TEXAS
Health and Human
Services Commission

Presentation to the Senate Finance Committee *and* Health and Human Services Committee

Health and Human Services Commission

May 24, 2004

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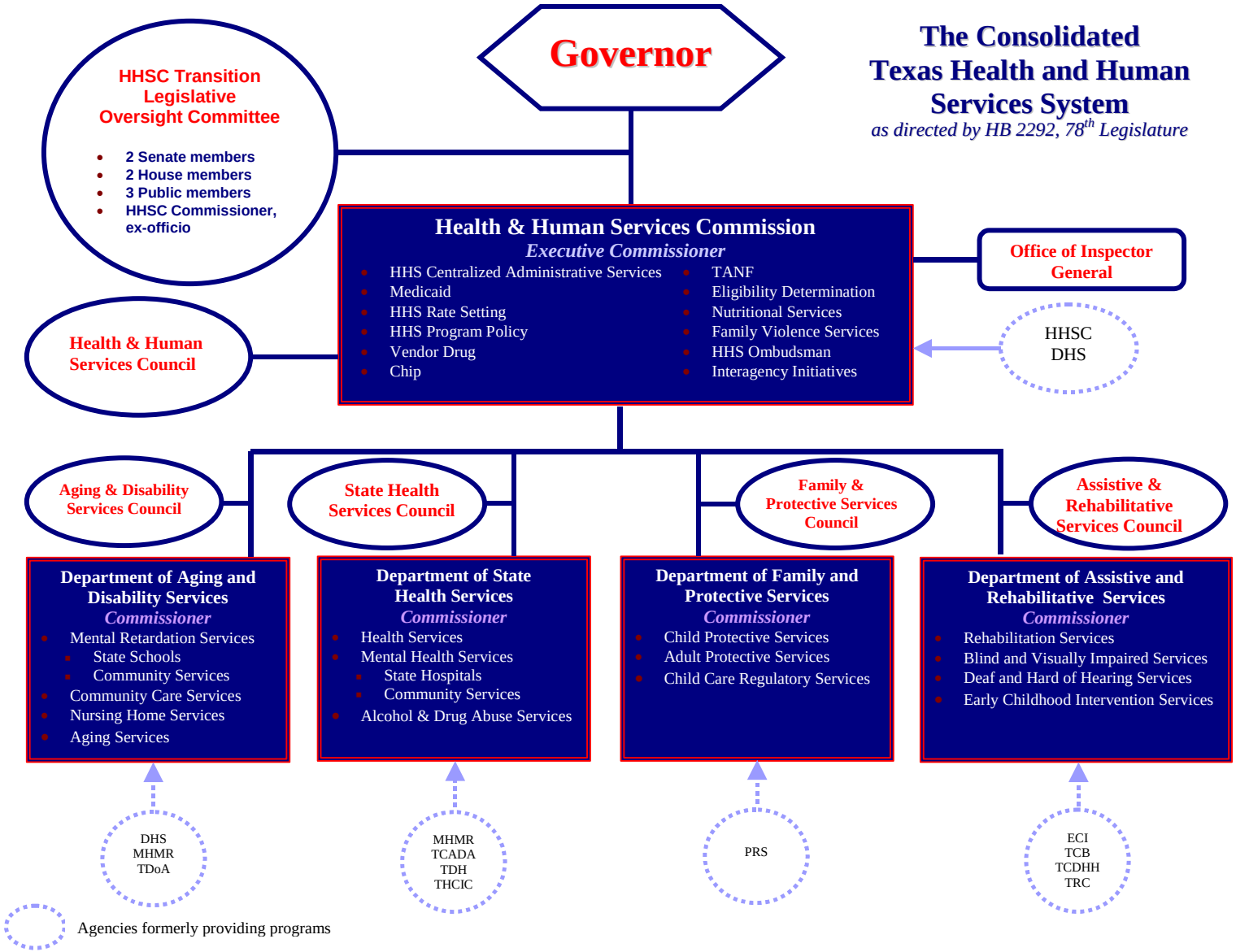
Process to Consolidate Health and Human Services Agencies

- H.B. 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
- With strengthened accountability and more effective use of tax dollars

Consolidation Organizational Structure



Transformation Timeline

- 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

Transformation Timeline (continued)

- 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)

Transformation Timeline (continued)

