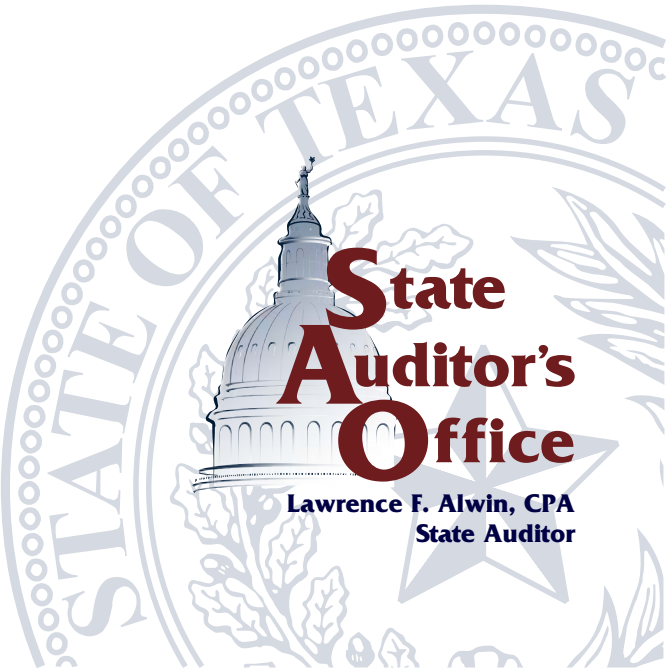
An Audit Report on

The Health and Human Services Commission's Monitoring of Managed Care Contracts

November 2003

Report No. 04-011



State Auditor's Office

Lawrence F. Alwin, CPA
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Overall Conclusion

The Health and Human Services Commission (Commission) does not adequately monitor and enforce its contracts with managed care organizations (MCO) that administer Medicaid managed care and the Children's Health Insurance Program (CHIP). The Commission did not critically assess the systems and controls used to oversee MCOs after Medicaid programs were transferred from the Department of Health to the Commission in September 2001, and it did not develop a comprehensive plan to integrate the oversight functions for Medicaid and CHIP MCOs. As a result, it has not effectively monitored or enforced key MCO contract provisions, and its contract management function lacks clear direction and focus.

Background Information

Managed care programs are considered a cost-effective way to provide quality health care services. The concept of managed care is based on (1) an MCO providing health care services to individuals for a specific payment rate per person and (2) the MCO accepting most, if not all, of the business and financial risk associated with providing health care services.

The Commission administers managed care programs through its contracts with 16 MCOs that participate in Medicaid and CHIP managed care.

MCO contracts for both Medicaid and CHIP exceeded $1.4 billion in fiscal year 2002.

Our audit identified more than $13 million in funds due to the State that the Commission was not actively attempting to collect or recoup from MCOs (this includes $10.2 million in CHIP experience rebates, $1.7 million in Medicaid experience rebates, and $1.5 million in improper audit fee payments). The following examples illustrate weaknesses in the Commission's monitoring of MCO contracts:

- The Commission did not ensure the timely collection of $21.6 million in experience rebates that MCOs owed the State under statutorily and contractually required profit-sharing provisions, including $10.2 million in experience rebates that the Commission did not collect from one CHIP MCO. Late payments of experience rebates resulted in lost interest earnings totaling $112,186. As of June 2003, an additional $1.7 million in Medicaid experience rebates remained uncollected. The Commission also agreed to reduce total experience rebates MCOs owed by $4.2 million without adequately verifying the underlying data supporting those reductions or monitoring MCOs' use of the rebate funds they were permitted to retain.

- The Commission has not audited or verified key financial and performance-related data that MCOs are required to provide and that is used to negotiate rates and calculate experience rebates. Audits of Medicaid MCOs previously conducted by the Department of Health identified significant concerns such as (1) $1.5 million in additional experience rebates that could be due to the State because of inaccurate financial reporting and (2) MCOs' failure to process claims in a timely manner. In addition, the Department of Health and the Commission paid $1.5 million in audit fees that the MCOs were contractually obligated to pay.

- The Commission did not adequately define key processes, roles and responsibilities, and policies and procedures for monitoring and amending MCOs' contracts. Delays in

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This audit was conducted in accordance with Texas Government Code, Sections 321.0131 and 321.0133.

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executing contract amendments have resulted in $3.5 million in overpayments to five MCOs since October 2002 (the Commission recouped the balance of these overpayments in September 2003).

- The Commission does not verify that correct capitation rates are used to calculate payments to CHIP MCOs. This resulted in the Commission overpaying one CHIP MCO by $3.7 million over a period of six months. (The Commission later recouped those funds.)

The issues in this report reflect the challenges that the Commission has faced in moving from an oversight and policy-setting role to direct operational responsibility for CHIP and Medicaid. The problems the Commission has experienced in transferring Medicaid programs and staff from the Department of Health should help in identifying potential high-risk areas associated with the upcoming consolidation of health and human service agency support and program functions under House Bill 2292 (78th Legislature, Regular Session).

We continue to audit the Commission's monitoring of the CHIP exclusive provider organization contract and subcontracts and plan to issue a separate report on the results of that work.

Key Points

The Commission has not effectively managed and integrated Medicaid and CHIP staff since the transfer of Medicaid programs to the Commission.

The Commission did not clearly define the roles and responsibilities of its health plan managers after Medicaid programs were transferred to the Commission, nor did it provide its health plan managers with updated policies and procedures to use in monitoring managed care contracts. In addition, the Commission's health plan managers spend as much as one-third of their time performing activities that could be automated or that are not directly related to contract monitoring.

There is confusion about whether certain MCO contract amendments have been executed, and the Commission lacks an effective records management system.

There is uncertainty about whether some MCO contract amendments were ever drafted or whether negotiated draft amendments were ever executed. In addition, the Commission has not designated an official custodian or created a central repository for its MCO contracts and other program-related documents. As a result, certain key program documents such as contracts, amendments, and program records are not readily accessible.

Summary of Management's Response and Auditor's Follow-up Comment

With one exception, the Commission generally agrees with our recommendations. The Commission's responses, which are presented in full in Appendix 2, demonstrate that Commission management has decided not to attempt to recoup the $1.5 million in funds improperly paid to MCOs to cover the cost of prior audits discussed in Chapter 1-B. However, the contract provisions themselves indicate the Commission could recoup those

funds. Its failure to review contract language after the transfer of Medicaid programs further illustrates weaknesses in the Commission's management of its contracts.

Summary of Objective, Scope, and Methodology

The primary objective of this audit was to assess the Commission's systems and controls for monitoring managed care contracts in connection with its Business Improvement Plan (required by Rider 18, page II-53, the General Appropriations Act, 77th Legislature).

Our scope included reviewing the Commission's monitoring of Medicaid and CHIP managed care contracts. The review included examining the Commission's contract oversight and monitoring processes, as well as selective examination of the payment/reimbursement and contract amendment processes. This audit did not include a review of information technology.

The audit methodology consisted of collecting information and documentation, performing selected tests and other procedures, analyzing and evaluating the results of tests, and conducting interviews with the Commission's management and staff.

Table of Results and Recommendations

The Commission has not ensured the timely collection of experience rebates and has reduced the amount of these rebates without proper verification and monitoring. (Page 1)

The Commission should:

- Assign appropriate staff to monitor and collect experience rebates according to the terms of MCOs' contracts.
- Amend its contracts with the MCOs to provide a mechanism for imposing financial penalties and/or collecting interest for late payment of experience rebates.
- Review legislative intent regarding experience rebates and ensure that experience rebate contract provisions align with that intent.
- Use audited information when making decisions that affect how experience rebates are calculated.
- Develop and use objective criteria to award rebate funding for PBIs that take into consideration (1) whether the PBI meets the needs of Medicaid and CHIP recipients, (2) what programs the PBI will fund, and (3) what amounts will be awarded for the PBI.
- Amend MCO contract provisions to include specific financial, performance, and reporting accountability requirements (as well as specific reporting formats) for PBIs. Alternatively, the Commission should consider developing separate contracts regarding the use of experience rebate funds for PBIs.
- Develop and use objective criteria to monitor the financial and operational performance of PBIs against contract terms.

The Commission has not obtained audits of Medicaid or CHIP MCOs. (Page 6)

The Commission should:

- Obtain audits of Medicaid and CHIP MCOs to verify the accuracy of financial reports provided by the MCOs and to ensure compliance with key contract provisions.
- Ensure that deficiencies identified in Medicaid MCO audits performed prior to September 1, 2001, are followed up on, corrected, and resolved.
- Develop and use risk-based criteria to select Medicaid and CHIP MCOs at which to conduct audits each fiscal year.
- Develop and implement a standardized process to ensure that MCOs correct audit findings and other identified deficiencies.
- Recoup from Medicaid MCOs the funds that the Department of Health and the Commission improperly paid to obtain audits.

The Commission has not effectively managed and integrated Medicaid and CHIP staff since the transfer of Medicaid programs to the Commission. (Page 8)

The Commission should:

- Develop objective policies and procedures for health plan managers to use in analyzing and monitoring MCOs' financial and operational deliverables.
- Develop and implement risk-based criteria and procedures for performing on-site inspections.
- Re-evaluate current deliverables that MCOs are required to provide to determine whether they meet the Commission's monitoring needs, and then develop a standardized template for MCOs to report data to the Commission in an electronic format that eliminates the need for staff to compile data in periodic status reports.
- Re-evaluate the activities and resources needed for adequate monitoring of managed care contracts. At a minimum, such an evaluation should consider:
  - 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 discussed in Chapter 1-C) should be re-established.
- Assess program staff competencies and provide any additional training needs identified.

