Texas Conservative Coalition Research Institute

House Committee on Human Services
June 4, 2024

Regarding the Committee's Charge:

Evaluate the appropriate role of the state in overseeing Medicaid managed care.

Background

The Texas Health and Human Services Commission (HHSC) is tasked with administering the state's managed care (MC) program. Under MC, HHSC contracts with private managed care organizations (MCOs), paying them a capitated fee in exchange for the MCO arranging for providers to deliver medical care to beneficiaries. As of April 2022, approximately 97 percent of the Texans covered by Medicaid or CHIP (Children's Health Insurance Program) were in the MC program, with the remaining 3 percent under a fee-for-service model.[i]

The state's MC program is further divided into the five following MC programs, the first four of which fall under the state's Medicaid system:

- STAR, which covers children and pregnant and post-partum women. This program covers the vast majority of MC enrollees;
- STAR+PLUS, which covers adults with disabilities and qualifying persons 65 and older;
- STAR Kids, which covers children with disabilities;
- STAR Health, which covers foster children; and
- CHIP is different than the others in that it is for children whose families make too much to qualify for Medicaid but still need government assistance. CHIP beneficiaries account for about 5 percent of MC enrollment.

While STAR+PLUS and STAR Kids have small enrollments relative to STAR, their per-enrollee costs are much higher than STAR's due to the disabilities their enrollees usually have.

The state's investment in the MC program is enormous; in FY 2022, it spent $37.5 billion on MC on Medicaid MC alone.[ii] [iii] The General Appropriations Act (GAA) for the 2024-2025 biennium (HB 1, 88R) appropriated a total of $321 billion in All Funds. Although that bill does not contain a line item for MC spending, it appropriated approximately $75 billion for Medicaid client services and $1.7 billion for CHIP client services (the category of "client services" excludes some spending, such as certain administrative spending). Because the overwhelming majority of Texans receiving services under Medicaid do so through the managed care program, it can safely be inferred that MC accounts for a large portion of the spending on Medicaid client services.[1] In addition, the Legislature frequently appropriates additional funds for Medicaid client services in a supplemental appropriations bill in the second year of the

[1] For FY 2022, the Kaiser Family Foundation estimates that funds for Medicaid MCOs comprised 65 percent of all Medicaid spending in Texas. However, that number likely understates matters because the denominator includes items such as Disproportionate Share Hospital (DSH) payments. See https://www.kff.org/other/state-indicator/total-medicaid-mco-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

biennium. For example, the supplemental appropriations bill Senate Bill 30 (88R, 2023) appropriated more than $7.2 billion in All Funds for Medicaid client services for the remainder of the 2022-23 biennium. Such supplemental appropriations must be considered with the GAA in determining total spending on Medicaid in general and MC specifically.

In any case, the key point is that the state makes a huge investment in MC. Given the magnitude of this spending, the state has a compelling interest in ensuring that the MCOs with which it contracts do the best job possible in overseeing the delivery of care to their enrollees.

Procurement by HHSC

Texas law sets forth guidelines for agencies to follow in the procurement process. "For a purchase of goods and services . . . each state agency, including the comptroller, shall purchase goods and services that provide the best value for the state."[iv] Unsurprisingly, statute makes clear that price is generally a component of best value;[v] however, HHSC's MC contract awards are an exception in that they do not involve competitive bidding based on price. Also unsurprisingly, statute lists other factors that an agency can consider, including quality and reliability of the goods and services and indicators of probable vendor performance, including a vendor's past performance.[vi]

It should be noted that there are a number of contracting preferences in statutes which are of questionable value. As TCCRI pointed out over a decade ago, these preferences constitute "a fairly voluminous set of provisions, all of which have a purpose, all of which have a constituency and almost none of which have any apparent discernible effect on the better operation of state government."

HHSC is given greater discretion that most other agencies in its procurement.[vii] Statute provides that HHSC "may consider all relevant factors in determining the best value," including the quality and reliability of the vendor's goods and services and indicators or probable vendor performance, such as past performance.[viii] In its request for bids, HHSC is generally required to specify the factors (other than price, if applicable) that the agency will consider in determining best value.[ix]

HHSC awards contracts for the MC programs discussed above on a staggered basis (although STAR and CHIP contracts are awarded jointly), with the term of each contract generally being six years, with the possibility of six additional years through extensions. The table below summarizes the current state of procurements in MC.

	STAR (and CHIP)	STAR+PLUS	STAR Kids	STAR Health
Date of Request for Proposals (RFP) Issued	December 2022	3/31/22	5/10/24	-
(Anticipated) Award Date	Q1, FY 2025 (Notice of Intent to Award issued 3/7/24)	September 2023	Q2, FY 2026	-
(Anticipated) Start Date	Q1, FY 2026	9/1/24	Q2, FY 2027	9/1/23

