# SUNSET ADVISORY COMMISSION

## STAFF REPORT

*Health and Human Services Commission*
*and*
*System Issues*

### OCTOBER 2014

# Sunset Advisory Commission

*Cover Photo: The Texas State Capitol was completed in 1888. With the Goddess of Liberty atop the dome, the Texas State Capitol Building is 19 feet taller than the U.S. Capitol Building in Washington, D.C. The photo shows the north facade of the Capitol. The gardens in the foreground sit atop a 667,000 square foot underground structure, the Capitol Extension, which houses many legislators' offices and committee rooms. Photo Credit: Janet Wood*

# HEALTH AND HUMAN SERVICES COMMISSION

## AND
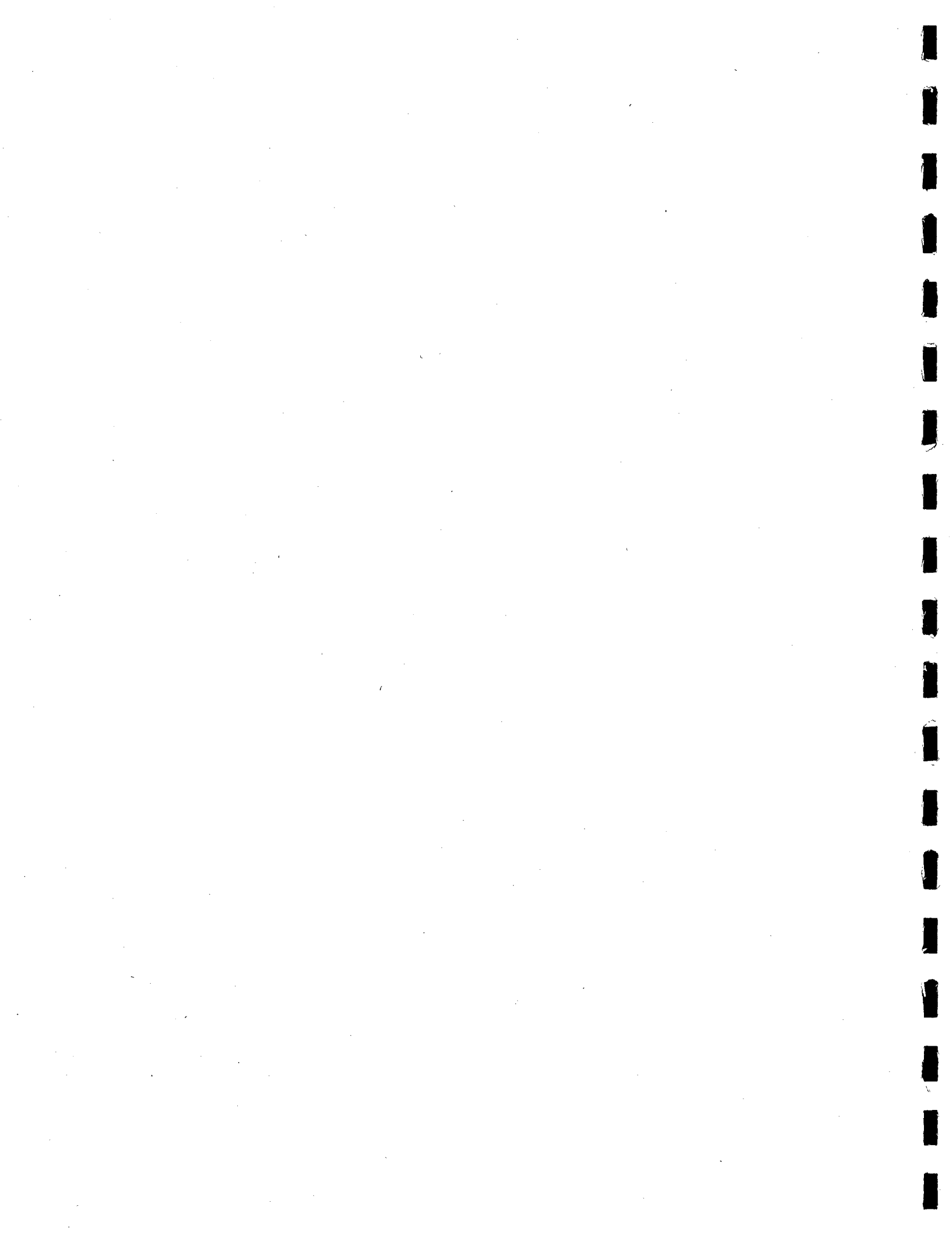
## SYSTEM ISSUES

SUNSET STAFF REPORT
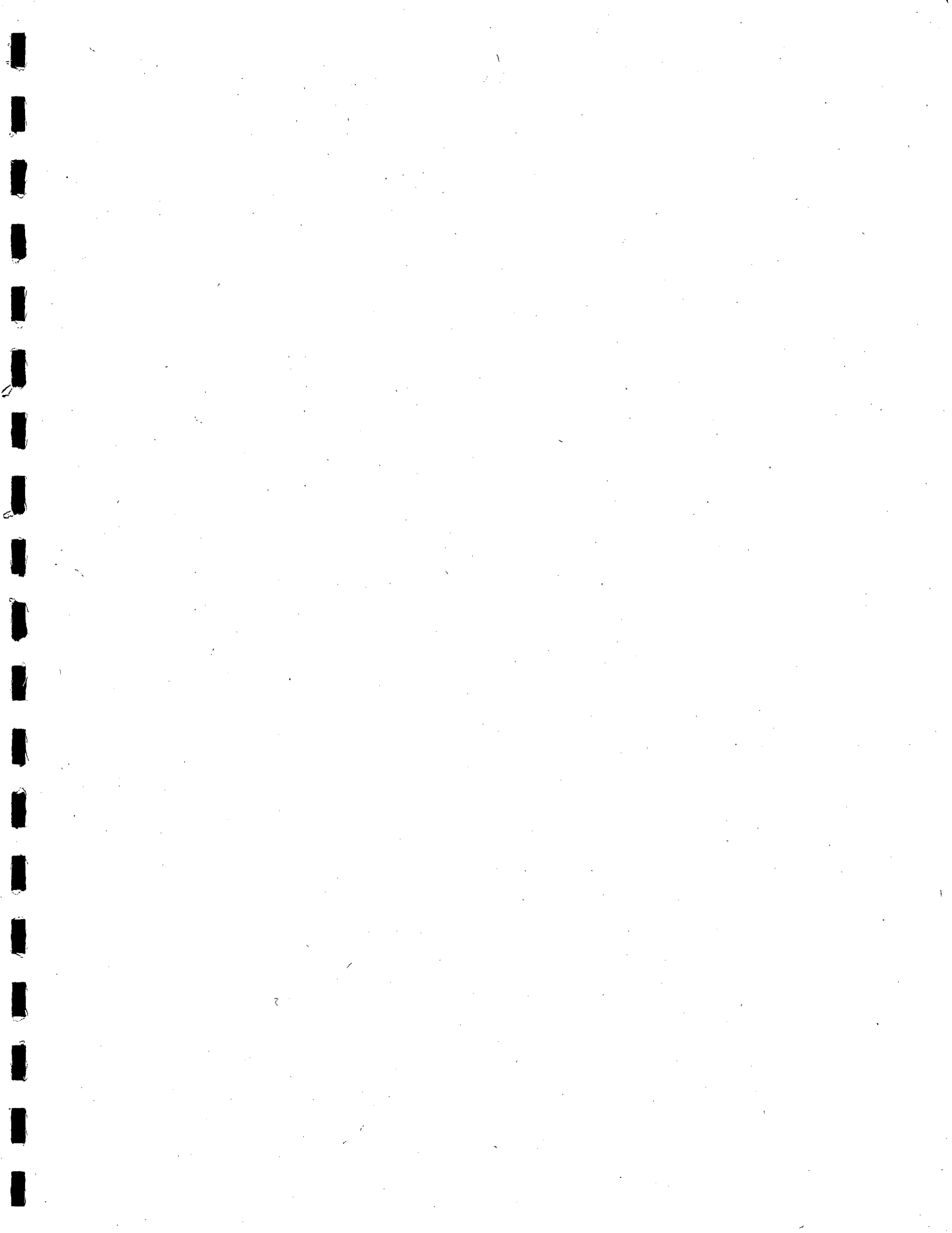
OCTOBER 2014

# TABLE OF CONTENTS

# APPENDICES

SUMMARY

# SUMMARY

Now is the time. So much is pointing to this time to act on the big issues that have long challenged the state's health and human services system. House Bill 2292, the landmark legislation from 2003 that established the system in its current configuration, presents an obvious starting point for the events that helped shape this review of the Health and Human Services Commission (HHSC) and its role in overseeing the state's health and human services system. This legislation reduced the number of agencies from 12 to five, envisioning a new system in which consolidated functions would save money and improve services by eliminating fragmentation.

After 11 years, the time has come to assess how well the system is working. The current review of HHSC and the recently concluded Sunset reviews of the other four system agencies provide just such an opportunity. The conclusion from this cumulative effort is that the vision of H.B. 2292 is far from complete. The problem is not with the concept of consolidation. Nor is the problem with the energetic, capable commissioners or the hard-working, dedicated employees at the agencies. The problem is with the nature of the system itself, and the incompleteness of its set up. The problem is that for whatever reason, the state did not finish the job. That is not to cast aspersions on the herculean effort required to set up the system in the midst of so many other changes back in 2003. Instead, that assessment should serve as a challenge to recognize this opportunity to take a big step toward completing the envisioned consolidation.

> *The time of reckoning for the difficult problems facing the health and human services system has arrived with the timing of this Sunset review.*

Problems observed in the system, including blurred accountability, ongoing fragmentation of similar programs and services, and organizational misalignments, have real significance for how these programs run and how clients are served. Even the confusion that persists about whether system agencies are, in fact, supposed to be state agencies can have a big impact on how they get supported to do their jobs. Having HHSC oversee this immense system while also running its own immense program in Medicaid only adds to the organizational difficulties. Issues 1 and 2 provide for a full system reorganization and consolidation of administrative support services to address these overarching concerns with the current system.

Other dynamics also hold large implications for further consolidation within the system. The ongoing transition to managed care from direct fee-for-service delivery brings into sharper focus the fragmentation that currently exists in the state's Medicaid program. Issue 3 describes how a more unified approach to administering Medicaid would help ease the transition for the vulnerable populations who will soon be affected. This shift to managed care also requires HHSC to adjust processes to oversee these sophisticated organizations, as discussed in Issue 4. Contracting with managed care organizations for services

and expectations for cost savings also require increased vigilance to ensure the quality of care provided to clients. Issue 6 describes opportunities to promote payment reform and align the state's major quality initiatives to have greater impacts. Issue 7 addresses the data needs of the system to inform successful quality efforts and improve the day-to-day operations of programs by better measuring impacts and outcomes.

Timing of other recent changes raises additional issues for discussion. Women's health services, for the first time ever this biennium, are funded almost solely by general revenue. Federal funds and associated restrictions no longer require a patchwork of confusing services to clients and administrative burdens for providers. However, these services remain split among three programs in two agencies. Constant changes in state women's health policies over the past four years have made stakeholders weary of revisiting an issue so fraught with controversy and emotion. As understandable as these concerns are, the state cannot afford to continue such a fragmented approach that is so difficult to navigate. Issue 8 would take advantage of this opportunity for streamlining and consolidation to benefit everyone involved: clients, providers, and the state.

Yet another powerful force helping focus a long-time issue is the state's push to integrate behavioral and physical health. The issue is NorthSTAR, a program providing behavioral health services to both Medicaid and indigent clients in the Dallas area, as a never-ending pilot program that began in 1999. The program's structure, innovative at the time, is now outdated, preventing application of emerging best practices, such as integration of behavioral and physical health throughout the rest of the state, and resulting in missed opportunities for federal funding. While the program demonstrated a new approach to delivering behavioral health services, it continues to exist as an island within the state, with none of the lessons learned from its model applied elsewhere. As Issue 9 describes, the time has come to move to a new model that can accommodate the changed landscape in delivery of behavioral health services, while maintaining the cost-effective practices that NorthSTAR demonstrates.

Another driver of change in the health and human services programs is the Patient Protection and Affordable Care Act. Aside from the more controversial aspects of this legislation, it added requirements for Medicaid providers to re-enroll on a periodic basis, placing tremendous pressure to finally fix the lengthy and burdensome provider enrollment process. Issue 5 describes a course of action to implement efforts that have been delayed for years.

The Affordable Care Act also brought changes to the way states must deal with fraud in Medicaid programs, requiring steps to stop payments to providers during investigations of credible allegations of fraud. In Texas, this responsibility lies with the Office of Inspector General (OIG), which has used these payment holds with its own efforts to increase enforcement activity, taking on more and higher profile cases than ever before. However, the increased attention and scrutiny brought by these actions has raised significant questions about OIG's processes and results, or lack thereof. The absence of standard tools such as priorities and criteria to guide the work, and a general reluctance to reach out to the other parts of the health and human services system or to providers and other stakeholders fuels a perception that OIG makes up the rules as it goes to back its "gotcha" approach. This Sunset review marks the first comprehensive evaluation of OIG since its creation in 2003. The expectations on OIG are high, given the recent growth in its budget and staffing. Make no mistake; OIG has a valuable role to play for maintaining the integrity of high-dollar public assistance programs and for its other investigatory work. However, as revealed in Issues 10 and 11, if the bold assertions and tough approach are not backed by fair, defensible processes, and results, it comes off as bluster with little to show for the effort.

The Sunset review also provided the opportunity to look at two other entities with their own Sunset dates, the Interagency Task Force for Children With Special Needs and the Texas Health Services

Authority (THSA). The Task Force, like many other advisory committees in statute described in Issue 13, could work more effectively if the executive commissioner could establish it to meet its needs outside current statutory restrictions. Finally, as Issue 15 lays out, the time has come for THSA, as a public, nonprofit corporation, to take its market-based approach fully into the private marketplace to oversee the development of health information exchanges in Texas, without its own statutory underpinnings.

The time of reckoning for these difficult problems has arrived with the timing of the Sunset review. In the context of the moment, some of these changes may appear to be pre-ordained. They were not. They were the result of almost a year of careful study. Events may have indicated a certain direction, but Sunset staff made the journey on its own. This opportunity seldom comes around. Recognizing this, the issues that follow lay out bold, and often controversial, steps to address historic and current challenges to improve services to Texans.

A summary follows of Sunset staff's recommendations on the Health and Human Services Commission and the overall health and human services system. The material also summarizes the Sunset staff's recommendations on the Interagency Task Force for Children With Special Needs and the Texas Health Services Authority.

# Issues and Recommendations

## Issue 1

### The Vision for Achieving Better, More Efficiently Run Services Through Consolidation of Health and Human Services Agencies Is Not Yet Complete.

In addition to saving money through program cuts and projected administrative efficiencies, the Legislature expected the 2003 consolidation of human services agencies under the direction of HHSC to strengthen accountability by streamlining programs, breaking down cultural and structural barriers, and eliminating fragmentation of services by combining like functions. While partially achieved, this vision is not yet complete.

The creation of the four system agencies as separate state agencies with their own commissioners, budgets, and statutes, within a system led by HHSC results in gray lines of accountability, policy disconnects, and lost efficiency between system agencies. The current system structure also aggravates fragmentation of client services, resulting in divided policy direction and administrative oversight, difficulty for customers to know where to go for services, duplicated administrative services, and unnecessary expenses. Regulatory functions fragmented into their respective agencies may be too closely connected with the programs they regulate and lose the benefits of being grouped together to take advantage of best practices. Management of state hospitals, state supported living centers, and other system facilities are split among agencies, reducing focused attention on similar issues. The system's organizational structure is also not designed to gain functional efficiencies and presents uncertainty given recent legislative changes regarding Medicaid managed care and behavioral health.

### Key Recommendations

- Consolidate the five HHS system agencies into one agency called the Health and Human Services Commission with divisions established along functional lines and with a 12-year Sunset date.

- Require formation of a transition legislative oversight committee and the development of a transition plan and detailed work plan to guide HHSC and the committee in setting up the new structure.

## Issue 2

### Incomplete Centralization of Support Services Deprives the State of Benefits Envisioned in Consolidating the Health and Human Services System.

A key tenet of the reorganization of the health and human services system in 2003 was consolidation of administrative support services under HHSC. Eleven years later, administrative consolidation is still incomplete, resulting in lost opportunities for efficiencies and cost savings. The review focused on information resources, contracting, and rate setting support functions, all still decentralized in various degrees within and outside HHSC, and all absolutely essential to running the system.

HHSC's Information Technology (IT) division has formal "paper" authority over this area, but that authority has not resulted in clear systemwide decision-making responsibility, sufficient oversight over all the system's major IT projects, or efficient planning and operation of the system's IT resources. Although in progress, HHSC has not yet finished development of statutorily required contracting tools, such as a central contract management database, and needs to heighten its level of sophistication to successfully oversee system contracts, amounting to $24 billion in fiscal year 2013. Unlike other system agencies, rate setting for DSHS has not been consolidated at HHSC, presenting opportunities for inconsistent rate setting methodologies and potentially unjustifiable differences in rates for the same or similar services.

### Key Recommendations

- Direct HHSC to further consolidate administrative support services, as defined in a consolidation plan developed by HHSC in consultation with other HHS system agencies.

- Direct HHSC to improve the accountability, planning, and integration of information technology in the HHS system by consolidating all IT personnel under HHSC control; clearly establishing HHSC IT's authority for overseeing IT in the system; and preparing and maintaining a comprehensive IT plan.

- Require HHSC to better define and strengthen its role in both procurement and contract monitoring by completing and maintaining certain statutorily required elements; strengthening monitoring of contracts at HHSC; improving assistance to system agencies; and focusing high-level attention to system contracting.

- Require HHSC to consolidate rate setting for the HHS system at HHSC.

## Issue 3

### Fragmented Administration of Medicaid Leads to Uncoordinated Policies and Duplicative Services and Could Place Future Transitions to Managed Care at Risk.

Fragmentation of the state's Medicaid program among three agencies hinders consistent decision making toward a shared vision, clear communication among staff who share the same organizational culture, and a shared awareness of program problems and how to fix them. This structure also impedes

cohesive Medicaid policy changes and program administration, efficient delivery of medically necessary services, and proper administrative oversight. As Texas' most vulnerable Medicaid populations are about to transition into managed care, the fragmented administration of Medicaid could affect the smooth transition for these critical populations.

## Key Recommendation

● Consolidate administration of Medicaid functions at HHSC.

## *Issue 4*

### HHSC Has Not Fully Adapted Its Processes to Managed Care, Limiting the Agency's Ability to Evaluate the Medicaid Program and Provide Sufficient Oversight.

State efforts to oversee Medicaid services have not kept pace with the state's movement into managed care. While the state could previously rely on its fee-for-service claims contractor to run data and analyze trends in the Medicaid program, the addition of 21 managed care organizations has made this task more difficult and requires increased sophistication for the agency to identify problems and make needed changes. Other aspects of managed care oversight that have similarly not evolved include monitoring of prescription drug benefits, coordination of managed care audits, inclusion of managed care organizations on certain advisory committees, and development of tools to better monitor billions of dollars in managed care contracts. In addition, having separate a Pharmaceutical and Therapeutics Committee and Drug Utilization Review Board, whose decisions work in tandem, could impede a unified approach with simultaneous decision making to ensure the safe and cost-effective use of prescription drugs.

## Key Recommendations

● Require HHSC to regularly evaluate the appropriateness of data, automate its data reporting processes, and comprehensively evaluate the Medicaid program on an ongoing basis.

● Adapt processes for the state's prescription drug program, audits, and advisory committees to reflect the state's transition to managed care.

● Eliminate the Pharmaceutical and Therapeutics Committee and transfer its functions to the Drug Utilization Review Board to create a single entity to oversee these related responsibilities.

## *Issue 5*

### Fragmented Provider Enrollment and Credentialing Processes Are Administratively Burdensome and Could Discourage Participation in Medicaid.

The state's lengthy and cumbersome Medicaid enrollment processes and its disconnect with managed care organizations' credentialing processes cause providers to submit the same information multiple times to numerous different entities to participate in Medicaid, creating an administrative burden for providers and delaying services to clients. In addition, OIG lacks decision-making guidelines for evaluating providers' criminal history and duplicates criminal history checks already performed by state licensing boards.

## Key Recommendations

● Require HHSC to streamline the Medicaid provider enrollment and credentialing processes.

● Require OIG to no longer conduct criminal history checks for providers already reviewed by licensing boards, develop criminal history guidelines for checks it will continue to perform, and complete background checks within 10 days.

# *Issue 6*

## The State Is Missing Opportunities to More Aggressively Promote Methods to Improve the Quality of Health Care.

HHSC's three largest quality initiatives are not aligned, limiting the agency's ability to accomplish meaningful change to improve healthcare delivery in the state. Specifically, quality initiatives for managed care organizations, hospital reimbursement rates, and Delivery System Reform Incentive Payment (DSRIP) program initiatives lack a cohesive vision for improving the quality of health care. Additionally, most managed care providers are paid through a fee-for-service approach, which may incentivize more, instead of necessarily better, care.

## Key Recommendations

● Require HHSC to develop a comprehensive, coordinated operational plan designed to ensure consistent approaches in its major initiatives for improving the quality of health care.

● Require HHSC to promote increased use of incentive-based payments by managed care organizations, including development of a pilot project.

# *Issue 7*

## HHSC Lacks a Comprehensive Approach to Managing Data, Limiting Effective Delivery of Complex and Interconnected Services.

In the course of running hundreds of programs, Texas' health and human services agencies have amassed more than 200 terabytes of information related to services provided to clients and public health trends — double the amount of everything the Hubble Telescope has sent to Earth. Organizing and analyzing this data has become of national importance in driving efficiency of healthcare programs, outcomes for clients, and planning for the future. However, the system's highly decentralized approach to data management prevents basic, appropriate uses of information to measure performance and inform key policy decisions. Fragmentation in oversight also creates risk considering the complicated privacy laws and other regulations governing the data, much of which contains protected personal information.

## Key Recommendation

● Direct the Health and Human Services Commission to elevate oversight and management of data initiatives, including creation of a centralized office with clear authority to oversee strategic use of data.

# Issue 8

## Administration of Multiple Women's Health Programs Wastes Resources and Is Unnecessarily Complicated for Providers and Clients.