- 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

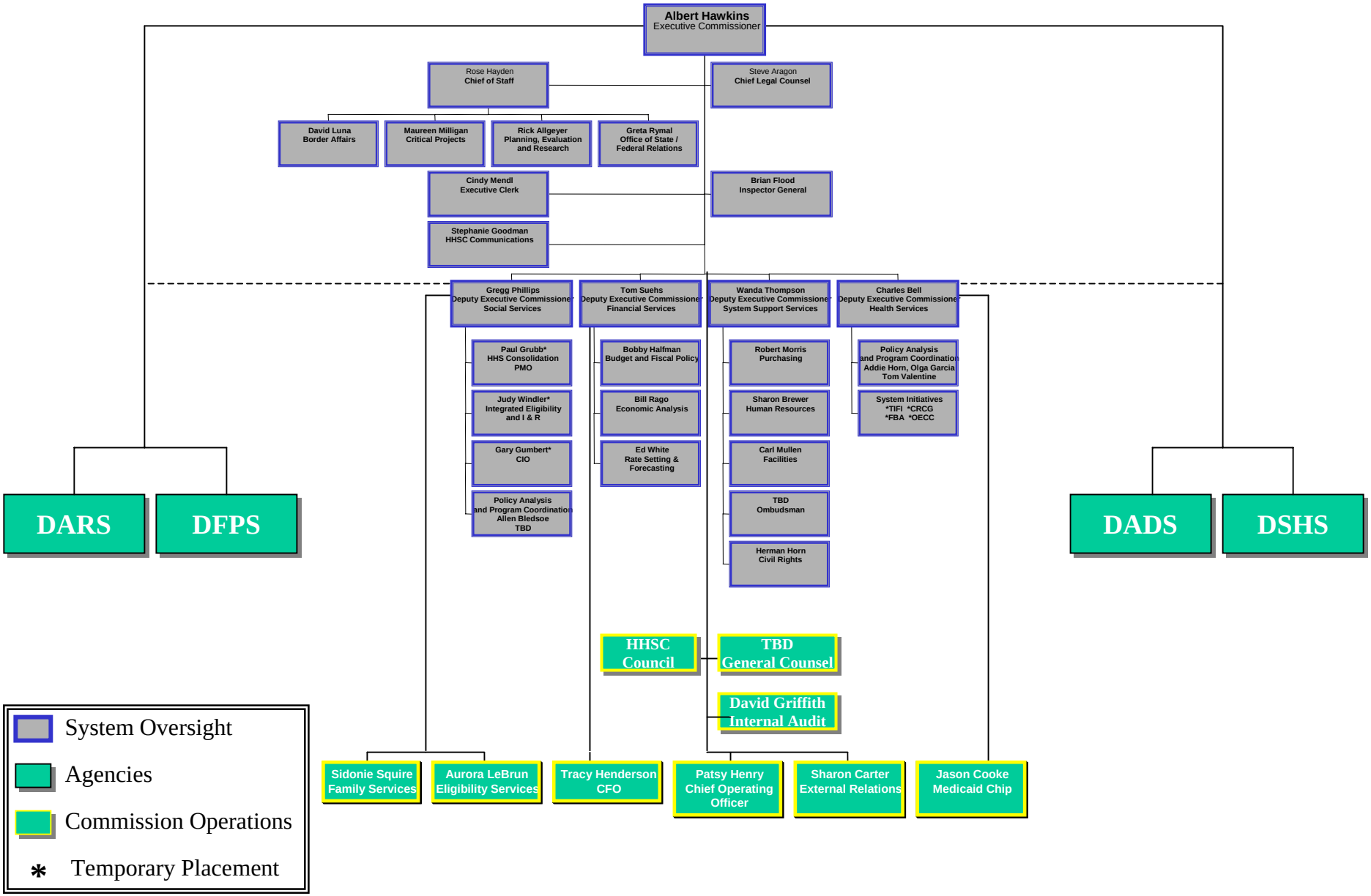
Transformation Timeline (continued)