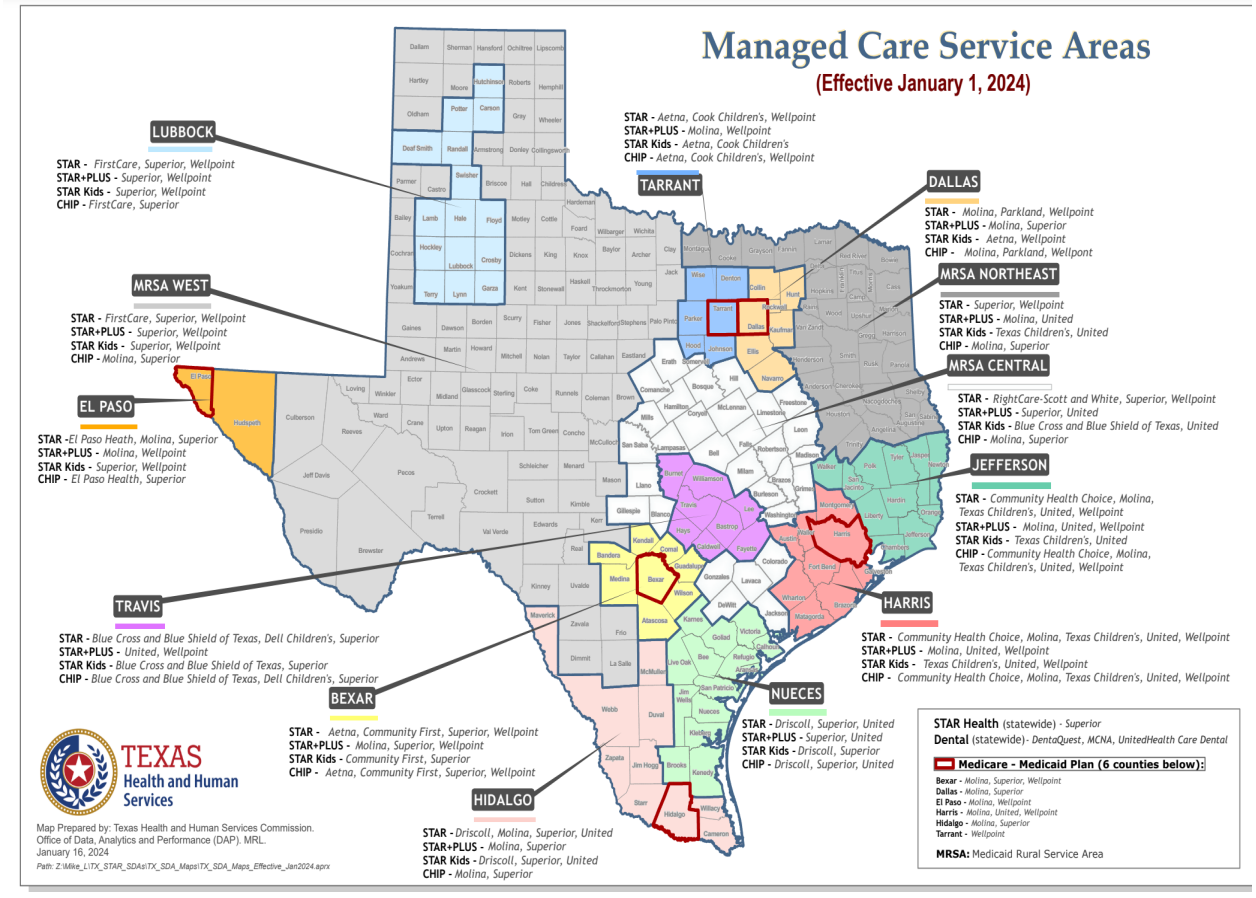
"-" indicates the date is no longer relevant given the awarding of the contract.

Source: HHSC[x]

As the table illustrates, HHSC released a notice of intent to award STAR (and CHIP) contracts in March of this year, and an RFP for STAR Kids was issued just a few weeks ago. The STAR Health contract currently in place will remain so for at least several more years.

When HHSC solicits bids for a MMC program, it issues a request for proposals (RFP). Interested MCOs respond with written answers to the technical questions set forth in the RFP. In addition, interested MCOs must complete an oral examination before HHSC regarding how the MCO will serve its Medicaid patients if is awarded the contract. MCOs' responses to the RFP are graded by HHSC, and these rankings are used to award contracts. The purpose of the questions and presentation is to allow HHSC to determine the MCOs' capabilities for arranging and coordinating health care delivery for its members. The highest possible scores for written answers and the oral examination are 1,800 and 2,000 points, respectively, making 2,000 points the highest overall score. Each individual question is awarded a grade of 0-5 points, a score which is determined through "consensus scoring," i.e., as a result of multiple HHSC employees' agreement.

The state's MC system is divided into 13 geographic regions, or service areas (SAs). The map below, taken from HHSC's website, displays the SAs currently in effect. Notably, the MCOs corresponding to the SAs on the map will change considerably if and when the March 2024 Notice of Intent to Award STAR/CHIP contracts is finalized.



