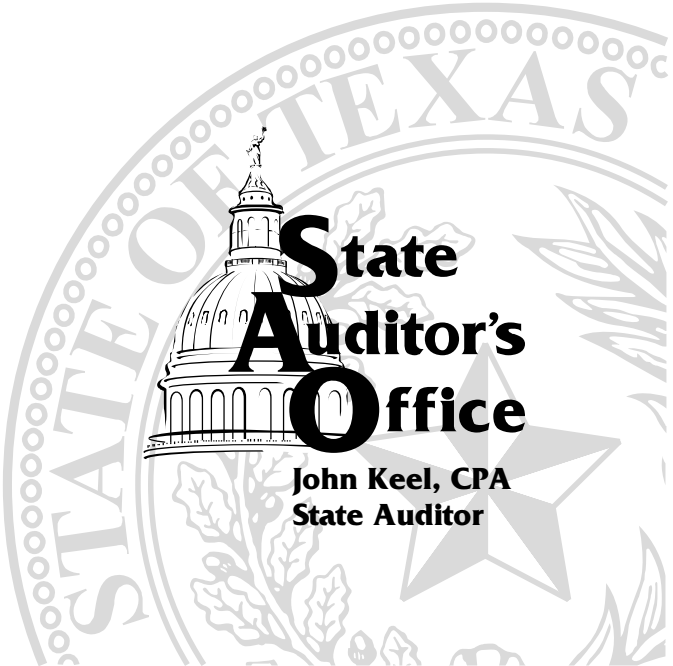
An Audit Report on

The Health and Human Services Commission's Monitoring of Its Contracted Medicaid Administrator

January 2005

Report No. 05-024



State Auditor's Office

John Keel, CPA
State Auditor

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Overall Conclusion

The Health and Human Services Commission (Commission) did not have a comprehensive plan to monitor ACS State Healthcare LLC (ACS), the State's present Medicaid administrator, for the **first nine months** of ACS's operations. During that time period, the Commission was focusing on developing its new contract management organizational structure in the Medicaid/Children's Health Insurance Program (CHIP) Division. Although the Commission conducted monitoring activities during this period that identified issues in certain aspects of ACS's performance, it should finalize its monitoring plan to ensure that ACS is carrying out all of its responsibilities effectively. In addition to processing Medicaid claims, ACS is required by its contract with the Commission to perform a significant number of other key services such as provider recruitment and the operation of call centers.

Background

The Health and Human Services Commission (Commission) entered into a contract with ACS State Healthcare LLC (ACS, a subsidiary of Affiliated Computer Systems, Inc.) in January 2003. ACS began serving as the State's Medicaid administrator and processing Medicaid claims in January 2004.

Under the fiscal agent arrangement the Commission has with ACS, the Commission receives weekly information regarding approved Medicaid claims from ACS and then sends ACS the funds necessary to pay those claims.

In addition to processing Medicaid claims, ACS performs a significant number of other key services for the Commission, such as:

- Provider recruitment.
- Operation of call centers.
- Provider and client services.
- System maintenance and modification.
- Prior authorization for Medicaid services.

ACS has been serving as the State's Medicaid administrator since January 2004 and, as of November 2004, had processed approximately $5 billion in Medicaid claims on the State's behalf. The Commission's contract with ACS requires it to pay ACS approximately $536.2 million in administrative fees over a period of four years.

Effectively monitoring ACS is critical, not only because of the size of the contract and the volume of Medicaid claims but also because serious issues were identified regarding the Commission's previous contracted Medicaid administrator.

In accordance with the requirements of the 76th Legislature, which mandated external audits of certain Medicaid contractors, the Commission has engaged contractors to conduct (1) a $174,880 attestation engagement to examine ACS's administrative services and (2) a $349,230 electronic data processing audit of the system ACS uses to process Medicaid claims. Therefore, we did not fully pursue our original audit objectives in the areas of claims processing and administrative expenses.

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This audit was conducted in accordance with Texas Government Code, Sections 321.0131 and 321.0132.

For more information regarding this report, please contact Nicole Guerrero, Audit Manager, or John Keel, State Auditor, at (512) 936-9500.

Key Points

The Commission did not dedicate adequate resources to implement its monitoring plan until August 2004.

