Health and Human Services Commission

Presentation to House Human Services Committee

August 8, 2006

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Presentation Overview

HHSC Current Initiatives

- Comprehensive Healthcare for Foster Children
- Use of Psychoactive Medications In Texas Foster Children
- Integrated Eligibility and Enrollment (IEE)

Looking Ahead

- Medicaid Access Card/Integrated Benefits Card

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Current Initiatives: Integrated Eligibility and Enrollment (IEE)

Integrated Eligibility and Enrollment

HHSC is responsible for determining eligibility for state services, including:

- Children's Health Insurance Program (CHIP)
- Medicaid
- Food stamps
- Temporary Assistance for Needy Families (TANF)
- Long-term care for the elderly and people with disabilities (financial eligibility)

Integrated Eligibility and Enrollment

Current Eligibility System:

There is a clear and compelling need to modernize the eligibility system.

The current model is based on a service delivery framework designed in the 1970s and continues to reflect certain inherent limitations:

- Outdated computer technology which is difficult and costly to maintain and update.
- Inflexible office-based system that cannot easily respond to demographic or workload changes, consumer preferences, or other external factors

Integrated Eligibility and Enrollment

Current Eligibility System:

- Limited use of technological tools and modern business practices to support eligibility processing.

Integrated Eligibility and Enrollment

Current Eligibility System:

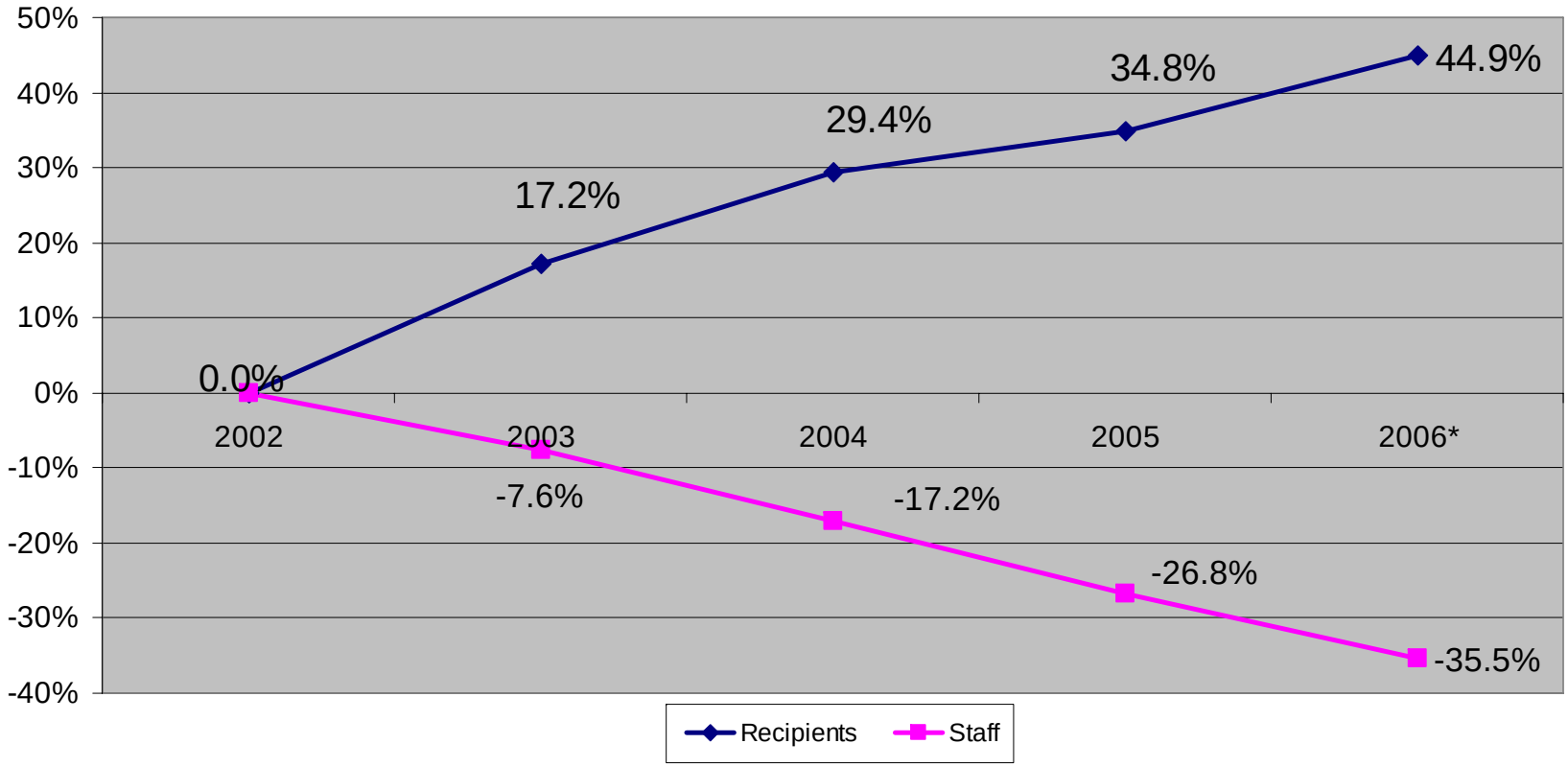
- Inconvenient for clients, who are tied to a specific office that is only accessible in person during business hours.
- Client surveys demonstrate demand for change.
  - 80 percent said they would be likely to use the phone to apply for services.
  - 36 percent said they would be interested in applying online.
  - 28 percent rely on public transportation or someone else to take them to an office.
  - 82 percent wanted to be able to apply outside of normal work hours and not lose time on the job.
  - 81 percent wanted to be able to apply in private “without others around.”