Source: HHSC

Once an RFP is issued, MCOs can submit a bid for any SAs in which they are interested, but HHSC's contract awards process precludes an MCO from having a presence in too many SAs with respect to a given managed care program (e.g., STAR+PLUS). In addition, the number of MCOs operating in a given SA with respect to each MC program is capped, although every SA must have at least two MCOs per MC program due to federal rules (except for Star Health, for which a single statewide contract is awarded). The March 2024 Notice of Intent to Award STAR/CHIP contracts, for example, specifies the following parameters:

- No MCO may receive an award for more than 7 SAs; [xi] [2]
- The minimum number of MCOs awarded contracts in a given SA is 3;[xii] and
- The maximum number of MCOs awarded contracts in certain SAs is either 5 (Harris SA) or 4 (Hidalgo, Dallas, Bexar, and Tarrant SAs), with 3 being both the minimum and the maximum in all other SAs.[xiii]

Bids on an MC program in an SA by MCOs interested in operating in that SA are ranked based on the score of MCOs on the 2,000-point scale. There is, however, one key exception to this rule: "mandatory contracts" pursuant to Section 533.004 of the Government Code complicate the award process. If the group of MCOs bidding for an MC program contract in an SA includes a certain type of MCO affiliated with a hospital district or a nonprofit corporation, HHSC must award one of the contracts for that SA to that MCO, irrespective of how high or low the MCO scored on the 2,000-point scale. Thus, it is possible for a health plan with mandatory contracting rights to secure a contract award in the applicable SA even if it is the lowest-scoring plan on the 2,000-point scale in the entire applicant pool.[3]

By way of example, the December 2022 RFP for STAR and CHIP contracts listed the following best value criteria (BVC) that HHSC used to evaluate the applicant MCOs:[xiv]

1) *Delivers Person-Centered Service Coordination that connects Member needs to effective care;*
2) *Ensures Members have timely access to the Services they need;*
3) *Encourages Providers to participate in the Medicaid program;*
4) *Ensures a sustainable Medicaid program by incentivizing value in the Service delivery model and optimizing resources; and*
5) *Uses data, technology, and reporting to facilitate and demonstrate strong performance and oversight.*

Each of these five BVC is divided into several sub-points. For example, one of the subpoints for BVC #3 above is "Demonstrates proactive strategies to streamline processes and reduce administrative burden for Providers."[xv]

In addition, the Oral Presentation tested MCOs on the following topics:[xvi]

- *Oversight and coordination with subcontractors;*
- *Addressing maternal mortality and morbidity;*
- *Coordination with Dental Maintenance Organizations (DMOs);*
- *Addressing preventive care rates.*

Monitoring of MCO Performance[xvii]

MCOs that are awarded MC contracts are subject to ongoing monitoring by HHSC and other government entities to ensure that they are arranging for cost-effective, quality health care for their enrollees. After HHSC awards an MC contract to an MCO, the agency monitors the MCO in at least five broad areas:

- Access to services;
- Service delivery

[2] Although in the unlikely event that an SA did not have 3 MCOs serving it after awards were made due to lack of interest from MCOs in that SA, the cap of 7 SAs for a given MCO could have been exceeded to ensure that floor was met.

[3] Section 533.005 of the Government Code does provide a minimal requirement for any health plan awarded an MC contract; HHSC must certify that the plan is "reasonably able to fulfill the terms of the contract, including all requirements of applicable federal and state law."

- Quality of care;
- Onsite operations; and
- Financial practices

Access to services focuses on factors such as network adequacy and appointment availability. Time and distance standards are used to ensure that clients do not have to travel an excessive amount to receive medical care. With respect to appointment availability, HHSC employs an external quality review organization (EQRO) to annually analyze availability in the areas of prenatal, primary care, vision and behavioral health. The EQRO uses a "secret shopper" approach in contacting providers and seeing how long the lag time is between the time of contact and the actual appointment date.[xviii] Standards depend on the time of service sought; for example, the lag time for a routine primary care appointment should be no more than 14 days. Additionally, HHSC periodically testes the accuracy of an MCO's provider directory by contacting providers listed in it. Finally, HHSC conducts staggered biennial satisfaction surveys of patient sub-populations, such as adults in STAR.

Service delivery determines whether MCOs are authorizing the care that their members require. This inquiry consists of two parts: first, utilization review of acute care, which is preventative care, primary care, or care for a condition that has a short duration.[xix] For example, an MCO that was refusing to approve a high number of prior authorization requests might not be providing members with medically necessary care. Second, service delivery analysis looks at utilization review of long-term services and supports (LTSS). Given the relatively high per-member costs of LTSS cases, it is important to verify that MCOs are not shirking their obligations to assess and classify their members with LTSS needs appropriately.