- 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

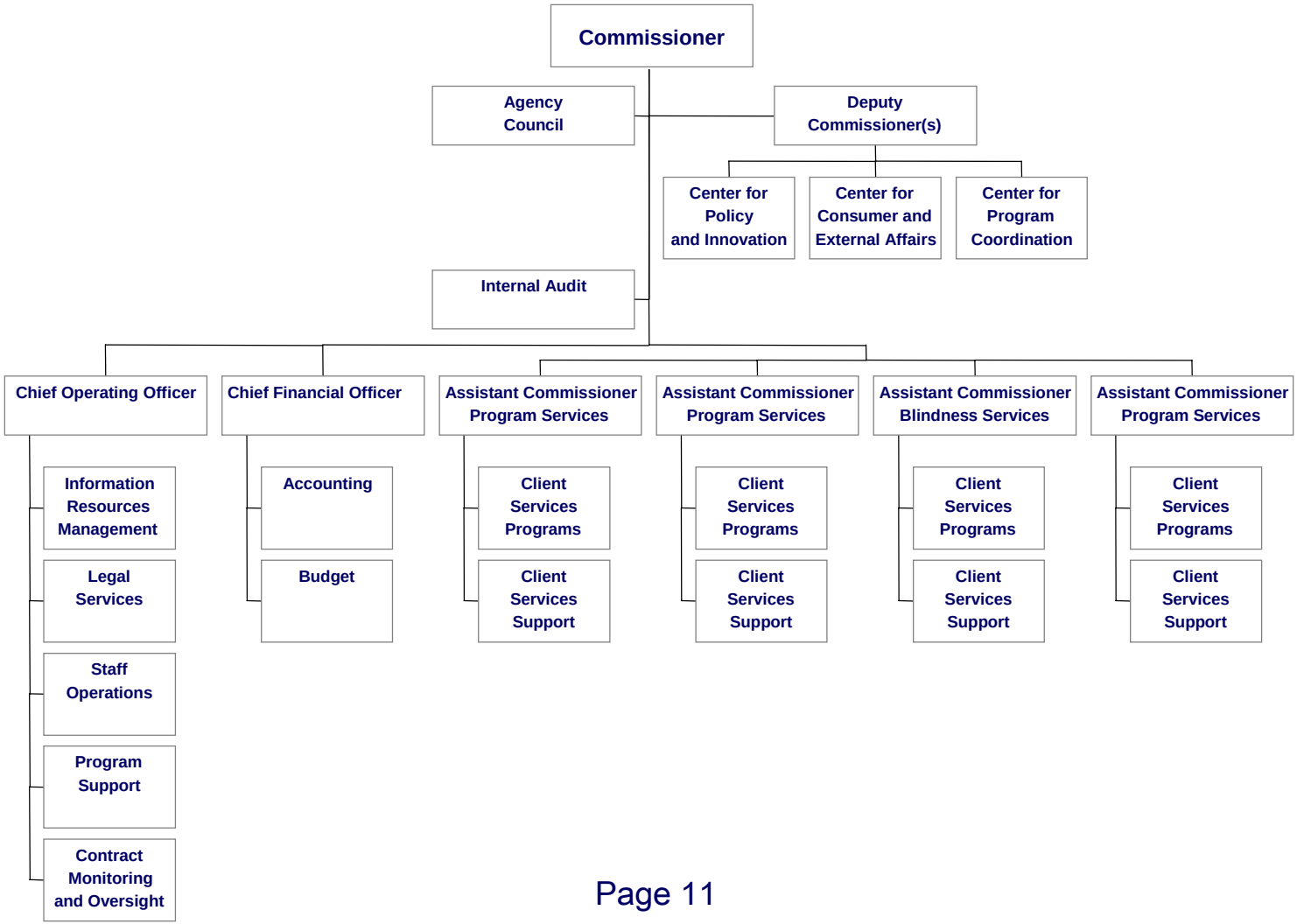
Transition Accomplishments

- Completed Administrative Consolidations
  - Human Resources Management
  - Office of Civil Rights
  - Procurement
  - Planning and Evaluation
  - Office of Inspector General
  - Forecasting
- Administrative Consolidations in Process
  - Financial Services
  - Information Technology
  - Rate Setting
- Program Consolidations at HHSC
  - Family Services
  - Family Violence
  - Refugee Assistance

Texas Health and Human Services Commission



HHS Uniform Organizational Chart



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

Contracts to Implement H.B. 2292, Article I

Contracts

- Project Management Office
  - Deloitte Consulting, L.P. (Consulting)
    - Project Management Office Development and Support
  - Accenture, L.L.P. (Consulting)
    - Risk Assessment
    - Communications Strategy
  - MAXIMUS, Inc. (Consulting)
    - Cost Allocation Plan

- Implementation Consultants

  Contracts have no fixed dollar value or commitment of funds, but authorizes the consultant to submit proposals in response to Task Orders issued by the HHSC Project Management Office for consulting services in support of the HHSC consolidation and transition.
  - JCFactor
    - TIERS Communication Plan and Support
  - Public Consulting Group, Inc. (PCG)
    - MHMR Closure/Consolidation Study
  - HHSC has confirmed the qualifications of an additional 74 consultants for potential awards in the future.

