

LEGISLATIVE AUDIT DIVISION

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MEMORANDUM

TO: Legislative Audit Committee Members
FROM: Nick Hill, Performance Auditor
CC: John Lewis, Director, Department of Administration
DATE: January 2019
RE: Performance Audit Follow-Up (19SP-05): State Employee Health Clinic Contract Management and Oversight (16P-03)
ATTACHMENTS: Original Performance Audit Summary

Introduction

The *State Employee Health Clinic Contract Management and Oversight* (16P-03) report was issued to the Legislative Audit Committee in June 2017. The audit included nine recommendations to the Department of Administration (department). We conducted follow-up work to assess implementation of the report recommendations. This memorandum summarizes the results of our follow-up work.

Overview

Between 2012 and June 2017, the department expended approximately \$26.1 million to operate the Montana Health Centers (MHC), also known as the employee health clinics. Our audit work found ongoing management challenges with operating the centers. These challenges began with a poorly drafted Request for Proposal and included contract management weaknesses and a lack of reliable data to assess vendor performance. Audit work also determined the department needed to work with the MHC vendor to make improvements to patient electronic medical records, establish clear and measurable performance guarantees, improve vendor reporting, enhance communication between the MHCs and patients, and establish a growth plan for future MHC expansion. Our performance audit contained nine recommendations. Based on our follow-up work, we determined the department has implemented five recommendations, two are being implemented, one is partially implemented, and one is not implemented.

Background

In an effort to control health care costs over the long term, many employers are focusing on improving the overall health of their workforce. One such method to achieve this goal is through the creation of on-site employee health clinics. In 2012, the state of Montana contracted with a private vendor to operate the Montana Health Centers (MHC). The first MHC opened in Helena in August 2012. Since that time, five additional MHCs opened across the state. MHCs are available to state employees and their dependents who are covered under the State of Montana Benefit Plan (State Plan). The MHCs specialize in primary care, health and wellness coaching, diagnostic service referrals, health screenings, and vaccinations. The MHCs are funded through the State Plan. The department's Health Care and Benefits Division (HCBD) is responsible for overseeing the MHC contract.

Audit Follow-up Results

The following sections summarize the progress toward implementation of the report recommendations. Audit staff met with HCBD staff, reviewed contract amendments and vendor reports on MHC operations, and reviewed a new communication plan created by the vendor. The following summarizes information on completed follow-up work and the implementation status of recommendations.

RECOMMENDATION #1

We recommend the Department of Administration:

- A. Require use of standardized definitions for an office visit, ancillary visit, and an encounter within the Montana Health Centers, and**
- B. Require the contractor to provide accurate Montana Health Center appointment and vacancy reporting based on actual appointment times.**

Implementation Status – Implemented

- A. Our analysis of the total number of MHC visits from August 2012 through December 2015 differed significantly from the totals the vendor stated in its reports. This is because the department, the vendor, and the department's contracted actuary who compiles data related to the MHCs all use different definitions of the three types of MHC visits: ancillary visits, office visits, and encounters. In addition, based on interviews with vendor staff, and reviews of vendor documentation, we determined the vendor also has varying visit definitions. These discrepancies resulted in inaccurate vacancy reports provided by the vendor. For example, our appointment analysis found there were a total of 140,335 office and ancillary visits, while the vendor reported 211,033 such appointments.

As a result of our recommendation, the department established standard definitions for these three types of visits. This was done in conjunction with the department, its third-party administrator (TPA), the MHC vendor, and the department's contracted actuary. Department staff said having these standardized definitions in place makes them more confident in the reporting they receive from the vendor and helps them verify the reporting data found in the TPA's data warehouse regarding MHC use. For example, back-to-back appointments with the same patient are now listed as one appointment, which eliminates inconsistencies in recording back-to-back appointments as two separate appointments when they are actually one appointment.

- B. We found oftentimes the back-to-back appointments discussed above were unnecessary. According to our employee survey, 44 percent of surveyed employees that reported being contacted after their HRA was completed were asked to schedule a 40-minute appointment. However, only about half of those respondents stated their appointment lasted over 20 minutes. This resulted in inaccurate vacancy reports. Department staff worked with the vendor and the TPA to develop new data feeds that will enable the department to accurately reconcile MHC use based on standardized visit definitions. Additionally, the department worked with the vendor to correct errors found in MHC data feeds that are used to report vacancy and appointment times. The new data feeds and data file corrections allow the department to obtain accurate vacancy and appointment time reporting. Our follow-up review of a weekly MHC utilization report from the vendor found it to be more detailed and accurate than those found during audit work.