Integrated Eligibility and Enrollment

Current Eligibility System:

- Staff and resource intensive process that cannot respond to caseload growth without substantial increases in appropriations.
  - If staffed at the FY 2002 level, the current eligibility model would require more than 13,000 staff-an increase of 7,000 over current staffing levels.
  - This level of staffing would cost more than $250 million per year in All Funds.

Integrated Eligibility and Enrollment



* Projected for 2006

Integrated Eligibility and Enrollment

New Eligibility System

The 78th Legislature, 2003, enacted statutory provisions to "achieve the cost savings and revenue necessary to finance certain health and human services." The legislation in part:

- Directed HHSC to establish call centers, if cost-effective.
- Required HHSC to outsource call centers unless HHSC determined that contracting for the operation of the call centers would not be cost-effective.

Rigorous and extensive administrative activities were conducted to govern the determinations required by law:

- Integrated Eligibility Discovery report completed in November 2003 examined the current system and defined the preliminary vision for IEE/call centers, established key metrics and created the financial model to support future business decision-making

Integrated Eligibility and Enrollment

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New Eligibility System

- Business case completed in March 2004 determined that the use of call centers would be cost-effective.
- Competitive procurement through an RFP determined that outsourcing was more cost-effective than state-operated call centers.
  - The cost of state-operated call centers were projected to be 15%, or $436.4 million, less than baseline costs over a 5-year period
  - The cost of outsourced call centers were projected to be 22%, or $646.1 million less than baseline costs over a 5-year period
- Texas HHS agencies and clients have had favorable results with outsourced, call center operations:
  - CHIP (outsourced, call center operation since inception)
  - Lone Star Card (EBT or electronic benefit transfer system)
  - Medicaid Managed Care (Enrollment Broker)

Integrated Eligibility and Enrollment

New Eligibility System:

Goals for the new eligibility system:

- Create options for consumers
  - Can apply in person at over 200 offices
  - Can apply by telephone, Internet, fax or mail
- Expand the use of technological tools and modern business processes
  - Convert to electronic case files, which creates a more flexible model
- Cost-effective use of taxpayers' money

Integrated Eligibility and Enrollment

Implementing the New Eligibility System:
HHSC contracted with the Texas ACCESS Alliance (TAA) for multiple responsibilities:

- Responsibilities assumed from previous vendors:
  - CHIP eligibility
  - Medicaid and CHIP managed care enrollment broker services
  - Maintenance of the Texas Integrated Eligibility Redesign System – TIERS – automated system
- New responsibilities:
  - Integrated eligibility services for Medicaid, Food Stamps, and TANF
    - Currently in pilot in 4 out of over 300 eligibility offices

Integrated Eligibility and Enrollment

Implementing the New Eligibility System:

- Performance issues have been identified in areas of vendor responsibility.
- Vendor has recognized need for improvement.

