

A Follow-Up Audit Report on

Managed Care Contract Administration at the Health and Human Services Commission

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Managed Care Contract Administration at the Health and Human Services Commission

Overall Conclusion

The Health and Human Services Commission (Commission) has made an effort to correct the majority of weaknesses in its administration of Medicaid and Children's Health Insurance Program (CHIP) managed care contracts. However, it has not fully implemented the majority of recommendations identified as high risk by the State Auditor's Office from three prior audit reports (see text box).

Of the 25 prior recommendations audited, the Commission has fully implemented 3 and substantially implemented 9; however, its efforts to address 10 recommendations remain incomplete or ongoing and the Commission has not implemented 3 other recommendations.

The Commission has substantially completed implementation of the following:

- The Commission has re-evaluated the activities and resources needed for monitoring managed care contracts in accordance with State Auditor's Office recommendations, but it has not standardized the resulting processes across all divisions.
- The Commission has established performance penalties to provide incentives for contractors in accordance with State Auditor's Office recommendations, but it has not maintained a standard process to impose performance penalties or assess damages.
- The Commission has developed procedures to determine whether subcontractor services are necessary and related payments are reasonable in accordance with a State Auditor's Office recommendation, but it has not yet reviewed any managed care subcontracts using those procedures.

Background Information

This follow-up audit determined the implementation status of high-risk recommendations related to administration of Medicaid and CHIP managed care contracts from three prior State Auditor's Office reports:

- *An Audit Report on the Health and Human Services Commission's Administration of the Exclusive Provider Organization Contract* (SAO Report No. 04-042, July 2004). At the time auditors completed follow-up work, this report had been released for 6 months; 15 of 34 recommendations related to contract administration from that report were audited.
- *An Audit Report on the Health and Human Services Commission's Monitoring of Managed Care Contracts* (SAO Report No. 04-011, November 2003). At the time auditors completed follow-up work, this report had been released for 14 months; 8 of 26 recommendations related to contract administration from that report were audited.
- *An Audit Report on the Children's Health Insurance Program at the Health and Human Services Commission* (SAO Report No. 03-022, March 2003). At the time auditors completed follow-up work, this report had been released for 22 months; 2 of 4 recommendations related to contract administration from that report were audited.



As part of its effort to implement prior State Auditor's Office recommendations, the Commission has developed a standardized contracting process for administering its contracts and is developing information systems to automate contract monitoring functions. However, **only 1 of the 32 managed care contracts or amendments** that the Commission executed between July 1, 2004, and November 9, 2004, was processed entirely using this established contracting process. The Commission processed the remaining contracts using its prior contracting processes or without following standardized processes. In addition, executive management has authorized two contractual-type documents that are not included in the standardized contracting process.

Summary of Management's Response

The Commission disagrees with some of the recommendations in the audit report. For example, it disagrees with a recommendation to review all managed care organizations' agreements with subcontractors and affiliates because it believes that this is the responsibility of the prime contractor.

The Commission also disagrees with some of the conclusions of this audit. Specifically, the Commission asserts that:

- It implemented a contract management structure on July 1, 2004, that addresses the incomplete/ongoing or not implemented findings in this audit and that most of the contracts reviewed in this audit were initiated before that date.
- The recommendations identified as not implemented or incomplete/ongoing generally relate to conditions that no longer exist, are immaterial to current operations, or do not pose significant ongoing risk.
- It took swift and immediate action to reduce payments to Clarendon (the former CHIP exclusive provider organization) in order to preserve state funds. The Commission adds that while it believes that strict adherence to contract administration processes is important, there must also be room to move quickly in an administrative emergency.

The Commission's responses and our comments regarding these responses are presented in Appendix 2.

Subsequent Events

The Commission asserts that it has restructured and updated processes within the Medicaid/CHIP division to better manage the performance of its managed care contractors, including forming a new management team with strong skills and qualifications and procuring financial and performance audit contracts to assist with oversight of its contracts with managed care organizations. The Commission also asserts that its contract oversight is improved by managed care organization

contracts that now contain performance standards and measures, along with damages for failure to attain required performance levels.

Summary of Objectives, Scope, and Methodology

The objectives of this audit were to determine whether the Commission has made progress in correcting deficiencies in its contract management, as identified in the following recent State Auditor's Office reports:

- *An Audit Report on the Health and Human Services Commission's Administration of the CHIP Exclusive Provider Organization Contract* (SAO Report No. 04-042, July 2004). At the time auditors completed follow-up work, this report had been released for 6 months; 15 of the 34 recommendations related to contract administration from that report were audited.
- *An Audit Report on the Health and Human Services Commission's Monitoring of Managed Care Contracts* (SAO Report No. 04-011, November 2003). At the time auditors completed follow-up work, this report had been released for 14 months; 8 of 26 recommendations related to contract administration from that report were audited.
- *An Audit Report on the Children's Health Insurance Program at the Health and Human Services Commission* (SAO Report No. 03-022, March 2003). At the time auditors completed follow-up work, this report had been released for 22 months; 2 of 4 recommendations related to contract administration from that report were audited.

The scope of this audit included reviewing the Commission's implementation of high-risk audit recommendations related to the administration of managed care contracts. These recommendations covered contract oversight, contract monitoring and amendment processes, and payments to its managed care contractors in August 2004. This audit did not include a comprehensive review of any information technology systems.

The methodology used for audit work consisted of identifying high-risk recommendations related to contract administration from prior State Auditor's Office audits and collecting information to determine the implementation status of those recommendations. Identification of high-risk recommendations was based on the following:

- The Commission's preliminary actions to implement prior recommendations
- Revisions to the Commission's scheduled implementation dates
- Inherent business, financial, or service risk

Audit information was collected by performing tests of selected contracting and payment documents, analyzing policies and procedures, and conducting interviews with Commission management and staff.

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Detailed Results

Chapter 1

The Commission Is in the Process of Implementing Prior Audit Recommendations

The Health and Human Services Commission (Commission) has made an effort to correct the majority of weaknesses in its administration of Medicaid and Children’s Health Insurance Program (CHIP) managed care contracts. However, it **has not fully implemented the majority of recommendations** identified as high risk by the State Auditor’s Office from three prior audit reports. Of the 25 prior recommendations audited, the Commission has fully implemented 3 and substantially implemented 9; however, its efforts to address 10 recommendations remain incomplete or ongoing and the Commission has not implemented 3 other recommendations. The text box below summarizes the implementation status and defines the degrees of implementation.

Prior Recommendations for Which Implementation Status Was Audited

The State Auditor’s Office followed up on the implementation status of 25 prior audit recommendations that were considered high-risk and that were related to the Commission’s administration of managed care contracts. Those recommendations were originally made in the following audit reports:

- *An Audit Report on the Health and Human Services Commission’s Administration of the Exclusive Provider Organization Contract* (SAO Report No. 04-042, July 2004)
- *An Audit Report on the Health and Human Services Commission’s Monitoring of Managed Care Contracts* (SAO Report No. 04-011, November 2003)
- *An Audit Report on the Children’s Health Insurance Program at the Health and Human Services Commission* (SAO Report No. 03-022, March 2003)

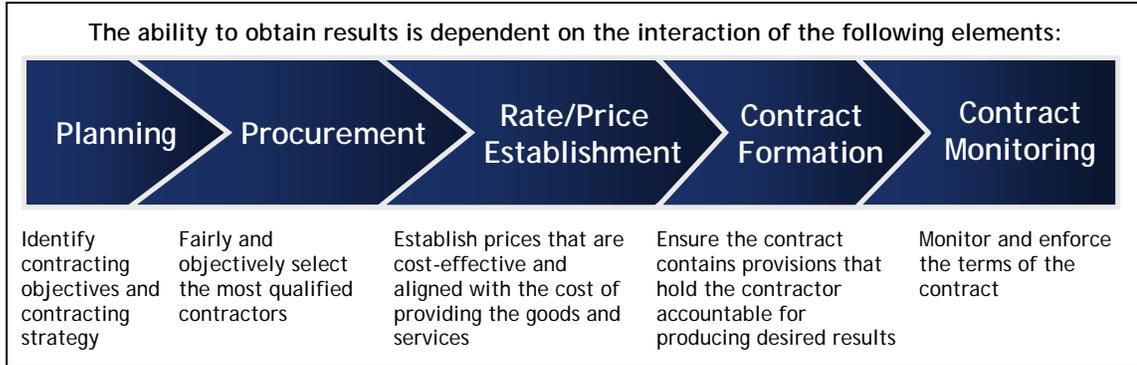
Table 1

Definition of Degrees of Implementation of Prior Audit Recommendations		
Degree of Implementation	Definition	Number of Prior Audit Recommendations in Category
Fully Implemented	Successful development and use of a process, system, or policy to implement a prior recommendation	3
Substantially Implemented	Successful development but inconsistent use of a process, system, or policy to implement a prior recommendation	9
Incomplete/Ongoing	Ongoing development of a process, system, or policy to address a prior recommendation	10
Not Implemented	Lack of a formal process, system, or policy to address a prior recommendation	3

Appendix 1 contains additional details regarding the scope and methodology used to select recommendations to follow up on during this audit.

