The bi-annual employee certifications will be populated into automated compensation allocation reports, which will be reviewed and verified by managers.

Responsible Persons:

Human Resources Director
Medicaid Finance Director Unit Managers

Implementation Date:

July 31, 2017

Chapter 1-C – Allocation Methodology and Costs

Recommendations

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Document its methodology for calculating allocated corporate costs for STAR+PLUS as required.
- Ensure that its methodology for calculating corporate allocation amounts align with the Commission's requirements.
- Maintain copies of emails and other documentation to support management assertions used for determining allocated corporate costs.

HealthSpring Management Response

HealthSpring agrees with the findings and recommendations and offers the following responses.

The unallowable costs identified by the auditors were expenses incurred during the limited period of September through December 2014. While the corporate allocations were correctly reported for the remainder of the year, HealthSpring acknowledges this isolated error.

HealthSpring will adopt formal written standards describing its methodology for calculating allocated corporate costs in accordance with the Commission's requirements. The standards also will require adequate documentation and improve internal controls to ensure proper verification of corporate cost computation and allocation prior to reporting.

Responsible Persons:

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Financial Analysis Manager
Medicaid Finance Director

Implementation Date:

June 1, 2017

Chapter 1-D – Documentation of Legal and Professional Services Costs

Recommendations

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Discuss with the Commission on how to resolve the questioned costs that auditors identified, including what adjustments should be made to the financial statistical reports for fiscal year 2015.
- Maintain supporting documentation to show that a vendor payment is for services related to STAR+PLUS and that the reported amounts are accurate.
- Report vendor payments based on the dates on which the costs were incurred.

HealthSpring Management Response -1

HealthSpring generally agrees with the findings and recommendations and offers the following responses.

HealthSpring will consult with the Commission to ensure that it is reconciling properly the requirement to avoid reporting accrual cost amounts, in accordance with the Chapter 1-C findings, while still appropriately report administrative expenses based on the date incurred rather than the date paid as described in Chapter 1-D. Upon clarification, HealthSpring will adjust any costs determined by the Commission to be unallowable and adopt written standards necessary to prevent recurrence of this concern.

Responsible Person:

Medicaid Finance Director

Implementation Date:

March 31, 2017

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HealthSpring Management Response – 2

HealthSpring anticipates discussions with the Commission will resolve successfully concerns with the questioned costs. Although the invoices at issue do not expressly reference the STAR+PLUS program, they were all mailed to the Bedford office, which is a center of operations that supports the STAR+PLUS program. HealthSpring is confident that the documentation is sufficient to resolve these questioned costs favorably.

Additionally, HealthSpring is working with vendors to enhance its automated documentation capabilities. HealthSpring anticipates that the revised documents will identify adequately the programs for which legal and professional services were rendered.

Responsible Person:

Medicaid Finance Director

Implementation Date:

June 1, 2017

Chapter 1-E – Affiliated Company Reporting

Recommendations

HealthSpring should:

- Report all its affiliated companies involved in its STAR+PLUS program and report accurate and complete information about those companies and costs to the Commission as required.
- Ensure that it provides the Commission copies of all its contracts with affiliate companies, including subcontract agreements, that provide services on its STAR+PLUS contract as required.
- Ensure that its contracts with affiliate companies clearly define all services that will be paid.
- Obtain and maintain documentation to support its payments to HMA for service coordinator-related expenses.

HealthSpring Management Response

HealthSpring generally agrees with the findings and recommendations and offers the following responses.

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HealthSpring traditionally has not reported affiliated companies that do not retain funds originating from STAR+PLUS contracts, either because they do not receive such funds or because they are solely pass-through entities. These companies include HealthSpring Management of America, LLC, and NewQuest, LLC. Additionally, HealthSpring has not reported affiliations with Bravo Health Mid-Atlantic, Inc., HealthSpring USA, LLC, and NewQuest Management of Illinois, LLC, because it has no affiliate agreements or financial relationships with any of these entities.

HealthSpring provided a copy of the Amended and Restated Management Agreement with HealthSpring Management of America, LLC in each of its responses to STAR+PLUS Requests for Proposal.

HealthSpring agrees to report all requested information relating to HealthSpring Management of America, LLC, beginning with the Affiliate Report due on August 31, 2017. HealthSpring also will provide a copy of the downstream management agreement between HealthSpring Management of America, LLC and GulfQuest, LP on a going forward basis beginning with that report. HealthSpring will break out the management fees attributable to STAR+PLUS contracts in disclosures going forward.

HealthSpring further agrees to submit an informational copy of its expense sharing agreement with its immediate parent organization, NewQuest, LLC, in which the parties agreed to the allocation of actual costs throughout the Cigna-HealthSpring organization. HealthSpring will also report a disclaimer to indicate that it pays no administrative fees to NewQuest, LLC under this agreement.

Finally, HealthSpring is amending the downstream management agreement between HealthSpring Management of America, LLC and GulfQuest, LP to clarify the payment of downstream management fees arising from the STAR+PLUS contracts. Once the amendment is finalized, HealthSpring will provide a copy to the Commission.

Responsible Persons:

Managing Counsel
Senior Compliance Specialist

Implementation Date:

August 31, 2017

Chapter 2 – Medical Claim Payments and Adjustments

Chapter 2-A – Documentation of Payment Adjustments

Recommendations

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HealthSpring should develop, document, and implement a process to ensure that it records the reason for all post payment adjustments to medical claims in its claims processing system and on the EOPs sent to medical providers.

HealthSpring Management Response

HealthSpring agrees with the recommendation. HealthSpring has completed a root cause analysis and determined that its post-payment memoranda were not consistently entered into the claims processing system. HealthSpring is revising its procedures to prevent a recurrence. Additionally, HealthSpring will train staff members on the revised procedures and will employ strategies to monitor their compliance with the new processes.

Responsible Persons:

Service Operation Director

Implementation Date:

March 1, 2017

Chapter 2-B – Timely Medical Claim Payment

Recommendations

HealthSpring should:

- Ensure that all medical claims are paid within the Commission's required timeframe.
- Pay interest penalties on all medical claims that are not processed within the Commission's required timeframe.

HealthSpring Management Response

HealthSpring is generally in agreement with the recommendations. Because the audit tested claims from fiscal year 2015, the findings do not reflect more recent changes to HealthSpring's controls, which enhanced the timely payment of medical claims. HealthSpring currently pays medical claims within the Commission's timeliness guidelines and interest does not normally accrue.

HealthSpring recognizes the importance of developing and maintaining a robust program to ensure appropriate payment, allocation, and reporting of costs. To that end, HealthSpring strives

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continually to strengthen its processes and procedures. We welcome the opportunity to collaborate with you and the Commission, as we fulfill our internal commitment to those guiding principles.

Very truly yours,



Jay Hurt

cc: Charles Smith
Executive Commissioner
Texas Health and Human Services Commission

Gary Jessee
Deputy Executive Commissioner, Medical and Social Services Division
Texas Health and Human Services Commission

Stuart Bowen
Inspector General
Texas Health and Human Services Commission

Karin Hill
Director of Internal Audit
Texas Health and Human Services Commission

Richard Appel
Medicare and Medicaid Compliance Director
Cigna-HealthSpring

Related State Auditor's Office Work

Related State Auditor's Office Work		
Number	Product Name	Release Date
17-007	An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission	October 2016

Copies of this report have been distributed to the following:

Legislative Audit Committee

The Honorable Dan Patrick, Lieutenant Governor, Joint Chair
The Honorable Joe Straus III, Speaker of the House, Joint Chair
The Honorable Jane Nelson, Senate Finance Committee
The Honorable Robert Nichols, Member, Texas Senate
The Honorable John Zerwas, House Appropriations Committee
The Honorable Dennis Bonnen, House Ways and Means Committee

Office of the Governor

The Honorable Greg Abbott, Governor

HealthSpring Life and Health Insurance Company, Inc.