Table of Results and Recommendations

The Commission does not execute MCO contract amendments in a timely manner and lacks adequate controls over these amendments. (Page 12)

The Commission should:

- Examine the causes for delays in executing contract amendments and implement changes to improve the timeliness of amendment negotiation and execution.
- Discontinue its practice of implementing changes to MCOs' contracts until negotiated agreements are executed.
- Standardize the process, roles, and responsibilities for formulating, executing, and maintaining MCO contracts and amendments. Additionally, ensure that staff, whose responsibilities are affected by changes in contract amendments, are informed of contract changes in a timely manner.
- Designate an appropriate staff member to be the process owner for the MCO contract amendment process.
- Inventory all MCO contracts and amendments to ensure that all contracts and amendments are in the Commission's possession.
- Ensure that contract amendments are developed in an organized and sequential order.

The Commission lacks an effective records management system for contracts and program-related documents. (Page 14)

The Commission should establish a central repository and an organized process for maintaining contracts and other program-related documents.

The Commission does not ensure that it pays CHIP MCOs in accordance with the capitation rates in their contracts. (Page 16)

The Commission should:

- Transfer the responsibility of calculating CHIP MCOs' payments from the CHIP enrollment broker to the Commission's financial services division.
- Verify the accuracy of CHIP MCO payment rates against executed contracts and amendments.

Recent SAO Work

Number	Product Name	Release Date
03-043	An Audit of National Heritage Insurance Company Accounts Receivable, Claim Counts, and Selected Trust Funds Related to Administering Medicaid Claims for the Health and Human Services Commission	July 2003
03-036	An Audit of the Administrative Expenses the National Heritage Insurance Company Charged to the Health and Human Services Commission in Fiscal Year 2002	June 2003
03-029	An Audit Report on the Health and Human Services Commission's Prescription Drug Rebate Program	April 2003
03-023	An Audit Report on the Department of Health's Implementation of a Business Improvement Plan	March 2003
03-022	An Audit Report on the Children's Health Insurance Program at the Health and Human Services Commission	March 2003
02-052	An Audit of Community Service Contracts at Selected Health and Human Service Agencies	June 2002

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Detailed Results

Chapter 1

The Commission's Contract Monitoring Processes Do Not Ensure that Managed Care Organizations Comply with Financial and Operational Requirements

The Health and Human Services Commission (Commission) has not ensured that the managed care organizations (MCO) with which it contracts for Medicaid managed care and the Children's Health Insurance Program (CHIP) comply with key financial and operational requirements. Specifically:

- The Commission did not actively monitor and collect $21.6 million in experience rebates in a timely manner, which resulted in approximately $112,186 in lost interest. It still has not collected an additional $1.7 million in rebates that MCOs owe. The Commission also reduced the experience rebates some MCOs owed by approximately $2.2 million without verifying the data on which the reductions were calculated. In addition, the Commission allowed one MCO to retain $2 million of the experience rebate it owed to fund additional services, but the Commission did not monitor to ensure that the funds were used as intended.

- The Commission has not obtained audits of Medicaid MCOs since Medicaid programs were transferred to the Commission from the Department of Health in September 2001. It has not audited CHIP MCOs since CHIP's inception in May 2000.

- The Commission has not effectively managed and integrated Medicaid and CHIP staff since the transfer of Medicaid programs to the commission.

Chapter 1-A

The Commission Has Not Ensured the Timely Collection of Experience Rebates and Has Reduced the Amount of These Rebates Without Proper Verification and Monitoring

The Commission has not actively monitored and collected experience rebates from MCOs, and it has reduced the amount of experience rebates that some MCOs owe.

The Commission did not monitor and collect $21.6 million in experience rebates in a timely manner; it still has not collected $1.7 million in experience rebates that MCOs owe.

As Table 1 shows, the Commission did not actively monitor and collect in a timely manner more than $21.6 million in experience rebates that Medicaid and CHIP MCOs owed for contracts ending in fiscal years 2001 and 2002. In addition to not having these funds available for Medicaid services and reappropriation, lost interest earnings on those funds totaled approximately $112,186. It is also important to note that the Commission did not collect $13.1 million of the $21.6 million in rebates until

after we brought this matter to its attention (this includes $10.2 million from a single CHIP MCO). In addition, after our discussions with Commission staff, the Commission identified $298,040 in rebates that MCOs had paid but that were unaccounted for because the Commission's financial services division had received the rebates and placed them in a suspense account. These rebate payments were in the suspense account for approximately four months before Commission program staff learned about them.

With the exception of one CHIP MCO's contract, all Medicaid and CHIP MCO contracts require the MCOs to pay experience rebates when they file their annual financial statistical reports with the Commission. However, none of the MCOs paid their experience rebates on the required date.

What Are Experience Rebates?

Texas Government Code, Section 533.014, requires the Commission to adopt rules that ensure that MCOs share profits they earn through the Medicaid managed care program. The Commission has incorporated profit-sharing provisions into its contracts with MCOs that require MCOs to pay the Commission experience rebates based on their profit levels.

The Commission's rules for Medicaid experience rebates are set forth in Texas Administrative Code, Title 1, Section 353.3, which establishes a graduated profit-sharing methodology for Medicaid MCOs. Although experience rebates for CHIP MCOs are not statutorily required, the Commission's CHIP contracts also contain experience rebate provisions.

Because Medicaid and CHIP are joint state and federal programs, Medicaid and CHIP experience rebates are subject to state/federal cost-sharing principles. Rider 57, page II-62, the General Appropriations Act (77th Legislature), requires that the State's share of Medicaid experience rebates be spent to fund Medicaid services. The Commission returns the State's portion of the CHIP experience rebates to the State's unappropriated General Revenue fund.

Table 1 - The Commission did not collect $21,615,047 in experience rebates in a timely manner, resulting in approximately $112,186 in lost interest.

Rebates Not Collected in a Timely Manner and Associated Lost Interest

Program	Service Area (County)	MCO	Rebate Amount	Rebate Due Date	Date Commission Deposited Rebate	Days of Lost Interest	Amount of Lost Interest
CHIP	Houston	MCO 1	$ 419,498	8/28/2001	5/7/2002	249	$ 6,838
Medicaid	Harris	MCO 1	1,316,405	8/31/2002	4/16/2003	226	12,535
CHIP	Statewide	MCO 2	10,261,418	9/30/2002	4/2/2003	182	76,763
Medicaid	Dallas	MCO 1	1,579,399	12/29/2002	4/1/2003	92	5,417
CHIP	Houston	MCO 1	1,515,148	8/28/2002	10/22/2002	54	4,193
CHIP	Dallas	MCO 1	39,663	8/28/2002	10/22/2002	54	110
Medicaid	Harris	MCO 3	587,029	12/29/2001	2/8/2002	39	1,281
Medicaid	Bexar	MCO 4	185,740	8/31/2002	10/7/2002	37	353
Medicaid	Dallas	MCO 1	112,300	8/31/2002	9/27/2002	27	155
Medicaid	Bexar	MCO 4	1,395,795	12/29/2001	1/18/2002	19	1,548
Medicaid	Lubbock	MCO 5	273,251	12/29/2001	1/11/2002	12	195
Medicaid	Harris	MCO 1	3,929,401	12/29/2001	1/10/2002	11	2,798
		Total Rebates	**$ 21,615,047**			**Total Lost Interest**	**$ 112,186**

Source: State Auditor's Office analysis

In addition, as of June 30, 2003, the Commission still had not collected an additional $1.7 million in rebates that MCOs owed for both the 2000–2001 and 2002 contract periods. As Table 2 shows, the lost interest on that amount was $15,313 as of June 30, 2003.

Table 2 - The Commission has not yet collected $1,712,255 in experience rebates that MCOs owe; as of June 30, 2003, the lost interest on that amount was approximately $15,313.

Rebates Not Yet Collected and Associated Lost Interest						
Program	Service Area (County)	MCO	Rebate Amount	Rebate Due Date	Days of Lost Interest (as of June 30, 2003)	Amount of Lost Interest (as of June 30, 2003)
Medicaid	Harris	MCO 6	$ 625,005	8/31/2002	300	$ 7,513
Medicaid	Lubbock	MCO 5	142,329	8/31/2002	300	1,711
Medicaid	Bexar	MCO 4	555,813	12/29/2002	181	3,582
Medicaid	Harris	MCO 7	389,108	12/29/2002	181	2,507
		Total Rebates	**$ 1,712,255**		**Total Lost Interest**	**$ 15,313**

Source: State Auditor's Office analysis

Commission management did not clearly assign staff responsibility for monitoring and collecting experience rebates. (The lack of clarity in staff roles and responsibilities is discussed in greater detail in Chapter 1-C.) Furthermore, executive management granted two MCOs extensions in making their rebate payments. Specifically:

- One MCO received an extension because it was negotiating with the Commission to retain its experience rebate to fund additional services under a population-based initiative.

- Another MCO received an extension for the 2000–2001 contract period to allow it to settle litigation regarding unpaid claims. This MCO received a second extension for the 2002 contract period because the Commission was considering (1) changing the 2002 experience rebate payment cycle to cover two years and (2) allowing the MCO to use its experience rebate to expand into other service areas. The Commission subsequently rescinded both of the extensions it granted this MCO and determined that the MCO should pay experience rebates in accordance with the terms of its contract.

The Commission reduced the experience rebates some MCOs owed by approximately $2.2 million without verifying the data supporting this reduction.

An amendment to the Commission's contracts with Medicaid and CHIP MCOs reduced the amount of fiscal year 2002 experience rebates some MCOs owed by approximately $2.2 million. The amendment, which was effective November 1, 2002, allowed MCOs to offset the experience rebates they owed (because they had made a profit in one service area) with the losses they experienced in another service

area.[1] The Commission did not verify the accuracy of the MCOs' financial reports to substantiate their assertions about their profits and losses. (As Chapter 1-B discusses in further detail, the Commission has not audited Medicaid MCOs since the transfer of Medicaid programs to the Commission in 2001 and has not audited CHIP MCOs since the program's May 2000 inception.)

The Commission asserted that it executed this amendment to help MCOs that were experiencing financial difficulties. However, as it was constructed, the amendment to reduce rebate amounts ultimately benefited only those MCOs that realized a profit in at least one service area; MCOs that experienced losses in all service areas or operated in only a single service area were unable to benefit from this amendment.

