TEXAS
Health and Human
Services Commission

House Appropriations Subcommittee on Health and Human Services

March 30, 2004

Presentation Overview

- HHS Consolidation
- TIERS Program and Integrated Eligibility (IE) Efforts
- Office of the Inspector General (OIG)
- Medicaid Managed Care Expansion

TEXAS
Health and Human
Services Commission

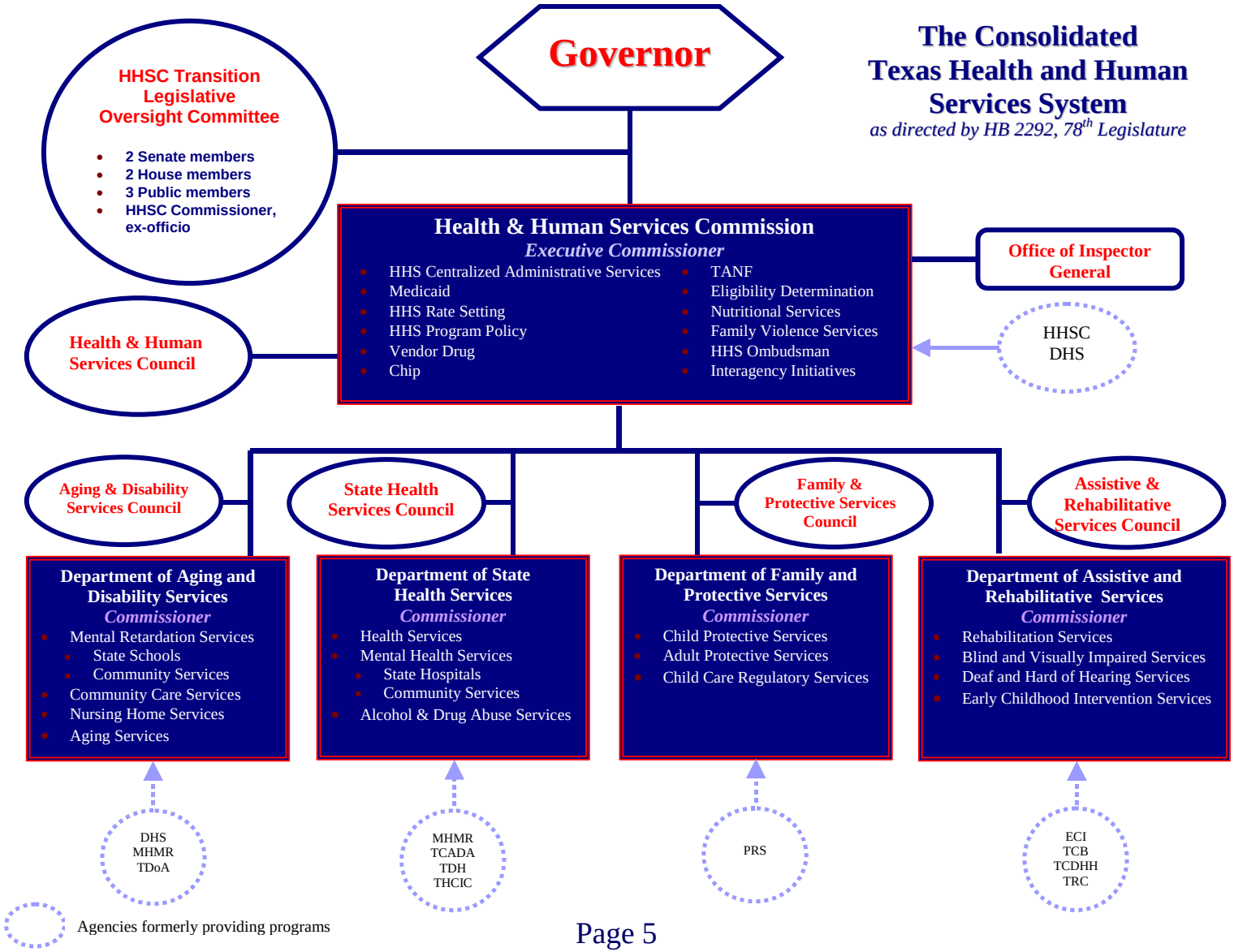
HHS Consolidation

Gregg Phillips, Deputy Executive
Commissioner of Program Services

HHS Transformation

- HB 2292 set a new direction for improving the delivery of health and human services for Texas
  - Build an organizational structure that is rational
  - Consolidate or better coordinate administrative systems
  - Structure programs based on similar processes to maximize efficiencies in delivery and capitalize on this synergy to improve service delivery
- With a renewed focus on measurable performance outcomes that matter
  - Improved client services
  - Reduced administrative costs
- And with strengthened accountability and more effective use of tax dollars

Consolidation Organizational Structure