Mr. Jay Hurt, Division President/Chief Executive Officer

Health and Human Services Commission

Mr. Charles Smith, Executive Commissioner



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Presentation to the House Appropriations Committee on House Bill 1

Health and Human Services Commission

Charles Smith, Executive Commissioner

February 2017



TEXAS
Health and Human
Services



“We stand ready to work with the Legislature throughout the budget process, and will make the adjustments necessary to live within our appropriation.”

-Charles Smith, Executive Commissioner



Presentation Overview

- ◆ Mission and Vision
- ◆ HHSC's Key Functions For Fiscal Years 2018-2019
- ◆ A Transformed HHS System
- ◆ Major Accomplishments For Fiscal Years 2016-2017
- ◆ Critical Budget Issues For Fiscal Year 2017
- ◆ HHSC Request Compared With H.B. 1
- ◆ Summary of H.B. 1
- ◆ Key Budget Drivers
- ◆ Medicaid Income Eligibility
- ◆ Medicaid Full Benefit Caseload
- ◆ Selected Key Caseloads
- ◆ Summary of Exceptional Item Requests
- ◆ Appendices – Exceptional Item Requests and Letter



Mission and Vision

Our Mission:

- ◆ Improving the health, safety and well-being of Texans with good stewardship of public resources

Our Vision:

- ◆ Making a difference in the lives of the people we serve



HHSC's Key Functions For Fiscal Years 2018-2019

- ◆ Provides oversight and administrative support for the HHS agencies
- ◆ Administers the state's Medicaid and other client services programs
- ◆ Provides a comprehensive array of long-term services and supports for people with disabilities and people age 60 and older
- ◆ Operates the state's mental health hospitals and state supported living centers
- ◆ Regulates healthcare providers, professions, and facilities to protect individuals' health and safety
- ◆ Sets policies, defines covered benefits, and determines client eligibility for client services programs



A Transformed HHS System

FY16 HHS System (5 agencies)

DSHS

HHSC

DADS

DARS

DFPS

FY18 HHS System (3 agencies)

DSHS

Public Health
Programs

HHSC

HHSC DADS DARS DSHS DFPS

- Client Services
- Facilities
- Regulatory Programs
- Regulatory Programs

DFPS

Protective and
Preventative Services



TEXAS
Health and Human Services

Major Accomplishments For Fiscal Years 2016-2017

Transformation

Phase One Accomplishments:

- ◆ Transferred more than 200 client services, programs, and administrative support functions to HHSC
- ◆ Moved more than 4,100 staff from DADS, DARS, and DSHS to HHSC

Phase Two Activities:

- ◆ By September 1, 2017, an additional 100 programs, services, and administrative support functions will transfer to HHSC
- ◆ More than 24,000 staff that support state supported living centers, state hospitals, and regulatory programs will move to HHSC
- ◆ After Phase Two transformation activities are complete, HHSC will have more than 40,000 staff



Major Accomplishments For Fiscal Years 2016-2017

HHS System Improvements

- ◆ Eliminated program silos by consolidating all Medicaid services in the HHS System under a single organizational structure
- ◆ Formalized a system-wide cross-division coordination network
- ◆ Implemented an efficient and effective centralized system of administrative services to support programs
- ◆ Strengthened contract oversight, improved contract processes, and reorganized contracting operations



Major Accomplishments For Fiscal Years 2016-2017

Program and Service Delivery Improvements

- ◆ Successfully negotiated a 15-month extension for the Medicaid 1115 transformation waiver
- ◆ Implemented the new STAR Kids Medicaid program
- ◆ Launched the new Healthy Texas Women and Family Planning programs
- ◆ Improved delivery and coordination of mental health and substance abuse services across the state
- ◆ Re-enrolled Medicaid providers as federally required by the Affordable Care Act



Critical Budget Issues For Fiscal Year 2017

HHS projects a net supplemental appropriation need of \$1.33 billion in General Revenue (GR)

Medicaid/CHIP	\$ 1.19 billion
Child Protective Services/DFPS	\$ 110 million
State Hospitals	\$ 19 million
State Supported Living Centers	\$ 11 million

Additional needs due to unforeseen disaster events can add to the totals above



HHSC Request Compared With H.B. 1: All Funds (in millions)

Items of Appropriation:	Legislative Appropriation Request All Funds, millions (FY18-19)			House Bill 1 (LBE)	Updated Agency Request	Updated Biennial Total Request	Variance, HB 1 to LAR	Variance, Updated to LAR
	Base	Exceptional	Biennial Total	Recommended	Exceptional			
A. Goal: Medicaid Client Services	\$61,093.8	\$4,827.1	\$65,920.9	\$60,684.9	\$4,654.8	\$ 65,339.7	\$ (5,236.0)	\$ (581.2)
B. Goal: Medicaid & CHIP Support	\$1,315.8	\$11.7	\$1,327.4	\$1,288.7	\$0.0	\$ 1,288.7	\$ (38.8)	\$ (38.8)
C. Goal: CHIP Client Services	\$2,012.9	\$106.4	\$2,119.2	\$1,970.4	\$53.2	\$ 2,023.6	\$ (148.8)	\$ (95.6)
D. Goal: Additional Health-Related Services	\$2,303.6	\$121.7	\$2,425.3	\$2,441.4	\$19.9	\$ 2,461.2	\$ 16.1	\$ 36.0
E. Goal: Encourage Self Sufficiency	\$1,812.8	\$0.0	\$1,812.8	\$1,748.9	\$0.0	\$ 1,748.9	\$ (64.0)	\$ (64.0)
F. Goal: Community & IL Services & Coordination	\$625.2	\$46.9	\$672.2	\$622.7	\$15.0	\$ 637.7	\$ (49.5)	\$ (34.4)
G. Goal: Facilities	\$2,457.2	\$576.5	\$3,033.7	\$2,389.0	\$57.9	\$ 2,446.9	\$ (644.7)	\$ (586.8)
H. Goal: Consumer Protection Services	\$313.9	\$47.9	\$361.8	\$298.4	\$24.0	\$ 322.4	\$ (63.4)	\$ (39.4)
I. Goal: Program Eligibility Determination & Enrollment	\$2,301.7	\$65.5	\$2,367.2	\$2,180.1	\$6.8	\$ 2,186.9	\$ (187.1)	\$ (180.3)
J. Goal: Disability Determination	\$230.4	\$0.0	\$230.4	\$230.4	\$0.0	\$ 230.4	\$ -	\$ -
K. Goal: Office of Inspector General	\$122.1	\$27.9	\$150.0	\$121.2	\$16.8	\$ 138.1	\$ (28.7)	\$ (11.9)
L. Goal: System Oversight & Program Support	\$1,024.0	\$173.2	\$1,197.2	\$960.5	\$57.0	\$ 1,017.5	\$ (236.7)	\$ (179.7)
Subtotal: HHSC	\$75,613.4	\$6,004.7	\$81,618.1	\$74,936.5	\$4,905.5	\$ 79,842.0	\$ (6,681.7)	\$ (1,776.2)
HHSC FTEs (Base Only)	40,709.0			39,736.6				(972.4)
M. Goal: Texas Civil Commitment Office	\$30.0	\$9.2	\$39.2	\$30.0	\$8.4	\$ 38.4	\$ (9.2)	\$ (0.8)
Grand Total: Health and Human Services Commission	\$75,643.4	\$6,014.0	\$81,657.3	\$74,966.4	\$4,913.9	\$ 79,880.3	\$ (6,690.9)	\$ (1,777.0)

HHSC Request Compared With H.B. 1: General Revenue (in millions)