In fiscal year 2014, HHSC and DSHS provided women's health and family planning services to an estimated 268,109 women through three programs: the Expanded Primary Health Care and Family Planning programs administered by DSHS and the Texas Women's Health Program administered by HHSC. The programs share similar goals but have distinct eligibility criteria, benefits packages, and administrative structures. As a result, state-funded women's health programs comprise a patchwork of services that are difficult to navigate and result in unnecessary administrative costs. Programmatic differences also limit useful data comparison to measure the impact of significant legislative investments, problems compounded by the lack of a comprehensive vision for women's health across agency lines. The programs were developed separately due to different funding sources and related requirements, but recent changes in state funding and policy provide, for the first time, an opportunity to improve service and efficiency for clients, providers, and the state.

### Key Recommendation

● Require HHSC to establish a single women's health and family planning program for the health and human services system.

# Issue 9

## NorthSTAR's Outdated Approach Stifles More Innovative Delivery of Behavioral Health Services in the Dallas Region.

An outdated model for delivery of behavioral health services for clients in the Dallas area hinders more holistic care for clients and misses opportunities to expand funding for behavioral health services. While the rest of the state is moving to integrate behavioral and physical health to reduce costs and improve client outcomes, the NorthSTAR model prevents such integration. NorthSTAR's structure also prevents the Dallas area from taking advantage of new federal funding opportunities, which does not incentivize local investment in the model, as other mechanisms provide greater local benefits. The NorthSTAR model also prevents a comprehensive evaluation of statewide behavioral health policies and outcomes in Medicaid.

### Key Recommendations

● Transition behavioral health services for both Medicaid and indigent populations in the Dallas area from NorthSTAR to an updated model, including associated legislative funding changes.

● Require the state to assist with maintenance of Medicaid eligibility and ensure full integration of behavioral health services into managed care organizations statewide.

# Issue 10

## Poor Management Threatens the Office of Inspector General's Effective Execution of Its Fraud, Waste, and Abuse Mission.

OIG has the difficult and crucial job of protecting the integrity of the HHS system and its public assistance programs, including Medicaid. However, OIG's highest profile responsibilities — investigative processes — lack structure, guidelines, and measurement of data needed to analyze and improve its processes and outcomes. Absence of basic tools such as decision-making criteria to guide its investigative work may contribute to inconsistent results and unfair investigative processes. Inefficient and ineffective processes lead to limited outcomes and a modest return on investment to the state. These concerns, taken in sum with other issues such as poor communication and transparency, limited staff training, and a lack of performance data from a case management system, point to limited oversight and the need for further review. OIG also performs many functions that do not align with its fraud, waste, and abuse mission, and OIG would benefit from increased focus on its most critical functions. Additionally, the inspector general's gubernatorial appointment and OIG's creation as a division of HHSC raise questions about the inspector general's accountability to the governor versus the executive commissioner.

### Key Recommendations

- Remove the gubernatorial appointment of the inspector general and require the inspector general to be appointed by and report to the HHSC executive commissioner.

- Require OIG to undergo special review by Sunset in six years.

- Require OIG to conduct quality assurance reviews and request a peer review of its sampling methodology used in the investigative process.

- Direct OIG to better define its role in managed care, and to work together with HHSC to transfer certain OIG functions to other areas of the HHS system where they would fit more appropriately.

- OIG should improve basic management practices, including establishing and tracking criteria and timelines for investigative processes and enforcement actions, narrowing its focus on the highest priority cases, and improving training and communication among staff.

# Issue 11

## Credible Allegation of Fraud Payment Hold Hearings Do Not Achieve the Law's Intent to Act Quickly to Protect the State Against Significant Cases of Fraud.

OIG is required by federal law to withhold Medicaid payments from providers under investigation based on a credible allegation of fraud. OIG's implementation of this mandatory payment hold, known as a credible allegation of fraud or CAF hold, has gone beyond the law's intent for use as an enforcement tool in serious matters. Hearings to appeal placement of a CAF hold have exceeded their narrow scope, duplicating the function of hearings used to establish whether the state overpaid a provider. CAF hold hearings provide for excessive process and create undue burdens on providers as compared to cases presenting more serious risks to the state and public.

**Key Recommendations**

● Require HHSC to streamline the CAF hold hearing process.

● Clarify OIG's payment hold authority, including adopting clearer standards for good cause exceptions and limiting payment holds to certain circumstances.

● Require OIG to pay all costs of CAF hold hearings at the State Office of Administrative Hearings.

## Issue 12

### HHSC's Uncoordinated Approach to Websites, Hotlines, and Complaints Reduces Effectiveness of the System's Interactions With the Public.

HHSC's statutory requirement to ensure the public can easily find information and interact with health and human services programs through the Internet has led to the five system agencies developing about 100 websites and maintaining 28 separate hotlines. The system's piecemeal approach to developing these resources requires users to navigate an increasingly complex network of information, frustrating even savvy stakeholders familiar with the system.

The Legislature also required HHSC to establish an ombudsman's office to provide systemwide dispute resolution and consumer protection services for the public. However, without more authority and visibility, the office cannot obtain a comprehensive understanding of the challenges faced by stakeholders, escalate appropriate issues stuck in agency complaint processes, identify systemwide problems, or know whether consumer complaints are actually resolved.

**Key Recommendations**

● Require HHSC to create an approval process and standard criteria for all system websites.

● Require HHSC to create policies governing hotlines and call centers throughout the health and human services system.

● Clarify the role and authority of the HHSC ombudsman's office as a point of escalation for complaints throughout the system and to collect standard complaint information.

## Issue 13

### HHSC's Advisory Committees, Including the Interagency Task Force for Children With Special Needs, Could be Combined and Better Managed Free of Statutory Restrictions.

HHSC oversees 41 advisory committees, 35 of which are in statute, to allow stakeholders and members of the public to provide input to the agency. However, the numerous advisory committees create an administrative burden to HHSC staff and their presence in statute can prevent the agency from responding to evolving needs. Additionally, some of these advisory committees are either no longer necessary or have overlapping jurisdiction, creating duplication. For example, the Interagency Task Force for Children With Special Needs, currently under Sunset review, is one of four advisory committees created to focus on issues related to children. While these four committees' compositions are different, their jurisdictions are difficult to distinguish and often overlap, causing confusion for HHSC staff, committee members, and involved stakeholders.

## Key Recommendations

● Remove advisory committees from statute, including those with Sunset dates, and allow the executive commissioner to re-establish needed advisory committees in rule.

● Remove the Task Force for Children With Special Needs, the Children's Policy Council, the Council on Children and Families, and the Texas System of Care Consortium from statute and direct the executive commissioner to recreate one advisory committee in rule to better coordinate advisory efforts on children's issues.

# Issue 14

## HHSC Statutes Do Not Reflect Standard Elements of Sunset Reviews.

Among the standard elements considered in a Sunset review are across-the-board recommendations that reflect criteria in the Sunset Act designed to ensure open, responsive, and effective government. HHSC's statutes do not include standard provisions relating to conflicts of interest and alternative rulemaking and dispute resolution. The Texas Sunset Act also directs the Sunset Commission to recommend the continuation or abolishment of reporting requirements imposed on an agency under review. Sunset staff found that the agency is required to produce 42 reports, four of which are no longer necessary and should be eliminated, and eight required by advisory committees would be removed from statute under Issue 13.

## Key Recommendations

● Update two standard Sunset across-the-board recommendations for HHSC.

● Eliminate four unnecessary reporting requirements, but continue others that serve a purpose.

# Issue 15

## Allow the Texas Health Services Authority to Promote Electronic Sharing of Health Information Through a Private Sector Entity.

The Legislature created the Texas Health Services Authority (THSA) as a public-private partnership to accelerate the adoption and secure sharing of health-related information among providers through seamless, integrated health information exchanges across the state. THSA is an independent entity that contracts with, but is not a part of, HHSC and is subject to the Sunset Act. While Texans have a clear interest in the development of health information exchanges for the improvements they bring to the overall healthcare system, the state does not need a statutorily authorized entity to support health information exchanges, which could be accomplished by an independent entity, such as THSA.

## Key Recommendation

● Remove the Texas Health Services Authority from statute, allowing its functions to continue only in the private sector.

# Fiscal Implication Summary

The recommendations contained in this report would result in savings to the General Revenue Fund of about $1.7 million in fiscal year 2016, or about $32.3 million over five years. Creation of a new behavioral health model capable of accessing federal funds in Issue 9 could also result in significant gain for the Dallas area of more than $40 million annually, although these would not be additional funds to the state. Issues containing significant fiscal implications are detailed below. Other recommendations contained in this report would help improve the efficient and effective use of funds or improve the quality of programs or health care overall, but would not result in significant overall fiscal impact, as summarized in each issue.

*Issue 1* — Consolidating the HHS system into a single agency would result in potentially large savings from more accountable operations, reduced fragmentation of services, and increased consolidation of administrative functions, but these could not be estimated at this time. Reductions from eliminating agency advisory councils would save about $48,000 in annual travel costs and about 6,400 hours of staff time. Costs associated with the consolidation would result primarily from modifications in information technology and administrative systems to accommodate the new organizational structure, and use of staff time to reorganize the system.

*Issue 8* — Consolidation of women's health programs into a single program would result in an estimated administrative savings to the state of $1.1 million annually. Consolidation of claims administration contracts would also likely result in savings, but those savings could not be estimated.

*Issue 9* — Discontinuing NorthSTAR and moving to a new model would result in about $2.4 million in savings to the state in fiscal year 2017. After implementation, the recommendation would result in a total of $28.9 million in savings over the first five years from integration of Medicaid primary care and behavioral health in the NorthSTAR area. More efficient administration of the Medicaid portion of the NorthSTAR contract would result in annual state savings of $107,367 from the reduction of about four staff. A new behavioral health model capable of accessing federal funds for indigent care in the Dallas area, while not increasing funds to the state, could also result in significant gain for the Dallas area of more than $40 million annually.

*Issue 10* — Recommendations to narrow the functions of OIG would result in about $898,000 in overall savings to the state each year through staff reductions associated with review of cost reports and narrowing the focus of OIG's employee investigations.

*Issue 13* — Abolishing the Medicaid-CHIP regional advisory committees would result in annual savings of $39,481 in general revenue from staff travel and time dedicated to supporting the committees.

### Health and Human Services Commission and System Agencies

| Fiscal Year | Savings to the General Revenue Fund | Change in the Number of FTEs From FY 2015 |
|---|---|---|
| 2016 | $1,717,481 | -32 |
| 2017 | $4,524,382 | -32 |
| 2018 | $8,499,191 | -32 |
| 2019 | $8,632,950 | -32 |
| 2020 | $8,942,956 | -32 |

# SYSTEM AND
# AGENCY AT A GLANCE
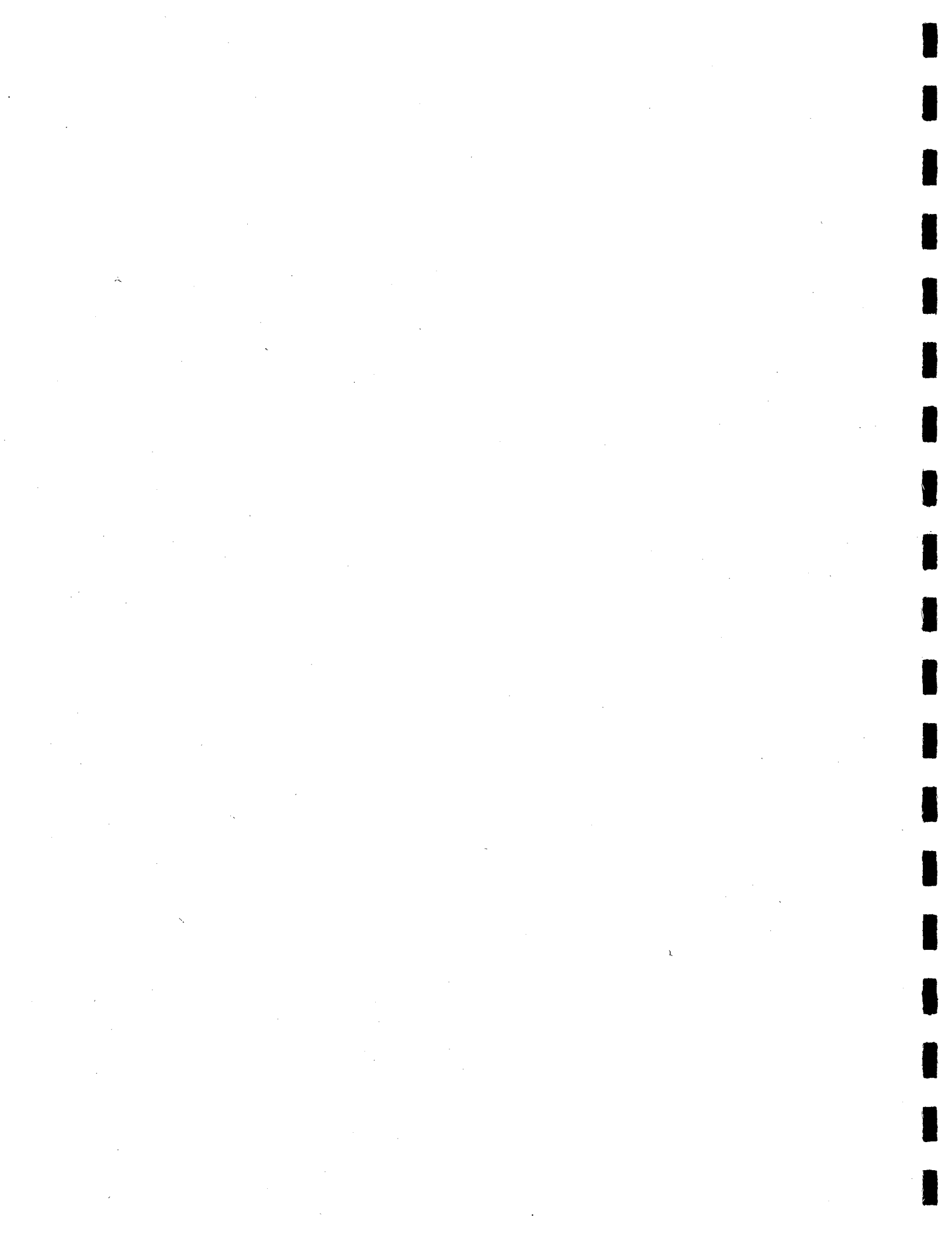
# SYSTEM AND AGENCY AT A GLANCE

In 2003, the Texas Legislature enacted House Bill 2292, consolidating 12 agencies and more than 200 programs into five agencies under the leadership of one umbrella organization, the Health and Human Services Commission (HHSC). The health and human services system comprises the following agencies and functions.

● **HHSC** provides oversight and support for the health and human services agencies, administers the state's Medicaid and other public benefit programs, sets policies, defines covered benefits, and determines client eligibility for major programs.

● **The Department of Aging and Disability Services (DADS)** provides a comprehensive array of long-term services and supports for people with disabilities and people age 60 and older, and regulates providers serving these populations in facilities or home settings to protect individuals' health and safety.

● **The Department of Assistive and Rehabilitative Services (DARS)** provides people with disabilities and children with developmental delays with time-limited services, such as gaining functionality, preparing for and finding employment, and living independently in the community.

● **The Department of State Health Services (DSHS)** oversees public health services; funds local health departments; operates the state's mental health hospitals, center for infectious disease, and public health laboratory; provides services for persons with infectious diseases, specific health conditions, substance use disorders, and mental illness; and regulates healthcare professions, facilities, and consumer services and products.

● **The Department of Family and Protective Services (DFPS)** investigates allegations of abuse and neglect perpetrated against children, older adults, and people with disabilities, administers the state's foster care system, and regulates child care facilities.

## Key Facts

● **System governance.** The governor appoints an executive commissioner to oversee the entire health and human services system, who in turn appoints a commissioner to each of the health and human services agencies described above. The executive commissioner also oversees the day-to-day operations of HHSC, including administration of the state's Medicaid program and approving policies and rules for the agency.

The governor appoints a nine-member advisory council to each of the health and human services agencies to assist the commissioners to develop policies, provide a venue for public review and comment on rules, and make recommendations regarding the operation and management of the agencies. The councils are purely advisory and do not have decision-making authority. HHSC's executive commissioner ultimately approves all rules developed by the other agencies and their councils. All council members serve staggered, six-year terms and the governor designates the chair. More than 95 advisory committees and boards also assist the health and human services system by providing advice and expertise on agency rules, policies, and programs.

● **Funding.** In fiscal year 2013, the health and human services agencies spent a combined $34.5 billion, about 58 percent of which were federal funds and 42 percent were general revenue and other state funds. The pie chart, *Expenditures by Agency*, illustrates total expenditures for each of the health and human services agencies.

## Expenditures by Agency
### FY 2013



DFPS
$1.4 Billion (4%)

DARS
$574 Million (1%)

DSHS
$3.0 Billion (9%)

DADS
$6.2 Billion (18%)

HHSC
$23.4 Billion (68%)

**Total:  $34.5 Billion**
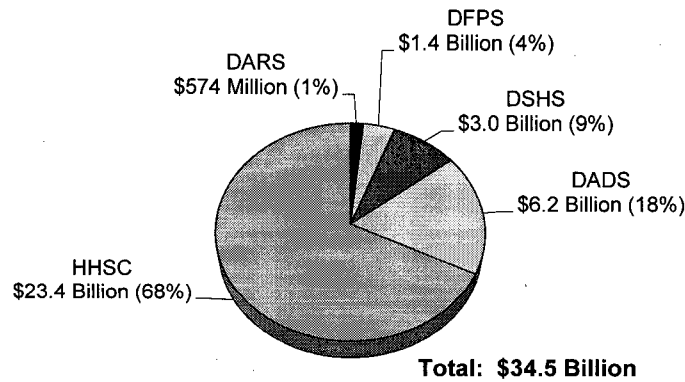
In fiscal year 2013, HHSC alone spent about $23.4 billion. HHSC's main expenditures were related to Medicaid, the Children's Health Insurance Program (CHIP), and integrated eligibility and enrollment services. About $14 billion, or 60 percent, of HHSC's revenue is from federal funding while the remaining $9.4 billion is from general revenue and other state funds. The graphic, *HHSC Expenditures by Program*, depicts the agency's expenditures. Appendix A describes HHSC's use of historically underutilized businesses in purchasing goods and services for fiscal years 2011–2013.

## HHSC Expenditures by Program
### FY 2013



System Oversight
$835.9 Million (4%)

TANF, Program Support, and IT
$405.0 Million (2%)

CHIP
$1.2 Billion (5%)

OIG, $61.0 Million (<1%)

Medicaid
$20.9 Billion (89%)

**Total: $23.4 Billion**

Disability Related
$4.4 Billion (21%)

Aged and Medicare Related
$3.4 Billion (16%)

Prescription Drugs
$2.9 Billion (14%)

Other*
$1.5 Billion (7%)

Children
$5.5 Billion (27%)

Health Steps Dental
$1.3 Billion (6%)

Contracts and Administration
$855.7 Million (4%)

Pregnant Women
$1.0 Billion (5%)

*Other – includes Non-Full Benefit Payments, Other Adults, and Transformation Payments

The agency spent an additional $3.8 billion in off-budget expenditures for fiscal year 2013, including about $2.2 billion in federal funds, $1.2 billion in intergovernmental transfers and interagency contracts, and $304.7 million in general revenue. Off-budget expenditures supplement hospitals'

gap in funding from serving patients with no, or insufficient, health insurance. These expenditures include uncompensated care, delivery system reform incentive payments, disproportionate share hospitals, and upper payment limit funding. The agency's off-budget expenditures will increase by about 50 percent in fiscal year 2014, climbing to more than $5.7 billion as funding for delivery system reform incentive payments and disproportionate share hospitals increases.

- **Staff.** In total, the health and human services agencies had more than 54,000 staff in fiscal year 2013, including more than 12,000 staff employed by HHSC and the Office of Inspector General (OIG). The majority of HHSC's staff, about 78 percent, determines eligibility and enrolls clients in programs to receive services. The diagram, *Health and Human Services Commission Organizational Chart*, outlines HHSC's structure. Appendix B compares HHSC's workforce composition to the civilian labor force for fiscal years 2011–2013.

### Health and Human Services Commission Organizational Chart
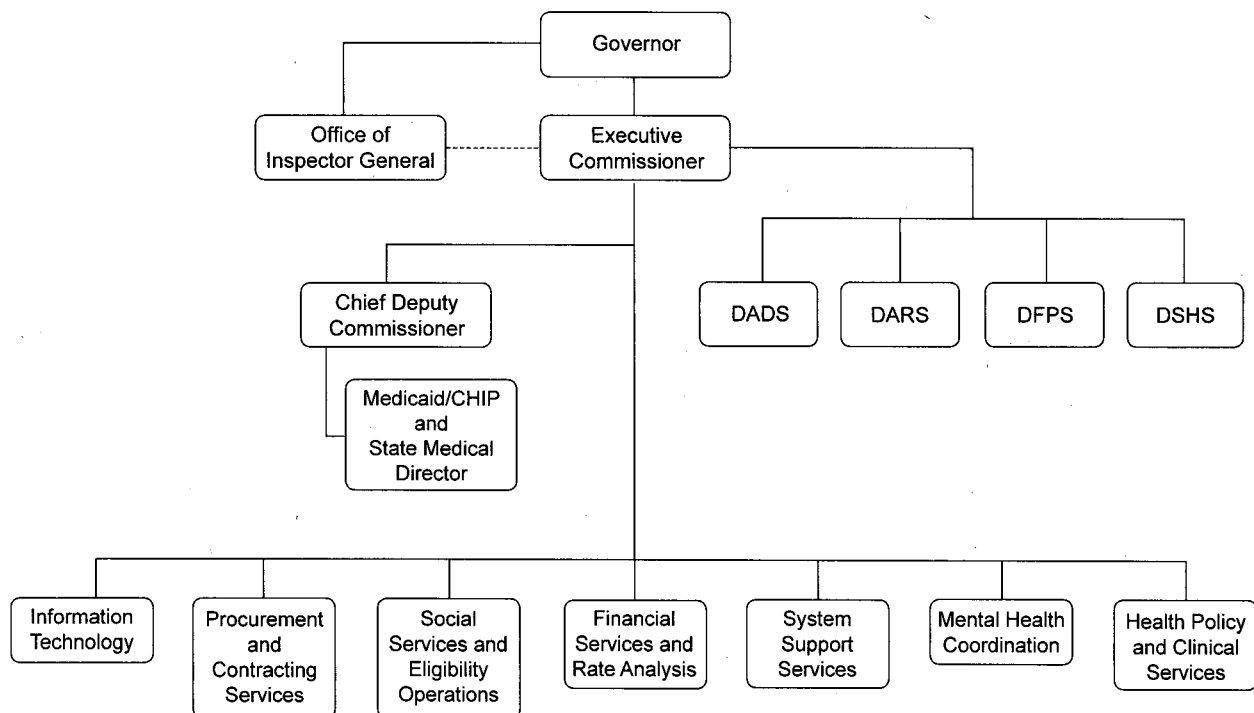


- **System oversight and support.** As the system's umbrella organization, HHSC oversees the operations of the health and human services agencies, provides strategic guidance, and approves all policies and rules. HHSC also provides administrative and system support services to all the agencies, including contracting, information technology, facility management, rate setting, and human resource services. In addition, HHSC oversees more than $16 billion in contracts that provide services to Texans that receive public benefits. HHSC's contract oversight functions include reviewing and analyzing reports, performing desk reviews and onsite audits, collecting and analyzing performance data, and taking enforcement action against vendors as necessary.