Details on the implementation status of prior State Auditor’s Office recommendations are provided in Chapters 1-A through 1-E and are organized according to the contract management elements outlined in the *State of Texas Contract Management Guide* (see Figure 1).

Figure 1 - The Five Contract Management Elements



Source: *State of Texas Contract Management Guide* - Version 1.1, page 5

Chapter 1-A

Implementation Status of Recommendations Related to Contract Planning

The State Auditor’s Office previously recommended that the Commission re-evaluate its plans for how it (1) uses deliverables and (2) maintains contracting documents (see Table 2). Planning for how it will use contractors’ deliverables and maintain contract documents is critical to the Commission’s ability to monitor managed care organizations’ performance.

The Commission is in the process of implementing those recommendations by developing three information systems to process and store this information. These systems were in various stages of development during this audit, and their completion could significantly improve the Commission’s ability to efficiently and effectively achieve its contracting objectives for Medicaid and CHIP. Chapter 3-C contains additional details on the status of the Commission’s information system projects.

Table 2

Status of the Commission’s Implementation of Prior Audit Recommendations Related to Planning			
State Auditor’s Office Report	Recommendation	Implementation Status	Auditor Comments
<i>An Audit Report on the Health and Human Services Commission’s Monitoring of Managed Care Contracts</i> (SAO Report No. 04-011, November 2003)	The Commission should re-evaluate current deliverables that managed care organizations are required to provide to determine whether they meet the Commission’s monitoring needs, and then develop a standardized template for	Incomplete/Ongoing	The Commission has not completed implementation of the two information systems (the Financial Statistical Reports Automated System and the Deliverables Tracking System) that it plans to use to receive and compile

Status of the Commission's Implementation of Prior Audit Recommendations Related to Planning			
State Auditor's Office Report	Recommendation	Implementation Status	Auditor Comments
	managed care organizations to report data to the Commission in an electronic format that eliminates the need for staff to compile data in periodic status reports.		electronic deliverables from the managed care organizations with which it contracts. Chapter 3 contains additional details on these information systems.
	The Commission should establish a central repository and an organized process for maintaining contracts and other program-related documents.	Substantially Implemented	The Commission has completed the first phase of development for its Contract Administration and Tracking System. This system is now online, but the Commission has not entered all necessary contracts and program-related documents into it.

Recommendations

The Commission should:

- Continue to complete the development and implementation of its Financial Statistical Reports Automated System and Deliverables Tracking System to enable the Commission to electronically determine the completeness and accuracy of contractors' financial and operational deliverables and compile these deliverables for reporting.
- Continue to develop and implement its Contract Administration and Tracking System in order to maintain contracts and other program-related documents.

Chapter 1-B

Implementation Status of Recommendations Related to Contract Procurement

The Commission is in the process of implementing prior State Auditor's Office recommendations related to contract procurement (see Table 3). However, the Commission's ability to fully implement prior recommendations is limited by Commission management's decision to exempt its contracts with managed care organizations from its requirement that cost-benefit analyses be documented for all contracts. (It has also exempted interagency contracts, direct benefit contracts, and contracts with less than \$10,000 in annual value from that requirement.)

While the Commission does not document a cost-benefit analysis for its managed care contracts, it does collect information related to the cost, quality, and accessibility of the services to be provided by managed care organizations with which it contracts. However, this process does not result in a documented cost-benefit analysis because it (1) is not a standardized

component of the Commission's formal contracting process and (2) does not document the Commission's selection of the most beneficial service delivery model for each of its managed care contracts. The Commission could significantly improve the analysis of its contracts by standardizing the documentation that it requires for its cost-benefit analysis for each managed care contract it selects and incorporating this documentation into its contracting processes. Ultimately, this would help the Commission to ensure that it fairly and objectively selects the best service delivery option and the most qualified managed care organizations with which to contract.

Table 3

Status of the Commission's Implementation of Prior Audit Recommendations Related to Procurement			
State Auditor's Office Report	Recommendation	Implementation Status	Auditor Comments
<i>An Audit Report on the Health and Human Services Commission's Administration of the CHIP Exclusive Provider Organization Contract</i> (SAO Report No. 04-042, July 2004)	The Commission should perform and document cost-benefit analyses to fully consider all options for achieving the most cost-effective CHIP exclusive provider organization service delivery. These analyses should identify the services the Commission needs and encompass benchmarking against market prices that contractors charge for those services.	Incomplete/Ongoing	The Commission began reprocurring its exclusive provider organization contract before the July 2004 release of the report containing the prior audit recommendation. As a result, the Commission did not document a cost-benefit analysis prior to the final award of its exclusive provider organization contract on May 21, 2004. However, prior audit recommendations issued in March 2003 also recommended that cost-benefit analyses be conducted. (See recommendation for SAO Report No. 03-022.) The Commission did perform an analysis comparing the costs of this contract with a primary care case management model in April 2004, but this analysis was not completed in time to be used to determine the type of managed care contract that should be procured. The Commission has not reprocurring its exclusive provider organization contract since the prior audit recommendation was issued in July 2004.
<i>An Audit Report on the Children's Health Insurance Program at the Health and Human Services Commission</i> (SAO Report No. 03-022, March 2003)	The Commission should perform a comprehensive cost-benefit analysis before implementing major policy changes to its programs.	Incomplete/Ongoing	The Commission requires that all proposed contracts have a contract workforce analysis form, which is a standardized form that includes a cost-benefit analysis. However, the Commission has exempted its managed care contracts from the requirement to complete the cost-benefit analysis portion of this document.
	The Commission should take into consideration all aspects of a policy change and perform a thorough analysis to determine the impact of the change based on accurate numbers for the program under consideration.	Incomplete/Ongoing	

Recommendations

The Commission should:

- Consolidate its documentation concerning the cost, quality, and access to its programs in the form of a formal cost-benefit analysis to ensure standardization in its selection of its managed care contracts.
- Review the documentation it prepares on the cost, quality, and accessibility of the services of managed care organizations prior to the selection of all managed care organizations to ensure that all options are fully considered. If additional information is required to complete its cost-benefit analysis, the Commission should collect and document that information.

Chapter 1-C

Implementation Status of Recommendations Related to Contract Rate/Price Establishment

The Commission has implemented prior State Auditor’s Office recommendations related to negotiating with and paying managed care contractors, but it has not implemented recommendations related to verification of the rates that managed care organizations pay their subcontractors (see Table 4).

Actions that the Commission has taken to address these recommendations for Medicaid and CHIP have limited, but not completely eliminated, the need for negotiations with managed care organizations. This represents a significant initial step toward standardizing the rate/price establishment process for managed care contracts. The Commission can continue to improve its contracting processes by collecting and reviewing subcontracts in accordance with prior State Auditor’s Office recommendations. Reviewing the rates that managed care organizations pay to their subcontractors will help ensure that the Commission’s managed care contracts are aligned with the cost of providing goods and services.

Table 4

Status of the Commission’s Implementation of Prior Audit Recommendations Related to Rate/Price Establishment			
State Auditor’s Office Report	Recommendation	Implementation Status	Auditor Comments
<i>An Audit Report on the Health and Human Services Commission’s Administration of the CHIP Exclusive Provider Organization Contract</i> (SAO Report No. 04-042, July 2004)	The Commission should, when negotiating administrative fees with contractors, compare administrative fee rates to market prices, including the rates charged by subcontractors and affiliates.	Fully Implemented	The Commission revised its rate-setting process, which now includes the explicit assignment of administrative fees. This compensates for benchmarking of negotiated administrative fees that the Commission paid to managed care contractors under the previous process.

Status of the Commission's Implementation of Prior Audit Recommendations Related to Rate/Price Establishment			
State Auditor's Office Report	Recommendation	Implementation Status	Auditor Comments
	The Commission should independently verify the rates contractors report they pay their subcontractors and affiliates.	Not Implemented	The Commission does not review the reasonableness of rates that managed care organizations pay to their subcontractors or affiliates.
	The Commission should ensure that all subcontractors receiving CHIP funds provide necessary, measurable products or services in exchange for the funds they receive.	Not Implemented	The Commission does not review managed care organizations' subcontracts to ensure that their products or services are necessary.
<i>An Audit Report on the Health and Human Services Commission's Monitoring of Managed Care Contracts</i> (SAO Report No. 04-011, November 2003)	The Commission should verify the accuracy of CHIP managed care organization payment rates against executed contracts and amendments.	Fully Implemented	The Commission paid its managed care contractors for services provided in August 2004 in accordance with the contract rates in effect at that time.

Recommendations

The Commission should:

- Review all managed care organizations' agreements with subcontractors and affiliates for the following:
 - ♦ Necessity of products and services
 - ♦ Ability to measure products and services
- Develop a definition for subcontractors and affiliates in order to determine when written agreements between managed care organizations and these subcontractors and affiliates are necessary. If any situations arise outside of those definitions, the Commission should document its rationale for not requiring a written agreement.