HB 2292 Transition Plan

November 3, 2003 - Transition Plan delivered to the Governor and the LBB

- **Goals and Vision**
  - Focus on client need and program delivery
  - Provide effective stewardship of public resources
  - Initiate cultural change and ensure accountability

- **Careful and Deliberate Approach to Reorganization**
  - Planning
  - Integration
  - Optimization
  - Transformation

New Agency Creation

December 2003 - Appointed Commissioners for new departments:

- Thomas Chapmond, Department of Family and Protective Services (DFPS)
- Terry Murphy, Department of Assistive and Rehabilitative Services (DARS)
- James Hine, Department of Aging and Disability Services (DADS)
- Eduardo Sanchez, M.D., Department of State Health Services (DSHS)

New Agency Creation

Agency Creation Guiding Principles:

- Focus on service delivery.
- Foster direct management accountability
- Reorganize around common service delivery
- Promote integration and consistency
- Establish appropriate span of control

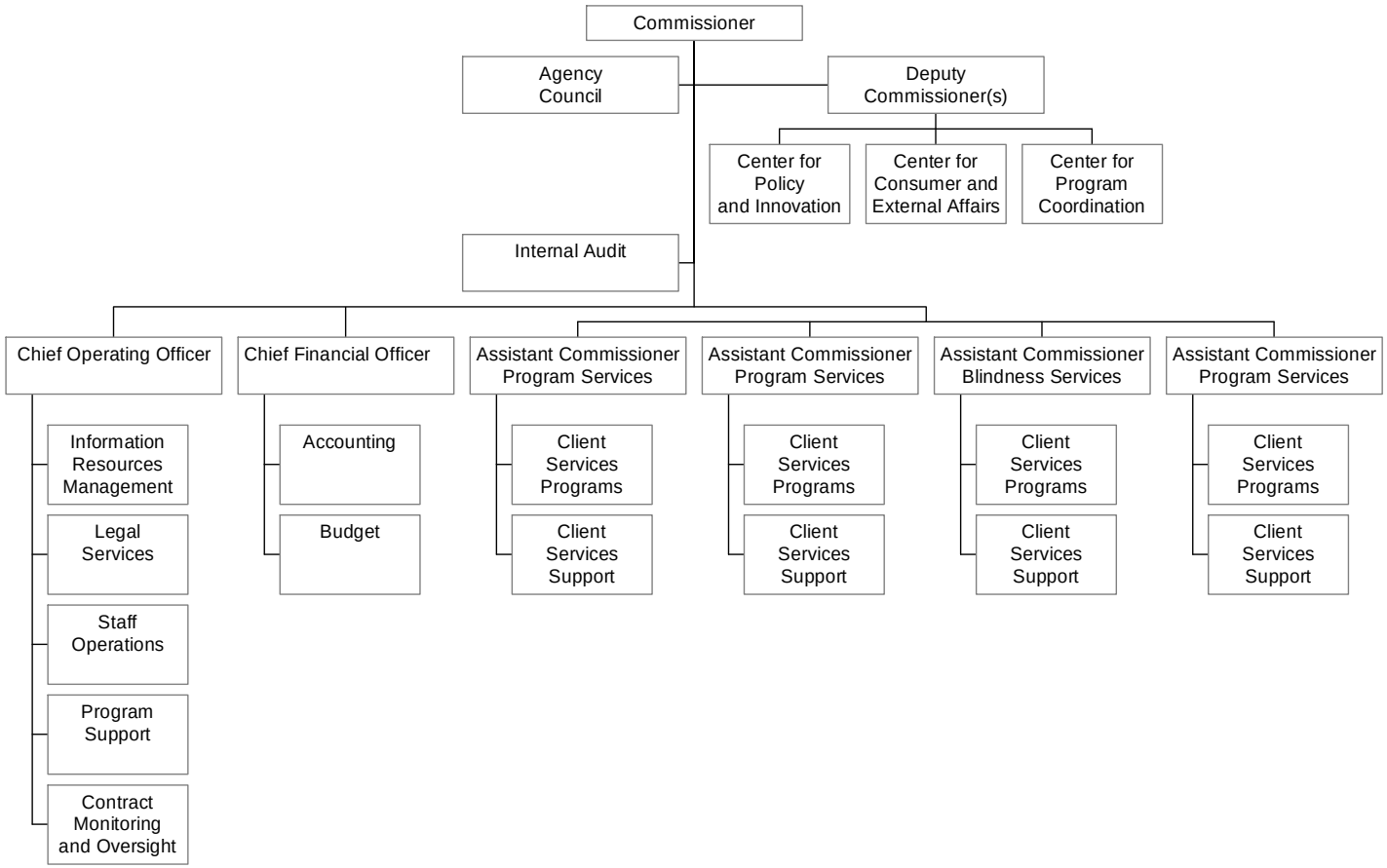
January 2004 – Operational Date for New Departments Finalized