- **Medicaid.** Medicaid is a jointly funded state and federal healthcare program created in 1967. Medicaid primarily provides healthcare coverage to low-income children, pregnant women, people age 65 and older, and children and adults with disabilities. Appendix C, *Income Limits for Medicaid*

*and CHIP Programs,* describes income eligibility thresholds for these programs. In fiscal year 2013, about 4.7 million Texans received more than $24 billion in Medicaid services, about 40 percent of which are paid for by the state with general revenue.

As the single state agency designated to administer Medicaid, HHSC sets policy, determines client eligibility, oversees provider and health plan contracts, and submits Medicaid plan amendments and waivers to the Centers for Medicare and Medicaid Services. HHSC ensures Medicaid coverage for eligible individuals through two models — managed care and fee-for-service. In managed care, the state pays managed care organizations a set rate for each client, providing an incentive to coordinate a client's healthcare services in the most efficient way. This approach is in contrast to the traditional fee-for-service model by which the state pays providers for each unit of service provided to clients. As of September 1, 2014, about 84 percent of Medicaid clients' healthcare services were coordinated by managed care organizations. By fiscal year 2017, more than 90 percent of all Medicaid clients are likely to receive services through managed care organizations.

- **Other public benefit programs.** In addition to Medicaid, HHSC administers and oversees a number of other public benefit programs, as described below.

  CHIP provides health insurance to low-income, uninsured children in families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. In fiscal year 2013, CHIP provided about $1.2 billion in healthcare coverage to more than one million Texas children.

  Supplemental Nutrition Assistance Program (SNAP), also known as food stamps, provides low-income households with monthly benefits to purchase food or seed items from participating grocery stores and other retailers. More than 6.1 million people received about $5.9 billion in SNAP benefits in fiscal year 2013.

  Temporary Assistance for Needy Families (TANF) provides short-term cash assistance for children and their families to purchase food, clothing, housing, and other basic needs. In fiscal year 2013, TANF provided a total of $85.7 million in cash assistance to about 200,000 low-income Texans.

- **Eligibility determination.** HHSC determines financial and categorical eligibility for clients applying to receive Medicaid, CHIP, SNAP, TANF, or Texas Women's Health Program benefits. The agency has 264 field offices located throughout the state to assist clients in obtaining these public benefits. In fiscal year 2013, HHSC processed about 5.3 million applications, about 38 percent of which were submitted through the agency's website.

- **Detect and deter fraud.** OIG prevents, detects, and investigates fraud, waste, and abuse throughout the health and human services system. The textbox, *OIG Functions*, highlights some of OIG's major responsibilities. In fiscal year 2013, OIG conducted more than 100,000 investigations, reviews, and audits and collected about $273 million.

| OIG Functions |
| --- |
| • Identifies and investigates provider and recipient fraud in public assistance programs |
| • Audits use of state and federal funds |
| • Recommends policies to prevent fraud, waste, and abuse |
| • Investigates health and human services employees |
| • Performs background checks of healthcare providers |

- **Texas Health Services Authority**. The Legislature created the Texas Health Services Authority in 2007 as a public-private partnership to accelerate the adoption and secure sharing of health-related information among hospitals and providers through seamless, integrated health information exchanges across the state. The Texas Health Services Authority is an independent entity that contracts with, but is not a part of, HHSC. Texas has 10 local health information exchanges that transfer, and improve access to, patient medical records among providers. The Texas Health Services Authority has also created a state health information exchange to connect local exchanges in Texas to each other and eventually to other out-of-state exchanges. In fiscal year 2013, more than 4.2 million patient medical records were sent and received by healthcare providers through health information exchanges.

- **Interagency Task Force for Children With Special Needs**. In 2009, the Legislature created the Task Force to advise HHSC on ways to improve the coordination, quality, and efficiency of services for children with special needs. The Task Force also recommends ways to improve crisis prevention and intervention with its member agencies and is developing a comprehensive website to list resources available to children with special needs. The Task Force's membership includes legislators, parents, state agencies that work with children with special needs, and a representative from a local mental health or intellectual and developmental disability authority.

# ISSUES

# ISSUE 1

*The Vision for Achieving Better, More Efficiently Run Services Through Consolidation of Health and Human Services Agencies Is Not Yet Complete.*

## Background

Today's consolidated health and human services (HHS) system had its genesis in the state's serious financial crisis leading in to the 2003 legislative session. The Texas comptroller's office estimated a budget deficit of $9.9 billion for the 2004–05 biennium.[1] The Texas Legislature saw the health and human services system as a source of possible savings to address part of this deficit. Expenditures of the system totaled about one-third of all state expenditures and comprised multiple agencies, each with its own administrative support structures and programs that could be streamlined. In addition, multiple agencies caused fragmentation of services resulting from overlapping clients and made the system difficult to navigate for the public.

In 2003, House Bill (H.B.) 2292 became the vehicle to transform the health and human services system from 12 to five agencies under the ultimate direction of the Health and Human Services Commission (HHSC). The Legislative Budget Board estimated a two-year net positive impact of about $1 billion from the enactment of H.B. 2292, with savings resulting from consolidation of administrative systems, various program improvements, and reduction in certain benefits.[2]

H.B. 2292 established the five agencies still in operation today: HHSC, the Department of Aging and Disability Services (DADS), Department of Assistive and Rehabilitative Services (DARS), Department of Family and Protective Services (DFPS), and Department of State Health Services (DSHS). The bill created a seven-member Transition Legislative Oversight Committee to guide the transition.[3]

H.B. 2292 required HHSC to develop a transition plan by December 1, 2003, just six months after enactment of the legislation, for approval by the legislative oversight committee. The legislation also required HHSC to develop a specific work plan to accomplish the transition that included four phases: planning, integration, optimization, and transformation. After finishing the planning and integration phases HHSC and system agencies were to continue adjusting systems and organizational arrangements during the optimization phase; and to then begin ongoing transformation, working as one system with integrated services and employees who abandon prior organizational allegiances to work as a unified whole. The newly formed health and human services system was in place on September 1, 2004, just one year and three months after enactment of H.B. 2292.

Today, as established by the Legislature, HHSC is the controlling policy and oversight entity over the consolidated system, significantly retaining rulemaking authority for all HHS system agencies. Statute requires the governor to appoint an executive commissioner for HHSC with the advice and consent of the Senate. The executive commissioner serves two-year terms and, in turn, appoints the commissioners of the other four agencies with the governor's approval. These commissioners serve at the pleasure of the executive commissioner. Statute requires each of the five agencies to have a nine-member governor-appointed advisory council that fulfills a purely advisory role and provides a venue for public input. The system operated with expenditures of $34.5 billion for fiscal year 2013 with more than 54,000 staff.

# Findings

### The Sunset review of HHSC and HHS system agencies provides the opportunity to assess the 2003 consolidation to further improve the system.

The Legislature expected H.B. 2292 to strengthen accountability by reducing the number of managers overseeing programs; break down the cultural and structural divisions, often referred to as silos, resulting from agencies with interrelated missions operating independently from each other; help eliminate fragmentation of services by combining like functions together; and result in more efficient operations through consolidation of administrative services.

The consolidation of 12 agencies to five under more unified leadership, and the efforts of that leadership to promote more seamless system operation, have resulted in efficiencies and better communication. The question remains whether the Legislature's ambitious vision of a truly unified system whose components all pull together as one has been realized. The Sunset review provides the opportunity to examine the entire system for the first time since its consolidation in 2003 and to assess whether H.B. 2292 achieved its goals in streamlining health and human services programs.

*Managed care and integrated behavioral and primary health care have strong implications for consolidation.*

Certainly, the dynamics have changed since 2003. The state is not experiencing the serious budget shortfall that served as a catalyst for the earlier action to achieve cost savings through greater efficiency. In addition, the transition to managed care and the move to integrate behavioral and primary health care have both had strong implications for consolidating service delivery models. The focus today is much more squarely on the delivery of services and how to do it better while ensuring quality and efficiency.

The previous Sunset reviews of the four HHS system agencies and the current review of HHSC continue this theme. The findings in the preceding Sunset reports relating to management disconnects and various organizational anomalies affecting services provide a prelude to many of the issues in this report regarding HHSC. Those issues and others contained here, including Medicaid consolidation, greater integration of administrative support services, and women's and behavioral health are intended, separately, to address problems as they exist under the current system configuration.

Addressing these issues on their own would do much to improve the functioning of the system. However, doing only that would miss the bigger picture and direction emerging to fix the larger problems particular to the HHS system and to better focus on improved service delivery for clients. As discussed in the following material, these problems include blurred accountability, ongoing fragmentation of like programs and services, and organizational misalignments that inevitably occur over time or for various other reasons.

Consolidating the elements of the system into a single agency may be viewed as simply an exercise of moving organizational boxes into a new configuration. Such a shakeup may be perceived as just the latest in a continuing flood of

changes to wash over a system fatigued by constant disruptions in the ability to perform its important job. This effort may also be seen as creating an organizational behemoth that is practically impossible to govern and that could marginalize certain aspects of the system and harm the delivery of services. Such concerns are understandable, but not insurmountable.

Proper organizational structure is important. Problems in the current system, as discussed in this issue, are real and affect the ability to provide critical services in the best, most efficient way to meet the needs of clients. Change is already coming, whether through managed care, behavioral health integration, or newly evolving service delivery models. The system needs to be able to anticipate and control the issues and changes that confront it to mitigate their adverse impacts. The system needs to have effective mechanisms to serve the needs of all parts of the system. The system is already big. What it needs is an organizational structure that works better to provide services to Texans.

*The system needs an organizational structure that works better to serve Texans.*

## Problems in design blur accountability and prevent more effective governance of the HHS system.

● **Unclear accountability for commissioners and their staffs.** Before the 2003 consolidation, 12 health and human services agencies operated under an umbrella organization, the Health and Human Services Commission, the predecessor of today's commission. One of the problems with this structure was blurred lines of accountability because the 12 agencies were accountable to both the then-HHSC commissioner as well as governing boards of their own agencies. Such divided allegiance "made it difficult for the agencies to function as an integrated system in pursuit of a common vision."[4] A document prepared to guide implementation of H.B. 2292 after its passage reflected this same concern, stating the following as a principle for the consolidation that clearly is not realized in today's HHS system structure.

> *HHSC should develop organizational structures that foster management accountability via direct reporting relationships, clear lines of responsibility, and avoidance of "shared" or matrix authority for service delivery.*[5]

Now, four agencies, with their own commissioners, legal basis as agencies, and separate appropriations, report to HHSC's executive commissioner instead of 12. Admittedly, HHSC does have one strong, cohesive power — its rulemaking authority; while HHS system agencies may propose rules, only the executive commissioner may approve them. However, this authority is not sufficient to correct the blurred lines of responsibility between agency staffs, their own commissioners, and the executive commissioner of HHSC. This arrangement gives system agencies mixed messages, giving rise to a corrosive form of bureaucratic "plausible deniability" that can have the following results:

— blurred lines as to who is in charge, which in turn creates lack of unity in deciding and carrying out policy;

– a tendency to perpetuate cultural differences that existed at the time the agencies combined, and the breakdown in communication that results;

– obstacles to clear and firm decision making, with a tendency to take actions by consensus because clear authority does not always exist; and

– difficulty in making organizational changes to move the system ahead as a unit.

These issues come to the fore in the HHS system's administrative support services such as purchasing, information technology, auditing, human resources, and others. Statute centralizes these services within HHSC, but, as described in Issue 2, HHSC and the system have fallen short of achieving an appropriate degree of centralized control. Various reasons exist for this shortfall, including sometimes poor support and the natural tendency for agencies to carry out their own statutory responsibilities instead of collaborating as a system to reach common goals. The result has been disjointed policymaking and operating inefficiencies that a more appropriate level of centralized control would fix. An example of the impact of this diffused authority is that systemwide decision making generally occurs through consensus and the force of personalities — a good tactic except when quick, forceful, or difficult decisions are needed.

*While set up to oversee the system, HHSC also has its own sizeable responsibilities with Medicaid.*

● **Divided responsibilities for the executive commissioner.** HHSC's executive commissioner serves as both the chief of HHSC and of the system. System agencies sometimes regard HHSC as having an upper hand because of this arrangement, with alleged faster administrative processing, higher salaries, and pressing agencies to agree with its policy changes.

While set up to be the driver for policy and rules for the system, HHSC also has its own sizeable programmatic responsibilities, with Medicaid and eligibility determinations competing for attention with other components of the system. Whether the executive commissioner pays not enough or too much attention to these responsibilities is likely a matter of one's perspective in the system. However, the lack of an agency administrator equivalent to other commissioners certainly affects the executive commissioner's ability to oversee the day-to-day operations of such large programs directly in the chain of command while also shepherding the system agencies. The deputy executive commissioner, too, has systemwide responsibilities. HHSC also lacks a high-level administrative point person that represents only HHSC's interests with systemwide administrative services, like other agencies do through a chief operating officer.

*The inspector general answers to both the governor and the executive commissioner, confusing lines of authority.*

● **Ambiguous accountability for the inspector general.** Statute creates the health and human services Office of Inspector General (OIG) as a division of HHSC, but requires the governor to appoint the inspector general, an appointing process unique to this division.[6] In practice, OIG operates independently of HHSC. As pointed out in Issue 10, which discusses OIG management, this structure confuses whether the inspector general answers to the governor or the HHSC executive commissioner, and is

the only instance of an OIG not reporting solely to a board or executive director in state government.[7] From an accountability standpoint, the governor has little time to devote to the activities of OIG, while the executive commissioner's authority confuses whether they are partners or purposely at odds with each other through OIG's system oversight role. Other performance concerns in Issue 10 suggest the need for stronger accountability and oversight not present in the current structure.

- **Limited usefulness of the five agency advisory councils.** H.B. 2292 established the executive commissioner position as the ultimate policy and rulemaking entity in the system, eliminating agency governing boards in the process. Statute created the five agency advisory councils to provide additional perspectives potentially lost in eliminating these boards. Statute charges the councils with assisting commissioners in developing rules and policies, and making recommendations to the executive commissioner and commissioners regarding the management and operation of each agency.

  The councils have no operating authority. While councils review proposed rule changes and take testimony on rules, the executive commissioner is not required to, and does not always, accept councils' recommendations. Councils have no input on the appointment of agency commissioners or ability to review commissioners' job performance. The councils serve as a forum for stakeholders to provide input to the agencies, but this input can be, and is, achieved in many other ways, such as through specific advisory committees.

- **No organizational home to govern systemwide performance.** As part of the 2003 reorganization of health and human services agencies, the Legislature required the executive commissioner to implement a program to "evaluate and supervise the daily operations of" each health and human services agency.[8] In practice, such tools to effectively govern the HHS system have not yet matured.

  Overall system performance. Without a system to measure performance, the executive commissioner cannot effectively govern the system and know whether agencies are accomplishing their mission. A lack of overall focus on performance also contributes to continued fragmentation of the system, and makes progress towards and communication about established priorities difficult. Although performance measurement and improvement efforts exist, these are mostly narrowly focused on specific programs and scattered throughout the system. While simplifying the performance of hundreds of diverse programs in key measures is a daunting task, this complexity need not prevent establishment of some basic yardsticks for communicating the current situation, identifying important trends, and raising potential red flags. For example, Maine's consolidated health and human services system has a single online dashboard of basic measures such as finances, health, safety, and quality.[9]

  Performance management and use of metrics has been an ongoing topic in public policy for some time, with an evolution in recent years away from

*A lack of focus on system performance makes progress towards established priorities difficult.*

simply collecting and reporting hundreds of data points to actually evaluating and using this information to inform policy decisions and management actions.[10] A key element to making this transition is developing a strong organizational focus and dedicated leadership responsible for these issues, which is lacking in the current system. Because performance management ultimately ties back to the quality and availability of information, any such efforts must also tie directly to data management and analytics systems, discussed in more detail in Issue 7.

*Sunset reviews of HHS system agencies revealed an unfocused approach to implementing change.*

Change management and implementation. The Sunset reviews of all the health and human services agencies have revealed persistent issues with a generally unfocused approach to implementing change. For example, most of the system agencies struggle to integrate services and culture from their legacy agencies 11 years later.

Any effort towards large-scale organizational change ultimately depends on the energy and focus of leadership, and persistent, clear accountability systems to keep the ball moving forward. However, in the midst of needing to also ensure continued delivery of services, a change management task quickly becomes overwhelming without an ongoing organizational home to own these efforts and provide the type of structure summarized in the textbox, *Key Practices for Organizational Transformation.* These components were not present and ongoing after the 2003 consolidation.

---

**Key Practices for Organizational Transformation[11]**

1. Ensure top leadership drives the transformation.

2. Establish a coherent mission and integrated strategic goals to guide the transformation.

3. Focus on a key set of principles and priorities at the outset of the transformation.

4. Set implementation goals and a timeline to build momentum and show progress from day one.

5. Dedicate an implementation team to manage the transformation process.

6. Use the performance management system to define responsibility and ensure accountability for change.

7. Establish a communication strategy to create shared expectations and report related progress.

8. Involve employees to obtain their ideas and gain their ownership for the transformation.

---

Ongoing evaluation and process improvement. The system also lacks centralized expertise to evaluate program effectiveness and focus on more day-to-day actions to improve operations. Such activities could include regular effectiveness reviews, policy evaluation, or special projects as directed by executive management. Other state agencies have implemented a more strategic focus on analysis and process improvement. For example, the Texas Workforce Commission dedicates about 20 employees to performance analysis, reporting, and process improvement initiatives.

Cross-system coordination. Regardless of the system's ultimate organizational structure, the interconnected and overlapping nature of human services programs and client groups will always present challenges in delivering effective services across so many divisions. Currently, HHSC lacks an organizational unit responsible for looking across the system to ensure the left hand knows what the right hand is doing between key programs that may be serving the same client groups, such as people with mental illness. Without dedicated, structured attention and support for cross-functional coordination in key areas, executive leadership loses visibility

into whether programs with interconnected goals and service groups are effectively sharing information and taking advantage of opportunities to improve service delivery.

For example, cross-program information sharing is critical in monitoring and responding to disease outbreaks, requiring close communication between staff enforcing regulatory standards in food manufacturing facilities and separate staff responsible for statewide monitoring of infectious diseases or other outbreaks such as *E. coli*, which may originate in the food supply. Similarly, the effectiveness of the state's institutions for people with severe mental illness or intellectual and developmental disabilities depends on links between staff running the institutions and other programs responsible for supporting and funding community services for the same client populations. An ongoing, high-level organizational spotlight on these types of cross-program efforts would help ensure the system functions effectively overall and that existing lines of communication are not lost in any potential reorganization.

## The current system structure aggravates fragmentation of like services and functions.

- **Incomplete administrative consolidation.** H.B. 2292 had as a major goal the consolidation of administrative services, such as information technology and human resources, within HHSC. The Legislature hoped to gain efficiencies and save dollars through eliminating duplication in administrative services that all agencies use. Although this goal has been partially achieved, consolidation of some administrative services, such as information technology, rate setting, and audit, have not occurred, as discussed in Issue 2. Lack of consolidation results in part from the sense of separateness of HHS system agencies, difficulties agencies have experienced in receiving HHSC services to meet their needs, and the absence of clear accountability over administrative functions.

Even in the human resource area, among the first services consolidated at HHSC, problems persist. For example, one system agency has recently found that it could not use another system agency's audited job classifications because they were deemed agency-specific and could not be shared. The current separate agency status of each of the five entities comprising the HHS system presents other problems that thwart smooth operations, as further addressed in Issue 2. As discussed, the confusing status of the HHS system as one entity with five agency components is a primary factor frustrating complete and effective administrative consolidation. Each of these agencies sees itself, and legally is, a separate agency with its own powers, appropriations, and agency needs, including support services. In contrast, questions of administrative consolidation do not arise in typical state agencies. These agencies do not have multiple agencies within them, so no separate administrative operations exist to consolidate. Divisions of these agencies expect to receive support services through the agency of

*The current separate agency status of system agencies presents problems that thwart smooth operations.*

which they clearly are a part. If the HHS system became just one agency, the structure of support services would be much like any other state agency.

● **Fragmented and poorly integrated programs and services.** Historically, Texas state government structured many human services programs according to client groups. For instance, before the 2003 consolidation, the Texas Department on Aging served aging Texans; the Texas Department of Mental Health and Mental Retardation served client groups with conditions related to behavioral health or developmental disabilities; and the Texas Commission for the Blind provided services to clients with that particular disability.[12]

The 2003 consolidation broke up some of the focus on client group services and began movement toward service-oriented delivery of services to clients. As pointed out in documentation previously mentioned, ongoing reorganization of the system should continue this effort.

> *By consolidating twelve agencies into four departments and a commission, H.B. 2292 takes an initial step toward organizing around common service delivery (i.e., common health-related services, rehabilitation related services, etc.). HHSC should continue this strategic focus by identifying appropriate opportunities to organize around common service delivery mechanisms, rather than purely around population groups.*[13]

Much remains to be done to more fully implement common service delivery. The chart, *Examples of the HHS System's Fragmented Services*, identifies some of the more well-known programs spread across the HHS system. The discussion that follows describes the impacts of fragmented programs and services on clients and the overall HHS system.

