Review of HHSC's Contract Management and Oversight Function for Medicaid and CHIP Managed Care and Fee-for-Service Contracts

As Required By
The 2016-2017 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 56)

Health and Human Services Commission
February 2017
# Table of Contents

1. Executive Summary ...................................................................................................................1
2. Introduction ................................................................................................................................1
3. Background .................................................................................................................................1
4. Managed Care Contract Oversight and Administration ..........................................................3
   - Health Plan Management ...........................................................................................................3
   - Encounters Oversight .................................................................................................................4
   - Pharmacy Benefit Monitoring ................................................................................................5
   - Financial Monitoring .................................................................................................................5
   - Quality Monitoring ....................................................................................................................6
   - Utilization Review ......................................................................................................................7
   - Utilization Management ...........................................................................................................7
   - Audits ........................................................................................................................................9
   - Liquidated Damages Process .....................................................................................................9
   - Contract and Performance Governance ....................................................................................10
5. Fee-For-Service Claims Administrator Oversight .................................................................10
6. Conclusion ..................................................................................................................................11

List of Acronyms ..........................................................................................................................12
1. Executive Summary

The 2016-17 General Appropriations Act, House Bill (H.B.) 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 56), requires the Health and Human Services Commission (HHSC) to conduct a thorough review of the agency's contract management and oversight function for Medicaid and Children’s Health Insurance Program (CHIP) managed care and fee-for-service (FFS) contracts and make recommendations to improve the state's ability to identify anomalies in service utilization and their underlying cause. The review should consider the:
- Effectiveness and frequency of audits;
- Appropriateness of existing contract requirements including penalties;
- Availability of necessary data;
- Need for additional training and resources; and
- Adequacy of current prior authorization (PA) and utilization review functions.

As the Medicaid program has transformed from a FFS to a managed care model, HHSC's Medicaid and CHIP Services (MCS) department adapted its contractual oversight structure and processes to effectively manage all contractors, vendors, and programs it administers, under the managed care delivery system framework. Within MCS, each area is involved in the monitoring and management of managed care contractors. Oversight and contract management functions are not facilitated exclusively by a singular area, but are instead, shared efforts among all MCS departments. This has resulted in a robust governance structure, providing comprehensive contract oversight, including the identification of anomalies in service utilization.

This report details MCS's managed care contract monitoring and administration efforts, including the oversight functions carried out by various units within the department. Additionally, it outlines the audit process established to validate contractor performance, the protocol for issuing liquidated damages when a contractor is found to be out of compliance and the governance process aimed at ensuring the engagement of leadership in contract oversight endeavors. Finally, the report provides additional insight into MCS's oversight of the contractor charged with carrying out specified functions for the remaining population served under FFS.

2. Introduction

This report provides an update on the infrastructure and business process improvements initiated to ensure comprehensive oversight of the Medicaid and CHIP managed care and FFS contracts. Recent enhancements to MCS's oversight processes have focused on roles and responsibilities within MCS and increased cross-departmental visibility into identified issues and trends. To this end, MCS has increased the use of data in driving decision-making and facilitates regular conversations through an established steering committees process where various metrics are reviewed in assessing contractor compliance and system performance.

3. Background

HHSC previously submitted a report on January 20, 2015, in response to the 2014-15 General Appropriations Act, Senate Bill (S.B.) 1, 83rd Legislature, Regular Session, 2013 (Article II, Health and Human Services Commission, Rider 65), which directed HHSC to conduct a review
of HHSC's contract management and oversight functions for Medicaid and CHIP managed care and FFS programs and make recommendations for improving the state's ability to identify anomalies in service utilization and their underlying cause. That report focused on the review of the effectiveness of the claims administrator operating in the FFS model, managed care contracts, and the Office of Procurement and Contracting Services, as well as the process improvements as a result of the review.

As described in the 2015 report, HHSC successfully implemented a number of strategies to improve its contract oversight governance structure and oversight processes. Significant contract oversight process improvements were realized through the creation of two new units to provide oversight for the claims administrator contract, known as the Medicaid Management Information System (MMIS) contract. These new units are the MMIS Contract Compliance and Performance Section and the MMIS Contract Operations Management Unit. The 2015 report recommended many of the improvements made to the management of the MMIS contract be applied to Medicaid and CHIP managed care contracts. Process improvements have continued to evolve since January 2015.