Pending RFP to Implement H.B. 2292, Article I: Human Resources and Payroll Services

- Purpose
  - To provide services in a broad array of human resources and payroll services for the health and human services agencies that currently employ an estimated 46,000 persons.
  - Services would include payroll, recruitment and selection, employee processing, compensation and class administration, benefits processing, time and leave, safety and health, administrative and training, and staff development.
- Timeline

Draft RFP for Comment Issued	January 16, 2004
Final RFP Released	February 20, 2004
Vendor Proposals Due	April 23, 2004
Evaluation of Proposals Completed	May 6, 2004
Notification of Award (no later than)	May 13, 2004*
Anticipated Contract Start Date	May 22, 2004*

*If deemed cost effective, these dates would apply.

Pending RFP to Implement H.B. 2292, Article I: Enterprise Messaging and Collaboration Infrastructure

- Purpose
  - To improve the efficiency and operations of all health and human services agencies;
  - To identify high quality, innovative, and cost-efficient solutions that enable HHS employees to collaborate and access enterprise information resources regardless of agency boundaries of geographic location; and
  - To establish a director-based enterprise-wide messaging and collaboration infrastructure that utilizes existing information resources, whenever possible; maintains flexibility and scalability; and is capable of integrating with other applications, directory services, and data repositories.
- Timeline

Final RFP Released	December 3, 2003
Vendor Proposals Due	January 16, 2004
Evaluation of Proposals Completed	April 2004
Tentative Award Announcement	Delayed
Anticipated Contract Start Date	Delayed

Contracts to Implement H.B. 2292, Article II

- Medicaid Managed Care
  - The Lewin Group
    - Actuarial assessment of the cost effectiveness and feasibility of a statewide managed care expansion.
    - Assessment of provider network adequacy and out-of-network rates
  - Bailit Health Purchasing, L.L.C.
    - Medicaid/CHIP Managed Care RFP
- Medicaid Vendor Drug Program
  - Winkelman Mgt Consulting
    - Prior Authorization/Preferred Drug List RFP Development
  - University of Texas
    - Prior Authorization Study
  - Provider Synergies
    - Preferred Drug List (PDL) and supplemental rebate services
  - Heritage Information Systems, Inc.
    - PDL prior authorization service

Contracts to Implement H.B. 2292, Article II (continued)

- Front End Authentication and Fraud Prevention System Pilot

  - MTG Management Consultants
    - Project Management
  - International Biometric Group, L.L.C.
    - Independent Evaluation Services
  - MAXIMUS, Inc.
    - Dallas and Harris Counties
  - EDS Information Services, L.L.C.
    - Hidalgo and Cameron Counties
  - Emedical Files, Inc.
    - Travis County
  - SchlumbergerSema, Inc.
    - Tarrant County

Pending RFP to Implement H.B. 2292, Article II: Prior Authorization Services for High-Cost Medical Services

- Purpose
  - To evaluate and implement, as appropriate, procedures, policies, and methodologies to require prior authorization for high-cost medical services and procedures
  - To perform high-cost medical services provided through the state's Title 19 Medical Assistance Program fee-for-service and primary care case management (PCCM) programs.
- Timeline

Final RFP Released	February 27, 2004
Vendor Proposals Due	April 19, 2004
Tentative Award Announced	May 14, 2004*
Anticipated Contract Start Date	June 1, 2004*

*If deemed cost effective, these dates would apply.

Efforts to Outsource a State Hospital and a State School

- H.B. 2292 directed the Texas Department of Mental Health and Mental Retardation (TDMHMR) to report to HHSC by April 1, 2004, on whether it had received proposals by private service providers to operate a state school for persons with mental retardation and/or a state hospital for persons with mental illness.