In June 2004, the Commission finalized a new organizational structure that separated the monitoring of the ACS contract from the monitoring of its other 90 Medicaid and CHIP contracts. It began to implement a focused approach to its ACS monitoring in August 2004, when it hired a deputy director responsible for overseeing only the ACS contract.

The Commission plans to assess whether it should adjust the administrative fees it pays ACS and whether the claims processing system that ACS uses is processing claims accurately.

The Commission has engaged a contractor to conduct an attestation engagement to examine ACS's administrative services. The Commission expects to receive results from that engagement in June 2005 and plans to use those results to determine whether it should adjust ACS's administrative fees. The total amount of the contract to conduct this engagement is $174,880.

The Commission also has engaged a contractor to audit its Medicaid and CHIP automated systems, which includes an audit of Compass 21, the Commission's Medicaid claims processing system that ACS uses to process Medicaid claims. An audit of Compass 21 could help the Commission ensure that the system (and, therefore, ACS) is processing Medicaid claims accurately. The total amount of the contract to conduct this audit is $349,230.

Summary of Management's Response

The Commission generally agrees with our recommendations, and its detailed responses are presented in Appendix 3.

Summary of Objective, Scope, and Methodology

Our objective was to determine whether the Commission's contract monitoring of the administration of the Medicaid program ensures that:

- The administrator is accountable for processing claims accurately and in a timely manner.
- The administrator is accountable for other contract responsibilities such as provider recruitment, third-party recoveries, and call center support.
- Administrative expenses charged to the Commission are appropriate.

Our scope covered the Commission's monitoring activities from January 2004 through November 2004.

Our methodology consisted of interviewing the Commission's personnel, reviewing monitoring plans, and reviewing monitoring activities and related documentation.

Recent SAO Work		
Number	**Product Name**	**Release Date**
04-042	An Audit Report on the Health and Human Services Commission's Administration of the CHIP Exclusive Provider Organization Contract	July 2004
04-011	An Audit Report on the Health and Human Services Commission's Monitoring of Managed Care Contracts	November 2003
03-043	An Audit of National Heritage Insurance Company Accounts Receivable, Claim Counts, and Selected Trust Funds Related to Administering Medicaid Claims for the Health and Human Services Commission	July 2003
03-036	An Audit of the Administrative Expenses the National Heritage Insurance Company Charged to the Health and Human Services Commission in Fiscal Year 2002	June 2003
03-029	An Audit Report on the Health and Human Services Commission's Prescription Drug Rebate Program	April 2003
03-022	An Audit Report on the Children's Health Insurance Program at the Health and Human Services Commission	March 2003
03-016	An Audit of the Administrative Expenses the National Heritage Insurance Company Charged to the Health and Human Services Commission	January 2003

Contents

Detailed Results

Chapter 1
The Commission Did Not Dedicate Adequate Resources to Implement Its Monitoring Plan Until August 2004 1

Chapter 2
The Commission Plans to Assess Whether It Should Adjust the Administrative Fees It Pays ACS and Whether the Claims Processing System that ACS Uses Is Processing Claims Accurately 4

Appendices

Appendix 1
Objective, Scope, and Methodology 6

Appendix 2
Deliverables in the Commission's Contract with ACS 8

Appendix 3
Management's Responses 10

Detailed Results

Chapter 1

The Commission Did Not Dedicate Adequate Resources to Implement Its Monitoring Plan Until August 2004

The Health and Human Services Commission (Commission) did not have a comprehensive plan to monitor ACS State Healthcare LLC (ACS), the State's present Medicaid administrator, for the **first nine months** of ACS's operations. During that time period, the Commission was focusing on developing its new contract management organizational structure in the Medicaid/Children's Health Insurance Program (CHIP) Division. Although the Commission conducted monitoring activities during this period that identified issues in certain aspects of ACS's performance, it should finalize its monitoring plan to ensure that ACS is carrying out all of its responsibilities effectively. In addition to processing Medicaid claims, ACS is required by its contract with the Commission to perform a significant number of other key services such as provider recruitment and the operation of call centers. Appendix 2 contains a summary of ACS's contract deliverables.

ACS has been serving as the State's Medicaid administrator since January 2004 and, as of November 2004, had processed approximately $5 billion in Medicaid claims on the State's behalf. The Commission's contract with ACS requires it to pay ACS approximately $536.2 million in administrative fees over a period of four years.