- February 1 2004 - DFPS
- March 1, 2004 - DARS
- September 1, 2004 –DADS and DSHS

January and February 2004 - Held public hearings on proposed agency organizational structure

New Agency Creation

HHS UNIFORM ORGANIZATIONAL CHART



New Agency Creation

February and March 2004 - Public Input on Role of Agency Councils

- February 2004 - Held a workshop with stakeholder organizations to develop proposed standard operating procedures and guiding principles
- March 2004 - Held public hearings around the state to receive public input into the process

Consolidation Activities

Completed Administrative Consolidations

- Human Resources Management
- Office of Civil Rights
- Procurement
- Planning and Evaluation
- Office of Inspector General

Administrative Consolidations in process

- Financial Services
- Information Technology

Program consolidations at HHSC

- Family Services

Consolidation Savings Plan

The General Appropriations Act includes approximately $900 million in savings related to HB2292 implementation.

HHS agencies must reduce an additional $180.1 million in General Revenue related to HB 2992 initiatives, according to the General Appropriations Act, Article II, Special Provisions, Section 28.

To achieve these goals HHSC has established a process to identify and track savings for each project related to HB 2292.

Business Decision Guidelines:

- Carefully compile decision criteria.
- Require an open and competitive procurement process.
- Establish strong contract management focused on performance and accountability.
- Develop a transition strategy for affected state employees.
- Provide open and active communications.

Consolidation Savings Plan

Process for tracking HB 2292 initiatives:

- Assign a project manager and a financial services contact to develop updated savings estimates.
- Designate staff to develop a detailed business case, indicating specific costs, benefits, and savings for each initiative, including impact on:
  - Agencies and budget strategies;
  - Methods of finance; and
  - FTEs.
- Submit detailed status report periodically.
- February 2005 – Submit final report on Section 28 reductions.

Communication Strategies

Launched HHS E-News Service

- Provides regular updates and information including issue alerts about the transformation
- Over 1,600 subscribers
- Subscribe to the E-News Service, go to
  - **www.hhsc.state.tx.us/Consolidation/Consl_home.html**

Employee Updates

- Timely transition information sent to HHS employees by e-mail each week

Stakeholders

- Developed distribution list of 90 publications and list-servs for advocacy groups and other stakeholders

TEXAS
Health and Human
Services Commission

TIERS and Integrated Eligibility

TIERS (STARS)

TIERS Background:

- Texas Integrated Eligibility Redesign System (TIERS) developed to replace 25 year old SAVERR and other legacy systems with a browser-based eligibility determination system.