RECOMMENDATION #2

We recommend the Department of Administration develop a process to independently and accurately compare and report health service costs and benefits of the Montana Health Centers to similar services, including those:

- A. Provided by local health care providers under a cost-per-service model, and**
- B. Provided under a value-based design model.**

Implementation Status – *Partially Implemented*

- A. The department contracts with a third-party actuary to conduct cost analyses and compare MHC costs to local private health care provider costs under a fee-for-service arrangement. Up until 2016, the MHC providers were not consistently including Current Procedural Terminology (CPT) codes in patient records. CPT codes consist of a series of numbers used to identify medical and diagnostic services. They are used as a form of communication between health care providers and insurance companies responsible for approving payment for service provided. Prior to 2016 it was difficult for the department to get an accurate comparison of costs for certain services versus similar services done in the private sector by health care providers within the MHC services areas. However, with CPT codes now being required in the medical records, the department's actuary can better compare services done in the MHCs to similar services provided in the private sector.
- B. We found the department has only had one actuarial review of the MHCs, and that occurred years ago when only one MHC was in operation. Having cost \$26.1 million between 2012 and June 2017, the department needs to determine if MHC benefits outweigh the costs. Interviews with department staff found they view the MHCs as a means of implementing a value-based design (VBD) model of health care delivery. Unlike a cost-for-service model, the VBD model aims to increase health care quality and decrease costs by using incentives to encourage cost-efficient health care services and choices by focusing on covering preventive care, wellness visits, and treatments at low to no cost, which would ultimately save money by reducing future expensive medical procedures. During audit work, department staff stated they were in discussions with the vendor about possible integration of the VBD model. While the department was considering this, it decided not to integrate a VBD model as part of MHC operations, so no further action will be taken.

RECOMMENDATION #3

We recommend the Department of Administration:

- A. Clearly define, in a growth strategy, criteria for any potential future expansion of the Montana Health Centers that addresses state employee populations, and partnering with local health care providers where expansion is feasible, and**
- B. Determine if the Miles City Montana Health Center should be closed or partnered with a local health care provider.**

Implementation Status – *Implemented*

- A. We found the department expanded the MHCs without a growth strategy. Such a strategy would include a cost-benefit analysis and identifying where larger state employee populations are throughout the state. After Helena opened in August 2012, four other centers opened in less than 30 months, which led to gaps in service and a MHC with a very low utilization rate. Presently, the department does not have any plans to expand the MHCs. According to department staff, they

believe the MHCs grew too fast, which resulted in mistakes being made. Staff indicated any future MHC expansion will be a collaborate effort between the director's office, the Governor's office, and the MHC vendor. In addition, a contract amendment between the department and the vendor created new guidance for the development of new MHCs. This requires the department and the vendor to work together to develop the new MHCs and directs the vendor to help the department make strategic decisions where expansion might make sense by analyzing identified geographic areas for population health needs, potential public procurement unit partners, and collaborative relationships with local health care providers.

- B. Soon after an MHC was opened in Miles City it was found its utilization rates were much lower than the other MHCs. Fewer than 300 employees lived within 30 miles of the Miles City center while all other MHCs had over 900 employees within the same radius. As a result, in 2015 the vacancy rate at this MHC was 56 percent and the center's cost-per-visit was 202 percent of the statewide average cost. As a result of the recommendation, the department closed the Miles City MHC in December 2017.

RECOMMENDATION #4

We recommend the Department of Administration:

- A. Work with the Montana Health Center's contractor to improve the communication and dissemination of patient medical records between the Montana Health Centers and private health care providers, and**
- B. Educate state employees and dependents on how to share patient medical records between the Montana Health Centers and private health care providers.**

Implementation Status – *Being Implemented*

- A. As part of a contract amendment signed in June 2018, a communication plan for both private health care providers and State Plan members was developed, as well as an update to the existing MHC brochure. Updates to the brochure include information for new and existing MHC patients, such as services offered, and how to schedule appointments.