Effectively monitoring ACS is critical, not only because of the size of the contract and the volume of Medicaid claims but also because serious issues were identified regarding the Commission's previous contracted Medicaid administrator.

The Commission did not have a comprehensive monitoring plan for the first nine months of ACS's operations.

Table 1 shows a time line of the Commission's activities since it contracted with ACS in January 2003. The Commission hired a deputy director to manage the staff responsible for overseeing the monitoring of all 91 Medicaid and CHIP contracts, including the ACS contract, two weeks before ACS began processing Medicaid claims in January 2004. During the next few months, the Commission was working to develop a monitoring plan and related tools, attending meetings with ACS, and receiving reports that ACS submitted. Although the Commission reviewed the deliverables it received from ACS, it did not verify that ACS provided all of the 1,243 deliverables it was required to provide.

In June 2004, the Commission finalized a new organizational structure that separated the monitoring of the ACS contract from that of the Commission's other 90 Medicaid and CHIP contracts. It began to implement a focused approach for monitoring ACS in August 2004, when it hired a deputy director responsible for overseeing only the ACS contract.

Table 1

Time Line for the Commission's Medicaid Administrator Contract with ACS

Date	Activity
January 1, 2003	The Commission announced the final award of the Medicaid administrator contract to ACS.
May 19, 2003	The Commission signed a contract with a vendor to assist with the oversight of the transition from the previous Medicaid administrator to ACS.
December 15, 2003	The Commission hired a deputy director to manage the staff responsible for overseeing its 91 Medicaid and CHIP contracts (including the ACS contract).
January 1, 2004	ACS began processing Medicaid claims.
January 1, 2004	The Commission hired an associate director and a manager to assist with staff management and oversight of its 91 Medicaid and CHIP contracts (including the ACS contract).
May 4, 2004	The Commission issued a request for proposal to hire a contractor to conduct a performance audit and an information technology audit of its Medicaid and CHIP programs. The Commission awarded this contract on October 15, 2004 (see below).
May 14, 2004	The Commission issued a request for proposal to hire a contractor to conduct a financial audit of its Medicaid and CHIP programs (including an audit of ACS's administrative expenses, which could result in a change in the administrative fees the Commission pays ACS). The Commission awarded this contract on October 15, 2004 (see below). The Commission expects to obtain the results of this audit in June 2005.
June 1, 2004	The Commission hired an associate director for Medicaid claims administrator operations. This individual became responsible for overseeing a subset of ACS's deliverables.
June 7, 2004	The organizational structure for the Commission's Medicaid/CHIP division was finalized. This organizational structure split responsibility for monitoring the Commission's Medicaid and CHIP contracts. The new Medicaid/CHIP Contract Management Division became responsible for monitoring all Medicaid and CHIP contracts except the ACS contract; the new Claims Administrator Contract Management Division became responsible for monitoring only the ACS contract.
June 30, 2004	The vendor that the Commission hired to assist with the oversight of the transition from the previous Medicaid administrator to ACS reported to the Commission that ACS was fulfilling most, but not all, of its requirements.
August 16, 2004	The Commission hired a deputy director for its Claims Administrator Contract Management Department. This individual's duties included managing the staff in the department that was responsible for overseeing the division that monitored only the ACS contract.
October 15, 2004	The Commission signed a contract with a vendor to conduct the performance audit and information technology audit of its Medicaid and CHIP programs. It also signed a contract with a vendor to conduct the financial audit of its Medicaid and CHIP programs.

Source: Compiled from information the Commission provided

Certain issues highlight the need for effective monitoring.

During our audit, we noted certain issues that illustrate why it is critical that the Commission conduct effective monitoring. Specifically:

- A vendor that the Commission hired to assist with the transition from the previous Medicaid administrator to ACS was required to provide several deliverables to the Commission by June 2004. However, the Commission was unable to provide us with copies of all of those deliverables, including

the vendor's monthly and quarterly reviews of ACS's operations. Therefore, we could not verify that the vendor had provided these deliverables.

