

An Audit Report on

The Health and Human Services Commission's Administration of the CHIP Exclusive Provider Organization Contract

July 2004

Report No. 04-042



The Health and Human Services Commission's Administration of the CHIP Exclusive Provider Organization Contract

Overall Conclusion

The Health and Human Services Commission (Commission) issued approximately \$20 million in unnecessary or excessive payments to Clarendon National Insurance Company (Clarendon), the exclusive provider organization (EPO) for the Children's Health Insurance Program (CHIP). These payments, combined with the Commission's serious deficiencies in contracting practices and contract monitoring, constitute an abuse of the Commission's fiduciary responsibility to appropriately oversee and manage the EPO contract and associated CHIP funds.

After reaching an impasse in negotiating a rate increase with Clarendon after the first year of the contract, the Commission appeared to make a reasonable decision to self-insure the cost of medical claims effective May 1, 2001. However, after making that decision, the Commission continued to pay Clarendon insurance-related fees that were unnecessary. In addition, the Commission paid Clarendon excessive amounts because it chose to not follow the professional advice it received regarding the rates paid to Clarendon for its administrative services.

Furthermore, the Commission's decision to self-insure the cost of medical claims fundamentally altered the nature of the EPO's financial obligation. However, the Commission made this change through a contract amendment, rather than through reprocurring the EPO's services, and this resulted in a noncompetitive procurement. In addition, the Commission made extensive use of contract amendments to make other changes retroactively. These amendments significantly undercut the competitive nature of the Commission's contracting practices because they effectively precluded the use of market competition to establish payment rates.

After the Commission began self-insuring the cost of medical claims, it did not establish contract terms or controls that adequately safeguarded CHIP funds. The Commission's monitoring and enforcement of its contract with Clarendon was inadequate to safeguard CHIP funds and to ensure that Clarendon used those funds as intended. The Commission has not enforced the financial reporting requirements in Clarendon's contract, nor has it

Elements of Business Practice Abuse

The U.S. General Accounting Office's Government Auditing Standard 7.25 defines abuse as an act "distinct from fraud, illegal acts, or violations of provisions of contracts or grant agreements. When abuse occurs, no law, regulation, or provision of a contract or grant agreement is violated. Rather, abuse involves behavior that is deficient or improper when compared with behavior that a prudent person would consider reasonable and necessary business practice given the facts and circumstances."

CHIP EPO Coverage

As the CHIP EPO, Clarendon was responsible for providing health care services to children living in 170 rural Texas counties. EPO enrollment from May 2000 through April 2003 averaged approximately 105,000 children per month. Clarendon was responsible for providing services to 28 percent of all children enrolled in CHIP, and it was the largest CHIP managed care organization.



audited Clarendon's financial records, despite a number of known problems with Clarendon's financial controls.

Key Points

The Commission paid Clarendon approximately \$20 million in unnecessary or excessive fees to insure and administer the CHIP EPO contract.

Despite the fact that Clarendon bore little or no risk for the cost of medical claims after the first year of the EPO contract, the Commission paid Clarendon approximately \$14.4 million in insurance-related fees from May 2001 through August 2003.

After assuming responsibility for the cost of medical claims, the Commission paid Clarendon at least \$5.3 million in excessive administrative fees from May 2001 through April 2003. The Commission's contracted actuary advised the Commission that the payment rate that led to these payments was excessive.

Clarendon and its claims administrator made excessive or undocumented payments to Clarendon's program manager.

For the period from May 2000 through April 2003, the program manager received \$5.5 million in excessive fees that did not directly benefit CHIP. This amount included \$2 million paid directly from Clarendon to the subcontracted program manager and \$3.5 million in undocumented payments from Clarendon's subcontracted claims administrator.

The \$5.5 million amount was excessive because the program manager had no employees and did not provide a service with readily identifiable, measurable outputs that directly benefited CHIP. In addition, while the program manager's contract with Clarendon assigned the program manager several coordination and oversight functions, it is questionable whether the Commission should pay a separate, additional fee to Clarendon to oversee its own subcontractors.

The Commission's contracting practices did not provide for adequate contract provisions or controls.

The Commission's contracting practices were not adequate:

- After the first year of the contract, the Commission continuously renegotiated Clarendon's obligations while it continued to pay Clarendon. For example, from May 1, 2001, through March 26, 2002, the Commission paid Clarendon at least \$123.26 million in payments that were the subject of these negotiations. These payments were not inappropriate given the terms of the original contract. However, this situation (1) created uncertainty regarding the State's financial obligation and (2) put the Commission in the potentially disadvantageous position of negotiating payments it had already made before contract terms were defined.
- Contract terms were inadequate to prohibit Clarendon from inappropriately using \$15.96 million of CHIP funds for its corporate use. Because the contract terms did not prohibit this, however, this was not a violation of the contract.

- Financial reporting requirements or controls failed to identify \$2.41 million of misreported revenues and expenditures that resulted in an inappropriate \$835,739 overstatement in Clarendon's invoice for additional contributions. The Commission identified part of the overstatement but paid the entire amount of this invoice anyway.

The Commission's monitoring and enforcement of its contract with Clarendon was inadequate to safeguard CHIP funds and to ensure that Clarendon used those funds as intended.

The Commission's monitoring of the EPO contract was inadequate to identify and resolve a number of financial- and service-related issues. For example:

- Clarendon inappropriately retained \$1.79 million of the \$3.36 million in CHIP funds it transferred into its corporate accounts to pay for reinsurance. Clarendon's retention of approximately \$750,000 of this amount violated the terms of the contract; whether Clarendon can retain the remaining \$1.04 million is not clearly addressed in the contract.
- Despite the fact that the Commission was aware of problems with Clarendon's and its subcontractors' financial controls, such as overpayments to providers and overpayments on drugs, the Commission has not audited or obtained an audit of Clarendon since CHIP began in May 2000.
- The Commission did not develop procedures to verify data supporting Clarendon's invoice requests for additional funding or enforce financial reporting required by the contract.
- The Commission did not ensure that Clarendon executed written contracts with its multiple subcontractors. This was particularly critical because Clarendon subcontracted virtually all of its work on the CHIP EPO contract.
- Readiness reviews performed for Clarendon were neither comprehensive nor timely.

Summary of Management's Responses and Auditor Comments

The Commission does not agree with several of our conclusions. Its responses and our comments regarding these responses are presented in Appendix 2. Although the Commission acknowledges that the insurance-related and administrative fees it paid Clarendon were "high," it disagrees that these fees were excessive. In addition, while the Commission asserts that the fees in question can be assessed as "high" only with the benefit of hindsight, this assertion ignores actuarial information available to decision-makers at the time the contract amendments in question were executed.

The Commission also asserts that it was in a weak negotiating position because Clarendon was the only firm willing to bid on EPO services. However, the Commission will never know whether other firms might have submitted bids to provide EPO services after the decision to self-insure the cost of medical claims because it did not attempt to reopen the procurement for competition.

Summary of Objective, Scope, and Methodology

The primary objective of this audit was to continue assessing 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) with respect to the CHIP EPO contract and subcontracts. Prior State Auditor's Office reports that addressed the Commission's business improvement plan include: *An Audit Report on the Health and Human Services Commission's Monitoring of Managed Care Contracts* (SAO Report No. 04-011, November 2003) and *An Audit Report on the Health and Human Services Commission's Prescription Drug Rebate Program* (SAO Report No. 03-029, April 2003).

Our scope included reviewing the Commission's monitoring of the CHIP EPO contract agreement with Clarendon. The review included examining the Commission's contracting practices and monitoring processes, including the selective examination of Clarendon's and its subcontractors' financial records and other related financial documents. This audit did not include a review of any specific information systems.

The audit methodology consisted of collecting information and documentation; performing selective tests and other procedures; analyzing and evaluating the results of tests; and conducting interviews of the Commission's, Clarendon's, and its subcontractors' management and staff.

Table of Results and Recommendations
The Commission paid Clarendon \$14.4 million in insurance-related fees, although Clarendon carried almost no financial risk. (Page 2)
The Commission should: <ul style="list-style-type: none"> ▪ Perform and document cost-benefit analyses to fully consider all options for achieving the most cost-effective CHIP EPO service delivery. These analyses should identify the services the Commission needs and encompass benchmarking against market prices that contractors charge for those services. ▪ Base contracting decisions on professional advice or document its justification for not following professional advice when significantly altering the scope of contracts. ▪ Establish effective performance penalties to provide adequate incentive for contractors to control costs and efficiently administer contracts.
The Commission paid at least \$5.3 million in excessive administrative fees to Clarendon. (Page 6)
The Commission should: <ul style="list-style-type: none"> ▪ When negotiating administrative fees with contractors, compare administrative fee rates to market prices, including the rates charged by subcontractors and affiliates. ▪ Independently verify the rates contractors report they pay to their subcontractors and affiliates.
Clarendon and its claims administrator made excessive or undocumented payments to Clarendon's program manager. (Page 9)
The Commission should: <ul style="list-style-type: none"> ▪ Ensure that all subcontractors receiving CHIP funds provide necessary, measurable products or services in exchange for the funds they receive. ▪ Given the unique financial risks associated with the CHIP EPO contract, independently audit subcontractors' use of CHIP funds to ensure that it is fully aware of how all these funds are used. ▪ Ensure that agreements among subcontractors are documented and that subcontractors' agreements and payment rates are reported to the Commission.
The Commission did not finalize amendments in its contract with Clarendon in a timely or appropriate manner. (Page 16)
The Commission should: <ul style="list-style-type: none"> ▪ Refrain from modifying existing agreements with contractors that extend beyond the scope of the contractors' original obligations without rebidding procurement for the service. ▪ Ensure that it competitively procures services provided by contractors. ▪ Execute contract amendments prior to their effective date. ▪ Rebid procurements for which it is not able to successfully negotiate an agreement within the scope of its original contract. ▪ Ensure that its contracts include clear specifications and time lines regarding the products and services that contractors agree to provide. It should adopt contracting practices that prohibit contract terms that specify only dollar amounts of items such as reinsurance. ▪ Prohibit staff and management from entering into informal contractual arrangements on behalf of the Commission and ensure that staff and management comply with all state contracting and procurement laws and requirements.
The Commission did not establish adequate terms in its contract with Clarendon to safeguard CHIP funds. (Page 18)
The Commission should: <ul style="list-style-type: none"> ▪ Audit Clarendon's use of premium payments it received after May 1, 2001, when the Commission began self-insuring the cost of medical claims. This audit should include verification of the dates of service for claims paid to verify that the Commission did not pay for claims for which Clarendon was financially responsible during the first contract period. ▪ Consider limiting contractors' possession of state and federal funds associated with contracted agreements. ▪ Determine whether Clarendon earned interest on (1) the \$10.3 million in CHIP funds it borrowed and (2) the balance in the CHIP claims fund (that rose as high as \$5.66 million) and recoup any applicable interest Clarendon earned on those funds. ▪ Stipulate that contractors hold state and federal funds in interest-bearing bank accounts and specify that interest earned on those funds should accrue to the State.

Table of Results and Recommendations

The Commission failed to establish financial reporting requirements or controls to monitor Clarendon's use of CHIP funds. (Page 21)

The Commission should:

- Recoup the \$835,739 overpayment it made to Clarendon based on the overstatements in Clarendon's March 13, 2003, invoice.
- Adequately define the manner in which contractors are required to report and classify all components that support contractors' invoices requesting additional funds from the Commission.
- Include requirements in its contractual agreements to ensure that contractors use state and federal funds only for purposes intended by the Legislature and federal law.
- When permitting contractors to retain custody of state or federal funds:
 - Specify bank account and financial control structures that account for all state and federal funds provided to or recouped by contractors.
 - Require periodic reporting of the use and balance of state and federal funds it provides to contractors.

The Commission did not adequately monitor Clarendon's use of CHIP funds or enforce contractual financial reporting requirements. (Page 24)

The Commission should:

- Develop objective policies and procedures to monitor the financial terms and payments made on reinsurance contracts obtained by contractors. It should also promptly obtain copies of these reinsurance contracts.
- Recoup the approximate \$750,000 that Clarendon transferred from the CHIP accounts to its corporate accounts for reinsurance (\$750,000 was the amount Clarendon was to contribute to reinsurance from its own funds). The Commission should also attempt to collect the balance of \$1,040,000 in unspent funds that Clarendon transferred from the CHIP accounts to its corporate accounts for reinsurance but did not spend.
- Recoup any profit commission (estimated at \$385,000) that Clarendon may receive from its reinsurer (given that CHIP funds were used to pay the entire cost of the reinsurance Clarendon obtained).
- Recoup any overpayments for medical claims or for prescription drugs that were made after May 1, 2001, when the State assumed responsibility for the cost of both of these items.
- Obtain regular, independent audits of the CHIP EPO at least every two years. These audits should encompass key financial components such as administrative revenues, administrative expenses, medical claims, and drug claims. These audits should also examine:
 - The accuracy of the EPO's financial deliverables, including the accuracy of revenues and expenditures reported in the EPO's annual FSR. The audit should verify key FSR components such as premium revenues, incurred claims, investment income earned on CHIP funds, medical expenses, medical management expenses, and administrative expenses.
 - The EPO's established internal controls for reporting program revenues and expenditures, including those internal controls related to reporting reinsurance premiums, reinsurance recoveries, medical claim refunds, and medical claim recoveries.
 - The EPO's compliance with statutory requirements regarding the timely processing and payment of provider medical claims.
 - If applicable, the EPO's subcontractors' internal controls that ensure compliance with federal, state, and contractual requirements.
- Develop objective policies and procedures to use in regularly analyzing and monitoring the EPO's financial deliverables. It should also ensure that the EPO provides data that is comprehensive enough to enable the Commission to independently and accurately calculate the claims fund balance.

The Commission did not monitor to ensure that Clarendon's subcontracts were written and executed with appropriate contractual provisions. (Page 29)

The Commission should:

- Develop objective policies and procedures to use in monitoring the CHIP EPO's compliance with contractual provisions.

Table of Results and Recommendations	
<ul style="list-style-type: none"> ▪ Ensure that the CHIP EPO has written, executed contracts with all subcontractors and affiliates that fully comply with the EPO's contract terms and applicable laws and regulations. ▪ Gain a thorough understanding of the role of all subcontractors and obtain all contracts between the CHIP EPO and its subcontractors. 	
Readiness reviews performed for Clarendon were neither comprehensive nor timely. (Page 31)	
The Commission should:	
<ul style="list-style-type: none"> ▪ Develop and implement risk-based criteria for readiness reviews that consider both the financial- and service-related significance of all primary and secondary health services provided under the CHIP EPO contract. ▪ Develop and implement a standardized process to conduct follow-up reviews regarding deficiencies identified during CHIP EPO readiness reviews. ▪ Determine whether any of the \$1.71 million in overpayments in prescription drug claims are recoverable and, if so, recoup those amounts. 	

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04-011	An Audit Report on the Health and Human Services Commission's Monitoring of Managed Care Contracts	November 2003
03-043	An Audit of National Heritage Insurance Company Accounts Receivable, Claim Counts, and Selected Trust Funds Related to Administering Medicaid Claims for the Health and Human Services Commission	July 2003
03-036	An Audit of the Administrative Expenses the National Heritage Insurance Company Charged to the Health and Human Services Commission in Fiscal Year 2002	June 2003
03-029	An Audit Report on the Health and Human Services Commission's Prescription Drug Rebate Program	April 2003
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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 Paid Clarendon Approximately \$20 Million in Unnecessary or Excessive Fees to Insure and Administer the CHIP EPO Contract

The Health and Human Services Commission (Commission) failed to appropriately negotiate the cost of a number of key Children's Health Insurance Program (CHIP) services that Clarendon National Insurance Company (Clarendon) provided after the

The Commission Self-Insured CHIP EPO Medical Claims After the First Year of the EPO Contract

After Clarendon reported losses of approximately \$11.28 million for the first year of the CHIP EPO contract, the Commission and Clarendon began negotiations over a premium rate increase, which was allowed under the terms of the contract. The Commission and Clarendon were unable to agree on a premium rate increase for the second period of the contract after Clarendon requested a premium rate increase of approximately 67 percent. This impasse in negotiations led to the Commission's decision to assume the financial risk for the EPO contract by self-insuring the cost of medical claims through a contract amendment.

Commission assumed responsibility for the cost of CHIP medical claims. The Commission's decision to continue contracting with Clarendon at unreasonably high rates, rather than pursue alternatives such as reprocurring the services or administering the contract in-house, resulted in the Commission's paying Clarendon approximately \$20 million in unnecessary or excessive fees to insure the cost of medical claims and administer the exclusive provider organization (EPO) contract.

The Commission contracted with Clarendon to be the EPO for CHIP starting at the inception of CHIP in May 2000. During the first year of the contract, Clarendon was responsible for paying the cost of all medical claims out of the premium rate the Commission paid it. After reaching an impasse in rate negotiations after the first year of the program, the Commission decided to self-insure the cost of the EPO

medical claims and amended the EPO contract (see text box for additional details).

A number of the fees that the Commission agreed to pay Clarendon after self-insuring the cost of medical claims were unnecessary or excessive. Specifically:

- Despite the fact that Clarendon bore little or no risk for the cost of medical claims after the first year of the EPO contract, the Commission paid Clarendon approximately \$14.4 million in insurance-related fees.
- The Commission chose not to follow the advice of its actuary and certain staff regarding the cost of Clarendon's administrative fees, which resulted in the Commission's overpaying Clarendon by at least \$5.3 million from May 2000 through April 2003.

The terms and conditions of the amended EPO contract generally provided little incentive for Clarendon to efficiently administer the EPO contract.