Items of Appropriation:	Legislative Appropriation Request General Revenue, millions (FY18-19)			House Bill 1 (LBE)	Updated Agency Request	Updated Biennial Total Request	Variance, HB 1 to LAR	Variance, Updated to LAR
	Base	Exceptional	Biennial Total	Recommended	Exceptional			
A. Goal: Medicaid Client Services	\$25,665.2	\$2,042.6	\$27,707.9	\$25,120.0	\$2,025.0	\$ 27,145.0	\$ (2,587.9)	\$ (562.9)
B. Goal: Medicaid & CHIP Support	\$402.8	\$5.8	\$408.6	\$389.6	\$0.0	\$ 389.6	\$ (19.1)	\$ (19.1)
C. Goal: CHIP Client Services	\$153.4	\$8.1	\$161.5	\$149.4	\$15.0	\$ 164.4	\$ (12.1)	\$ 2.9
D. Goal: Additional Health-Related Services	\$1,534.0	\$118.8	\$1,652.8	\$1,671.8	\$0.1	\$ 1,671.9	\$ 19.0	\$ 19.1
E. Goal: Encourage Self Sufficiency	\$523.7	\$0.0	\$523.7	\$551.2	\$0.0	\$ 551.2	\$ 27.5	\$ 27.5
F. Goal: Community & IL Services & Coordination	\$282.5	\$46.9	\$329.4	\$282.5	\$15.0	\$ 297.5	\$ (47.0)	\$ (31.9)
G. Goal: Facilities	\$1,475.8	\$344.8	\$1,820.6	\$1,421.0	\$35.7	\$ 1,456.7	\$ (399.6)	\$ (363.9)
H. Goal: Consumer Protection Services	\$130.3	\$39.9	\$170.2	\$123.9	\$23.5	\$ 147.4	\$ (46.3)	\$ (22.8)
I. Goal: Program Eligibility Determination & Enrollment	\$968.4	\$36.5	\$1,005.0	\$912.2	\$3.1	\$ 915.3	\$ (92.8)	\$ (89.7)
J. Goal: Disability Determination	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$ -	\$ -	\$ -
K. Goal: Office of Inspector General	\$44.3	\$9.4	\$53.6	\$43.8	\$5.9	\$ 49.7	\$ (9.8)	\$ (3.9)
L. Goal: System Oversight & Program Support	\$342.4	\$114.8	\$457.2	\$319.2	\$32.1	\$ 351.3	\$ (138.0)	\$ (105.9)
Subtotal: HHSC	\$31,522.8	\$2,767.7	\$34,290.5	\$30,984.6	\$2,155.4	\$ 33,139.9	\$ (3,306.0)	\$ (1,150.6)
M. Goal: Texas Civil Commitment Office	\$29.8	\$9.2	\$39.1	\$29.8	\$8.4	\$ 38.2	\$ (9.2)	\$ (0.8)
Grand Total: Health and Human Services Commission	\$31,552.7	\$2,776.9	\$34,329.6	\$31,014.4	\$2,163.8	\$ 33,178.2	\$ (3,315.2)	\$ (1,151.4)

Summary of H.B. 1

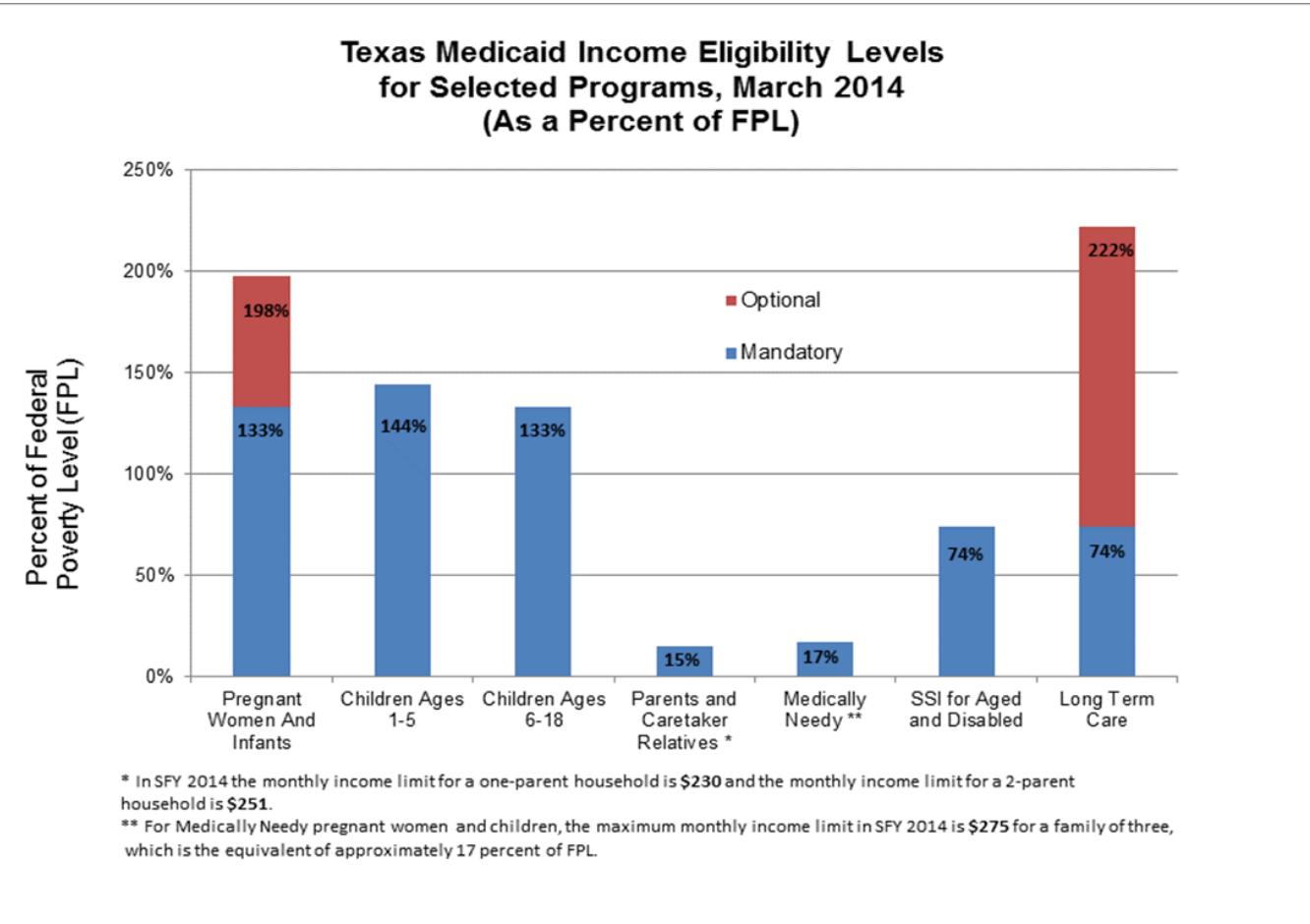
Area	LAR / LAR Update		H.B. 1	
	Base	Exceptional Items	Base	Agency Response (exceptional item)
Client Services, Entitlement	<ul style="list-style-type: none"> FY 2017 Costs Caseload growth over FY 2017 in LAR 	<ul style="list-style-type: none"> Cost growth only 	<ul style="list-style-type: none"> Caseload growth over FY 2017 No Cost Growth 	<ul style="list-style-type: none"> Additional caseload growth and cost growth forecast
Client Services, Non-Entitlement	<ul style="list-style-type: none"> FY 2016-17 Average for Base 	<ul style="list-style-type: none"> Cost growth, plus maintenance of clients served 	<ul style="list-style-type: none"> Forecasted (CHIP) Medicaid Waivers Maintenance funded Other client service varied 	<ul style="list-style-type: none"> Criteria of cost avoidance and protection
Administration	<ul style="list-style-type: none"> FY 2016-17 Average for Base Reductions ~ 3-4% 	<ul style="list-style-type: none"> Enhance contract monitoring Replace federal dollars lost due to cost allocation 	<ul style="list-style-type: none"> LAR Base as submitted, with additional 5.3%++ reductions Removal of funding for vacant positions on 8/31/16 	<ul style="list-style-type: none"> Items resulting in cost avoidance, child protection, and federal minimums /requirements
Capital	<ul style="list-style-type: none"> FY 2016-17 Average for Base, including adjustments based on projected capital need 	<ul style="list-style-type: none"> Meet federal requirements, state billings (DIR) and improve operational efficiency 	<ul style="list-style-type: none"> Reductions of \$66 million AF to Capital Base; \$22m GR reductions 	<ul style="list-style-type: none"> Items resulting in cost avoidance, child protection, and federal minimums /requirements
Facilities	<ul style="list-style-type: none"> FY 2016-17 Average for Base 	<ul style="list-style-type: none"> Deferred maintenance; Facility New Construction Placeholder 	<ul style="list-style-type: none"> Funding based on reduced census counts, other reductions 	<ul style="list-style-type: none"> SSLC Staff ramp-down, plus special needs for cost avoidance/savings; Facility New Construction Placeholder