Chapter 1-D

Implementation Status of Recommendations Related to Contract Formation

The Commission has not fully implemented prior State Auditor's Office recommendations that could help it form contracts containing provisions to hold managed care contractors accountable for their performance (see Table 5). The Commission has begun acting to implement all but one of the prior recommendations related to contract formation, but it has not integrated those actions into its formal contracting process, procedures, and systems.

The Commission has substantially implemented recommendations to (1) discontinue the use of retroactive amendments and (2) rebid procurements

when a potential amendment would extend the scope of the contractors' original obligations for the service. However, because the Commission's efforts to implement other recommendations related to contract formation remain incomplete or ongoing and other recommendations have not been implemented, the Commission does not have a standardized approach to forming its contracts. As a result, the Commission is not able to consistently ensure that its contracts have been adequately reviewed and include terms that hold managed care organizations accountable for their performance.

Table 5

Status of the Commission's Implementation of Prior Audit Recommendations Related to Contract Formation			
State Auditor's Office Report	Recommendation	Implementation Status	Auditor Comments
<i>An Audit Report on the Health and Human Services Commission's Administration of the CHIP Exclusive Provider Organization Contract</i> (SAO Report No. 04-042, July 2004)	The Commission should base contracting decisions on professional advice or document its justification for not following professional advice when significantly altering the scope of contracts.	Incomplete/Ongoing	While the Commission has obtained professional advice in some instances, it has not developed any processes or procedures to ensure that it obtains professional advice when necessary or documents that professional advice is not needed.
	The Commission should establish effective performance penalties to provide adequate incentive for contractors to control costs and efficiently administer contracts.	Incomplete/Ongoing	The Commission has established performance penalties, but it has not maintained a standard process to impose penalties and assess any liquidated damages that may result from inadequate performance.
	The Commission should refrain from modifying existing agreements with contractors that extend beyond the scope of the contractors' original obligations without rebidding procurement for the service.	Substantially Implemented	The Commission has developed a contracting manual that clarifies when a contract should be rebid, extended, or amended. However, the Commission does not consistently follow this contracting manual.
	The Commission should prohibit staff and management from entering into informal contractual arrangements on behalf of the Commission and ensure that staff and management comply with all state contracting and procurement laws and regulations.	Not Implemented	The Commission issued a memo to its employees indicating that informal agreements with contractors are prohibited, but it has not started to implement any policies or additional controls to prevent staff and management from entering into informal contractual arrangements on behalf of the Commission.
	The Commission should ensure that the CHIP exclusive provider organization has written, executed contracts with all subcontractors and affiliates that fully comply with the exclusive provider organization's contract terms and applicable laws and regulations.	Incomplete/Ongoing	The Commission has not determined whether it will require its CHIP exclusive provider organization to provide its written agreements with affiliates.

Status of the Commission's Implementation of Prior Audit Recommendations Related to Contract Formation			
State Auditor's Office Report	Recommendation	Implementation Status	Auditor Comments
<i>An Audit Report on the Health and Human Services Commission's Monitoring of Managed Care Contracts</i> (SAO Report No. 04-011, November 2003)	The Commission should discontinue its practice of implementing changes to managed care organizations' contracts until negotiated agreements are executed.	Substantially Implemented	From August 1, 2004, through November 9, 2004, the Commission executed all but 2 of the 32 managed care contracts prior to the effective dates for those contracts.

Recommendations

The Commission should:

- Incorporate the following into its contract administration process:
 - ♦ Objective criteria for determining when it needs to obtain professional advice
 - ♦ Procedures for using professional advice
- Develop a process to impose performance penalties within a specified time after determining that managed care organizations are not compliant with performance requirements in their contracts. This process should include steps for imposing penalties and assessing liquidated damages.
- Develop and enforce a formal policy to prohibit staff from entering into informal contractual arrangements.
- Ensure that all contracts and contract amendments are processed entirely through its contract administration process prior to the effective date of each contract.

Chapter 1-E

Implementation Status of Recommendations Related to Contract Oversight

The Commission's Medicaid/CHIP Division has made significant progress toward implementing prior State Auditor's Office recommendations related to the oversight of managed care contracts (see Table 6). For example, this division conducted an assessment of its contract management processes that included (1) an organizational analysis that allowed it to separate its special projects from its contract monitoring function and (2) a business process analysis, which included the development of policies and procedures for monitoring managed care organizations with which the Commission contracts. However, the resulting contracting processes do not address the application of sanctions when managed care organizations' deliverables do not meet performance standards or are not submitted at all. Without a standardized

process for applying sanctions, the Commission may not be able to ensure that its performance penalties are appropriately applied when managed care organizations do not comply with the terms of their contracts.

The Commission also has made significant progress toward obtaining financial audits of its managed care organizations. The Commission has executed contracts with external auditors to conduct financial audits of its Medicaid and CHIP programs. The terms of these contracts address the issues identified in prior State Auditor’s Office reports followed up on during this audit.

The Commission is awaiting completion of the financial audit of Clarendon before pursuing (1) any of the \$835,793 overstatement in Clarendon’s March 13, 2003, invoice and (2) the \$750,000 to \$1,790,000 in overpayments that it made to Clarendon for reinsurance. However, the Commission did enter into an “interim agreement” with Clarendon that permits the Commission to retain an additional \$1,606,671 of Clarendon’s August 2004 premium payment subject to the completion of the financial audit. This “interim agreement” does not include resolution of any amounts that the Commission indicated it would recoup, but the \$1,606,671 retained by the Commission helps to offset interest on state and federal funds that may accrue from forgoing the recommended recoupments between August 31, 2004, and the time the recoupment occurs.

Table 6

Status of the Commission’s Implementation of Prior Audit Recommendations Related to Contract Oversight			
State Auditor’s Office Report	Recommendation	Implementation Status	Auditor Comments
<i>An Audit Report on the Health and Human Services Commission’s Administration of the CHIP Exclusive Provider Organization Contract</i> (SAO Report No. 04-042, July 2004)	The Commission should recoup [from Clarendon] any overpayments for medical claims or for prescription drugs that were made after May 1, 2001, when the State assumed responsibility for the cost of both of these items.	Substantially Implemented	The Commission has executed a contract with an external auditor that requires the external auditor to audit overpayments for prescription drugs.
	The Commission should, given the unique financial risks associated with the CHIP exclusive provider organization contract, independently audit subcontractors’ use of CHIP funds to ensure that it is fully aware of how all these funds are used.	Substantially Implemented	The Commission has executed a contract for a financial audit of Clarendon. According to this contract, the Commission’s contracted external auditor will trace payments from Clarendon to Clarendon’s subcontractors.
	The Commission should audit Clarendon’s use of premium payments it received after May 1, 2001, when the Commission began self-insuring the cost of medical claims. This audit should include verification of the dates of service for claims paid to verify that the Commission did	Substantially Implemented	The Commission has executed a contract for a financial audit of Clarendon. According to this contract, the audit of Clarendon will determine whether the Commission paid for claims for which Clarendon was financially responsible during

Status of the Commission's Implementation of Prior Audit Recommendations Related to Contract Oversight			
State Auditor's Office Report	Recommendation	Implementation Status	Auditor Comments
	not pay for claims for which Clarendon was financially responsible during the first contract period.		the first contract period.
	The Commission should recoup the \$835,793 overpayment it made to Clarendon based on the overstatements in Clarendon's March 13, 2003, invoice.	Incomplete/Ongoing	The Commission has not recouped the overpayment it made to Clarendon based on overstatements in Clarendon's March 13, 2003, invoice. Commission management decided to delay all recoupments until the Commission's financial audit of Clarendon is complete. However, it is important to note that the Commission has reached an agreement with Clarendon through which the Commission withheld \$1,606,671 of Clarendon's August 2004 premium payment subject to the completion of the financial audit.
	The Commission should recoup the approximate \$750,000 that Clarendon transferred from the CHIP accounts to its corporate accounts for reinsurance. The Commission should also attempt to collect the balance of the \$1,040,000 in unspent funds that Clarendon transferred from the CHIP accounts to its corporate accounts for reinsurance but did not spend.	Incomplete/Ongoing	The Commission has not recouped the overpayment it made to Clarendon for reinsurance. Commission management decided to delay all recoupments until the financial audit of Clarendon is complete. It is important to note that the Commission has reached an agreement with Clarendon through which it withheld \$1,606,671 of Clarendon's August 2004 premium payment subject to the completion of the above-mentioned audit. However, the Commission's agreement with Clarendon does not include resolution of any amounts that the Commission indicated it would recoup.
	The Commission should develop objective policies and procedures to monitor the financial terms and payments made on reinsurance contracts obtained by contractors. It should also promptly obtain copies of these reinsurance contracts.	Substantially Implemented	The Commission has developed a process to collect and analyze reinsurance funds paid to managed care organizations and has completed these analyses for the State of Texas Access Reform (STAR) Medicaid managed care program. However, the Commission has not completed these analyses for its STAR PLUS Medicaid managed care or CHIP programs.