Fragmented programs result in divided policy direction and weakened administrative oversight. Issue 3, dealing with consolidation of Medicaid programs, points out this deficiency. The program operates in three agencies, HHSC, DADS, and DSHS, with their own cultures and commissioners, as pointed out in the chart. Medicaid programs administered by DADS and DSHS do not answer directly to the state Medicaid director.

This divided arrangement relies largely on compatible personalities rather than organizational authority to ensure coordination in providing services. Program oversight loses unified focus, weakening basic oversight of appropriate use of funds and allowing different priorities on program aspects needing coordinated attention. Further, innovation to modernize becomes harder because of fragmented leadership. Demonstrating these characteristics, as explained in Issue 3, DSHS continues to operate Medicaid programs that do not follow the clear trend toward integrating primary, behavioral, and substance abuse programs into managed care. Certainly, the integration of programs at an organizational level does not equate to integration at a delivery system level. However, such integration enables

*Medicaid programs administered by DADS and DSHS do not answer directly to the state Medicaid director.*

**Examples of the HHS System's Fragmented Services**

| Service | Agencies with Major Involvement |
|---|---|
| Medicaid program | • **HHSC** is the single state agency responsible for Medicaid and main administrator of managed care services.<br>• **DSHS** administers three Medicaid programs: Texas HealthSteps for early and periodic screening, diagnosis, and testing; NorthSTAR for behavioral health services in the Dallas area; and Youth Empowerment Services (YES) for children with severe emotional disturbances, under HHSC's supervision.<br>• **DADS** administers a variety of Medicaid programs offering long-term services and supports, under HHSC's supervision. |
| Behavioral health services | • **DSHS** is the state's lead agency in planning, providing, and overseeing state behavioral health services for the indigent.<br>• **HHSC** provides mental health services to Medicaid clients and funds "transformational" projects through the federal Delivery System Reform Incentive Payment (DSRIP) program, many of which target behavioral health services. |
| Women's health | Two agencies provide women's health and family planning programs with various overlapping services and different eligibility requirements.<br>• **HHSC** operates the Texas Women's Health Program; and<br>• **DSHS** operates the Expanded Primary Health Care and Family Planning programs. |
| Vocational rehabilitation programs | Both **DADS** and **DARS** offer vocational rehabilitation programs to assist clients obtain and retain employment. |
| Home visiting programs | Several agencies have home visiting programs aimed at children's health or well-being. Among these are the following:<br>• **DFPS** provides home visiting services offered through a variety of prevention programs;<br>• **HHSC** operates the Nurse Family Partnership program and the Texas Home Visiting program; and<br>• **DSHS** operates the Pregnant Post-Partum Intervention program and the Parenting Awareness and Drug Risk Education program. |
| Brain injury programs | • **DARS** offers services to clients with spinal cord and brain injuries.<br>• **HHSC** runs a program to identify and coordinate services for clients with acquired brain injuries. |

more meaningful policy and administrative oversight, paving the way for service delivery integration with enhanced referral processes, coordination of care, and follow up.

Fragmented programs make it difficult for customers to know where to go for services. Consumers of services are confused by where to go and who to talk to for getting services. As described in Issue 8, addressing fragmentation in the system's women's health programs, and shown in the chart above, HHSC operates one such program, while DSHS operates two. Each of these programs has variations in services and locations offered, has different requirements for participation, and may require participation in more than one program for the client's needs to be fully met. Moreover, agencies still use separate locations for different populations to receive

*Fragmenting women's health programs between HHSC and DSHS exemplifies similar programs with duplicated functions.*

services according to the approaches used by their legacy, pre-consolidation agencies. Clients receive aging services through area agencies on aging, but obtain long-term service and supports that DADS operates through DADS' regional offices. Clients access mental health services through local mental health authorities, but receive substance abuse benefits through outreach, screening, assessment, and referral centers. In both cases, client populations for these services overlap.

Fragmented programs create duplicated and unnecessary expenses. The three women's health programs demonstrate this characteristic. The programs duplicate functions for claims processing, reporting requirements, websites, administrative support staff, and more. In Medicaid, separate benefit administrators in DADS, HHSC, and DSHS may not know which clients may be receiving services from other Medicaid programs, much less know a client's participation in the long list of general revenue-funded programs for clients who do not qualify for or lose Medicaid eligibility, opening the door to unnecessary services being provided.

Fragmented categories of services impede integration of services to treat the whole person. Beyond the specific programs mentioned above, large categories of programs are divided among the five HHS system agencies, which combined together, are intended to serve a continuum of a person's needs. Such categories include, among others, medical and behavioral services; long- term services and supports; and social assistance programs, including the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Women, Infants, and Children program (WIC).

Separation of these services in different agencies as opposed to a more unified location complicates serving the range of persons' needs and creates inefficiencies in eligibility determinations, as clients qualifying for one type of service often qualify for others. Agencies tend to concentrate on the specific services they offer, not those of other agencies. For example, this tendency creates difficulty for persons dually diagnosed with behavioral health needs and intellectual and developmental disabilities, to receive coordinated services from DADS and DSHS to address both needs. In addition, as children age out of children's benefit programs and enter more restrictive adult programs, they can face dramatic changes in the transition to new programs with different, potentially fewer benefits and a new administering agency with a different culture and policies.

Fragmentation in programs and services leads to fragmented data. This outcome is almost certain because data collected tends to be specific to the narrow interests of an agency and the programs, or portions of programs, it operates. Issue 7, concerning data management in the HHS system, identifies issues in data development and use, including lack of common standards for setting up information systems.

Fragmented data complicates managing or analyzing a program, or several similar programs, split among agencies. Certainly, fragmented data prevents measuring program outcomes. Basic information Sunset staff requested to analyze and describe Medicaid's NorthSTAR program and, separately, women's health services required herculean efforts for agency personnel to collect, and then with mixed results, because of incompatible data or important missing data elements.

Fragmentation in programs and services leads to many doors to determine program eligibility. Some common eligibility systems exist in the system as a result of legislative mandate, the major example being the Texas Integrated Eligibility Redesign System (TIERS), which helps determine eligibility for Medicaid, the Children's Health Insurance Program (CHIP), SNAP, and TANF. However, most programs have their own process for determining eligibility. Clients have many doors to pass through if they need assistance from several programs. A single entryway helping to sort out clients' service needs, applicable programs, and qualifications for participation is far in the future and fraught with structural challenges, particularly given the fragmented nature of HHSC programs and services.

*A single door to serve clients' needs is far off, especially given fragmented programs.*

- **Regulatory services spread among agencies**. Regulatory activities are not properly focused within the HHS system and may be too closely connected with the programs they regulate. Some of the regulatory issues often identified follow.

DADS contracts with providers to offer long-term services and supports to people with disabilities and the aging in the community or institutional settings such as nursing homes, assisted living facilities, private intermediate care facilities, and home health agencies. In addition, DADS directly operates the state supported living centers (SSLCs) for persons with intellectual and developmental disabilities. At the same time, DADS regulates more than 11,000 of these providers of long-term services and support, including its own SSLCs. Questions arise as to whether program interests in finding placements for individuals in sometimes scarce community settings might override appropriate regulatory attention.

*DADS and DSHS directly operate and regulate state facilities.*

DSHS contracts with providers to assist individuals requiring assistance with mental health or substance abuse issues find services in various settings, including, for example, crisis stabilization units, psychiatric hospitals, and substance abuse treatment facilities. In addition, DSHS operates the state's mental health hospital system. DSHS also regulates these behavioral health-related facilities, substance abuse providers, psychiatric hospitals, crisis centers, and its own mental health hospital system. The issues of conflict of interest in these settings are very similar to those for DADS. Possible conflicts exist in DSHS regulating its own state hospitals; and DSHS struggles to expand its service network through additional legislative funding while appropriately enforcing regulatory standards.

Among its duties, DFPS contracts with substitute care providers such as child placing agencies and itself serves as a child placing agency for placing children in contracted substitute care when the agency determines the safety risk to the child is too great to remain in the home. DFPS also regulates these providers — and itself — raising questions about the obvious conflict within its organizational walls and echoing the concerns raised above about the competing issues of finding adequate placements, yet taking firm and appropriate enforcement action when necessary.

The Sunset reviews of all three agencies highlighted problems resulting from having the regulatory and programmatic duties so closely linked, suggesting further care needs to be taken to more appropriately separate these functions to the extent possible. Ideally, these regulatory functions would be independent, away from the perceived conflict of a commissioner who oversees both the programs and the regulators. However, short of creating a new agency, greater independence than currently exists for this regulatory effort may still be achieved by separating this function as much as possible from the same chain of command within the system.

*DADS, DSHS, and DFPS regulate thousands of facilities requiring similar inspection and complaint activities.*

The HHS system misses efficiencies that could be gained by putting regulatory functions together to realize consistency and best practices in similar activities. DSHS' wide-ranging regulatory responsibilities include about 70 regulatory programs covering more than 370,000 licensees ranging from food and drug manufacturing, radiation control, and healthcare occupations such as emergency medical services personnel. DADS, DSHS, and DFPS regulate thousands of facilities that require similar administrative steps to manage inspections and complaints, for example. DFPS also has authority over abuse, neglect, and exploitation investigations, which can intersect with regulatory activities occurring in various DADS and DSHS facilities.

● **Management of institutions and other system facilities not functionally aligned.** Management of state institutions and office facilities involves many of the same functions. Placing their oversight and operation in three separate agencies, as shown in the table, *State Institution Responsibilities*, lessens opportunities to collaborate on shared issues, to share information on best practices, and to undertake other complementary activities.

*Placement of state institutions away from the executive commissioner does not afford maximum oversight.*

Facility management of state hospitals and SSLCs is a particular concern. These entities, staffed with about 20,000 employees, are the subject of much interest and concern in the system because of crumbling infrastructures, changing characteristics of residents, and the movement of clients to the community. The current organizational placement of these institutions within system agencies, as well as operational support such as food service and construction project oversight consolidated at HHSC, hamper focus on common issues like meeting workforce challenges in far-flung locations. Similarly, placement of these institutional programs away from the executive commissioner does not afford the highest level of oversight and accountability possible in these times of significant change for these institutional settings.

### State Institution Responsibilities

| Agency | Facilities |
|--------|-----------|
| DADS | State Supported Living Centers – provides 24-hour residential services, assessment, day habilitation, behavioral treatment, comprehensive medical care, and therapies for people with intellectual and developmental disabilities. |
| DSHS | State Hospitals – treats people with serious mental illness who cannot obtain needed care in the community and/or have been committed through the court system. |
| | Rio Grande State Center – operates a unique facility integrating state hospital and state supported living center functions with a state-operated outpatient healthcare clinic providing primary care, women's health, diagnostic, and pharmacy services for residents of the lower Rio Grande Valley. |
| | Texas Center for Infectious Disease – treats persons with tuberculosis and other infectious and contagious diseases. |
| HHSC | Provides facilities management for state institutions operated by DSHS and DADS, handling functions such as nutrition and food service, facility risk management, laundry, and construction project oversight. Also oversees facility needs for the system's regional offices, which number about 550. |

## The current system organization is not designed to gain functional efficiencies and presents uncertainty given recent legislative changes.

- **Overly broad focus of DSHS.** The Sunset report on DSHS points out that the broad scope of that agency's programs complicates agency administration and impedes adequate focus on its core public health mission. Many of DSHS's programs offer direct services to clients, including, for example, healthcare services provided to targeted populations such as women and people with kidney disease; treatment for people with mental illness or substance use disorders; and supplemental nutrition for women, infants, and children. These programs often have overlapping client populations and are functionally similar to other medical and social services programs, such as Medicaid, CHIP, and SNAP. Additionally, as discussed above, while many of DSHS' regulatory programs have a direct link to public health, separating them out from other system regulatory functions bypasses the possibilities for greater regulatory efficiencies and focus of administration.

- **Questionable future for DADS.** The 83rd Legislature's passage of Senate Bill 7 will move some or all long-term care services into managed care, under the direction of HHSC. Such a large move raises questions about the future of DADS, given that a large section of the agency may move through this policy change. Continuation of other, general-revenue funded programs for the aging and persons with disabilities will be structurally and

*Legislative action toward moving long-term services into managed care raises questions about DADS' future.*

functionally separated from administration of these same services through the Medicaid program at HHSC. While not set in stone, changes in administration of long-term care through continued expansion of Medicaid managed care will reshape how client services are administered, regardless of whether state structure similarly adjusts to create new efficiencies.

- **Small, singular focus of DARS.** DARS, the smallest of the HHS agencies, successfully maintains its own agency for services that in some cases duplicate services at DADS, although with a short- instead of long-term focus and for smaller client populations. This structural arrangement raises questions as to why these functions are administered in a separate agency away from similar services. Other, more unique services or programs do not similarly have their own agencies, such as social and nutrition-based programs like SNAP, WIC, and TANF, or prevention programs currently housed at DFPS, HHSC, and DSHS.

## The state has a continuing need to perform the vital health and human services functions that HHSC and other system agencies perform.

- **Current functions of HHSC.** HHSC operates a variety of programs, but the largest by far are federal assistance programs helping millions of low-income Texans with their healthcare needs through Medicaid, short-term cash assistance through the TANF program, and monthly benefits to purchase food through SNAP. These needs will not cease, creating a necessary role for a state entity to determine eligibility, process claims, and handle many other administrative functions, including deterring fraud, waste, and abuse.

  HHSC serves as the single state agency for administration of Medicaid in Texas, as required by federal guidelines, allowing the state to draw down more than $14 billion in federal funds for Medicaid and other programs. In fiscal year 2013, HHSC processed almost 5.3 million applications for benefits and provided Medicaid healthcare services to almost 4.7 million Texans.

- **Functions of other HHS system agencies.** The continuing need for the functions of Texas' other four health and human services agencies is described in the Sunset reports on each of those agencies. DADS, DARS, DFPS, and DSHS all provide a broad array of essential programs. Caring for aging Texans and those with disabilities, protecting public health, and protecting vulnerable populations from harm all continue to be necessary. Additionally, Texas would lose more than $3 billion annually in federal funds if child welfare programs, long-term care facility inspections, and other functions currently housed at the four agencies did not continue. As decided by the Sunset Commission in earlier decisions, however, various regulatory programs that DSHS carries out should be discontinued or transferred to other agencies.

# Recommendations

The recommendations that follow are intended to accommodate the other recommendations in this report and the Sunset Commission's recommendations for the other four system agencies. The prior work of the Sunset Commission and the efforts the system agencies have already made in responding to the earlier Sunset recommendations would not be undone by the proposed reorganization below. Subsequent recommendations in other issues in this report and the earlier Sunset recommendations may need to be adapted to reflect these organizational changes. Although each of these other recommendations applies to the system as it is currently configured, they would also work under this new proposal, maintaining their substance and intent.

## *Change in Statute*

### 1.1 Consolidate the five HHS system agencies into one agency called the Health and Human Services Commission, with divisions established along functional lines and other features as described below.

This recommendation would eliminate DSHS, DARS, DADS, and DFPS as separate agencies, merging their functions into a newly constituted Health and Human Services Commission. Elimination of separate agency designations for other entities in the system clarifies lines of authority, improves accountability, and helps to reduce the silo mentality that the five-agency system reinforces. More importantly, achieving a more simplified, streamlined functional approach would improve the delivery of health and human services by reducing the fragmentation and inefficiency of the current structure. Major components follow.

■ **Require the governor to appoint an executive commissioner, with Senate confirmation, to lead the new agency.**

As now, the governor would appoint the executive commissioner, with Senate confirmation, for a two-year term.

■ **Establish divisions along functional lines as the basic organizational framework for the consolidated agency.**

Statute would not prescribe the organization of the agency, other than as outlined below. This approach would allow the agency to change over time without the continual need for legislative retooling. Statute would require the executive commissioner to consider an organizational structure set up broadly along functional lines, with specific consideration given to the functions set out below, such as regulatory services or medical and social services programs. The graphic, *Health and Human Services Commission Example of Functional Organization*, on page 39 depicts the organizational arrangement to be considered. Using these divisions as a starting point, the executive commissioner and transition legislative oversight committee described in Recommendation 1.2 would retain flexibility to fill in and adjust organizational details.

A key consideration, given the critical nature of services to be provided, is the need to accommodate or maintain structures to ensure that decisions and services requiring immediate action are not delayed. For example, statewide intake for child and adult protective services and child care licensing cases would need to be carefully considered for how to maintain its essential service to these programs under a different organizational configuration.

Statute would direct the executive commissioner to develop clear, publicly available qualifications for each division head to ensure these individuals are experienced leaders in their field and have high-level administrative experience. The executive commissioner also would be required to develop clear policies for delegating specific decision-making authority, including budget authority, to each division head. Delegated authority should be similar to the authority that current commissioners exercise so that division heads take a significant share of the enormous task of managing the system's many programs, thus reducing the potential for decision making bottlenecks at the executive commissioner level.

- **Central and Support Services.** This division would house most of the administrative support services currently among the statutory responsibilities of HHSC, including legal, human resources, information resources, purchasing, contract management, financial management, and accounting services.[14] This structure would continue the vision of H.B. 2292 to achieve administrative efficiencies and cost savings through continued consolidation of such services.

  Additional consolidation should occur, as recommended in Issue 2 in this report, which contains specific recommendations for consolidating support services under the current HHS system that can guide this effort. By clearly removing separate agency status for each HHS agency, this recommendation envisions that support services would be provided from a central administrative division, much like other state agencies. The guiding principles for providing support services through such a large organization —especially for ensuring an ongoing, high level of customer service by treating each division as a client — would certainly apply here as well.

- **Medical and Social Services.** All medical and behavioral client services, as well as social services, would be grouped in this division, along with a single eligibility office. HHSC's current programs would be housed here, along with DARS' current programs and DSHS programs focusing on behavioral health, social services such as WIC, and other medically-oriented programs. As the transition legislative oversight committee and the executive commissioner organize activities within this broad division, attention should be placed at ensuring that all populations, such as persons with intellectual and developmental disabilities or behavioral health issues, as well as blind or aging populations, do not lose the visibility or attention they need.

  Placing these services in one division would help eliminate programs and services fragmented in different agencies, such as Medicaid, and help counter silos that impede coordinated services. The addition of a single office to determine clients' eligibility for programs is an important feature of this recommendation. An eligibility office, combined with less fragmentation of services and placement of all client services in one division, would advance the long sought vision of one door that a client could walk through to receive a range of services meeting his or her needs.

- **State Institutions and Facilities.** This division would bring together in one place administrative operations over SSLCs currently at DADS; and such operations over state mental health hospitals, Rio Grande State Center, and Texas Center for Infectious Disease, currently at DSHS. In addition, other facility management operations for office space or other functions located around the current HHS system would be centralized here. The division also would work closely with medical and social services to realize continuing efforts to move residents to community settings, as appropriate.

  This arrangement would allow for efficiencies gained by putting similar functions together. As importantly, this approach would elevate attention on state hospitals and SSLCs, currently undergoing serious scrutiny and change, by making the division directly accountable to the executive commissioner.

- **Family and Protective Services.** This division would continue DFPS' family focus on child and adult protective services and prevention of child abuse, neglect, and juvenile delinquency. Current DFPS programs regulating residential child care facilities and day care facilities would transfer to the regulatory services division, along with investigations of alleged abuse, neglect, and exploitation of individuals receiving mental health, intellectual disability, or developmental disability services in state-operated or state-contracted settings. This arrangement would keep a high-level focus on the serious issues of protecting children and vulnerable adults, while grouping regulatory activities with the system's other regulatory functions.

- **Public Health Services.** This division would encompass the public and community health programs currently at DSHS, moving direct client services to the medical and social services division. Regulatory activities remaining at DSHS would transfer to the new regulatory services division. These changes would allow better focus on public health without spreading administrative oversight too thinly, as is now the case with DSHS.

- **Regulatory Services.** Regulatory activities from around the system would be functionally grouped in this separate division, keeping like functions together and allowing for consistency and adoption of best practices for regulatory activities.

- **Office of Inspector General.** This office would remain a division of HHSC, as currently required in statute. However, the inspector general would no longer be appointed by the governor, but by the executive commissioner of HHSC, as recommended in Issue 10 related to OIG. Instead of serving a one-year term, as required in current statute, the inspector general would serve at the pleasure of the executive commissioner.

The descriptions of divisions above and in the following graphic do not imply organization of sections within them. For instance, if thought beneficial by the transition legislative oversight committee recommended later, behavioral health services could be placed high in the organizational hierarchy of the medical and social support services division.

This recommendation would also remove structural components for entities that are administratively attached to the system to allow the executive commissioner flexibility to assign these functions to appropriate areas of the agency. Specifically, this recommendation would affect the Texas Office for the Prevention of Developmental Disabilities at HHSC, and the Texas Council on Autism and Pervasive Developmental Disorders and Texas Autism Research and Resource Center, recently moved to DARS. The functions of these entities would remain in statute, but any structural components, such as administrative attachment, governing boards or appointment structures, or status as an independent entity would be removed. Consistent with Issue 13, related to advisory committees, the executive commissioner could create advisory committees in rule under existing authority if the agency determines a need for public input specific to these functions. Because of the need to maintain its independent nature, the Office of Independent Ombudsman at DADS, which provides ombudsman services for state supported living centers, would be retained in its current structure but its administrative attachment would move from DADS to HHSC.

This arrangement of divisions would promote integration of services and minimize fragmentation of programs found in the current organizational arrangement. However, a need would still exist to coordinate highly linked functions found in separate divisions through cross-functional staff teams. For example, programs operating services for behavioral health and persons with intellectual and developmental disabilities have a close working relationship with state mental health hospitals and SSLCs. The

new Policy and Performance Office recommended below would look for these cross connections and recommend formation of such teams to the executive commissioner.

### ■ Establish a Policy and Performance Office.

Statute would require HHSC to designate and maintain a high-level executive office to coordinate the following policy and performance efforts across the system. While the following basic elements would be required, the executive commissioner should have flexibility to develop and refine the office's specific structure and duties as appropriate.

● **Performance management system.** The office would take responsibility for developing a systemwide performance management system, including gathering, measuring, and evaluating existing performance measures and accountability systems and developing new and refined approaches as appropriate. A key initial focus should be on establishing targeted, high-level system metrics that could be used to communicate overall system performance and goals internally and to outside stakeholders through tools such as dashboards. As part of this effort, the office should take on the more focused data oversight and analytics responsibilities recommended in Issue 7.