TIERS development stages:

- Stage 1 – STARS (State of Texas Assistance and Referral System) and Scheduler
  - Implemented in July 2001, STARS has received 1.5 M hits
  - STARS currently receives about 70,000 hits per month

TIERS PILOT (Texas Works)

Stage 2 – Texas Works (TW) (Food Stamps, TANF, Medicaid) Eligibility Piloted in 5 Offices

- Since June 2003, delivered more than $45 M in food stamp and over $5 M in TANF benefits
  - In February 2004, TIERS determined benefits for over 18,802 food stamp households, 2,925 TANF cash assistance households and 55,122 Medicaid clients
- TIERS implementation beyond pilot on hold until impact of HB 2292 and integrated eligibility project are determined.
- Pilot Site Business Process Review.
  - System changes needed to support new business processes
  - Training needed to make TIERS knowledge base consistent across areas
  - Future enhancements

TIERS (Long Term Care)

Stage 3 – Long Term Care (LTC) Eligibility

- Planning and Support of Merged TW/LTC Application.
- Using Lessons Learned in current pilot, actively define the TIERS business processes for LTC pilot
- Pilot concept and priority changes
- Assess application for possible IE impact
  - Policy
  - Interfaces/Trading Partners
  - Conversion Process
  - Testing
  - Training Needs
- TW/LTC merged application to be piloted in April 2004

TIERS

The Future of TIERS:

- System is flexible enough to accommodate future agencies, programs, policies and processes.
- System allows for TIERS and Integrated Eligibility enhancements to create new automated and business processes to support call centers.

Integrated Eligibility

HB 2292 required:

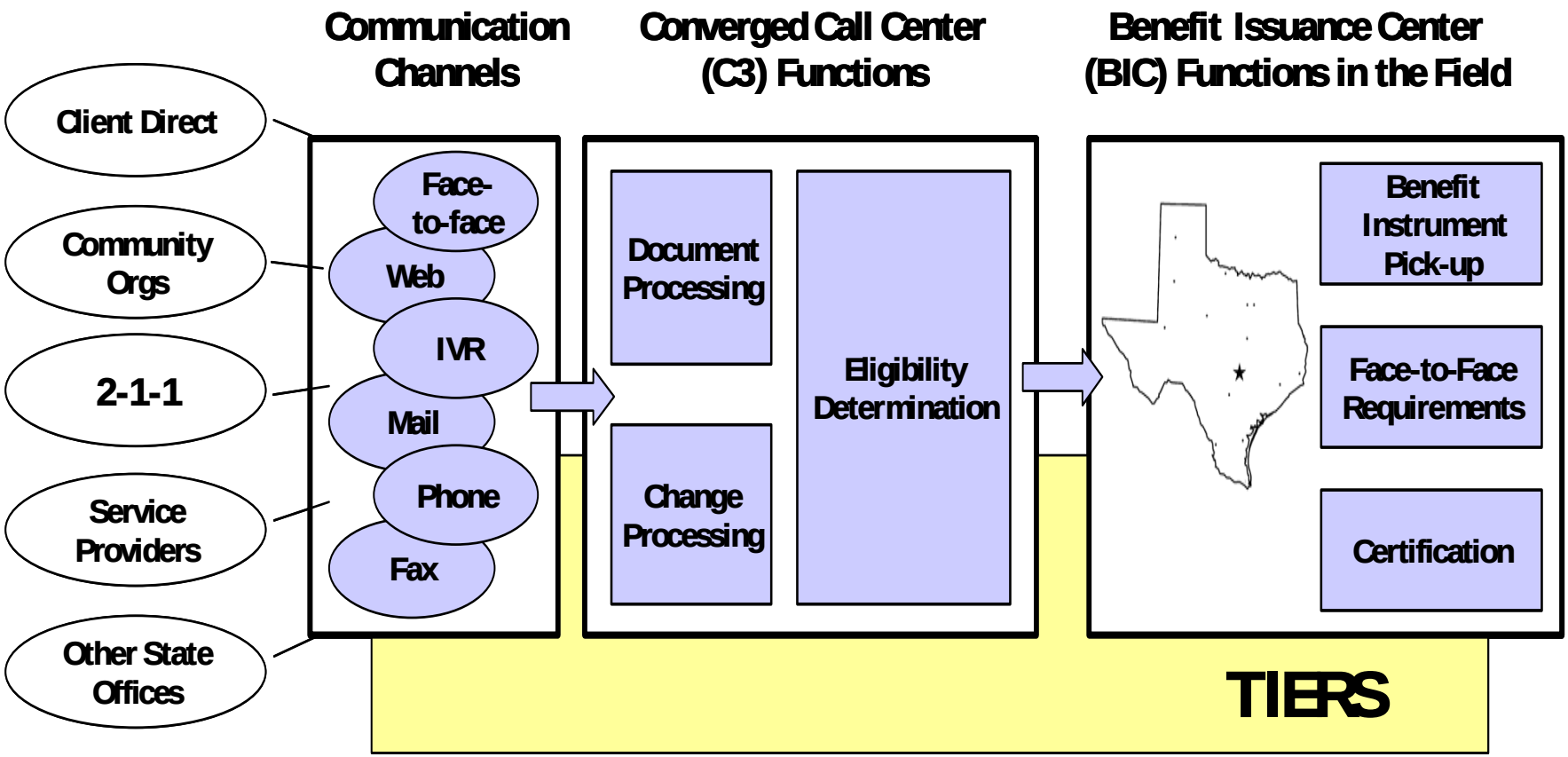
- Consolidation of eligibility determination for HHS programs into one department within HHSC; and
- Development of call centers, if cost effective, to administer eligibility and assist people in need.