Key Budget Drivers

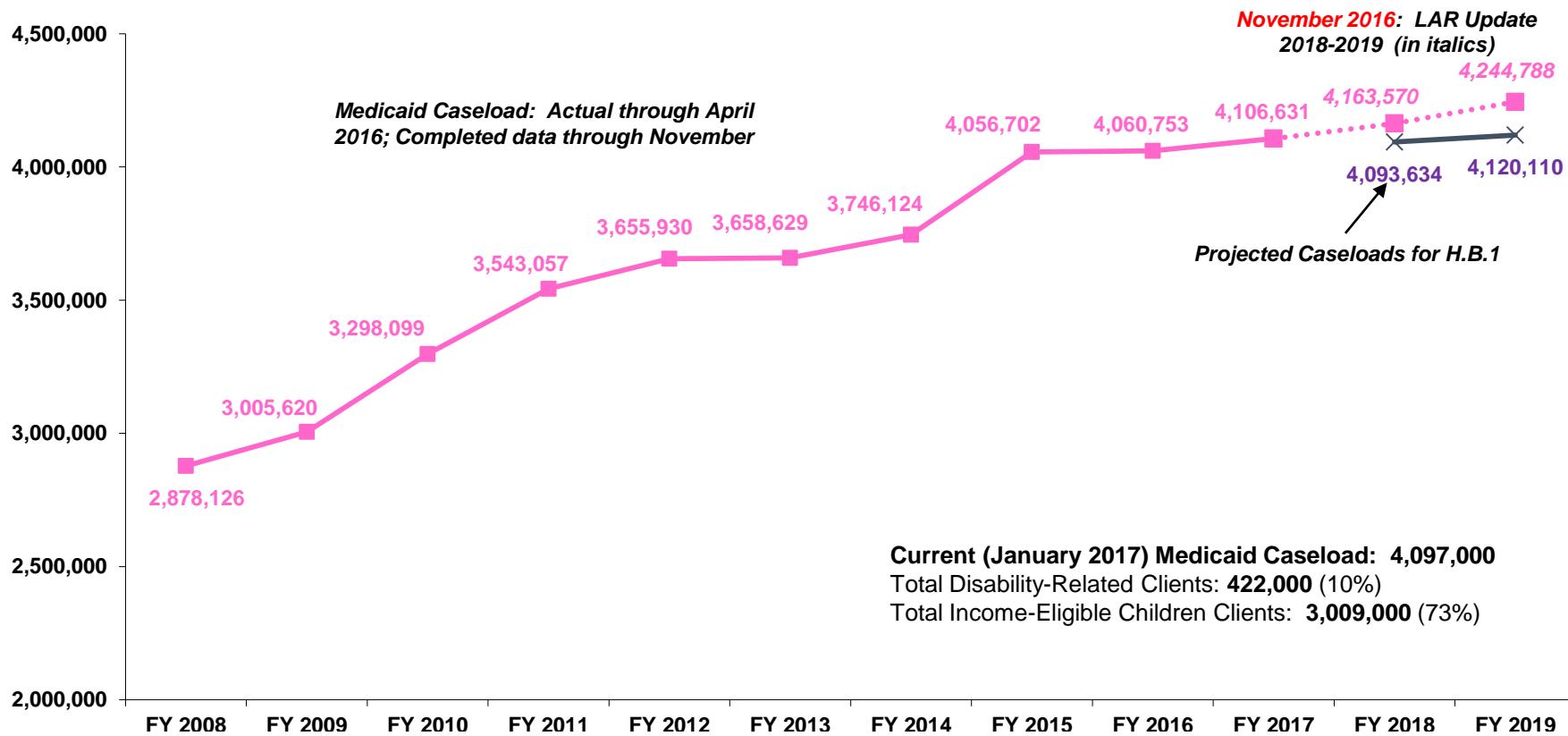
- ◆ Projected caseloads are expected to increase by less than 2 percent each year of the biennium for Medicaid and just less than 5 percent each year for CHIP
- ◆ Acute care Medicaid cost growth ranges between 2.5 percent and 5.6 percent each year of the biennium
- ◆ Cost growth is impacted by many factors: utilization trends; benefit changes; population acuity factors; aging and births; and both evolutionary and revolutionary advances in medicine
- ◆ Cost growth for the Medicaid program in Texas has averaged a slower rate of increase when compared to national trends, but Texas does experience cost growth each biennium