The Commission allowed one Medicaid MCO to retain $2 million in experience rebate funds for a population-based initiative, but it did not monitor to ensure that those funds were used as intended.

The Commission approved one Medicaid MCO's proposal to use $2 million in experience rebates it owed to the State to fund a population-based initiative (PBI) (see text box for additional details on PBIs). However, the Commission did not adequately monitor or establish reporting requirements for this PBI to ensure that the funds were used as intended. The PBI was established to fund previously existing preventive health programs such as smoking cessation and diabetes awareness. At the time the Commission approved this PBI, it was operating under a Medicaid cost containment rider in the General Appropriations Act (77th Legislature) that required it to save $174.1 million in General Revenue during fiscal years 2002 and 2003.

Population-Based Initiatives

The Medicaid and CHIP contracts define population-based initiatives (PBI) as Commission-approved projects or programs that (1) are designed to improve some aspect of quality of care, quality of life, or health care knowledge of Medicaid or CHIP participants (and/or their adult caretakers) and (2) may also benefit the community as a whole.

The Commission did not require this MCO to enter into a separate contract for the PBI. Although the Commission asserts that its primary contract with this MCO adequately addressed PBIs, that contract did not contain reporting or monitoring requirements for PBIs. In addition:

- While the Commission's June 2002 letter approving the PBI listed general categories for reporting regarding the PBI, it did not provide a template for specifically reporting on the use of the $2 million. For example, although the letter required the MCO to provide a project budget, it did not require the MCO to report expenditures related to the PBI.

- While the Commission's approval letter for the PBI required an evaluation of the effectiveness of the PBI program, the Commission did not specify whether the MCO was required to identify the number of Medicaid clients served or the outcomes for Medicaid clients from the PBI.

[1] Another provision, which became effective as of fiscal year 2003, allows MCOs that operate both Medicaid and CHIP plans to reduce the amount of the experience rebates they owe by offsetting profits from one program with losses experienced in another program.

- The MCO coordinated with a local hospital district to provide the PBI services, but the Commission did not require the MCO to have a written agreement with the hospital district specifying allowable expenditures or reporting requirements.

The Commission required the MCO to pay to the Commission $300,000 of the $2 million approved for the PBI. The Commission planned to hold that amount and return it to the MCO after the MCO provided the final reports required in its PBI approval letter. As of July 2003, the Commission reported that it had not returned the $300,000 to the MCO because the Commission made a preliminary determination that the MCO had not provided adequate oversight of the PBI.

Recommendations

The Commission should:

- Assign appropriate staff to monitor and collect experience rebates according to the terms of MCOs' contracts.

- Amend its contracts with the MCOs to provide a mechanism for imposing financial penalties and/or collecting interest for late payment of experience rebates.

- Review legislative intent regarding experience rebates and ensure that experience rebate contract provisions align with that intent.

- Use audited information when making decisions that affect how experience rebates are calculated.

- Develop and use objective criteria to award rebate funding for PBIs that take into consideration (1) whether the PBI meets the needs of Medicaid and CHIP recipients, (2) what programs the PBI will fund, and (3) what amounts will be awarded for the PBI.

- Amend MCO contract provisions to include specific financial, performance, and reporting accountability requirements (as well as specific reporting formats) for PBIs. Alternatively, the Commission should consider developing separate contracts regarding the use of experience rebate funds for PBIs.

- Develop and use objective criteria to monitor the financial and operational performance of PBIs against contract terms.

Chapter 1-B

The Commission Has Not Obtained Audits of Medicaid or CHIP MCOs

Audits of MCOs that were conducted before Medicaid programs were transferred to the Commission identified significant concerns.[2] For example, those audits identified MCOs that were underreporting experience rebates they owed, processing provider payments in an untimely manner, and submitting financial deliverables late. Despite having this evidence, the Commission has not audited or contracted to obtain audits of Medicaid MCOs since Medicaid programs were transferred to the Commission from the Department of Health in September 2001. The Commission also has not audited or contracted to obtain audits of CHIP MCOs since the inception of the program in May 2000.

The Commission Has Clear Authority to Audit MCOs

Medicaid MCOs' contracts with the Commission authorize the Commission to examine and audit MCO books and records relating to:

- Risk of potential financial losses.
- Services performed and determination of amounts payable.
- Fraud and abuse.
- Other purposes deemed necessary to perform regulatory functions and/or enforce contract provisions.

CHIP MCOs' contracts with the Commission specify that MCOs must make all books, records, and supporting documentation available for inspection, monitoring, auditing, or evaluation by the Commission or other state or federal oversight agencies.

Prior audits identified $1.5 million in additional experience rebates that Medicaid MCOs could owe the State, as well as MCOs' failure to process claims in a timely manner.

The results of prior audits demonstrate how audits help to hold MCOs accountable. For example, before Medicaid programs were transferred to the Commission in 2001, the Department of Health contracted to obtain audits at 14 Medicaid MCOs. Those audits found that six of those MCOs could owe an additional $1,568,555 in experience rebates to the State. This is because these six MCOs understated their net incomes for the period of September 1, 1999, through February 28, 2001.

In addition, Medicaid audits that the Department of Health contracted for in 1999 and 2000 indicated that the number of claims that MCOs did not process in a timely manner increased dramatically from one year to the next. This is significant because untimely processing of claims could result in late payments to providers and discourage providers from participating in the program.

The 1999 audits found that 8 percent of claims selected from a sample that covered 10 Medicaid MCOs had not been processed in a timely manner. In 2000, audits of six Medicaid MCOs (five of which were audited in 1999) found that approximately 32 percent of the sample claims had not been processed in a timely manner. The Commission reported to the Legislature that it would contract with an auditor to conduct a follow-up review of those MCOs to ensure that the claims processing issue was corrected and that the MCOs achieved compliance with contractual requirements regarding payment timeframes. However, the Commission never contracted with an external auditor to conduct a follow-up review.

[2] "Audit" is the term used by the Commission to describe contracted external auditors' prior engagements. However, these engagements were performed as agreed-upon procedure reviews and not as audits as defined by the American Institute of Certified Public Accountants.

The Importance of MCO Audits

Audits of MCOs can do the following:

- Verify data supporting experience rebates and help to ensure that the State receives all experience rebates to which it is entitled.
- Verify the accuracy of data that the Commission uses in the MCO rate-negotiation process.
- Help to ensure that MCO revenues and expenditures are reported according to contract terms.
- Examine the timeliness of MCOs' payments to health care providers and help to ensure that MCOs pay health care providers according to required time lines. Those time lines are as follows:
  - Medicaid MCOs must pay Medicaid claims in accordance with requirements in the *Texas Medicaid Managed Care Claims Manual*, which specifies that MCOs must pay or deny 90 percent of all complete and accurate claims received within 30 days.
  - CHIP MCOs must pay claims in accordance with the Texas Insurance Code, which specifies that complete and accurate claims must be paid at a minimum of 85 percent of the contracted rate within 45 days.

The only review of CHIP MCO claims processing the Commission has conducted identified significant deficiencies.

In 2001, Commission staff reviewed the claims processing function of one CHIP MCO because of ongoing concerns regarding claims processing noncompliance. From the error rates it derived from a statistical sample of transactions, the Commission estimated that the MCO had made overpayments to providers (during the first nine months of the program) ranging from $997,496 to $1,096,404 and underpayments to providers ranging from $145,647 to $161,188. The review also determined that the MCO's subcontractors were not trained adequately regarding state laws, regulations, and administrative rules for processing claims. When the Commission performed a desk review of claims for this MCO in 2002, it determined that the MCO still was not processing claims in accordance with its contract and state requirements.

The Department of Health and the Commission paid $1.5 million for audits for which MCOs were contractually obligated to pay.

The Commission reports that the Department of Health and the Commission paid a combined $1.5 million for audits of Medicaid MCOs conducted on financial data that covered the periods from 1996 through February 2001; however, MCOs' Medicaid contracts stipulate that the MCOs should pay for these audits.[3] CHIP MCOs' contracts are silent regarding which entity (the Commission or the MCO) should pay for audits.

Recommendations

The Commission should:

- Obtain audits of Medicaid and CHIP MCOs to verify the accuracy of financial reports provided by the MCOs and to ensure compliance with key contract provisions.
- Ensure that deficiencies identified in Medicaid MCO audits performed prior to September 1, 2001, are followed up on, corrected, and resolved.
- Develop and use risk-based criteria to select Medicaid and CHIP MCOs at which to conduct audits each fiscal year.

[3] MCOs are allowed to include the cost of these audits as an allowable expenditure when calculating experience rebates. However, because of the graduated profit-sharing methodology governing experience rebates, including such costs as allowable expenditures would not necessarily result in a dollar-for-dollar reduction in the amount of the experience rebate an MCO owes the State.

- Develop and implement a standardized process to ensure that MCOs correct audit findings and other identified deficiencies.

- Recoup from Medicaid MCOs the funds that the Department of Health and the Commission improperly paid to obtain audits.

Chapter 1-C

The Commission Has Not Effectively Managed and Integrated Medicaid and CHIP Staff Since the Transfer of Medicaid Programs to the Commission

The Commission did not critically evaluate its managed care contract monitoring processes, policies, and procedures after Medicaid programs were transferred to the Commission from the Department of Health in September 2001. Weaknesses in existing contract management practices, combined with problems arising from the transfer of Medicaid programs, resulted in gaps in critical monitoring functions and the continuation of procedures that do not add significant value to the contract monitoring function. The Commission's nine health plan managers have not received adequate guidance from management on how to monitor MCO contracts, and they spend as much as one-third of their time performing activities that could be largely automated or are not directly related to contract monitoring. As a result, the Commission is not making full use of resources available to monitor MCOs' compliance with their contracts.

The Commission did not clearly define the roles and responsibilities of its health plan managers after the transfer of Medicaid programs.