The new communication plan for both members and private providers includes four separate communications to be distributed to members in 2018. These four plans include:

1. **Medical Record Policies:** This communication included instructions on how to facilitate the sharing of a patient's medical records between the MHCs and non-MHC providers.
 2. **Wellness/Health Coaching:** This communication markets the wellness and health coaching available for free to patients at the MHCs.
 3. **Chronic Conditions Infographic:** This flyer will inform members how the MHCs can help diagnosis and treat many chronic conditions. This will be mailed to members in March 2019.
 4. **MHC Vendor Mobile App:** This communication will market the vendor's mobile app available to MHC patients, along with its functionalities. It is estimated to be available in June 2019.
- B. We found some patients become confused in regard to sharing their medical records between the MHCs and private health care providers. For example, some patients assumed their private

providers already had their MHC records before their visit takes place. There were also issues with record requests being unfulfilled. However, follow-up work found there are two methods being planned to educate state employees on how to share medical records with private health care providers. One is an update to the existing MHC brochure found in the MHCs explaining steps patients should take to share medical records with a private health care provider. The second is a communication plan developed by the vendor that will focus on sharing medical records between MHCs and private health care providers.

RECOMMENDATION #5

We recommend the Department of Administration:

- A. Require the Montana Health Centers' contractor to provide all services stipulated in the contract, or**
- B. Amend the contract to eliminate stipulated services that are not performed at the centers.**

Implementation Status – *Implemented*

During audit work we found there were two contracted services that were not being offered within the MHCs: well-baby services, and workers' compensation and occupational services. Interviews with department staff found it would have required additional staff, equipment, and immunization costs to offer the well-baby services, and additional mechanisms for billing and generating claims to provide workers' compensation services. Our recommendation called for the department to either provide these services, or amend the contract to eliminate the services. The department reviewed the services provided in the contract and issued a contract amendment to remove references to any service not being performed by the MHCs.

RECOMMENDATION #6

We recommend the Department of Administration tie performance guarantees or any other contract incentives to the goals of the Montana Health Centers using clear, precise, and easily understood language with clearly defined, measurable outcomes.

Implementation Status – *Implemented*

A review of the original MHC contract and its associated amendments found goals were not clear or measurable. For example, the stated goal to "reduce costs for the state health plan and plan members" does not indicate against which baseline this reduction should occur, nor does it outline a timeframe for these cost reductions. In addition, the vendor is rewarded for accomplishing certain performance measures. However, we found the vendor created the performance guarantees found in the original contract, and four of the seven guarantees were not measurable. Because of the limitations of both the vendor's and the department's data, the department was not able to independently verify the vendor's reporting on its compliance with performance guarantees.

A review of four contract amendments issued since the completion of our audit found the department has implemented this recommendation. We found new performance guarantees are more clear and measurable than what existed during our audit work. For example, the department created an opportunity for a performance bonus if the vendor can increase the number of members who use the MHCs from one year to the next. This performance bonus allows the vendor to be awarded a separate cash bonus equal to one percent of their annual management fee. The state pays the vendor a management fee, which is \$14.75 per-employee-per-month (PEPM) for the first 5,000 employees, and \$11.75 PEPM thereafter for those employees covered under the State Plan that live within an MHC service area. To receive this

bonus, the contract now clearly specifies MHCs must obtain at least a 5 percent increase in State Plan members using the MHC for their primary care needs.

RECOMMENDATION #7

We recommend the Department of Administration finalize the development of the data warehouse and collect accurate and comprehensive data to verify that contract goals are being met.

Implementation Status – Being Implemented

We found the department lacks data to effectively monitor the MHC contract and determine whether the vendor is meeting contract requirements. Since the first MHC opened, department staff have rarely had enough data to undertake thorough analysis of the performance and return on investments of the centers. As a result, the department has had to rely upon the vendor's own reporting data, which was found to be inconsistent and unreliable. Without data, such as a means to positively identify the patient, it is harder to measure and accomplish these goals, especially regarding the treatment of patients with chronic conditions. For several years, the department tried to improve access to data by creating a data warehouse in-house that would be comprised of data from all of the State Plan's vendors (i.e. the MHC vendor, the health care TPA, the dental TPA, and the pharmaceutical TPA). The data warehouse would allow department staff to have direct access to all data and run its own reports regarding patient health outcomes. However, the development was delayed throughout audit work and we recommended the department finalize the development of the data warehouse. Follow-up audit work found the department decided to forgo this data warehouse as it would not meet their needs. Instead, the department issued a request for proposal (RFP) in July 2018 for a new vendor that specializes in data warehouses. The contract was awarded to the same vendor used by the state's TPA.