Integrated Eligibility and Enrollment

Implementing the New Eligibility System:

Vendor Accountability:
Financial interests of the state are protected through strong performance-based contract standards:

- Key Performance Requirements
  - Includes timeliness and accuracy standards
- Fixed and Variable Costs
  - Payment structure NOT tied to eligibility determination outcome
- Consequential and Liquidated Damages
  - Vendor liable for sanctions imposed by federal agencies

Integrated Eligibility and Enrollment

Implementation Timeline

- Enrollment Broker – Assumed responsibilities from previous vendors on November 1, 2005
- TIERS Maintenance – Assumed responsibilities from previous vendor on November 1, 2005
- CHIP – Assumed responsibilities from previous vendor on December 1, 2005
- Children's Medicaid Applications statewide – January 1, 2006 (excludes recertifications)
- New Eligibility System Pilot – January 2006 – Two counties - Travis and Hays.
    - *All other counties are operating under the old state operated system.*

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Current Initiatives: Comprehensive Healthcare for Foster Children

Comprehensive Healthcare for Foster Children

- SB 6, 79th Regular Session directs HHSC to develop a new statewide model for children in foster care.
- Children in foster care are a high-risk population with greater need for care coordination.
  - In FY 2005, Texas Medicaid served 25,000 children per month in foster care.
  - Average total monthly healthcare cost for foster children is 5 times higher than for TANF non-foster children.
  - Cost of behavioral health care is 40 times higher for foster children than for TANF non-foster children.

Comprehensive Healthcare for Foster Children

Timeline:

- March 1, 2006 – Draft RFP released
- July 20, 2006 - Final RFP released
- September 21, 2006 - Final bidder proposals due
- November 3, 2006 - Tentative contract awards
- September 1, 2007 - Operational Start Date

Comprehensive Healthcare for Foster Children

Target Population:

- Children and young adults in DFPS conservatorship;
- Emancipated minors and young adults, ages 18-21, who voluntarily continue in a foster care placement; and
- Young adults who have exited foster care and are participating in the foster care youth transitional Medicaid program.

Comprehensive Healthcare for Foster Children

The goal of the new health care model is:

- To deliver integrated physical and Behavioral Health Services, centralize Service Coordination, and effectively manage health care data and information;
- To provide the Target Population with a consistent source of health care through a Medical Home; and
- To improve health care outcomes through enhanced quality of services.

Comprehensive Healthcare for Foster Children

- HHSC is seeking to implement either a capitated or non-capitated managed care model to provide and coordinate services statewide.
  - By contracting with only one MCO, HHSC can ensure better accountability for outcomes and better track children's care.
- Final RFP includes opportunity for two types of bidders to submit proposals: full risk (HMO or Exclusive Provider Plan), and non-risk (Prepaid Inpatient Health Plan often called an ASO).

Comprehensive Healthcare for Foster Children

Program components include:

- Expedited enrollment for immediate services through the coordinated care model
- A Medical Home, better preventive care, and coordinated care through a Primary Care Provider (PCP) or PCP Team
- Improved access through a defined network of providers
- Improved access to health history and medical records via web-based Health Passport
- 7-day, 24-hour Nurse Hotline and Behavioral Health Hotline for caregivers and caseworkers
- Medical advisory committees to monitor provider/network performance

Comprehensive Healthcare for Foster Children

Benefits to be managed by the MCO include the following:

- Physical and behavioral health
- Pharmacy (optional for full risk bidders)
- Dental services
- Mental health rehabilitative services
- Attendant care (long-term service)
- Service Coordination
- Health Passport
- Hotlines for physical and behavioral health and provider assistance