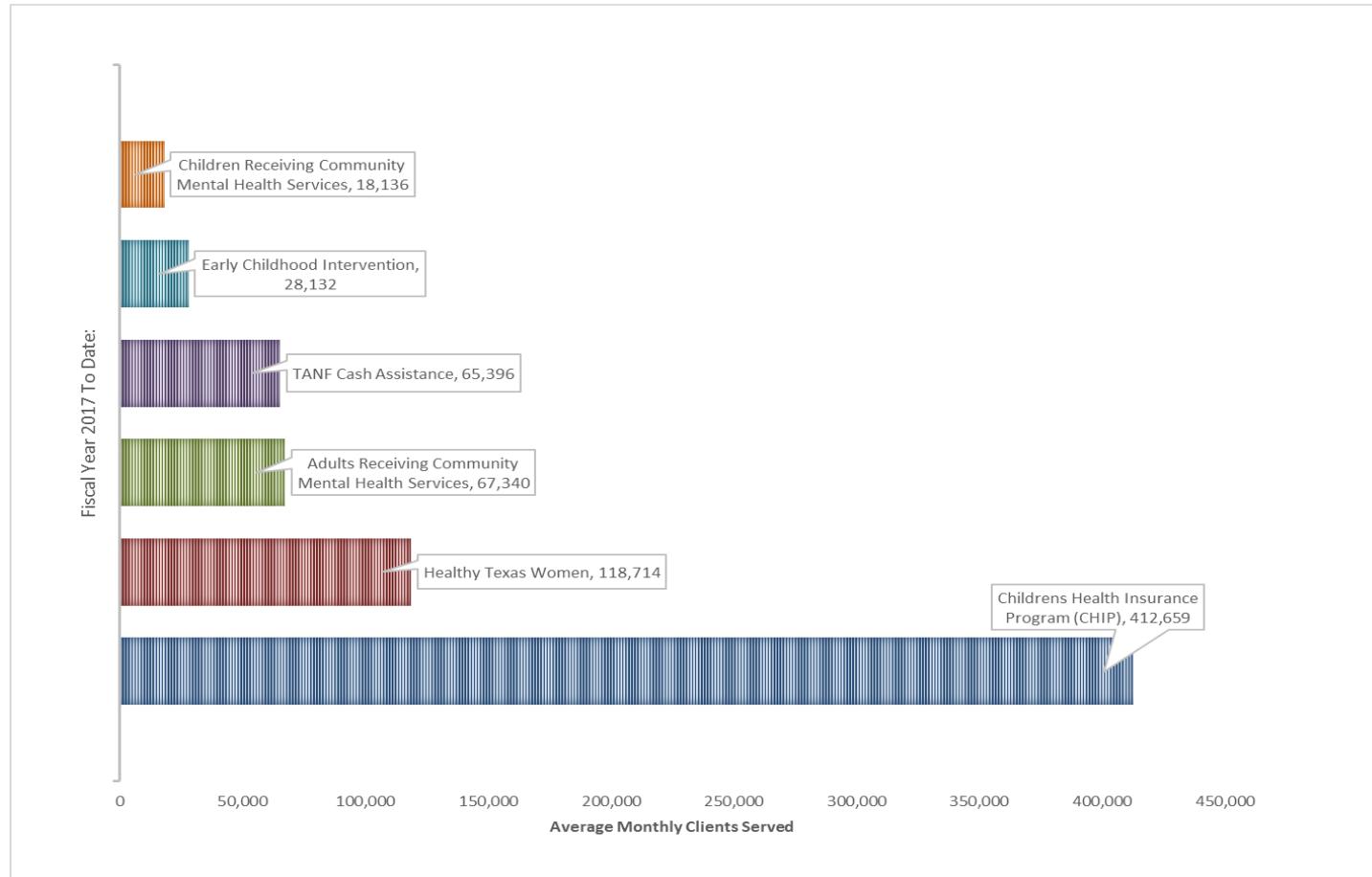
Medicaid Income Eligibility



Medicaid Full-Benefit Caseload: Historical and Estimated Caseloads Compared With 85th Legislature, Caseload Measures for Fiscal Years 2008 - 2019



Selected Key Caseloads



Summary of Exceptional Item Requests

Priority	Name	FY 2018		FY 2019		Biennial		FTEs		Status
		GR	AF	GR	AF	GR	AF	18	19	
1	Maintain Medicaid Entitlement Program Growth in FY 2018-19	687,993,214	1,509,739,854	1,261,281,759	2,967,942,011	1,949,274,973	4,477,681,865			Keep As Amended
2	Maintain CHIP Non-Entitlement Program Growth in FY 2018-19	6,020,710	31,265,618	8,965,234	21,958,706	14,985,944	53,224,324			Keep As Amended
3	CASA/CAC - Increase Capacity	4,000,000	4,000,000	4,000,000	4,000,000	8,000,000	8,000,000			No Change
4	Child Care Licensing	6,330,186	6,439,011	5,568,314	5,654,832	11,898,500	12,093,843	97.5	97.5	Keep As Amended
5	Increase Staff Resources to meet Caseloads for CCL	6,010,593	6,010,593	5,286,184	5,286,184	11,296,777	11,296,777	89.5	90.5	Keep As Amended
6	Family Violence Program	1,500,000	1,500,000	1,500,000	1,500,000	3,000,000	3,000,000			No Change
7	ECI Maintain Svcs 2017 Levels	-	7,493,290	-	12,261,888	-	19,755,178			Keep As Amended
8	Home and Community-Based Services Requirement	-	-	29,872,474	70,024,554	29,872,474	70,024,554			Keep As Amended
9	Critical Incident Reporting	1,014,000	2,028,000	250,000	500,000	1,264,000	2,528,000			No Change
10	PASRR LTC Online Portal Improvement	2,068,125	8,272,500	2,068,125	8,272,500	4,136,250	16,545,000			No Change
11	Avatar Support for State Hospital Systems	3,044,180	3,044,180	3,044,180	3,044,180	6,088,360	6,088,360			No Change
12	Social Security Number Removal	539,328	5,302,121	185,252	1,844,724	724,580	7,146,845	17	3	No Change
13	Mortality Review	1,237,500	2,475,000	500,000	1,000,000	1,737,500	3,475,000			No Change
14	Transition State Supported Living Centers	17,259,499	39,854,665	-	-	17,259,499	39,854,665	676		Keep As Amended
15	Maintain Biennial SB 208	4,584,539	4,584,539	4,584,539	4,584,539	9,169,077	9,169,077			Keep As Amended
16	Provide Transition to Community Service (Promoting Independence)	12,898,745	29,769,256	36,293,628	84,738,223	49,192,373	114,507,479	8	26	Keep As Amended
17	Facilities - New Construction	1	1	1	1	2	2			No Change
18	Regional Laundry	2,843,650	2,843,650	-	-	2,843,650	2,843,650			Keep As Amended
19	Fleet Operations	3,855,454	3,855,454	4,033,034	4,033,034	7,888,488	7,888,488			Keep As Amended
20	Litigation Support & Legal Asst	1,546,444	1,599,138	1,538,293	1,590,987	3,084,737	3,190,125	12	12	No Change
21	HHS Electronic Discovery Solution	4,854,784	6,591,953	1,259,480	1,710,215	6,114,264	8,302,168	2	2	No Change
22	ReHabWorks Replacement Solution	3,179,520	3,179,520	89,760	89,760	3,269,280	3,269,280			No Change
23	Hospital-Life Record at RGSC	1,000,000	1,000,000	1,000,000	1,000,000	2,000,000	2,000,000			No Change
24	Seat Management	3,229,160	3,445,323	3,139,471	3,353,834	6,368,631	6,799,157			Keep As Amended
	HHSC Total	775,009,631	1,684,293,666	1,374,459,728	3,204,390,172	2,149,469,359	4,888,683,837	902	231	
25	IG Additional Investigations Staff	468,378	936,756	434,652	869,304	903,030	1,806,060	9	9	Keep As Amended
26	IG Medicaid Fraud & Detection System	1,250,000	5,000,000	1,250,000	5,000,000	2,500,000	10,000,000			Keep As Amended
27	IG Case Management System	1,500,000	3,000,000	1,000,000	2,000,000	2,500,000	5,000,000			No Change
	Inspector General Total	3,218,378	8,936,756	2,684,652	7,869,304	5,903,030	16,806,060	9	9	
28	TCCO Caseload Growth	1,229,721	1,229,721	3,881,309	3,881,309	5,111,030	5,111,030			No Change
29	TCCO Offsite Healthcare	778,079	778,079	891,795	891,795	1,669,874	1,669,874			No Change
30	TCCO Supported Living Unit	1,056,450	1,056,450	556,450	556,450	1,612,900	1,612,900			No Change
	TCCO Total	3,064,250	3,064,250	5,329,554	5,329,554	8,393,804	8,393,804	-	-	

Appendix – Exceptional Items



Exceptional Item #1

Maintain Medicaid Entitlement Program Cost Growth in FY 2018-19

This exceptional item request would provide for the incremental caseload and cost increase in fiscal years 2018-19 over fiscal year 2017 levels forecasted for H.B.1 for all acute and long-term services and supports entitlement services according to current program design. To the extent the Legislature wants to make adjustments to optional benefits and eligibility, this funding request may be reduced.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	688.0	1261.3	1949.3
All Funds	1509.7	2967.9	4477.7
FTEs	0	0	0
Program Impact	FY 2018	FY 2019	
HHSC Caseload above Projected Performance Measure	69,936	124,678	
% Caseload Increase from Prior Year	1.4%	2.0%	



Exceptional Item #2

Maintain CHIP Non-Entitlement Program Cost Growth in FY 2018-19

This request represents caseload and cost growth above the forecasted amounts in H.B. 1.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	6.0	9.0	15.0
All Funds	31.3	22.0	53.2
FTEs	0	0	0
Program Impact	FY 2018	FY 2019	
CHIP Caseload above Projected Performance Measure	12,875	17,477	
% Caseload above Projected	3.0%	3.9%	



Exceptional Item #3

CASA/CAC-Increase Capacity

This exceptional request would increase this availability of child advocacy services for Court Appointed Special Advocates (CASA) and Child Advocacy Centers of Texas (CAC).

