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Services Commission

Senate Committee on Health and Human Services

October 19, 2004

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Child Protective Services Reform

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Deputy Executive Commissioner

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CPS Reform Presentation Overview

- Executive Order RP 35 Overview
- Child Protective Services Reform
  - OIG Compliance Review
  - Immediate and Future Corrective Actions
  - Recommendations for Legislative Action

Child abuse is too big for any one agency to solve. We are dependent on other agencies, the judicial system, and on communities to work together to prevent and respond effectively to child abuse and neglect in Texas

Overview of Governor's Executive Order

- Executive Order RP35 was issued on July 2, 2004, in response to reports that indicate systemic problems within the Child Protective Services (CPS) program
  - The order directs the Health and Human Services Commission (HHSC) to oversee the systemic reform of the CPS program of the Department of Family and Protective Services (DFPS)
  - Specific actions and outcomes required under the executive order:
    - Review of case files
    - Administrative practices and organizational structure
    - Partnering with law enforcement & local communities
    - Review of state laws and policies

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Key Report Dates

- October 1, 2004 – Submitted Implementation Plan to Governor
- December 31, 2004 - Final report due

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90-Day Implementation Plan

Overview:

- HHSC charged the Office of Inspector General (OIG) with conducting a compliance review
  - Detailed review of more than 2,200 cases
- Immediate Corrective Actions
- Program Operations Review of all aspects of CPS
- Independent Review of National Practices

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OIG Review

- OIG's review was used as a diagnostic tool to provide HHSC information needed to analyze the issues and identify steps needed to address them
- Overall, OIG findings indicate:
  - Policies and procedures appear sound
  - Staff, however, often did not comply with policies and procedures
  - OIG concluded that the volume of work leads to breakdowns in following policies and procedures

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Current CPS Workload

- Average caseloads for investigators have risen from 47.9 in November 2001 to 61.4 in August 2004
- Nearly four out of ten new caseworkers quit within the first year
  - The turnover rate for new investigative staff exceeds 51%
- Average tenure of CPS Supervisors decreased two years in a two-year period

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Immediate Corrective Actions

- Accelerating the hiring of 123 new positions, focusing on investigation caseworkers and supervisors, and child safety specialists
- Provide incentive payments to retain experienced caseworkers in the CPS investigation units
  - Tenured CPS employees who chose to stay or move back to investigations will be eligible for $3,000 after 12 months of service in those units
- Direct CPS caseworkers to refer uncooperative families to local prosecutors for appropriate legal action
  - Example – obtain court order to require parents to participate in services or place the child in foster care

Immediate Corrective Actions

- Require an independent review before closing cases involving younger children, especially three years and under, when abuse and neglect cannot be ruled out
- Provide caseworkers access to medical professionals for immediate consultation and determination on a child's well-being
- Train investigative caseworkers in the use of forensic photography for improved case review, documentation, and medical assessments

CPS Program Operations Review

- Initial phase of CPS review identified six key priorities for improvement:
  - Reduce caseloads
  - Maintain a well-trained workforce
  - Retain experienced staff
  - Ensure compliance with CPS policies and procedures
  - Develop effective community partnerships
  - Ensure child centered outcomes

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Independent Review

- HHSC will use an organization with a national view of child welfare systems to evaluate HHSC's review and provide additional guidance
- The review will focus on:
  - Workforce structure
  - Effective models for investigations of child abuse and neglect
  - Comparative review of county and state administered child welfare systems
  - Ways to strengthen foster care and adoption
  - Strategies for better identifying valid cases at intake
  - Identification of best practices in child welfare and prevention of abuse and neglect

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Next Steps

- Combined results from the OIG review, program operations evaluation, and the independent review will form the basis for corrective actions and recommendations for the Legislature
- Final report, due December 31, 2004, will include:
  - Complete review of CPS
  - Implementation plan for additional program improvements
  - Recommendations for legislative actions

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Summary

- HHSC has collected and reviewed information to determine the scope of the problem and what actions need to take place
- HHSC has taken immediate action to protect children at risk and will continue to implement improvements to the CPS program
- We recognize the need for structural reform of the CPS program and are working with national experts to make recommendations for change