The Commission Paid Clarendon \$14.4 Million in Insurance-Related Fees, Although Clarendon Carried Almost No Financial Risk

The Commission agreed to pay Clarendon \$14.4 million in insurance fees for the second, third, and fourth periods of the contract that were either unnecessary or excessive. As Table 1 on the following page shows, that amount included:

Responsibility for Payment of CHIP EPO Medical Claims by Contract Period

In contract period one (May 1, 2000, through April 30, 2001), Clarendon was fully responsible for paying the cost of all claims:

- Clarendon was responsible for paying the cost of all medical claims and administrative costs out of the premium rate that the Commission paid it.

In contract period two (contract amendment two covering the period from May 1, 2001, through September 30, 2002), the Commission assumed full responsibility for paying the cost of all claims:

- The Commission continued to pay Clarendon the same baseline premium rate it paid Clarendon the first year, but the Commission also assumed responsibility for paying the cost of medical claims that exceeded the amount available in a claims fund that was established under contract amendment two. The claims fund was defined as the sum of the Commission's premium payments to Clarendon, minus administrative fees, a risk charge fee, reinsurance fees, and paid claims.
- If the amount of unpaid claims exceeded the balance of the claims fund, Clarendon was allowed to invoice the Commission at least weekly for the excess amounts, and the Commission was to remit the balance of the excess amount within 15 days of receipt of the invoice.

In contract period three (contract amendment five covering the period from October 1, 2002, through August 31, 2003), the Commission continued to retain the majority of the responsibility for paying the cost of claims, and Clarendon had limited liability:

- The Commission capped its responsibility for paying the cost of medical claims that were less than \$150,000. The Commission's maximum liability for these claims was approximately 145 percent (depending on age group) of the baseline premium rates it paid Clarendon.
- The Commission was responsible for paying a deductible of \$3.25 per member per month (approximately \$5 million) for individual claims in excess of \$150,000.

In contract period four (contract amendment six covering the period from May 1, 2003, through August 31, 2003), the Commission reduced its maximum obligation by 52 cents per member per month.

- \$10.1 million¹ that the Commission paid to Clarendon in the second, third, and fourth periods of the contract as an "underwriter's fee," despite the fact that Clarendon had no liability for medical claims in the second period of the contract, extremely limited liability in the third and fourth periods of the contract, and limited internal administrative costs.
- Nearly \$3.3 million that the Commission paid to Clarendon for reinsurance costs in the second, third, and fourth periods of the contract, despite the fact that the Commission's contracted actuary questioned the need for the reinsurance policies.
- A \$1 million "risk charge" the Commission agreed to pay Clarendon in contract period two, despite the fact that the Commission's contracted actuary advised the Commission that Clarendon's risk under the contract was negligible. (Clarendon retained one-half of that amount and later refunded one-half to the Commission.)

¹ Contract amendment two established a total administrative fee paid to Clarendon on a per-member, per-month basis. In the contract negotiations that established this rate, the Commission and Clarendon agreed on what portion of the overall administrative fee Clarendon would receive. As custodian of the CHIP premium payments, Clarendon paid itself a portion of the administrative fees by transferring funds from the CHIP account to its own corporate account.

Table 1

Insurance Fees the Commission Paid to Clarendon			
Fee	Contract Period Two (17 months) May 2001 - September 2002	Contract Periods Three and Four (11 months) October 2002 - August 2003	Total
Clarendon Underwriter's Fee	\$6,259,808	\$3,864,041	\$10,123,849
Clarendon Reinsurance	683,898	2,613,750	3,297,648
Clarendon Risk Charge	1,000,108	0	1,000,108 ^a
Total Insurance Fees	\$7,943,814	\$6,477,791	\$14,421,605

^a In accordance with contract amendment two, the Commission recovered \$500,261 (50 percent) of the risk charge it paid to Clarendon.

Source: Audited payments from May 1, 2001, through April 30, 2003, and data reported by Clarendon's affiliate for the period from May 1, 2003, through August 31, 2003

It is not apparent why the Commission chose to pay \$10.1 million in underwriter's fees to Clarendon in the second, third, and fourth contract periods because Clarendon had no financial risk in the second contract period and extremely limited financial risk in the third and fourth contract periods. Clarendon reported that its annual internal administrative costs for the EPO contract for items such as accounting and actuarial services averaged \$621,000 for calendar years 2001, 2002, and 2003.² In

Clarendon Subcontracted All Nonprovider Administrative Functions

Clarendon subcontracted out the following administrative components of its EPO contract with the Commission:

- Claims administration
- Network management
- Medical management
- Pharmacy benefit management
- Program management

See Appendix 3 for additional details.

contrast, Clarendon paid its subcontractors (excluding its pharmacy benefit manager) \$47.6 million for the two-year period from May 2001 through April 2003. Clarendon's own internal administrative costs were limited because all nonprovider administrative functions were performed by subcontractors and a Clarendon affiliate (see text box).

In the spring of 2001, during the Commission's premium rate negotiations with Clarendon, the Commission's contracted actuary noted that there were serious flaws with the cost-effectiveness of proposed reinsurance arrangements and administrative fees. The actuary and senior Commission staff suggested that one option available to the Commission was to fully self-fund the plan and contract for the necessary

administrative functions to run the program itself. Although the Commission would have incurred additional administrative costs to manage and oversee the administrative subcontractors, these costs would have been more than offset by eliminating the cost of Clarendon's fees.

² We did not audit or verify Clarendon's self-reported costs for internal administration. The method for allocating Clarendon's staff costs to the Texas CHIP EPO contract was not provided.

Specific reinsurance and risk fees that the Commission paid to Clarendon in contract period two were unnecessary or excessive, and potential contractor penalties were ineffective.

After assuming complete responsibility for paying the cost of medical claims in contract period two, the Commission paid Clarendon \$683,898 to purchase excess loss reinsurance coverage. This reinsurance provided coverage for individual catastrophic claims between \$1 million and \$5 million. However, paying for this reinsurance conflicted with the advice the Commission received from its own contracted actuary, who advised the Commission that the State could afford the risk associated with these claims and could avoid the cost of reinsurance. In fact, Clarendon reports that no individual claims exceeding \$1 million have been filed. In addition, during negotiations over the contract amendment to self-insure the cost of medical claims, the actuary advised the Commission that it would be more cost-effective and simple for the State to entirely self-fund the contract, thereby eliminating the need for this reinsurance and its associated profit margin.

The Commission also paid Clarendon a \$0.57 per-member, per-month “risk charge” that totaled \$1,000,108 for contract period two. Clarendon requested the risk charge to ensure its profit margin and to prevent any temporary negative cash flow if claims exceeded the balance of the claims fund.³ However, the Commission’s actuary advised the Commission that the proper risk charge for the level of risk assumed by Clarendon should not have exceeded \$0.05 per member per month. The contract amendment through which the Commission began self-insuring the cost of medical claims specified that up to one-half of the risk charge was refundable to the Commission. Clarendon refunded \$500,261 of the risk charge to the Commission in December 2003 and, per the terms of the contract amendment, it retained the balance of the risk charge.

Performance penalties the Commission implemented in contract period two were ineffective.

Although the Commission included performance penalties beginning in contract period two as an incentive for Clarendon to control the cost of medical claims, those provisions were not structured effectively. The provisions were ineffective because the maximum allowable claims cost permitted before a penalty could be triggered was set too high. As Table 2 shows, the actual average per-member, per-month claim cost reported by Clarendon was 17 to 33 percent below the maximum allowable cost that would trigger these penalties.

³ The claims fund balance averaged \$12.9 million during contract period two. The claims fund maintained a surplus balance until February 2003. Clarendon invoiced the Commission for approximately \$4.4 million in claims in March 2003. The March 2003 invoice is discussed in more detail in Chapter 3-C.

Table 2

The Actual Cost of Claims Never Approached the Maximum Allowable Costs that Would Trigger Imposing Penalties Against Clarendon				
Time Period	Maximum Allowable Claim Cost (per member per month) that Would Trigger Penalties	Actual Average Claims Cost (per member per month) ^a	Difference Between Actual Average and Maximum Allowable Claims Cost	Percent of Actual Average Claims Cost Below Maximum Claim Cost
May 2001 - September 2001	\$102.37	\$68.61	\$33.76	33%
October 2001 - February 2002	\$94.50	\$78.52	\$15.98	17%
March 2002 - September 2002	\$73.80	\$55.48	\$18.32	25%
^a The actual average claims cost in this table is based on the State Auditor's Office's calculation of self-reported claims data from Clarendon for contract period two.				

Sources: Maximum allowable claim costs are from amendment two to the Clarendon contract.

Specific reinsurance, risk, and deductible fees the Commission agreed to pay for contract periods three and four were unnecessary or excessive.

The Commission capped its maximum obligation for paying medical claims for the third contract period effective October 1, 2002. During contract periods three and four, the Commission limited its obligation for claims costs to an approximate average of 145 percent (depending on the age group) of the monthly minimum funding amount. See Appendix 4 for additional details regarding the maximum obligation the Commission agreed to pay.

In contract periods three and four, the Commission continued to pay Clarendon the same monthly premium payments it had established in the original contract (adjusted for the removal of the prescription drug benefit). The Commission further agreed to pay all claims less than \$150,000 until its maximum obligation was reached. Although this change technically shifted some of the financial risk for medical claims back to Clarendon, the point at which Clarendon would be required to start paying claims was so high that the likelihood of Clarendon's having to pay for the cost of medical claims was remote. At the end of contract period four (August 31, 2003), the Commission's contracted actuary estimated that the Commission would still have to pay \$24.6 million before reaching the maximum obligation.

The Commission also increased the amount of reinsurance fees it paid Clarendon in contract period three.⁴ The Commission's obligation to Clarendon for these reinsurance fees totaled \$2.61 million. The Commission's contracted actuary advised the Commission that it was unlikely that the reinsurance coverage would be needed based on the expected claims experience. Effective September 1, 2003, the Commission extended its obligation to pay Clarendon for reinsurance through the August 31, 2004, expiration date of the EPO contract.

⁴ The contract amendment covering contract period three stipulated a reinsurance amount equal to \$2.15 per member per month (pmpm). Of this amount, the Commission was responsible for \$1.67 pmpm, and Clarendon was responsible for \$0.48 pmpm.

Although the necessity for purchasing reinsurance for contract period three was questioned by the Commission's actuary, the Commission also agreed to pay a deductible before a reinsurance policy would provide payments for claims in excess of \$150,000. Specifically, the Commission agreed to pay Clarendon a deductible (called an "otherwise recoverable amount") equal to \$3.25 per member per month. The total amount of these fees resulted in a deductible equal to approximately \$5 million before the reinsurance coverage would pay for claims in excess of \$150,000.

Clarendon reported that, as of October 31, 2003, only four claims in excess of \$150,000 were paid during contract periods three and four, for a total of \$208,429.⁵ Thus, the Commission was still obligated to pay approximately \$4.8 million in additional deductible amounts before the reinsurance coverage would pay for these types of claims. It is also important to note that there have been no individual claims that have exceeded \$1 million, thus making the need for reinsurance even more questionable. Additional issues pertaining to the reinsurance policies are discussed in Chapter 3-A and Chapter 4-A.

Recommendations

The Commission should:

- Perform and document cost-benefit analyses to fully consider all options for achieving the most cost-effective CHIP EPO service delivery. These analyses should identify the services the Commission needs and encompass benchmarking against market prices that contractors charge for those services.
- Base contracting decisions on professional advice or document its justification for not following professional advice when significantly altering the scope of contracts.
- Establish effective performance penalties to provide adequate incentive for contractors to control costs and efficiently administer contracts.

Chapter 1-B

The Commission Paid at Least \$5.3 Million in Excessive Administrative Fees to Clarendon

After assuming responsibility for the cost of medical claims, the Commission paid Clarendon at least \$5.3 million in excessive administrative fees from May 2001 through April 2003. The decision to self-insure the cost of the EPO medical claims resulted in the Commission's essentially paying Clarendon for only its administrative services; however, the Commission did not promptly adjust Clarendon's administrative fee to reflect this change (see Appendix 3 for additional background information about Clarendon's administrative costs).

⁵ This amount is the sum of the amounts exceeding \$150,000 for each of the four claims.

During rate negotiations, Clarendon represented to the Commission that its administrative costs were fixed because it had three-year contracts with its subcontractors. However, this representation was not completely accurate because, during rate negotiations, Clarendon did not have contracts for program management services (these services were provided by a Clarendon affiliate and an unaffiliated program manager operating without a signed contract). In addition, although the Commission's contracted actuary advised the Commission that Clarendon's administrative rate was excessive, the Commission did not attempt to competitively rebid the EPO services. Instead, the Commission essentially incorporated Clarendon's subcontractors' unverified rates into the overall administrative fee it agreed to pay Clarendon. This resulted in the Commission's paying Clarendon at

least \$5.3 million more in administrative fees than was necessary between May 1, 2001, and April 30, 2003.⁶ (This amount excludes the portion of Clarendon's underwriter's fee that is discussed separately in Chapter 1-A.)

The administrative fee was unreasonable under federal regulations (see text box) because:

- The Commission did not compare Clarendon's fee to market prices.
- The Commission did not act with prudence when it failed to verify Clarendon's reported subcontractor rates.
- The comments of the Commission's actuary indicated that Clarendon's fee was not ordinary and necessary.

What Is a "Reasonable" Cost?

Code of Federal Regulations, Title 48, Sections 31.201-3, states that "a cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person in the conduct of competitive business...."

The determination of a reasonable cost is based on the following circumstances or conditions:

- Market prices for comparable goods and services
- Whether the individuals concerned acted with prudence in the circumstances considering their responsibilities to the governmental unit, its employees, the public at large, and the federal government
- Whether the cost is of a type generally recognized as ordinary and necessary for the operation of the governmental unit or the performance of the federal award
- The restraints or requirements imposed by such factors as sound business practices; arms-length bargaining; federal, state, and other laws and regulations; and, terms and conditions of the federal award

The excessive nature of the administrative fees the Commission paid to Clarendon is also evidenced by the fact that the Commission did eventually reduce the administrative rate it paid Clarendon on September 1, 2003. That change was made after portions of Clarendon's subcontracted administrative services were consolidated. As Table 3 shows, effective September 1, 2003, the Commission reduced Clarendon's overall administrative rate (less Clarendon's fee) from \$14.64 per member per month to \$13.04 per member per month. This difference of \$1.60 per member per month multiplied by the number of children enrolled in the CHIP EPO from May 1, 2001, through April 30, 2003, totals approximately \$5.3 million.

⁶ Our analysis of the difference in the rates is through April 2003 because we do not have information regarding whether Clarendon amended the rates it paid its subcontractors between May 1, 2003, and August 31, 2003. Had the rates remained the same for that time period, the amount of excess funds paid by the Commission for Clarendon's subcontracted administrative services would equal approximately \$6.21 million.

Table 3

Per-Member, Per-Month Rates for Subcontracted Administrative Functions			
Subcontracted Function	May 2001 - April 2003	Effective September 2003	Difference
Program Management ^a	\$2.34	\$1.34	\$1.00
Claims Administration	6.00	6.00	—
Network Management	2.50	2.50	—
Medical Management	3.80	3.20	0.60
Totals	\$14.64	\$13.04	\$1.60
^a Depending upon the timeframe, program management was provided by a Clarendon affiliate, Clarendon's subcontracted program manager, and the program manager's successor company.			

Source: Clarendon subcontractor contracts and financial information provided by Clarendon.

Recommendations

The Commission should:

- When negotiating administrative fees with contractors, compare administrative fee rates to market prices, including the rates charged by subcontractors and affiliates.
- Independently verify the rates contractors report they pay to their subcontractors and affiliates.

Clarendon and Its Claims Administrator Made Excessive or Undocumented Payments to Clarendon's Program Manager

Further evidence that the Commission paid Clarendon excessive administrative fees is the fact that Clarendon and its claims administrator were able to issue \$5.5 million in payments to Clarendon's subcontracted program manager for the period from May 2000 through April 2003. These payments were excessive in relation to the amount and nature of the work the program manager performed. In addition, Clarendon made approximately \$1.5 million in payments to the program manager's successor company from July 2002 through April 2003. It is not readily apparent what contracted services the program manager's successor company provided during this time period.

The \$5.5 million included \$2 million paid directly from Clarendon to the program manager and more than \$3.5 million in undocumented payments from Clarendon's subcontracted claims administrator. The \$5.5 million amount was excessive because:

- Program management is not a service defined in the contract between the Commission and Clarendon, nor is it a service typically subcontracted by managed care organizations.
- The program manager's contract with Clarendon assigned the program manager several coordination and oversight functions. However, it is questionable whether the Commission should pay a separate, additional fee to Clarendon to coordinate and oversee Clarendon's own subcontractors.
- The program manager had no employees and did not provide a service with readily identifiable, measurable outputs. The lack of employees and lack of clearly defined work products that directly benefited CHIP makes the program manager's compensation of \$5.5 million excessive.
- The program manager and the program manager's successor company operated simultaneously from July 2002 through February 2003. Clarendon paid the program manager's successor company \$1.5 million during this time period. (The \$1.5 million amount the successor company received was not part of the \$5.5 million the program manager received.) Clarendon had an agreement with the program manager's successor company to assume certain responsibilities performed by Clarendon's other subcontractors when the other subcontractors' three-year contracts expired on May 1, 2003. However, given the fact that the program manager's successor company did not assume any of the other subcontractors' responsibilities until May 1, 2003, it is not readily apparent what services this company provided that directly benefited CHIP.