Funds will allow CACs to facilitate and strengthen joint investigations of child abuse with Child Protective Services and law enforcement. Funds will also allow CASA to increase service capacity and reduce disparate service levels statewide.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	4.0	4.0	8.0
All Funds	4.0	4.0	8.0
FTEs	0	0	0



Exceptional Item #4

Child Care Licensing

This exceptional item request would support staffing increases and costs to implement certain portions of the Child Care and Development Fund (CCDF) program. This request also includes funding for the additional staff necessary at DFPS to conduct background checks to support increased child care regulatory workload to fully implement the provisions of CCDF regulations.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	6.3	5.6	11.9
All Funds	6.4	5.7	12.1
FTEs	97.5	97.5	



Exceptional Item #5

Increase Staff Resources to Meet Caseloads for Child Care Licensing

This item reduces average daily caseloads for Child Care Licensing (CCL). Reduced caseloads results in faster response times, increased quality of work performed, and improved safety of the clients being served. Without this item CCL cases per worker would continue to increase above previously funded levels, which increases the safety risks of children, youth, adults, and their families.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	6.0	5.3	11.3
All Funds	6.0	5.3	11.3
FTEs	89.5	90.5	0



Exceptional Item #6

Family Violence Program

This request would provide additional funding for emergency shelter and support services to victims and their children, educates the public, and provides prevention support to various agencies.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	1.5	1.5	3.0
All Funds	1.5	1.5	3.0
FTEs	0	0	0



Exceptional Item #7

Maintain ECI Caseload and Program Cost Growth in FY 2018-19

Early Childhood Intervention (ECI) program costs associated with federal requirements and not reimbursed by Medicaid has resulted in the agency using more federal IDEA Part C funding for allowable program expenses. This exceptional item request would fund the projected caseloads in fiscal years 2018 and 2019.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	0.0	0.0	0.0
All Funds	7.5	12.3	19.8
FTEs	0	0	0
Program Impact	FY 2018	FY 2019	
ECI Caseload Increase	(132)	79	
% Caseload Increase	-0.5%	0.3%	



Exceptional Item #8

Community Day Habilitation Programs(CDHP) – HCBS Requirement

New Community-based Services (HCBS) rules from the Center for Medicare and Medicaid Services (CMS) require state compliance with guidelines by March 17, 2019. This exceptional item request would assist community providers and their subcontracted providers to comply with CMS HCBS requirements, including rate changes for additional services, adding services to the existing service array, and providing for increased contract oversight of program providers.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	0.0	29.9	29.9
All Funds	0.0	70.0	70.0
FTEs	0	0	0



Exceptional Item #9

Critical Incident Reporting

The Center for Medicare and Medicaid Services (CMS) requires the reporting of incidents both critical, serious and non serious from community-based programs. This exceptional item request would provide a new comprehensive web based incident reporting system that consolidates multiple and disparate systems across HHS departments to increase internal efficiencies and ensure federal compliance.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	1.0	0.3	1.3
All Funds	2.0	0.5	2.5
FTEs	0	0	0



Exceptional Item #10

PASRR LTC Online Portal Quality Improvements

This exceptional item is to fund one-time improvements to the Long-term Care (LTC) online portal functionality and preadmission screening and resident review (PASRR) forms. Automating certain processes will provide better access to care for individuals eligible for specialized services as a result of PASRR, and updated fields and options on the PASRR forms will provide data needed for improved state oversight. The projects represented in this request will ensure Texas is in compliance with federal PASRR requirements by improving providers' ability to efficiently document information related to PASRR specialized services, submitting claims more promptly and allowing effective validation of service delivery for approximately 13,600 PASRR individuals.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	2.1	2.1	4.1
All Funds	8.3	8.3	16.5
FTEs	0	0	0



Exceptional Item #11

Avatar Support for State Hospital Systems

This exceptional item will provide sufficient funding to State hospitals to meet operating costs associated with Avatar, which as the Electronic Health Record (EHR) system, is vital to state hospital functions.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	3.0	3.0	6.1
All Funds	3.0	3.0	6.1
FTEs	0	0	0



Exceptional Item #12

Social Security Number Removal

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (PL 114-10) requires the Center for Medicare and Medicaid Services (CMS) to replace Social Security Numbers (SSNs) on cards and systems and replace with a Medicare Beneficiary Identifier (MBI). This exceptional item request would provide for the examination and identification of policies and systems and the appropriate changes to also be identified and tested prior to the distributions of new Medicare cards (est. April 2018) for all HHS systems. This project will receive enhanced Federal Funding (90/10).

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	0.5	0.2	0.7
All Funds	5.3	1.8	7.1
FTEs	17	3	



Exceptional Item #13

Mortality Review in Community IDD Programs

This exceptional item request would provide funding to implement a mortality review process for 1915(c) waiver programs for individuals with intellectual and developmental disabilities (IDD) and intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID). A mortality review process in community IDD programs will bring HHSC into compliance with current state statute and contribute to quality improvement across IDD programs.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	1.2	0.5	1.7
All Funds	2.5	1.0	3.5
FTEs	0	0	0



Exceptional Item #14

Maintain State Supported Living Centers for FY 2018 Only

The item requests funding to allow development of a viable expenditure reduction plan for the State Supported Living Centers that will not jeopardize resident care.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	17.3		17.3
All Funds	39.9		39.9
FTEs	676	0	



Exceptional Item #15

Maintain Biennial Funding (S.B. 208)

This exceptional item provides the General Revenue which replaces the federal funds which were transitioned out of the HHS System as a result of S.B. 208 and which were only funded for one year in the 2016-17 biennium as part of Art II, SP, Sec 57 Contingency for S.B. 208 (GAA FY 2016-17).

This item also provides the funding for field support FTEs in Comprehensive Rehabilitation Services, Children's Blindness Services, and Independent Living Services which were only funded for one year of the 2016-17 biennium.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	4.6	4.6	9.2
All Funds	4.6	4.6	9.2
FTEs	0	0	0



Exceptional Item #16

Provide Transition to Community Services

This exceptional item would provide funding for community placement options in lieu of institutional placements under the promoting independence initiative. This request would create: 500 Home and Community-based Services (HCS) slots for individuals in State Supported Living Centers or Intermediate Care Facilities; 400 HCS slots for individuals in crisis or imminent risk of institutionalization; 276 slots for children in transition from foster care or transitioning from general residential operations facilities; 120 HCS slots for individuals with an intellectual or developmental disability (IDD) moving from state hospitals; and 1,300 slots for individuals with IDD relocating or being diverted from nursing facilities.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	12.9	36.3	49.2
All Funds	29.8	84.7	114.5
FTEs	8	26	



Exceptional Item #17

Facilities – New Construction Placeholder

This exceptional item request allows for a placeholder as discussion regarding the vision for state facilities is further developed.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue			
All Funds			
FTEs			



Exceptional Item #18

Regional Laundry

This exceptional item request would replace laundry equipment at the Kerrville and North Texas State Hospitals, and the Mexia, Abilene, and Richmond state supported living centers.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	2.8	0.0	2.8
All Funds	2.8	0.0	2.8
FTEs	0	0	0



Exceptional Item #19

Fleet Operations

This exceptional request item would ensure SSLC residents, state hospital patients and facility staff safety when traveling in state agency vehicles.