Status of the Commission's Implementation of Prior Audit Recommendations Related to Contract Oversight			
State Auditor's Office Report	Recommendation	Implementation Status	Auditor Comments
<p><i>An Audit Report on the Health and Human Services Commission's Monitoring of Managed Care Contracts</i> (SAO Report No. 04-011, November 2003)</p>	<p>The Commission should obtain audits of Medicaid and CHIP managed care organizations to verify the accuracy of financial reports provided by the managed care organizations and to ensure compliance with key contract provisions.</p>	Substantially Implemented	<p>The Commission has executed a contract with an external auditor that requires the external auditor to conduct financial audits of managed care organizations. However, the external auditor has not completed those audits.</p>
	<p>The Commission should develop objective policies and procedures for health plan managers to use in analyzing and monitoring managed care organizations' financial and operational deliverables.</p>	Incomplete/Ongoing	<p>The Commission does not consistently sanction managed care organizations for inaccurate deliverables or failure to submit deliverables. In addition, the Commission has not implemented its procedures for its performance measure related to the managed care organization administrative cost ratio because it cannot determine an appropriate benchmark.</p>
	<p>The Commission should re-evaluate the activities and resources needed for adequate monitoring of managed care contracts. At a minimum, such an evaluation should consider:</p> <ul style="list-style-type: none"> ▪ Whether current activities could be eliminated by redesigning reporting requirements. ▪ Whether special projects assigned to health plan managers properly align with the contract monitoring function and whether these assignments duplicate other policy analysis functions within the Commission. ▪ Whether activities not currently performed (such as on-site inspections) should be re-established. 	Substantially Implemented	<p>The Commission has identified areas for redesign and has implemented changes to its information systems and contracting processes. Specifically, it has:</p> <ul style="list-style-type: none"> ▪ Developed an information system, the Deliverables Tracking System, to receive electronic deliverables from managed care organizations, store them in a central location, and notify staff of their receipt. However, this system does not determine the completeness or accuracy of the deliverables it receives. ▪ Moved special projects to a part of the organization that is separate from its contract monitoring function. ▪ Initiated the process of contracting for on-site inspections. However, it has not yet finalized this process.
	<p>The Commission should transfer the responsibility of calculating CHIP managed care organizations' payments from the CHIP enrollment broker to the Commission's financial services division.</p>	Fully Implemented	<p>The Commission's financial services division now calculates payments for CHIP managed care organizations based on rates from current contracts and amendments.</p>

Recommendations

The Commission should continue to:

- Ensure that it obtains financial audits of its managed care organizations in accordance with the terms of its contract to obtain these audits.
- Based on the results of the financial audits of managed care organizations, recoup any funds associated with overpayments of medical claims or prescription drugs.
- Implement a process for on-site monitoring inspections of managed care organizations.

The Commission Continues to Implement Its Standardized Contract Administration Process

The Commission implemented its standardized contract administration process in July 2004. This new process addressed several prior State Auditor's Office recommendations (see Chapter 1). However, for the 32 managed care contracts the Commission executed or amended between July 1, 2004, and November 9, 2004, it followed this entire process for only 1 contract amendment. The Commission processed the remaining contracts using its prior contracting processes or without following standardized processes.

The Commission has not ensured that its contract administration process includes two types of agreements.

Letter of Intent. The Commission's Medicaid/CHIP Division has implemented a process for executing letters of intent that does not follow the standardized documentation, review, and controls associated with the Commission's new contract administration process. The Medicaid/CHIP Division uses letters of intent when it must quickly create or modify contractual terms and does not have time to follow the Commission's contract administration process.

The Medicaid/CHIP Division has executed only one letter of intent since the Commission finalized its contract administration process in July 2004. Executed on October 3, 2004, the letter of intent specified that the Commission would pay \$400,000 to the vendor for implementation expenses if the Commission and the vendor did not execute a contract by November 1, 2004.¹ This letter of intent contained all elements of a contract, but it was not processed using the Commission's contract administration process. This is significant because, when the Commission executes agreements without using its standardized contract administration process, it cannot ensure that these agreements contain provisions to hold managed care organizations accountable for their performance.

"Interim Agreement." In addition, the Commission has executed an "interim agreement" that does not follow the standardized documentation, review, and controls associated with its new contract administration process (see Appendix 3 for the "interim agreement"). Specifically, in August 2004, the Commission entered into an "interim agreement" with a CHIP managed care organization, but the "interim agreement" did not go through any parts of its standardized contract administration process, including completion of (1) required documentation and (2) a formalized financial, program, and legal review. Without documentation and required reviews, there is a risk that the

¹ The Commission was negotiating with this vendor to provide disease management services. The Commission executed this contract on October 29, 2004; therefore it was not required to pay this vendor \$400,000.

agreement will not be legally enforceable and that the Commission will not be able to properly monitor the contractor's performance.

Under the "interim agreement," the Commission withheld \$1.6 million from a monthly payment to Clarendon, which served as the Commission's CHIP exclusive provider organization from May 1, 2000, through August 31, 2004. Commission management reviewed and approved the terms of this "interim agreement," which was used to withhold funds that were in question until the completion of a financial audit of Clarendon.

Recommendations

The Commission should:

- Ensure that it processes and executes all contractual agreements using its standardized contract administration process.
- Review its standardized contract administration process to ensure that this process addresses all types of agreements (including letters of intent, "interim agreements," and any other variations of a typical contract) that the Commission uses.

The Commission Has Initiated Large-Scale Projects to Comply with Statute and Prior Recommendations

To comply with statute and prior State Auditor's Office recommendations, the Commission has initiated the following large-scale projects:

- Development of a contracting policies and practices manual
- Procuring contracts to obtain financial and performance audits of managed care organizations
- Development of a contract administration tracking system and a deliverables tracking system

If successfully implemented, these projects will significantly increase the Commission's ability to manage contracts; however, they are not yet complete.

Chapter 3-A

The Commission Has Developed a Contracting Policies and Practices Manual, but That Manual Should Contain More Detail

The Commission has developed a contracting policies and practices manual in accordance with requirements of the Texas Government Code (see text

**The Texas Government Code
Requires the Commission
to Publish a
Contract Management Handbook**

Texas Government Code, Section 2155.144 (j), states that "the Health and Human Services Commission shall publish a contract management handbook that establishes consistent contracting policies and practices to be followed by health and human services agencies."

box), but that manual does not include details necessary to enable staff in all divisions to administer contracts. According to the Commission, the objective of the contracting manual is to establish standard contracting processes and procedures and to establish consistent methodologies, guidelines, and accountability for the Commission. In October 2003, the Commission assigned its Administrative Services Development Division responsibility for developing the manual. This division is responsible for overseeing contract management to ensure compliance with applicable statutes, rules, regulations,

policies, procedures, and contract terms and conditions.

The level of detail in the Commission's contracting manual is insufficient because the Administrative Services Development Division has not yet had the opportunity to document all the contracting processes that each of the Commission's divisions actually use. Therefore, some of the specific steps that a particular division may take in order to process a contract or amendment may not be included in the current manual.

For example, as previously discussed in Chapter 2, the Medicaid/CHIP Division has developed a process for letters of intent. However, that process has not been approved by the Administrative Services Development Division,

the Commission's authority for contract administration, and is not covered by the current contracting manual. (Letters of intent are short-term or emergency agreements that the Medicaid/CHIP Division uses in the place of an executed contract amendment.)

In addition, because the current contracting manual does not contain sufficient detail in the area of contract routing and amendment processes, the Medicaid/CHIP Division has developed separate and temporary processes and procedures for these areas. The Medicaid/CHIP Division did this in an attempt to achieve consistency among its contract specialists.

The Commission states that training on its contracting manual was provided in June 2004 and that it intends to provide additional training after January 2005. The Administrative Services Development Division intends to continue revising the contracting manual as it proceeds with documenting all the contracting processes that each of the Commission's divisions actually use.

Recommendations

The Commission should:

- Continue integrating the processes of all divisions into a single, standardized process that is documented in its contracting manual.
- Continue to train staff on the contracting manual and the associated processes.
- Cease using letters of intent until the Commission has decided to integrate that type of contract into its formalized contracting process and has developed the policies and procedures needed to control its use.

Chapter 3-B

The Commission Has Contracted to Obtain Financial and Performance Audits of Managed Care Organizations

As discussed in Chapter 1, the Commission has substantially completed the implementation of prior State Auditor's Office recommendations to obtain financial audits of managed care organizations. The Commission has contracted for those audits; however, the audits are not yet complete. Specifically:

- The firm with which the Commission contracted to obtain financial audits of Medicaid and CHIP managed care organizations for state fiscal years 2002 and 2003 is expected to complete those audits by July 15, 2005.
- The firm with which the Commission contracted to obtain performance audits of Medicaid and CHIP managed care organizations for state fiscal year 2005 is expected to complete those audits in fiscal year 2006.

The Commission will use the results of the financial audits to require managed care organizations to correct their financial reports, adjust experience rebate amounts, and pay any amounts due to the State.