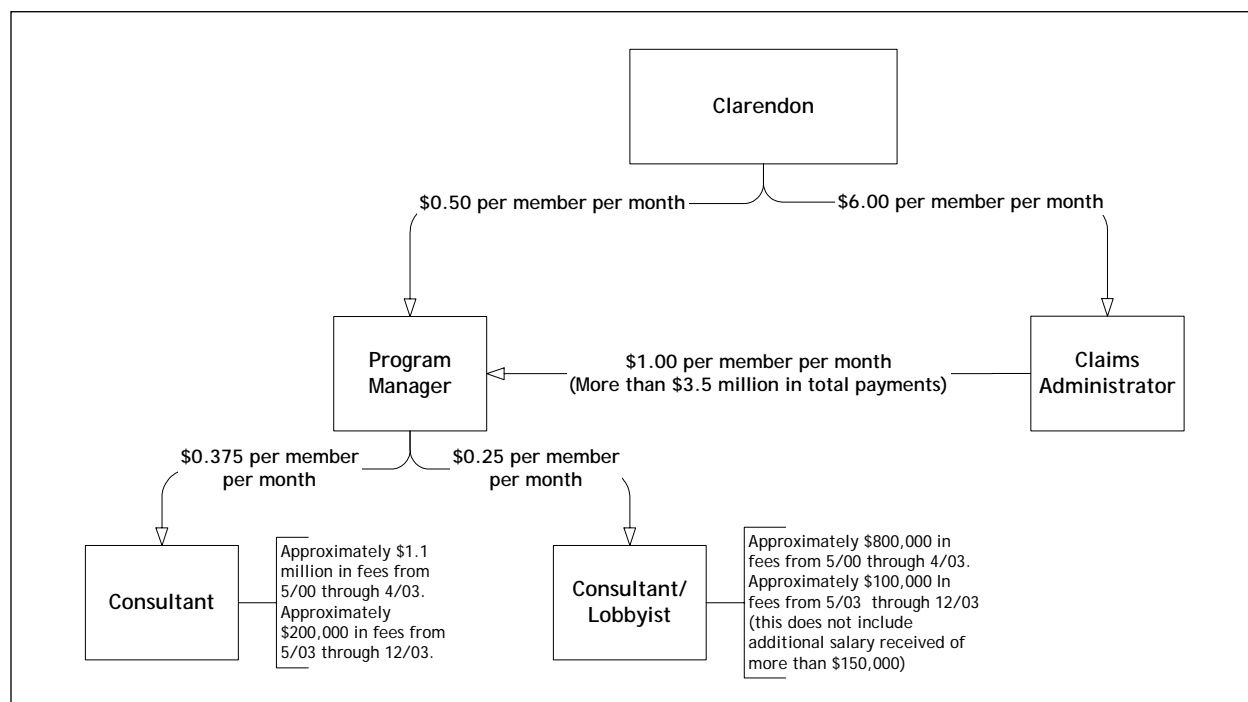
Based on the program manager's records, \$3.6 million (65 percent) of the \$5.5 million the program manager received went to four individuals: (1) the two owners of the program manager's company paid themselves \$1.7 million in commissions and salaries, and (2) the program manager paid a consultant and a consultant/lobbyist \$1.9 million. Approximately \$2 million in payments appeared to go toward a combination of business and personal expenses, including payments on credit cards

and a line of credit, tax payments, and payments to other individuals.⁷ Supplemental information reported by the program manager that extends beyond April 2003 indicates that the consultant and the consultant/lobbyist received additional compensation through December 2003 of \$0.3 million, for a total of \$2.2 million.

The program manager received more than \$3.5 million in undocumented payments from Clarendon's subcontracted claims administrator; this allowed the program manager to make payments to a consultant and a consultant/lobbyist.

Clarendon directed its subcontracted claims administrator to make more than \$3.5 million in payments to Clarendon's subcontracted program manager (see Figure 1). There was no written contract covering these undocumented payments, yet these payments effectively changed the payment rates that Clarendon had informed the Commission each of these subcontractors would receive. It is also significant that Clarendon misrepresented to the Commission how its subcontracted program manager was compensated, as well as the total amount of compensation that the program manager received for Texas CHIP. This resulted in the Commission's unawareness of the actual rate Clarendon was paying its program manager. The lack of a written contract does not comply with federal regulations⁸ or the terms of Clarendon's contract with the Commission.

Figure 1 – Undocumented payments among Clarendon subcontractors



⁷ The program manager reported an additional \$1 million in revenue from sources other than Texas CHIP funds; therefore, we were unable to determine what portion of the \$2 million was paid with Texas CHIP funds.

⁸ Code of Federal Regulations, Title 42, Section IV 434.6, requires written subcontracts for services provided under a federal health care program.

During the time that the program manager was receiving the undocumented payments from the claims administrator, the program manager was paying a consultant and a consultant/lobbyist fees that equaled and later exceeded the contracted rate of

The Program Manager Paid Two Individuals Rates that Equaled or Exceeded Its Contracted Rate of Payment from Clarendon

The program manager had agreements with a consultant and a consultant/lobbyist that provided for them to be paid an approximate total of \$2.2 million from May 2000 through December 2003. The payment rates in the agreements equaled the program manager's contracted rate of payment with Clarendon for the first 12 months of the program and exceeded the program manager's contracted rate of payment with Clarendon after the first year of the program.

The average rate of compensation for the consultant and consultant/lobbyist, based on actual payments received, exceeded the program manager's contracted rate of compensation with Clarendon for the first 32 months of the program (May 2000 through December 2002). In addition, the consultant/lobbyist received additional compensation as an employee of the program manager's successor company. The consultant/lobbyist's total salary reported for April 2002 through September 2003 was approximately \$150,000.

payment the program manager received directly from Clarendon (see text box for additional details). The program manager paid the consultant and consultant/lobbyist approximately \$2.2 million in fees between May 2000 and December 2003. Those payments were made to compensate these two individuals for their efforts in helping to secure the CHIP EPO contract for Clarendon and for ongoing consulting services. The fees were to continue for as long as the program manager's contract with Clarendon remained in effect. The program manager's agreement to pay the consultant was never signed by either party, and its agreement to pay the consultant/lobbyist was supported by a written contract that was executed one year after the agreement's effective date.

Because these payments were undocumented and occurred at the subcontractor level, our audit of the Clarendon contract and Clarendon's financial records would not have identified the payments between (1) the claims administrator and the program manager or (2) the program manager and the two individuals discussed above. We detected these payments only during our review of the program manager's financial records. It is important to note that the Commission's philosophy of contract monitoring focuses only on the prime contractor and typically does not extend to monitoring subcontractor activities.

Clarendon's current management was not able to sufficiently explain the undocumented payments between its subcontractors.

Clarendon's current management stated that it was unaware of the more than \$3.5 million in payments made by the claims administrator to the program manager. These payments, made at the rate of \$1.00 per CHIP member per month, effectively reduced the claims administrator's payment rate from Clarendon from its contracted rate of \$6.00 per member per month to \$5.00 per member per month. Similarly, the program manager's payment rate from Clarendon effectively increased from the contracted rate of \$0.50 per member per month to \$1.50 per member per month.⁹ When we inquired about the purpose of the \$1.00 per member per month payments between these subcontractors, Clarendon's senior vice president replied in a December 2003 letter:

“After making certain internal inquiries within the Clarendon Insurance Group, there appears to be no knowledge of why this arrangement was put in place.”

⁹ As discussed in Chapter 4-B, the program manager operated without a written contract from the beginning of CHIP in May 2000 until February 2002. The contract signed in February 2002 listed an effective date of October 1, 1999.

Clarendon's senior vice president subsequently contacted the former vice president of Clarendon¹⁰ and requested an explanation for the \$1.00 per member per month payment arrangement between the claims administrator and the program manager. The former vice president of Clarendon replied that the program manager initially agreed to a fee of \$0.50 per member per month directly from Clarendon; however, after reviewing the amount of effort that would be involved, plus the additional expenses the program manager would incur, the former vice president of Clarendon instructed the claims administrator to pay \$1.00 per member per month of the fee it received from Clarendon to the program manager. He stated that this agreement was oral and that there were no documents supporting or explaining it.

Both the program manager and the claims administrator stated that the payment arrangement was in place from the inception of CHIP and that the program manager used these funds for program development and management services.

Explanations offered by the former vice president of Clarendon, the claims administrator, and the program manager for why Clarendon chose to route more than \$3.5 million in payments to its program manager through its claims administrator are inconsistent. Their statements conflict regarding when the payment rates that each subcontractor received from Clarendon changed. Specifically, our review of Clarendon's CHIP-related bank records indicates that the program manager received payments equivalent to \$1.50 per member per month directly from Clarendon from May 2000 through October 2000. During this same period, Clarendon's records also show that it paid the claims administrator amounts equivalent to \$5.00 per member per month. After paying the two subcontractors at these rates for six months, in November 2000 Clarendon increased the claims administrator's payment rate to \$6.00 per member per month and decreased the program manager's rate to \$0.50 per member per month. At the same time that change was made (November 2000), the claims administrator began making the \$1.00 per member per month payment to the program manager.

The undocumented payments the claims administrator made to the program manager beginning in November 2000 effectively changed the claims administrator payment rate to \$5.00 per member per month and the program manager's rate to \$1.50 per member per month. However, the subcontractor contracts that Clarendon submitted to the Commission specified that the payment rates for the claims administrator and the program manager were \$6.00 per member per month and \$0.50 per member per month, respectively. Therefore, the contracted payment rates appear to misrepresent the payments that each subcontractor actually received.

The undocumented payments from the claims administrator to the program manager continued after Clarendon sold the claims administrator to a company unaffiliated with Clarendon. In addition, after Clarendon sold the claims administrator affiliate company, the former vice president of Clarendon, who approved the undocumented payments to the program manager, received remuneration from both the program manager and its successor company as a consultant and employee. These payments

¹⁰ This individual served as vice president of Clarendon and as president of the Clarendon affiliate that performed the claims administration function for Clarendon's Texas CHIP operation at the beginning of the program in May 2000. Clarendon sold the claims administrator affiliate in December 2000.

totaled approximately \$190,000, and the majority of the payments were made between August 2001 and May 2003.

The nature of the specific services that the consultant and consultant/lobbyist provided the program manager was unclear.

The consultant's agreement with the program manager (never signed by either party) and the consultant/lobbyist's agreement with the program manager (executed one year after the agreement's effective date) both stated that:

“This fee is paid for your efforts in helping secure the program, as well as your continued consulting services for the length of the contract.”

In response to our inquiry about the nature of the consultant's services, the program manager stated that the consultant provided “services in the areas of business development and economic and strategic consulting.” When we requested to review examples of the consultant's work products, the program manager responded that the consultant “was generally not asked to produce work products.”

With respect to the consultant/lobbyist's engagement with the program manager, we noted the following:

- This consultant/lobbyist was registered as a lobbyist for Clarendon (from 2002 through 2003), the program manager (2001), and the program manager's successor company (from 2001 through 2003). The owner of the program manager company has, on numerous occasions, represented himself as an agent of Clarendon. Given the ambiguity of the program manager's role (see Chapter 4-B for additional details), it is not clear whether payments of CHIP funds from the program manager to the consultant/lobbyist comply with state laws prohibiting the use of state funds for lobbying activities.
- The program manager stated that the consultant/lobbyist provided consulting services at no cost for approximately one year prior to the start-up of CHIP on May 1, 2000. According to the program manager, the arrangement was that if “... the program was successfully launched” (that is, if Clarendon was awarded the EPO contract), then the consultant/lobbyist would be compensated. In addition, according to the program manager, “If the program did not materialize, then ... [the consultant/lobbyist] ... worked at her own expense/risk.” The program manager reports that the consultant/lobbyist's agreement was terminated effective December 31, 2003.

The Commission has indicated that it was aware that the consultant and consultant/lobbyist worked for the program manager but that it was not aware of the terms of the agreements.

Recommendations

The Commission should:

- Ensure that all subcontractors receiving CHIP funds provide necessary, measurable products or services in exchange for the funds they receive.
- Given the unique financial risks associated with the CHIP EPO contract, independently audit subcontractors' use of CHIP funds to ensure that it is fully aware of how all these funds are used.
- Ensure that agreements among subcontractors are documented and that subcontractors' agreements and payment rates are reported to the Commission.

The Commission's Contracting Practices Did Not Provide for Adequate Contract Provisions or Controls

After the Commission began self-insuring the cost of medical claims that Clarendon processed, its contracting practices did not establish provisions or controls that adequately safeguarded CHIP funds. The decision to self-insure the cost of medical claims beginning on May 1, 2001, fundamentally altered the scope and nature of the Commission's contract with Clarendon. After this modification, the Commission assumed financial responsibility for the medical claims that Clarendon processed and Clarendon assumed little to no financial risk for the EPO contract.

Although the Commission assumed financial responsibility for the cost of medical claims, it allowed Clarendon to continue to act as a custodian of CHIP funds without adequate contract terms or financial controls over the use of those funds. The following are examples of the Commission's inadequate contracting practices:

- After the first year of the contract, the Commission continuously renegotiated Clarendon's obligations while it continued to pay Clarendon. For example, from May 1, 2001, through March 26, 2002, the Commission paid Clarendon at least \$123.26 million in payments that were the subject of these negotiations. These payments were not inappropriate given the terms of the original contract. However, this situation (1) created uncertainty regarding the State's financial obligation and (2) put the Commission in the potentially disadvantageous position of negotiating payments it had already made before contract terms were defined.
- The Commission did not establish adequate contract terms to prohibit Clarendon from inappropriately using \$15.96 million of CHIP funds for its corporate use. Because the contract terms did not prohibit this, however, this was not a violation of the contract.
- The Commission did not establish adequate financial reporting requirements or controls to identify \$2.41 million of misreported revenues and expenditures that resulted in an inappropriate \$835,739 overstatement in Clarendon's invoice for additional contributions. The Commission identified part of the overstatement but paid the entire amount of this invoice anyway.

While making contracting decisions was within the Commission's authority, management's execution of modifications to Clarendon's contract constituted a non-competitive procurement. After its decision to self-insure medical claims, the Commission did not request bids to procure the services Clarendon provided in order to determine the market rate of those services. In addition, the Commission's extensive use of contract amendments to retroactively change contract terms significantly undercut the competitive nature of its contracting practices because it effectively precluded the opportunity for other contractors to submit bids to provide these services. Contract modifications created additional risks that the Commission was not paying a market rate for Clarendon's services and that Clarendon could inappropriately use CHIP funds.

The Commission Did Not Finalize Amendments in Its Contract with Clarendon in a Timely or Appropriate Manner

The Commission paid Clarendon while it continued to negotiate the terms of Clarendon's contract and alter the scope of services Clarendon was required to provide. Most of the payment terms and the scope of service changes were made through retroactive amendments. While retroactively amending the contract was within Commission management's authority, frequent use of retroactive contract amendments does not represent best management practice. Modifications to Clarendon's contract resulted in uncertainty regarding the Commission's financial obligations. Retroactively amending the contract also put the Commission at a disadvantage when it negotiated the cost and scope of services provided and financial risk assumed in return for funds it had already paid to Clarendon. In addition, the Commission did not specify the level of reinsurance coverage Clarendon should obtain with the \$2.61 million the Commission paid Clarendon for this purpose. The Commission also inappropriately intervened in a dispute between Clarendon and a subcontractor that increased the amount the Commission paid Clarendon by \$120,967.

The Commission consistently amended Clarendon's contract retroactively.

While simultaneously renegotiating Clarendon's and the Commission's obligations, from May 1, 2001, through December 12, 2003, the Commission made payments to Clarendon that were the subject of these negotiations. These payments were not inappropriate given the terms of the original contract. However, this situation (1) increased financial uncertainty and (2) put the Commission in the potentially disadvantageous position of negotiating payments it had already made.

It is significant that, from May 1, 2001, through December 12, 2003, the Commission was not paying Clarendon under finalized contract terms; it later executed retroactive contract amendments for this entire period. The amendments retroactively adjusted the Commission's financial obligations and Clarendon's corresponding role as insurer for the program. In some instances, these retroactive amendments required Clarendon to adjust payments to its reinsurers.

Examples of retroactive amendments to the Commission's contract with Clarendon include the following:

- On March 26, 2002, the Commission finalized an amendment that retroactively shifted financial responsibility for the cost of medical claims to the Commission effective May 1, 2001 (10 months and 25 days earlier). During this period, the Commission paid Clarendon \$123.26 million while still negotiating these contract terms.
- On May 21, 2003, the Commission finalized an amendment that retroactively removed Clarendon's responsibility for administering the CHIP drug benefit and reduced Clarendon's premium payments by approximately 20 percent after March 1, 2002 (14 months and 20 days earlier).
- On May 21, 2003, the Commission finalized an amendment that retroactively committed the Commission to pay \$2.61 million in reinsurance costs and limited

the Commission's maximum financial obligation as of October 1, 2002 (seven months and 20 days earlier).

- On December 12, 2003, the Commission finalized an amendment that eliminated Clarendon's obligation to pay for a portion of reinsurance coverage effective October 1, 2002 (14 months and 11 days earlier) and reduced Clarendon's administrative fees effective September 1, 2003 (3 months and 11 days earlier). See Chapter 4-A for additional details regarding this reinsurance issue.

We have previously reported on the Commission's lack of timeliness in executing contractual agreements (see *An Audit Report on the Health and Human Services Commission's Monitoring of Managed Care Contracts*, SAO Report No. 04-011, November 2003).

The Commission did not specify the level of reinsurance coverage Clarendon would obtain.

The Commission paid Clarendon a total of \$2.61 million for reinsurance coverage between October 1, 2002, and August 31, 2003, without establishing contract terms specifying the type or amount of reinsurance coverage Clarendon should purchase. Amendment five to the Commission's contract with Clarendon allowed Clarendon to use CHIP funds to secure reinsurance coverage for this period. However, that amendment did not include a specific description of the type and amount of reinsurance coverage that Clarendon should purchase or the deadline by which Clarendon should have purchased this reinsurance. By not including specific terms regarding reinsurance coverage in its contract, the Commission inappropriately relied on Clarendon to use \$2.61 million in a manner that would mitigate the Commission's exposure to financial risk. As noted in Chapter 1-A, the need for this reinsurance was questionable; Chapter 4-A provides additional details regarding Clarendon's inappropriate use of funds intended for reinsurance.