Funding this item would allow for the replacement of 110 state hospital vehicles and 109 state supported living center vehicles.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	3.9	4.0	7.9
All Funds	3.9	4.0	7.9
FTEs	0	0	0



Exceptional Item #20

Litigation Legal Support & Legal Assistance

This exceptional item request provides funding for litigation support for 12 legal staff and other operating expenses for dedicated representation in health and human services litigation at the Office of Attorney General.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	1.5	1.5	3.1
All Funds	1.6	1.6	3.2
FTEs	12	12	



Exceptional Item #21

HHS Electronic Discovery Solution

This exceptional item request is to establish a Legal Case Management Solution and refresh eDiscovery technologies currently in use to better manage and respond to litigation matters, investigations and public information requests that require evidence and information to be identified, culled, vetted, reviewed, analyzed and produced.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	4.9	1.3	6.1
All Funds	6.6	1.7	8.3
FTEs	2	2	



Exceptional Item #22

RehabWorks Replacement Solution

This exceptional item request further supports the intent of S.B. 208 by allowing the Blindness Education, Screening, and Treatment (BEST), Independent Living (IL), Comprehensive Rehabilitation Services (CRS) programs to transition off the RehabWorks case-review system which has transitioned to TWC. RehabWorks is currently being modified as a result of the Workforce Innovation and Opportunity Act (2014). These modifications make the system less effective for the legacy DARS programs which transitioned to HHSC.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	3.2	0.1	3.3
All Funds	3.2	0.1	3.3
FTEs	0	0	0



Exceptional Item #23

Hospital Life Record at RGSC

This exceptional item request would provide for the installation and maintenance services of the Life Record system at the Rio Grande State Center (RGSC) to align it with the state supported living center (SSLC) system. RGSC clinicians need to have access to the records of current SSLC patients for treatment and to ensure continuity of care is maintained.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	1.0	1.0	2.0
All Funds	1.0	1.0	2.0
FTEs	0	0	0



Exceptional Item #24

Seat Management

This exceptional item request would cover maintenance and lease payments above base funding for existing leased computer equipment at DFPS and DSHS.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	3.2	3.1	6.4
All Funds	3.4	3.4	6.8
FTEs	0	0	0



Message From Executive Commissioner Charles Smith

In light of the Comptroller's biennial revenue estimate and the respective budgets filed by both the Texas House of Representatives and Texas Senate, I am fully aware of the budgetary projections that our state faces and realize that cuts to programs and services will be necessary as a result. The HHS revised exceptional item list has been winnowed and updated to reflect this current circumstance.

With the exception of the first two items, the revised list of exceptional items either reduce costs for the HHS System or request vital funding to support the protection of children. However, please note that items one and two deal with the funding needs of entitlement services. These program designs have been established by previous Legislatures, and some categories exceed federal minimum eligibility requirements. Because I realize that the Legislature may decide to revisit previous decisions, this information has been provided for planning and informational purposes. Please note that it is possible to make reductions in optional eligibility services and work toward the funding levels established in H.B. 1.

The HHS System welcomes the opportunity to work with the Legislature as it makes these difficult choices ahead. Our staff will provide to you in the immediate future relevant information about the impact of the H.B. 1 reductions below our base request. In addition, should the Legislature want to contemplate funding for other important needs, I would point to the HHS System LAR as our blueprint.

I understand this is a difficult budget cycle. Please rest assured that the HHS System will make the adjustments necessary to live within our appropriations for entitlement and non-entitlement programs.

-Charles Smith, Executive Commissioner



Exceptional Items Included In LAR

But Not In Updated Request

Priority	Item
1	Maintain Current Funding for Client Services
3	Maintain Medicaid Non-Entitlement Cost Growth in FY 2018-19
5	Maintain Mental Health Community Services Programs at FY 2017 Levels
7	Funding to Sustain Enhanced Community Coordination and Transition Support Teams to Ease Community Transition for Persons with Intellectual and Development Disabilities
8	Maintain Psychiatric Bed Capacity in the State
9	Maintain Critical Direct Delivery Staffing in State Hospitals and State Supported Living Centers Through Recruitment and Retention
10	Maintain Critical Operations & Support of Direct Delivery Staff for Child Care Licensing and Adult Protective Services Investigations
2	Restore Four-Percent Reductions
12	Restore Client Service 4% Reductions for Blindness Education, Screening, and Treatment (BEST) and Comprehensive Rehabilitation Services (CRS)
13	Restore Client Service 4% Reductions for Child-Care Licensing and Adult Protective Services Investigations
4	Reduce Community Program Interest Lists
15	Reducing Community Program Interest List for LTSS Community-Based Services (19,010)
16	Reducing the Community Mental Health Waitlist
17	Reducing the Comprehensive Rehabilitation Services and Independent Living Services Waitlist
5	Provide Essential Repairs for State Operated Facilities
18	Facilities Repair and Renovation for State Hospitals and State Supported Living Centers
6	Increase Capacity to Meet the Growing Need for Psychiatric Treatment
22	Provide Critical Capacity to Meet the Need for Psychiatric Treatment Beds
7	Offer Acute, Long-Term, and Behavioral Health Treatment
23	Family Planning Services
26	Intensive Behavioral Intervention
27	Hepatitis C Treatment at State Hospitals
28	Enhance Community Services for Substance Abuse and Behavioral Health Treatment
29	State Supported Living Centers Services to the Community
30	Increase Aging and Disability Resource Centers Supports for Veterans
31	PACE Full Funding Adjustment
8	Ensure Quality System Oversight and Client Service Delivery
32	Contract Management, Oversight and System Improvements for ICF/IID and Medicaid
33	Maintaining Regulatory Timeframes Amid Increased Workload
38	Attendant Wage Increase, \$8.00 to \$8.50
39	Increased Wage Enhancement Funding for IDD Programs
9	Provide Critical Information Technology Infrastructure and Support
42	Quality Reporting System Updates
47	Hospital Infrastructure: Maintain State Hospital Technology for Patient Care
48	TIERS Vendor Transition Planning and Maintenance
51	HHS Cybersecurity Project
52	DIR Data Center Services
53	Legacy System Modernization - Non DCS IT Infrastructure
55	Enterprise Identity & Access Management Expansion
10	Office of Inspector General
59	Provider Enrollment Background Check Staff

Presentation to the House Appropriations Committee on House Bill 1

Health and Human Services Commission

Office of Inspector General

Stuart W. Bowen, Jr., Inspector General

February 2017



TEXAS
Health and Human
Services

Presentation Overview

- ◆ Mission and Vision
- ◆ Major Accomplishments For Fiscal Years 2016-2017
- ◆ FY 16-17 HB 1 Comparison
- ◆ Exceptional Item Requests



Mission, Vision and Values

Our Mission:

- ◆ To detect, prevent, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used to deliver all health and human services in Texas.

Our Vision:

- ◆ Ensure that more of every tax dollar appropriated for the delivery of health and human services to people in need in Texas is actually spent on those services, thus improving our state's collective well-being.

Our Values:

- ◆ Professionalism. Productivity. Perseverance.





Inspector General Budget and Exceptional Items



Fiscal Years 2016-2017 Accomplishments

- ◆ The IG recovered \$29.5 million more in GR in FY16-FY17 than was recovered in FY14-FY15.
- ◆ The IG recovers \$2 in state funds for every \$1 that is expended. This is a significant increase over the previous biennium.
- ◆ Total recoveries (All Funds) are up 48 percent over the previous biennium.
- ◆ The IG has improved investigations and audit engagements by initiating the Texas Fraud Prevention Partnership and completed Medicaid managed care SIU audits that have resulted in liquidated damages.
- ◆ A backlog of 1,118 cases was eliminated in 10 months and the IG has greatly improved processing times for investigations and provider enrollment applications.



FY 16-17 – HB 1 Comparison

Fiscal Years	General Revenue	All Funds	FTEs
FY 2016-2017	\$40.7	\$124.4	736.3
FY 2018-2019 LAR	\$44.3	\$122.1	736.3
FY 2018-2019-HB1	\$43.8	\$121.2	736.3
Variance, Current Funding to HB1	\$3.1	(\$3.1)	-

IG proposed contingency rider: Restoring reduction contingent on increased recoveries.