In addition to obtaining financial audits of managed care contracts, the Commission has contracted with a firm to conduct performance audits at managed care organizations. Those audits will be based on a risk assessment conducted to identify (1) whether there is a need for additional on-site inspections and (2) the specific managed care organizations and contract provisions on which to focus during those inspections. The risk assessment must be completed every two years beginning in fiscal year 2006.

Recommendations

The Commission should:

- Continue to monitor the completion of financial and performance audits of managed care organizations to ensure that they are completed in accordance with contract terms and prior State Auditor's Office recommendations.
- Use the results of audits at managed care organizations to identify common errors in financial reports and develop controls to prevent future errors.
- Follow its plans to use audited financial deliverables to adjust experience rebate amounts and resolve any amounts that may be due to the State or managed care organization.

Chapter 3-C

The Commission Is Developing a Contract Administration and Tracking System and a Deliverables Tracking System

The Commission has not completed the creation of a central repository for contracting documents, and its Administrative Services Development Division is still in the process of obtaining all contracts from various divisions throughout the Commission. Although the central repository does not yet contain all contracts, the Administrative Services Development Division anticipates that it will locate and file all contracts in the central repository in about one year. Until that occurs, the Commission continues to risk being unaware of its contractual obligations, as well as those of its contractors.

To correct this issue over the long term, the Commission is developing a Contract Administration and Tracking System. This system is currently in the first phase of a two-phase implementation process and is currently online. Phase one, which covers entering all available contracts in the system, has a target completion date of February 1, 2005. Phase two, which does not have a target completion date (as of January 18, 2005), calls for the following:

- Collection and integration of subcontracts, including historically underutilized business (HUB) data
- Integration of contract deliverables
- Standardization of contract renewal options for (1) renewing under current contract terms, (2) renewing with adjusted contract terms, and (3) reprocurring contracts

In addition to developing a Contract Administration and Tracking System, the Commission also is developing a Deliverables Tracking System to collect deliverables from managed care organizations and store them in a specified location for use by plan managers. However, it is important to note that this system does not currently include controls on the timeliness, completeness, or accuracy of those deliverables. The Deliverables Tracking System does not perform any degree of review of the integrity of data or content of deliverables that it collects.

The Commission is currently working on the second phase of the development of the Deliverables Tracking System. The second phase will include developing a mechanism to inform Commission plan managers whether managed care organizations have submitted deliverables by the due date. Future additional enhancements to the Deliverables Tracking System include a searchable list of deliverables and a function to allow for review and reporting of the data submitted.

Recommendations

The Commission should:

- Ensure that its Contract Administration and Tracking System has complete information in the following categories:²
 - ♦ All contracts and amendments
 - ♦ All subcontracts
 - ♦ All contract deliverables
- Continue to implement the second phase of the Deliverables Tracking System to enable the system to inform plan managers whether managed care organizations have submitted deliverables by the due date.

² It is important to note that, at the time this audit, these were functionalities that were still planned for the Contract Administration and Tracking System. However, full implementation of prior State Auditor's Office recommendations cannot be determined until the Contract Administration and Tracking System has been fully implemented.

- Continue to implement the Deliverables Tracking System's searchable list of deliverables and a function to allow for review and reporting of the data submitted.

Appendices

Appendix 1

Objectives, Scope, and Methodology

Objectives

The objectives of this audit were to determine whether the Health and Human Services Commission (Commission) has made progress in correcting deficiencies in its contract management, as identified in the following recent State Auditor's Office reports:

- *An Audit Report on the Health and Human Services Commission's Administration of the CHIP Exclusive Provider Organization Contract* (SAO Report No. 04-042, July 2004). At the time auditors completed follow-up work, this report had been released for 6 months; 15 of 34 recommendations related to contract administration from that report were audited.
- *An Audit Report on the Health and Human Services Commission's Monitoring of Managed Care Contracts* (SAO Report No. 04-011, November 2003). At the time auditors completed follow-up work, this report had been released for 14 months; 8 of 26 recommendations related to contract administration from that report were audited.
- *An Audit Report on the Children's Health Insurance Program at the Health and Human Services Commission* (SAO Report No. 03-022, March 2003). At the time auditors completed follow-up work, this report had been released for 22 months; 2 of 4 recommendations related to contract administration from that report were audited.

Scope

The scope of this audit included reviewing the Commission's implementation of high-risk audit recommendations related to the administration of managed care contracts. These recommendations covered contract oversight, contract monitoring and amendment processes, and payments to its managed care contractors. Review of the Commission's contracting process covered contracts that the Commission executed or amended between July 1, 2004, and November 19, 2004. Review of the Commission's payments to its managed care contractors covered payments approved during August 2004. This audit did not include a comprehensive review of any information technology systems.

Methodology

The methodology consisted of identifying high-risk recommendations related to contract administration from prior State Auditor's Office audits and collecting information to determine the implementation status of those recommendations. Identification of high-risk recommendations was based on the following:

- The Commission's preliminary actions to implement prior recommendations
- Revisions to the Commission's scheduled implementation dates
- Inherent business, financial, or service risk

Audit information was collected by performing tests of selected contracting and payment documents, analyzing policies and procedures, and conducting interviews with Commission management and staff.

Information collected and reviewed included the following:

- Interviews with Commission's management, program management and staff, and fiscal and accounting services management and staff
- The Commission's Contracting Processes and Procedures Manual and related forms
- Medicaid/Children's Health Insurance Program (CHIP) Division policies and procedures for contract administration
- Contracts and amendments for the Commission's managed care contracts, selected subcontractors, and contracted auditors
- Managed care organizations' financial and operational deliverables
- Documentation and support for the Commission's payments to managed care organizations
- Deliverables from the Medicaid/CHIP Division's Transformation Project
- Planning documents for the Commission's Contract Administration and Tracking System
- Planning documents for the Medicaid/CHIP Division's Deliverables Tracking System
- The Commission's correspondence with managed care organizations and other contractors
- Commission reports, organizational charts, and interoffice memoranda

Procedures and tests conducted included the following:

- Review of rates the Commission paid its managed care contractors
- Review of contracts and amendments that the Commission executed
- Assessment of the Commission's contract administration practices and processes
- Limited review of the Commission's performance measures for its managed care contractors
- Limited review of the Medicaid/CHIP Division's Transformation Project and resulting processes

Criteria used included the following:

- Prior State Auditor's Office recommendations
- United States Code of Federal Regulations
- Texas Constitution
- Texas Statutes, including Government Code
- *State of Texas Contract Management Guide*, Version 1.1
- Commission policies and procedures

Other Information

We conducted fieldwork from August 2004 through December 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:

- Kels Farmer, CISA (Project Manager)
- Ray Ruiz, CFE (Assistant Project Manager)
- Joe Lawson, CPA
- Laura Mansfield, CPA
- Leslie Ashton, CPA (Quality Control Reviewer)
- Joanna B. Peavy, CPA (Audit Manager)

Management's Responses and Auditor Comments

Auditor Comments Regarding Management's Overall Responses

The Health and Human Services Commission (Commission) has repeatedly stated that it implemented a standardized contracting process on July 1, 2004. This follow-up audit was conducted to determine whether that process was being used. Audit work addressed the most recent information available with the intent of providing the most current and relevant information on the Commission's contract administration processes and practices. Audit work found that the Commission does not yet consistently use the contracting processes that it implemented in July 2004. Specifically, only 1 of the 32 managed care contracts or amendments that the Commission executed between July 1, 2004, and November 9, 2004, was processed entirely using the standardized contracting process that it implemented on July 1, 2004. The remaining contracts and amendments were completed using processes that the Commission replaced or without following a standardized process at all. The Commission's responses indicate that many of the procedures it implemented in July 2004 will not be completely integrated until June 2005.

The Commission also asserts that the expiration of its contract with its prior exclusive provider organization, along with the procurement of a replacement contract, has absolved it of the findings identified in the prior audit of that contract. However, this audit fully considered those circumstances. Each of the 15 prior recommendations from *An Audit Report on the Health and Human Services Commission's Administration of the Exclusive Provider Organization Contract* (SAO Report No. 04-042, July 2004) was selected based on the risk remaining after that contract had expired. Recommendations selected address the Commission's contracting processes and procedures that allowed for the problems identified in that report, including the following:

- Inability to verify financial and operational deliverables
- Inadequate support for contracting decisions
- Inadequate review of subcontractor rates and performance
- Inconsistent utilization of professional advice
- Prevention of informal contracts between staff and contractors

The Commission also asserts that this audit did not allow for adequate time to address the 15 prior recommendations from *An Audit Report on the Health and Human Services Commission's Administration of the Exclusive Provider Organization Contract* (SAO Report No. 04-042, July 2004). However, time is not a limiting factor for the majority of those 15 prior recommendations:

- Ten prior recommendations are administrative in nature, involving either (1) development or modification of the Commission's policies and procedures or (2) adequate documentation of the Commission's contracting decisions.
- Two prior recommendations are related to the Commission's failure to obtain audits of its health plans since September 2001. State Auditor's Office reports have repeatedly issued similar findings, dating back to March 2003.