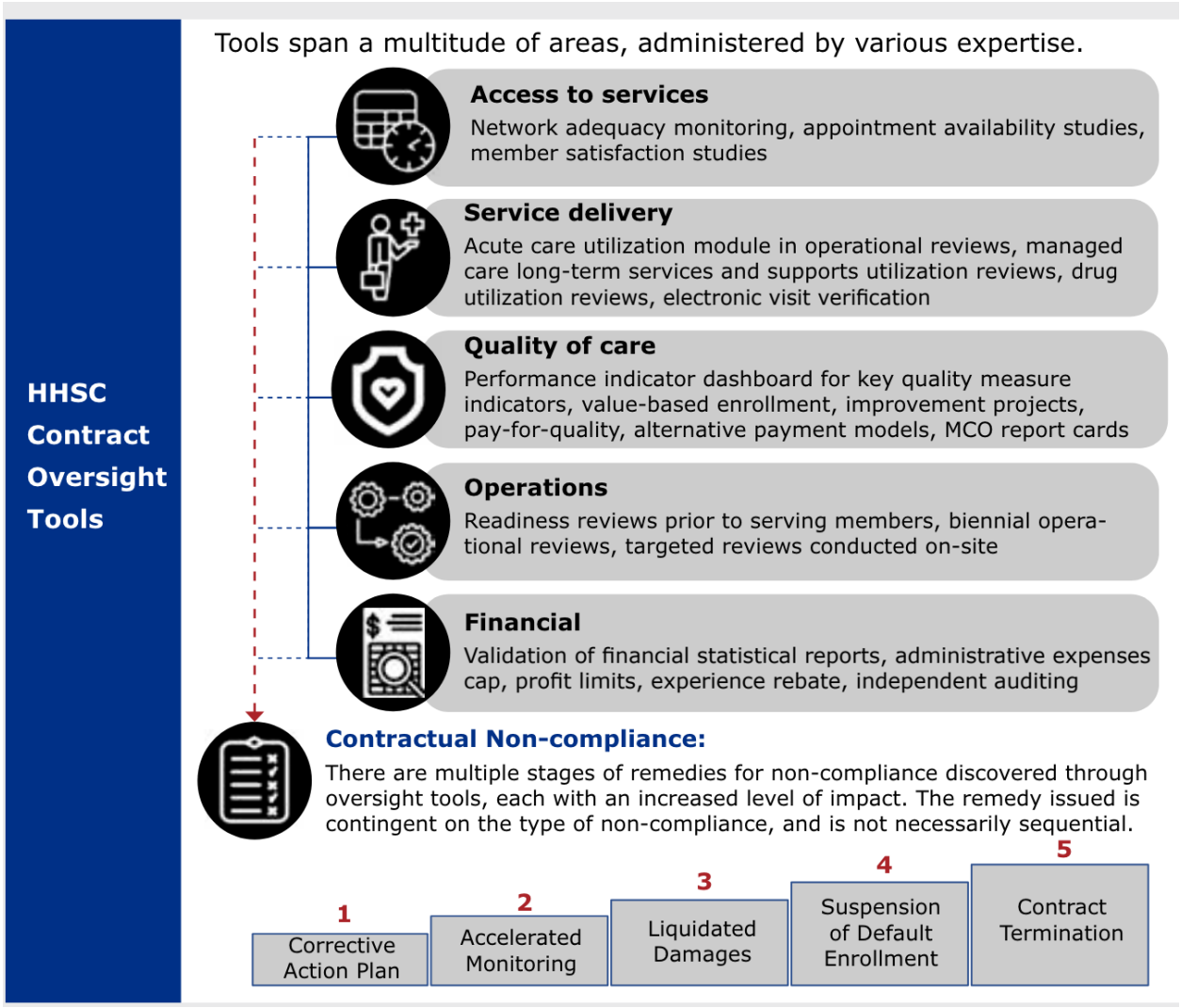
Quality of care provided by MCOs is monitored closely by HHSC, with the agency often using an EQRO to analyze MCO documents and providers' medical records, and interview MCO administrators, providers, and members. The data HHSC compiles on the quality of care that every MCO in each SA provides to its members is quite detailed, with information on HPV vaccinations, opioid disorders, cancer screenings, and blood glucose levels (to name just a few) being available through the Texas Healthcare Learning Collaborative.[xx] HHSC compiles data to generate annual report cards for the MCOs in each SA (discussed further below in this testimony), which can be viewed by the public. This includes people who are enrolling in Medicaid and have the option of choosing their MCO rather than waiting for HHSC to assign them to an MCO (this latter method of assignment is termed "default enrollment").

Onsite operations entail HHSC staff visiting MCOs and assessing subjects such as their claims processing, prior authorization process, provider training, and complaints and appeals processes to ensure that the MCO is complying with the requirements in the contract between it and HHSC.

Financial practices refer to HHSC's examination of a plan after a given year ends; this examination ensures that the MCO is submitting the financial data that all MCOs are required to submit to HHSC and which is used to set future capitation rates. In addition, HHSC will confirm that the MCO's administrative expenses have not exceeded permissible caps. Moreover, HHSC will determine whether an MCO was profitable to the extent that the state is entitled to a rebate of some of the profits (MCOs owe the state these rebates if their profit exceeds 3 percent of their annual revenue).

The chart below, taken from HHSC's December 2022 Medicaid and Chip Reference Guide, summarizes the tools HHSC has to monitor MCOs for compliance with the terms of their contracts, as well as the sanctions that the agency can impose on an MCO for non-compliance.