Commission health plan managers that we interviewed more than one year after the transfer of Medicaid programs were uncertain about the Commission's expectations regarding their contract monitoring responsibilities. In November 2002, program management indicated that staff had not been evaluated because expectations had not been clearly defined since the transfer of Medicaid programs to the Commission. The lack of specific direction from management regarding job responsibilities resulted in certain critical gaps in MCO contract monitoring. For example:

- The Commission did not clearly assign Commission staff responsibility for monitoring and collecting experience rebates from MCOs (those rebates are discussed in greater detail in Chapter 1-A). Although one staff member monitored Medicaid experience rebates, responsibility for ensuring that unpaid Medicaid experience rebates were actually collected was not clearly assigned to staff or monitored by management. The Commission did not assign staff responsibility for either monitoring or collecting CHIP experience rebates.

- The Commission did not monitor a $2 million population-based initiative (PBI) it awarded to one Medicaid MCO (see Chapter 1-A for greater detail on PBIs). The health plan manager assigned to this MCO did not clearly understand his role in monitoring the PBI, and program management did not provide any specific guidance on how to monitor it.

- Because it had not filled its claims auditor position, the Commission originally assigned responsibility for monitoring MCOs' claims processing to all the health

plan managers. However, most of the health plan managers lacked experience in reviewing claims data, and the Commission had no policies or procedures for how to review this data. (As discussed later in this chapter, the Commission subsequently filled its claims auditor position in September 2002.)

The Commission lacks objective policies and procedures for contract monitoring.

The Commission did not develop new contract monitoring policies and procedures after the transfer of Medicaid programs to the Commission. Although Commission health plan managers indicate that they use Department of Health Medicaid policies and procedures to monitor Medicaid and CHIP MCOs, the Department of Health's policies and procedures do not generally provide substantive or objective criteria to analyze and evaluate performance data that MCOs provide.

The Commission has not developed any monitoring tools specific to CHIP MCOs, nor has it developed policies and procedures to review Medicaid and CHIP MCOs' claims payment reports. In addition, the Commission has not developed a sanction policy with objective criteria specifying when it should invoke penalties for contract noncompliance.

Health plan managers have monitored MCOs based on their individual experience and knowledge of contract monitoring. Some health plan managers are experienced in only Medicaid contracts, others are experienced in only CHIP contracts, and some have limited contract monitoring experience. Nevertheless, all health plan managers are assigned to monitor both Medicaid and CHIP MCOs.

The lack of objective policies and procedures increases the risk that MCOs may not comply with their contracts. It also increases the risk that the Commission may not treat MCOs consistently if it identifies noncompliance.

The Commission discontinued on-site inspections of MCOs' daily operations after the Medicaid program was transferred to the Commission.

The Commission discontinued on-site inspections of daily Medicaid MCO operations after the Medicaid program was transferred to the Commission in September 2001. On-site inspections assist in ensuring the validity of MCOs' self-reported data about operational issues such as member complaints, provider networks, and prior authorization for services. For example, when the Department of Health conducted on-site inspections in the past, it found that one MCO reported it had no complaints because it had been erroneously classifying complaints as "client inquiries."

Although Commission management asserted that it viewed the on-site inspection procedures the Department of Health used as inadequate, the Commission did not attempt to improve these inspections. Instead, it elected to discontinue performing on-site inspections because of a perceived lack of value in the inspection procedures and a lack of funds for travel.

Health plan managers spend significant amounts of time performing activities that do not add value or are not directly related to contract monitoring.

Health plan managers consistently reported that they had difficulty completing their workload assignments. However, they devote as much as one-third of their time to activities that could be largely automated or that are not directly related to their primary function: contract monitoring. Moreover, these activities appear to have significantly displaced the health plan managers' primary function.

Health plan managers report spending as much as one-third of their time performing data entry of status report information and working on special projects. Status reports are compilations of data that MCOs report either monthly or quarterly (see text box for additional details). In compiling the status reports, health plan managers simply enter data that MCOs report in a variety of formats into a template. The Commission could avoid expending the resources to prepare these status reports if it required MCOs to report data using a standardized electronic reporting template.

Status Reports Prepared by Health Plan Managers

The status reports that health plan managers compile using MCOs' periodic status reports are intended to provide the Commission with summary information on performance trends and concerns regarding Medicaid and CHIP.

The status reports provide information on the following areas of MCO operations:

- Member enrollment
- Finances
- Network adequacy
- Complaints
- Spot audits that may have been performed
- Noncompliance notifications
- Other areas determined significant by program staff

Health plan managers also reported spending a significant amount of time performing special projects that management has assigned to them. Many of these projects are policy-oriented and appear unrelated or only peripherally related to contract monitoring.

Program management estimated that 20 percent of health plan managers' total time was devoted to special projects. In our interviews with them, health plan managers estimated that, on average, 37 percent of the projects on which they worked were special projects. While not precise, these estimates indicate that health plan managers spend a significant portion of their time on activities that are not directly related to contract monitoring.

The Commission's current job description for health plan managers resembles the job description for health plan managers that was used when Medicaid programs still resided at the Department of Health. However, unlike the Department of Health's job description, the Commission's job description has no estimates of the percentage of time health plan managers should devote to discrete blocks of activities. While both agencies' job descriptions include a category of "other duties as assigned," the Department of Health's job description limits that activity to a marginal 5 percent of total time; the Commission's job description does not specify a maximum percentage of time for that activity.

The Commission did not appoint a claims auditor until September 2002.

The Commission did not fill its claims auditor position until September 2002, two years after the position became vacant at the Department of Health and one year after Medicaid programs were transferred to the Commission. The claims auditor is responsible for monitoring MCOs' claims processing performance based upon their self-reported data. Before Medicaid programs were transferred to the Commission,

the claims auditor at the Department of Health was responsible for scheduling and coordinating the audits of claims processing conducted by external auditors. The claims auditor also had the following responsibilities:

- Develop and maintain claims processing procedures in the *Texas Medicaid Managed Care Manual*.
- Monitor and evaluate MCOs' claims processing compliance.
- Develop claims audit procedures and report audit findings.

The claims auditor position, originally located at the Department of Health before the transfer of Medicaid programs, had been vacant since September 2000. That position was still vacant when Medicaid programs transferred to the Commission in September 2001.

After the transfer, the Commission originally spread the claims auditor's responsibilities across all the health plan managers. However, it later identified a need to re-establish the claims auditor position in order to monitor and ensure claims processing compliance, and it subsequently filled the position in September 2002.

Recommendations

The Commission should:

- Develop objective policies and procedures for health plan managers to use in analyzing and monitoring MCOs' financial and operational deliverables.
- Develop and implement risk-based criteria and procedures for performing on-site inspections.
- Re-evaluate current deliverables that MCOs are required to provide to determine whether they meet the Commission's monitoring needs, and then develop a standardized template for MCOs to report data to the Commission in an electronic format that eliminates the need for staff to compile data in periodic status reports.
- Re-evaluate the activities and resources needed for adequate monitoring of managed care contracts. At a minimum, such an evaluation should consider:
  - 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 discussed in Chapter 1-C) should be re-established.
- Assess program staff competencies and provide any additional training needs identified.

Chapter 2

The Commission Lacks Adequate Processes and Controls for Amending MCO Contracts and Does Not Have an Effective Agency-wide Records Management Process

The Commission does not follow a standardized process or have adequate controls for formulating, executing, and maintaining amendments to its contracts with MCOs. Untimely execution of contract amendments has resulted in the need to make more than $4 million in adjustments to payments to MCOs since October 2002. In addition, procedural breakdowns between the Commission's program and legal departments have resulted in confusion about whether certain contract amendments were ever executed. These conditions create unnecessary work for staff in the departments that are affected and, in some cases, can create uncertainty regarding the State's financial obligations.

The Commission also lacks an effective agency-wide records management process. This has been compounded by both the transfer of Medicaid programs to the Commission from the Department of Health and by gaps and disconnects between the Commission's program divisions and its legal department. In a number of cases, the lack of a records management process has resulted in confusion about the location of contracts and program-related documents.

Chapter 2-A

The Commission Does Not Execute MCO Contract Amendments in a Timely Manner and Lacks Adequate Controls Over These Amendments

The Commission has not finalized a number of MCO contract amendments in a timely manner, including amendments that affect the capitation rates that determine the amount of MCOs' payments. Delays in executing contract amendments have resulted in the need to adjust payments to MCOs when executed contract amendments retroactively change capitation rates (and, therefore, MCO payment amounts). Since October 2002, the Commission has identified $3.5 million that it needs to recoup from five MCOs because of overpayments that resulted from retroactive changes to capitation rates. The Commission recouped the balance of this amount in September 2003. The Commission also had to refund $783,158 to five MCOs because it did not execute contract amendments that affected their payment terms in a timely manner.

The lack of adequate controls over contract amendments also has created confusion at the Commission regarding whether certain amendments were actually executed. Although the Commission's legal department has outlined a standard process for contract preparation, negotiation, and execution, it appears that this process is not consistently followed. The Commission does not consistently assign sequential numbers to its MCO contract amendments. The lack of sequential numbering, combined with delays in finalizing amendments and the lack of a central repository for contracts (as discussed in Chapter 2-B), creates uncertainty over whether some amendments were ever drafted or whether negotiated draft amendments were ever executed. For example, we requested all contract amendments for four CHIP MCOs.

The Commission was unable to verify whether 12 contract amendments had been drafted or executed based on the last known executed amendment and an expectation that prior amendments were sequentially numbered.

We identified the following control problems regarding certain CHIP MCO contract amendments:

- The Commission informed us that negotiations to remove a provision regarding the management of the CHIP drug benefit from one MCO's contract had stalled and, therefore, the amendment to implement this change was never signed. However, we contacted the MCO and obtained a copy of this amendment and found that it had, indeed, been signed by both parties and had been executed 17 months before the Commission informed us that the amendment had never been signed.