Comprehensive Healthcare for Foster Children

Health Passport

- Web-based electronic medical record
- Allows for improved information sharing and coordination of medical services
- Provides DFPS with up-to-date medical information on children in conservatorship
- Provides user-specific access to records
- Requires strict security provisions and privacy compliance
- The successful vendor will develop specific requirements for the passport with input from HHSC and DFPS

Comprehensive Healthcare for Foster Children

Tiered approach to coordinated services:

- Tier One: Medical Home
- Tier Two: Service Coordination
- Tier Three: Service Management

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Current Initiatives: Use of Psychoactive Medications in Texas Foster Children

Use of Psychoactive Medications In Texas Foster Children

- In February 2005, Psychotropic Medication Utilization Parameters for Foster Children were distributed to Medicaid providers.
  - A 2004 report by the Office of Inspector General (OIG) raised concerns about the use of psychoactive medications in foster children.
  - HHSC, along with DFPS and DSHS, implemented a number of strategies to get a more detailed assessment of the problem and assist providers in utilizing these medications appropriately.
  - Guidelines issued by Department of State Health Services with input from various medical professional associations.

Use of Psychoactive Medications In Texas Foster Children

- Follow-up study released in June 2006, examined the use of psychoactive medications in foster children in the five months before the release of the guidelines and the five months after the guidelines were distributed
- Guidelines were successful in reducing use of psychoactive medications in foster children.
  - Prescribing trends for foster children decreased in the five months following the release of the guidelines.

Use of Psychoactive Medications In Texas Foster Children

Utilization:

- 26% of foster children received a psychoactive medication for at least 60 days in SFY 2005.
- The use of psychoactive medications in foster children increases with age. (*Less than 1% under age 3 to 52% in ages 13-17.)*
- 86 children (0.8%) under age 3 received psychoactive medications for a period of 60 days or longer in FY 2005

Use of Psychoactive Medications In Texas Foster Children

Utilization:

- 396 of 37,052 foster children (1.1 percent) received 5 or more psychoactive medications at the same time.
- No children under age 4 received five or more medications at the same time.
- Older children more commonly suffer from Bipolar Disorder and Schizophrenia.

Use of Psychoactive Medications In Texas Foster Children

Utilization:

- 134 (1.4%) foster children who received psychoactive medication for 60 days or more did not have a mental health diagnosis.
- The perception by some providers that if they list a mental health diagnosis on the claim, they either will not be paid or will be paid a lower rate.
- Some providers may see Medicaid patients, but not bill for the services due to the program's payment rates and administrative requirements. The patients then fill the prescriptions, but there is no medical service claim to support the prescription. This makes it appear in the data that there is no mental health diagnosis.

Use of Psychoactive Medications In Texas Foster Children

Changes in Prescribing Post Guidelines:

- Prescribing trends decreased in the 5 months following the release of the guidelines
- Percentage of children taking two or more psychotropic medications decreased by 28.7%
- Prescribing 5 or more medications at the same time decreased by 30.9%
- Prescribing to children without a mental health diagnosis decreased by 21.8%

Use of Psychoactive Medications In Texas Foster Children

Next Steps

- Develop strategies to understand the clinical need to clinically manage patients outside the guidelines.
- Work with prescribers to see if other treatment alternatives might assist in decreasing the number of psychoactive medications prescribed.
- Implementation of comprehensive health care model for foster children.
  - Vendor to work with providers to encourage appropriate prescribing of psychoactive medication.

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Looking Ahead: Medicaid Access Card/Integrated Benefits Card

Medicaid Access and Integrated Benefits Cards

Medicaid Access Card:

- Client and Provider Benefits:
  - Faster check-in process for clients and providers
  - Easier for clients to carry 1 permanent card, instead of maintaining monthly paper cards
  - Automated eligibility verification for all clients at point of service
  - Ensures services are rendered to enrolled client

Integrated Benefits Card:

- Single platform for clients to access benefits from multiple state programs:
  - Medicaid, TANF, Food Stamps, and WIC