HHSC's Tools for Monitoring Compliance and Responses to Non-Compliance

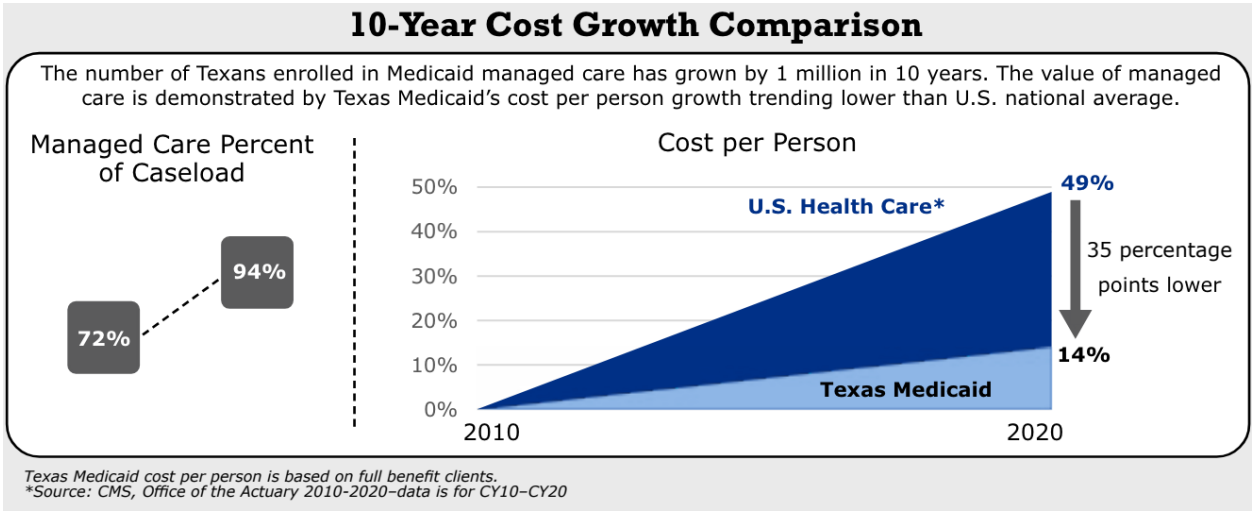


Source: HHSC[xxi]

Corrective action plans (CAPs) and liquidated damages (LDs) are HHSC's most common ways of addressing non-compliance. Plans are evaluated monthly for the need for CAPs, which essentially identify a failure to perform by the plan in some respect, explain its cause, and set forth how it will be corrected. LDs are imposed on a quarterly basis and are generally related to failure to adhere to a performance standard, such as satisfying appointment availability requirements or failing to process claims with a certain number of days. All MCOs have at least a few CAPs and LDs in their history, although the very small dollar amounts (relative to the contract size) and the few occurrences of a given class of violation (often just a single occurrence) make clear that MCOs are not flouting their contractual responsibilities. Data on CAPs and sanctions against MCOs are publicly available and can be viewed here.

Assessing State Contracting with MCOs

Overall, managed care has been a great success in Texas, growing from a tiny program in the mid-1990s to covering more than 4 million people. The graph below shows the financial impact of this impressive performance over the 2010-2020 period:



Source: HHSC[xxii]

As TCCRI discussed in a 2018 paper, a 2015 study prepared by the Milliman Group on behalf of the Texas Association of Health Plans estimated that over the six-year period of state fiscal years 2010-2015, Medicaid managed care resulted in savings of $3.8 billion All Funds (including $2 billion in general revenue) to the state.[xxiii] Moreover, patient satisfaction (or the satisfaction of caregivers for patients who are minors) according to surveys is generally at or above national averages, although some improvement in the CHIP survey responses is needed.[xxiv] HHSC deserves significant credit for overseeing the expansion of managed care in the state.

Unfortunately, over the last decade, HHSC has had several well-documented missteps in the MC contracting process. Most recently, *The Texas Tribune* reported on April 26, 2024 that HHSC had responded to a public information request by an MCO bidding on STAR/CHIP contracts (that were the subject of a December 2022 RFP) by releasing the proposals of competing MCOs, along with those MCOs' answers to written questions, to that MCO prior to the oral presentation phase of the bidding process.[xxv] Thus, that MCO arguably received a benefit over the other MCOs. Unsurprisingly, at least eight MCOs have filed protests regarding the pending STAR/CHIP awards.[xxvi]

With companies competing fiercely for MC contracts, it is likely there will always be at least a few complaints regarding the award of any MC contract. The statutory command is for HHSC to obtain the "best value" for the state; the word "best" necessarily implies a hierarchy, and the only sound, principled way to determine the best is some sort of merit-based scoring system under which some MCOs will be relatively low-ranked. With price not being a component in HHSC's decision of how to award MC contracts, the focus of the procurement process should be on identifying the MCOs that will provide the best performance. The question is how an MCO's likelihood of excellent performance can best be determined.

Undoubtedly, there is considerable value in HHSC seeing MCOs' responses to written questions and later their oral presentations. The entire bidding process and the associated 2,000-point scoring system is essentially HHSC interviewing MCOs to determine their potential for strong performance. But intuitively, actual performance by an MCO- particularly recent performance- should be weighed heavily in the awards process. Interviewing is simply an attempt to determine future performance, but the importance of an interview is lessened if the applicant has already demonstrated that it has performed strongly in the same SA with respect to the same MC program.

As discussed above, the quality of services and the past performance of vendors are factors for HHSC to consider in its procurements. It is unclear to what extent HHSC is weighing past performance, with the tentative awards of STAR/CHIP contracts in March 2024 serving as an illustrative example. As noted

above, HHSC issues annual report cards for MCOs assessing the patient experience and the quality of care provided to patients. These report cards are issued to an MCO for each MC program in each SA in which it participates, so an MCO generally has multiple report cards. In addition, separate report cards for an MCO with a STAR contract are issued for STAR (Children) and STAR (Adults).

STAR/CHIP report cards for 2023 were released in March 2024, the same month that HHSC released its Notice of Intent to Award for new STAR/CHIP contracts. Given that timeline, it is interesting to compare MCOs' recent past performance (as measured by the report cards) with the tentative award of contracts. The table below compares the 2023 rankings of every incumbent MCO in every SA, disaggregated by whether the MCO "won" a new contract in the awards tentatively announced in March 2024. Although there are "newcomer" MCOs in some SAs, the table does not list them because they have no past performance/report card for STAR in that SA (separate report cards are issued to an MCO for each MC program in which it participates in every SA in which it operates). It is difficult to give a composite score for an MCO in a given SA because HHSC publishes report cards for MCOs' performance in STAR broken down by Adult members and Child members (CHIP is not covered by the report cards). References in the table to "2WT" mean "two-way tie," and so forth.