● **Policy responsibilities.** The office would take the lead in supporting and providing oversight for the implementation of major policy changes, including working with the transition legislative oversight committee to achieve the reorganization efforts proposed in this recommendation. This office should assist in ensuring that all population groups, such as those noted in the discussion of medical and social services, do not lose the visibility or attention they need. The office should own these efforts, establishing timelines and milestones, supporting system staff in transitioning between existing service delivery and new approaches, and providing feedback to executive management on needed technical assistance and other support to achieve success.

  This office should also take the lead in managing changes in the organization, including addressing cultural differences among HHS staff; and keeping staff informed of organizational changes, timelines, and steps to expect in the transition. In addition, the office should track and oversee on an ongoing basis implementation of major policy changes, such as legislation and associated rule revisions.

● **Program and process improvements.** The office would also be a centralized "think tank" within the system to offer program evaluation and process improvement expertise, both generally and for specific projects identified through executive and stakeholder input or through risk analysis. As part of this effort, the office should pay special attention to the formation and monitoring of cross-functional efforts needed to improve coordination of services, and provide support and oversight of established cross-functional teams as appropriate.

### ■ Replace the five agency advisory councils with an executive council comprising the executive commissioner and division heads to obtain public input.

Statute would require the executive commissioner to chair this new council, which would include all division directors reporting directly to the executive commissioner and other persons the executive commissioner thinks necessary. The executive council would meet to take public comment on proposed rules, recommendations of advisory committees, legislative appropriations request and other documents required in the state's appropriations process, operation of agency programs, and other issues for the entire system. HHSC would propose and adopt rules for the operation of the council.

The committee is not a "governmental body" as defined by the Open Meetings Act, exempting it from requirements that do not appropriately apply, given that the council would not deliberate or make decisions as a group but would operate as a committee formed to take public input. The executive commissioner would retain all decision-making authority. Executive council meetings should be held at least quarterly, with authority to call a special meeting when necessary, and all such meetings should be publicly announced. Meetings of these officials outside this executive council are not subject to public announcement or other state meeting requirements, given that these individuals could normally meet in the course of their daily work to discuss agency business.

All meetings of the executive council should be webcast. This recommendation does not limit the authority of the executive commissioner to appoint advisory committees as necessary to receive input.

### 1.2 Require development of a transition structure, including formation of a transition legislative oversight committee, and development of a broad transition plan and a detailed work plan to guide HHSC in setting up the new structure.

These transitional elements are similar to those used to implement H.B. 2292 in 2003. The transition legislative oversight committee would comprise seven members: four legislative members, two appointed by the speaker and two by the lieutenant governor, and three public members appointed by the governor. The HHSC executive commissioner would serve as an ex officio, non-voting member. The committee would meet quarterly to oversee progress in the transition.

The HHSC executive commissioner would submit a transition plan to the governor and Legislative Budget Board (LBB) by December 1, 2015, to carry out the consolidation. HHSC would flesh out details of the transition in a work plan that contains the details of program movement and timelines. The transition plan should require reorganization to be complete by September 1, 2016.

### 1.3 Continue the basic functions of the health and human services agencies in the single, reconstituted Health and Human Services Commission for 12 years.

Functions performed by system agencies would continue in the reconstituted Health and Human Services Commission except for the DSHS regulatory programs that the Sunset Commission recommended be discontinued or transferred to other agencies. Unless specified otherwise in earlier decisions of the Sunset Commission, the need for all system functions continue. The Commission would remain subject to the Sunset Act and would have a Sunset date of September 1, 2027.

## Fiscal Implication

Unlike the situation in the 2003 consolidation, this next step to achieve the 2003 vision of the Legislature is not aimed at saving money but increasing service quality and achieving savings through more accountable, less fragmented, and, therefore, more efficient health and human services programs.

Fiscal implications cannot be accurately estimated without extensive information from HHSC and LBB, as occurred in legislative consideration of H.B. 2292. However, any costs of the new system should at least be a wash with current HHS system expenditures.

**Potential savings.** These include the following.

- Attainment of more accountable operations throughout the system.

- Reduction in fragmented services through functional organization, resulting in elimination of overlapping and duplicative services, improved communication, better use of staff time, and, ultimately, intangible savings.

- Increased consolidation of administrative functions, resulting in more efficient operations and the potential downsizing of positions no longer needed because of consolidations.

- Reductions in cost from elimination of agency advisory councils, totaling about $48,500 in travel costs annually, and about 6,400 hours of staff time preparing for council meetings and work sessions. Offsetting this amount, staff time would be required to prepare for the quarterly public meetings of the recommended executive council, but that time would likely be less than that required under the current arrangement for receiving public input.

**Potential costs.** These include the following.

- Employment of six division directors to replace the four positions now serving in commissioner posts, assuming the organization proposed in this issue.

- Modifications in information technology and administrative systems to support the new organization.

- Replacement of signage and various office products so that they reflect the new organizational arrangement.

- Creation of the policy and performance office.

- Use of staff time and additional effort required to reorganize the system.

## Health and Human Services Commission
## Example of Functional Organization

The following diagram is an example of an HHS organization built around functional lines. *Bulleted items are not intended to be an exhaustive list of all functions carried out in the functional area.* Each functional area under the executive commissioner would be led by a high-level executive such as the commissioners in the current HHS system, who would have broad discretion to make decisions to help limit the administrative burden on the executive commissioner. High-level managers would be responsible for the day-to-day management of functional areas. HHSC, through the Policy and Performance Office, would develop teams cutting across divisional lines to help ensure needed coordination of related programs. For example, cross-functional teams could be established between programs for persons with intellectual and developmental disabilities, or programs for behavioral health, and the state-run institutions assisting both those populations.

**Executive Commissioner and Executive Offices**

- Chief Counsel
- Internal Audit
- Policy and Performance Office
- Government Relations

**Office of Inspector General**

**Medical and Social Services**
- Medicaid and CHIP
- Behavioral health
- Public benefit programs (SNAP, TANF, WIC)
- Women's health
- Services for people with disabilities and the aging
- Disability determination (federal)
- Centralized eligibility determination

**State Institutions and Facilities**
- State supported living centers
- State hospitals
- Texas Center for Infectious Disease
- Rio Grande State Center
- HHSC regional and state office facility management

**Family and Protective Services**
- Child protective services
- Adult protective services
- Prevention and early intervention

**Public Health Services**
- Disease control and prevention
- Emergency preparedness and response
- Regional and local health services
- State public health laboratory
- Population data (vital statistics, registries, healthcare information)

**Regulatory**
- Emergency medical and trauma services
- Food and drug safety
- Healthcare facilities
- Radiation use
- Long-term care providers
- Abuse, neglect, and exploitation investigation
- Child care licensing

**Centralized Services**
- Budget / Financial
- Procurement / Contract Oversight
- Human Resources
- Rate Analysis and Forecasting
- Information Technology
- Ombudsman
- Legal

¹ Legislative Budget Board, *Fiscal Size Up 2004-05*, p. 1, accessed May 24, 2014, http://www.lbb.state.tx.us/Documents/Publications/Fiscal_SizeUp/Fiscal_SizeUp_2004–05.pdf.

² Legislative Budget Board, fiscal note for enrolled version of House Bill 2292, 78th Legislature, Regular Session, May 31, 2003, http://www.legis.state.tx.us/tlodocs/78R/fiscalnotes/pdf/HB02292F.pdf#navpanes=0.

³ Membership of the committee included two members from the House appointed by the speaker, two members from the Senate appointed by the lieutenant governor, and three members appointed by the governor, with the HHSC executive commissioner serving as an ex officio member.

⁴ Health and Human Services Commission, *Benefits of consolidation: Four-Year Report* (Austin: Health and Human Services Commission, 2009), p. 2.

⁵ Deloitte, *H.B. 2292 Organizational Design Analysis and Approach* (Austin: Deloitte, 2003), p. 6.

⁶ Sections. 531.008(c)(2) and 531.102(a-1), Texas Government Code.

⁷ Inspector general-related operations in major agencies such as the Department of Public Safety, Texas Department of Criminal Justice, and the Texas Juvenile Justice Department answer to the boards of those organizations. The Texas Workforce Commission operates an office of investigations within one of its divisions that answers to the executive director. Other agencies may have such functions contained within their divisions.

⁸ Section 531.0055(h), Texas Government Code.

⁹ "Dashboard home," Maine Department of Health and Human Services, accessed September 5, 2014, http://gateway.maine.gov/dhhs-apps/dashboard/.

¹⁰ Hatry, Harry P., *Transforming Performance Measurement for the 21st Century* (Washington, D.C.: Urban Institute, 2014).

¹¹ United States General Accounting Office, *Implementation Steps to Assist Mergers and Organizational Transformations*, report no. GAO-03-669 (Washington, D.C., July 2003), pp. 2–3.

¹² While part of the former agency's name, the term mental retardation has generally been replaced with intellectual disability.

¹³ Deloitte, *H.B. 2292 Organizational Design Analysis and Approach* (Austin: Deloitte, 2003), p. 6.

¹⁴ Section 531.0055(d), Texas Government Code.

# Issue 2

*Incomplete Centralization of Support Services Deprives the State of Benefits Envisioned in Consolidating the Health and Human Services System.*

## Background

In 2003, the Texas Legislature enacted House Bill 2292, the landmark legislation that transformed the health and human services system from 12 to five agencies under the ultimate direction of the Health and Human Services Commission (HHSC). A key tenet of H.B. 2292 was to consolidate administrative services in HHSC. The purpose of this consolidation was to eliminate redundant administrative and support services, facilities, and technology existing in the previously separate agencies, thereby saving money and increasing overall organizational efficiency. The following statute, as well as other provisions, strongly emphasize HHSC's control over these services.

> *The commission shall plan and implement an efficient and effective centralized system of administrative support services for health and human services agencies. The performance of administrative support services for health and human services agencies is the responsibility of the commission. The term "administrative support services" includes, but is not limited to, strategic planning and evaluation, audit, legal, human resources, information resources, purchasing, contract management, financial management, and accounting services.*[1]

Statute also separately gives HHSC authority over rate setting in the health and human services system (HHS system).[2]

The scope of administrative functions for HHS system agencies is enormous, supporting a human services system whose budget is more than $75 billion in the 2014–15 biennium and a total staff of more than 54,000.

This issue reviews the overall status of administrative services consolidated in HHSC, now 11 years after creation of the system. The issue also takes a deeper look at three key administrative activities headed by HHSC: information technology (IT), contracting, and rate setting. The efficient and economical operation of the system and its success in serving clients relies in no small part on these functions.

This issue addresses system support services in the context of the HHS system's current organizational arrangement. The findings and recommendations of this issue also apply in concept and are easily adaptable to the treatment of administrative services in the proposed reorganized system set out in Issue 1.

## Findings

### Consolidation of Administrative Support Services

**Administrative consolidation at HHSC is incomplete, resulting in lost efficiencies.**

Consolidation of administrative services has been piecemeal and sporadic after the first several years of operation. The chart, *Status of Administrative*

*Consolidation Efforts,* pictures in thumbnail the system's progress in achieving administrative consolidation at HHSC. As used here, consolidation means not only combined personnel at HHSC but also clear and recognized decision-making authority over the function in actual practice.

*Lack of consolidation results in lost efficiencies and sets the stage for agencies acting independently.*

Lack of consolidation results in lost opportunities for efficiencies and cost savings. A function split among agencies muddies the water on who is in charge, obscuring clear priorities for the HHS system and paving the way for individual agencies to act on their own. Possibilities for savings through standardizing and consolidating common approaches across the system become harder to realize, and making improvements through a system perspective becomes elusive as system agencies act independently. Movement forward often depends on interagency cooperation when decision making is diffused. Failing that cooperation, decisions can slow down or be put off.

### Status of Administrative Consolidation Efforts

| Function | Degree of Consolidation and Control at HHSC | | | Comment |
|---|---|---|---|---|
| | Low | Mid | High | |
| Human resources | | | | First high profile service consolidated at HHSC |
| Facilities management | | | | Most regional management activities and personnel are centralized in HHSC |
| Rate setting | | | | HHSC sets fees for all Medicaid programs and many for other parts of the system |
| Financial management – actuarial analysis, forecasting | | | | Forecasting and actuarial analysis are mostly consolidated |
| Financial management – budget and fiscal policy | | | | Agencies maintain their own chief financial officers |
| Contracting services – competitive procurements | | | | HHSC takes the lead in competitive procurements |
| Contracting services – noncompetitive procurements | | | | System agencies drive most of these processes |
| Strategic planning and evaluation | | | | Some functions are also carried out by staff in other agencies, but coordinated through HHSC |
| Information resources | | | | Function also carried out by staff in other agencies, but coordinated through HHSC |
| Accounting | | | | Function also carried out by staff in other agencies, but coordinated through HHSC |
| Legal | | | | Discussions of consolidation of legal services at HHSC ongoing at the time of this review |
| Audit | | | | All agencies have their own internal audit staff, with little coordination through HHSC. HHSC coordinates or performs enterprise audits. |

Ambiguous decision-making authority shows up in various ways, including consolidated purchasing. For example, some HHS system agencies have negotiated separate contracts for managing hardware and software at individual work stations in their agencies, a service called "seat management." Given the huge number of employees with work stations in the system, having one umbrella contract negotiated by HHSC could result in large savings. However, with leadership for information technology spread across the system, this unified approach did not occur.

In another similar example, HHSC recently negotiated a contract to consolidate service agreements for maintenance and upkeep of office equipment such as copiers, computers, fax machines, and vehicles. The contract guarantees a 26 percent savings over current service agreement expenses. Although all HHS system equipment may not be appropriate for contract coverage, based on total maintenance and repair expenses for system agencies in fiscal year 2013 of about $115.4 million, the possibility of savings through the contract is likely in the millions. However, HHSC has taken the approach of allowing system agencies to voluntarily enter into the contract, rather than mandating its use. In these situations, which HHSC judges to be beneficial for all system agencies, decisions and efficiencies languish as a result of HHSC's fuzzy authority in a system in which administrative services are not clearly consolidated.

Finally, perhaps owing to their separate agency status, HHSC as well as other HHS system agencies have their own separate internal audit staffs and audit plans, with no central authority over the entire group. While this approach allocates audit resources on separate agency interests needed to inform management of potential problems, it misses the mark of more efficiently assigning auditors to projects based on prioritized risk areas across the system. The HHS system also loses the opportunity for further efficiency from combining audit administrative staff and possibly hiring additional auditors from savings. Having a centralized audit shop improves independence of these efforts from the operations they oversee, while still allowing dedicated staff with needed expertise to meet these agencies' needs.

Statutory language applied to all state agencies requires them to have an internal audit program.[3] Whether this requirement currently applies to individual system agencies is unclear; however, lack of clarity could be seen as unnecessarily limiting the HHS system from consolidating internal audit functions.

## Incomplete consolidation of administrative services may relate to the competing views of HHS system agencies as "silos" resistant to change or as client agencies needing support services to do their jobs.

Various reasons underlie the system's piecemeal consolidation of administrative services. One view is that the five HHS system agencies "operate in silos" and in fundamental ways still do not see themselves as part of a unified system. This viewpoint impedes strong central control from HHSC and consolidation of any type. The silo mentality has its cultural roots in the separate agencies

that existed before consolidation of the system in 2003. Even after merging 12 agencies into five, the legacy of previously independent agencies often lives on in their new consolidated home. Key system personnel can end up having divided loyalties between system interests and the interests of their own separate agency, and consolidated services at HHSC may not always support their own agency's interests.

System agencies contend that what some may view as silo mentality could be agency staff trying to do their jobs and not getting the attention or services needed from HHSC. They point to past consolidations of administrative services in which they have lost staff to HHSC to provide services, yet aspects of the work remained at the agency. System agencies receiving services from HHSC worry about their basic ability to perform their jobs without having support staff onsite, who work with program staff on a daily basis, and who understand and can help address the program's needs. Agency staff see HHSC, with its own immense program responsibility as the state Medicaid agency, as perhaps not the most objective overseer of the system because of a natural propensity to serve its needs first. System agencies also point to a perception of condescension and even arrogance by HHSC staff that impedes the harmony and goodwill needed to achieve consensus on system changes.

*No plan currently exists to finish the job of consolidating administrative support services.*

No active plan currently exists to finish the job of consolidating administrative support services, probably for the reasons outlined above. Without such a plan, the situation changes slowly with uncoordinated consolidation initiatives occurring from time to time as strong personalities or outside attention on some failure in operations dictates.

The HHS system faces risk in this arrangement. Health and human services programs are becoming increasingly more complex and expensive, and clear, forceful decision making in administrative services is needed to support programs efficiently and save taxpayer dollars. In that complexity and expense, however, HHSC has an obligation to pay honest attention to the needs of the system agencies, treating them as true clients of the services provided. Issues encountered in the three selected support services covered below — IT, procurement and contracting, and rate setting — often trace back to the systemic cultural problems outlined above but are the shared responsibility of the system as a whole.

## Information Technology

Staffing and responsibility for IT, including information security, in the HHS system is split among HHSC and other system agencies. The chart, *HHS System Budgeted IT Personnel,* displays the division of staff among the five HHS system agencies.

### HHS System Budgeted IT Personnel – FY 2013

| Agency | Budgeted State FTEs | Budgeted Contractor FTEs (more than six months) | Budgeted Contractor Staff (less than six months) |
|--------|---------------------|--------------------------------------------------|---------------------------------------------------|
| HHSC   | 734                 | 152                                              | 7                                                 |
| DADS   | 155                 | 22                                               | 8                                                 |
| DARS   | 62                  | 10                                               | 0                                                 |
| DFPS   | 167                 | 17                                               | 4                                                 |
| DSHS   | 276                 | 37                                               | 18                                                |
| Total  | 1394                | 238                                              | 37                                                |

IT underlies almost every aspect of the system's work. Internal and external communications, movement of data and information, and processing of millions of transactions with clients, all rest on the system's IT resources. In addition, increasing integration of services and supports throughout the system requires greater compatibility of IT resources.

## HHSC IT's formal "paper" authority has not resulted in clear decision-making responsibility, sufficient oversight, and efficient planning and operation of the system's IT resources.

In addition to HHSC's statutory authority over the system's information technology, agency policy also specifies that HHSC IT has the responsibility of planning and managing information resources across the HHS system. Policy further instructs HHSC to establish an interagency IT structure to help govern and coordinate system needs.[4] As a final responsibility, HHSC oversees information security in the system. These clear leadership directives do not work out as written in day-to-day operations.

*Splitting of IT staff between HHSC and system agencies blurs HHSC's overall authority.*

- **Key personnel split among agencies.** Division of staff between HHSC IT and IT offices in other agencies complicates decision making. Of particular note, apart from HHSC, each system agency has its own information resource manager and information security officer, with technology staff in each HHS system agency answering to those individuals. This division of responsibilities among agencies results in diffused rather than clear lines of authority, an arrangement that complicates decision making when agencies disagree.

  Currently, general state statute requires information resource managers to report to the executive or deputy executive head of their respective agencies.[5] This provision could impede consolidation of all IT personnel at HHSC because of the separate agency status of all five agencies within the HHS system.

- **Limited project oversight.** In practice, HHSC IT has clear oversight responsibility for its own agency-specific projects as well as those involving both HHSC and other system agencies. HHSC IT does not have such oversight for projects of other system agencies in which HHSC does not participate.

  *HHSC IT has no official role in monitoring major projects it is not involved in.*

  No policy requires HHSC IT to review or sign off on any IT procurement or procurement with a major IT component outside its own solicitations, although this check-off sometimes does occur informally. Absent this step, HHSC lacks a safeguard to help ensure IT procurements' compatibility with existing systems.

  HHSC IT has no official role in monitoring major initiatives other than those it is directly involved in, and owners of other projects across the system have no formal responsibility to inform HHSC IT when a project is going off track. Such notifications sometimes come when a project is already in the ditch. To name one such project, the Department of Aging and

Disability Services (DADS) began in June 2010 to merge two long-term care payment information systems into a single system called the Single Service Authorization System. Three years later, DADS and HHSC halted the project after costs ballooned from $8.5 million to $15.2 million. If HHSC and its executive commissioner had been aware of problems and growing costs, this failure might have been avoided.

**Status of Major System Information Resource Projects – FY 2013**

| Agency | On Track | Off Budget or Schedule |
|--------|----------|------------------------|
| HHSC   | 1        | 5                      |
| DADS   | 0        | 2                      |
| DARS   | 0        | 1                      |
| DSHS   | 1        | 6                      |
| DFPS   | NA       | NA                     |

A review of the December 2013 report of the state's Quality Assurance Team gives some insight into HHS system IT projects. This team, composed of staff from the Legislative Budget Board, the State Auditor's Office, and the Department of Information Resources, provides statistics showing that only two of the system's 16 major information projects are on time and budget, as depicted in the chart, *Status of Major System Information Resource Projects*. The net increase between the original and current budgets for all 16 projects is $118.7 million.[6] Although good reasons may underlie some of these numbers, they still suggest the need for continued attention and careful control of major HHS system IT projects.

- **Fragmented IT planning.** HHSC and system agencies comply with state requirements for high- level strategic planning for IT. However, critical and detailed IT planning at HHSC has not fully matured, exposing the system to future expenditures that are not optimally focused on long-term needs. Just in the last two years, HHSC IT has begun to identify IT needs for the short-term, which it uses in the development of agencies' legislative appropriations requests. However, this effort is not a centralized, structured planning process looking at least three to five years into the future for the system as a whole to ensure that short-term projects will align with business drivers and system priorities, and will help meet long-term agency and system needs.

*Critical and detailed IT planning at HHSC has not fully matured.*

- **No specific IT guidelines for the HHS system.** Absence of a formal means of communicating basic policies or procedures hampers coordinated, consistent IT operations across the HHS system.

- **Uncoordinated networks and IT support.** Decentralized IT administration and legacy IT systems have resulted in HHS system networks and support systems that operate inefficiently. For example, in the Winters complex in Austin, each of the four HHS system agencies occupying the complex supports its own local area network and provides desktop services for its respective staffs, a situation not unique to the system. Multiple networks, for example, may prevent full development of standard business practices, such as the sharing of printers and scanners among staff in colocated facilities, the use of video conferencing resources across separate agencies, and the needed support of a mobile workforce. Lack of unified support also can yield strange service patterns in regional offices outside Austin. A colocated regional office could have two computers sitting side by side but belonging to different HHS system agencies. If one computer breaks

down, IT support for that agency could be required to fix it, potentially traveling from another regional office, even if IT staff from the "wrong" agency sits in the next room.