- Two months after our request to see the amendment to remove a provision regarding the management of the CHIP drug benefit from another MCO's contract, the Commission indicated that it was unable to locate that amendment. We later confirmed with the MCO that the amendment had not been executed; however, the Commission later incorporated this nonexistent amendment by reference in a subsequent amendment that reduced this MCO's capitation rate.

- The Commission had two versions of an amendment to provide supplemental payments to one MCO. Both versions were fully signed and executed between April and June 2002 by both the Commission and the MCO although the payment amounts, each in excess of $1.4 million, were different. The confusion about which amendment was correct was clarified in a subsequent amendment; however, that amendment was not signed until almost one year later.

The Commission's inability to verify whether certain contract amendments have been executed increases the risk of making incorrect payments to MCOs and creates uncertainty about the State's financial obligations. Deficiencies noted in the contract amendment process also have an impact on the records management function discussed in Chapter 2-B and the payment processing function discussed in Chapter 3.

The Commission has not clearly designated a staff person to be the process owner over the contract amendment process and to ensure that amendments to MCOs' contracts are fully executed and properly filed. The Commission's legal department indicates that program staff play a significant role in amending MCOs' contracts. However, the respective roles of program and legal department staff do not appear to be adequately defined or enforced.

Recommendations

The Commission should:

- Examine the causes for delays in executing contract amendments and implement changes to improve the timeliness of amendment negotiation and execution.
- Discontinue its practice of implementing changes to MCOs' contracts until negotiated agreements are executed.
- Standardize the process, roles, and responsibilities for formulating, executing, and maintaining MCO contracts and amendments. Additionally, ensure that staff, whose responsibilities are affected by changes in contract amendments, are informed of contract changes in a timely manner.
- Designate an appropriate staff member to be the process owner for the MCO contract amendment process.
- Inventory all MCO contracts and amendments to ensure that all contracts and amendments are in the Commission's possession.
- Ensure that contract amendments are developed in an organized and sequential order.

Chapter 2-B

The Commission Lacks an Effective Records Management System for Contracts and Program-Related Documents

As of July 11, 2003, the Commission had not designated an official custodian or created a central repository for its MCO contracts and other program-related documents. This, combined with inconsistent handling of contract amendments by program and legal departments (discussed in Chapter 2-A), has made it difficult for the Commission to locate executed contract amendments.

We identified a number of instances in which the Commission was unable to locate or had difficulty locating contract amendments and other program-related documents. Program staff took approximately three weeks to locate and provide the following amendments:

- 15 experience rebate amendments for Medicaid MCO contracts
- 13 amendments to transfer the management of the CHIP drug benefit from the MCOs to the Commission. In addition, the Commission was not able to verify whether 2 of the 13 CHIP MCOs had signed these amendments.

The Commission also had difficulty locating other program-related documents:

- Commission staff was able to provide copies of CHIP experience rebate deposits after spending approximately two weeks determining who managed the CHIP experience rebate financial records.

- The Commission had to contact its contracted actuary for a copy of the contract for actuarial services.

- The Commission spent approximately two weeks locating four external audit contract agreements. Program and legal staffs were uncertain where these records were stored following the transfer of Medicaid from the Department of Health.

- The Commission was unable to locate the fiscal year 2000 claims review records for a Medicaid MCO.

The lack of readily accessible contracts and program-related documents creates a barrier to effective monitoring of MCOs' contracts and hinders verification of the accuracy of capitation premium payments.

Recommendation

The Commission should establish a central repository and an organized process for maintaining contracts and other program-related documents.

Chapter 3

The Commission Does Not Ensure that It Pays CHIP MCOs in Accordance with the Capitation Rates in Their Contracts

The Commission does not verify that the capitation rates used to calculate payments to CHIP MCOs are the same as the capitation rates specified in the CHIP MCOs' contracts (see text box for details).

The Commission contracts with its CHIP enrollment broker to calculate CHIP MCO payment amounts. To do this, the enrollment broker uses capitation rates that the Commission's program development division provides. However, the Commission does not ensure that the enrollment broker has the most current capitation rates for calculating MCO payments. Specifically:

- The Commission's program development division staff do not verify that amendments altering capitation rates are formally executed before informing the enrollment broker of any changes to capitation rates.

- Although the Commission's financial services division reviews the payment amounts before it pays CHIP MCOs, it does this using a schedule of capitation rates provided by the Commission's contracted actuary. Although the actuary is involved in rate negotiations, the actuary is not formally notified when contracts and amendments affecting capitation rates are officially executed.

Capitation Rates and the Calculation of CHIP MCO Payments

- Each CHIP MCO's contract specifies capitation rates for five different age groups of children, which determine the amount of money that the MCO will receive per member per month.
- The Commission's enrollment broker collects enrollment data, which determines how many members the MCO serves each month.
- To calculate monthly payments to a CHIP MCO, the enrollment broker multiplies the number of members the MCO served during the month by a capitation rate that the Commission provides. However, neither the enrollment broker nor the Commission verifies that the capitation rate used in this calculation is the same as the capitation rate specified in the MCO's contract.

These gaps in the verification of payment amounts have resulted in the Commission making incorrect payments to CHIP MCOs. Examples of incorrect payments include the following:

- The Commission amended the capitation rate for a CHIP MCO effective March 2002. However, the reduction in the capitation rate was not promptly communicated to the enrollment broker. As a result, the Commission's financial services division continued to pay the MCO based on the old, higher capitation rate for six months. Although the Commission later recouped the $3,722,650 in overpayments it made, it incurred additional staff time to recoup the amount of the overpayments and lost approximately $9,198 in interest earnings it could have received on those funds.

- The Commission amended the capitation rate for another CHIP MCO in May 2003. However, the enrollment broker did not adjust its payment calculations to reflect that change until July 2003. This resulted in the June 2003 capitation payment's being over by approximately $263,855 and resulted in approximately $377 in lost interest earnings. The Commission recouped the overpayment in September 2003.

- Another CHIP MCO's capitation rate was reduced to reflect the removal of drug benefit administration from the premium. Payments were approved and made to

this MCO at this lower rate for 15 months before the rate change was formalized in an executed contract amendment.

It is also not apparent why the Commission contracts with its enrollment broker to calculate CHIP MCO payment amounts. The actual calculation of payment amounts due to the 14 CHIP MCOs is a procedure that could be automated easily and would simply require obtaining monthly enrollment numbers and the verification of periodic changes to capitation rates. This calculation is a process that more appropriately resides at the Commission than with an external party. It is important to note that the Commission calculates Medicaid MCO payments internally.

Recommendations

The Commission should:

- Transfer the responsibility of calculating CHIP MCOs' payments from the CHIP enrollment broker to the Commission's financial services division.

- Verify the accuracy of CHIP MCO payments against executed contracts and amendments.

Appendices

Appendix 1

Objective, Scope, and Methodology

Objective

Our objective was to assess the Health and Human Services Commission's (Commission) systems and controls for contract management of managed care programs in connection with the Commission's Business Improvement Plan. The Business Improvement Plan was required by Rider 18, page II-53, the General Appropriations Act (77th Legislature). Rider 18 also required the State Auditor's Office to monitor the implementation of the plan.

Scope

Our scope covered the Commission's administration of Medicaid and the Children's Health Insurance Program (CHIP) managed care contracts. For Medicaid managed care programs, the scope covered the period from September 2001 (when Medicaid programs were transferred from the Department of Health to the Commission) through August 2003. For CHIP, the scope covered the period from the inception of the program in May 2000 to August 2003. Our primary focus was on processes related to contract oversight and monitoring. Issues identified in oversight and monitoring processes led to selective work on payment/reimbursement processes and contract establishment processes with respect to the amendment of contracts. This audit did not include a review of information technology.

Methodology

The audit methodology consisted of collecting information and documentation, performing selected tests and other procedures, analyzing and evaluating the results of the tests, and conducting interviews with the Commission's management and staff.

Information collected included the following:

- Interviews with Commission executive management, program management and staff, and fiscal and accounting services management and staff
- Interviews with the Centers for Medicaid and Medicare Services (CMS)
- Interviews with Medicaid and CHIP managed care organizations
- The Commission's contract management policies and procedures for the managed care program
- The Commission's job descriptions for health plan managers
- Commission reports, interoffice memoranda, program reports, and accounting records

- Contract procurement documents
- Managed care contracts and amendments for Medicaid and CHIP
- External independent audit reports on Medicaid managed care organizations
- Newspaper articles and reports relating to the Commission and the managed care program
- Prior State Auditor's Office reports

Procedures and tests conducted included the following:

- Analysis of experience rebates owed, collected, and outstanding
- Review of prior claims and compliance audit findings in the Medicaid managed care program
- Limited review of selected Medicaid and CHIP readiness reviews performed by the Department of Health and the Commission
- Analysis of program staff contract management workload
- Limited review of select original contracts and respective contract amendments
- Assessment of program practices and processes

Analytical techniques used included the following:

- Reconciliation
- Data comparison
- Data completeness and standardization
- Process mapping

Criteria used included the following:

- Texas Statutes and Texas Administrative Code
- Social Security Act
- CMS State Medicaid Manual, Texas Medicaid 1915 (b) waiver, and the Texas CHIP state plan
- Texas Medicaid and CHIP contracts
- Commission policies and procedures
- State Auditor's Office methodology manual

Other Information

We conducted fieldwork from November 2002 through August 2003. This audit was conducted in accordance with generally accepted government auditing standards; there were no significant instances of noncompliance with these standards.

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

- John Young, MPAff (Project Manager)
- Kels Farmer
- Ricardo A. Garcia, MPAff
- Willie J. Hicks, MBA
- Michael Simon, MBA
- Leslie Ashton, CPA (Quality Control Reviewer)
- Joanna B. Peavy, CPA (Audit Manager)
- Frank Vito, CPA (Audit Director)

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

October 24, 2003

John Young
State Auditor's Office
1501 North Congress Avenue
Austin, Texas 78701

Dear Mr. Young:

Attached please find the Health and Human Services Commission's (HHSC) management response to the State Auditor's Office draft audit report on monitoring Managed Care contracts.