- The Commission became aware of problems involving one call center only through frequent complaints it received directly from providers. Providers felt that call center agents were not courteous and were providing incorrect information when answering Medicaid-related questions. More effective monitoring on the Commission's part could have identified that, while ACS was meeting contract reporting requirements in this area, it was not reporting the results of its quality assurance reviews. Receiving this type of information may have allowed the Commission to address this issue before providers began contacting the Commission.

- The Commission's contract with ACS requires ACS to perform Medicaid provider recruitment activities, but the contract requires ACS to only report the total number of providers that enroll each month. Because the Department of State Health Services also recruits Medicaid providers, the Commission is unable to determine from ACS's reports how many providers ACS recruited. Therefore, the Commission cannot monitor the effectiveness of ACS's provider recruitment activities.

We also noted that, as of September 2004, the Commission had not completed its process to assign staff to review each of the deliverables that ACS is required to provide.

Recommendations

The Commission should:

- Finalize and implement its plan for monitoring ACS as soon as possible. As part of this process, the Commission should:

  - Complete its process to assign staff to review each of the deliverables that ACS is required to provide.

  - Evaluate the usefulness of all contract deliverables.

  - Ensure that it provides required input into the intent of contract requirements.

  - Routinely document the result of its monitoring activities and related action plans.

  - Enforce the assessment of liquidated damages based on the results of monitoring efforts.

- Periodically assess its monitoring plan and adjust the plan as necessary to ensure that its monitoring efforts remain effective.

Chapter 2

The Commission Plans to Assess Whether It Should Adjust the Administrative Fees It Pays ACS and Whether the Claims Processing System that ACS Uses Is Processing Claims Accurately

In accordance with the requirements of the 76th Legislature, which mandated external audits of certain Medicaid contractors, the Commission has hired a contractor to conduct an attestation engagement to examine ACS's administrative services. The Commission expects to receive results from that engagement in June 2005 and plans to use those results to determine whether it should adjust ACS's administrative fees. The total amount of the contract to conduct this engagement is $174,880.

The Commission paid its previous Medicaid claims administrator by reimbursing that administrator for the administrative expenses it asserted it had incurred. When the Commission contracted with ACS, it changed that payment methodology and established monthly fixed and variable administrative fees that ACS would be paid. This change was an improvement over the prior payment methodology because it eliminated the possibility that the contractor could receive reimbursement for administrative expenses that it did not incur.

The attestation engagement for which the Commission has contracted is critical because the Commission's contract with ACS requires the Commission to review ACS's profit at the end of the first year of operations. If ACS earns a profit that is 20 percent more than the agreed-upon 11 percent profit, the Commission can lower the fixed and administrative fees that it pays ACS in the second through fourth years of the contract. In addition, the original contract specified that ACS would receive $386,920,200 in administrative fees, and subsequent contract amendments have added $149,371,487 to that amount (see Table 2).

Table 2

Administrative Fees in the Commission's Contract with ACS

Item	Date	Description	Amount
Original Contract	January 1, 2003	Fixed and variable administrative fees originally specified in the contract	$ 386,920,200
Amendment 1	March 17, 2003	Made changes to adjust processes to move from an insurance arrangement to a fiscal agent arrangement	12,065,840
Amendment 2	July 17, 2003	Made changes to adjust for modifications in federal Health Insurance Portability and Accountability Act (HIPAA) requirements	1,530,041
Amendment 3	November 17, 2003	Made changes to increase the number of ACS personnel for pharmacy provider enrollment support services	250,800
Amendment 4	November 21, 2003	Added a contingency fee that ACS could receive for its third-party recoveries from sources other than Medicaid	0

Administrative Fees in the Commission's Contract with ACS			
Item	**Date**	**Description**	**Amount**
Amendment 5	December 18, 2003	Adjusted the contract to include additional services necessary to complete work that was not contemplated in the original request for proposal and services necessary to meet additional workload requirements, determined in accordance with pre-established contract provisions	40,678,503
Amendment 6	April 1, 2004	Made changes to increase the number of ACS personnel for vendor drug help-desk support services	201,600
Amendment 7	March 1, 2004	Adjusted the contract to include ACS's acquisition and conversion of imaging system software	5,500,000
Amendment 8	March 1, 2004	Adjusted the contract to continue processing non-HIPAA compliant claims and to develop system modifications	3,019,681
Amendment 9	August 10, 2004	Made changes to accommodate the expansion of Medicaid managed care	86,125,022
		Total Contract Amount	**$536,291,687**