- **Inconsistent security measures across the HHS system.** HHS policy set out in 2007 required HHSC to develop an information security program for the HHS system. The policy charged information security officers from HHS system agencies to develop security programs for their agencies that did not conflict with HHSC's systemwide program.[7]

  At this point, agencies have developed their own security programs, but their approaches are inconsistent, primarily because systemwide information security standards and guidelines are optional. These different approaches make it difficult to efficiently manage the system. Also, different security systems create inefficiencies in procurement because needs are not standard and purchasing cannot be efficiently consolidated.

*Separate IT staff could keep one agency from fixing computers for another agency next door.*

## Contracting

The HHS system depends on contracting to carry out almost every aspect of its work. Benefits to Medicaid recipients, delivery of services to HHS system clients, underlying technology for the storage and movement of data and communications, and other functions, are all dependent on contracted services. HHSC estimates that contract expenditures for the system total about $24.1 billion in fiscal year 2013, as shown in the chart, *HHS System Contract Expenditures.*

**HHS System Contract Expenditures FY 2013**

| Agency | Number of Contracts | Expenditures |
|--------|--------------------|--------------|
| HHSC | 8,395 | $16,240,258,002 |
| DADS | 12,706 | $5,316,952,628 |
| DSHS | 7,690 | $1,812,877,564 |
| DFPS | 2,917 | $572,009,362 |
| DARS | 2,174 | $203,259,793 |
| Total | 33,882 | $24,145,357,348 |

HHSC's statutory responsibilities over contracting include activities to *procure* goods and services, such as development of solicitations up to contract approval; and *contract management*, those activities that occur after contract execution, such as monitoring services and enforcing contract terms.

HHS system procurements are either competitive or noncompetitive. The HHS system commonly solicits competitive procurements by issuing a request for proposal (RFP) as well as other competitive types of solicitations. For example, HHSC selects managed care organizations through an RFP process. A common form of noncompetitive procurement in the HHS system uses an "enrollment" process in which an HHS agency awards an enrollment contract to a provider or vendor based on the entity's ability to meet minimum qualifications. Providers of medical or other services often operate through enrollment contracts.

HHSC policy divides procurement and contract management responsibilities in the system, centralizing procurement under a separate deputy who reports directly to the executive commissioner and leaving contract management to HHS agencies or HHSC's own program or administrative divisions.[8] The centralized procurement and contracting office at HHSC has responsibilities

beyond procurement, including offering technical assistance and coordinating various systemwide contracting activities on occasion.

**HHSC's centralized procurement and contracting office has yet to develop clear oversight authority for certain types of procurements and is missing required tools for managing system contracting.**

*HHSC has not finished developing contract management tools required since 1999.*

- **Unclear role over enrollment contracts.** HHSC appropriately pays most attention to competitive procurements because these are procedurally complex and must meet tightly defined standards of fairness and vendor selection. However, enrollment contracts often involve large sums paid to groups of providers, and should not be totally excluded from attention. This centralized office's role in these procurements, while evolving, has not been clearly defined in practice.

- **Long-standing absence of required management tools.** Since 1999, statute has required HHSC to develop the following:

  - a contract management handbook that establishes consistent contracting policies and practices for the HHS system;

  - a single contracting risk analysis procedure that each HHS system agency must comply with that identifies contracts requiring enhanced contract monitoring and that coordinates contract monitoring efforts in the system; and

  - a central contract management database identifying all HHS system contracts.[9]

These requirements were put into statute for a reason. Managing a complex universe of contracts without these tools increases the risks of contracting problems, with the potential for significant harm to individuals and to the state. For the state to entrust such sensitive responsibilities affecting the health and well-being of vulnerable populations to outside parties through contractual arrangements requires such effort to ensure the integrity of the entire system.

*Obtaining a systemwide list of contracts took exceptional effort.*

As of September 2014, HHSC had not completed and initiated use of these tools, although efforts seem to be close to completion on the risk analysis and handbook. HHSC is currently considering a procurement for the database.

Sunset staff experienced firsthand the need for a contract database. Responding to a request for a list of contracts for all HHS agencies to show the scope of contracting systemwide, HHSC coordinated the information gathering, but the effort took three months from request through corrections to final delivery, and HHSC could not ensure that the data is complete, consistent, or reliable.

Lack of a contract management handbook increases risk that contract managers are uninformed as to standard enterprise procedures and best contract management practices. Having no single contracting risk analysis procedure in common use carries its own risk of failing to identify and appropriately monitor high-risk contracts. Failure to maintain a comprehensive central contract management database also means failure to have a complete picture of the contracting going on in the system, to keep track of problematic contracts, and to produce timely and accurate reports for upper management and oversight entities.

- **Weak and informal monitoring.** Agency policy and practice does not specifically define the extent of authority for HHSC's central procurement and contracting office in contract monitoring actions. Monitoring does occur, at least informally, for contracts in which HHSC is involved, but monitoring practices fade for agency-specific contracts. Some of these contracts cost millions, such as DADS' Single Service Authorization System, that failed in its original conception after the expenditure of $15.2 million. Although the primary responsibility of the operating agency, in reality, accountability does not and should not stop with that agency's commissioner, but reaches up to the executive commissioner as the final person in charge.

*The HHS system lacks a formal policy and process for reporting on large contracts.*

Currently, procedures do not require the executive commissioner's signature on major or high-risk contracts "owned" by HHS system agencies other than HHSC. In addition, HHSC has not created a formal policy defining an ongoing and formal reporting structure for the entire system that shows for large contracts any corrective action plans, their status, and any liquidated damages assessed and collected. Finally, procedures do not define a dependable means of escalating attention on large and problematic contracts to HHSC's central procurement and contract office, and ultimately the executive commissioner, before problems become unfixable.

## HHSC's procurement and contracting office has not yet developed sufficient assistance and communications channels with system agencies.

- **Insufficient technical support to client agencies and programs.** When agencies lose their own designated offices for activities like procurement and contracting, they lose their ready source for basic information to help them be good consumers of services, make their needs known, and know what questions to ask. HHSC has recently and appropriately begun to develop this function more systematically, but it is a long way from maturity. The system needs this kind of centralized help to ensure that agencies take the steps to properly develop, monitor, and strictly enforce contracts.

*HHSC's technical support for system agencies' contracting is a long way from maturity.*

- **No designated points of contact in system agencies.** The current communication arrangement between HHSC and HHS system agencies lacks a standard and designated point of contact within each agency to serve as contracting liaisons to provide the needed two-way flow of information.

The lack of such contacts impairs the effective flow of communication between the central office and system agencies.

● **Lack of centralized training policies and designated training role.** HHSC policy does not explicitly define the training role of its central procurement and contract office in the system. A leadership role in training is appropriate for this central oversight office, but lack of explicitly stating that role leaves it open to question across the system.

Legislation enacted in 2013 strengthens requirements for contract management training, mandating that contract managers receive certification from the comptroller's office by September 1, 2015. This legislation also requires abbreviated training for agency governing bodies.[10]

HHSC's central procurement and contract office has taken a central role in coordinating HHS staff compliance with this training, a duty appropriate to its general oversight of contracting in the system. Although the legislation covers training for policy bodies, HHSC's executive commissioner is not explicitly covered as a single appointed executive head. A contract training policy would be appropriate for the executive commissioner or other high-level staff, given the system's dependence on contracting.

### Despite recent efforts, the history of contract oversight in the HHS system indicates the need for greater sophistication in system contracting.

Contracting is deceptively hard to do well. Agencies must maintain close collaborative ties with independent contractors to ensure mutual understanding of often very complex tasks and needs, but also maintain sufficient distance to enforce compliance when contract terms are not met. In the HHS system, the multimillion dollar size of many contracts, the everyday demands of running programs, and the tendency for agencies to act on their own add complications to consistent and high-quality contracting.

*Contracting is high risk, with system expenditures of $24.1 billion in fiscal year 2013.*

Although HHSC is in the process of addressing them, the contracting deficiencies mentioned before, such as the absence of the statutorily required system contract management handbook or reliable contracting database, suggest that high-level HHS system executive management needs a more sophisticated approach to contracting in this difficult environment. Much is at risk if contracting is not done well. In fiscal year 2013, the system expended $24.1 billion on contracts. HHSC alone had contracting expenditures of more than $16 billion. Among these, critical contracts with managed care organizations serving the Medicaid program totaled more than $10 billion, a contract with an enrollment broker for support services related to eligibility operations for Medicaid and various other programs accounted for $112.2 million, and a contract with the claims administrator for the Medicaid program represented another $358.1 million.

Actual experience also suggests a hard-learned lesson for HHSC regarding contract oversight. HHSC's claims administrator contract with the Texas Medicaid and Healthcare Partnership (TMHP) is a recent example of a large, high-risk engagement that went off track. Those responsible for various components of the contract were spread across HHSC, DADS, and the Department of State Health Services (DSHS), with responsibilities not only for monitoring many contract requirements, but also for other full-time duties.[11] After problems ensued, the agency cancelled the contract in May 2014. The state followed that action with a suit against the company, alleging various well-publicized breaches of contract related to prior authorization of orthodontic services. However, several aspects of the contract itself and HHSC's handling of it have come under scrutiny as well. The accompanying textbox describes the recent findings of the U.S. Department of Health and Human Services Office of Inspector General report on the prior authorization process for orthodontic services in the TMHP contract.

---

### U.S. Office of Inspector General
### Report on the TMHP Contract

The U.S. Department of Health and Human Services' Office of Inspector General (OIG) issued a recent report in which it found that HHSC did not ensure that the TMHP prior authorization process was used to determine medical necessity of orthodontic services and did not ensure that TMHP followed Medicaid policies and procedures when determining medical necessity.[12]

In its response, HHSC acknowledged that it "relied to its detriment on ... TMHP to manage the Medicaid orthodontia prior authorization program effectively in compliance with HHSC's policy for orthodontia services." HHSC further replied that "(b)y failing to follow the approved policies and procedures, (the contractor) not only violated its contractual obligations, but opened the door to potential fraud by unscrupulous orthodontic providers who could exploit (the contractor's) lax prior authorization process by receiving Medicaid reimbursement for orthodontic services the providers knew, or should have known, were not medically necessary."[13]

Ultimately, the U.S. OIG concluded, "We maintain that TMHP's deficiencies were due to a lack of State agency oversight because the State agency is responsible for contractor compliance."[14]

---

Better contracting requires the continuing leadership of HHSC's executive management and the commitment of high-level managers throughout the system. The system currently lacks formal processes for focusing that commitment. At one point, the central procurement and contract office participated in an enterprise contract council, which could have been one such vehicle, but the council was disbanded in 2013. Whatever the mechanism, cross-system emphasis needs to be given to contracting to improve this function and help avoid repeating costly mistakes.

*The HHS system lacks processes for focusing high-level leadership specifically on contracting.*

## Rate Setting

HHSC sets Medicaid rates for any agency operating a Medicaid program, but many non-Medicaid programs requiring payment rates operate in the system. The Medicaid program alone requires the development of close to 200,000 rates, generally updated annually or biennially, and covering rates for managed care organizations, acute care services, long-term services and supports, hospital and clinical services, and other services.[15] The other system agency that continues to have extensive rate setting activities is DSHS, which sets numerous rates for non-Medicaid programs. The great majority of these, around 700, relate to its Family and Community Health Services Program.

### Lack of consolidated rate setting can result in inconsistent rates and methodologies, too little assurance of rate-setting expertise, and loss of taxpayer dollars.

*Fragmented rate setting can result in inconsistent rates for similar services.*

- **Possible rate inconsistencies.** Different rates may be appropriate for the same service if, for instance, a higher rate may be needed to attract providers in a remote location. Rate differences, however, may also occur for no apparent good reason. In early 2013, HHSC Rate Analysis reviewed the Department of Assistive and Rehabilitative Services' (DARS') rates on direction of HHSC management after problems emerged in DARS' Post-Acute Brain Injury program. HHSC concluded that the vast majority of DARS rates for medical services with an equivalent Medicaid service appeared to be much higher than the Medicaid rate for the same service, and that no compelling reasons for the differences appeared to exist.

  In addition to its cost implications, variances of this nature are unfair to providers, who may receive more or less, when providing the same service in an agency program, or even across agencies. This situation can lead to providers choosing to offer service only in the higher rate programs, leaving the other programs with lower rates struggling to maintain their network of providers.

  This lack of consistency could have been avoided if rate setting were consolidated in one location. HHSC leadership apparently came to the same conclusion in March 2014, transferring most rate-setting responsibilities for DARS to HHSC on a staggered basis.

- **No assurance of expertise or process.** In addition to consistency, consolidated rate setting also accomplishes centralization of expertise in a visible, professional staff that uses a proven process. These characteristics may not be present in other agencies' rate-setting activities.

- **Possible lack of separation from the program.** Program staff in other agencies may also be involved in rate setting, whereas at HHSC, rate setting is independent of programs such as Medicaid or CHIP. Staff's close working relationship with programs could result in a loss of objectivity that could influence rates for contracted providers.

## Further transparency in setting rates for managed care organizations should be examined.

Transparency in rate setting is critical to produce confidence in the fairness and accuracy of rates. Although rate setting overall is accomplished openly, room for improvement still remains, as discussed below.

- **More information for calculating capitated rates.** HHSC makes available large amounts of data to managed care organizations to help them determine how the agency calculates their capitated rates. In a few areas, HHSC may not provide enough detail early enough in the process for the managed care organizations to more easily understand various adjustment factors, causing additional questions to arise in the rate-setting process.

- **Short time to review draft capitated rates.** Because of deadlines set by the federal Centers for Medicare and Medicaid Services and other limitations in receiving timely and required data, HHSC recently has sent managed care organizations draft rates and associated data just a few days before meeting with them as a group to go over those preliminary rates. The schedule gives managed care organizations little time to digest the information and prepare questions, although limited time is available for separate discussions between managed care organizations and HHSC after the group meeting and before HHSC sets final rates.

## Recommendations

As mentioned previously, this issue addresses system support services in the context of the HHS system's current organizational arrangement. The recommendations that follow also apply in concept and are easily adaptable to the treatment of administrative services in the proposed reorganized system set out in Issue 1.

### Consolidation of Administrative Support Services – Management Action

### 2.1   Direct HHSC to further consolidate administrative support services.

- **Consolidation plan.** HHSC, in consultation with other HHS system agencies, should develop a consolidation plan, including a schedule with milestones, for reviewing and implementing consolidation changes. Some administrative functions, such as human resources, already are generally consolidated; other administrative functions, such as contract management in system agencies, are not appropriate for consolidation at HHSC. However, the plan should review each administrative function and their major components and make a determination as part of the written plan as to the desirability of further consolidation. The plan should address functions currently named in statute, including strategic planning and evaluation, audit, legal, IT, contracting, financial management, accounting, rate setting, and facilities management. The plan may also address other items that HHSC considers its final responsibility, such as, potentially, privacy considerations. As part of this plan, HHSC should also evaluate mechanisms for assigning or otherwise dedicating staff to the system agencies to provide the proximity and expertise to serve their needs.

- **Principles.** The HHS system should use the following guidelines in considering consolidations.

  - Consolidation should result in clearly placed accountability to eliminate confusion as to who bears the ultimate responsibility.

  - The agency should stagger transfers so problems that occur are kept manageable and do not overwhelm the system with simultaneous change.

  - Consolidation should occur in consultation with system agencies to ensure responsiveness to their needs as clients of support services.

    - HHSC should develop, in consultation with system agencies, agreements setting out measurable goals that HHSC is expected to meet. Service should be as good, if not better, as that existing before the consolidation. Agencies should have the ability to seek permission from the executive commissioner to find alternative ways to address their needs if HHSC fails to meet them.

    - HHSC should take steps to ensure that large agencies and programs, such as HHSC and Medicaid, do not end up first in line to receive necessary services, but that small programs in smaller agencies, such as DARS and DFPS, also receive support adequate to meet their needs.

    - Staff providing services consolidated in HHSC should be located close to those requiring those services to help ensure an understanding of program needs and quick and responsive action.

  - Consolidation of staff should be accomplished so that parts of the system losing staff have adequate resources to carry out remaining duties.

  - HHSC and HHS agencies should establish clear points of contact and responsibility for each consolidated function.

  - Each consolidation should be formally and clearly documented and communicated in a common format that lays out in detail responsibilities, contact points, transfer of personnel, budget considerations, and other items critical to the support service under consideration.

  ### Statutorily authorize HHSC to establish a centralized internal audit staff under HHSC's control for all HHS agencies.

The statute should clearly exempt individual system agencies from the requirement that all state agencies have an internal audit, clearing the way for possible internal audit consolidation, if such a determination is made.

## Information Technology – Management Action

### 2.2 Direct HHSC to take the following steps to improve the accountability for, as well as the planning and integration of, information technology and information security in the HHS system.

- **Consolidate all IT personnel under HHSC control.** HHSC should consolidate within HHSC IT agencies' information resource managers, information security officers, and related staff. Care should be taken to ensure that HHS system agencies have sufficient and readily available IT support to meet their needs. HHSC should address specific IT functions and services that would result

in efficiencies and cost savings through consolidation. Consolidation would address confusion in responsibilities and promote a centralized vision for IT in the system.

- **Give clear authority for overseeing HHSC system IT.** HHSC should clearly define and direct in policy that HHSC IT sign off on any IT procurement or procurement with a major IT component, regardless of the originating agency. HHSC IT should also have clear authority and top management support to monitor all major IT projects with high risk, or other projects as deemed necessary, throughout the system. Strengthened monitoring would help ensure overall compatibility of IT throughout the system and catch and fix emerging problems before they become unsolvable.

- **Prepare and maintain a comprehensive IT plan.** HHSC guidelines should require that HHSC IT, in consultation with HHS system agencies, develop a comprehensive plan of information technology projects looking forward at a minimum three years that aligns with the program's vision, strategy, needs, and priorities. The plan, which could be included as part of the strategic planning process, should prioritize projects by agency and within the HHS system, and should be updated in conjunction with development of HHS system legislative appropriations requests. HHSC's executive commissioner should sign off on the plan. An IT plan developed and used with commitment would give the system a roadmap to more successful, integrated operations.

- **Develop guidelines.** The HHSC executive commissioner should adopt a set of guidelines setting out the responsibilities of HHSC IT and HHS system agencies for information technology, working with the Department of Information Resources as appropriate. The guidelines would leave no question that HHSC IT has the authority to take actions to increase the efficiency and accountability of information technology in the system. The guidelines would be developed by HHSC IT and reviewed for comment by each HHS system agency. The guidelines would summarize basic processes to be followed by HHSC, as well as system agencies, in developing IT projects, including a summary of steps required to comply with state requirements for reporting to state oversight entities such as the Quality Assurance Team. Guidelines would go far to clarify responsibilities and procedures for HHS system IT, and go hand in hand with the consolidation of IT personnel within HHSC.

- **Consolidate authority for system networking and customer support.** Consolidating these functions in HHSC IT would promote development of integrated HHS system networks and eliminate inefficiencies in computer support for employees.

- **Put in place an HHS security system meeting consistent minimum standards.** HHSC guidelines should require that HHSC set, and HHS system agencies comply with, minimum security standards for the system. HHS system agencies could establish more stringent requirements as their needs dictate. The sensitive information maintained in the system requires careful and coordinated oversight to protect sensitive information and quickly and efficiently deal with any security issues that may arise.

**Statutorily exempt HHS system agencies from the general state requirement that each state agency's information resource manager report to the executive head of the agency.**

This exemption would allow information resource managers in each HHS system agency to report to HHSC rather than the executive heads of their respective agencies. This change would facilitate the general recommendation to consolidate IT functions and personnel at HHSC.

## Contracting – Management Action

### 2.3 Require HHSC to take the following actions to better define and strengthen its role in both procurement and contract monitoring.

- **Clarify and standardize HHSC's role over enrollment contracts.** Although becoming more defined, the role of HHSC's centralized procurement and contract office over enrollment contracts has not been clearly developed. HHSC's role over these contracts, along with other roles in procurement and contracting, should be clearly defined in policy to avoid confusion, improve oversight, and help ensure standard and consistent contracting practices.

- **Complete, maintain, and update the statutorily required contract management handbook, risk analysis procedure, and central contract management database.** The handbook and risk assessment have been in development throughout the course of the Sunset review. HHSC should ensure the newly created and statutorily required contract management guide and risk assessment are kept up to date and followed by HHS system agencies. HHSC's procurement and contract shop should oversee agencies to ensure compliance with the principles in the guide and risk assessment. The guide should clearly outline roles of HHSC's procurement and contract office and system agencies in procurement and contract management. In addition, the contract management database should be completed as soon as budget and technology allow. The database should include all types of contracts for the system and enable quick and timely retrieval of contract information considered basic to managing system contracts. These efforts would bring HHSC in line with statute and provide essential tools to oversee procurements and monitor contracting generally.

- **Strengthen monitoring of contracts at HHSC.** HHSC should develop policies to accomplish the following:

  - require the executive commissioner's signature on large or complex contracts managed by any of the HHS system agencies, or develop other clear processes for high-level oversight of such contracts, if the burden on the executive commissioner becomes too great;

  - require development of a formal policy defining an ongoing reporting structure that shows for large contracts any corrective action plans, their status, and any liquidated damages assessed and collected; and

  - define a means of escalating attention on large and problematic contracts to HHSC's central procurement and contract office, and ultimately, the executive commissioner.

  These policies would improve HHSC's ability to spot problems and resolve them early in the process, regardless of which agency they occur in.

  While HHSC's high-level monitoring of contracts should be strengthened, these recommendations do not imply that day-to-day *management* of contracts should be removed from the agency programs those contracts support. Staff running programs need to understand contract requirements and appropriately manage their contractors.

### 2.4 Direct HHSC's procurement and contract office to improve assistance to and communications with system agencies as follows.

- **Strengthen technical assistance to system agencies.** HHSC should continue strengthening its efforts in this area to help understand and meet the needs of clients throughout the system. This effort should also include ensuring and documenting adherence to policies, awareness of respective roles

of central office and system agencies, and effectiveness in managing contracts, including monitoring performance measures and submission of deliverables.

- **Designate points of contact within HHSC and each HHS system agency.** These points of contact would facilitate procurement and contracting-related communications between agency personnel and HHSC, making it clear who to go to for getting questions answered and problems resolved.