Integrated Eligibility (IE) project:

- Leverage work already completed in automating the eligibility determination process.
- Provide additional client access to benefits through the use of call centers.
- Establish business requirements to fully comply with all federal regulations for Texas Works, Long Term Care, and other programs, as identified (for example: CHIP and WIC).

Integrated Eligibility Model

Model for Integrated Eligibility Determination



Integrated Eligibility

Progress to date:

February 2004

- Released Discovery Document indicating call center model would support process improvements and that cost effective operations are feasible.

March 2004

- Released Business Case (cost-effectiveness study) indicating proposed model for call centers is cost effective and provides:
  - Client Benefits by:
    - Increasing convenience and decreasing bureaucracy
    - Improving access and efficiency
    - Offering alternative access channels
  - Improved Worker Productivity by:
    - Streamlining processes
    - Allowing focus to be on value-added services
    - Increasing efficiency and as a result reducing client complaints

Integrated Eligibility

Next Steps (to be completed Spring 2004):

- Develop and publish proposed rules
- Conduct public hearings
- Develop detailed implementation plan
- Prepare and release RFP to determine if outsourcing is cost-effective

TEXAS Health and Human Services Commission

Office of the Inspector General

Brian Flood, Inspector General

Office of the Inspector General (OIG)

HB 2292 establishes within HHSC an independent Office of Inspector General (OIG) overseen by an Inspector General appointed by the Governor.

- Responsible for investigation of fraud and abuse in health and human services programs.
- Will provide oversight of HHS activities, providers, and recipients through compliance and enforcement activities designed to:
  - identify and reduce waste, abuse, or fraud; and
  - improve efficiency and effectiveness within the HHS system.
- Assumed duties of HHSC's Office of Investigation and Enforcement and fraud and abuse functions of other health and human services (HHS) agencies.
- Began consolidated operations on January 1, 2004.

Office of the Inspector General

Mission: To protect the integrity of Health and Human Services programs in Texas, as well as the health and welfare of the recipients of those programs.

Goals and Benefits:

- All oversight, review, remediation and investigative functions will be moved into the Office of Inspector General.
- Consolidation of functions into one office will create a synergy of purpose and efficiencies of scale.
- Consolidation will allow the focusing of multiple skill sets to single or cross-agency issues.
- Model will allow escalated or coordinated responses to issues: Compliance will emphasize education and remediation with the focus being problem avoidance and correction while Enforcement will remediate issues.