- August 2003
  - TDMHMR organized a cross-sectional workgroup to develop Requests for Proposals (RFPs) to solicit proposals from private service providers.

- September 2003
  - TDMHMR released a Request for Information (RFI) to solicit input from private service providers to use in the development of the RFPs.

- December 2003
  - RFPs were published and released on December 12, 2003, and a Pre-Proposal Conference for perspective respondents was held on December 19, 2003.

Efforts to Outsource a State Hospital and State School (continued)

- January 2004
  - Potential respondents were offered opportunities to visit and inspect all the state hospitals and state schools. The opportunity to submit written questions for clarification of the RFPs' requirements and additional information and receive formal written responses from TDMHMR was available during the RFP process.
  - By January 16, 2004, TDMHMR had received Letters of Intent to submit proposals from eight private service provider organizations, encompassing all the state hospitals and state schools.
- February 2004
  - Proposals due and none were received for any state hospitals.
  - Proposals for three state schools were received from one private service provider; however, it did not meet the minimum requirements for further consideration.
- March 2004
  - A survey of private service providers who had expressed an interest in submitting a proposal was taken to determine the factors that influenced these providers' decisions to not submit proposal. Results indicated that the requirements to operate the facility at 25% less than the current cost and to provide the same services, at the same quality level, to the same population as when the department operated were decision factors.

H.B. 2292 FTE Transfers to HHSC
(as of April 1, 2004)

Function	FTEs Tranferred	FTEs Filled as of 2-29-04	FY2004 All Funds (in millions)	FY2004 General Revenue (in millions)	Effective Date
Human Resources	493	415.3	$ 17.3	$ 7.5	June 2003
Procurement	335	287.0	9.9	4.8	October 2003
Civil Rights	59	55.0	2.6	1.1	October 2003
Family Violence	10	10.0	0.4	0.4	October 2003
Refugee Assistance	10	9.0	0.4	-	October 2003
Office of Inspector General	474	415.0	12.8	5.1	January 2004
Planning and Evaluation	30	20.0	0.9	0.4	January 2004
Family Services	277	246.0	4.7	1.3	April 2004
Totals	1,688	1,457.3	$ 49.0	$ 20.6	

*Funds shown above do not reflect full-year costs.

Consolidation Savings Plan

To achieve the goals of a $180.1 million reduction in General Revenue spending related to H.B. 2292 initiatives, required by the General Appropriations Act, Article II, Special Provisions, Section 28, HHSC has established a process to identify and track savings for each project related to H.B. 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 (continued)

- Process for tracking H.B. 2292 initiatives:
  - Assigned a project manager and a financial services contact to develop updated savings estimates
  - Designated 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
    - FTEs
  - Detailed status reports are submitted to executive staff periodically
  - February 2005 – Submit final report on H.B. 1, Article II, Special Provisions, Section 28 reductions

Update on Key Projects

- Integrated Eligibility (Call Centers)
- Texas Integrated Eligibility Redesign System (TIERS)
- Medicaid Fraud and Abuse/Office of Inspector General
- Managed Care Expansion

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Integrated Eligibility (Call Centers)

Integrated Eligibility

H.B. 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)
- New model will require 3,377 Full Time Equivalents in Call Centers and Benefit Issuance Centers.
  - Current model requires 7,864 workers