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CPS Case Reviews

Brian Flood

Inspector General

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CPS Case Review

- July 12, 2004 -Team of 30 deployed to Arlington
- Statewide random sample of cases
  - Cases were read by CPS staff under guidance of Office of Inspector General (OIG) Internal Affairs personnel
  - Case reading staff results were audited by OIG auditors and HHSC Internal Audit
  - Random field reviews and employee interviews were done by OIG field staff in the General Investigations Division

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CPS Case Review

- Auditing of CPS cases for compliance with CPS policies, procedures, documentation, and reporting standards
  - ➢ OIG reviewed 2,221 CPS investigation case files statewide
    - OIG reviewed 1,103 from Region 3 – Arlington

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CPS Case Review

Case Review Findings:

- CPS caseworkers are inundated with increasing caseloads
  - Resulting in noncompliance with policies and premature closing of cases
- CPS policy is not consistently applied across the state
- CPS caseworkers, in more than half of investigations:
  - Did not maintain required contact with the child
  - Did not involve a supervisor for appropriate support and direction
  - Did not provide all the needed services to the children

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CPS Case Review

Other Findings:

- Face-to-face contact with a child and family within the time frame set by CPS policy was not being followed
- Service plans for further services and actions did not always adequately address the issues of abuse or neglect as identified in the investigation
- CPS did not always initiate or maintain contact with clients referred for the Family Based Safety Services
- Higher level CPS administrators were not involved in exceptionally difficult or complex investigations
- Subsequent referrals continue to present reoccurring issues not resolved in previous cases
- CPS did not maintain regular contact with children placed in foster care

Ongoing OIG Review Efforts

- OIG is continuing to review:
  - CPS quality assurance processes
  - Community perception of CPS
  - Program's relationship with community
  - First line staff recommendations to improve services

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Medicaid/CHIP Transformation

David J. Balland

Interim Associate Commissioner

for Medicaid and CHIP

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Contract Summary

HHSC's Medicaid/CHIP Division manages some of the largest, most complex contracts in the state, including:

- Medicaid Claims and PCCM Administration
  - Contract worth over $130 million/year
- Medicaid and CHIP HMOs
  - 17 managed care organizations (some with multiple contracts) paid a capitated rate per enrollee
- Vendor Drug
  - 3 contracts worth over $8 million/year
- Over 30 other contracts
  - including enrollment broker (over $20 million/year), CHIP administration (over $10 million/year), community-based organizations (35 contracts over $1.5 million/year)

Contract Summary

HHSC's Medicaid/CHIP Division manages and supports large, complex contract procurements, including:

- Re-procurement of all managed care organizations
- Integrated eligibility and enrollment
- Vendor drug outsourcing evaluation

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Challenges

Challenges in the past have included:

- Contract “management” vs. “administration” **not clearly defined**
- Contract management **spread across the Division** with unclear accountability
- Similar business process **not standardized**
- Contractor **performance monitoring** not consistent
- Insufficiently **experienced contract managers** and financial analysts

Approach to Improvements

Medicaid/CHIP, with the assistance of Deloitte Consulting, has recently completed a transformation effort aimed at:

- Improving **accountability** of the program and its staff
- Clarifying staff **roles and responsibilities**
- Implementing new **performance measures** for staff and contractors
- Increasing **efficiency** of staff and contractors
- **Reorganizing** to promote improved management
- **Reducing risk** of future cost overruns and other problems
- Improving **financial management** of the program

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Results

The results of this transformation effort have included:

- **Separated** contract management from administrative duties
- **Centralized contract management** within Medicaid/CHIP
- **Reengineered business processes** to standardize and improve internal controls, including:
  - Amendment of contracts
  - Contract payments
  - Performance monitoring and management
- Hired additional **senior-level staff** to manage the TMHP contract
- Implemented **new performance measures** for staff and contractors
- Procured independent external financial, performance, and IT **audit services**
- **Trained Division staff** on new processes and business values