We appreciate the opportunity to review the draft, identify and resolve outstanding issues, and provide our response to SAO's draft findings.

I have designated Jason Cooke, Associate Commissioner for Medicaid and Chip, as the lead staff on this matter. Should you have questions or need additional information, you may contact Mr. Cooke by phone at 512-794-6838 or by email at Jason.cooke@hhsc.state.tx.us.

Sincerely,

Albert Hawkins

c: Jason Cooke, Associate Commissioner for Medicaid and CHIP
Charles Bell, Deputy Commissioner for Health Services
Maureen Milligan, Health Plan Operations Manager
David Griffith, HHSC

AH/DG/bw

/

P. O. Box 13247 • Austin, Texas 78711 • 4900 North Lamar, Fourth Floor, Austin, Texas 78751

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

The Health and Human Services Commission's Monitoring of Managed Care Contracts

The Health and Human Services Commission (HHSC) appreciates the time and care that the State Auditor's Office (SAO) has devoted to its audit of HHSC's monitoring of managed care contracts in Medicaid and the Children's Health Insurance Program (CHIP). SAO in its audit report has identified a number of significant management issues that HHSC will address through an aggressive series of far-reaching corrective initiatives.

To improve program management and build on improvements already implemented, the Medicaid/CHIP Division will carry out a Performance Improvement Plan. The foundation of the plan is a major restructuring of the Division which will focus on clarifying organizational and individual responsibilities, strengthening systems and processes, utilizing performance accountability measures, and improving efficiency. The reorganization will ensure that the Division has the right people with the right skills in the right places in the organization. Consistent with the reorganization, a new management structure will be developed to support the organization and its goals. Because management positions in the new organization will not exist as they do today, all of the current Department Director and Unit Manager positions will be vacated and filled through a competitive process.

The Performance Improvement Plan and restructuring will result in improved accountability and communication, particularly among the Medicaid/CHIP Division and HHSC Financial Services and Office of General Counsel. The process will be supported by a control/risk self-assessment program. The Division will use the program to periodically self-assess the level of those risks, evaluate whether the associated management control system is adequate to manage those risks, and on an on-going basis make the necessary adjustments or improvements in the control system as the environment changes.

In addition to these important improvements to critical business processes, HHSC is moving to structure the Division's current management team. This process began with the notification of all managers in the Division that their positions will be vacated effective November 30 and restructured with the new management positions being posted internal and external to the agency. The new management team in turn will be charged with completing the reorganization through a top-to-bottom detailed review and, as necessary, reengineering of all Division functions and the business processes that support them. The final phase of the reorganization will also assure that the Division's staff resources are appropriately allocated to functions based on risk.

To ensure the resolution of the specific issues identified in the audit report, HHSC has created a Managed Care Contract Monitoring Oversight Committee with a core membership that includes the Director of Medicaid/CHIP Program Operations, the HHSC Deputy CFO for Financial Services, the HHSC Director of Purchasing, the HHSC Director of Accounting Operations, and the Medicaid/CHIP Audit Director. The Oversight Committee has assumed the role of regularly

reviewing progress on the implementation of the action plans detailed in the management responses, reviewing proposed process improvements, and reviewing the impact and cost-effectiveness of implemented improvements. The Oversight Committee is charged with periodically reporting to the Associate Commissioner for Medicaid and CHIP and the Deputy Commissioner for Health Services on the performance of the managed care organization (MCO) contract monitoring function.

As the audit report notes, the deficiencies in the Medicaid/CHIP Division reflect the challenges that HHSC has faced in moving from an oversight and policy-setting role to the shouldering of operational responsibility for Medicaid and CHIP. With the enactment of HB 2292, 78th Regular Session, the evolution of HHSC will continually require us to assume broader operational responsibilities and, with those responsibilities, increase emphasis on accountability and results. Anticipating that progression, HHSC has performed an internal organizational capabilities assessment to identify risks and has charged a series of workgroups with implementing risk mitigation strategies. HHSC also is consolidating contracting functions and imposing greater discipline through commonly accepted management controls, including the development of a contract procedures manual by the Office of General Counsel and the centralization of purchasing and contract administration functions under seasoned managers.

The Commission's development of the administrative infrastructure of an operating agency is complemented by the creation of a Project Management Office (PMO). The management and organizational development expertise in the PMO not only will help guide the overall HHS system consolidation required by HB 2292, but its presence gives HHSC a critical asset in further solidifying the Commission's own management control structures.

HHSC welcomes the SAO's constructive recommendations in its audit report on the Medicaid/CHIP Division's contract monitoring practices and is taking decisive action to ensure that the Division's operations meet the highest standards of performance and accountability.

Chapter 1-A

SAO Recommendation: *Assign appropriate staff to monitor and collect experience rebates according to the terms of MCOs' contracts.*

Management Response: Early in the transition of MCO financial oversight from TDH to HHSC, the Commission identified the lack of appropriate skill sets in the staff assigned to and responsible for financial monitoring, management and oversight as a high-risk area for the agency. HHSC concludes that the root cause of a majority of issues identified by SAO that relate to financial monitoring, enforcement, compliance, collection, and audits is related to lack of appropriate staffing. HHSC began addressing this issue in the spring of 2002 through the reorganization of the MCO financial area at HHSC and the subsequent hiring of individuals with specific, technical managed care industry expertise in monitoring, analysis, audit, and enforcement. Of the new staff hired, a financial analyst has been assigned to monitor and collect experience rebates. HHSC's assessment is that there has been a marked improvement in

performance of financial contract management subsequent to this re-organization and hiring of highly qualified staff.

Action Planned: HHSC will continue to ensure that only well qualified individuals with applicable industry and technical experience are selected for any future vacancies. Additional hiring may result from the Division reorganization and functional assessment currently underway. To assure that monitoring and collection activities are performed as required, HHSC will institute quarterly management reports summarizing experience rebate monitoring and collection activity and will develop and implement related policies and procedures.

Estimated Completion Date: December 2003 for development of report formats and related policies and procedures.

Title of Responsible Person: Manager, Health Plan Operations

SAO Recommendation: *Amend its contracts with the MCOs to provide a mechanism for imposing financial penalties and/or collecting interest for late payment of experience rebates.*

Management Response: Agree.

Action Planned: HHSC plans to include provisions in MCO contract amendments that will allow it to impose penalties and/or interest for late payment of experience rebates.

Estimated Completion Date: February 2004

Title of Responsible Person: Manager, Health Plan Operations

SAO Recommendation: *Review legislative intent regarding experience rebates and ensure that experience rebate contract provisions align with that intent.*

Management Response: Agree.

Action Planned: HHSC will perform a thorough review of legislation related to experience rebates, confirm, through a review of bill analysis, the intent of the legislation, and confirm that the way HHSC calculates experience rebates, including the use of multi-market experience, is consistent with that legislative intent. Any required adjustments will be made though new contract provisions.

Estimated Completion Date: November 2003 - Analysis
February 2004 - Contract implementation

Title of Responsible Person: Manager, Health Plan Operations

SAO Recommendation: *Use audited information when making decisions that affect how experience rebates are calculated.*

Management Response: Agree.

Action Planned: HHSC will procure audit services to examine the financial information of 15 CHIP plans for contracts extending from May 2000 through August 2003 and 18 Medicaid plans for contracts in effect from September 1999 through August 2003 in order to verify the information used to calculate experience rebates. HHSC Medicaid/CHIP Division Audit will provide oversight of procured audit services. Based on the vendor's final reports, HHSC's Health Plan Operations will require MCO modifications to financial statistical reports (FSR) and will collect any experience rebate amounts owed to state, if applicable.

Estimated Completion Date: December 2003 - Award contract
August 2004 - Complete audits and collections if applicable

Title of Responsible Person: Associate Medicaid/CHIP Director for Division Audit

SAO Recommendation: *Develop and use objective criteria to award rebate funding for PBIs that take into consideration (1) whether the PBI meets the needs of Medicaid and CHIP recipients, (2) what programs the PBI will fund, and (3) what amounts will be awarded for the PBI.*

SAO Recommendation: *Amend MCO contract provisions to include specific financial, performance, and reporting accountability requirements (as well as specific reporting formats) for PBIs. Alternatively, the Commission should consider developing separate contracts regarding the use of experience rebate funds for PBIs.*

SAO Recommendation: *Develop and use objective criteria to monitor the financial and operational performance of PBIs against contract terms.*

Management Response: HHSC management has made a decision to disapprove any future Population Based Initiative (PBI) requests and intends not to include PBI provisions in future MCO contracts. In the event HHSC decides to approve PBIs in the future, it will include contract provisions that clearly detail requirements for performance expectations and financial accountability.

Action Plan: One Medicaid PBI is currently in effect. Medicaid/CHIP Division Audit staff will conduct a performance and financial audit of the Medicaid PBI to evaluate the efficiency and effectiveness of the program and to confirm the appropriateness of PBI expenses.

Estimated Completion Date: February 2004

Title of Responsible Person: Associate Medicaid/CHIP Director for Division Audit

Chapter 1 - B

SAO Recommendation: *Obtain audits of Medicaid and CHIP MCOs to verify the accuracy of financial reports provided by the MCOs and to ensure compliance with key contract provisions.*

Management Response: HHSC agrees that it should implement financial and performance assessments to verify information provided to HHSC and assure compliance with contract provisions.. HHSC currently has on its website a draft RFP for procurement of services to provide the required limited scope audits and assessment of MCO claims information submitted to HHSC.

Action Planned: HHSC will complete the procurement of services intended to verify the accuracy of the information contained in the MCO financial reports and related information such as claims. HHSC will procure services under an additional RFP that will also include performance related audits.

HHSC Medicaid/CHIP Division Audit will provide oversight of procured audit services. For financial information, Health Plan Operations will use the results, if applicable, to require the MCOs to correct their financial reports, adjust experience rebate amounts, and pay any amounts due to the state. For other performance audit areas, the Medicaid/CHIP Health Plan Operations will use the results to assess and enforce contract compliance provisions.