Cost-Benefits of Integrated Eligibility

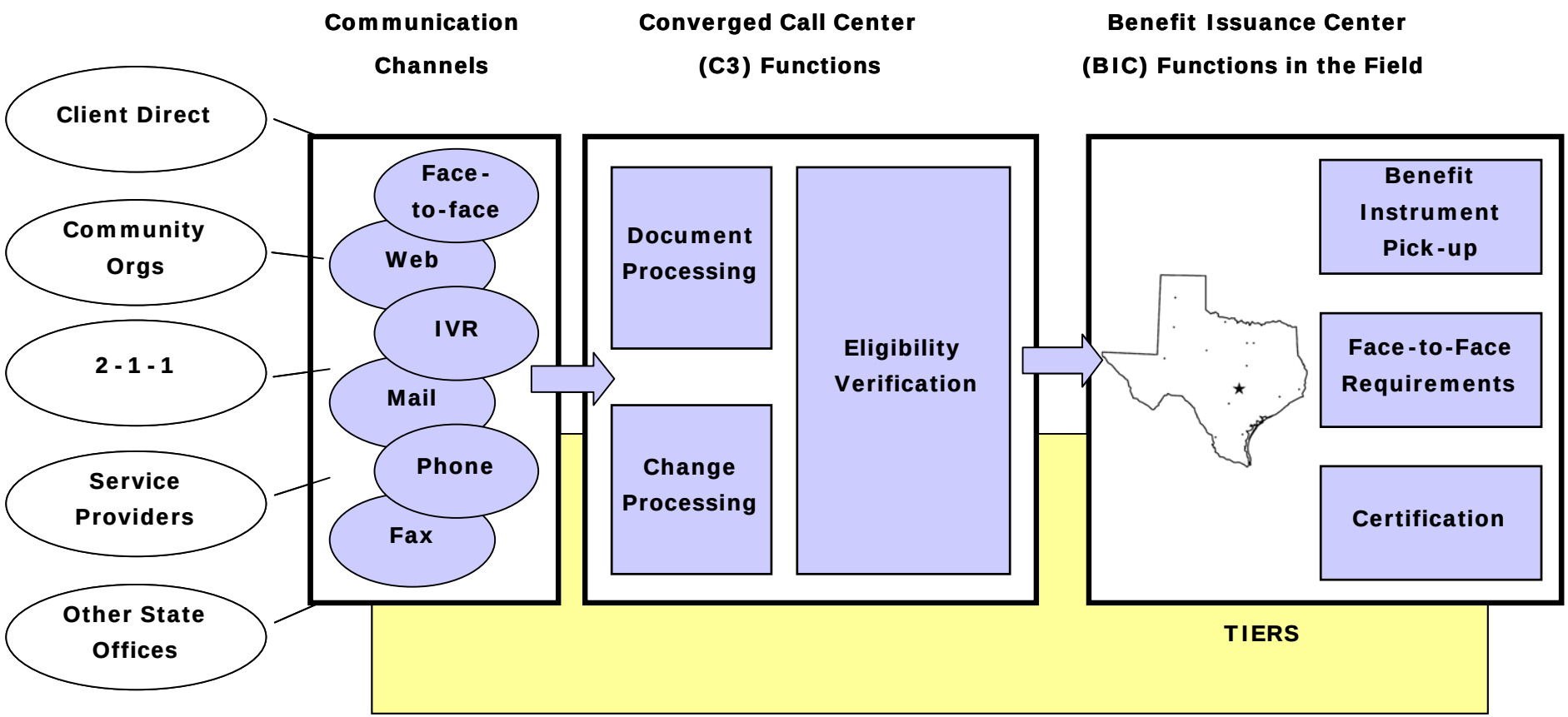
Potential net savings of the proposed model:

- FY04 – FY08: General Revenue savings = $178,612,829
- FY04-FY08: Federal savings = $210,236,075
- Total savings over the next five years of $388,848,904 gained by streamlining central office administration, information system support, and other eligibility support functions.
- Savings under the proposed model in FY2005 and FY2006 could be reallocated to pay for the necessary investment.

PROJECTED ANNUAL SAVINGS	2004	2005	2006	2007	2008	%
General Revenue	77,162	14,471,184	50,591,837	52,241,121	61,231,525	46%
Federal (Total)	78,476	16,905,312	58,951,746	61,214,077	73,086,464	54%
Annual TOTAL Savings	155,637	31,376,496	109,543,583	113,455,198	134,317,989	
Federal TANF (Subset of Federal)	756	2,633,957	8,760,997	9,432,000	12,488,340	9%
Cumulative GR	77,162	14,548,345	65,140,182	117,381,304	178,612,829	46%
Cumulative Federal (Total)	78,476	16,983,788	75,935,534	137,149,611	210,236,075	54%
Cumulative TOTAL	**155,637**	**31,532,134**	**141,075,717**	**254,530,915**	**388,848,904**	
Cumulative Federal TANF	756	2,634,712	11,395,709	20,827,709	33,316,048	9%

Integrated Eligibility Model

Model for Integrated Eligibility Determination



Integrated Eligibility (continued)

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 (continued)

Next Steps:

➢ Develop and publish proposed rules	April 9, 2004
➢ Conduct public hearings	April 30, 2004
➢ Develop detailed implementation plan	May 2004
➢ Prepare and release RFP to determine if outsourcing is cost effective	May 2004

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Texas Integrated Eligibility Redesign System (TIERS)

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 Five 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 H.B. 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.