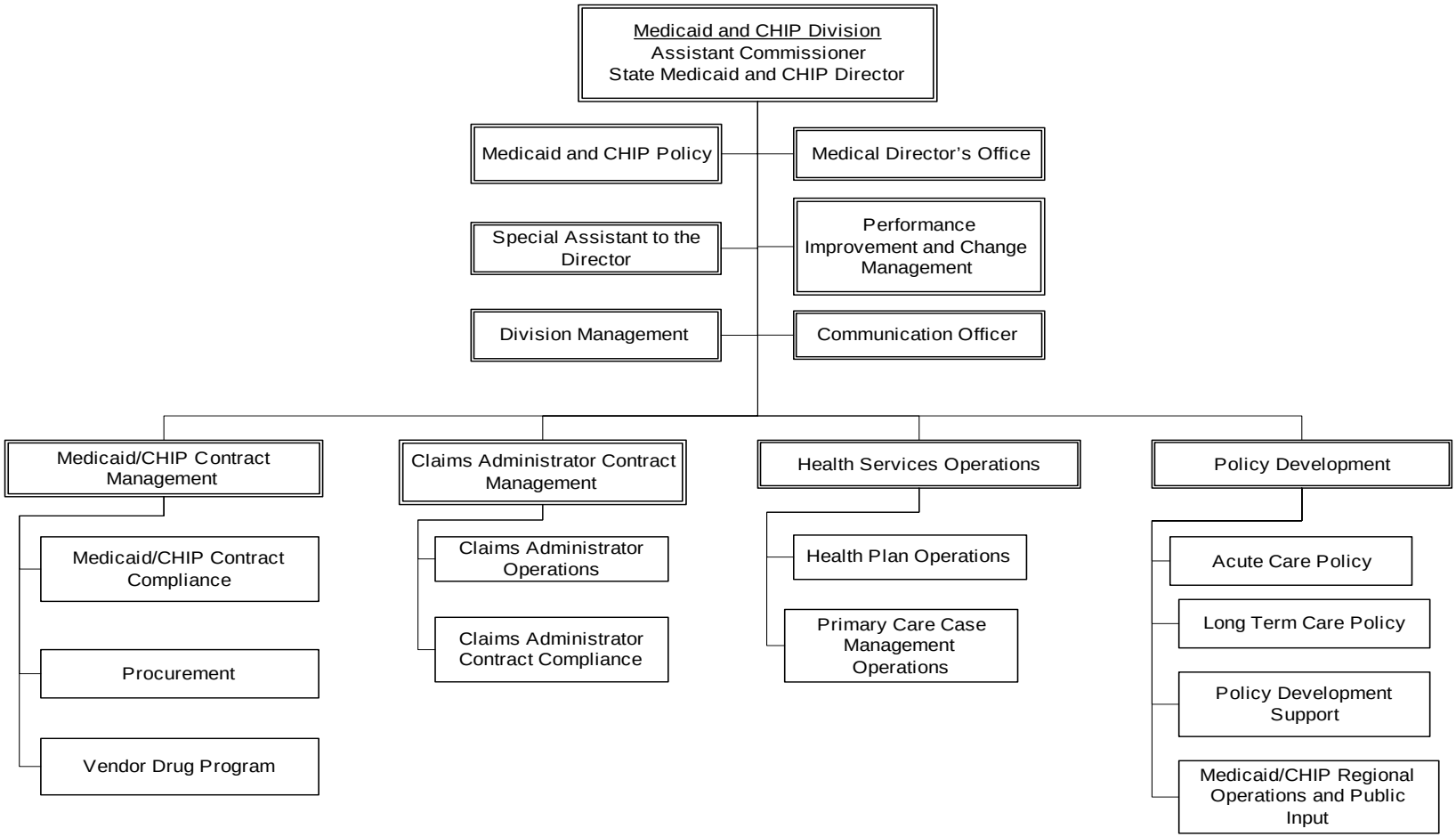
Ongoing Improvements

In addition to these results, Medicaid/CHIP is pursuing further improvements to its management of contracts, including:

- Hiring additional **certified contract managers**
- Hiring additional contract **financial analysts**
- Implementing **new tools** to manage contractor performance
- Improving the coordination of contractor **deliverable tracking and analysis**
- Implementing new **value-based performance contracts** in managed care
- Procuring **independent verification and validation** (IV&V) services for the claims and PCCM contract

Medicaid/CHIP Division Organizational Chart

New Medicaid/CHIP Division Organization (effective June 7)



Contract Management Improvements

- Re-engineered business processes
- Centralized contract management
  - Medicaid Claims/PCCM Contract with Texas Medicaid & Healthcare Partnership (TMHP)
    - Placed under a single senior manager with dedicated staff reporting directly to State Medicaid/CHIP Director
  - All other Medicaid/CHIP contracts
    - Placed under a single senior manager with dedicated staff reporting directly to State Medicaid/CHIP Director