Source: Contract and amendment information provided by the Commission

In accordance with the requirements of the 76th Legislature, the Commission also has engaged a contractor to audit its Medicaid and CHIP automated systems, which includes an audit of Compass 21, the Commission's Medicaid claims processing system that ACS uses to process Medicaid claims. The goal of the audit is to ensure that data maintained by Medicaid and CHIP contractors is of the required integrity and is properly managed in accordance with applicable federal and state regulations and contract requirements. Compass 21 is the state-owned system that the State's Medicaid administrator has used since September 2001 to process Medicaid claims. An audit of Compass 21 could help the Commission ensure that the system (and, therefore, ACS) is processing Medicaid claims accurately. The total amount of the contract to conduct this audit is $349,230.

Appendices

Appendix 1

Objective, Scope, and Methodology

Objective

Our objective was to determine whether the Health and Human Services Commission's (Commission) contract monitoring of the administration of the Medicaid program ensures that:

- The administrator is accountable for processing claims accurately and in a timely manner.
- The administrator is accountable for other contract responsibilities such as provider recruitment, third-party recoveries, and call center support.
- Administrative expenses charged to the Commission are appropriate.

Scope

The scope of our audit covered the Commission's monitoring activities from January 2004 through November 2004. Our audit did not include a review of information technology.

Methodology

The audit methodology consisted of interviewing the Commission's personnel and reviewing monitoring plans, monitoring activities, and related documentation.

Information collected included the following:

- Monitoring tools that will be used to monitor the receipt and review of deliverables
- Payments processed during fiscal years 2004 and 2005 from the Uniform Statewide Accounting System
- The request for proposal for a Medicaid claims administrator
- The Commission's contract with ACS and other associated contracts
- A draft monitoring plan
- Documentation provided to support monitoring activities
- Monthly and weekly status reports

Procedures, tests, and analyses conducted included the following:

- Interviewed the Commission's staff responsible for monitoring activities
- Analyzed payment information
- Reviewed documentation provided
- Tested selected deliverables for monitoring activities upon availability

Criteria used included the following:

- The Commission's contract with ACS
- The Commission's request for proposal for the Medicaid claims administrator

Other Information

We conducted fieldwork from March 2004 to November 2004. This audit was conducted in accordance with generally accepted government auditing standards. The following members of the State Auditor's staff performed this audit:

- Angelica Martinez (Project Manager)
- Richard Maxwell, CIA (Assistant Project Manager)
- Elizabeth Godwin
- William Hurley
- Laura Mansfield
- Dennis Ray Bushnell, CPA (Quality Control Reviewer)
- Nicole Guerrero, MBA (Audit Manager)

Appendix 2

Deliverables in the Commission's Contract with ACS

Table 3 describes the deliverables in the Commission's contract with ACS State Healthcare LLC (ACS).

Table 3

ACS Contract Deliverables	
Category of Deliverable	**Number of Deliverables**
Financial Accounting Reporting	20
Fund Management	15
System Support	5
General Vendor Responsibilities	41
Surveillance/Utilization Review	67
Third-Party Resources. Examples of deliverables include: ▪ Research potential and update existing casualty cases. ▪ Research and resolve "non-dispositioned" checks for which the vendor is responsible. ▪ Maintain statistical data identifying numbers of Health Insurance Premium Payment System (HIPPS) and Insurance Premium Payment Assistance (IPPA) recipients and dollars expended.	57
Health Insurance Premium Payment System (HIPPS)	24
Claims Processing. Examples of deliverables include: ▪ Select a statistically valid random sample of different claim types in various statuses on a monthly basis and perform a quality control check on the claims to ensure accurate processing, including editing, auditing, and pricing. ▪ Provide a monthly listing of edits/audits by program and benefit plan applied to each processing cycle. This listing must include edit/audit number, description, overrideability, disposition of transaction upon failure, and date the edit/audit was last changed.	71
Long-Term Care Client Assessment Review and Evaluation Forms Processing System. Examples of deliverables include: ▪ Ensure that all Client Assessment Review and Evaluation (CARE) forms (forms 3652, 3618, and 3619) received on paper are data entered within ten business days with 100% accuracy. ▪ Edit CARE forms against provider file containing nurse licensing status information. ▪ Assist providers, Medicaid clients, and state Medicaid Eligibility Workers with information regarding Medical Necessity status.	29
Long-Term Care Programs	59
Children with Special Health Care Needs Program	13
Family Planning. Examples of deliverables include: ▪ Approve "Funds Gone" claims for payment only if additional funds from the same fiscal year in which the services were provided become available. ▪ Develop, maintain, and provide technical and user training packages for family planning providers. Conduct family planning-specific training annually, or more frequently if needed, for providers across the state. ▪ Include non-Medicaid family planning modules in the Compass 21 billing software.	26
County Indigent Health Care Program	5
Medically Needy Program	17