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Medicaid and Fraud Abuse
Office of Inspector General (OIG)

Office of Inspector General (OIG)

H.B. 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 (continued)

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

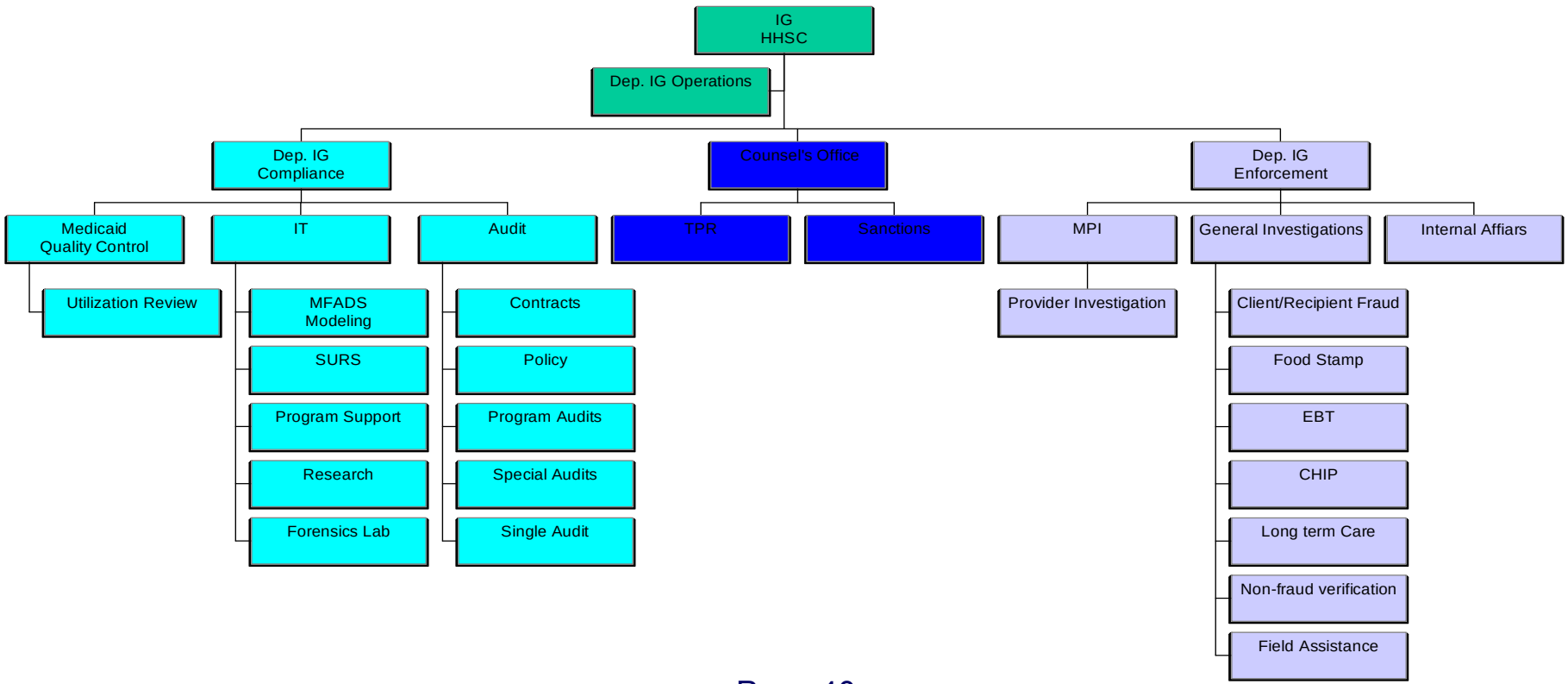
- Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

- 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.