The 2015 report recognized the need to enhance governance structures related to managed care organization (MCO) contracts, which began with the formation of a Managed Care Steering Committee in mid-2015. This structure and related processes have been further enhanced, as described in Section 4 of this report.

The 2015 report also recommended HHSC improve audit coordination between the various entities having authority over the Medicaid and CHIP programs. This recommendation was also identified in an audit conducted by the Texas State Auditor's Office (SAO) in 2016. The process improvements implemented are described in section 4 of this report.

In fiscal year 2016, the SAO audited HHSC Medicaid managed care contract processes. This audit provided meaningful insight into contract and health plan management oversight processes. HHSC developed a management response outlining actions taken and plans to address the audit's findings and the development of process improvements to noted deficiencies. The full report, including HHSC's management response, was issued in October 2016.

The objective of the SAO audit was to determine whether HHSC and the Office of the Inspector General (IG) administer Medicaid managed care contract management processes and related controls in accordance with contract terms, applicable laws, regulations, and agency policies and procedures. The scope covered activities from fiscal year 2011 through 2015. HHSC's External Quality Review Organization (EQRO) activities were reviewed for fiscal years 2014 and 2015. The SAO collected and reviewed 14 specific document types and performed 16 procedures and tests.

HHSC responded to the report with identified enhancements to specific programs, processes, and procedures to alleviate the deficiencies outlined in the report. In some cases, process changes were already in place before the audit period ended and were noted as such in the report. In other instances, HHSC outlined steps it would take going forward to address identified deficiencies.
HHSC has implemented numerous enhancements to its monitoring and oversight processes since January 2015, in response to both the growth of managed care in Texas and the audit findings issued by the SAO in the report published in October 2016. These have focused on managed care contract management and oversight process advancements including the delineation of roles and responsibilities within MCS and the establishment of collaborative opportunities to discuss identified issues and trends illustrating the performance of the MCOs and the Medicaid managed care system more generally.

4. Managed Care Contract Oversight and Administration

MCS imposes contractual requirements on MCOs, including stipulating expectations related to claims payment timeliness, setting service availability standards, mandating a sufficient provider network, and establishing minimum performance standards on specified quality measures. As the Texas Medicaid program has carved-in populations into managed care, the methods, staffing model, and collaboration among all areas within MCS has concurrently expanded to meet the oversight needs of the program. These distinct areas within MCS and their oversight responsibilities are outlined below.

Health Plan Management

Health Plan Management (HPM) is responsible for managing the day-to-day operations of the Medicaid and CHIP managed care programs, including STAR, STAR+PLUS, STAR Health, CHIP, and CHIP and Children's Medicaid Dental. Managed care services are carried out through twenty-one contracts with MCOs, including nineteen contracts for acute services and two contracts for statewide dental. HPM has the authority to monitor MCO compliance under Texas Government Code, Chapter 533, Medicaid Managed Care Program, and Texas Administrative Code, Title 1, Part 15, Chapter 353, as well as applicable sections of the Code of Federal Regulations (CFR), Title 42, Part 438.

The scope of HPM responsibilities include:
- Evaluating operational performance measures;
- Collecting and analyzing operational data to identify trends;
- Recommending remedies, corrective action and/or liquidated damages;
- Acting as a liaison between the health plan and HHSC areas as needed;
- Serving as the point of contact for reporting;
- Implementing uniform Managed Care Manual (UMCM)/Uniform Managed Care Contract (UMCC) amendments and revisions;
- Reviewing and approving MCO member outreach materials as well as Texas provider outreach materials relating to program initiatives or implementation;
- Receiving, managing, and responding to complaints, inquiries and disenrollment requests;
- Assisting and, when needed, escalating access to care and legislative issues; and
- Ensuring the MCOs are compliant with UMCC, UMCM, and other HHSC directives in key areas.

HPM is tasked with conducting MCO compliance and readiness reviews prior to the operational start date of a contract. The readiness review includes both desk and onsite review components.
Under the terms of the contract, HPM staff must complete readiness review activities 60 days prior to the operational start date. This requirement enables HPM staff to ensure a contracted MCO is fully able to administer services for Medicaid clients prior to the start date. HPM staff provide HHSC leadership with information collected through the compliance and readiness review process, about the preparedness of the MCO to fully operationalize the contract on the identified start date.