At the Commission's direction, Clarendon used funds that were earmarked for the payment of medical claims to settle a payment dispute with a subcontractor.

At the direction of the Commission, Clarendon used \$120,967 in funds that were earmarked for the payment of medical claims to pay for an enrollment enhancement project. Clarendon subcontracted this entire project, but the payment terms it reached with its subcontractor resulted in an additional financial obligation for Clarendon. In a December 2001 letter, the Commission intervened in the subcontractor's dispute with Clarendon by allowing Clarendon to use \$120,967 from its CHIP bank accounts to resolve the dispute. On December 14, 2001, Clarendon paid its subcontractor that amount.

These costs were outside the Commission's contractual obligation. The Commission's paying these costs resulted in an apparent violation of the Texas Constitution, Article III, Sections 51 and 44, which prohibit agencies from paying extra compensation beyond that specified in the contract. In addition, the manner in which the Commission chose to provide Clarendon with additional funds did not comply with the terms of its contract with Clarendon. The contract prohibited changes to contracted services, deliverables, or any other aspect of the contract without the execution of a written contract amendment.

Recommendations

The Commission should:

- Refrain from modifying existing agreements with contractors that extend beyond the scope of the contractors' original obligations without rebidding procurement for the service.
- Ensure that it competitively procures services provided by contractors.
- Execute contract amendments prior to their effective date.
- Rebid procurements for which it is not able to successfully negotiate an agreement within the scope of its original contract.
- Ensure that its contracts include clear specifications and time lines regarding the products and services that contractors agree to provide. It should adopt contracting practices that prohibit contract terms that specify only dollar amounts of items such as reinsurance.
- Prohibit staff and management from entering into informal contractual arrangements on behalf of the Commission and ensure that staff and management comply with all state contracting and procurement laws and requirements.

Chapter 3-B

The Commission Did Not Establish Adequate Terms in Its Contract with Clarendon to Safeguard CHIP Funds

The Commission did not establish contract terms to (1) prohibit Clarendon from using \$15.96 million inappropriately for its corporate use or (2) ensure that Clarendon identified \$2 million in erroneous and unsupported transfers between its CHIP and corporate accounts. The Commission's decision to self-insure medical claims increased the risk of fraud and inaccuracy of financial reporting because Clarendon retained custody of CHIP funds but, at the same time, was no longer financially responsible for erroneous, exorbitant, or fraudulent payments. Prior to the decision to self-insure, the Commission had relied on Clarendon's financial liability for program costs as a control to promote efficiency and reduce fraud; this incentive was no longer applicable after the Commission decided to self-insure medical claims.

Clarendon inappropriately used \$15.96 million in CHIP funds.

We identified the following instances in which Clarendon inappropriately used funds in its CHIP bank accounts:

- Clarendon inappropriately used as much as \$10.3 million from its CHIP bank accounts to cover part of the loss it incurred from paying medical claims from the first contract period. Clarendon reported that it incurred a loss of approximately \$11.28 million when it fully insured claims in the first contract period. To offset most of this loss, however, Clarendon inappropriately applied capitation payments it received during the second contract period to the losses it incurred in the first contract period. It appears that the Commission's intent was that Clarendon should use funds received in the second contract period to pay claims costs incurred after the Commission began self-insuring claims (beginning with

the second contract period on May 1, 2001). It is significant that the Commission did not adopt contract terms that specifically prohibited Clarendon from borrowing from its CHIP bank accounts to pay for medical claims costs that it incurred in the first contract period.

Clarendon borrowed the \$10.3 million from its CHIP bank accounts and did not completely reimburse these accounts until 27 months later. It transferred approximately \$6.8 million on March 22, 2002; \$1.9 million on May 5, 2003; and \$2.2 million on July 7, 2003. Moreover, Clarendon did not completely reimburse these accounts until after we began reviewing transfers from its CHIP bank accounts in April 2003. In addition, Clarendon's contract with the Commission does not address whether Clarendon would owe the Commission interest during the period that Clarendon held these funds. If the Commission had restricted Clarendon's use of its CHIP bank accounts and required Clarendon to pay interest at the rates received by the Texas Local Government Investment Pool (TexPool), we estimate that an additional \$286,760 would be available for the CHIP program.

- Clarendon arbitrarily transferred amounts out of its CHIP bank accounts into its corporate bank accounts to pay for its underwriting fees and reinsurance. These transactions occurred on an irregular basis and did not equal Clarendon's own calculations of what it should have paid itself. The balance of these transfers, when compared with the monthly payments Clarendon earned from the Commission, varied from a positive balance of \$5.66 million to a negative balance of \$1.92 million for the period from May 1, 2001, to April 30, 2003. The retroactive nature of the Commission's contract modification process (discussed above) limited Clarendon's ability to pay itself correctly for underwriting fees and reinsurance.

Clarendon reconciled its underwriting and reinsurance fees between May 1, 2001, and April 30, 2003, but these reconciliations of Clarendon's fees still were not adequate to prevent the positive and negative balances described above. If the Commission had required Clarendon to pay interest on the claims fund balance at the rates received by TexPool, Clarendon could have incurred an interest liability of \$99,541 through April 30, 2003, on excessive monthly balances in its corporate bank accounts. We were not able to verify whether Clarendon accrued interest on state and federal funds held in its corporate bank accounts.

The Commission lacked controls to detect \$2 million in errors and unsupported transactions processed by Clarendon.

The Commission failed to develop an adequate control structure to ensure that Clarendon used approximately \$2 million of CHIP funds as the Legislature intended. The following examples of errors and unsupported transactions underscore the need for controls to monitor Clarendon's use of CHIP funds:

- On July 2001, Clarendon transferred \$1 million into its CHIP bank accounts in error. It did not identify and reverse this transaction until July 2003, two years after the error occurred.

- In August 2002, Clarendon deposited \$130,000 of recoupments it had received from erroneous claims payments into its corporate accounts. Clarendon asserts that this error occurred because one of its employees did not understand which accounts were associated with CHIP and which accounts were Clarendon's separate corporate bank accounts.
- Clarendon's reconciliations of its underwriting fees and reinsurance excluded transactions totaling \$872,742 that were associated with transfers into its CHIP bank accounts. We were not able to determine the impact of these transactions on the balance of the CHIP funds that Clarendon paid itself because Clarendon was not able to provide sufficient documentation for their purpose.

In addition, on April 20, 2001 (10 days before the Commission began self-insuring claims and during the time that Clarendon was reporting a loss of approximately \$11.28 million), Clarendon transferred \$3 million from its CHIP bank accounts into its corporate bank account and held these funds until December 11, 2002. It transferred that amount back into its CHIP bank accounts approximately 20 months later. This transfer did not affect the balance of the CHIP claims fund calculation or interest because it involved funds the Commission paid Clarendon during the first contract period when Clarendon was still insuring medical claims. However, it is an example of Clarendon's lack of control and monitoring of CHIP funds. Clarendon asserts that this transfer occurred because of an error on the part of a new employee.

Recommendations

The Commission should:

- Audit Clarendon's use of premium payments it received after May 1, 2001, when the Commission began self-insuring the cost of medical claims. This audit should include verification of the dates of service for claims paid to verify that the Commission did not pay for claims for which Clarendon was financially responsible during the first contract period.
- Consider limiting contractors' possession of state and federal funds associated with contracted agreements.
- Determine whether Clarendon earned interest on (1) the \$10.3 million in CHIP funds it borrowed and (2) the balance in the CHIP claims fund (that rose as high as \$5.66 million) and recoup any applicable interest Clarendon earned on those funds.
- Stipulate that contractors hold state and federal funds in interest-bearing bank accounts and specify that interest earned on those funds should accrue to the State.

The Commission Failed to Establish Financial Reporting Requirements or Controls to Monitor Clarendon's Use of CHIP Funds

The Commission did not establish adequate financial reporting requirements or controls to ensure that CHIP funds were used as the Legislature intended. Information the Commission collected from Clarendon was not adequate to determine how Clarendon used the funds in its CHIP bank accounts.

The Commission did not establish adequate requirements for Clarendon to request additional contributions to the CHIP claims funds.

After the Commission began self-insuring claims, it did not establish requirements to address how Clarendon should report \$2.41 million in revenues and expenditures when it submitted invoices to request additional contributions to pay medical claims. This resulted in Clarendon's submitting an invoice for additional funding that was overstated by \$835,739. The Commission did not establish requirements that provided adequate guidance for reporting transactions such as certain administrative fees, recoupments from claims overpayments, and additional funds for an enrollment enhancement project. As a result, Clarendon's first invoice to the Commission to request \$4.4 million in additional funding inappropriately included the following errors, resulting in invoice overstatements (these are examples only, and the net effect of the overstatements listed below and understatements subsequently listed below does not equal the full \$835,739 overstatement):

- \$630,581 in fees that Clarendon paid a consultant but that it reported as medical claims
- \$318,099 in payments Clarendon received from the Commission for an enrollment enhancement project but did not include in its invoice; Clarendon received these funds in association with a prior contract amendment
- \$283,543 in administrative drug processing fees that Clarendon reported as prescription drug claims
- \$32,266 in administrative processing fees that Clarendon reported as claims payments

Examples of invoice understatements and other errors included:

- \$564,599 in payments that Clarendon made to a subcontractor for an enrollment enhancement project but did not include in its invoice; Clarendon made these payments in association with a prior contract amendment with the Commission
- \$582,422 in refunded claims Clarendon had recouped from erroneous claim payments, duplicate claim payments, or adjustments in claims payments that were reported as medical claims (because it inadvertently resulted in the correct net impact on the amount Clarendon requested, this reporting inaccuracy did not affect the amount of funds Clarendon requested from the Commission)

The Commission's contracted actuary identified the \$630,581 in consulting fees and the \$32,266 in administrative processing fees as discrepancies, but the Commission

still contributed the entire amount Clarendon requested on its invoice for additional funds to pay medical claims.

In addition, at the time Clarendon invoiced the Commission to request this additional funding, it had not reimbursed its CHIP bank accounts for approximately \$4.1 million of the \$10.3 million in CHIP funds that it had inappropriately used to cover its reported loss in the first contract period. Clarendon submitted a second invoice to the Commission for the month of April 2003¹¹ before it had settled this obligation. While this was inappropriate, the Commission did not identify this and did not specifically prohibit Clarendon from borrowing from its CHIP bank accounts.

The Commission did not establish adequate reporting requirements or controls to track the balance of the CHIP claims fund calculation.

The Commission did not modify its requirements for Clarendon's financial deliverables to enable it to verify the claims fund balance calculation, which was the basis for determining whether the Commission was obligated to contribute additional funds to pay the cost of medical claims. In addition, Clarendon's bank account structure did not directly track the correct, mathematical calculation of the CHIP claims fund balance. This prevented the Commission from independently monitoring its financial responsibility for the Clarendon contract.

The Commission required Clarendon to submit financial statistical reports (FSR) at least quarterly to report its monthly expenditures for CHIP. However, the components reported on its FSR and the manner in which these components were used in calculations were not adequate to determine the true balance of the CHIP claims fund calculation.

The contract amendment through which the Commission self-insured the cost of medical claims did not specify the account structure Clarendon should use to track the correct, mathematical balance of the CHIP claims fund. Despite the establishment of the claims fund calculation, the amendment did not require Clarendon to separate CHIP funds in bank accounts that would specifically compose the CHIP claims fund. As a result, when Clarendon requested additional funding on March 13, 2003, its invoice was based on a claims fund calculation that did not equal the amount of funds in its CHIP bank accounts. To determine the true amount of CHIP funds in Clarendon's possession at any time, the Commission would have had to perform (but did not perform) additional monitoring and verification of Clarendon's underlying bank accounts. Chapter 4 discusses additional inadequacies in the Commission's contract monitoring practices.

Recommendations

The Commission should:

- Recoup the \$835,739 overpayment it made to Clarendon based on the overstatements in Clarendon's March 13, 2003, invoice.

¹¹ We did not audit or review Clarendon's April 2003 invoice requesting additional contributions to pay medical claims.

- Adequately define the manner in which contractors are required to report and classify all components that support contractors' invoices requesting additional funds from the Commission.
- Include requirements in its contractual agreements to ensure that contractors use state and federal funds only for purposes intended by the Legislature and federal law.
- When permitting contractors to retain custody of state or federal funds:
 - ♦ Specify bank account and financial control structures that account for all state and federal funds provided to or recouped by contractors.
 - ♦ Require periodic reporting of the use and balance of state and federal funds it provides to contractors.

The Commission's Monitoring and Enforcement of Its Contract with Clarendon Was Inadequate to Safeguard CHIP Funds and to Ensure that Clarendon Used Those Funds as Intended

The Commission did not adequately monitor and enforce its contract with Clarendon to safeguard CHIP funds and to ensure that those funds were used as intended. Some of the issues that the Commission's monitoring failed to identify or adequately address include the following:

- Approximately \$1.79 million in CHIP funds that were not used for reinsurance coverage as intended (\$750,000 of that amount was inappropriately transferred from the CHIP bank accounts to Clarendon's corporate bank accounts)
- Provisions in the reinsurance contract that allow Clarendon to recover as much as 35 percent (approximately \$385,000) of the net profit from reinsurance
- Potential recovery of any of the overpayments made on medical claims or any of the \$1.71 million in overpayments for prescription drug claims reported by Clarendon

The Commission did not enforce the financial reporting requirements in Clarendon's contract, nor did it audit Clarendon's financial operations, despite a number of known problems with Clarendon's financial controls. In addition, the Commission did not ensure that Clarendon executed written contracts with the subcontractors to which it subcontracted virtually all of its administrative functions. Furthermore, the Commission did not appropriately carry out its own responsibilities to ensure that Clarendon's subcontractors were able and prepared to fulfill Clarendon's contractual obligations.

Chapter 4-A

The Commission Did Not Adequately Monitor Clarendon's Use of CHIP Funds or Enforce Contractual Financial Reporting Requirements

The Commission did not adequately monitor or enforce numerous provisions in its contract with Clarendon. After the Commission assumed liability for the cost of EPO medical claims in the second year of CHIP, it did not develop any new policies or procedures to ensure that Clarendon spent CHIP funds in a manner compliant with the financial and administrative provisions of its contract.

CHIP funds that the Commission paid to Clarendon to purchase reinsurance coverage were not used as intended.

The Commission did not monitor Clarendon's use of the \$2.61 million in funds it paid to Clarendon to purchase reinsurance coverage. As noted in Chapter 3-A, the Commission did not define the type and amount of reinsurance it required in contract amendment five; instead, it specified only the amount of funding that the Commission and Clarendon would each contribute to purchase reinsurance. In addition, the Commission reports that, until December 2003, it did not obtain a copy

of the reinsurance policy Clarendon purchased for the period from October 2002 through August 2003.

Our review of the reinsurance contract Clarendon purchased pursuant to contract amendment five and of related financial records identified that Clarendon (1) transferred \$3.36 million in funds from CHIP bank accounts, which inappropriately included \$750,000 Clarendon should have contributed separately from its own funds, (2) did not spend the full amount of the Commission's contributions for reinsurance, (3) will likely recover a 35 percent profit commission on the net profit from reinsurance, and (4) obtained reinsurance coverage for time periods that were not consistent with the coverage periods defined in amendment five:

- Clarendon collected \$3.36 million, instead of \$2.61 million, from CHIP bank accounts for reinsurance. Contract amendment five specified that total reinsurance contributions would be \$2.15 per member per month, of which the Commission would contribute \$1.67 per member per month and Clarendon would contribute \$0.48 per member per month (Clarendon was to pay this amount out of its own funds). These rates equaled contribution amounts of approximately \$2.61 million from the Commission and approximately \$750,000 from Clarendon, for a total reinsurance cost of approximately \$3.36 million.¹² Although the Commission later retroactively rescinded Clarendon's obligation to pay for part of the reinsurance coverage, Clarendon did not contribute its share of the purchase price of the reinsurance premiums stipulated in the contract amendment during the effective period of the amendment, nor did it reduce the amount of fees it paid to itself to reflect its own contribution to the purchase of reinsurance coverage. Clarendon transferred the full \$3.36 million, instead of \$2.61 million, from the CHIP bank accounts to its corporate bank account. As of March 2004, Clarendon had not returned approximately \$750,000 that it had inappropriately transferred to its own corporate account for reinsurance.
- Clarendon did not spend the full amount of the Commission's contribution for reinsurance. Clarendon paid only \$1.57 million to the reinsurer for reinsurance coverage, leaving approximately \$1.79 million (of the \$3.36 million that Clarendon transferred into its account) in excess funds unspent. The contract amendment between the Commission and Clarendon did not address the ownership of unspent reinsurance contributions made by the Commission or whether the Commission and Clarendon should have made prorated contributions toward the price paid for the reinsurance coverage.
- Clarendon's reinsurance contract contained a "profit commission" clause that allowed it to recover 35 percent of the net profit from reinsurance. As discussed in Chapter 1-A, it is very unlikely that reinsurance will be needed; thus, Clarendon could collect a profit commission totaling as much as \$385,000¹³ based on its actual reinsurance payments of \$1.57 million. Although the

¹² The Commission retroactively rescinded Clarendon's contribution amount of \$0.48 per member per month with the execution of amendment seven in December 2003. Amendment seven redefined the total reinsurance amount from \$2.15 per member per month to \$1.67 per member per month.

¹³ The profit commission amount is based on the assumption that no reinsurance claims will be submitted and that reinsurance expenses account for 30 percent of the gross reinsurance payments, which includes all deductions and brokerage fees, in accordance to the terms of the reinsurance contract.