ACS Contract Deliverables	
Category of Deliverable	**Number of Deliverables**
General Operations Requirements. Examples of deliverables include: ▪ Assess ad hoc requests and identifies candidate reports for consideration as production reports. ▪ Ensure the accuracy of all reports produced. ▪ Submit a monthly monitoring report on all items listed in Appendix D [of the request for proposal]. The report format must be developed within the first six months of contract operations and implemented by the first day of the seventh month. When implemented, the report must be received by the State by the 15th business day of each month. ▪ Perform ongoing assessments of the quality of its operational activities and report to the State.	53
Financial Management	48
Provider Reimbursement - Verification of Cost Data Audits. Examples of deliverables include: ▪ Have a plan for cost verification that ensures compliance with the state and federal requirements concerning institutional reimbursement. ▪ Perform desk audits, tentative/final cost settlements, and cost settlement activities for inpatient and outpatient hospital services for hospitals with 100 or fewer licensed beds and in accordance with the reimbursement methodologies defined by the State.	13
Hospital Rate Calculation and Payment	13
Management and Administrative Reporting	20
Ad Hoc Reporting and Computer Output to Laser Disk	41
Reference Data Maintenance	27
Recipient Eligibility File Maintenance	22
Eligibility Verification System	20
Systems Operations, Integrated Testing Facility, and Disaster Recovery	34
System Maintenance and Modification	38
Texas Health Network (THN) Administration	48
Provider Services	181
Client Services. Examples of deliverables include: ▪ Furnish and maintain an English and Spanish client administrative support toll-free line to assist clients with issues other than health care concerns. Information must be communicated in other languages when necessary. ▪ Respond to written inquiries from clients within ten business days of receipt of correspondence. ▪ Establish and maintain a client complaint tracking system based on State guidelines.	54
Administrative Cost Containment	5
Health Care Cost Containment	5
Medical/Dental Policy	44
Prior Authorization and Referral Management	43
Transition Phase Requirement – Technical Support	10
System Transfer and Testing	9
Operations Preparedness	39
Demonstration and Assessment of Operational Readiness	12
Cutover	11
Post-Transition Support	4
Total Contract Deliverables	**1,243**

Source: The Commission's contract with ACS

Management Response
to the State Auditor's Office Audit Report on:

Health and Human Services Commission's
Monitoring of Its Claims Administrator Contract

Chapter 1

Management Response:

HHSC's contract monitoring plan began with the reprocurement and development of a new claims administrator contract. HHSC altered the pricing system to eliminate the possibility of administrative expense overpayment – an issue identified in the previous contract structure and oversight. The SAO noted this change as a significant improvement in the contract's payment structure. The new contract eliminated the requirement for the previous insured arrangement, significantly increasing the competitive field for the procurement, and simplifying contract payment and performance. Additionally, HHSC combined the Primary Care Case Management (PCCM) and claims administrator contracts to consolidate contractor functions and oversight and produce related savings.

The contract also reflected HHSC's shift to performance based contracting, identifying clearly defined performance requirements, contract deliverables, and provisions for a series of progressive remedies, including financial penalties, to be imposed should the contractor fail to meet contractual obligations. These significant changes in the contract were critical to improve subsequent contract performance and monitoring.

After initiating contract monitoring improvements through changes in the contract, HHSC's management and oversight of the claims administrator contract continued through a very successful operational transition to the new contractor, and evolved through the post-transition success to include development of an operational oversight division focused solely on the contract.