During the operations phase of the contract, subsequent to the readiness period, HPM staff monitor adherence to identified service delivery and provider network requirements and provide technical assistance to the MCOs. HPM's scope includes monitoring of compliance with service coordination standards, call center expectations such as average speed of answer, claims processing requirements including claims payment timeliness, and encounter submission standards, as well as complaint trends. Staff also monitor quality of care and access to care in collaboration with the MCS Quality section. MCO provider networks are monitored through the analysis of MCO network adequacy data, such as the number of single case agreements, geo access reports, and out-of-network utilization. Additionally, staff review provider turnover rates, network panel status reports, and the reliability of provider directories.

HPM is also responsible for reviewing provider outreach materials for the Medicaid FFS, Medicaid Managed Care, CHIP, and CHIP and Children’s Medicaid Dental programs. Materials submitted are reviewed and either approved or denied by HPM staff. This process is a result of S.B. 8, 83rd Legislature, Regular Session, 2013.

Additionally, HPM houses a research and resolution unit, which is responsible for responding to inquiries and complaints from providers and members. Complaints, as described by CFR Title 42, Part 438.400, may include, but are not limited to, the quality of services provided, and instances involving a failure to respect a Medicaid member’s rights.

**Encounters Oversight**

Operations Management (OM) staff are tasked with ensuring encounter data submitted by MCOs is accurate. This data is used in a variety of ways, most notably in setting MCO capitation rates. OM staff work in conjunction with internal state stakeholders and Texas Medicaid & Healthcare Partnership (TMHP) to provide oversight of encounter data received from MCOs. TMHP provides reports which are used to determine trends in encounter data and errors, such as encounter rejection counts, invalid member IDs, and invalid plan codes. OM staff also regularly run queries, providing statistical reports which determine how these errors impact data accuracy.

When encounter errors are identified, OM staff work with appropriate state and MCO staff to research examples, resolve identified issues and ultimately correct the encounter data. If the encounter data is not corrected in a timely manner, HHSC staff work with the Contract Compliance and Performance Management area to create a formal corrective action plan for the MCO, including the issuance of liquidated damages when appropriate.
Pharmacy Benefit Monitoring

Contractor Performance Management (CPM) is a unit within the HHSC Vendor Drug unit. CPM conducts performance management activities and provides contract oversight of the pharmacy benefits administered by the MCOs, their pharmacy benefit managers, and other pharmacy contractors.

CPM performs contract oversight by:
• Ensuring MCOs respond appropriately and expeditiously to access to care issues and any other pharmacy related issues identified by internal and or external stakeholders;
• Meeting with MCOs to discuss encounter and claims processing error trends;
• Reviewing policies and procedures and outreach materials; and
• Reviewing data self-reported by MCOs and performance measures provided by the HHSC Data Analytics and Finance areas.

CPM reviews the following deliverables for compliance with contractual requirements:
• MCO pharmacy audits and retrospective drug utilization reviews;
• Clinical PA denials/appeals;
• PA requests/appeals/denials;
• Network adequacy reports;
• Financial statistical report to encounter reconciliation reports; and
• Pharmacy preferred drug listings.

HHSC uses encounters and MCO self-reported information to conduct quarterly desk reviews, evaluating Pharmacy Benefit Manager (PBM) compliance. This includes the review of quarterly reports monitoring compliance with the preferred drug list, changes in pharmacy networks, pharmacy member appeals and complaints, pharmacy claims adjudication timeliness, and reconciliation of pharmacy encounters to financial status reports. These processes have been developed over time beginning with the partial carve-in of pharmacy benefits in 2012. External audit firms have been engaged and are performing data validation of 12 MCO quarterly self-prepared reports. Audit engagement letters for nine additional MCOs will be executed in February 2017, with audit work to begin shortly thereafter. In addition, the IG will consider MCO PBMs in the development of their audit plan.

Any identified MCO or subcontractor (e.g. pharmacy benefit managers) issues of non-compliance are reviewed with the Contract Compliance and Performance Management area. As appropriate, compliance action is taken, including the creation of formal corrective action plans and the issuance of liquidated damages.