Table: STAR Adult and Children Report Card Rankings for Incumbent MCOs in all 13 SAs, disaggregated by whether the MCO "lost" its contract or "won" another contract as tentatively outlines in the March 2024 Notice of Intent to Award

	STAR (for Adults)			STAR (for Children)	
Service Area*	**Report Card Ranking of "Losing" Incumbent Plan(s)**	**Report Card Ranking of "Winning" Incumbent Plan(s)**		**Report Card Ranking of "Losing" Incumbent Plan(s)**	**Report Card Ranking of "Winning" Incumbent Plan(s)**
Austin (Travis)**	**Superior: 1 of 3 (3.5 stars);**	**Dell: 2 of 3 (2.5 stars);** **BCBS: 3 of 3 (2 stars)**		**Superior: 1 of 3 (3.5 stars)**	**Dell: 2 of 3 (3 stars);** **BCBS: 3 of 3 (2.5 stars)**
Beaumont (Jefferson)	**Molina: 1 of 5 (3 stars, 4WT);** **Community Health Choice: 1 of 5 (3 stars, 4WT);** **Texas Children's: 5 of 5 (2.5 stars)**	**Wellpoint***: 1 of 5 (3 stars, 4WT);** **United: 1 of 5 (3 stars, 4WT)**		**Community Health Choice: 1 of 5 (3WT, 3.5 stars);** **Texas Children's: 1 of 5 (3WT, 3.5 stars);** **Molina: 4 of 5 (2-way tie, 2.5 stars)**	**United: 1 of 5 (3WT, 3.5 stars);** **Wellpoint: 4 of 5 (2WT, 2.5 stars)**
Central Area (MRSA Central)	**RightCare: 1 of 3 (2WT, 3.5 stars);** **Superior: 1 of 3 (2WT, 3.5 stars);** **Wellpoint: 3 of 3 (2.5 stars)**	**n/a**		**RightCare: 1 of 3 (2WT, 3 stars);** **Superior: 1 of 3 (2WT, 3 stars);** **Wellpoint: 3 of 3 (2.5 stars)**	**n/a**
Corpus Christi (Nueces)	**Driscoll: 1 of 3 (3.5 stars);** **United: 3 of 3 (2.5 stars)**	**Superior: 2 of 3 (3 stars)**		**United: 1 of 3 (2WT, 3.5 stars);** **Driscoll: 3 of 3 (3 stars)**	**Superior: 1 of 3 (2WT, 3.5 stars)**
Dallas**	**Wellpoint: 1 of 3 (3 stars)**	**Parkland: 2 of 3 (2.5 stars);**		**Wellpoint: 1 of 3 (2WT, 3 stars)**	**Parkland: 1 of 3 (2WT, 3 stars);**

		Molina: 3 of 3 (2 stars)			Molina: 3 of 3 (2.5 stars)
El Paso**	Superior: 2 of 3 (2WT, 3.5 stars)	Molina: 1 of 3 (4 stars); El Paso Health: 2 of 3 (2WT, 3.5 stars)		Superior: 1 of 3 (4.5 stars)	El Paso Health: 2 of 3 (4 stars); Molina: 3 of 3 (3.5 stars)
Fort Worth (Tarrant)	Wellpoint: 1 of 3 (2WT, 2.5 stars); Cooks: 3 of 3 (2 stars)	Aetna: 1 of 3 (2WT, 2.5 stars)		Wellpoint: 1 of 3 (2WT, 3 stars); Cooks: 2 of 3 (2WT, 2.5 stars)	Aetna: 2 of 3 (2WT, 2.5 stars)
Houston (Harris)**	Texas Children's: 1 of 5 (3WT, 3 stars)	Community Health Choice: 1 of 5 (3WT, 3 stars); United: 1 of 5 (3WT, 3 stars); Molina: 4 of 5 (2WT, 2.5 stars); Wellpoint: 4 of 5 (2WT, 2.5 stars)		Texas Children's: 1 of 5 (2WT, 4 stars)	Community health Choice: 1 of 5 (2WT, 4 stars); United: 3 of 5 (3.5 stars); Wellpoint: 4 of 5 (3 stars); Molina: 5 of 5 (2.5 stars)
Lubbock	FirstCare: 1 of 3 (2WT, 3 stars)	Superior: 1 of 3 (2WT, 3 stars); Wellpoint: 3 of 3 (2.5 stars)		Firstcare: 2 of 3 (2WT, 3 stars)	Superior: 1 of 3 (3.5 stars); Wellpoint: 2 of 3 (2WT, 3 stars)
Northeast Area (MRSA Northeast)	Superior: 1 of 2 (3.5 stars)	Wellpoint: 2 of 2 (2.5 stars)		Superior: 1 of 2 (3.5 stars)	Wellpoint: 2 of 2 (3 stars)
San Antonio Area (Bexar)**	Superior: 1 of 4 (2WT, 3 stars); Wellpoint: 4 of 4 (2 stars)	Community First: 1 of 4 (2WT, 3 stars); Aetna: 3 of 4 (2.5 stars)		Superior: 1 of 4 (3.5 stars); Wellpoint: 2 of 4 (3WT, 3 stars)	Community First: 2 of 4 (3WT, 3 stars); Aetna: 2 of 4 (3WT, 3 stars)
Valley Area (Hidalgo)	Superior: 1 of 4 (4 stars); Driscoll: 2 of 4 (3WT, 3.5 stars)	Molina: 2 of 4 (3WT, 3.5 stars); United: 2 of 4 (3.5 stars)		Superior: 1 of 4 (3WT, 4 stars); Driscoll: 1 of 4 (3WT, 4 stars)	United: 1 of 4 (3WT, 4 stars); Molina (4 of 4 (3.5 stars)
West Area (MRSA West)	FirstCare: 2 of 3 (2WT, 3 stars)	Superior: 1 of 3 (3.5 stars); Wellpoint: 2 of 3 (2WT, 3 stars)		FirstCare: 1 of 3 (2WT, 3 stars)	Superior: 1 of 3 (2WT, 3 stars); Wellpoint: 3 of 3 (2.5 stars)