- *Subsequent to contractor selection, HHSC implemented an on-site transition team to constantly monitor transition progress and the contractor's ability to perform requirements. A dedicated project management software system containing all contract requirements, performance parameters and real time performance metrics was used throughout and beyond the transition of the contract functions to assure performance would and did meet contract requirements. The system*

identified transition and contract performance risks, including a risk related to call center deployment.

- *As the implementation shifted from the critical transition phase to ongoing operational management and oversight, responsibility shifted from the existing Project Manager to a deputy director specifically hired to oversee Medicaid/CHIP contracts. Contract monitoring identified areas in which contractor performance improvement was needed. Deficiencies were corrected within the defined timeframes.*

- *In the months following the transition, HHSC finalized plans for a dedicated Claims Administrator Contract Management Department within Medicaid/CHIP. In August, a deputy director with extensive private sector contract management and operations experience was hired to manage and assure contract compliance of the claims administrator contract. Additional resources have been added for this function.*

We agree with the SAO that a final monitoring plan has not been implemented, however, HHSC believes its approach to and implementation of contract management for the contract was successful. HHSC's contract management and monitoring followed the progression of contract assessment from development through the transition process and review towards finalizing a long term plan for ongoing contract management and oversight. HHSC's contract management resulted in a successful transition and subsequent performance of the claims administration function.

Implementation of the actions planned as a result of the State Auditor's Office recommendations below will assist HHSC as it continues its emphasis on contract management improvement and fully implements its plan to improve the monitoring of the claims administrator contract in the Medicaid/CHIP Division.

Actions Completed or Planned:

- *HHSC will complete and implement its comprehensive plan to monitor the performance of ACS, its contracted claims administrator, and ACS' subcontractors. In addition, it will complete development of supporting policies and procedures, and train applicable staff on related monitoring processes.*

  Estimated Completion Date: *Monitoring plan completion - March 2005 Policies and procedures developed and implemented, and staff trained - May 2005*

- *HHSC assigned responsibility for review of each contract deliverable to staff who receive deliverables submitted by ACS, determine whether deliverables are complete and timely, and evaluate whether the quality of the content is acceptable.*

Estimated Completion Date: *Complete*

- *Staff assigned to review contract deliverables completed an initial evaluation, in coordination with subject matter experts, to ensure that the content and format of each deliverable provided useful and meaningful information. HHSC will develop and implement procedures detailing the ongoing review of contract deliverable content and usefulness, and actions to be taken if a deliverable does not meet contract requirements or indicates performance is not meeting expectations.*

  Estimated Completion Date: *May 2005*

- *HHSC will establish policies and procedures detailing ongoing processes to identify contract requirements that should be strengthened. Management will evaluate recommendations for improvements, and make appropriate cost-effective revisions to the contract through subsequent amendments.*

  Estimated Completion Date: *May 2005*

- *HHSC will refine its methodology for routinely documenting the activity associated with contract monitoring activities, decisions it makes related to that monitoring effort, and actions it takes to ensure that performance issues are aggressively addressed. Management will develop and implement policies and procedures to support this methodology.*

  Estimated Completion Date: *May 2005*

- *HHSC will develop and implement policies and procedures related to the enforcement of liquidated damages. The policies and procedures will include criteria for appropriately assessing the degree of harm a deficiency caused the State, and determining whether liquidated damages or other performance penalties should apply.*

  Estimated Completion Date: *May 2005*

- *HHSC will ensure that the monitoring plan includes a process for periodic review of the plan and a mechanism for adjusting the plan as needed.*

  Estimated Completion Date: *March 2005*

  Title of Responsible Person: *Deputy Medicaid/CHIP Director, Claims Administrator Contract Management*

Copies of this report have been distributed to the following:

Legislative Audit Committee

The Honorable David Dewhurst, Lieutenant Governor, Joint Chair
The Honorable Tom Craddick, Speaker of the House, Joint Chair
The Honorable Steve Ogden, Senate Finance Committee
The Honorable Thomas "Tommy" Williams, Member, Texas Senate
The Honorable Jim Pitts, House Appropriations Committee
The Honorable Brian McCall, House Ways and Means Committee

Office of the Governor

The Honorable Rick Perry, Governor

Health and Human Services Commission

Mr. Albert Hawkins, Executive Commissioner