Reinsurance Profit Commission

An insured company is allowed to recover a specified percentage of net profit it realizes on the difference between (1) its payments to the reinsurer and (2) the reinsurer's payments and other incidental costs toward the company's insured liabilities.

Commission paid for the reinsurance coverage, its contract with Clarendon did not address whether the Commission would receive any portion of the profit commission Clarendon could receive from reinsurance coverage (see text box for additional details).¹⁴ Other than how much the Commission and Clarendon would each contribute to the purchase price of the reinsurance, the Commission's contract with Clarendon did not discuss any details of the terms and conditions of reinsurance.

- The reinsurance contract that Clarendon purchased specified internally inconsistent coverage periods, none of which coincided with the timeframes stipulated in Clarendon's contract amendment with the Commission. The overall period of coverage for the reinsurance contract Clarendon purchased was specified as October 1, 2002, through September 1, 2003. However, the reinsurance contract was internally inconsistent because it also specified periods of coverage for three

liability levels that went from October 1, 2002, through September 30, 2003. Moreover, neither the reinsurance contract's overall period of coverage nor the periods of coverage for the three liability levels agreed with the period of coverage defined in contract amendment five, which defined the reinsurance period as October 1, 2002, through August 31, 2003.

Despite Numerous Red Flags, the Commission Has Not Audited Clarendon's Financial Records

The Commission has not audited Clarendon, despite numerous red flags that indicated Clarendon had financial control problems. Examples include the following:

- In February 2001, the Department of Health cited Clarendon for inadequate staffing and information systems, a lack of documented policies and procedures, and inadequate tracking mechanisms for provider billings.
- A subsequent follow-up by the Commission in July 2001 found similar problems. Specifically, subcontractor staff were inadequately trained on state laws and regulations, provider claims were not priced according to contract requirements, and claims policies and procedures were not documented. In addition, the Commission's review of Clarendon's claims administrator determined an error rate of 21.7 percent in claims processing during the first nine months of the contract. The Commission's July 2001 report estimated that overpayments to providers ranged from \$997,496 to \$1,096,404 and that underpayments ranged from \$146,647 to \$161,188.
- Clarendon reported operating losses of approximately \$11.28 million for the first year of CHIP, which was the largest reported loss of any of the CHIP managed care organizations. Clarendon's reinsurer notified Clarendon in March 2002 that it was withholding approximately \$2 million in reinsurance payments to Clarendon due to concerns about claims overpayments and administrative problems. The reinsurer required Clarendon to audit its outpatient physician, pharmacy, and hospital claims as a prerequisite to a settlement of the withheld amount.
- The Commission was aware that Clarendon had hired a consultant to study its pharmacy benefit manager. The consultant identified overpayments in excess of \$1.7 million. Many of these overpayments were made after the Commission self-insured CHIP EPO medical claims. The Commission did not request a copy of the consultant's report to determine whether any of the overpayments had been recovered or should have been reimbursed to the State.

Although the EPO contract permits it to do so, the Commission did not audit Clarendon's financial records.

Despite known problems with Clarendon's financial controls such as overpayments to providers and overpayments on drugs (see text box), the Commission has not audited or obtained an audit of Clarendon (or any of its CHIP managed care organizations) since CHIP began in May 2000. The Commission's contract with Clarendon permits the Commission to audit Clarendon's financial records and supporting documents related to the program. We previously reported on the Commission's failure to audit managed care organizations (see *An Audit Report on the Children's Health Insurance Program at the Health and Human Services Commission*, SAO Report No. 03-022, March 2003; and *An Audit Report on the Health and Human Services Commission's Monitoring of*

¹⁴ Any profit commission that Clarendon could realize will be determined by November 15, 2004.

Managed Care Contracts, SAO Report No. 04-011, November 2003).

The Commission did not develop procedures to verify Clarendon's invoice for additional funding and the balance of the CHIP EPO claims fund.

The Commission did not develop procedures to (1) verify data supporting Clarendon's invoice requests for additional funding and (2) monitor components of the claims fund calculation.

As discussed in Chapter 3-C, we reviewed Clarendon's invoice for additional funding submitted in March 2003¹⁵ and identified \$946,390¹⁶ in administrative fees that Clarendon inappropriately paid using funds intended for the payment of claims.

Clarendon included these administrative fees in its request for additional funding despite its contracted agreement to provide all administrative services at the fixed per-member, per-month rate it received. The contract does not include reimbursement provisions that allow Clarendon to recoup any additional administrative expenses from the Commission. Clarendon states that it received permission from the Commission to pay these administrative expenses with funds intended for the payment of claims. However, neither Clarendon nor the Commission was able to provide any documentation that supports or refutes this assertion. We were not able to determine whether Clarendon reimbursed any of the CHIP bank accounts for the \$946,390 it inappropriately paid based on the financial data we obtained from Clarendon. Additional issues we identified regarding Clarendon's invoices requesting additional funding and the claims fund bank accounts are discussed in further detail in Chapter 3-C.

The Commission's assumption of the financial liability for EPO medical claims on May 1, 2001, created the need to develop new monitoring procedures over the claims fund balance and to verify any requests by Clarendon for additional funding. However, the monitoring procedures the Commission developed were inadequate. These procedures relied on the Commission's contracted actuary to use unverified data that Clarendon self-reported. In addition, the information the actuary used for monitoring was not comprehensive enough to enable the actuary to independently and accurately calculate the claims fund balance. As discussed in Chapter 3-C, the actuary identified only \$662,847 of the \$2.41 million in discrepancies we identified on Clarendon's March 2003 invoice requesting additional funds to pay medical claims.

The Commission's assumption of liability also increased the need for regular audits of Clarendon's CHIP-related finances. The lack of audits and monitoring procedures for Commission staff to verify the claims fund balance prevents the Commission from safeguarding CHIP funds and ensuring the accuracy of invoices requesting additional funding for the claims fund.

¹⁵ Clarendon submitted a second invoice for April 2003, which we did not review.

¹⁶ The \$946,390 figure includes \$630,581 in consulting fees reported as medical claims, \$283,543 in administrative drug processing fees reported as prescription drug claims, and \$32,266 in administrative processing fees reported as claims payments.

The Commission did not enforce Clarendon's contractual financial reporting requirements.

Clarendon submitted incomplete CHIP financial statistical reports (FSR) to the Commission for four contract periods covering calendar years 2000 through 2003.

CHIP Financial Statistical Reports

A CHIP financial statistical report (FSR) is a quarterly report of a CHIP managed care organization's self-reported administrative, reinsurance, and medical expenditures; enrollment figures; and demographics associated with CHIP. The FSR compiles key operating program costs associated with claims payment processing and the medical provider network. The FSR was designed to enable the Commission to evaluate and assess CHIP medical expenditures.

All CHIP managed care organizations (including Clarendon) are required to file FSRs with the Commission on a quarterly basis, and they are required to submit an annual FSR for each contract period. Although improvements to the FSR format are needed (as discussed in Chapter 3-C), the report does provide some useful financial information for monitoring purposes. Our limited review of Clarendon's FSRs identified several compliance issues and accuracy problems in the financial information Clarendon reported:

- Clarendon did not consistently report the correct monthly capitation payments it received from the Commission.
- Clarendon did not report the cost components of its subcontracted administrative costs as required in the FSR template. Clarendon did not report the actual payments made to its claims administrator¹⁷ or its program management subcontractor (see Chapter 2 for discrepancies regarding the payment rates to both of these subcontractors). In addition, Clarendon did not separately identify and include in the appropriate section of the FSR the payments it made to its affiliate for additional program management services. Those payments totaled \$5.53 million from May 1, 2000, through April 30, 2003.
- Clarendon did not report detailed administrative overhead expenses such as salaries, rent, utilities, and fees as the FSR requires. Instead, it reported a summary of its total program administrative expenses.
- Clarendon did not report \$6.96 million in reinsurance recoveries it received from May 1, 2001, through April 30, 2002.

Inaccurate and incomplete financial reporting by Clarendon poses a significant barrier to the Commission's ability to monitor the use of CHIP funds.

Recommendations

The Commission should:

- Develop objective policies and procedures to monitor the financial terms and payments made on reinsurance contracts obtained by contractors. It should also promptly obtain copies of these reinsurance contracts.
- Recoup the approximate \$750,000 that Clarendon transferred from the CHIP accounts to its corporate accounts for reinsurance (\$750,000 was the amount Clarendon was to contribute to reinsurance from its own funds). The Commission should also attempt to collect the balance of \$1,040,000 in unspent

¹⁷ Costs associated with the claims administrator represent approximately 29 percent of the total program administration costs.

funds that Clarendon transferred from the CHIP accounts to its corporate accounts for reinsurance but did not spend.

- Recoup any profit commission (estimated at \$385,000) that Clarendon may receive from its reinsurer (given that CHIP funds were used to pay the entire cost of the reinsurance Clarendon obtained).
- Recoup any overpayments for medical claims or for prescription drugs that were made after May 1, 2001, when the State assumed responsibility for the cost of both of these items.
- Obtain regular, independent audits of the CHIP EPO at least every two years. These audits should encompass key financial components such as administrative revenues, administrative expenses, medical claims, and drug claims. These audits should also examine:
 - ♦ The accuracy of the EPO's financial deliverables, including the accuracy of revenues and expenditures reported in the EPO's annual FSR. The audit should verify key FSR components such as premium revenues, incurred claims, investment income earned on CHIP funds, medical expenses, medical management expenses, and administrative expenses.
 - ♦ The EPO's established internal controls for reporting program revenues and expenditures, including those internal controls related to reporting reinsurance premiums, reinsurance recoveries, medical claim refunds, and medical claim recoveries.
 - ♦ The EPO's compliance with statutory requirements regarding the timely processing and payment of provider medical claims.
 - ♦ If applicable, the EPO's subcontractors' internal controls that ensure compliance with federal, state, and contractual requirements.
- Develop objective policies and procedures to use in regularly analyzing and monitoring the EPO's financial deliverables. It should also ensure that the EPO provides data that is comprehensive enough to enable the Commission to independently and accurately calculate the claims fund balance.

Chapter 4-B

The Commission Did Not Monitor to Ensure that Clarendon's Subcontracts Were Written and Executed with Appropriate Contractual Provisions

The Commission did not ensure that Clarendon had written and executed contracts with its multiple subcontractors or that those contracts included provisions that were appropriate to the service or activity Clarendon delegated to the subcontractor. This is particularly critical because Clarendon subcontracted virtually all of its work on the CHIP EPO contract to subcontractors (see Appendix 3).

Both federal regulations¹⁸ and the Commission's own contract with Clarendon require contracts with subcontractors to be in writing. However, with the exception of Clarendon's subcontracted program manager contract, which is discussed below, the Commission did not obtain any of Clarendon's contracts with subcontractors until May 2001, a full year after Clarendon began serving as the CHIP EPO. In addition, although the Commission's contract with Clarendon provides for the Commission's review and approval of contracts with subcontractors, the Commission did not review or approve any of these contracts. Furthermore, the Commission did not serve Clarendon with a notice of default for noncompliance with notification requirements concerning contracts with subcontractors until May 2003, three years after Clarendon began serving as the CHIP EPO.

The Commission was unaware of the terms between Clarendon and its affiliate, which provided program management services to the CHIP EPO program. From May 1, 2000, through April 30, 2003, Clarendon paid this affiliate \$5.53 million in administrative fees; however, there was no contract or service agreement regarding this affiliate's administrative responsibilities or the basis of its fees.

The lack of written contracts among Clarendon and its subcontractors does not comply with federal regulations governing the use of federal funds or with Clarendon's contract with the Commission. The absence of written contracts also increases the risk that services will not be provided or administered as specified in Clarendon's contract with the Commission and that CHIP funds will not be used as intended.

The Commission lacked an adequate understanding of the role of Clarendon's program manager.

The Commission's ability to monitor the Clarendon contract was hindered by its inadequate understanding of the role of Clarendon's program manager. The program manager operated on Clarendon's behalf for CHIP without a written contract from the beginning of the program in May 2000 until February 2002. Additional issues involving the program manager's remuneration are discussed in Chapter 2.

The Commission has indicated that it was aware that a consultant and a consultant/lobbyist worked for the program manager but that it was not aware of the terms of the agreements. Payments for these agreements totaled approximately \$2.2 million from May 2000 through December 2003 and are discussed in more detail in Chapter 2. The Commission stated in its May 2003 notice of default to Clarendon that notification requirements extended to "contracts negotiated by subcontractors, such as the [successor program manager]'s subcontract with [the claims administrator]."

Commission management and staff have provided different descriptions of the relationship between the program manager and Clarendon. Different Commission staff members believed that the program manager was (1) an employee of Clarendon, (2) acting as a general managing agent for Clarendon, (3) a broker for Clarendon, and/or (4) a contractor for Clarendon. The program manager's contract that was finally executed with Clarendon in February 2002 assigned the program manager

¹⁸ Code of Federal Regulations, Title 42, Section 434.6 (b)

several responsibilities. However, the program manager's role was essentially that of providing advice, coordination, and monitoring. The program manager contract did not give the program manager authority to make decisions on Clarendon's behalf.

The reviewing of subcontracted service agreements is an essential component in coordinating and monitoring the use of federal and state funds and ensuring that those funds are spent in the most cost effective manner, particularly when the Commission has assumed the financial liability of medical claims.

Recommendations

The Commission should:

- Develop objective policies and procedures to use in monitoring the CHIP EPO's compliance with contractual provisions.
- Ensure that the CHIP EPO has written, executed contracts with all subcontractors and affiliates that fully comply with the EPO's contract terms and applicable laws and regulations.
- Gain a thorough understanding of the role of all subcontractors and obtain all contracts between the CHIP EPO and its subcontractors.

Chapter 4-C

Readiness Reviews Performed for Clarendon Were Neither Comprehensive nor Timely

The initial readiness review performed for Clarendon was not as thorough as the readiness reviews conducted for the other CHIP managed care organizations. In addition, the readiness review report was not released until May 2000, the month in which the CHIP EPO contract became effective. At that time, however, a number of Clarendon's operational and information systems were still not complete, and Clarendon's contract with the Commission had still not been executed. This is evident in some of the issues identified in the readiness review. For example, the readiness review indicated that the following items still needed to be addressed:

What Are Readiness Reviews?

Texas Health and Safety Code, Section 62.051, requires the Commission to review each entity that contracts to provide CHIP managed care services to ensure that the entity is prepared and able to fulfill its contractual obligations.

- Verify the execution of final contracts with all subcontractors.
- Monitor the development of the provider network.
- Review and verify the development of the provider information system to be used by subcontractors.
- Review the complaints and appeals process and any coordination requirement if either was to be included in the final contract between the Commission and Clarendon.
- Verify the member services handbook and the training of member services staff.
- Review Clarendon's ability to reconcile accounts.

- Monitor whether Clarendon experiences any claims payment difficulties that may result from the program's not relying on Social Security numbers.

The Commission did not follow up on all of the operational issues that were identified in the initial readiness review. In November 2000 (more than six months after the start of CHIP), a follow-up review of information systems related to the provider network and claims payment processing was conducted. Although the review did examine some of the issues that the initial readiness review recommended for follow-up, it did not (1) follow up to ensure that Clarendon executed written contracts with its subcontractors or (2) review Clarendon's ability to reconcile accounts. As discussed in Chapter 4-B, problems with unexecuted contracts with some subcontractors continued to persist, and, as discussed in Chapter 3-B, problems related to Clarendon's ability to reconcile its accounts also continued to persist.

The Commission did not ensure that a readiness review was conducted for the drug claims payment process of Clarendon's pharmacy benefit manager.

The Commission elected not to conduct a readiness review of the claims processing system of Clarendon's pharmacy benefit manager (PBM).¹⁹ The Commission has indicated that it did not view PBMs as a primary system under a managed care organization service delivery framework. However, from May 1, 2000, through April 30, 2002, drug claim payments and associated processing costs totaled \$27.83 million, approximately 17 percent of Clarendon's total expenditures during that period.

A consultant Clarendon hired at the behest of its reinsurer later determined that the PBM had made estimated overpayments of approximately \$1.71 million for the period from May 1, 2000, through February 28, 2002. The Commission did not follow up on the consultant's report until after we inquired about the status of any possible recoveries of overpayments and whether any recoveries might be due back to the State.

The Commission did not adequately ensure that Clarendon corrected deficiencies identified in the readiness review of a new medical management services subcontractor.

Although the Commission had approximately seven months to perform a readiness review of Clarendon's new medical case management subcontractor, it did not complete its review of that subcontractor until two weeks before that subcontractor was to assume these duties. The Commission's delay left inadequate time for Clarendon to correct a serious deficiency prior to the Commission's approving the change in subcontractors. Specifically, the Commission's readiness review determined that Clarendon could not ensure that the previous subcontractor would transfer key historical data relating to the medical management and care coordination functions to the new medical management subcontractor. Despite Clarendon's failure to correct this deficiency, the Commission approved the change in subcontractors. The Commission's contract with Clarendon requires the Commission to approve or disapprove terminations or substitutions in major nonprovider contracts; however, the Commission gave its approval for the change in

¹⁹ The Commission did not review the pharmacy benefit management functions for any of the CHIP managed care organizations. The Commission took over the management of the CHIP drug benefit during 2002.

subcontractors based on a contingency plan that did not include transferring historical medical management and care coordination data from the old subcontractor to the new one.

Recommendations

The Commission should:

- Develop and implement risk-based criteria for readiness reviews that consider both the financial- and service-related significance of all primary and secondary health services provided under the CHIP EPO contract.
- Develop and implement a standardized process to conduct follow-up reviews regarding deficiencies identified during CHIP EPO readiness reviews.
- Determine whether any of the \$1.71 million in overpayments in prescription drug claims are recoverable and, if so, recoup those amounts.