Financial Monitoring

MCS monitors the fiscal soundness of all MCO contracts and recovers any excess profits from the MCOs through the annual experience rebate process. MCO self-reported financial deliverables are reviewed and validated through a rigorous and comprehensive reconciliation process to ensure program integrity. The financial performance of all MCOs is monitored, including subcontracts and affiliate relationships. If issues are identified, MCS Finance staff
assist with the recommendation of strategies to address known issues. If it is determined there are issues of non-compliance, finance staff work with the Contract Compliance and Performance Management area to issue contract remedies, including the creation of formal corrective action plans and the issuance of liquidated damages, as appropriate.

**Quality Monitoring**

The Balanced Budget Act of 1997 requires state Medicaid agencies to provide an annual external independent review of quality outcomes, timeliness of services, and access to services provided by Medicaid MCOs. To comply with federal requirements, and to provide HHSC with data analysis and information to effectively monitor its Medicaid managed care programs, HHSC contracts with an EQRO, the Institute for Child Health Policy (ICHP), in providing oversight of the Medicaid managed care program and CHIP. HHSC works closely with ICHP to annually evaluate MCO and dental maintenance organizations’ (DMOs) performance on an established set of standardized, nationally-recognized measures including:

- The National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®);
- Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators/Prevention Quality Indicators;
- 3M® Software for Potentially Preventable Events (PPEs); and

In addition to the monitoring of key quality metrics, HHSC and ICHP also evaluate plan performance through federally-required performance improvement projects (PIPs). Topics for these two-year initiatives are based on MCO performance in the previous year. Each MCO must develop two PIPs per program (e.g., STAR, STAR + PLUS, etc.) and are required to follow Centers for Medicare and Medicaid Services (CMS) EQRO protocols. Examples of recent PIP topics include asthma, comprehensive diabetes care and potentially preventable admissions.

HHSC also administers the legislatively-mandated (S.B. 7, 83rd Legislature, Regular Session, 2013) Dental and Medical Pay-for-Quality (P4Q) program to further incentivize health plan performance on key quality metrics (e.g., HEDIS and PPEs). This annual program provides financial incentives and disincentives to DMOs and MCOs. HHSC recoups a percent of poor-performing health plans’ capitation while providing financial rewards to those who demonstrate marked improvement.

Through its posting of annual MCO report cards, HHSC provides information to Medicaid and CHIP members regarding MCO performance during the enrollment process on outcome and process measures. ICHP generates a report card for each program by service area, which allows members to compare the MCOs using specific quality measures (e.g., HEDIS and CAHPS).

In response to a finding from the SAO audit published in October 2016, HHSC will use all information available from its EQRO, including member survey results and validation of paid claims, to strengthen the monitoring of MCO performance.
Utilization Review

Following a directive from S.B. 8, 83rd Legislature, Regular Session, 2013, the Acute Care Utilization Review (UR) Section was added to the MCS Office of the Medical Director. This section, managed by a registered nurse reviews the PA practices in managed care programs. The section also uses the information gathered by the IG to inform their reviews, including an informational report on MCO Acute Care Utilization Management (UM) practices published August 2016. This report is published on the Inspector General's website at https://oig.hhsc.texas.gov/reports

Following the directive from S.B. 348, 83rd Legislature, Regular Session, 2013, during fiscal year 2015, UR staff conducted a review of long-term care, which centered on a sample of 272 members newly-enrolled in the STAR+PLUS Home and Community Based Services (HCBS) program. A review of assessments, service delivery plans, and supporting documentation was conducted to:

- Determine if services were appropriate and timely to meet the needs of an individual;
- Evaluate the quality of the assessments; and
- Evaluate the quality of the services delivered.

In fiscal year 2016, the UR section used the review findings to provide on-site intensive technical assistance to each of the STAR+PLUS MCOs. Additionally, HHSC presented a series of webinars targeted to MCO service coordinators to provide training on STAR+PLUS HCBS waiver program requirements and responsibilities encompassing assessments, service planning, ongoing monitoring of member needs and related topics. Going forward, the section will conduct reviews of STAR Kids MCOs.