Source: HHSC[xxvii]

*The names used to refer to the 13 SAs in the table above are sometimes different than those on the map provided above in this testimony, but an SA's name on the map, if different, is listed in parentheses in the table.

**Signifies that the SA has a mandatory contract.

*** Wellpoint was formerly known as Amerigroup.

The table above suggests that excellent past performance is not being heavily weighed by HHSC in more than a few cases. In the Travis, Jefferson, Central, Dallas, Tarrant, Harris, Northeast, and Hidalgo SAs, an incumbent MCO "lost" a contract even though it had the highest 2023 ranking (or was tied for the highest ranking) on *both* the applicable STAR (Adults) and STAR (Children) report cards. In fact, one company (Superior) had the best report cards for both Adults and Children in each of the Travis and Northeast SAs (with no ties) and still did not receive a contract in either SA. That is not to say that HHSC erred in any way; for example, there could have been relative shortcomings in the written answers and oral presentations of the "losing" incumbent MCOs. But more clarity on how much (if at all) past performance matters in the procurement process would be helpful to all parties.[4]

On an unrelated point, given the split report card system for STAR, it should be noted that most Medicaid clients are children,[xxviii] which might perhaps argue for the report card rankings for STAR (Children) to be accorded greater weight than those for STAR (Adults).

Policy recommendations and suggested questions for the Committee to explore

Below are several policy recommendations and questions the Committee may want to ask of any witnesses.

Recommendation/Question 1: The Legislature (or HHSC, at its direction) should amend the procurement process to make clear that an MCO's past performance in a given SA with respect to an MC program will be considered to an extent, and detail how that performance will be weighed. At a minimum, an MCO that has had the highest report card ranking (with no ties) in an SA in recent year(s) should have that performance taken into consideration when new contract awards are being issued.

Recommendation/Question 2: How, if at all, does HHSC currently consider an MCO's past performance in an MC program in an SA- whether positive or negative- in the procurement process?

Recommendation/Question 3: Does HHSC currently have any process for determining how well an MCO's performance on the written question and oral presentation correlate with its future performance?

Recommendation/Question 4: What is HHSC's reasoning for capping the number of SAs in which an MCO can operate with respect to an MC program? Presumably the state wishes to avoid a scenario in which it is overly dependent on a single MCO, but there might be other considerations involved. More specifically, why was 7 chosen as the cap?

Recommendation/Question 5: Similarly, how is HHSC calculating the cap on the number of MCOs awarded a contract for a given MC program in an SA? Based on the data in the December 2022 RFP for STAR/CHIP, there is obviously a relationship between an SA's number of enrollees in an MC program and the number of MCOs awarded contracts for that MC program in that SA. In the December 2022 RFP for STAR/CHIP, all of the SAs with an average monthly enrollee count of fewer than 175,000 have the cap (and the floor) set at 3. This makes sense generally; however, the cap for Dallas is just 4, even though its average monthly enrollee count was slightly over 450,000, far in excess of Lubbock's (86,240) or Jefferson's (90,840). Presumably, one reason for a cap is to ensure that MCOs have large enough memberships to generate some efficiencies of scale, but more specific information would be helpful.

[4] Notably, an MCO's performance as measured by report cards is part of the formula used in HHSC making default enrollments. See https://www.hhs.texas.gov/sites/default/files/documents/texas-medicaid-chip-reference-guide-14th-edition.pdf (p. 65).

Recommendation/Question 6: Eliminate mandatory contracts. There are only a handful of mandatory contracts in place; however, these contracts undermine the goal of competition among MCOs in that some health plans are guaranteed a contract in the relevant SA no matter how poor their performance has been (leaving aside the very low bar that they must be certified as being able to satisfy state and federal requirements). Not only is this arrangement unfair to competing MCOs, but more importantly it is unfair to the managed care population in that SA. If HHSC's evaluations of MCOs have any purpose or merit, then granting a mandatory contract to a low-ranked or low-scoring health plan is simply accepting that the relevant managed care population will receive lower-quality healthcare than it otherwise would.

Health plans that secure mandatory contracts often argue that they do not have the resources to respond to RFPs with the same precision as larger, national health plans. If this claim is accepted as true, the answer may lie in Recommendation 1 above: focusing on whether such a health plan has displayed strong recent performance irrespective of HHSC's scoring of its application. In any case, while the exact mechanism of how to rank MCOs competitively is subject to debate, there should be some sort of mechanism. Currently there is none for health plans with mandatory contracts.