Appendices

Appendix 1

Objective, Scope, and Methodology

Objective

The primary objective of this audit was to continue assessing the Health and Human Services Commission's (Commission) 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) with respect to the Children's Health Insurance Program (CHIP) exclusive provider organization (EPO) contract and subcontracts. Prior State Auditor's Office reports that addressed the Commission's business improvement plan include: *An Audit Report on the Health and Human Services Commission's Monitoring of Managed Care Contracts* (SAO Report No. 04-011, November 2003) and *An Audit Report on the Health and Human Services Commission's Prescription Drug Rebate Program* (SAO Report No. 03-029, April 2003).

Scope

Our scope included the Commission's administration of the managed care contract with Clarendon National Insurance Company (Clarendon), the CHIP EPO. The scope covered the following:

- Review of the Commission's records from May 2000 through December 2003.
- Review of Clarendon's records from May 2000 through April 2003.
- Review of selected records of Clarendon's subcontracted program manager from May 2000 through May 2003.

Our primary focus was on processes related to contract oversight and monitoring. Issues identified in oversight and monitoring processes led to selected work on financial accountability controls, payment/reimbursement processes, and contract establishment processes related to the amendment of managed care contracts. This audit did not include a review of any specific information systems.

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 the Commission's executive management, actuary, program management and staff, and fiscal and accounting services management and staff

- Interviews with executive management and/or staff of Clarendon and its subcontractors
- The Commission's contract management policies and procedures for managed care
- Commission reports, interoffice memoranda, program reports, and accounting records
- CHIP EPO contract procurement documents
- CHIP EPO contract and amendments between the Commission and Clarendon
- Clarendon's subcontractor agreements
- Subcontractors' vendor agreements
- CHIP EPO reinsurance contracts
- Clarendon's and selected subcontractors' CHIP EPO-related bank statements and financial records

Procedures and tests conducted included the following:

- Analysis of Clarendon's and selected subcontractors' bank statements and financial records
- Limited review of the Commission's actuarial CHIP EPO financial analysis
- Assessment of the Commission's monitoring practices and processes
- Limited review of Clarendon's readiness reviews
- Limited review of Clarendon's and its subcontractors' original contracts and respective contract amendments
- Limited review of Texas CHIP EPO reinsurance contracts
- Assessment of Clarendon's and other CHIP managed care organizations' CHIP financial statistical reports
- Limited review of Clarendon's and its claims administrator's claims payment data

Analytical techniques used included the following:

- Data reconciliation
- Data comparison
- Data completeness and standardization

Criteria used included the following:

- United States Code of Federal Regulations
- Social Security Act
- The Texas Constitution, Texas statutes, and the Texas Administrative Code
- U.S. Centers for Medicare and Medicaid Services' State Medicaid Manual and the Texas CHIP State Plan
- State Auditor's Office methodology manual
- The Commission's policies and procedures

Other Information

The fieldwork for this audit was performed from November 2002 through March 2004 in accordance with generally accepted government auditing standards; there were no 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
- Dorvin Handrick, CISA, CDP
- Leslie Ashton, CPA (Quality Control Reviewer)
- Joanna B. Peavy, CPA (Audit Manager)
- Frank Vito, CPA (Audit Director)

Management's Responses and Auditor's Comments

Auditor's Comments Regarding Management's Overall Responses

To clarify our position, we acknowledge the noncompetitive environment that existed when the contract was originally let, and we are not questioning the Commission's decision to enter into a full-risk arrangement in the first year of its contract with Clarendon. We are also not questioning the Commission's decision to self-insure the cost of medical claims beginning in the second contract period. Our issues center on the administrative and insurance-related fees that the Commission paid Clarendon after self-insuring the cost of medical claims. Given the assumption of risk by the Commission, continuing to pay these fees was not necessary, not reasonable, and not prudent. Although the Commission disagrees that these fees were excessive, it does not disagree with our recommendations and asserts that it is implementing significant changes to its contracting practices.

The Commission's assertion that the fees in question can be assessed as "too high" only with the benefit of hindsight ignores actuarial advice available to decision-makers at the time the contract amendments in question were executed. Much of our conclusion regarding the Commission's abuse of its fiduciary responsibility hinges on the Commission's choice to disregard the actuarial advice it received at the time it was making decisions. The Commission could not provide evidence indicating why it disregarded its contracted actuary's analysis, and it lacked other analyses that would confirm or dispute its contracted actuary's analysis.

The Commission also asserts that it was in a weak negotiating position because Clarendon was the only firm willing to bid on services. The Commission will never know whether other firms might have submitted bids to provide EPO services after it decided to self-insure the cost of medical claims because it did not attempt to reopen the procurement for competition. As we specified in the report, the decision to self-insure the cost of the EPO medical claims resulted in the Commission's essentially paying Clarendon for only its administrative services. If the Commission had rebid the newly revised EPO contract services for the second year of the contract, it is likely that other firms would have submitted competitive bids to administer an essentially no-risk contract. In addition, the Commission was under no contractual obligation to renegotiate with Clarendon at all, and it was not obligated to pay Clarendon the fees Clarendon demanded.

In its response, the Commission asserts that it assessed the possibility of bringing the EPO services in-house. However, during our audit, it could not provide us with any documentation regarding this type of analysis.

With respect to specific comments in the Commission's overall responses, we offer the following comments:

Underwriter's fees. The Commission lacks an adequate explanation for why it believed it was required to pay Clarendon underwriter's fees. As noted in our report, the Commission paid \$10.1 million in underwriter's fees between May 2001 and August 2003 *after* the Commission decided to self-insure the cost of medical claims. Clarendon carried little or no insurance risk, and it subcontracted all administrative

functions (for which it received a separately negotiated fee). The Commission had feasible and more economical service delivery alternatives to paying Clarendon an underwriter's fee when Clarendon provided little or no insurance coverage. By the time its contract expires in August 2004, Clarendon will have received an additional year of underwriter's fees past the time period we audited.

Reinsurance. The purchase of reinsurance for any of the three contract periods was simply not necessary from a risk perspective. The Commission's own actuary advised the Commission that it could avoid the cost of reinsurance and that it was unlikely that reinsurance coverage would be needed. That advice has proven to be accurate given actual claims experience. With respect to the \$2.61 million the Commission paid Clarendon to purchase reinsurance on its behalf for contract periods three and four, the Commission asserts that it was eliminating the State's exposure to risk. This statement is unsupported, however, because the Commission's contract amendment with Clarendon to purchase reinsurance only states how much money the Commission will pay Clarendon. The amendment does not define what type of reinsurance Clarendon should purchase or whether the reinsurance should provide coverage for catastrophic claims or aggregate claims. Hence, the Commission lacks the grounds to assert that the agreement eliminated risk to the State or provided any degree of certainty.

Risk Charge. The Commission notes that it recouped \$500,261 of the \$1 million it paid Clarendon for a risk charge. This recoupment was made in accordance with the terms of the contract. However, the critical point is that Clarendon was allowed to keep approximately \$500,000 of CHIP funds, when the Commission's contracted actuary advised against paying Clarendon a risk charge at all (or paying Clarendon a relatively minimal amount). It is not clear why the Commission agreed to pay Clarendon this risk charge.

Administrative Fees. The Commission asserts that administrative fees were established through a negotiation process. However, as noted above, the Commission was under no contractual obligation to renegotiate with Clarendon at all, and it was not obligated to pay Clarendon the fees Clarendon demanded. Our estimate of \$5.3 million in excessive fees is the most conservative estimate that can be made given the fact that the Commission never competitively rebid the EPO contract and never established objective, documented benchmarks for administrative fees.

The Commission's statement that it saved \$1.8 million by reducing administrative fees as of September 1, 2003, reinforces our conclusion that the rates in effect before that date were excessive. The rates in effect as of September 1, 2003, are the same rates we used to calculate the \$5.3 million in excessive fees *prior* to September 1, 2003.

Management's Overall Responses



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

June 30, 2004

Lawrence F. Alwin, CPA
State Auditor's Office
1501 North Congress Avenue
Austin, Texas 78701

Dear Mr. Alwin:

Attached please find the Health and Human Services Commission's (HHSC) management response to the State Auditor's Office draft audit report on the administration of the CHIP Exclusive Provider Organization (EPO) contract. We appreciate the opportunity to review the draft, identify and resolve outstanding issues, and provide a response to SAO.

HHSC's experiences over the past several years with the CHIP EPO contract, as well as other contracts, led to the recognition that many improvements in contract management were required. Management took decisive action to affect significant change throughout the division, including a comprehensive transformation project in the Medicaid/CHIP Division that included re-engineering contract management policies and procedures. The recommendations in this report serve both to inform and to validate many of the improvements already implemented in Medicaid/CHIP including:

- Reprourement of the CHIP EPO with a new EPO contract structure including specific improvements such as a Tailored Remedies Matrix to clearly identify required performance and identify related remedies for non-performance of contract requirements and Financial Reporting Requirement improvements,
- Procurement of resources to conduct financial audits,
- Consolidation of contract oversight functions and establishment of standardized contract processes and management policies and procedures,
- System design and testing of an automated Contract Administration and Tracking System (CATS),
- Restructuring of Medicaid/CHIP Division organization and management,
- Development of a performance audit request for proposals (RFP), and
- Procurement of readiness review services.

The issues raised in this and previous audits have been extremely helpful to our implementation of more rigorous contract administration and management practices and we are grateful to you

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

and your staff for the guidance you have provided. However, I believe it important to point out that the draft report omits the historical context necessary to understand that the first EPO contract was negotiated rather than competitively procured—a primary factor affecting the cost of the contract.

The audit scope, from May 2000 through December 2003, covers the CHIP EPO procurement during its riskiest time. The EPO model was a new concept for Texas. That fact, doubled with the newness of the CHIP program without any historical data on which to develop rates, precluded a competitive procurement. The state established an objective in May 1999 that HHSC role out CHIP statewide by July 1, 2000. HHSC released a request for proposals (RFP) for EPO services in Texas rural communities and in response, HHSC received no proposals that were responsive to the requirements of the RFP.

Following the failed EPO procurement, the Texas Department of Insurance (TDI) brought HHSC and Clarendon together during the winter and spring of 1999-2000. TDI also arranged for HHSC to meet with other national insurance companies during the same period. One company made an offer for a fully-insured arrangement of about \$120 per member per month (PMPM). HHSC began negotiations with Clarendon—the only respondent to the RFP—and, in time to meet the deadline for statewide implementation, negotiated a fully-insured agreement that cost about 30 percent less than the other company.

A loss of over \$10 million during the first year of the contract made the situation even less attractive to the marketplace for the following years and, as a result of these losses, Clarendon and HHSC renegotiated the PMPM fee. Clarendon originally offered to continue its fully-insured arrangement for the second year of the contract at a 67 percent rate increase. Although the program was new and the early experience had been poor, it was the opinion of HHSC and its consulting actuary that Clarendon's proposed rate increase was excessive. At this point HHSC faced a number of options; refuse to negotiate, at the risk that Clarendon would back out of the contract due to its actual and anticipated losses, maintain the current agreement but at a significantly increased rate, bring the function in-house, or attempt to reprocur EPO services.

There was no reason for any prudent decision-maker to believe a second procurement would produce a result different from the first - the only factor that changed in the environment that produced no viable proposals a year earlier was the recent history of losses experienced in the previous year by Clarendon. HHSC assessed the possibility of in-sourcing management and administration of the EPO program but due to federal limitations on program administration expenses elected to continue to outsource for EPO services. HHSC decided, with the assistance of its consulting actuary, to enter into a partially self-funded arrangement. The results of this decision were more favorable to the state compared to the other alternatives.

Now four years later, with the viability of the EPO model proven, HHSC had a competitive procurement that resulted in another contractor securing the CHIP EPO business.

The draft we have reviewed states that HHSC paid \$20 million in “excessive or unnecessary” fees to Clarendon and has abused its fiduciary responsibilities. Given the level of information, experience, and understanding now available, a retrospective conclusion that rates paid were too high is clearly justifiable. However, to characterize the decisions reached in a negotiated arrangement to achieve expressed state objectives as an abuse of “fiduciary responsibility” is overly subjective and unfair. The following sections detail HHSC’s perspective associated with the components of these fees.

Underwriter’s fees

If the CHIP EPO function was to be contracted, rather than managed in-house, this fee would be required, even when the arrangement with Clarendon changed in the second and subsequent periods of the contract. This fee was negotiated and it was management’s decision that the fee was reasonable in the context of the overall contract and necessary payment levels.

Reinsurance

Although HHSC’s external consulting actuary advised HHSC with respect to contract period two that the state could afford the risk associated with the amounts covered by reinsurance, HHSC made the decision to eliminate that risk and instead pay a set fee for reinsurance to cover individual catastrophic claims between \$1 million and \$5 million. A single claim in this range, had it occurred, would have cost significantly more than the premium of about \$684,000 over that seventeen-month period. The same can be said for contract periods three and four. HHSC made the decision to pay a finite amount to purchase reinsurance, rather than accept the risk to which not purchasing reinsurance would expose the state. These decisions were made under conditions of uncertainty. While the advice of actuaries, staff, and others were considered, HHSC made decisions considering the information and the position of the insurance market that existed at the time.

Risk Charge

HHSC recouped \$500,261, or about half of the risk charge it paid Clarendon for contract period two, and did not pay a risk charge at all beginning with contract period three.

Administrative fees for the Clarendon contract were not unilaterally established by HHSC, but were developed through a negotiation process. Because Clarendon was the only firm willing to work with HHSC to put a CHIP EPO plan together, there were no market prices for comparable goods and services. This provided Clarendon with a strong negotiating position. In addition, HHSC relied on Clarendon’s representations about contractual obligations to its subcontractors that, based on the SAO report, may not have existed at the time fees were negotiated.

During the period from May 2001 through August 2003, HHSC actively attempted to negotiate reduced administrative fees. Except for a few instances of minor fee reductions, Clarendon refused to reduce the charge until September 1, 2003, when HHSC successfully negotiated an administrative fee reduced to a level deemed appropriate by HHSC and its external consulting actuary. SAO estimated \$5.3 million in excess administrative fees by calculating the difference

HHSC Management Response
June 30, 2004
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between (1) the original fee HHSC paid while negotiations took place and (2) the fee that HHSC would have paid over that period of time had the later negotiated rate been in place. We disagree that this was a reasonable way to assess the impact of the negotiated fee reductions. It is not reasonable or supportable in a dynamic environment to assume that a rate negotiated in current conditions could have been achieved in a period two years earlier. In reality, by renegotiating administrative fees as of September 1, 2003, HHSC calculates that it has reduced costs approximately \$1.8 million to date.

Finally, I believe it is important to remember that Texas implemented its CHIP program in less time than any comparable program in the nation. The model Texas used for CHIP required the program to be built from the ground up. Many states opted to integrate the CHIP program within an already existing Medicaid program.

While there were challenges and weaknesses in managing the CHIP EPO contract, from a service delivery standpoint the CHIP program in Texas has been an overall success. The 76th Texas Legislature passed the enabling legislation for CHIP in May 1999. The program was operational by May of 2000, and within 12 months, over 300,000 children had been enrolled in the program.

Sincerely,



Albert Hawkins

c: Legislative Audit Committee
Dr. Charles Bell, Deputy Executive Commissioner for Health Services
David Balland, Interim Associate Commissioner for Medicaid and CHIP
Billy Millwee, Deputy Medicaid/CHIP Director for Contract Operations
David Griffith, HHSC Internal Audit Director

AH/BM

Management's Responses to Individual Chapters

Chapter 1-A

Management Response: While HHSC recognizes that fees paid were high, HHSC disagrees that it paid Clarendon excessive insurance-related fees during the second, third, and fourth periods of the contract. HHSC's decisions related to these fees were made under conditions of uncertainty. While the advice of actuaries, staff, and others were considered, HHSC made decisions considering the information and the position of the insurance market that existed at the time.

Actions Completed or Planned:

- *Re-procure the CHIP EPO contract where the contractor is at "full risk" for costs in excess of the negotiated premiums paid.*

Estimated Completion Date: New contract will go into effect on September 1, 2004

- *Institutionalize cost/benefit analysis in each contact and amendment HHSC elects to award to an external vendor.*

Estimated Completion Date: Implemented

- *HHSC assessed the effectiveness of the EPO model and completed a cost/benefit analysis to determine if the Primary Care Case Management (PCCM) model would be more cost effective or better meet the needs of HHSC, providers, and clients. Based on the results of that analysis, HHSC completed the award of the full-risk EPO contract to Superior Health Plans, Inc. HHSC will continue to assess the costs and benefits associated with maintaining the EPO model in the CHIP program.*

Estimated Completion Date: Complete

- *Effective June 7, 2004, the Medicaid/CHIP Division consolidated contract administration within the division. One of the reasons for segregating contract administration from program management was to ensure subrogation of responsibilities. The Contract Operations Unit will not complete or process a contract amendment without a written assessment by program staff of all associated risks and any dissenting opinions about the proposed contract change. If professional advice was obtained in assessing various contract options, staff will be required to indicate if the professional advice provided was followed and if not, why not.*

Estimated Completion Date: Complete

- *Each Medicaid/CHIP contract, including the CHIP EPO contract, now contains an appendix that establishes contract performance measures and associated liquidated damages for failure to perform. The recently awarded CHIP EPO contract contains these performance management provisions.*

Estimated Completion Date: Complete.

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

Auditor's Follow-Up Comment

The Commission's decision to self-insure the cost of medical claims beginning in the second contract period removed uncertainty regarding the financial risk the EPO contractor would assume. Therefore, it is disingenuous for the Commission to suggest that, after that decision, it was operating under conditions of uncertainty. After the decision to self-insure medical claims was made, the Commission continued to pay Clarendon insurance-related fees to insure the program despite the fact that Clarendon bore little to no risk for the cost of medical claims. Therefore, insurance-related fees were avoidable.