According to department staff, this newly contracted vendor will have a data warehouse solution ready for use in May 2019 and will house MHC claims data from January 1, 2016, going forward and all other non-MHC medical data from January 1, 2013, going forward. Department staff stated they will be able to run reports and create queries without having to go through the TPA. Another benefit is the MHC vendor will now reconcile their patient data before being uploaded into the system. The data warehouse will also incorporate all medical data from all the contracts the department has with non-MHC medical providers. For example, in Helena the department contracts with a private x-ray imaging business to provide x-rays for members ordered by an MHC. When a MHC provider refers a patient to this specific imaging center for an x-ray, the imaging center will now upload patient data into the data warehouse, so the department can reconcile invoices.

RECOMMENDATION #8

We recommend the Department of Administration document any contract modifications to the Montana Health Centers through a mutual, written agreement between the department and the contractor.

Implementation Status – Implemented

During audit work we identified instances of modifications to the contract between department and the vendor that were not in compliance with contract stipulations or were lacking proper documentation. For example, there was a verbal agreement between the vendor and the department to increase remote health risk assessment staffing costs, but this was not amended within the contract. These additional costs amounted to approximately \$202,000 in payments above what was allowed in the contract. Because of the recommendation, the department is now documenting any contract modifications that occur. For example, follow-up work noted the department documented four contract amendments since June 2017. These included improving communications between the MHCs and patients; eliminating occupational health

services, workers' compensation services, and well-baby exams; decreasing vendor management fees; and improving MHC performance guarantees and goals.

RECOMMENDATION #9

We recommend the Department of Administration work with stakeholders to determine if the Montana Health Centers should continue to be a health care option for state employees, and either:

- A. End Montana Health Center services at the end of the current contract extension period, or**
- B. Develop and submit a new Request for Proposal based on a clearly defined vision and goals.**

Implementation Status – *Not Implemented*

Overall, we found a number of issues regarding the administration of the MHCs. For example, MHC goals and original performance guarantees were not measurable, patient data was not accurate, MHC expansion was not properly planned, vendor reports were inaccurate, and savings to the State Plan were unfounded. All these concerns generally tie back to the original planning and development of the MHCs. From the time the idea of the MHCs was presented to the time the first center opened was within a span of eight to nine months, with little input from stakeholders. As a result, we recommended the department either cease operations of the MHCs, or issue a new vendor RFP after receiving input from stakeholders regarding the goals and intent of the centers.

Instead of issuing a new RFP for a new MHC vendor, the department decided to continue to use the current vendor and renew its contract through December 31, 2019. According to department staff, our audit report resulted in positive changes related to the MHC vendor. For example, the management fee given to the vendor to operate the MHCs decreased and the department believes data provided by the vendor is more accurate, reliable, and verifiable. In addition, the vendor hired a new senior medical director to focus exclusively on Montana MHCs operations. This position works as a liaison between department staff, the vendor, MHC staff, and the state's TPA. This director is currently working on a project with the state's pharmaceutical TPA to integrate pharmaceutical data into MHC patient medical records. Staff also stated there are still areas that need to be improved, such as reducing turnover in the MHCs, and filling vacancies in the Helena, Missoula, and Billings MHCs. Overall, the department indicated it has seen positive changes in MHC operations since our audit was completed.

However, given the numerous issues we identified in the initial procurement and contracting processes, we continue to believe the best option available to the state (assuming continuing provision of services through the centers) is to pursue a new RFP for the MHCs. This could provide the department with a better understanding of available service delivery models, an updated understanding of the price competitiveness of the current contractor, and will also demonstrate a commitment to transparency and stakeholder involvement in the further development of its vision for MHC services.