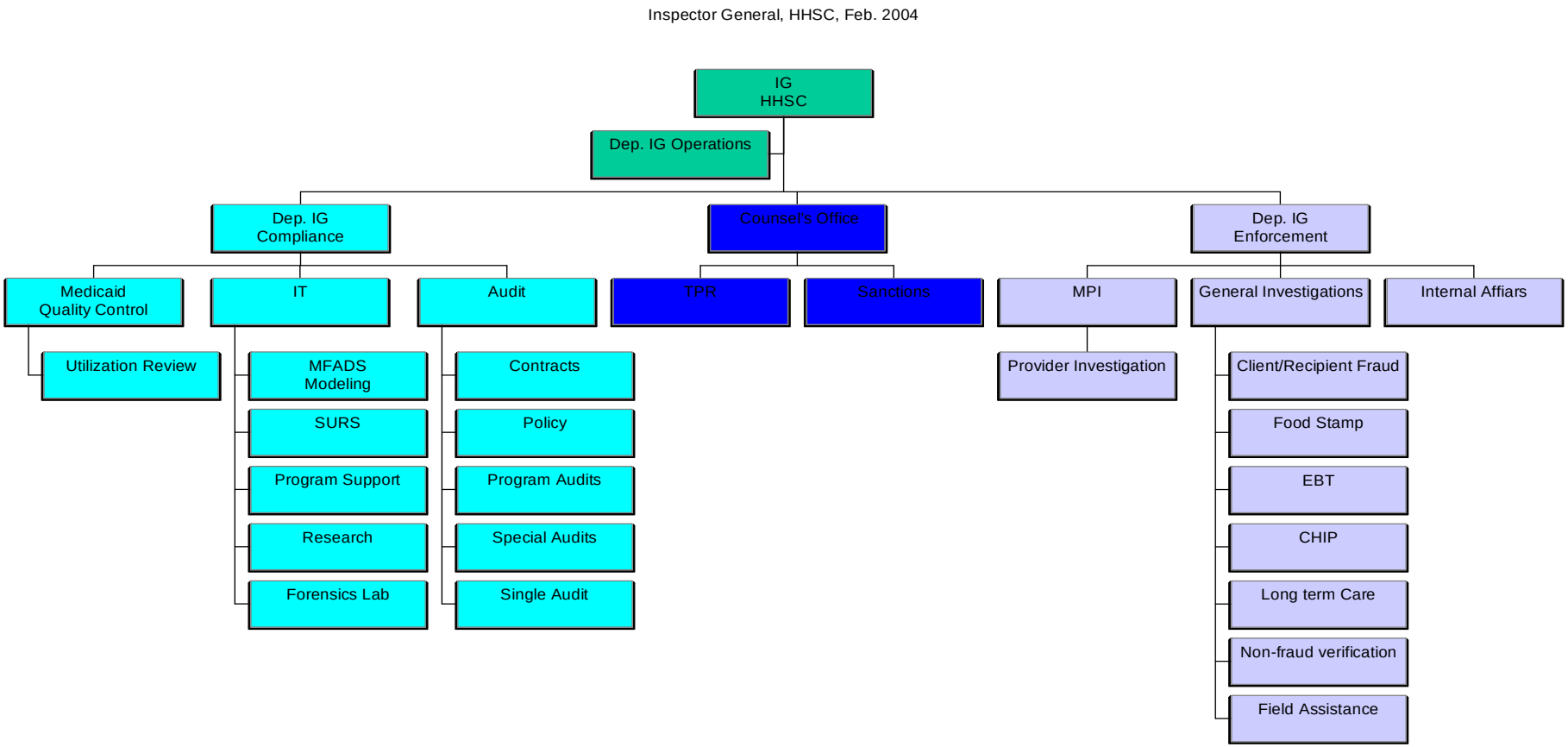
Definitions

- Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

- Fraud means an intentional deceit or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Organizational Structure

Activities to develop an integrated model to implement the mission: compliance, enforcement, recovery and sanctions.