Organizational Improvements

- Medicaid/CHIP Contract Management:
  - Handles contract administration and compliance of all contracts except for the TMHP contract.
  - Manages and enforces contract terms and conditions
  - Processes amendments and change orders
  - Tracks deliverables
  - Reviews invoices and manages payments
- Claims Administrator Contract Management (non-HMO):
  - Manages the Affiliated Computer Systems (ACS) and TMHP contracts
- Health Services Operations:
  - HMO plan management
  - Works with the contractor to resolve service delivery issues
  - Directs daily operations and quality control for HMO contracts
  - Reviews HMO deliverables for quality purposes

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Medicaid Managed Care

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Medicaid Managed Care

- HB 2292 Requirements:
  - HHSC must provide Medicaid acute care services through the most cost effective managed care model(s)
  - HMO may not be used in Cameron, Hidalgo or Maverick counties
  - If no model of managed care is cost effective, fee-for-service (FFS) may be used

Medicaid Managed Care

- To comply with HB 2292 requirements:
  - HHSC completed an actuarial assessment of managed care cost effectiveness
    - Determined the cost implications of expanding the use of Medicaid managed care in Texas:
      - STAR HMO
      - STAR PCCM
      - STAR+PLUS
      - Exclusive Provider Organization (EPO)
    - Assessed each model's cost savings potential by:
      - Geographic region
      - Medicaid risk group (eligibility category)

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Medicaid Managed Care

- Summary of Actuarial Findings:
  - Large-scale savings are possible through managed care expansion, particularly for urban disabled population
  - Estimated overall savings is $72 million annually
  - HMO model yields largest medical cost savings
  - HMO model is not always the most cost-effective overall option
  - Non-HMO managed care options are projected to yield savings relative to FFS, even in rural areas
  - Managed care models should not compete within the same market

Medicaid Managed Care

- Medicaid Managed Care Expansion Proposal
  - **STAR HMO**
    - **Retain STAR** HMO model in all existing areas
    - Add STAR to **Nueces Service Area** (New service consisting of nine counties: Aransas, Bee Calhoun, Jim Wells, Kleberg, Nueces, Refugio, San Patricio and Victoria)
  - **STAR+PLUS**
    - **Harris County** (Expand Harris County to include the following additional counties: Brazoria, Fort Bend, Galveston, Montgomery, Waller, Austin, Colorado, Matagorda, Washington, Wharton)
    - **Bexar Service Area** (Bexar, Atascosa, Comal, Guadalupe, Kendall, Medina, Wilson)

Medicaid Managed Care

- Medicaid Managed Care Expansion Proposal **(continued)**
  - **STAR+PLUS**
    - **Dallas Service Area** (Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, Rockwall, Fannin, Grayson)
    - **El Paso Service Area** (El Paso)
    - **Lubbock Service Area** (Lubbock, Crosby, Floyd, Garza, Hale, Hockley, Lamb, Lynn, Terry)
    - **Travis Service Area** (Travis, Bastrop, Burnet, Caldwell, Hays, Lee, Williamson)
  - **PCCM**
    - Withdraw PCCM from urban areas (Dallas, El Paso, Lubbock, Harris, Bexar) contingent upon:
      - HMOs demonstrating adequate provider access
      - The availability of at least two HMOs in each service area
    - Implement in remaining counties of the state

Medicaid Managed Care

- Managed Care Procurement Changes
  - HHSC is changing the way it contracts with HMOs in the managed care expansion procurement:
    - **Contracts** spell out the specific responsibilities of HMOs and establish corresponding liquidated damages for failure to perform
    - **Information/Measures** support contract management
    - **Quality management** drives continuous improvements in the process of health care purchasing and in the delivery of health care services
    - **Improvement goals** are established with HMOs to reflect state priorities
    - **Incentives** are used to encourage and reward desired practices by HMOs
    - **Disincentives** are used to discourage undesired practices by HMOs

Medicaid Managed Care

- Managed Care Procurement Changes (continued)
  - Use of Performance Indicator Dashboard:
    - identifies key aspects of performance, such as access to care, quality of care, and claims payment
    - assembles the most important dimensions of HMO performance and identifies measures
  - Performance metrics for each HMO will be publicly shared to further motivate performance and create transparency within the program
  - HHSC will actively manage HMO performance to assure HMO accountability.