At the time it was making decisions, the Commission chose to disregard the actuarial advice specifying that the insurance-related fees Clarendon proposed were either excessive or unnecessary. The Commission could not provide evidence indicating why it disregarded its contracted actuary's analysis, and it lacked other analyses that would confirm or dispute its contracted actuary's analysis.

Chapter 1-B

Management Response: HHSC recognizes that fees paid were high, however, HHSC disagrees that it paid as much as \$5.3 million in excessive administrative fees to Clarendon. Because HHSC's negotiations with Clarendon took place in a noncompetitive environment created by the fact that Clarendon was the only respondent to the Request for Proposals (RFP) issued by the Commission, Clarendon was in a strong negotiating position. During the period from May 2001 through August 2003, HHSC attempted to negotiate a reduction in administrative fees to a level more consistent with other CHIP health plans. Except for a few instances of minor fee reductions, an agreement to significantly reduce the charge was not reached until September 1, 2003, when HHSC was successful in negotiating an administrative fee to a level deemed appropriate by HHSC and its external consulting actuary. The key to that success was the change in the market environment where more than one insurer had expressed interest in an EPO procurement.

Although the administrative fee required by Clarendon was higher than that charged by the other CHIP health plans, it was the best rate HHSC could negotiate. While it is conceivable that re-bidding the contract once it moved to a self-funded arrangement could have resulted in a lower rate, the rural nature of this plan severely limited the number of potential vendors. In fact, during the initial implementation phase, HHSC had received offers and/or held discussions with most of these potential vendors and was satisfied that, at the time, Clarendon offered the best value.

At the time HHSC decided to move to a self-insured arrangement, the program still was in its infancy and experience with the contractor was limited. In those circumstances, management had every reason to believe that it could effect a reduction in administrative costs through negotiation. Once it became clear that such reductions could not be negotiated and that other insurance entities would

compete in any reprocurement, HHSC management used the planned reprocurement to leverage administrative cost reductions effective September 2003.

Actions Completed or Planned:

- *Re-procure the CHIP EPO contract and pursue a full-risk arrangement.*

Estimated Completion Date: Complete

- *The Medicaid/CHIP Division has implemented a process to better analyze proposed contractor fees. Specifically for contract amendments, the contractor is required to provide detailed cost information for the prime contractor as well as any subcontractors. HHSC validates the projected workload data and metrics against (1) the original workload, metrics, and costs proposed by the contractor in the base contract or (2) if the work is new, to prevailing market rates.*

Estimated Completion Date: On-going

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

- *An RFP to acquire financial audit services for its managed care and Texas Medicaid Administrative System (TMAS) contracts has been initiated. A contract will be awarded by August 2004. Independent verification of the rate contractors report they pay to their subcontractors and affiliates will be a part of the audit work plan. The audit will be coordinated and performed with oversight provided by the Health and Human Services Office of the Inspector General (OIG) with possible assistance from HHSC Internal Audit.*

Estimated Completion Date: A contract will be awarded by August 2004 and estimated completion date for the audit is January 2005.

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

Auditor's Follow-Up Comment

The Commission's response acknowledges that Clarendon's administrative fees were too high and that the Commission spent more than two years attempting to negotiate a reduction in those fees. After deciding to self-insure the cost of EPO medical claims, the Commission chose to agree to rates that its actuary assessed as excessive rather than attempt to competitively bid the administrative services provided by Clarendon. The Commission's decision to self-insure the cost of medical claims created a fundamental change in the nature of the EPO contract, and that change dramatically increased the likelihood that other contractors would bid to provide administrative services on what had essentially become a no-risk contract. It is worth noting that the Commission itself points out that it was market competition that forced Clarendon to agree to a rate reduction.

Chapter 2

Management Response: Although program management is a function typically provided by managed care organizations, HHSC agrees that it is not a service

typically separately subcontracted by managed care organizations. The exclusive provider organization, however, is in no way a typical managed care organization. There is no comparable plan for coverage of statewide rural children in Texas. Because of this, there is no historical factual basis for making comparisons between this arrangement and others. This is a one-of-a-kind plan that required innovative approaches from both HHSC and its contractor.

Actions Completed or Planned:

- *HHSC has implemented a requirement that contract administration, as well as contract financial support staff, review all subcontracts entered into by any Medicaid/CHIP contractor. Contract administration staff will ensure that the duties performed by the subcontractor are reasonable and necessary for the execution of contract requirements and financial staff will ensure that costs are reasonable.*

Estimated Completion Date: Complete

- *An RFP to acquire financial audit services for its managed care and Texas Medicaid Administrative System (TMAS) contracts has been initiated. A contract will be awarded by August 2004. Independent verification of subcontractor's use of CHIP funds will be a part of the audit work plan. The audit will be coordinated and performed with oversight provided by the Health and Human Services Office of the Inspector General (OIG) with possible assistance from HHSC Internal Audit.*

Estimated Completion Date: A contract will be awarded by August 2004 and estimated completion date for the audit is January 2005.

- *Based on the results of the audit, HHSC will determine if any of the undocumented payments to Clarendon's Program Manager are recoverable, and recoup those amounts.*

Estimated Completion Date: Any identified recoupments will be initiated within 30 days of the receipt of final audit results.

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

- *HHSC will contractually require vendors to submit any subcontracts to HHSC for review before implementation. Absent an HHSC reviewed and approved subcontract, any expense paid to a subcontractor by the prime contractor will be disallowed.*

Estimated Completion Date: Complete

Auditor's Follow-Up Comment

The Commission's response does not explain why it paid Clarendon for subcontracted program management. As we specify in our report, payments to the program manager were excessive, and it is questionable whether the Commission should pay a separate, additional fee to Clarendon to coordinate and oversee its own subcontractors. The Commission asserts that the "one-of-a-kind" nature of the EPO

contract required it to develop “innovative approaches” such as program management services. However, it is important to note that the EPO was required to operate under a model that relied on managed care principles followed by all managed care organizations. The Commission’s original contract with Clarendon also did not contain terms defining the unique program management responsibilities or why subcontracted program management was required.

Chapter 3-A

Management Response: HHSC agrees that contract amendments were not always processed at the point in time that a contract change was required. The contracting and amendment process requires negotiation, significant internal review, and final approval by both HHSC and the contractor. Since it is necessary to continue to provide services to program enrollees while negotiations and activities leading to contract execution are taking place, amendments are sometime retroactive. During the period leading to contract execution, it is necessary to continue providing services and paying for services under existing contract provisions.

Actions Completed or Planned:

- *HHSC has undergone a transformation of staff and duties. A newly created contract administration staff has begun to oversee contracts and amendments. Workflow and process training has been provided to all affected Medicaid/CHIP staff. HHSC staff and processes have been put in place to allow for the efficient movement of contracts and amendments.*

Estimated Completion Date: December 2004

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

- *The Medicaid/CHIP Division consolidated contract administration into a single unit. In addition, a position for a certified contract manager was created. HHSC believes that this consolidation of contract administration within a single unit in the division, as well as establishing minimum, generally accepted credentials for the contract manager, will significantly improve HHSC’s ability to manage Medicaid/CHIP contracts.*

Estimated Completion Date: December 2004

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

- *The Medicaid/CHIP Division, as part of an overall organizational transformation process, developed performance standards for processing contract amendments. Through implementation of the previously mentioned consolidated contract administration unit and performance standards for contracting processes, HHSC believes this change will significantly improve HHSC’s ability to manage Medicaid/CHIP contracts.*

Estimated Completion Date: December 2004

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

- *HHSC developed a performance requirement summary that is incorporated with each contract. Each major contract performance requirement contains a corresponding liquidated damage for failure to perform.*

Estimated Completion Date: Complete

- *The State Medicaid/CHIP Director will issue a notice to all Medicaid/CHIP staff indicating that informal agreements between contractors and HHSC are prohibited. Any contract related agreement must follow the change process established in the affected contract.*

Estimated Completion Date: July 2004

Title of Responsible Person: Associate Commissioner, Medicaid/CHIP

Chapter 3-B

Management Response: An external accounting firm contracted by HHSC will audit the Clarendon contract. The audit will examine all financial aspects of the Clarendon contract, and determine the extent of any fiduciary breach by the contractor and any overpayment of funds. HHSC will recoup these funds and any associated interest.

Actions Completed or Planned:

- *An RFP to acquire financial audit services for its CHIP, managed care, and Texas Medicaid Administrative System (TMAS) contracts has been initiated. Verification of the dates of service for claims paid to confirm that the Commission did not pay for claims for which Clarendon was financially responsible during the first contract period will be a part of the audit work plan. In addition, based on the results of this audit HHSC will determine whether Clarendon earned interest on CHIP funds. If it did, HHSC will recoup any applicable interest Clarendon earned on those funds. Any future Medicaid/CHIP contracts that involve a contractor retaining state funds, similar to the Clarendon arrangement, will contain explicit cash management and interest reporting requirements. The audit will be coordinated and performed with oversight provided by the Health and Human Services Office of the Inspector General (OIG) with possible assistance from HHSC Internal Audit.*

Estimated Completion Date: A contract will be awarded by August 2004 and estimated completion date for the audit is January 2005.

- *HHSC has re-procured the CHIP EPO contract. The new contract is to be based on a full-risk model, which means the contractor will not have custody of federal or state funds.*

Estimated Completion Date: September 2004

- *The requirement that contractors hold state and federal funds in interest-bearing bank accounts and specify that interest earned on those funds should accrue to the state will be included in all future Medicaid/CHIP contracts.*

Estimated Completion Date: September 2004

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

Chapter 3-C

Management Response: The initial Financial Statistical Reporting (FSR) requirements were written for a full risk contract. With the May 2001 contract changes, HHSC determined that the FSRs were not sufficient as a basis for additional payments to Clarendon. To mitigate this weakness, HHSC requested and received improved lag reports, breakdowns of claims, and detailed invoices. These additional items gave HHSC: (1) the Contract period reflecting differences in rates, (2) claims paid, (3) case management fees, (4) prescription payments, (5) enrollments, (6) previous payments to the claims fund, (7) delivery supplemental payments. These additional items helped HHSC distinguish between valid payments and problem areas.

HHSC received input from its external consulting actuary before making additional claims payments to Clarendon. The actuary analyzed the financial condition of the EPO plan each month and prepared a monthly report that HHSC used to determine amounts of additional funding that were required and to estimate funding required for the remainder of the contract period.

Actions Completed or Planned:

- *HHSC recouped \$662,847 of the \$835,739 overpayment, and will issue a demand letter to Clarendon for the balance.*

Estimated Completion Date: July 2004

Title of Responsible Person: Deputy Medicaid/CHIP Director for Health Services

- *Policies and procedures are now in place for both the review of FSRs and for the review, approval, and processing of invoices from contractors.*

Estimated Completion Date: Complete

- *Policies and procedures have been established for contractors to report and classify all components that are necessary to support contractor's invoices requesting additional funds.*

Estimated Completion Date: Complete

- *HHSC will include in all future contracts, requirements that contractors (1) use state and federal funds only for purposes intended by the Legislature and federal law and (2) when given custody of state or federal funds, specify the bank account and financial control structure that account for all state and federal funds provided to or recouped by contractors. In addition, HHSC will require*

periodic reporting of the use and balance of state and federal funds it provides to contractors.

Estimated Completion Date: September 2004

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

Auditor's Follow-Up Comment

The Commission asserts that it mitigated risk by requesting additional information. However, it did not adjust contract terms to formally require the contractor to report data specific to the financial risk the Commission assumed after its decision to self-insure the cost of medical claims. In addition, the Commission did not validate the completeness or accuracy of the information it requested.

Chapter 4-A

Management Response: HHSC does not agree that after it assumed liability for the cost of EPO medical claims in the second year of the CHIP program, it did not develop any new policies or procedures to ensure that Clarendon spent CHIP funds in a manner compliant with the financial and administrative provisions of its contract. When HHSC assumed the risk for the EPO plan, it began preparing a monthly EPO financial statement to determine if Clarendon was allocating CHIP funds to the proper period. HHSC used this information to verify the appropriateness of Clarendon's invoice for additional funds and monitor funds expended by Clarendon. This report also includes an allocation of experience by month, an estimate of the liability for unpaid claims, and a determination of the claims fund balance. The monthly report is a tool that HHSC uses to determine if Clarendon is allocating CHIP funds to the proper period.

Actions Completed or Planned:

- *HHSC will issue a demand letter for payment of the \$750,000 that Clarendon transferred from the CHIP accounts to its corporate accounts for reinsurance and the balance of \$1,040,000 in unspent funds that Clarendon transferred from the CHIP accounts to its corporate accounts.*

Estimated Completion Date: August 2004

Title of Responsible Person: Deputy Medicaid/CHIP Director for Health Services

- *HHSC will issue a demand letter for payment of the \$385,000 profit commission that Clarendon may have received from its reinsurer.*

Estimated Completion Date: August 2004

Title of Responsible Person: Deputy Medicaid/CHIP Director for Health Services

- *HHSC implemented policies and procedures designed to assure that desk review materials and desk reviews are adequate. For future contracts, the FSRs have been revised with complete instructions. HHSC intends to begin recoupments of*

funds based on the SAO findings and assures recoupment of all problematic payments following the HHSC Financial Audit.

Estimated Completion Date: A contract financial audit contract will be awarded by August 2004, the estimated completion date for the audit is January 2005 and any identified recoupments will be initiated within 30 days of receipt of final audit results.

Title of Responsible Person: Deputy Medicaid/CHIP Director for Health Services

- *The Medicaid/CHIP and HHSC Financial Services Divisions will jointly review existing HHSC policies and procedures associated with re-insurance contracts obtained by contractors. The Medicaid/CHIP Division, Health Plan Operations Unit will develop internal policies and procedures.*

Estimated Completion Date: November 2004

Title of Responsible Person: Deputy Medicaid/CHIP Director for Health Services

- *An RFP to acquire financial audit services for its CHIP, managed care and Texas Medicaid Administrative System (TMAS) contracts has been initiated. Through this audit vehicle, HHSC will conduct financial monitoring of division contracts on either an annual or bi-annual basis dependent upon level of risk. The audit will be coordinated and performed with oversight provided by the Health and Human Services Office of the Inspector General (OIG) with possible assistance from HHSC Internal Audit.*

Estimated Completion Date: A financial audit contract will be awarded by August 2004, the estimated completion date for the audit is January 2005 and any identified recoupments will be initiated within 30 days of receipt of final audit results.

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

- *HHSC has developed written policies and procedures to use in analyzing and monitoring EPO financial deliverables. Health Plan Operations staff will ensure that the EPO provide financial and claims data that is comprehensive enough to enable HHSC to independently and accurately calculate the claims fund balance.*

Estimated Completion Date: September 2004

Title of Responsible Person: Deputy Medicaid/CHIP Director for Health Services

Auditor's Follow-Up Comment

After it began self-insuring the cost of medical claims, the Commission did not develop policies and procedures to verify the amount of additional funding Clarendon requested on its invoices. The procedures the Commission asserts it performed were actually performed by its contracted actuary, not by Commission staff. In addition, the procedures the contracted actuary performed were inadequate, as evidenced by its failure to identify the invoice overstatement and associated discrepancies we described in Chapter 3-C.

Chapter 4-B

Management Response: In an attempt to understand the role of the Clarendon program manager, HHSC requested organizational charts for Clarendon and its subcontractors and updated charts representing organizational changes, and met with Clarendon staff on a number of occasions to clarify its understanding of subcontractor roles and responsibilities.

In addition, the Clarendon Program Manager had been employed by Community Health Solutions but, at HHSC's insistence, was transferred to Clarendon's employment in order to render her more effective in monitoring non-provider subcontractors.

Actions Completed or Planned:

- *The new EPO RFP, which will be implemented on September 1, 2004, contains penalties of up to \$5,000 per each incidence of non-compliance in regards to performance of administrative functions, to include providing HHSC subcontracts in accordance with the terms of the contract.*

Estimated Completion Date: September 2004

- *Effective with the development of the RFP to re-procure CHIP EPO services, minimum contract performance standards were developed for use in monitoring EPO performance. These standards will be used as the basis for monitoring the CHIP EPO contractor.*

Estimated Completion Date: September 2004

- *A provision to ensure the CHIP EPO has written, executed contracts with all subcontractors and affiliates that fully comply with the EPO's contract terms and applicable laws and regulations will be incorporated into the CHIP EPO contract. Similar provisions will be included in other division contracts.*

Estimated Completion Date: September 2004

- *All contractors will be required to submit to the Medicaid/CHIP Contract Administration Unit copies of all subcontracts before final execution. Medicaid/CHIP staff will assess each subcontract to determine the value added to the project because of the service provided and the role subcontractors will play in the delivery of services.*

Estimated Completion Date: September 2004

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

Auditor's Follow-Up Comment

To clarify, it appears that the Commission has confused the subcontracted program management company with a contract employee of that company whose title was "program director."

Chapter 4-C

Management Response: As part of the Medicaid/CHIP joint procurement project, HHSC will procure services of a qualified vendor to assist the State by conducting ongoing Managed Care Organization (MCO) Management Information System (MIS)/Operations Readiness and Assessment Reviews. The objectives of this procurement are to provide the State with an independent assessment of each MCO's ability to meet the operational requirements outlined in the MCO contract, improve public accountability, and facilitate decision making by parties with responsibilities to oversee MCO actions to achieve compliance.

Within HHSC's pre-approved schedule, the vendor will be required to perform readiness reviews of each MCO and their material subcontractors, to determine preparedness and readiness for implementation. The vendor will submit a written recommendation to the State, of each MCO's ability to perform the required functions on the required start date of the contract.

A draft Request for Proposal to procure these services is scheduled to be released during August 2004 with a final RFP planned for release during September 2004. Contract award will occur in November 2004.