Although Commission management has written a general response stating that it believes a majority of the incomplete/ongoing or not implemented findings have limited applicability to its current contract management, the responses to the specific findings demonstrate general agreement and plans to implement.

Management's Overall Responses

Health and Human Services Commission Management Response to the State Auditor's Office Follow-Up Audit Report on: Managed Care Contract Administration at the Health and Human Services Commission

While the State Auditor's Office identified prior audit recommendations and action plans that were incomplete or not implemented, HHSC believes that a majority of these findings have limited application to HHSC's current contract management structure and improvements in its ability to effectively manage contracts.

Nine of the 13 recommendations cited by the State Auditor's Office as not implemented or incomplete involved the Children's Health Insurance Program (CHIP) Exclusive Provider Organization (EPO) contract that was terminated on August 31, 2004. These nine recommendations were made by the State Auditor's Office just one month before the current follow-up audit began, and just six months before the State Auditor's Office concluded its follow-up field work. This left HHSC little time to fully implement recommendations.

The State Auditor's Office recently testified that the CHIP EPO contract was unique. Many of the recommendations related to that contract addressed circumstances that existed because of the unique nature of the terminated EPO contract. Those circumstances have now changed, and a competitive market condition led to the recent successful reprocurement of the EPO contract. A competitive market produces an inherent incentive for cost control and value not found in the original contract. HHSC has no other contract structures similar to the original CHIP EPO contract, and has neither the need for, nor the intent to enter into such agreements in the future.

It is important to note that two of the recommendations the State Auditor's Office identified as incomplete related to policy analysis and development related to HHSC's 2002 development of the CHIP drug rebates. These had no direct bearing on HHSC's contract management.

Additionally, two recommendations cited as not implemented or incomplete are pending the outcome of an external financial audit, currently underway, of the contractor before any HHSC and the Attorney General's Office recoupment action can be taken. The State Auditor's

Office cited a separate recommendation, also pending the outcome of the same external financial audit, as substantially implemented.

One issue is related to financial information and a deliverables tracking system that reflect HHSC's institution of processes and approaches that fundamentally alter and improve contract management under HHSC. The State Auditor's Office reported that these systems will "significantly increase the Commission's ability to manage contracts" if successfully implemented. The State Auditor's Office has termed these "large scale projects." As such, they take time for system development and implementation.

The recommendations identified as not implemented or incomplete generally relate to conditions that either no longer exist, are immaterial to HHSC's current operations, or do not pose significant ongoing risk to HHSC.

Furthermore, HHSC disagrees with the State Auditor's Office review methodology as used for an assessment of deficiencies in contract management and related risk. First, two of the three factors the State Auditor's Office used to select recommendations for review and to assess risk (the Commission's preliminary actions to implement prior recommendations, and revisions to scheduled implementation dates) do not address the importance of recommendations or associated action plans relative to essential business, financial, or service risks in contract management. These criteria make it more likely that the recommendations reviewed by the State Auditor's Office will be incomplete, but they have no inherent relevance for an assessment of actual risk related to HHSC's contract management. Second, the timeframe for the follow-up audit does not meet standards of reasonableness in regard to one of the audits included and from which the majority of incomplete or not implemented findings arise. The CHIP EPO recommendations were published only six months before the field work for this current audit was completed.

HHSC implemented or initiated actions targeted to address State Auditor's Office recommendations related to its most critical processes and activities; those addressing business, financial, and service delivery risks.

In its effort to quickly address issues related to its most critical processes, HHSC targeted significant resources to achieve improvements recommended by the State Auditor's Office in the areas of instituting a value/performance-based request for proposal and contract for managed care procurements, creating a central repository and organized process for maintaining contracts and amendments; initiating financial and performance audits, developing objective policies and procedures for contract monitoring, including financial monitoring, and assessing and

addressing activities, resources and skills needed for adequate monitoring of contracts.

HHSC continues to implement a strategy designed to achieve substantial improvements in its contract development and management infrastructure.

As the report indicates, HHSC has initiated large-scale projects that address prior State Auditor's Office recommendations. The State Auditor's Office report does not specifically note, however, that HHSC has taken action to institute processes and approaches that fundamentally alter and improve contract management within HHSC.

Due to the nature of some of the initiatives that are in progress, including those achieved through the managed care reprocurement, development and implementation of an electronic contract database for HHSC, development and implementation of automated web-based deliverables and financial statistical report submission and tracking systems, the full benefit of the changes will not be realized until well after initial implementation. Through these initiatives, HHSC is implementing an infrastructure and ongoing improvement process for sound contract management.

In addition, some tasks required to conclude HHSC's full implementation of a number of planned actions can be initiated only after the completion of substantial preliminary activities such as external independent financial and performance audits of managed care organizations, and value-based purchasing managed care procurement and development.

The State Auditor's Office categorized several long-term activities as partially implemented without adding the context necessary to recognize that progress, in most cases, was being made on schedule.

HHSC made fundamental structural improvements in its CHIP Exclusive Provider Organization and managed care contracts.

HHSC has instituted processes and approaches that strengthen and improve the fundamental structure of contract management within HHSC. These changes address the most critical components of contract oversight and management. Contract improvements include:

- *Deploying a new, competitively acquired full-risk CHIP EPO contract,*
- *Using the commercial industry standard "value or performance-based" purchasing approach to reprocure and contract for new managed care organization services-- holds managed care*

organizations to higher standards of accountability and performance,

- *Restructuring contracts to include more specific performance standards and measures, and identifying associated liquidated damages for failure to perform,*
- *Developing and implementing a web-based deliverables tracking system that will automatically create managed care organization “Performance Indicator Dashboards,” illustrating key aspects of managed care organization performance, such as access to care, quality of care, and claims payment,*
- *Using performance improvement goals to achieve continued improvement in selected areas such as immunization rates, or managing disease conditions,*
- *Using managed care organization performance profiling to identify and compare managed care organization performance across contractors and to HHSC standards and/or external benchmarks,*
- *Performance-based capitation, in which one percent of each managed care organization’s capitation rate will be retained and paid out only for meeting certain performance standards, and*
- *Utilization of HHSC’s uniform administrative contracting policies, procedures and processes.*

To better manage performance of managed care organizations, HHSC restructured and updated processes within the Medicaid/CHIP Division. This redesign includes:

- *A new management team with strong skills and qualifications,*
- *Recruiting staff with managed care, insurance, financial services and audit experience to assist in contract oversight, and hiring additional staff, including lead plan managers, financial managers, and analysts to help assure consistent, effective contract management practices are followed,*
- *Realignment of functions within the division, and*
- *Procurement of financial and performance audit contracts to assist with managed care organization oversight.*

Management's Responses to Individual Chapters

Chapter 1-A

SAO Recommendation: The Commission should continue to complete the development and implementation of its Financial Statistical Reports Automated System and Deliverables Tracking System to electronically determine the completeness and accuracy of contractors' financial and operational deliverables and compile these deliverables for reporting.

Management Response: The first phase of the Deliverables Tracking System is complete and became operational on July 1, 2004.

Action Planned: HHSC Information Technology (IT) staff will complete phase two of the Deliverables Tracking System, which will add a delinquency module that will notify the managed care organization, the health plan manager, and HHSC contract management staff when a report is not received on time.

IT staff will also complete its design and implement an automated centralized database to streamline submission of financial statistical reports and permit Medicaid/CHIP Division Health Plan Operations Finance staff to review the reports in an efficient and effective manner. The new system will produce standard and ad hoc queries for Health Plan Operations Finance staff.

Estimated Completion Date: April 2005

Title of Responsible Person: Director of Health Plan Operations

SAO Recommendation: The Commission should continue to develop and implement its Contract Administration and Tracking System in order to maintain contracts and other program-related documents.

Action Planned: HHSC will continue the development and implementation of its Health and Human Services Commission's Contract Administration and Tracking System (H-CATS) to maintain contract and other associated contract documents.

Estimated Completion Date: September 2005

Title of Responsible Person: Director of Administrative Services Development

Chapter 1-B

SAO Recommendation: *The Commission should consolidate its documentation concerning the cost, quality, and access to its programs in the form of a formal cost-benefit analysis to ensure standardization in its selection of its managed care contracts.*

Management Response: HHSC obtained the services of The Lewin Group, a nationally recognized management and accounting firm, to complete an actuarial assessment of the cost effectiveness of potential managed care models. HHSC used the results of that assessment as the basis for developing the framework for its managed care expansion proposal. HHSC demonstrated the cost effectiveness of its selected model with thorough and comprehensive cost-benefit analyses that were part of its applications for federal waivers. These waivers allow HHSC to provide Medicaid services through its managed care model. HHSC's waiver applications have been approved by the Centers for Medicare and Medicaid Services.

Action Planned: HHSC will develop a standardized process to ensure that the evaluations and analyses it performs to support its assessment of cost, quality, and access to its programs, and which it uses to select managed care contractors, are fully and consistently documented.