Estimated Completion Date: August 2004 for completion of financial audit activity.
May 2004 - Performance audit contract awarded and work initiated

Title of Responsible Person: Associate Medicaid/CHIP Director for Division Audit

SAO Recommendation: *Ensure that deficiencies identified in Medicaid MCO audits performed before September 1, 2001, are followed up on, corrected, and resolved.*

Management Response: Agree.

Action Planned: HHSC will evaluate the results of completed audits and take appropriate action to collect any amounts due to the state.

Estimated Completion Date: February 2004 - Finish assessment and collection related to any completed audits

Title of Responsible Person: Manager, Health Plan Operations

SAO Recommendation: *Develop and use risk-based criteria to select Medicaid and CHIP MCOs at which to conduct audits each fiscal year.*

Management Response: Agree.

Action Planned: HHSC will assure that it develops and uses risk-based criteria by including language in an RFP that will require the performance of an assessment using risk-based criteria to recommend which MCOs should be examined on an annual basis. The contractor will develop risk-based criteria subject to HHSC Medicaid/CHIP Division Audit and Health Plan Operations review and approval. Risk-based criteria will then be applied by the contractor to evaluate the relative risks of the MCOs. Medicaid/CHIP Division Audit will use the risk assessment results to select which MCOs and contract provisions will be audited by the contractor.

Estimated Completion Date: May 2004 - Performance audit contract awarded and work initiated. Audits under this contract will be performed at least through the next two years.

Title of Responsible Person: Associate Medicaid/CHIP Director for Division Audit

SAO Recommendation: *Develop and implement a standardized process to ensure that MCOs correct audit findings and other identified deficiencies.*

Management Response: Agree.

Action Planned: HHSC will develop and implement standardized policies and procedures it will follow to ensure that MCOs correct any deficiencies identified in the audits and make any subsequent corrections to their FSRs.

Estimated Completion Date: January 2004

Title of Responsible Person: Manager, Health Plan Operations

SAO Recommendation: *Recoup from Medicaid MCOs the funds that the Department of Health and the Commission improperly paid to obtain audits.*

Management Response: Current Medicaid MCO contract language states "HMO is responsible for paying the costs of an audit conducted under this Article." When this language was initially included in the contract, there was also a requirement for MCOs to submit copies of their annual financial statement audits and management letters to the state for review. These audits cover all lines of business offered by MCOs including Medicaid, other government programs, and commercial insurance and are contracted by and paid for by the MCOs. These audits are also a different type of audit than the limited-scope Medicaid-only audits contracted for by the state . The contract requirement that MCOs pay for the costs of the audit referred to the audits performed on all lines of business.

The requirement that MCOs submit annual financial statement audits to Medicaid/CHIP was removed from the MCO contracts as part of an HHSC deliverables streamlining project because MCOs are required to provide financial statement audits to the Texas Department of Insurance

(TDI). The contract reference clarifying MCO responsibility to pay for these total business audits, however, was not deleted at that time. (Copies of these audits have been received from TDI in the past. A Memorandum of Understanding between HHSC and TDI is being finalized that will allow more direct access to these reports.)

HHSC's Office of General Counsel has concluded that the contract language requiring MCOs to pay the costs of an audit was not intended to mean that the MCO should reimburse the state for limited-scope audits which the state, or its contractors, perform on specific Medicaid financial information in order to verify Medicaid-only financial reporting.

Action Planned: HHSC will include in its next RFP for procuring Medicaid Managed Care and CHIP contractors, a requirement that MCOs pay for limited-scope audits to be performed by the state or its contractors.

Estimated Completion Date: January 2005

Title of Responsible Person: Manager, Health Plan Operations

Chapter 1 - C

HHSC agrees that additional improvements can be made to improve performance related to contract management. The transition of CHIP financial monitoring and collection responsibilities did not result in timely assignment of or clear accountability for those functions. While staff were assigned to monitor and collect Medicaid experience rebates, collection activity was not adequately performed, and policies and procedures for performing contract management functions could have been improved and/or developed sooner to clearly identify HHSC's expectations regarding staff processes and accountability for contract management.

Subsequent to the transition, however, HHSC management initiated improvements designed to critically evaluate and improve contract monitoring functions to reflect HHSC's culture and expectation for contract management analysis and accountability. The financial management section was re-organized starting in the spring of 2002. HHSC subsequently hired individuals with specific experience and expertise in MCO financial analysis and contract enforcement. Contract management for CHIP and Medicaid was integrated based on management approval of a coordinated staff analysis and subsequent recommendations to improve and streamline contract management. Staff training on CHIP and Medicaid operations, including claims, program policy, marketing, eligibility and enrollment, training by the Texas Department of Insurance, CHIP rate development and analysis, and team building was provided to staff early in the transition.

Management improvements included an initial phase of staff changes in the fall of 2002 to provide additional management structure, oversight and technical industry expertise. These included a position to oversee contract compliance, a contract manager to oversee contract procurement, development and amendments, a systems and claims analyst to manage technical components of readiness review, and dedicated administrative support in addition to the financial reorganization initiated in the spring of 2002. Prior to hiring a claims auditor in the fall of 2002,

the Commission assigned an existing staff member with over 13 years of claims experience to lead managed care claims monitoring for the area and provide training and assistance to staff regarding claims monitoring and compliance.

Management conducted a detailed staffing and risk assessment in the fall of 2002 to identify additional areas for improvement. HHSC assessed staff workload through a survey that showed that the majority of staff time was directly related to contract monitoring functions. An average of 12% of staff time was dedicated to developing management reports on plan performance and 17% of staff time was reported as being spent on special projects the majority of which directly pertained to contract functions. While automation of deliverables was not pursued under TDH, HHSC initiated automation projects to more efficiently capture plan reported data for operational deliverables, web based financial reports and web based claims reports.

Program improvements include the use of electronic deliverables, integration and improvements in HUB reporting and performance, development of Medicaid plan performance reporting consistent with CHIP reporting, improvements to the content and format of the Financial Statistical Report, and deliverables streamlining. Development of monitoring tools for CHIP member handbooks, provider manuals and provider directories were completed in spring 2002 and provided to staff. A CHIP and Medicaid marketing requirement summary and comparison was also completed in the spring of 2002 and provided to plan managers with plan manager training conducted in July 2002. Core business areas were identified and communicated to staff. Subject matter experts were assigned to improve consistency across plans and provide access to expertise in critical areas such as provider networks, claims and marketing.

HHSC recently contracted with a consultant to assist HHSC in re-engineering the entire MCO contract management function to a value based purchasing approach described by the Commission in its report on Medicaid managed care provided to the 77th Legislature. The re-engineering of MCO contract management to this value-based purchasing system will be in place for HHSC's first procurement of Medicaid and CHIP contracts and is expected to result in additional, significant, measurable improvements to staff and contractor performance.

SAO Recommendation: *Develop objective policies and procedures for health plan managers to use in analyzing and monitoring MCO's financial and operational deliverables.*

Management Response: Agree. In implementing the Medicaid/CHIP Division's 2003 Operating Plan, HHSC has recently made significant progress toward completing its policies and procedures, including those related to analyzing and monitoring MCOs' financial, claims and operational deliverables. HHSC will conclude that effort as quickly as possible.

Action Plan: Complete development of policies and procedures for use in analyzing and monitoring MCO financial and operational deliverables.

Estimated Completion Date: November 2003

Title of Responsible Person: Manager, Health Plan Operations

SAO Recommendation: *Develop and implement risk-based criteria and procedures for performing on-site inspections.*

Management Response: Agree. HHSC currently conducts onsite reviews at the beginning of a contract and when an additional site visit is necessary because a major subsystem change or the need to monitor a corrective action plan indicates that a site visit is necessary. Additional on-site evaluations are conducted by the External Quality Review Organization (EQRO) to provide assessments of plan systems, processes, and outcomes related to plan performance on non-financial components. The financial audit services HHSC are procuring will provide an additional risk-based on-site assessment of plan performance. HHSC will perform further risk assessments to identify whether additional program review has benefit to the program.

Action Plan: A contract for MCO performance auditing services is scheduled to be awarded and work to be initiated by May 2004. Services will include development of criteria, policies and procedures, and performance of a risk assessment to identify whether additional on-site inspections would benefit the program, and if so, which MCOs and which contract provisions should be inspected.

Estimated Completion Date: May 2004 – Performance contract awarded
August 2004 – Risk assessment criteria developed, approved, and initiated.

Title of Responsible Person: Associate Medicaid/CHIP Director for Division Audit

SAO Recommendation: *Re-evaluate current deliverables that MCOs are required to provide to determine whether they meet the Commission's monitoring needs and then develop a standardized template for MCOs to report data to the Commission in an electronic format that eliminates the need for staff to compile data in periodic status reports.*

Management Response: Agree. HHSC will continue its ongoing assessment of deliverables analysis and streamlining. Prior to the transition of TDH functions to HHSC, HHSC initiated a deliverables streamlining project to assess the value of deliverables for contract monitoring and enforcement, and improved the deliverables process by eliminating unnecessary deliverables. Since the transition, HHSC has implemented an electronic deliverables submission process. HHSC has also awarded a contract to Bailit Health Purchasing, LLC that includes providing assistance to HHSC in developing a value-based purchasing approach to MCO contract management as part of HHSC's first procurement of health plan services scheduled for 2005. The value-based purchasing approach uses the competitive market and a specific management strategy to achieve public policy goals through contract alignment of program goals, accountability, reporting, monitoring, performance, and payment. Over the past year, HHSC has also initiated automation projects designed to automate receipt and reporting of MCO existing operational deliverables, claims data, and FSRs. HHSC will develop an automated assessment and tracking system to reflect its value-based approach to contract management for implementation with the next Medicaid and CHIP MCO contract procurement.

Action Plan: Complete automation projects and implement value-based contract approach with the next contract procurement.

Estimated Completion Date: May 2004 - Automation projects for claims and FSRs
January 2005 - Medicaid/CHIP procurement and automation project for deliverables assessment and tracking.