OIG Consolidation

October 2003 - Inspector General Appointed

December 2003

- Conducted program review and compiled consolidation recommendations
- Completed Memorandum of Understanding (MOU) between OIG and Attorney General (AG)
- Conducted introductory meetings with provider associations

January 2004

- Began consolidated operations/transferred staff
- Completed MOU with Board of Dental Examiners
- Implemented Fiscal Agent Rules
- Gained access to National Insurance Crime Bureau ISO database
- Completed agreement regarding FBI fleeing felons data match

OIG Consolidation

February 2004

- Established interim budgets
- Completed hiring of top-level management within office; posted positions for next level of organizational structure
- Created statewide Health Care Fraud Working Groups with the AG's office, NICB, FBI, U.S. Attorney's offices, and local law enforcement

March 2004

- Reviewing LBB measures
- Began optimization process for office with Deloitte
- Initiated discussions on an MOU with the Texas State Board of Pharmacy
- Conducted open house and training session for the representatives of the AG's Medicaid Fraud Control Unit and medical examiners' offices

Transition Timeline

Next Steps:

May 2004

- Publish new policies and procedures:
  - A group of 40 subject matter experts and stake-holders has been assembled to contribute input.

July-August 2004

- Examine consolidated structure for changes
- Examine budget structure for changes

TEXAS Health and Human Services Commission

Medicaid Managed Care Expansion

Billy Millwee, Deputy Medicaid/CHIP Director
for Health Services

Medicaid Managed Care Expansion

HB 2292:

- Directed HHSC to provide Medicaid services through the most cost-effective model(s) of managed care.

- Required HHSC to conduct a study to determine which managed care model(s) are the most cost effective for the Medicaid program.

Medicaid Managed Care Expansion

Goal:

Achieve cost savings for the Medicaid program while providing a foundation for improved health outcomes through care coordination.

Criteria for Development:

- Balance cost effectiveness with community needs.
- Improve access to and appropriate utilization of care.
- Provide opportunities for improvement in each managed care model.
- Maximize the state's ability to obtain the best value from managed care contractors.
- Integrate managed care expansion with other initiatives
  - disease management
  - preferred drug list
  - integrated eligibility

Recent Activities

- Fall 2003 – Retained The Lewin Group to conduct the cost effectiveness study.
- January 2004 – Released the Lewin study.
- February 2004 – Released preliminary expansion proposal.
- March 2004 – Released a draft RFP for HMO managed care services.
- March 8-19, 2004 – Held statewide public hearings.
- Through March 31, 2004 – Accept public comment:
  - HHSC website Managed Care Expansion page
  - U.S. mail
  - Facsimile
  - E-mail

Cost Effectiveness Study

Key findings:

- PCCM and HMO models are more cost effective than traditional Medicaid.
- Greatest opportunity for cost savings with management of care for disabled population.
- For low-income pregnant women and children, HMO model only slightly more cost effective than PCCM.
- For disabled populations, HMO model is more cost effective than traditional Medicaid or PCCM.
- Competition between HMOs is more cost effective than competition between HMOs and other delivery models, such as PCCM and fee for service.

Preliminary Framework for Expanding Managed Care

- Expand STAR HMO model into designated counties adjacent to existing service areas.
- Implement STAR HMO model in one new service area consisting of Nueces and surrounding counties.
- Implement STAR PCCM model in all remaining counties.
- Discontinue STAR PCCM model in any existing or expansion STAR HMO service area where adequate STAR HMO coverage exists.
- Expand STAR+PLUS program (acute and long-term care services) in all service areas where STAR HMO model will be available.

Public Input Summary

Public comment clearly and strongly indicates the need to modify the preliminary framework.

Highlights of comments:

- PCCM should not be discontinued in current SDAs where HMO and PCCM models are operating (suggests maintaining status quo in existing service area).
- Managed care may not be an effective method for delivering Medicaid services, especially in less populated counties (suggests the need for establishing criteria relating to the client and provider base for implementing PCCM in a given area).
- There is a need to better manage care for the disabled population (supports expansion of STAR+PLUS).
- Need to increase oversight of HMOs to ensure compliance with timely payment of claims.
- DRAFT RFP is a major step forward in establishing greater accountability with HMOs.

Next Steps

April 2004 – Modify framework

May 2004 – Undertake further steps as appropriate under modified framework

Timeline considerations:

- Assess timeline against budgetary impact (payment of claims versus payment of premiums).
- Operational capabilities to offer managed care services (need to phase in).