Outcomes of UR activities have informed contract policy and have prompted the implementation of operational enhancements including:

- Changing contract language to improve oversight of timeliness of specific activities in the STAR+PLUS HCBS waiver program;
- Changing contract language regarding liquidated damages;
- Updating handbook policies to clarify expectations for the STAR+PLUS HCBS waiver program for the MCOs;
- Revising individual service planning documents for the STAR+PLUS HCBS waiver program to reduce redundant information, making service planning clearer to the MCOs and improving oversight activities; and
- Conducting research to identify anomalies in service utilization.

Utilization Management

The IG issued a report on Acute Care Utilization Management in Managed Care Organizations, which provided an analysis of non-audited information submitted by MCOs and other sources. This report, published on August 15, 2016 (IG Report No. IG-16-060), offers insight into MCO UM practices which will assist MCS in improving contract oversight and identifying anomalies in service utilization. This report is published on the IG website at https://oig.hhsc.texas.gov/reports.
Through this review, the IG found, on average, nine percent of PA requests are being denied by MCOs, with forty-two percent of all appealed PA denials ultimately being reversed. MCOs documented the following reasons for PA denials:

- Criteria not met;
- Benefit not covered; and
- Clinical information required to determine medical necessity missing.

The review highlighted MCOs employ various UM practices to ensure appropriate care is authorized and maintained. These include both concurrent and retrospective UR to evaluate the ongoing health care needs of members (i.e. extensions of services) and reviews of historical data to allow for identification of service utilization trends.

MCOs noted they monitor UM effectiveness via the following methods:

- Conducting annual evaluations of the UM program and work plan;
- Analyzing UM data and statistics;
- Monitoring provider utilization through provider profile reports; and
- Surveying member and provider satisfaction.

Examination and continued monitoring of MCO UM processes is an integral piece of the managed care contract oversight conducted by MCS, at times in partnership with the IG. Appropriate UM practices ensure Medicaid members are receiving medically necessary services in the appropriate amount, duration, and scope. The continued monitoring of MCO processes assists in identifying differences in rates of PA denials between MCOs and enables HHSC to determine if such differences are due to valid medical reasons.

To ensure access to needed services and compliance with contractual requirements, HHSC has taken a critical step in improving PA processes in managed care through the use of standardized forms. All MCOs are now required to accept PA requests on the standardized Texas Department of Insurance form. Additionally, effective March 1, 2017, MCOs will be required to maintain portals, which allow providers to submit PA requests. This charge includes requiring online processes for the submission of electronic claims and all related claims documentation requested by the MCO, claims appeals and reconsiderations, and required clinical data. HHSC is also currently exploring options to share PA content between payers when members enrolled in Medicaid or CHIP make a change to another plan. This will ensure continuity of care as members transition from one plan to another.

Further, an amendment has been incorporated into the current MCO contracts, requiring licensed therapists either directly perform final PA determinations or review final determinations of other licensed persons. This amendment ensures PAs are evaluated by individuals with the requisite credentials, required to make accurate determinations of the need for a particular service. This should minimize or eliminate differences in PA approval rates which may have previously been caused by inconsistent skill levels of PA evaluators.
Audits

HHSC requires all MCOs to be audited by an external contractor on an annual basis. Two audit firms, DK Partners PC, and Myers and Stauffer LC, conduct risk assessments on a bi-annual basis as well as periodic performance audits, initiated at HHSC’s discretion. MCS also consults with the IG in conducting performance audits of one or more MCOs each year.

As a result of the SAO audit report released on October 2016, HHSC agreed to develop a more structured and documented approach to the process it uses to prioritize and select MCOs for performance audits and include previous audit coverage as a risk factor. HHSC also agreed to establish a process to document its follow-up on performance audit findings and verify the implementation of audit recommendations. Additional process enhancements include the development of standard operating procedures for the determination and issuance of corrective action plans (CAPs) and continued monitoring efforts once a CAP is imposed.