Estimated Completion Date: April 2005

Title of Responsible Person: Director of Health Plan Operations

SAO Recommendation: *The Commission should review the documentation it prepares on the cost, quality, and accessibility of the services of managed care organizations prior to the selection of all managed care organizations to ensure that all options are fully considered. If additional information is required to complete its cost-benefit analysis, the Commission should collect and document that information.*

Management Response: HHSC reviews and adequately evaluates applicable documentation prior to its selection of managed care providers. It has included these processes in its standardized process for selecting managed care contractors.

Estimated Completion Date: Completed

Chapter 1-C

SAO Recommendation: *The Commission should review all managed care organizations' agreements with subcontractors and affiliates for the following:*

- *Necessity of products and services*
- *Ability to measure products and services*

Management Response: HHSC disagrees with this recommendation. HHSC sets actuarially sound premium rates for contracted managed care plans based on Centers for Medicare and Medicaid Services regulations contained in 42 CFR 438.6(c). The rates are based on managed care plan financial and utilization data experience. Rates are intended to encompass all required covered services. Each managed care plan contracts with HHSC to deliver all required covered services within the paid rate. If they fail to deliver the required services, they are in breach of the contract. They can deliver some of the services through subcontracts. In terms of what the state pays, however, it is irrelevant whether a subcontractor or the prime contractor delivers the services. The amount paid by the state is exactly the same. Each managed care plan must make a business decision regarding use of subcontractors. Part of that business decision involves determining if the subcontractor's services are necessary to the contractor and if the price is reasonable. HHSC reviews the reasonableness of subcontractor services and prices during its initial review of subcontractor agreements, as part of its ongoing contract monitoring, and through procurement of external financial audits. Performance is measured during HHSC's general and on-going review of contractor deliverables.

Estimated Completion Date: Completed

SAO Recommendation: The Commission should develop a definition for subcontractors and affiliates in order to determine when written agreements between managed care organizations and these subcontractors and affiliates are necessary. If any situations arise outside of those definitions, HHSC should document its rationale for not requiring a written contract.

Management Response: HHSC established a policy for reviewing written subcontractor agreements of \$100,000 or more.

Action Planned: Expand the definition of subcontractors in the Uniform Managed Care Contract Terms and Conditions to include affiliates.

Estimated Completion Date: April 2005

Title of Responsible Person: Director of Health Plan Operations

Chapter 1-D

SAO Recommendation: The Commission should incorporate the following into its contract administration process:

- *Objective criteria for determining when it needs to obtain professional advice*
- *Procedures for using professional advice*

Management Response: When external resources are required to provide professional advice the requesting manager prepares an HHSC Action Memo and submits this memo to the Deputy or Executive Commissioner for approval. In the Action Memo the requesting manager outlines the rationale for requesting external professional assistance. Further, prior to obtaining funding for a consultant contract HHSC must submit a “finding of fact” to the Office of the Governor for approval. This “finding of fact” further establishes the justification for obtaining external professional advice. On the contract routing documents, staff are required to disclose whether or not any external professional advice was obtained and, if so, was the advice provided used or discarded. If staff did not incorporate the professional advice into the final product then an explanation must be submitted providing justification on the contract routing form.

Estimated Completion Date: Complete

State Auditor’s Office Follow-Up Comment

The Commission’s response to this recommendation addresses its process of obtaining a contract for professional advice after the decision to obtain that advice has been made. However, the Commission’s response does not address the condition that is the basis of this finding: that it does not have any processes or procedures to ensure that it (1) obtains professional advice when necessary or (2) documents that professional advice is not needed.

SAO Recommendation: The Commission should develop a process to impose performance penalties within a specified time after determining that managed care organizations are not compliant with performance requirements in their contracts. This process should include steps for imposing penalties and assessing liquidated damages.

Management Response: The new managed care organization contracts contain performance standards and measures with associated damages for failure to attain required performance measures. Further, the contracts incorporate a progressive remedies provision that allow for escalating penalties for non-performance.

Action Planned: HHSC will examine this issue and make a determination about whether to include detailed processes for addressing contractor performance issues in its contracting policy and procedures manual.

Estimated Completion Date: April 2005

Title of Responsible Person: Associate Director for Contract Compliance

SAO Recommendation: The Commission should develop and enforce a formal policy to prohibit staff from entering into informal contractual arrangements.

Management Response: The Associate Commissioner for Medicaid and CHIP sent an email to all Medicaid/CHIP Division staff in August 2004 advising that only the Executive Commissioner or Deputy Executive Commissioner are authorized to approve any change to contracts terms and conditions and that changes to contracts may only be completed through the contract amendment process and prior to the effective date of the amendment. Staff violations of the policy will be handled per Human Resources guidelines for policy violations, including progressive disciplinary action.

Action Planned: HHSC will establish a formal policy.

Estimated Completion Date: May 2005

Title of Responsible Person: Director of Administrative Services Development

SAO Recommendation: The Commission should ensure that all contracts and contract amendments are processed entirely through its contract administration process prior to the effective date of each contract.

Management Response: Effective with the implementation of HHSC standardized contract administration practices in July 2004, the majority of Medicaid/CHIP Division contracts have been processed through the standard process.

Action Planned: Management will monitor to ensure that all contracts subject to HHSC contracting procedures follow the required process.

Estimated Completion Date: April 2005

Title of Responsible Person: Associate Director for Contract Compliance

Chapter 1-E

SAO Recommendation: The Commission should continue to ensure that it obtains financial audits of its managed care organizations in accordance with the terms of its contract to obtain these audits.

Management Response: Financial audit contracts were awarded to an independent audit firm in September 2004. Contracted auditors completed state fiscal year 2000 through 2003 financial statistical report analyses, risk assessments, and audit plans by November 30, 2004.

Action Planned: Continue to monitor financial audit deliverables through weekly status meetings with auditors and ongoing email and telephone communications.

Estimated Completion Date: State fiscal year 2004 financial statistical report analyses, claims analyses, risk assessments, and audit plans are scheduled for completion by April 2005.

State fiscal year 2000 through 2003 audits are scheduled for completion by July 15, 2005.

State fiscal year 2004 audits and claims reviews are scheduled for completion by December 2005.

Title of Responsible Person: Associate Director for Contract Compliance

SAO Recommendation: The Commission should continue to, based on the results of the financial audits of managed care organizations, recoup any funds associated with overpayments of medical claims or prescription drugs.

Action Planned: HHSC will evaluate the results of the completed financial audits of managed care organizations, and recoup any funds associated with overpayments of medical claims or prescription drugs.

Estimated Completion Date: April 2006

Title of Responsible Person: Director of Health Plan Operations

SAO Recommendation: The Commission should continue to implement a process for on-site monitoring inspections of managed care organizations.

Management Response: HHSC awarded a performance audit contract to an independent audit firm on October 14, 2004.

Action Planned: HHSC's contracted independent audit firm will perform risk assessments of all Medicaid and CHIP managed care organizations every other year, beginning with state fiscal year 2006. The outcome of these risk assessments will determine the need for, and result in the completion of, on-site performance audits for managed care organizations identified as high risk

Estimated Completion Date: August 2006

Title of Responsible Person: Director of Health Plan Operations

Chapter 2

SAO Recommendation: *The Commission should ensure that it processes and executes all contractual agreements using its standardized contract administration process.*

Management Response: The August 2004 change to the Clarendon contract was completed as an administrative emergency to ensure the proper safeguarding of state funds. Based on the July 2004 State Auditor's Office report, An Audit Report on the Health and Human Services Commission's Administration of the CHIP Exclusive Provider Organization Contract, the State Auditor's Office indicated that HHSC issued approximately \$20 million in unnecessary or excessive payments to Clarendon National Insurance Company, the exclusive provider organization for the Children's Health Insurance Program. As a result of this report, HHSC took swift and immediate action to reduce payments to Clarendon in order to preserve state funds. While HHSC believes that strict adherence to contract administration processes is important, there must also be room to move quickly in an administrative emergency involving millions of dollars in state revenue.

Action Planned: Management will monitor to ensure that all contracts subject to HHSC contracting procedures follow the required process.

Estimated Completion Date: April 2005

Title of Responsible Person: Associate Director for Contract Compliance

SAO Recommendation: *The Commission should review its standardized contract administration process to ensure that this process addresses all types of agreements (including letters of intent, "interim agreements," and any other variations of a typical contract) that the Commission uses.*

Action Planned: Management will monitor to ensure that all contracts subject to HHSC contracting procedures follow the required process.

Estimated Completion Date: April 2005

Title of Responsible Person: Associate Director for Contract Compliance

Chapter 3-A

SAO Recommendation: *The Commission should continue integrating the processes of all divisions into a single, standardized process that is documented in its contracting manual.*

SAO Recommendation: *The Commission should continue to train staff on the contracting manual and the associated processes.*

SAO Recommendation: The Commission should cease using letters of intent until the Commission has decided to integrate that type of contract into its formalized contracting process and has developed the policies and procedures needed to control its use.

Action Planned: HHSC will continue to integrate the processes of all divisions into its HHSC Contracting Policy and Procedures Manual. A process is in place to provide quarterly training to contract management staff to ensure that all divisions effectively implement new procedures.