- **Take a more active role in training.** HHSC procedures should establish contract training requirements for HHS system leadership, including at least the executive commissioner and commissioners of each agency, as well as those serving as the agencies' second in command. In addition, procedures should require HHSC's central procurement and contract office to develop training requirements for agency personnel involved in contract development and management, and oversee and coordinate contract-related training required by the state for contract management personnel. Building a bigger pool of better trained personnel for contract development and management is critically important in a human services delivery system that depends on contracting.

## 2.5 Direct HHSC to develop ways to apply focused, high-level attention to system contracting.

HHSC executive management should consider various mechanisms for focusing needed resources and attention on contracting, including reinstating some form of the disbanded enterprise contract council as a place to spearhead discussion of contracting issues and solutions. Whatever the mechanism, characteristics of a focused approach to improving contract management should include, among others:

- leadership of HHSC management, including the clear involvement of the executive commissioner;

- involvement of all major contract owners throughout the system;

- awareness that one size does not fit all when developing contracting processes;

- emphasis on ways to provide focused technical assistance and training to contract managers;

- consideration of ways to structure contracting to help ensure close coordination with the contracted entity while still maintaining objectivity when assessing contractor compliance;

- emphasis on measuring outcomes of contracts through appropriate performance measures; and

- structured ways to implement best practices gleaned from outside sources and lessons learned from the rich store of contracting experiences found in the HHS system.

This type of focus helps promote ongoing improvement in contracting, more consistency in structure and operations across the system, and high-level attention and accountability on major contracts.

## *Rate Setting – Management Action*

### 2.6 Consolidate rate setting for the HHS system at HHSC.

HHSC should establish this consolidation in policy, determining a transition schedule for moving different types of rates to HHSC in stages, along with any identified staff. When staff are transferred, care should be taken not to reduce an agency's staff below a level that unreasonably increases workload for remaining employees. The transition would also identify contracted services in agencies whose underlying payments are not based on standard rates and thus are not appropriate for rate analysis, such as, potentially, negotiated fees determined through contract deliberations.

Consolidation of rate setting would promote the consistent review of the same or similar rates with consistent methodologies; reduce the possibility of setting unjustifiably different rates in different parts of the system for the same service; and make available expert staff for rate setting that are separate from the programs whose contractors have large interest in, and possible influence on, rates that are set.

### 2.7   Improve transparency in setting capitated rates.

- **Additional information to managed care organizations.** HHSC should consider providing additional information to managed care organizations so that these entities can independently calculate various factors making up their capitated rates. If achievable, availability of this information would remove a point of contention between managed care organizations and HHSC.

- **More time for managed care organizations to review preliminary capitated rates.** Currently, this span of time can be only several days, making analysis of HHSC data provided to managed care organizations difficult. HHSC is looking for ways to provide managed care organizations with information in time to be of greater use in rate setting, adding more rationality to the process.

## Fiscal Implication

The consolidations called for in these recommendations would result in significant administrative efficiencies, reducing costs, or more efficiently offering services to clients, but the specific items or areas positively affected cannot be foreseen and estimated. For example, decisive direction to consolidate separate agencies' IT contracts for supporting employee work stations would save money. The same sorts of savings would potentially accrue from consolidation of service agreement contracts for maintenance and upkeep of equipment. While perhaps not appropriate for all maintenance, potential for large savings exists, considering HHS system maintenance expenditures of about $115.4 million in fiscal year 2013. Even a minimal 5 percent average savings would result in about $6 million saved. In addition, savings of just 0.1 percent in overall system contracts would be $24 million. Other, less quantifiable but more important long-term efficiencies would result simply from better and more consistent administrative decision making across the system.

Consolidation of rate setting at HHSC would likely require increased staff in the affected HHSC office to carry out the additional workload appropriately. However, this increase could occur through transfer of some reasonable portion of rate-setting staff from other agencies or other adjustments in system staffing at no significant additional cost to the state.

..............................................

1     Section 531.0055(d), Texas Government Code.

2     Section 531.0055(g), Texas Government Code.

3     Section 2102.005, Texas Government Code.

4     HHS Circular C-009, "Health and Human Services Enterprise, Information Technology Governance Policy," April 27, 2010.

5     Section 2054.075, Texas Government Code.

6     Quality Assurance Team, *2013 Annual Report: Overview of Major Information Resources Projects Reported to the Quality Assurance Team,*" accessed May 25, 2014, http://qat.state.tx.us/1046_2013_QAT_AnnualReport_112613.pdf.

7     HHS Circular C-21, "HHS Enterprise Information Security Policy," July 31, 2007.

8     Action memorandum from Wayne Wilson, Deputy Executive Commissioner for Procurement and Contracting Services, to the Executive Commissioner, March 12, 2013.

9     Chapter 1460 (H.B. 2641), Acts of the 76th Texas Legislature, Regular Session, 1999.

10     Chapter 1227 (S.B. 1681), Acts of the 83rd Texas Legislature, Regular Session, 2013.

11     Health and Human Services Commission, *Self-Evaluation Report*, p. 220, accessed August 26, 2014, https://www.sunset.texas.gov/public/uploads/files/reports/Health%20and%20Human%20Services%20Commission%20SER%202013%2084%20Leg.pdf.

12     U.S. Department of Health and Human Services, Office of Inspector General, *Prior Authorization of Medicaid Orthodontic Services in Texas* (A-06-12-00039), (U.S. Department of Health and Human Services, August 2014), pp. 3 and 4.

13     Ibid., pp. 9 and 11.

14     Ibid., p. 6.

15     HHSC, *Self-Evaluation Report*, p. 87.

# ISSUE 3

*Fragmented Administration of Medicaid Leads to Uncoordinated Policies and Duplicative Services and Could Place Future Transitions to Managed Care at Risk.*

## Background

Medicaid is a jointly funded state-federal healthcare program created in 1967. Medicaid primarily provides health coverage to low-income children, pregnant women, people age 65 and older, as well as people with disabilities. Medicaid pays for acute care and long-term services and supports, examples of which are provided in the textbox, *Medicaid Services*. In fiscal year 2013, the total Medicaid budget was $24.2 billion, with approximately 41 percent or $9.9 billion funded by the state, providing healthcare coverage to about 4.7 million Texans.

> ### *Medicaid Services*
>
> **Acute care**: doctor visits, inpatient and outpatient hospital visits, lab, pharmacy, and x-ray services
>
> **Long-term services and supports**: home and community-based services, nursing facility services, and services provided in intermediate care facilities for people with intellectual and developmental disabilities

The health and human services system manages Medicaid through two systems. Medicaid payments have historically been through a fee-for-service model in which Medicaid providers bill the state for each service rendered to a Medicaid client. Today, that model is shrinking as the system moves to managed care, an approach by which the state contracts with managed care organizations to coordinate clients' care across all providers treating the client for covered services.

About three million, or 82 percent, of Medicaid members were enrolled in managed care in fiscal year 2013, and plans are underway to transition additional groups into managed care in the future. Texas administers the managed care programs listed below, and the accompanying textbox describes future populations transitioning into managed care.

> ### *Future Populations Transitioning to Managed Care*
>
> *March 2015.* Nursing facilities move into STAR+PLUS.
>
> *September 2016.* STAR Kids rolls out to coordinate acute and long-term care services for persons under age 21 with disabilities or social security income or related eligibility. Participation in managed care becomes mandatory, instead of voluntary, for these populations.
>
> *September 2017.* Texas Home Living program moves into STAR+PLUS.
>
> *September 2020.* Some or all of the remaining waiver programs for individuals with intellectual and developmental disabilities, including Home and Community-based Services, Community Living Assistance and Support Services, Deaf Blind with Multiple Disabilities, and community intermediate care facilities, move into STAR+PLUS.

- **STAR (State of Texas Access Reform).** STAR is a statewide managed care program in which Health and Human Services Commission (HHSC) contracts with managed care organizations to provide, arrange for, and coordinate preventive, primary, and acute care covered services. STAR

provides services for Medicaid clients: pregnant women, newborns, children with limited income and Temporary Assistance for Needy Families-eligible program recipients.

- **STAR+PLUS.** The STAR+PLUS program provides long-term services and supports in addition to acute care services to individuals who are age 65 or older or have a disability and who have chronic and complex conditions. STAR+PLUS has operated in urban areas of the state for many years and expanded statewide on September 1, 2014.

- **STAR Health.** Implemented in 2008, STAR Health is a statewide program designed to provide coordinated health services to children and youth in foster care and kinship care.

- **NorthSTAR.** The Legislature created NorthSTAR as a pilot in 1999 to integrate the Dallas-area publicly funded systems of mental health and substance use disorder services in hopes of eliminating wait lists and improving services. Using Medicaid, state general revenue, federal block grant funds, and some local funds, NorthSTAR serves both Medicaid and indigent populations. NorthSTAR is the only managed care contract not administered by HHSC; the Department of State Health Services (DSHS) manages this contract.

- **Children's Medicaid dental services.** HHSC contracts with two dental managed care organizations to deliver statewide services for Medicaid beneficiaries under 21.

## Findings

### The fragmentation of Medicaid among three agencies impedes effective communication, cohesive Medicaid policy changes and program administration, and efficient delivery of medically necessary services.

Programs that share the same objectives and interests should typically be administered under unified administrative direction. This approach promotes consistent decision making toward a shared vision, better communication among staff who share the same organizational culture, and more shared awareness of program problems and how to fix them. The state's Medicaid program does not operate in this fashion.

*HHSC is the single state agency with ultimate authority over the Medicaid program.*

The federal government officially recognizes HHSC as the single state agency with ultimate authority over the Medicaid program, and HHSC directly administers the great majority of Medicaid, including almost all of managed care.[1] However, the Department of Aging and Disability Services (DADS) and DSHS administer Medicaid programs separate from the bulk of the program at HHSC. The Centers for Medicare and Medicaid Services have raised questions about whether the Legislature's direct appropriations to separate agencies, such as DADS and DSHS, complies with requirements for HHSC to be the single state agency for Medicaid administration.[2] The table, *Agencies Administering Medicaid Programs*, shows each agency's major Medicaid duties.

**Agencies Administering Medicaid Programs**

| HHSC | DADS | DSHS[3] |
|---|---|---|
| • Single state agency for Medicaid administration<br><br>• Establishes Medicaid policy<br><br>• Coordinates waivers and state plan amendments, including the 1115 transformation waiver and associated DSRIP projects[4]<br><br>• Oversees 21 managed care organizations<br><br>• Oversees the state's fee-for-service program for acute care<br><br>• Determines financial and categorical client eligibility<br><br>• Administers the Vendor Drug Program<br><br>• Contracts for functions such as claims processing, data broker services, managed care, and enrollment<br><br>• Establishes Medicaid reimbursement rates for providers and managed care organizations<br><br>• Coordinates implementation of changes to federal law, including the Patient Protection and Affordable Care Act | • Determines functional eligibility for long-term services and support waivers<br><br>• Administers the following long-term services and support waivers: Medically Dependent Children Program, Deaf Blind with Multiple Disabilities, Community Living Assistance and Support, Home and Community-based Services, Texas Home Living<br><br>• Administers the following Medicaid entitlement benefits: Community Attendant Services, Day Activity and Health Services, Primary Home Care, and Program of All-Inclusive Care for the Elderly | • Administers early periodic screening, diagnosis, and treatment (Texas HealthSteps), including assessments for personal care services and various case management functions<br><br>• Manages the managed care contract for NorthSTAR for behavioral health services in the Dallas area<br><br>• Administers the Youth Empowerment Services (YES!) behavioral health waiver |

The state's continued expansion of managed care will precipitate the movement of long-term services and supports under HHSC's oversight of managed care organizations over the next few years. The shift to managed care will inevitably require the transfer of program staff from these agencies to HHSC when the programs transition. Continued separation of the remaining, smaller Medicaid functions outside of HHSC and the direct control of the Medicaid director unnecessarily complicates the scheduled managed care transitions and potentially makes the duplication and problems in the system even worse, as described below.

*Medicaid staff in DADS and DSHS report to their commissioners, not the state Medicaid director.*

• **Divided policy direction.** HHSC has directed the move away from the fee-for-service model to managed care, a difficult transition to a new delivery system that has required innovation and considerable effort. DADS and DSHS are organizationally insulated from this policy culture and HHSC's efforts. Medicaid staff in the three agencies report to their own agency commissioners, and not to the state Medicaid director, making innovation or policy changes more difficult to drive on the state Medicaid director's

own authority. This organizational separation places a premium on the personalities of the principals involved to ensure needed coordination occurs and that matters not fall through the cracks. The situation presents a special challenge for stakeholders to successfully participate in three agencies' different processes and to navigate separate policies.

The program's organizational divide affords DSHS and DADS more latitude to continue "business as usual" rather than being innovative and making sweeping improvements to outdated systems. While HHSC maintains oversight of the Medicaid program as the federally required single state Medicaid agency, DADS still operates its Medicaid waiver programs, much as they were administered before consolidation. Related to managed care, statute allows individuals with intellectual and developmental disability benefits in the DADS waiver programs to continue outside of managed care, setting the stage for continuation of two separate agencies to administer the same program, one through managed care and one through fee-for-service. A split in the provision of services between HHSC and DADS for individuals in DADS waiver programs could create inconsistencies in care for clients and inefficiencies for the state through administration of duplicative programs.

DSHS continues to administer Medicaid programs that are not in line with emerging best practices to integrate all primary care, mental health, and substance abuse programs together in statutorily mandated expansions of managed care. DSHS' NorthSTAR, discussed in Issue 9, is an example of a managed care program that is now out of step with this type of full integration, being limited to mental health and substance abuse services. In addition, planned statewide expansion of DSHS' Youth Empowerment Services (YES) program providing intensive community-based services for children with severe emotional disturbances results in three separate waivers and behavioral health policy approaches — NorthSTAR, YES, and managed care — on top of each other in the Dallas area.

*Services at DADS and DSHS are largely delivered as they were before consolidation.*

Divisions in policy direction also affect clients. Both DSHS and DADS have failed to streamline access to their Medicaid services into a consolidated approach even within their own agencies, still organizing access to Medicaid programs by the legacy agency from which the programs were transferred. Specifically, at DADS, clients largely access aging services through area agencies on aging, and access waiver programs through local authorities. At DSHS, clients access mental health services through local mental health authorities and access substance abuse benefits through outreach, screening, assessment, and referral centers. In both cases, client populations for these services overlap.

- **Duplicated and unnecessary expenses**. The separation of Medicaid benefits across agencies can lead to clients obtaining duplicative or unnecessary benefits. For example, DADS administers long-term services and support waivers to a very limited number of clients, offering Cadillac-style benefits, such as through the Home and Community-based Services waiver,

sometimes beyond a person's needs and despite wait lists for services. In fact, the long wait times may actually encourage an instinct to over-subscribe to benefits simply because of time investment.

Certainly changes to long-term care services and supports cannot be made in isolation from the Legislature and stakeholders. However, outside the HHSC policy scope, DADS lacks the vision and motivation to improve the waivers to serve more people at only their needed level of services, a more cost-effective approach for the state. DADS also organizes itself inefficiently, by funding stream or by legacy agency, missing efficiencies that could be gained by a more functional approach and taking a bigger picture view of the services it provides.

The division of the Medicaid program among three agencies sets up a situation in which different benefit administrators deal with the same eligible populations. Separate benefit administrators may not know which benefits clients are already getting from other programs. To make matters worse, no common information technology system exists to help determine if clients are already receiving benefits. Clients can end up receiving benefits they do not need because of this murky system.

*Clients can receive benefits they do not need because of the division of services.*

As a specific example, some children end up receiving both private duty nursing through HHSC and attendant care both through personal care services at DSHS and through DADS waiver programs, causing these children to receive more in benefits than may be medically necessary. Home health agencies, which both assess and provide services to children in DADS programs, have an incentive to over-allocate hours for benefits such as private duty nursing. These inflated benefits are not cost-effective for the state and can create difficulties as children transition to more restrictive adult programs in which such generous benefits will not be available. While these issues will likely be addressed by HHSC through the planned transition of these services into the STAR Kids managed care program in September 2016, the problems persist as a result of separate, uncoordinated delivery systems.

Texas has a limited amount of resources to meet a great need. When systems create inefficiencies or allow for unnecessary benefits, other needs go unaddressed. In many cases, the state ends up having to fund unmet needs through other, general revenue-funded programs that offer wrap-around services for clients who do not qualify for or slip on and off Medicaid.

- **Weak administrative oversight.** Separation of services among different agencies makes ensuring appropriate use of Medicaid funds difficult. The lack of strong oversight for use of Medicaid funds places the agency at increased risk for recoupment of funds by the Centers for Medicare and Medicaid Services. Administration of Medicaid programs across multiple agencies also results in a complicated system of interagency contracts to transfer Medicaid funds that causes confusion and almost eliminates budget transparency, giving the false appearance of inflating administrative costs.

*Separation of administration affects budget transparency and weakens oversight.*

In another example, DSHS personal care service claims, such as for attendant care, are processed by a contractor of HHSC, but between the two agencies, limited oversight exists to ensure the necessity of the services filed by DSHS caseworkers, much less to perform utilization reviews or other trend analyses to properly manage the program. In addition, in fiscal year 2014, DSHS proposed to increase Medicaid rates for NorthSTAR providers without the buy-off of HHSC. As the single state agency for Medicaid administration, HHSC retains authority and responsibility for the Medicaid budget, and should be the decision maker for rate increases that affect HHSC's bottom line.

Beyond the fragmentation of whole Medicaid functions among different agencies, several components of the program are themselves split among agencies, making it more difficult to maintain strong oversight and accountability. For example, Medicaid provider enrollment functions are split among four agencies, third-party liability efforts are split among three agencies, and numerous vendor contracts exist across agency lines. The State Auditor's Office noted in a recent audit that fragmentation among agencies and the lack of a single program manager increased the difficulty in monitoring trends to enable better management of the state's Medicaid programs.[5]

- **Lack of expertise at HHSC for scattered Medicaid programs.** HHSC does not have much subject-matter expertise on staff to aid in the upcoming transitions to managed care. HHSC staff has gained experience and learned many lessons through initial transitions into managed care. However, HHSC is more likely to make mistakes on the programs moving into managed care without the programs' subject-matter experts from other agencies. HHSC has already begun carving in staff from other agencies to serve this need, but like other efforts, this staffing relies more on the personalities of individuals involved rather than the structural alignment within the agency needed to ensure expertise. By using experts to address issues before transitions occur, HHSC can anticipate and design processes to minimize the perceived negative consequences of managed care. In the current siloed administrative structure, staff at DADS and DSHS are not kept informed about upcoming managed care transitions. Moreover, advice offered by advisory committees, while critical for communication to and from HHSC, does not substitute for expertise in the program's administration.

*HHSC is more likely to make mistakes in managed care transitions without subject matter experts.*

Adding to the problem, HHSC has had limited experience expanding managed care into new populations. Many of HHSC's recent managed care expansions have been expansions into additional service areas or adding benefits to programs. HHSC does serve high-need clients in STAR+PLUS, but the success of the program's recent statewide expansion and inclusion of acute care services for individuals with intellectual and developmental disabilities, which tested the agency's ability to transition fragile persons with disabilities and chronic healthcare needs, is too early to evaluate.

For the 2014 transition of mental health benefits, a lack of program expertise, together with incredibly short timeframes, have prevented HHSC from achieving the desired efficiencies and outcomes of true integration. Instead of adjusting the managed care contract timelines and requiring full integration of mental health benefits with primary care, the additional mental health benefits were merely added into existing contracts. Efforts to better integrate these systems are underway, but the presence of subject matter expertise at HHSC could have promoted this integration sooner.

Program expertise at HHSC is also critical to development of managed care contracts. These contracts, the instrument that ultimately holds managed care organizations accountable, must be developed with the help of knowledgeable program experts so that contractual requirements meet client needs, correctly reflect program components, and include proper performance measures and sanctions to hold managed care organizations accountable.

*Program expertise is critical to development of managed care contracts.*

Problems that have already occurred in the managed care roll outs may potentially have been avoided if Medicaid functions were not split among several agencies. For example, managed care client enrollment letters were sent out prematurely to individuals with intellectual and developmental disabilities on four separate occasions, causing confusion among both clients and providers. If separate information technology systems were not involved, enrollment letters might have been better coordinated and this confusion could have been avoided.

## As Texas' most vulnerable Medicaid populations are about to transition into managed care, a smooth transition is more critical than ever.

An integrated, consistent, and well-managed expansion of managed care is essential in future managed care roll outs. Interruptions in service or lapses in care resulting from systems or business process changes can be fatal for vulnerable Medicaid clients. The upcoming transitions include clients that cannot necessarily communicate their own needs and present much greater challenges. By 2016 STAR Kids will provide services to fragile children on Medicaid with significant healthcare needs, and the adult Medicaid populations in nursing homes will be carved into STAR+PLUS. By 2020, some or all of the DADS waiver programs for persons with intellectual and developmental disabilities will transfer into STAR+PLUS.[6]

*Future managed care transitions that include fragile populations will present new challenges.*

Future transitions also present new challenges for managed care organizations, requiring attentive oversight by the state. The populations that have yet to transition into managed care fear cuts in benefits and services resulting from pressure on managed care organizations to contain costs. Some children that will be served in STAR Kids may, in fact, experience drops in benefits as care is coordinated and medically unnecessary services are adjusted. In addition, managed care organizations, more accustomed to the acute care arena where improvement in clients' conditions is the norm, have historically not provided

services to individuals with intellectual and developmental disabilities or people with severe and persistent mental illness. While service coordination for these individuals could certainly be improved by managed care, the long-term needs and diagnoses of these individuals will be new for managed care organizations. HHSC and managed care organizations must be diligent in ensuring continuity and quality of care for these vulnerable individuals.

# Recommendation

## *Change in Statute*

This issue addresses consolidation of Medicaid in the context of the health and human services system's current organizational arrangement. The findings and recommendations of this issue are assumed as part of the proposed reorganized system set out in Issue 1. If Issue 1 is adopted, however, this recommendation should be adopted as a management, and not a statutory, recommendation.

### 3.1 Consolidate administration of Medicaid at HHSC.

This recommendation would consolidate Medicaid functions at HHSC.

**DADS.** This recommendation would move all pieces of the Medicaid program administered by DADS to HHSC, including the following.