HHSC is also taking a number of steps to establish policy and guidelines, ensuring appropriate communication and collaboration between HHSC and the IG in the planning and performance of MCO audits. These steps include:

- Coordination between IG and MCS in the development and periodic revision of proposed MCO audits included in the IG Audit Plan;
- Quarterly briefings by the IG Audit division with the MCS associate commissioner and senior staff on the status of active MCO audits;
- Participation by MCS in the planning process of IG MCO audits;
- Provision of input from MCS to IG on the timing of audits, applicable risks, and proposed audit scope and objectives; and
- Participation by MCS in key MCO audit meetings, including entrance conferences, status updates, and exit conferences.

In addition, HHSC is in the process of developing an agency guidance circular, "Coordination of Managed Care Organization Audits," to define the roles of the various areas with authority to conduct MCO audits.

Liquidated Damages Process

When issues of non-compliance are identified, HHSC has a transparent and thorough process for assessing and remediating contractor deficiencies and issuing liquidated damages through the Contract Compliance and Performance Review area within the MCS department. This process is conducted on a quarterly basis and includes extensive involvement of HHSC program staff. The assessment of liquidated damages is thoroughly reviewed by leadership and any mitigating circumstances are considered by the Managed Care Steering Committee. The committee provides direction as to whether the liquidated damages should be maintained, reduced or waived. All issues of noncompliance and any damages imposed on MCOs are posted on the HHSC website and serve as public notice.
Contract and Performance Governance

In July 2015, HHSC instituted a steering committee to provide strategic direction and oversight of critical risks and issues related to managed care contract oversight. The Managed Care Steering Committee is comprised of executives across the MCS and meets at least quarterly to review:

- Implementation of legislative mandates related to managed care;
- Decisions related to identified process improvements;
- Contract amendments and other items requiring executive direction;
- Implementation of audit action plans; and
- Liquidated damage recommendations.

Additionally, the Managed Care Steering Committee provided input into the leadership dashboard required by S.B. 200, 84th Legislature, Regular Session, 2015, which was implemented in March 2016. More recently, the Managed Care Steering Committee authorized development of a subcommittee, referred to as the Performance Analysis Subcommittee, to ensure a systematic review of performance data to investigate trends and anomalies identified by HHSC's Data Analytics team and the EQRO. The subcommittee is also charged with reviewing MCO compliance data to inform compliance action, including corrective actions and liquidated damages.

This work is supported by HHSC's Data Analytics team which has been actively implementing its principal strategy to make program monitoring data accessible to leadership in meaningful forms. These efforts include the creation of dashboards enabling the visualization of data. The team provides broad support to MCS, providing a line of sight into performance and compliance trends and also develops specialized dashboards in response to various specific needs across the department.

5. Fee-For-Service Claims Administrator Oversight

Though a majority of the population served by Medicaid has now transitioned to a managed care service delivery model, approximately eight percent remain under FFS. FFS claims are processed by TMHP, which is monitored by the Claims Administrator Contract Oversight (CACO) unit. HHSC and TMHP staff are charged with monitoring service level expectations for key business outcomes, executing contract monitoring activities based on risk assessments of key functional business objectives, addressing deficiencies through root cause analysis and corrective/preventative actions, and actively managing risks and issues at appropriate governance meetings.

TMHP is required to satisfy a number of performance measures in targeted areas of functional responsibility such as claims processing, provider enrollment, PA, and call center services. The contractor's performance level is measured monthly against contracted service levels for compliance and quarterly for trends. HHSC continually looks for opportunities to improve service level expectations for appropriate intent and relevance, for service level threshold adjustments, and for improved measurement methods to ultimately optimize the operational and financial performance of the delivery of Medicaid and other healthcare programs for the state of Texas.
In addition to monitoring contracted service level expectations on a monthly basis, CACO executes site visits and desk reviews based on risk assessments of key functional business objectives. In the event non-compliance occurs, a remedy review process is initiated in which a corrective action plan is required, including a root cause analysis. In some instances, this may require additional sampling of cases and/or significant analysis of TMHP business functions to understand whether technology, business processes, or staffing is affecting expected performance outcomes.

For the FFS claims administrator contract, governance processes include multiple oversight committees to provide direction with regard to strategic, management, and operational issues. These oversight committees include:

- Texas MMIS Claims Administrator Steering Committee (Strategic);
- Texas MMIS Claims Administrator Operating Committee (Management);
- HHS Internal Governance Committee (Operational); and
- HHSC Medicaid Claims Administration Contract Management Committee (Operational).