Actions Completed or Planned:

- *HHSC will procure services of a qualified vendor to assist the state by conducting ongoing Managed Care Organization (MCO) Management Information System (MIS)/Operations Readiness and Assessment Reviews.*

Estimated Completion Date: January 2005

- *HHSC is currently developing a risk and criterion-based readiness review process and will procure services of a qualified vendor to assist the State by conducting ongoing Managed Care Organization (MCO) Management Information System (MIS)/Operations Readiness and Assessment Reviews.*

Estimated Completion Date: January 2005

- *The risk and criterion-based readiness review process HHSC is currently developing includes a follow-up review provision to address deficiencies identified during the readiness reviews, and will procure services of a qualified vendor to assist the State by conducting ongoing Managed Care Organization (MCO) Management Information System (MIS)/Operations Readiness and Assessment Reviews.*

Estimated Completion Date: January 2005

- *HHSC has prepared an RFP to acquire financial audit services for its CHIP, managed care and Texas Medicaid Administrative System (TMAS) contracts. Based on audit results, HHSC will determine if any of the \$1.71 million in overpayments to prescription drug claims are recoverable and recoup these amounts.*

Estimated Completion Date: A contract financial audit contract will be awarded by August 2004, the estimated completion date for the audit is January 2005 and any identified recoupments will be initiated within 30 days of receipt of final audit results.

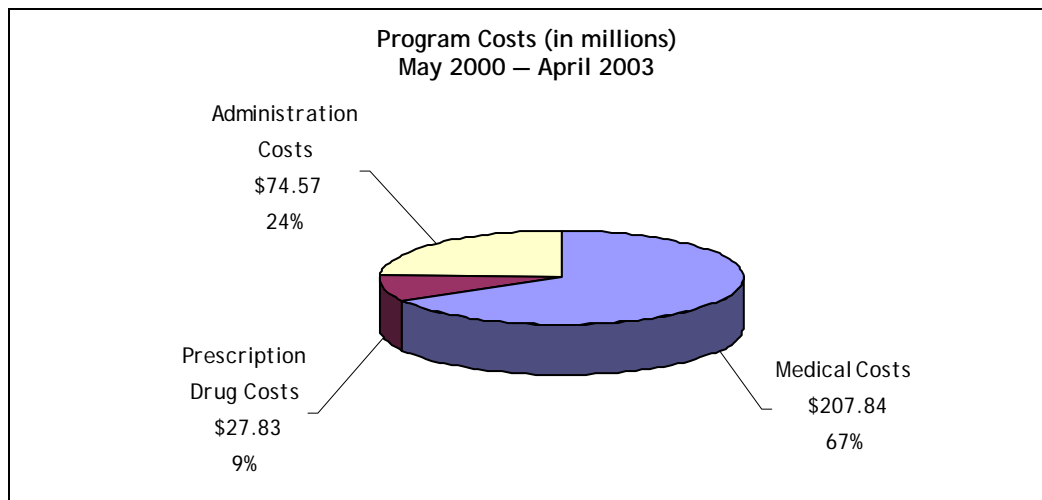
Title of Responsible Person: Deputy Medicaid/CHIP Director for Contract Operations

Background Information on the Children's Health Insurance Program Exclusive Provider Organization Service Delivery Model

Since May 1, 2000, the Commission has contracted with Clarendon to administer the delivery of health care benefits to an average of 105,000²⁰ children per month who live in 170 predominantly rural Texas counties under CHIP. As of April 30, 2003, Clarendon's enrollment population represented 28 percent of the entire CHIP enrollment population. The Commission has paid a capitated-based total amount of approximately \$297 million for the period from May 1, 2000, through April 30, 2003, plus an additional \$1.4 million in supplemental funding for Clarendon's administration of CHIP.

Figures 2 and 3 show (1) an allocation of the primary costs associated with Clarendon's administration of CHIP and (2) the allocated costs associated with the administrative activities managed by Clarendon, respectively.

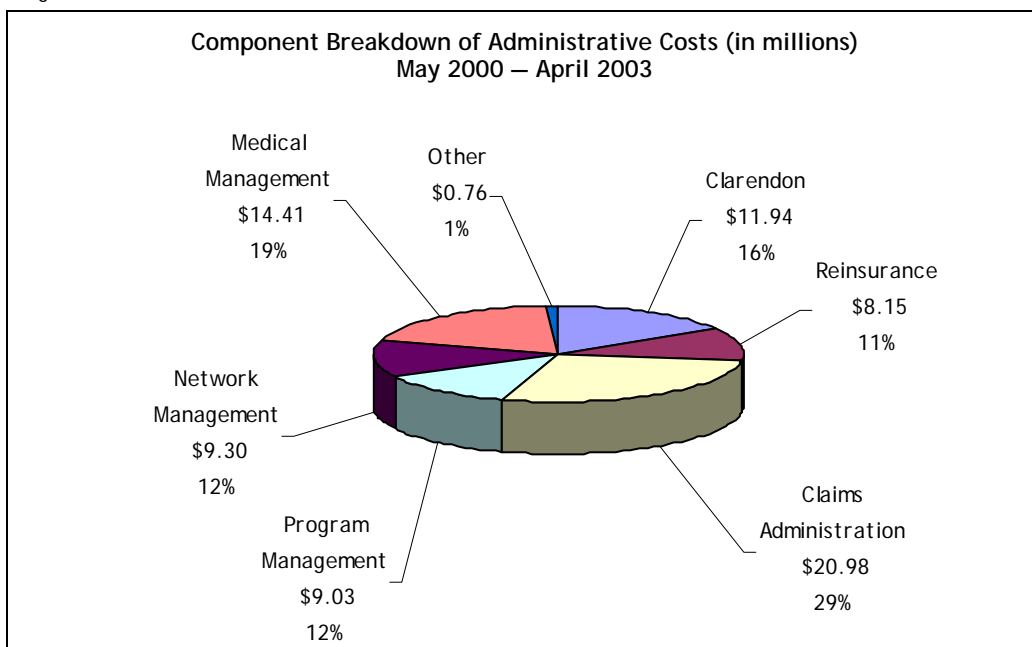
Figure 2



Source: State Auditor's Office analysis of (1) unaudited medical costs reported by Clarendon to pay for claims incurred through April 30, 2003; (2) audited Clarendon administrative costs; and (3) unaudited prescription drug costs reported by Clarendon. The difference between the total expenditures in Figure 2 and the \$298.4 million in payments to Clarendon noted above (\$297 million in capitation and \$1.4 million in supplemental funding) is attributable to Clarendon's reported loss for the first year of the contract and rounding differences.

²⁰ Reported enrollment figure is based on the State Auditor's Office analysis of Clarendon's average monthly enrollment of children from May 2000 through April 2003 according to enrollment reports prepared by the Commission's contracted enrollment broker.

Figure 3



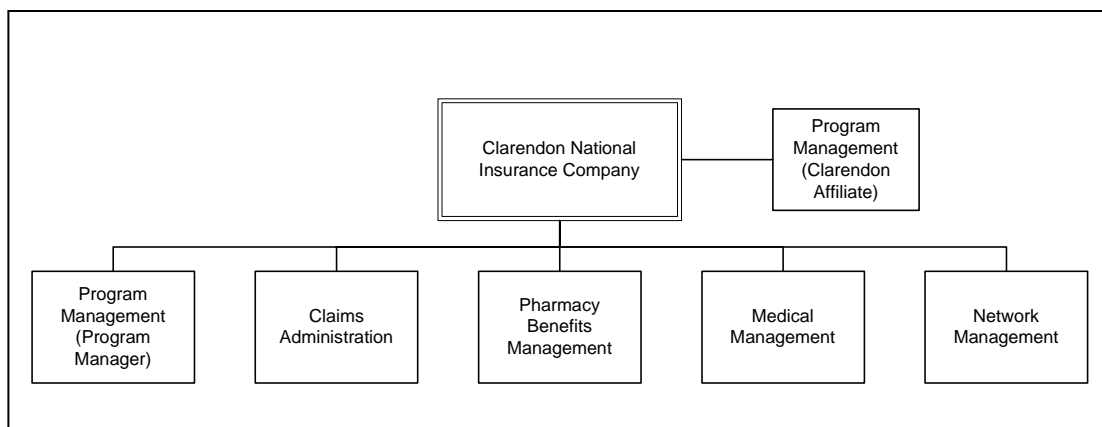
Source: State Auditor's Office analysis of audited Clarendon administrative costs

Clarendon administers CHIP services to children using an exclusive provider organization (EPO) arrangement. The Commission defines an EPO as a group health insurance plan that pays benefits for exclusive provider services. The exclusive provider is a health care professional or an institution that renders its services to covered persons under a group contract pursuant to a contract with an insurance entity licensed by the Texas Department of Insurance.²¹

Clarendon manages the administrative activities associated with the program administration and the operational performance of the CHIP EPO. Clarendon outsources the greater part of these administrative activities. Figure 4 illustrates operational activities that Clarendon outsources to subcontractors.

²¹ When the CHIP EPO was implemented on May 1, 2000, no statutory insurance requirements existed for monitoring or regulating EPO entities. On September 1, 2003, the Department of Insurance adopted Texas Administrative Code, Title 28, Section (1)(3)(kk), to regulate EPO entities. Title 28 establishes regulatory requirements for EPO health insurance plans regarding premium rates, providers and provider networks, quality improvement, utilization management, complaints system, and disclosures.

Figure 4



Source: State Auditor's Office review of Clarendon's subcontractor agreements

- **Program Management** Program management is not an administrative service defined by the contract between the Commission and Clarendon nor is it a typical service subcontracted by health care entities. However, our review of Clarendon's operations indicated that program management encompassed general administrative activities such as accounting services and financial reporting, which were provided by Clarendon's affiliate. Additionally, for the CHIP EPO, program management involves assistance in rate negotiations, marketing oversight, medical provider recruitment, addressing health care provider concerns and issues, subcontractor performance, and various brokering services provided by a subcontracted program manager.
- **Claims Administration** Claims administration involves the processing and payment of medical provider payment claims for health care services provided to health plan members.
- **Pharmacy Benefits Management** Pharmacy benefits management (PBM) involves the processing and payment of pharmaceutical drug claims. Pharmacy benefits management services were provided from May 2000 through February 2002. In March 2002, these services were discontinued after the Commission assumed PBM responsibilities as authorized by contract amendment three.
- **Medical Management** Medical management involves performing a prospective or concurrent review of the medical necessity and appropriateness of health care services currently provided or proposed to be provided to specific patients. Additionally, case management services are provided for special health care needs that require follow-up treatment or specialized health care services.
- **Network Management** Network management involves developing and maintaining a network of medical health care providers and specialists that will offer medical services for the health plan.

The Commission's Maximum Obligations for Paying Medical Claims in Contract Periods Three and Four

The Commission capped its maximum obligation for paying medical claims for the third contract period effective October 1, 2002. During contract periods three and four, the Commission limited its obligation for claims costs to an average of 145 percent (depending on the age group) of the monthly minimum funding amount. Table 4 provides additional details regarding the maximum obligation the Commission agreed to pay.

Table 4

The Commission's Maximum and Minimum Obligation for Medical Claims for Contract Periods Three and Four				
	Under Age 1	Ages 1-5	Ages 6-14	Ages 15-18
Amendment 5 - Contract Period Three (October 2002 - April 2003)				
Minimum Funding Amount (MFA)	\$378.82	\$61.07	\$32.07	\$ 86.03
Maximum Obligation (MO)	\$514.09	\$89.63	\$50.90	\$122.98
Difference (MO - MFA)	\$135.27	\$28.56	\$18.83	\$ 36.95
Percentage of MO/MFA	136%	147%	159%	143%
Average Percentage of MO/MFA for All Age Groups	146%			
Amendment 6 - Contract Period Four (May 2003 - August 2003)				
Minimum Funding Amount (MFA)	\$379.34	\$61.59	\$32.59	\$ 86.55
Maximum Obligation (MO)	\$514.09	\$89.63	\$50.90	\$122.98
Difference (MO - MFA)	\$134.75	\$28.04	\$18.31	\$ 36.43
Percentage of MO/MFA	136%	146%	156%	142%
Average Percentage of MO/MFA for All Age Groups	145%			

Source: State Auditor's Office's analysis of contractual rates in amendments five and six to the Clarendon contract. The rates do not include the portion of premium payments earmarked for administration, reinsurance, risk charge, or case management.

Children's Health Insurance Program Exclusive Provider Organization Enrollment Figures

The CHIP EPO enrollment figures presented in Table 5 are provided by the Commission's Financial Services Division as originally reported by the Commission's contracted enrollment broker. The reported enrollment totals do not include retroactive enrollment adjustments determined after the original reporting month.

Table 5

Reporting Month	CHIP EPO Membership Total
May 2000	4
June 2000	4,930
July 2000	9,813
August 2000	16,180
September 2000	23,073
October 2000	31,329
November 2000	42,866
December 2000	53,019
January 2001	61,498
February 2001	68,314
March 2001	77,162
April 2001	87,472
May 2001	98,222
June 2001	105,927
July 2001	114,075
August 2001	119,083
September 2001	126,935
October 2001	131,117
November 2001	138,375
December 2001	143,250
January 2002	146,495
February 2002	149,572
March 2002	150,802
April 2002	152,155
May 2002	152,477
June 2002	151,124
July 2002	148,671
August 2002	147,133
September 2002	145,263
October 2002	144,121
November 2002	142,201

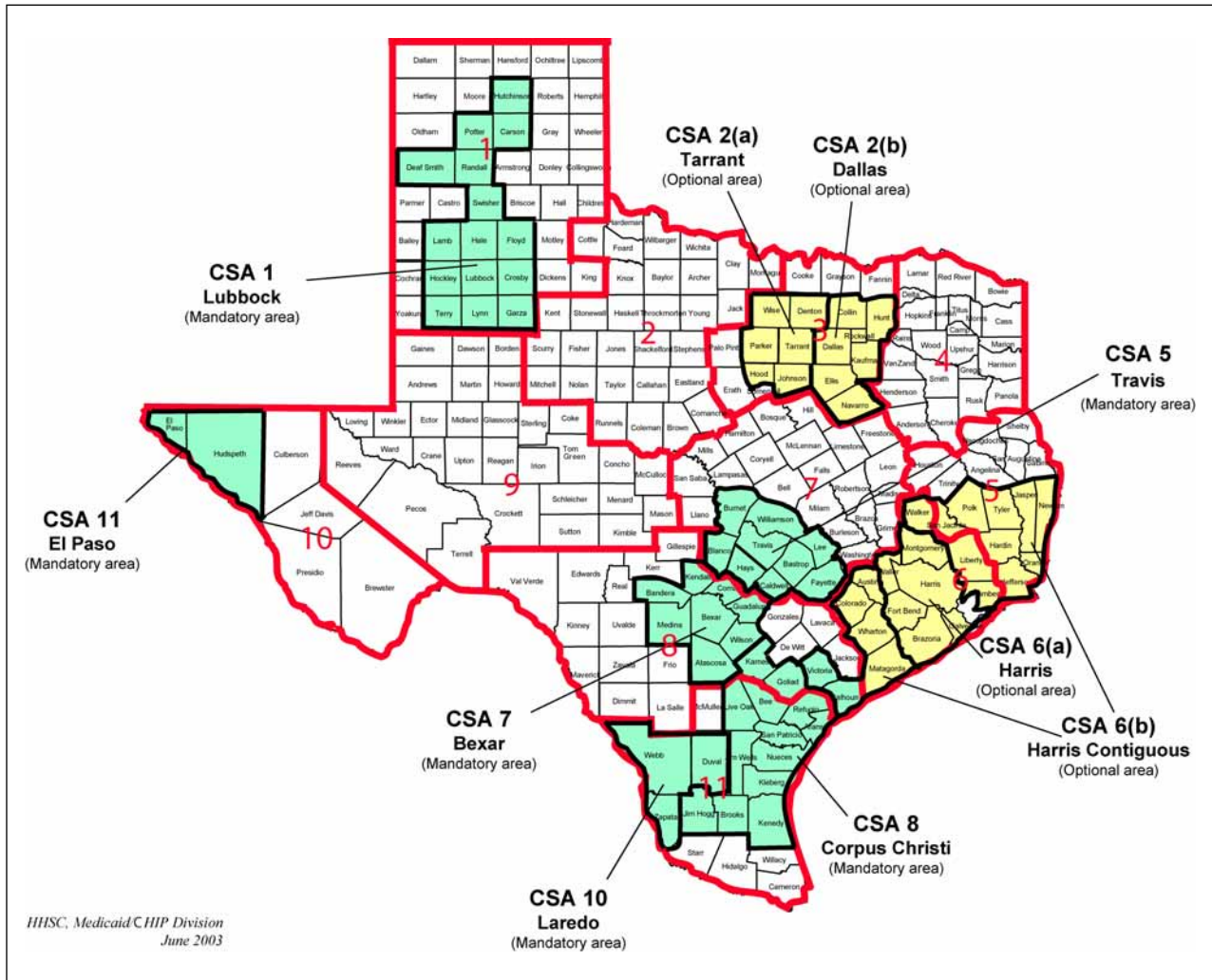
Reporting Month	CHIP EPO Membership Total
December 2002	140,714
January 2003	142,252
February 2003	141,083
March 2003	141,630
April 2003	142,650
May 2003	143,868
June 2003	143,193
July 2003	142,032
August 2003	141,334

Children's Health Insurance Program Service Areas (CSA)

Figure 5 shows the CHIP service areas (CSA) for the state of Texas, taken from the Commission's request for proposal released July 18, 2003. The request for proposal solicited responses from qualified insurers to provide comprehensive exclusive provider health insurance coverage in these respective CSAs, and the diagram below is reproduced with the Commission's permission.

All unshaded areas in the map below represent Clarendon's service area.

Figure 5



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