It should be noted that advocates of mandatory contracts often argue that health plans with such contracts have heavy responsibilities to provide indigent care. While hospital financing is a complex subject, it is important to acknowledge all revenue streams received by these health plans, such as federal funds in the form of Disproportionate Share Hospital (DSH) payments, a type of payment made to hospitals that serve a large number of Medicaid beneficiaries and low-income patients. In FY 2023 alone, just four such health plans (affiliated with hospital districts in Dallas, Harris, Bexar, and El Paso counties) collectively received hundreds of millions of dollars in DSH payments.[xxix]

Recommendation/Question 7: Direct the State Auditor's Office (SAO) or another agency to study how procurement professionals at HHSC are compensated relative to their peers in the private sector and across the country. In a 2013 paper on state procurement, TCCRI addressed this subject and found a significant discrepancy (at least 20 percent and sometimes more) between what the state pays its procurement professionals and what the private sector and federal government pay theirs. That paper pointed out:

> …[T]he state still views *and compensates* purchasing and contracting professionals as administrative versus strategic positions. State agencies often take the position that all allocated FTE positions must be kept filled, for fear of ultimately losing these positions. This often results in spreading limited salary appropriations among as many employees as possible, with an ultimate outcome of more, but lower paid employees. On the flip side, there are agencies that have recognized the need for higher skilled employees, and have been able to accomplish this by reducing the total number of FTEs. By hiring fewer, but better skilled, employees at a higher salary, some state agencies have been successful in increasing the competency and skills in their organization without increasing total salary expenses.[xxx]

Given the state dollars involved in MC, the state should aim to hire outstanding procurement professionals, with their salaries being commensurate with their expertise.

Recommendation/Question 8: HHSC's organizational chart can be viewed here. It indicates (in the leftmost column) that the Deputy Executive Commission for Procurement and Contracting Services reports to the Chief Operating Officer. This arrangement "siloes" procurement from the Chief Medicaid and CHIP Services Officer. In light of the enormous sums involved in managed care contracting, the Committee should inquire into whether procurement could be made more efficient by placing procurement (or a different procurement unit) under the Chief Medicaid and CHIP Services Officer.

ENDNOTES

[i] https://www.hhs.texas.gov/sites/default/files/documents/texas-medicaid-chip-reference-guide-14th-edition.pdf (p. 4).
[ii] https://www.kff.org/other/state-indicator/total-medicaid-mco-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[iii] https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[iv] Section 2155.074(a), Government Code.
[v] Section 2155.074(b), Government Code.
[vi] Sections 2155.074(b-1)(3), (5), Government Code.
[vii] Section 2155.144(b), Government Code.
[viii] Section 2155.074(d), Government Code.
[ix] Section 2155.144(c), Government Code.
[x] https://www.hhs.texas.gov/business/contracting-hhs/procurement-opportunities
[xi] HHSC, "Request for Proposals (RFP) for STAR & CHIP Managed Care Services, RFP No. HHS0011152," (December 2022) (p. 29), https://www.txsmartbuy.com/esbd/HHS0011152 (first link under "Attachments").
[xii] Id. at p. 5.
[xiii] Id. at pp. 29-30.
[xiv] pp. 25-26.
[xv] p. 25
[xvi] P. 27
[xvii] The information for this section of this testimony is drawn primarily from Chapter 3 of the Texas Medicaid and Chip Reference Guide, 14th Edition (December 2022), pp. 54-77, https://www.hhs.texas.gov/sites/default/files/documents/texas-medicaid-chip-reference-guide-14th-edition.pdf.
[xviii] Notably, federal Centers for Medicare and Medicaid Services (CMS) finalized new rules regarding access to care in April 2024, which states must implement in the near future. See https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/ (Point #8).

[xix] https://www.hhs.texas.gov/handbooks/star-kids-handbook/glossary#:~:text=Acute%20care%20%E2%80%94%20Preventive%20care%2C%20primary,under%20the%20State%20Medicaid%20Plan.
[xx] See https://thlcportal.com/measures/medical.
[xxi] https://www.hhs.texas.gov/sites/default/files/documents/texas-medicaid-chip-reference-guide-14th-edition.pdf (p. 50).
[xxii] https://www.hhs.texas.gov/sites/default/files/documents/texas-medicaid-chip-reference-guide-14th-edition.pdf (p. 82).
[xxiiixxiii]
https://www.arkleg.state.ar.us/Home/FTPDocument?path=%2FAssembly%2FMeeting+Attachments%2F836%2FI14185%2FMilliman-Texas-Medicaid-Managed-Care-Cost-Impact-Study-20150211-2.pdf (p. 1).
[xxiv] See https://thlcportal.com/survey.
[xxv] https://www.texastribune.org/2024/04/26/texas-medicaid-contracts/
[xxvi] Id.
[xxvii] See https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/managed-care-report-cards.
[xxviii] See https://www.hhs.texas.gov/sites/default/files/documents/texas-medicaid-chip-reference-guide-14th-edition.pdf (pp. 3, 13).
[xxix]See https://pfd.hhs.texas.gov/sites/rad/files/documents/hospital-svcs/2023-dsh-pmnt.pdf
[xxx] Paper on file with TCCRI.