Collectively these bodies provide a structured mechanism for MCS to work with stakeholders across HHSC to report on contractor performance, plan for proactive management of operational changes to service delivery, and provide an escalation path for risk management and issue resolution from the operational governance bodies to the strategic governance bodies or vice versa.

Risks and issues are managed jointly between the contractor and HHSC to successful resolution and closeout, regardless of whether or not it rises to the level of contractual noncompliance. All identified risks and issues are discussed at the Texas MMIS Claims Administrator Operating Committee and the most significant risks and issues are reported at the Texas MMIS Claims Administrator Steering Committee.

6. Conclusion

Since the Rider 65 report was submitted in 2015, HHSC has made additional improvements in its contract management functions to further support HHSC's efforts in providing comprehensive oversight and addressing anomalies in service utilization. HHSC will continue to successfully implement the recommendations resulting from the audits noted in this report, conducted by the SAO and HHSC's Internal Audit group. Those audit entities will monitor HHSC's progress in implementing the process improvements agreed upon in the final audit reports.

MCS remains committed to improving its managed care and FFS contract oversight. Recently, emphasis has been placed on enhancing collaboration among MCS functional areas and increasing cross-departmental visibility into compliance concerns, deficiencies and progress across the Medicaid system. As the Medicaid model continues to mature in Texas, MCS will persist in its efforts to identify opportunities for ensuring efficient, thorough, comprehensive oversight of the service delivery system.
# List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHRQ</td>
<td>Agency for Healthcare Research and Quality</td>
</tr>
<tr>
<td>CACO</td>
<td>Claims Administrator Contract Oversight</td>
</tr>
<tr>
<td>CAP</td>
<td>Corrective Action Plan</td>
</tr>
<tr>
<td>CAHPS</td>
<td>Consumer Assessment of Healthcare Providers and Systems</td>
</tr>
<tr>
<td>CHIP</td>
<td>Children's Health Insurance Program</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid</td>
</tr>
<tr>
<td>CPM</td>
<td>Contractor Performance Management</td>
</tr>
<tr>
<td>DMO</td>
<td>Dental Maintenance Organization</td>
</tr>
<tr>
<td>EQRO</td>
<td>External Quality Review Organization</td>
</tr>
<tr>
<td>FFS</td>
<td>Fee-For-Service</td>
</tr>
<tr>
<td>H.B.</td>
<td>House Bill</td>
</tr>
<tr>
<td>HCBS</td>
<td>Home and Community Based Services</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Healthcare Effectiveness Data and Information Set</td>
</tr>
<tr>
<td>HHSC</td>
<td>Health and Human Services Commission</td>
</tr>
<tr>
<td>HPM</td>
<td>Health Plan Management</td>
</tr>
<tr>
<td>ICHP</td>
<td>Institute for Child Health Policy</td>
</tr>
<tr>
<td>IG</td>
<td>Inspector General</td>
</tr>
<tr>
<td>LD</td>
<td>Liquidated Damage</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed Care Organization</td>
</tr>
<tr>
<td>MCS</td>
<td>Medicaid and Chip Services</td>
</tr>
<tr>
<td>MMIS</td>
<td>Medicaid Management Information System</td>
</tr>
<tr>
<td>PA</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>PBM</td>
<td>Pharmacy Benefit Manager</td>
</tr>
<tr>
<td>PIP</td>
<td>Performance Improvement Project</td>
</tr>
<tr>
<td>PPE</td>
<td>Potentially Preventable Event</td>
</tr>
<tr>
<td>S.B.</td>
<td>Senate Bill</td>
</tr>
<tr>
<td>SAO</td>
<td>State Auditor's Office</td>
</tr>
<tr>
<td>UM</td>
<td>Utilization Management</td>
</tr>
<tr>
<td>UMCM</td>
<td>Uniform Managed Care Manual</td>
</tr>
<tr>
<td>UMCC</td>
<td>Uniform Managed Care Contract</td>
</tr>
<tr>
<td>UR</td>
<td>Utilization Review</td>
</tr>
<tr>
<td>TMHP</td>
<td>Texas Medicaid and Healthcare Partnership</td>
</tr>
</tbody>
</table>