Title of Responsible Person: Director, Information Resources Management, HHSC Administrative Operations, Manager, and Health Plan Operations

SAO Recommendation: *Re-evaluate the activities and resources needed for adequate monitoring of managed care contracts. At a minimum, such an evaluation should consider:*

a. *Whether current activities could be eliminated by redesigning reporting requirements.*
b. *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.*
c. *Whether activities not currently performed (such as on-site inspections discussed in Chapter 1-C) should be re-established.*

Management Response: When HHSC assumed responsibility for contract management activities, there was an insufficient number of staff in the contract area, and not all staff had skill sets sufficient to adequately analyze and monitor contracts. . After developing and implementing a reorganization of the financial area starting in the spring of 2002, HHSC management performed a detailed risk assessment of the entire MCO contract area in the fall of 2002. This assessment concluded that the existing staffing levels as well as technical and industry expertise among the staff were inadequate, and identified risks due to inadequate staffing. These risks included staff management, financial functions and audit functions as historically managed, staff turnover, contract management and staff performance. .

Within one year of the transition, HHSC implemented an initial phase of staff changes to provide additional oversight, and technical expertise. The financial section was reorganized and individuals with specific technical managed care industry expertise in monitoring, analysis, audit, and enforcement were hired. Additional hiring in this area may result from the Division reorganization and functional assessment currently underway.

A spring 2003 survey of staff activities and workload indicated that the majority of the activities performed by staff were clearly related to the contract monitoring function and in support of the Medicaid/CHIP Division's mission. An example of recent work on a special project resulted in an estimated return of over $30 million in general revenue funds.
In addition, completion of automation projects outlined in the response above and implementation of value-based purchasing will further streamline health plan manager activities through the redesign of reporting requirements. Monitoring, management, and staffing

assessments will also be conducted as part of the Division-wide performance improvement plan now in implementation.

Action Plan: HHSC has tentatively awarded a contract to Bailit Health Purchasing, LLC, that includes providing assistance to HHSC in developing a value-based purchasing approach to MCO contract management, monitoring and enforcement and initiated automation projects to streamline reporting. On an ongoing basis, HHSC management will continue to review projects assigned to health plan managers to ensure proper alignment with contract monitoring functions and special projects that support the Commission's mission.

Estimated Completion Date: May 2004 - Automation projects for claims and FSRs
January 2005 - Medicaid/CHIP procurement and automation project for deliverables assessment and tracking

Title of Responsible Person: Manager, Health Plan Operations

SAO Recommendation: *Assess program staff competencies and provide any additional training needs identified.*

Management Response: Agree.

Action Plan: As part of the Division-wide performance improvement plan now in implementation, staff competencies are being assessed and will be addressed through the completion of the Division restructuring and, as appropriate, on an ongoing basis through training.

Estimated Completion Date: March 2004

Title of Responsible Person: Deputy Medicaid/CHIP Director for Program Operations

Chapter 2 - A

SAO Recommendation: *Examine the causes for delay in executing contract amendments and implement changes to improve the timeliness of amendment negotiation and execution.*

Management Response: Agree to the extent that there are delays in executing CHIP contracts. HHSC's initial assessment is that CHIP amendment delays are related to rate negotiation processes and coordination processes between Program Operations in the Medicaid/CHIP Division and the HHSC Office of General Counsel. HHSC analysis indicates that the CHIP negotiation process has historically been successful both in controlling program costs and in concluding negotiations without losing the participation of a single MCO or disrupting the health care of CHIP enrollees.

Action Planned: Medicaid CHIP Program Operations, HHSC Financial Services and HHSC Office of General Counsel will assess causes for delay and address those causes in Service Level Agreements between Medicaid/CHIP Program Operations and both HHSC Financial Services and HHSC Office of General Counsel currently being developed as part of the Division-wide performance improvement plan to define Division roles and streamline the negotiation and contract amendment processes.

Estimated Completion Date: December 2003

Title of Responsible Person: Deputy Medicaid/CHIP Director for Program Operations

SAO Recommendation: *Discontinue its practice of implementing changes to MCO's contracts until negotiations are executed.*

SAO Recommendation: *Standardize the process, roles, and responsibilities for formulating, executing, and maintaining MCO contracts and amendments. Additionally, ensure that staff whose responsibilities are affected by changes in contract amendments are informed of contract changes in a timely manner.*

Management Response: Agree. Health Plan Operations staff has developed and is finalizing with other HHSC Divisions policies and procedures governing contract amendment formulation and maintenance.

Action Plan: HHSC will finalize and implement policies and procedures for amendment development, execution, and maintenance.

Estimated Completion Date: November 2003

Title of Responsible Person: Manager, Health Plan Operations

SAO Recommendation: *Designate appropriate staff member to be the process owner for the MCO contract amendment process.*

Management Response: Agree.

Action Plan: HHSC will designate a process owner and ensure that the process is coordinated with all involved functions and formalized with written policies and procedures and applicable Service Level Agreements between Medicaid/CHIP Program Operations and HHSC Office of General Counsel currently being developed as part of the Division-wide performance improvement plan.

Estimated Completion Date: December 2003

Title of Responsible Person: Deputy Medicaid/CHIP Director for Program Operations

SAO Recommendation: *Inventory all MCO contracts and amendments to ensure that all contracts and amendments are in the Commission's possession.*

Management Response: Health Plan Operations, in coordination with HHSC Office of General Counsel, completed an inventory of all MCO contracts and amendments on file as of September 2003.

Action Plan: Health Plan Operations will work with HHSC Office of General Counsel to compare the inventory with the amendments that should be on file and locate or reproduce any missing documents.

Estimated Completion Date: December 2003

Title of Responsible Person: Deputy Medicaid/CHIP Director for Program Operations

SAO Recommendation: *Ensure that contract amendments are developed in an organized and sequential order.*

Management Response: Agree. The Commission's current practice for organizing and providing sequential order to contract amendments can be improved.

Action Plan: HHSC Program Operations will coordinate with HHSC Office of General Counsel to develop and implement a system to sequentially number and track all future amendments which will enable HHSC to adequately account for all MCO contracts and amendments. HHSC will also develop a comprehensive policy and procedure on contract amendment processing.

Estimated Completion Date: December 2003

Title of Responsible Person: Deputy Medicaid/CHIP Director for Program Operations

Chapter 2 - B

SAO Recommendation: *The Commission should establish a central repository and an organized process for maintaining contracts and other program-related documents.*

Management Response: Agree. HHSC is establishing a central repository for all MCO contracts and amendments, both paper and electronic, and is developing a file plan methodology. The Deputy Medicaid/CHIP Director for Program Operations designated a File Plan Custodian in September 2003 to manage and maintain the central repository of the file plan and ensure that the functional file plan is periodically updated, facilitate staff training, and ensure compliance with the file plan. HHSC is also currently convening a contract administration and management workgroup that will improve and develop the policies and procedures necessary to ensure that best practices are put in place.

Action Planned: HHSC will finalize its file plan methodology in Health Plan Operations which will include a file plan for each functional area, detailing the locations of both paper documents and electronic files for timely retrieval of program records and contract agreements.

Estimated Completion Date: January 2004

Title of Responsible Person: Manager, Health Plan Operations

Chapter 3

SAO Recommendation: *Transfer the responsibility of calculating CHIP MCOs' payments from the CHIP enrollment broker to the Commission's financial services division.*

Management Response: Agree.

Action Planned: HHSC will transfer responsibility for this function from the CHIP enrollment broker to Financial Services by amending the enrollment broker contract to delete that function from that contract. This responsibility is being included in the Service Level Agreement between Medicaid/CHIP and HHSC Financial Services as part of the Division-wide performance improvement plan. Further, in transferring this function to Financial Services, HHSC will assess the existing process for improvements including improved control, specific decision points and policies and procedures for validating the payment amounts. HHSC will appoint a project manager to develop and implement the transition. HHSC will also include in the workload to be performed by contracted Electronic Data Processing (EDP) auditors, validation of the processes and systems used to generate enrollment data required to calculate CHIP MCO payments.

Estimated Completion Date: February 2004 - transition of the process and completion of policies and procedures.
April 2004 – Contract award for EDP audit services.

Title of Responsible Person: Associate Medicaid/CHIP Director for Division Audit for EDP audit; Deputy Medicaid/CHIP Director for Program Operations for contract amendment; HHSC Deputy Chief Financial Officer for Fiscal Management for implementation of new process at HHSC.

SAO Recommendation: *Verify the accuracy of CHIP payments against executed contracts and amendments.*

Management Response: HHSC staff verifies accuracy based on negotiated rates. This process needs to be improved to verify against executed contracts and amendments.

Action Plan: HHSC will develop a process and associated procedures to include the verification of CHIP payments against the rates identified in executed contracts and amendments. .

Estimated Completion Date: December 2003

Title of Responsible Person: Manager, Health Plan Operations

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Auditor's Follow-up Comment to Management's Response

In its response to Chapter 1-B, the Commission management indicates that it has decided not to attempt to recoup $1.5 million in funds that the Department of Health (Department) and Commission improperly paid Medicaid MCOs to cover the cost of prior audits. However, the contract language itself indicates that the Commission could recoup those funds. Developing clear and unambiguous contract language is a prerequisite to effective contract management. The Commission's failure to review contract provisions after the transfer of Medicaid programs further illustrates weaknesses in its management of contracts.

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Copies of this report have been distributed to the following:

Legislative Audit Committee

The Honorable Tom Craddick, Speaker of the House, Chair
The Honorable David Dewhurst, Lieutenant Governor, Vice Chair
The Honorable Teel Bivins, Senate Finance Committee
The Honorable Bill Ratliff, Senate State Affairs Committee
The Honorable Talmadge Heflin, House Appropriations Committee
The Honorable Ron Wilson, House Ways and Means Committee

Office of the Governor

The Honorable Rick Perry, Governor

Health and Human Services Commission

Mr. Albert Hawkins, Commissioner