HHSC will integrate use of letters of intent into its formalized contracting process and develop policies and procedures to control their use.

Estimated Completion Date: June 2005

Title of Responsible Person: Director of Administrative Services Development

Chapter 3-B

SAO Recommendation: The Commission should continue to monitor the completion of financial and performance audits of managed care organizations to ensure that they are completed in accordance with contract terms and prior State Auditor's Office recommendations.

Management Response: A Contract Management Project Director monitors the progress of contracts by holding regularly scheduled status meetings and tracking the completion of contract deliverables. Additional contract monitoring information is recorded via informational contacts and emails. Medicaid/CHIP Health Plan Operations staff, HHSC Office of Inspector General, and HHSC Internal Audit participate in status meetings, tracking of deliverables, and evaluating deliverables.

Action Planned: Monitoring of the financial and performance audits will continue until the contracts are completed.

Estimated Completion Date: April 2006

Title of Responsible Person: Associate Director for Contract Compliance

SAO Recommendation: The Commission should use the results of audits at managed care organizations to identify common errors in financial reports and develop controls to prevent future errors.

Action Planned: HHSC will identify any common errors in financial reports that surface during the performance of managed care organization audits, and will develop mitigating management controls designed to reduce or prevent similar errors in the future.

Estimated Completion Date: August 2006

Title of Responsible Person: Director of Health Plan Operation

SAO Recommendation: The Commission should follow its plans to use audited financial deliverables to adjust experience rebate amounts and resolve any amounts that may be due to the State or managed care organization.

Management Response: HHSC developed and implemented policies and procedures that include provisions for adjusting experience rebate amounts based on the results of audited financial deliverables.

Action Planned: HHSC will follow its policies and procedures to ensure that appropriate adjustments to experience rebate amounts reflect information obtained from audited financial deliverables.

Estimated Completion Date: August 2006

Title of Responsible Person: Director of Health Plan Operations

Chapter 3-C

SAO Recommendation: The Commission should ensure that its Contract Administration and Tracking System has complete information in the following categories:

- *All contracts and amendments*
- *All subcontracts*
- *All contract deliverables*

Action Planned: HHSC will populate its Contract Administration and Tracking System with comprehensive data that includes contracts and amendments, subcontracts, and contract deliverables, in addition to many other elements useful in developing and managing contracts.

Estimated Completion Date: June 2006

Title of Responsible Person: Director of Administrative Services Development

SAO Recommendation: The Commission should continue to implement the second phase of the Deliverables Tracking System to enable the system to inform plan managers whether managed care organizations have submitted deliverables by the due date.

Action Planned: The second phase of the Deliverables Tracking System will add a delinquency module that will notify the managed care organization, the health plan manager, and the HHSC contract management staff when a report has not been received on time.

Estimated Completion Date: April 2005

Title of Responsible Person: Director of Health Plan Operation

SAO Recommendation: *The Commission should continue to implement the Deliverables Tracking System's searchable list of deliverables and a function to allow for review and reporting of the submitted data.*

Management Response: Each deliverable is uniquely identified by a naming convention specifying the plan, report, and period. If the deliverable is correctly identified and named, an email delivery notification is sent to the health plan manager and the contract manager. An email receipt is sent to the managed care organization. Once notified, the health plan manager notes the timeliness of the deliverable and retrieves it from the central server for review. If the deliverable is not correctly identified and named, an email "non-compliance" notification is sent to the managed care organization to request resubmission.

Action Planned: Health Plan Operations health plan managers and finance staff will review the deliverables and contact managed care organizations about any required adjustments or corrections to reported data.

Estimated Completion Date: April 2005

Title of Responsible Person: Director of Health Plan Operations

The Commission's "Interim Agreement"

Interim Agreement Regarding Payment of Medical Costs for the Children's Health Insurance Program ("CHIP") Exclusive Provider Organization ("EPO") Contract

1. The Texas Health and Human Services Commission ("HHSC") has determined that, based on the findings of the Texas State Auditor's Office in its audit report numbered 04-042 (July 2004), Clarendon National Insurance Company ("Clarendon") may have received certain sums relating to administrative expenses and fees and reinsurance costs under its contract numbered 529-00-078 ("the Contract") that are either excessive, undocumented, or otherwise unallowable ("the Disputed Fees").

2. Clarendon disputes the alleged overpayments and expressly does not waive claims under the Contract to invoiced administrative fees. Clarendon also represents that the medical claims fund maintained by Clarendon under the Contract is currently insufficient to cover the cost of estimated, incurred, and/or paid medical claims. However, in the interest of facilitating an efficient and economical disposition of the Disputed Fees and to ensure continuity of services, the Parties mutually agree that HHSC may withhold all payments other than payments to cover the cost of properly estimated, adjudicated and/or payable medical claims filed by enrolled and non-network providers under the Contract ("the Medical Premiums") pending the Parties' resolution of the Disputed Fees. The agreement of the Parties is represented by this Interim Agreement.

3. Accordingly, HHSC will pay Clarendon fees for properly estimated and/or incurred medical claims for the months of June, July, and August 2004 pursuant to the Contract ("the Total Medical Premiums") and invoiced, initially, on or about July 30, 2004, and subject to adjustment for supplemental claims.

4. In accordance with paragraph 3 above and subject to the conditions specified in this interim agreement, HHSC will pay Clarendon, on or around August 27, 2004, as follows:

	Enrollees	Total Premiums	— Administrative Fee ²	= Medical Premiums
CSA ¹ 12	11,677	\$ 800,844.71	- \$ 175,135.00	= \$ 625,689.71
CSA 13	33,644	\$2,314,058.64	- \$ 504,660.00	= \$1,809,398.64
CSA 14	14,119	\$ 974,348.78	- \$ 241,785.00	= \$ 762,563.78
CSA 15	36,941	\$2,536,429.39	- \$ 554,115.00	= \$1,982,314.39
Totals:	96,381	\$6,625,681.52	- \$1,445,715.00	= \$5,179,966.52
Supplemental Delivery Fees		+ \$ 3,000.00		+ \$ 3,000.00
Retroactive Adjustments		- \$ 448.69		- \$ 448.69
			Less Reinsurance Fees ³	- \$ 160,956.27
Total HHSC Payments		\$6,628,232.83	Total Medical Premiums	\$ 5,021,562.96

¹ "CSA" means "CHIP Service Delivery Area."
² Administrative Fee determined by multiplying number of enrollees by \$15.00.
³ Reinsurance Fees calculated at \$1.67 per member per month.

5. The Total Medical Premiums will not include funding for the administrative fees for Clarendon or any third party subcontractor to Clarendon or the cost of reinsurance to be obtained by Clarendon. Clarendon agrees to be responsible for any amounts due and owing to a third party subcontractor or reinsurer pending the resolution of the Disputed Fees.

6. Further, the Parties agree to the following:

a. Clarendon expressly waives any potential interest liability under the Prompt Payment Act regarding the ~~June~~ ^{July} 30, 2004 Clarendon invoice.

b. Clarendon expressly agrees to fully cooperate with the Office of the Attorney General in its review of the Contract and Disputed Fees and with HHSC in its conduct of an audit of Clarendon beginning as early as September 2004.

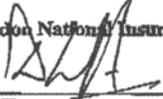
c. Clarendon is not prohibited from seeking payment or reimbursement for supplemental medical claims, provided the requests do not include claims for administrative fees, reinsurance, or other third party payments ("the Supplemental Medical Claims"). HHSC will promptly review such Supplemental Medical Claims and will not withhold payment on the basis of the Disputed Fees. Clarendon agrees to submit any documentation reasonably required by HHSC to support payment of the Supplemental Medical Claims.

d. The Parties will commit to an expeditious and equitable review of the facts and circumstances regarding the Disputed Fees, including an audit of Clarendon's books, records, and other documentation. The Parties also agree that, if such Disputed Fees are resolved and no amounts are found owing to HHSC, HHSC will promptly release all amounts withheld under this Interim Agreement (\$1,606,671.27) following resolution of the Disputed Fees.

7. The Parties agree this interim agreement does not in any way constitute a waiver by either Party to seek any and all remedies available to them, but is merely an interim agreement to avoid disruption in the delivery of services under the Contract and benefits to members enrolled in the CHIP EPO program.

8. The Parties agree that any dispute arising from the independent audit referred to in paragraph 6 of this Interim Agreement that cannot be resolved through the Parties' good faith negotiation will be referred to an impartial third party in accordance with a procedure authorized under Chapter 2009, Government Code, and Chapter 154, Civil Practices & Remedies Code, unless either Party determines that an alternative dispute resolution is not in its best interests, in which case the Party may seek appropriate relief allowed under law.

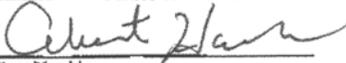
Clarendon National Insurance Company


Dominic Hagger
Senior Vice President

Date

August 26th 2004

Health & Human Services Commission


Albert Hawkins
Executive Commissioner

Date

8-27-04

Initials:

AA

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