Exceptional Item #1

New MFADS System

- ◆ This request funds, per statutory requirement, a new Medicaid Fraud and Abuse Detection System.
- ◆ The new system will have an increase in potential detection of fraud, waste, and abuse through an automated, objective system.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	\$1.25	\$1.25	\$2.5
All Funds	\$5.0	\$5.0	\$10.0



Exceptional Item #2

Case Management System

- ◆ This request will enable the IG to design, develop and implement a much needed Case Management System to track investigations across the IG rather than the current, multiple systems and spreadsheets utilized.
- ◆ This item will produce increased operational efficiencies, mitigate risks, and enhance data collection and tracking.

MOF (\$ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	\$1.5	\$1.0	\$2.5
All Funds	\$3.0	\$2.0	\$5.0



Exceptional Item #3

Oversight Staff

- ◆ The IG requests funding for nine oversight staff to conduct investigations and audits of HHS programs. This oversight staff will focus on programs with high rates of state collections.

MOF	FY 2018	FY 2019	Biennium
General Revenue	\$0.7	\$0.6	\$1.3
All Funds	\$0.9	\$0.9	\$1.8





TEXAS CIVIL COMMITMENT OFFICE

MARSHA MCLANE
EXECUTIVE DIRECTOR

House Appropriations Committee: Written Testimony

The Texas Civil Commitment Office (TCCO), formerly known as the Office of Violent Sex Offender Management (OVSOM) is pleased to provide an update of the agency's activities and present our Legislative Appropriations Request (LAR) for your committee's consideration.

AGENCY UPDATE

- Senate Bill 746, 84th Legislative Session, changed the agency's name from OVSOM to TCCO, increased the size of the agency's board from 3 to 5 members, amended the civil commitment process and created a tiered treatment program.
- TCCO program was changed from a solely outpatient program to a program allowing movement along a continuum from a total confinement facility to less restrictive alternatives based on the individual's progress and behavior. TCCO, rather than the court, is now able to make decisions regarding a client's residence.
- New civil commitment trials now take place in the individual's last county of conviction for a sexually violent offense and those being released to independent living must return to that last county of conviction.
- Immediately after the signing of SB 746, TCCO issued an RFP for a Civil Commitment Center to provide housing and treatment to TCCO's clients. A contract was signed on 7/31/15 and the Texas Civil Commitment Center (TCCC) in Littlefield, Texas opened and accepted its first residents on 9/1/15.
- TCCC houses Tiers 1 through 4 of the treatment program. TCCC residents receive 6 hours of group sex offender treatment per week and individual sessions at least once a month. Additional programming includes: therapeutic study hall, community meetings, structured recreation, open recreation, AA/NA, life skills programming, education programming and a therapeutic work program. The program at TCCC for Tiers 1 through 4 is a 100% increase in hours of sex offender specific treatment over the previous program, in addition to being a therapeutic community.
- In fiscal year 2016 three individuals who no longer had the behavioral abnormality that qualified them for commitment were released by the court. All three remain subject to sex offender registration statutes.
- Effective September 1, 2016, TCCO's administrative attachment was transitioned from the Department of State Health Services to the Health & Human Services Commission (HHSC).

- Total Number of Civil Commitment Clients – 416 (as of 01/23/2017)
 - In the community – 265
 - In prison pending release – 151

ISSUES FACING THE AGENCY

- Expected Caseload Growth
 - Under the previous system, new civil commitment cases were centralized in the 435th District Court of Montgomery County with cases tried by the Special Prosecutions Unit. As a result of SPU's funding, there was a cap on the number of new commitments TCCO could expect to receive each year. With cases now going back to the county of last conviction, TCCO projects higher caseload increases.
 - As a small agency, larger caseloads have a significant impact on the agency's available resources and its ability to supervise clients who will be located throughout the state.
- Texas Civil Commitment Center Capacity and Renegotiations
 - The TCCC contract expires on 8/31/2017. TCCO and the vendor will begin renegotiations in February 2017 and TCCO is also preparing an RFP for the TCCC in the event it becomes necessary.
 - Based on current caseload projections, TCCC will reach full capacity in FY 2019 resulting in the need for additional bed space elsewhere.
- Civil Commitment Clients with Special Needs
 - Clients with severe mental health issues are being civilly committed and released from prison and state hospitals, including some that have been found to be incompetent to stand trial and unable to regain competency. These clients are unable to effectively participate in the TCCO sex offender treatment program.
 - TCCO faces difficulty in receiving appropriate mental health care for these clients and the Department of State Health Services states that they do not have statutory authority to provide inpatient treatment to these clients.
- Health Care Needs
 - Clients residing at the TCCC average 55 years old and many require considerable medical care including eleven who are currently in need of Hepatitis C treatment. TCCO has worked with the Health and Human Services Commission to piggyback on their contract to purchase medications to treat Hepatitis C. Under that contract, the medications have a cost of \$50,000 to \$80,000 per person.
- Community Resources for Clients Transitioning to Tier 5
 - TCCO currently has clients from 95 different counties throughout the state and will have to arrange for treatment, supervision, housing and related services in each of those areas as clients near readiness to transition to Tier 5. RFPs for these services have received few responses.

LEGISLATIVE APPROPRIATIONS REQUEST

BASELINE REQUEST:

Our baseline request asks for \$29,970,030 for the biennium to supervise, monitor and treat sexually violent predators (SVPs) that are currently civilly committed. These funds are made up of \$29,846,030 in General Revenue funds and \$124,000 in reimbursements received from SVPs for their housing,

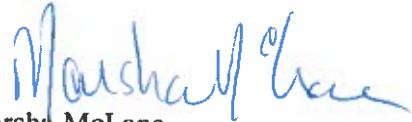
treatment and GPS tracking costs as required in SB 746. Our baseline request retains our 35 authorized FTE's. In addition, TCCO's appropriations request includes three exceptional items. They are:

EXCEPTIONAL ITEMS REQUEST:

1. **Caseload Growth** – This exceptional item requests \$1,229,721 in FY 2018 and \$3,881,309 in FY 2019 for a total of \$5,111,030 in additional funds for the biennium to pay for the expected growth in the number of individuals committed to the sexually violent predator civil commitment program. TCCO has no control over the size of our caseload increase but is statutorily required to provide appropriate supervision and treatment to those who are committed. SB 746 passed during the 84th Legislative Session shifted jurisdiction for prosecuting civil commitment cases from a centralized Special Prosecution Unit and 435th District Court to cases being prosecuted by local District Attorneys in the client's county of last conviction. The number of SVPs who are civilly committed and in our program is projected to be 340 in FY 2018 and 409 in FY 2019.
2. **Offsite Healthcare for Civilly Committed Sexually Violent Predators** – This exceptional item requests \$778,079 in FY 2018 and \$891,795 in FY 2019 for a total of \$1,669,874 in additional funds for the biennium to pay for offsite healthcare. SVPs located at the Texas Civil Commitment Center (TCCC) in Littlefield average 55 years of age and many require considerable medical care, including several that are in need of Hepatitis C treatment. Our TCCC contract includes an on-site primary health care clinic and covers the first \$25,000 in off-site medical care for each SVP and specifically excludes Hepatitis C medications. The funds requested in this Exceptional Item would pay for SVP off-site medical care above the \$25,000 covered in the current contract and help ensure that catastrophic medical care costs do not fall on the taxpayers of a small community, which could overwhelm the local indigent care system.
3. **Supported Living Unit** – This exceptional item requests \$1,056,450 in FY 2018 and \$556,450 in FY 2019 for a total of \$1,612,900 in additional funds for the biennium to accommodate some SVPs located at the TCCC facility in Littlefield that have medical and psychiatric needs that require additional services such as safe rooms and significantly increased monitoring and supervision. The Littlefield facility does not have the accommodations needed. This Exceptional Item will establish a Supported Living Unit of 5 safe rooms and beds, and provide the staffing necessary to supervise and monitor civilly committed clients with special medical and psychiatric needs.

I appreciate your consideration of our legislative appropriations request as we work to enhance public safety and protect the citizens of Texas through effective management of the civil commitment program.

Respectfully,


Marsha McLane
Executive Director