Inspector General, HHSC, Feb. 2004



Medicaid Fraud and Abuse

Medicaid Program Integrity (MPI): [Provider Fraud]

A. Investigates allegations of waste, abuse, and fraud involving Medicaid providers and other health and human services programs;

B. Refers cases and leads to law enforcement agencies, licensure boards, and regulatory agencies;

C. Conducts criminal investigations of providers and refers complaints to the Attorney General's Medicaid Fraud Control Unit;

D. Provides investigative support and technical assistance to other OIG divisions and some outside agencies;

E. Imposes civil and administrative sanctions; and

F. Monitors recoupment of:

1. Medicaid overpayments
2. Civil monetary penalties
3. Damages
4. Other administrative sanctions

Medicaid Fraud and Abuse (continued)

General Investigations (GI): [Recipient Fraud]

A. Investigates allegations of waste, fraud, and abuse involving Medicaid recipients, and other health and human services programs

B. Functions:

1. Expedited fraud investigations
2. Client fraud investigations
3. Food stamp disqualifications
4. Food stamp trafficking
5. HMO marketing misconduct
6. Non-fraud verification
7. Data match clearance

Medicaid Fraud and Abuse (continued)

Internal Affairs (IAD):

A. Tracks and coordinates three computer data matches designed to locate wanted felons and missing children
   1. DPS data match (Texas-wide)
   2. FBI felony data match (nationwide)
   3. National Center for Missing and Exploited Children data match (nationwide)

B. Investigates traditional internal affairs cases involving allegations of
   1. Theft
   2. Worker's compensation
   3. Misuse of state property
   4. Policy and procedure violations

C. Investigates:
   1. Waste
   2. Abuse and neglect in state hospitals and state schools
   3. Fraudulent issues

OIG Compliance Divisions

Quality Review

A. Monitors utilization review activities in Medicaid contract hospitals;

B. Performs case mix assessment reviews in nursing facilities, including hospice recipients residing in nursing facilities;

C. Performs fiscal monitoring and food delivery reviews for Women, Infants, and Children (WIC);

D. Monitors WIC authorized grocery stores and farmer's markets through covert compliance buy investigations and on-site evaluations; and

E. Reviews and approves the plans for the Managed Care Organizations (MCOs) Special Investigations Unit.

Information Technology

A. Performs and supports the business needs of the OIG;

B. Maintains and supports the Medicaid Fraud Abuse Detection System (MFADS);

C. Monitors the MFADS contract; and

D. Performs the Surveillance Utilization Review functions.

OIG Compliance Divisions (continued)

Audit

A. Performs contract compliance (third party) audits;

B. Completes cost report audits which are used to assist in the establishment of reimbursement rates; and

C. Performs single audit reviews.

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 (continued)

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. Attorneys' offices, and local law enforcement

March 2004

- Began 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

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Managed Care Expansion

Traditional Medicaid vs. Managed Care

- Traditional Medicaid
  - Client must search for a doctor who will accept Medicaid
  - Treats people after they become sick
  - Clients tend to have high ER utilization
- Medicaid Managed Care
  - Provides a regular source of health care through a Primary Care Provider (PCP)
  - Improved access to a defined network of providers
  - Promotes preventive care
  - Promotes continuity of care
  - Encourages appropriate utilization of care

Medicaid Managed Care

- Health Care Delivery Models:
  - Health Maintenance Organization (HMO)
    - Primary Care Providers (PCPs) and specialists contracted directly with HMO
    - PCPs must refer patients to specialists within the HMO's network
    - Providers paid by HMO
    - HMO assumes risk
  - Primary Care Case Management (PCCM)
    - Texas Health Network
    - PCPs contracted directly with state
    - PCPs can refer patients to any Medicaid specialist
    - Providers paid by state
    - State assumes risk

Medicaid Managed Care (continued)

- Medicaid managed care in Texas is known as **S**tate of **T**exas **A**ccess **R**eform (STAR) which includes two managed care programs:
  - STAR (H.B. 7, 72nd Legislature, R.S., 1991)
    - Current monthly enrollment approximately 1,000,000
    - Provides acute care services to low-income families (primarily pregnant women and children)
    - Mandatory: Low-income families (primarily pregnant women and children)
    - Voluntary: Certain blind and disabled (SSI) Medicaid eligibles, under age 65
  - STAR+PLUS (SCR 55, 74th Legislature, R.S., 1995)
    - Current monthly enrollment approximately 60,000
    - Integrates acute care and long-term care services to aged and disabled Medicaid clients
    - Mandatory to HMO: Aged, blind and disabled Medicaid eligible adults (SSI and SSI-related)
    - Mandatory to either HMO or PCCM: Blind and disabled children under age 21 (SSI and SSI-related)

Medicaid Managed Care Expansion

H.B. 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 (continued)

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 – Accepted 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)