- Waiver Programs: Medically Dependent Children Program, Texas Home Living, Deaf Blind with Multiple Disabilities, Community Living Assistance and Support Services, and Home and Community-based Services

- Entitlement Programs: Community Attendant Services, Day Activity and Health Services, Primary Home Care, and Program of All-Inclusive Care for the Elderly

- Any other associated functions or contracts related to the Medicaid program, including functional eligibility determinations, nursing home quality initiatives, hospice and community intermediate care facility programs, consumer directed services, relocation services, personal needs allowance; support functions such as third-party liability, claims administration, and provider enrollment; Medicaid-related long-term care initiatives such as Money Follows the Person, and the Medicaid Estate Recovery Program

Regulation of long-term care facilities and operation of state supported living centers would not transfer, as these functions can involve payers beyond Medicaid for which the state is responsible.

**DSHS.** This recommendation would also move all pieces of the Medicaid program administered by DSHS to HHSC, including Texas HealthSteps, personal care services, other Medicaid case management functions, YES Waiver, and any other Medicaid-associated functions or contracts. NorthSTAR would be discontinued, as recommended in Issue 9.

**Transition.** As part of this recommendation, HHSC would create a transition plan to provide for the details of program movement and timelines related to transfer of these programs to the agency no later than January 1, 2016. Consolidation of Medicaid functions at HHSC should be accomplished no later than September 1, 2016.

## Fiscal Implication

These recommendations would have no net fiscal impact. Transfers of Medicaid program components would include minimal transition costs offset by savings from better coordination of program administration, potential consolidation of similar contracts, and elimination of unnecessary Medicaid benefits to clients.

............................................

[1]    Section 531.021, Texas Government Code.

[2]    Letter from Centers for Medicare and Medicaid Services to Albert Hawkins, Executive Commissioner, March 9, 2007.

[3]    Until September 1, 2014, Medicaid rehabilitation and targeted case management were also operated by DSHS.

[4]    Waiver to Section 1115 of the Social Security Act, establishing the Delivery System Reform Incentive Payment funding pool.

[5]    Texas State Auditor's Office, *An Audit Report on the Health and Human Services Commission's Administration of Home Health Services within the Texas Health Steps Program*, accessed July 17th, 2014, http://www.sao.state.tx.us/reports/report.aspx?reportnumber=13-005.

[6]    Some or all of the benefits in these waivers may transfer, and clients currently enrolled in the waivers may choose to stay in fee-for-service. Section 534.202(g), Texas Government Code.

# ISSUE 4

*HHSC Has Not Fully Adapted Its Processes to Managed Care, Limiting the Agency's Ability to Evaluate the Medicaid Program and Provide Sufficient Oversight.*

## Background

In response to rising healthcare costs in the early 1990s, the Texas Legislature created a managed care model that promised to coordinate delivery of Medicaid services more cost-effectively.[1] In managed care programs, the state pays managed care organizations a fixed rate for each Medicaid client, providing an incentive to coordinate a client's healthcare services in the most efficient way.[2] This approach is in contrast to the traditional fee-for-service model by which the state pays providers for each unit of service provided to clients.[3] Managed care organizations coordinate acute care services such as doctor visits, inpatient and outpatient hospital services, prescription drug benefits for most Medicaid clients, and have growing experience with long-term services and supports, with additional transitions in the near future.[4]

Since managed care was initially rolled out, the state has steadily expanded the model statewide and into additional Medicaid populations.[5] The chart, *Managed Care Expansion*, illustrates the increase in Medicaid clients served by managed care organizations over the last five years and the corresponding decrease in fee-for-service clients. As of September 1, 2014, about 84 percent of Medicaid clients' healthcare services were coordinated by managed care organizations. By fiscal year 2017, more than 90 percent of all Medicaid clients are likely to receive services through managed care organizations.[6]



**Managed Care Expansion**
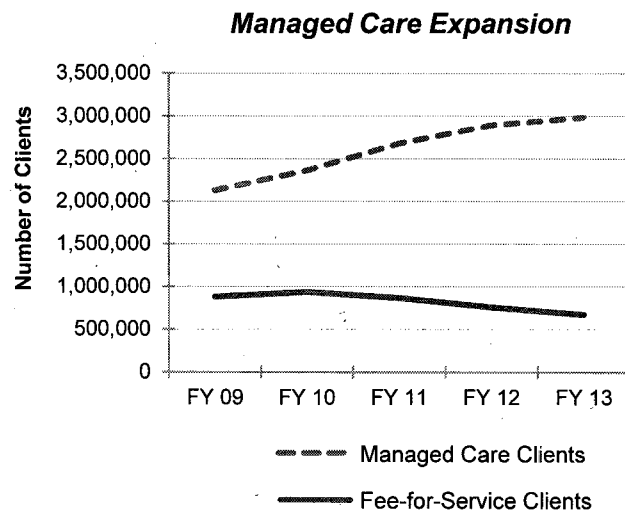
The Health and Human Services Commission (HHSC) contracts with 19 health maintenance organizations and two dental maintenance organizations to manage healthcare and dental services for about 3 million Medicaid clients. In fiscal year 2013, these managed care contracts totaled more than $10.2 billion. HHSC's contract oversight functions include reviewing and analyzing quarterly reports, performing desk reviews and onsite audits, collecting and analyzing performance data, and taking enforcement action against managed care organizations as necessary. The Office of Inspector General (OIG) also audits managed care organizations to detect, deter, and investigate fraud, waste, and abuse in the Medicaid program.[7] In addition to overseeing managed care contracts, HHSC, with input from advisory committees and stakeholders, sets policies, defines covered benefits, and determines eligibility for the entire Medicaid program, including both managed care and fee-for-service.

# Findings

## HHSC does not use data or analyze trends to comprehensively evaluate the state's Medicaid program on an ongoing basis.

Although statute requires HHSC to comprehensively evaluate the Medicaid program, the agency's data analysis efforts remain fragmented and reactive.[8] In a strictly fee-for-service world, HHSC's claims administrator could provide for most of the agency's data needs. The addition of 21 separate managed care organizations, combined with the need for ever more sophisticated analysis, makes regular, comprehensive evaluation, such as of service utilization and cost trends, of the program increasingly complex. HHSC's current efforts are limited to forecasting analyses, reviewing dozens of quarterly reports containing a large amount of detailed information, and spot-checking issues in an ad hoc manner only after they are identified.

*HHSC lacks an ongoing effort to analyze trends to identify problems and prevent them from occurring.*

HHSC's lack of a proactive and ongoing effort to look at Medicaid data and trends across all 21 managed care organizations and the remaining fee-for-service population limits the agency's ability to consistently identify problems, understand why these problems occur, and make changes to policy to prevent these issues from escalating or happening again. This also prevents HHSC from determining if an issue is systemic in the Medicaid program or if the issue is unique to a particular managed care organization or region. For example, HHSC's lack of comprehensive data analysis prevented the agency from quickly identifying a recent spike in speech therapies approved for Medicaid clients, determining where and why this trend occurred, and adjusting policy to ensure proper utilization of treatment.

Data and trend analysis is essential to effective program management. However, HHSC has only recently received about $900,000 to fund data analytics staff for a Medicaid program as large and complex as Texas'. In comparison, the state has heavily invested in OIG's efforts, appropriating approximately $20 million in federal and state funding to OIG to develop a data analytics system to identify fraud, waste, and abuse through analysis of claims, encounter data, and other relevant data for the Medicaid program. Although the state's efforts to analyze data for fraud, waste, and abuse purposes are clearly worthwhile, the state has not invested sufficient resources on the front-end to prevent these issues from occurring in the first place. Opportunities exist for the state to better leverage its resources to perform needed data and trend analysis for the Medicaid program.

*HHSC manually enters data to monitor more than $10.2 billion in managed care contracts.*

## HHSC lacks the tools necessary to more efficiently and effectively monitor billions of dollars in managed care contracts.

- **Automated processes.** Managed care organizations submit a significant amount of data to HHSC which staff manually enters into quarterly reports and subsequently re-enters this same data into federally required reports. Manually entering data to monitor more than $10.2 billion in contracts

takes valuable staff time away from providing thorough oversight of managed care organizations, prevents more complex analysis of performance data, and creates potential for errors. In fiscal year 2013, HHSC estimates staff spent more than 6,000 hours, representing approximately $160,000, manually entering data into quarterly and federal reports, time that could be used to more closely monitor these sophisticated organizations.

- **Dashboard.** HHSC lacks a dashboard for agency leadership to easily monitor important performance data and trends necessary to identify potential problems in the Medicaid program. Although the agency produces a variety of reports, these efforts are lengthy, disconnected, and only give a partial picture of the condition of the program. Without a comprehensive document to highlight key performance measures, agency leadership must look through dozens of detailed reports for separate programs, service delivery areas, and managed care organizations, or risk being uninformed about program performance overall. A dashboard contains comparative information that would allow HHSC to distinguish between important high-level measures agency leadership needs to know to identify problems and make corresponding policy changes, versus detailed contract requirements agency staff needs to monitor on a daily basis.

- **Regular evaluation of performance data.** HHSC receives an overwhelming amount of data from managed care organizations, including more than 90 deliverables and reports for each managed care organization, Medicaid program, and service area. However, HHSC lacks a process to regularly evaluate whether data it collects is still needed or if the agency should collect different, more appropriate performance data. For example, the agency does not judge the quality of service provided to Medicaid clients, such as the time it takes managed care organizations to process referrals for specialists or requests for certain benefits or medication that require approval by managed care organizations, known as prior authorizations.

## Several of the agency's processes and programs have not adapted to managed care.

While the state has transitioned from a fee-for-service to managed care delivery model, several agency programs have not fully adapted their roles and processes to provide sufficient oversight of managed care organizations. The nature of managed care may be partly to blame, contributing to a mindset that paying managed care organizations a specified rate more or less leaves these entities free to deliver care with the incentive to earn a profit by containing costs. However, the state still has an interest in ensuring clients receive an appropriate level of care. Some agency programs have been slow adapting to managed care because of a long-standing orientation and expertise in the fee-for-service world, which, as noted, is declining as a proportion of the Medicaid market. This slow adjustment to the evolving managed care environment results in duplication of effort and misallocation of resources as discussed in the following material.

*Some programs have been slow adapting to managed care because of their orientation with fee-for-service.*

● **Audits lack coordination.** HHSC and OIG have not defined the respective roles of their managed care audits, duplicating each other's work and wasting staff time and resources. While HHSC is statutorily required to coordinate all of its oversight activities, including audits of managed care organizations to minimize duplication, OIG, with its free-ranging approach to recouping money for the state, is not required to coordinate its audits.[9] As a result, several of OIG's audits review the same managed care organizations and information that HHSC examines as part of its audits. Also, OIG does not consult with HHSC before to selecting a managed care organization to audit or share its audit plan with HHSC to avoid unnecessary duplication. Further, because OIG learns of prior audits through Google searches, it does not consider results of onsite visits that HHSC performs in response to issues or complaints with the managed care organization that are not formally published documents and do not appear on Google searches. In addition, audits of managed care organizations are different from audits OIG has more experience conducting in the fee-for-service setting, requiring specialized knowledge of contracting for these entities to effectively do the job. Without communication and coordination with HHSC staff more experienced with managed care, these OIG audits run the risk of being ineffective or inaccurate.

*The lack of coordination potentially causes HHSC and OIG to duplicate audits.*

● **Oversight of drug benefits has not adjusted to managed care.** While the agency transitioned prescription drug benefits into managed care in March 2012, HHSC's administration and oversight of these benefits remain focused on the dwindling fee-for-service population a year and a half later.[10] The chart, *Medicaid Prescriptions Filled*, illustrates the sharp decline in prescriptions for fee-for-service clients since managed care organizations began overseeing drug benefits for most Medicaid clients.

### Medicaid Prescriptions Filled
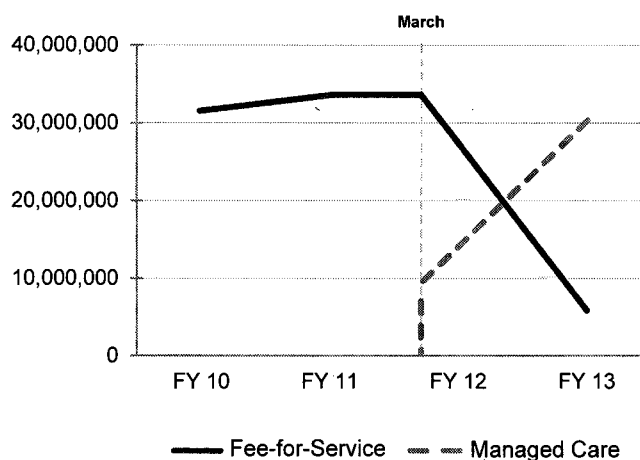


Oversight. HHSC's continued focus on fee-for-service comes at the expense of the state providing sufficient oversight of managed care organizations and their subcontracted pharmacy benefit managers — who perform a similar role for managed care clients as HHSC provides for fee-for-service clients,

such as enrolling providers, approving prior authorizations, and processing and paying prescription drug claims for managed care organizations. As such, the agency cannot ensure these entities meet the needs of their clients or fully implement or comply with state drug restrictions and cost containment initiatives. For example, HHSC does not track whether managed care organizations implement clinical restrictions on drug access designed to ensure that a person's medical condition matches the criteria for dispensing the drug without separate approval through prior authorization. These restrictions, called clinical edits, are to achieve patient safety goals and cost savings associated with the restrictions.

HHSC also lacks comprehensive evaluation of drug data or trends across the Medicaid program, including all 21 managed care organizations and the remaining fee-for-service population. For example, HHSC performs one analysis for fee-for-service and requiring each managed care organization to perform its own separate analysis, preventing the agency from seeing trends across the Medicaid program as a whole.

Regional staff and call center. HHSC still uses regional pharmacists to perform onsite visits and desk reviews of pharmacies serving fee-for-service clients, even though staff's fee-for-service workload has decreased by more than two-thirds, from about 605,000 claims reviewed in fiscal year 2010 to less than 185,000 claims in 2013. Although HHSC repurposed some staff during the last two years, most staff's time is spent on fee-for-service clients. Similarly, the agency's pharmacy call center has seen a two-thirds drop in its call volume over the last four fiscal years. Given the reductions in HHSC's fee-for-service workload and corresponding increase in managed care workload, resources for the agency's regional pharmacists and call center functions could be better used for other aspects of managed care oversight.

*HHSC drug program staff could be better used to provide managed care oversight.*

Committees. Although separate, the Pharmaceutical and Therapeutics Committee (committee) and the Drug Utilization Review Board (board), described further in the textbox, *Selected Medicaid Advisory Committees*, both restrict access to drugs using similar safety, cost, and utilization data. The

### Selected Medicaid Advisory Committees

| Committee | Purpose | Composition |
|---|---|---|
| Pharmaceutical and Therapeutics Committee | Statutorily created committee that recommends to the executive commissioner which drugs should be added to the state's preferred drug list based on the drug's safety, efficacy, and cost.[11] | 11 members, including physicians and pharmacists |
| Drug Utilization Review Board | Federally required board that recommends clinical and utilization restrictions, such as clinical edits and educational interventions, for prescription drugs to the executive commissioner to ensure appropriate prescribing and dispensing of covered drugs.[12] | 10 members, including physicians and pharmacists |
| Medical Care Advisory Committee | Federally required committee that advises the Medicaid agency about health and medical services.[13] | 12 members, including physicians, consumer groups, and the director of the public welfare department |

committee recommends to HHSC's executive commissioner which drugs should be added to the state's preferred drug list, a list of cost-effective drugs that do not require prior authorization. The board recommends clinical edits to drugs and educational interventions for physicians that describe best practices for prescribing medications for their patients.

The preferred drug list, clinical edits, and educational interventions are all tools created by the state to ensure patient safety and contain costs by curbing unnecessary or undesired drug utilization. While not duplicative, the two committees' decisions to implement restrictions on drugs work side by side, and a unified approach with all of the tools described above could more effectively achieve the state's program goals. The two committees' decisions can also depend on one another and would benefit from simultaneous decision making, as described in the textbox example, *Hepatitis C Drug*. Moreover, the state could likely realize cost savings through re-evaluation and potential combination of the three separate vendor contracts — which total about $27.5 million for the life of the contracts — that support these bodies by analyzing similar clinical, cost, and utilization information.

> ### *Hepatitis C Drug*
>
> The Centers for Medicare and Medicaid Services recently required state Medicaid programs to cover a new and very expensive Hepatitis C drug. Texas' Drug Utilization Review Board and Pharmaceutical and Therapeutics Committee considered adding restrictions to control utilization and contain costs for the drug.
>
> Because the board did not approve clinical edits restricting access to the drug, the committee did not add the drug to the state's preferred drug list, because doing so would allow clients broad access to the drug, which the state cannot afford.
>
> Since the committees failed to adopt guidelines for provision of the drug, the executive commissioner will fulfill the committee's duties to adopt restrictions and place it on the preferred drug list. If the committees were able to make such decisions simultaneously, they would have been able to more easily adopt prior authorization criteria for clinical edits and the preferred drug list.

- **Advisory committees lack managed care representation.** While managed care organizations coordinate services for most of the state's Medicaid clients, these organizations lack representation on several key advisory committees whose recommendations directly affect the program's policies. The table on the previous page, *Selected Medicaid Advisory Committees*, describes the purpose and compositions of three committees that help direct Medicaid policy, but which managed care organizations lack representation. As administrators of the program for a large majority of clients, managed care organizations have valuable experience and perspective that would benefit the work of these committees.

# Recommendations

## *Management Action*

### 4.1 Direct HHSC to comprehensively evaluate data and trends for the Medicaid program on an ongoing basis.

As required by statute, this recommendation directs HHSC to collect data and evaluate trends for the entire Medicaid program, including fee-for-service and managed care, to better inform policy decisions, evaluate impacts, and contain rising healthcare costs.[14] HHSC should also consider use of existing

contracts for systems that offer data analytic capabilities on Medicaid data, such as OIG's fraud detection system, to leverage these resources and better analyze trends, utilization patterns, or other issues in the Medicaid program.

## *Change in Statute*

### 4.2 Require HHSC to regularly evaluate the appropriateness of requested performance data and develop a dashboard that identifies key performance data for agency leadership.

- **Evaluate continuing need for data.** This recommendation would require HHSC to evaluate whether data submitted by managed care organizations continues to serve a useful purpose or if other data is needed to oversee contracts or evaluate the Medicaid program as a whole. The intent of this recommendation is to better tailor the data HHSC collects by giving the agency the flexibility to add and remove data through a regularly occurring process. This recommendation would also require the agency to collect managed care data that reflects quality of service to Medicaid clients, such as the time it takes managed care organizations to approve or deny prior authorizations, process physician referrals, and respond to clients' requests for care coordination.

- **Create a dashboard.** This recommendation would also require HHSC to develop a dashboard for agency leadership that identifies only a concise list of key data, performance measures, trends, or problems to help oversee the Medicaid program and compare managed care organizations. For example, the agency could consider including enrollment data, claims processing measures, network adequacy measures, call center volume, complaint trends, or other data important to agency leaders managing the Medicaid program.

## *Management Action*

### 4.3 HHSC should develop a system to automate data entry.

This recommendation would direct HHSC to create an interface that either allows managed care organizations to submit performance and contract data to HHSC online, or that electronically pulls submitted data into a standard reporting format to avoid agency staff manually entering data into reports. HHSC should ensure this system or interface allows the agency to manipulate data to more easily observe trends or outliers when analyzing performance data.

## *Change in Statute*

### 4.4 Require OIG and HHSC to define, in rule, the respective roles and purpose of managed care audits and to coordinate all audit activities.

This recommendation would require both OIG and HHSC to define, in rule, the roles, jurisdiction, and frequency of their managed care audits. This change in law would also require OIG to coordinate all audit and oversight activities with HHSC to minimize duplication, including requiring OIG to seek input from HHSC and consider previous HHSC audits and onsite visits before determining which managed care organization to audit. To further improve coordination, OIG and HHSC would share audit plans, risk assessments, and findings on an annual basis. OIG should request, and HHSC should share, results of any informal audits or onsite visits that could inform OIG's risk assessment when choosing or scoping an audit of a managed care organization.

## Management Action

### 4.5  Direct HHSC to redefine the role of its prescription drug program to provide better oversight of drug benefits in managed care.

This recommendation would list activities for HHSC's prescription drug program to oversee drug benefits in managed care, including:

- assisting other divisions within the agency oversee drug benefits and compliance with associated contract requirements administered by managed care organizations and their sub-contracted pharmacy benefit managers;

- monitoring performance data specific to prescription drug benefits on both a comprehensive basis and specific to each managed care organization or entity still under fee-for-service;

- supporting the functions and evaluating the impact of drug restrictions recommended by any advisory committees; and

- performing other activities to ensure Medicaid clients have access to needed medication.

As part of this recommendation, HHSC should eliminate positions for regional pharmacists and reduce the size of its call center to align with the remaining fee-for-service workload.

## Change in Statute

### 4.6  Eliminate the Pharmaceutical and Therapeutics Committee, transfer its functions to the Drug Utilization Review Board, and expand the repurposed board's membership to include managed care representation.

This recommendation would eliminate the Pharmaceutical and Therapeutics Committee and transfer the committee's statutory duties to the Drug Utilization Review Board, creating a single advisory board that would:

- recommend drugs for the state's preferred drug list;

- suggest restrictions, or clinical edits, on prescription drugs;

- recommend educational interventions for Medicaid providers;

- review drug utilization across the Medicaid program; and

- other duties specified by state or federal law.

All confidentiality provisions that currently apply to committee members would apply to members of the repurposed Drug Utilization Review Board. The board would meet at least quarterly, make recommendations to the executive commissioner, and elect its own chair.

This recommendation would change the composition of the repurposed board to include 11 members, including five physicians, five pharmacists, and one managed care organization serving as a non-voting member. While allowed to participate in quarterly meetings, the non-voting member would not attend executive sessions or access confidential drug pricing information.

This recommendation would provide that all current board member terms expire on September 1, 2015. Future members would be appointed by the executive commissioner to serve four-year, staggered terms. To provide continuity and expertise on the board, the executive commissioner should consider

reappointment of some current members of the two committees. HHSC would be directed to re-evaluate the need for having three separate vendors provide similar data to inform the board's decision making process. HHSC should also amend its rules to reflect changes to the board's functions and membership by January 1, 2016.

### 4.7  Expand the Medical Care Advisory Committee's membership to include managed care representation.

This recommendation would add one managed care organization to the membership of the Medical Care Advisory Committee, increasing its membership from 12 to 13 members. HHSC should amend its rules to reflect changes to the committee's membership by January 1, 2016.

## Fiscal Implication

These recommendations would have no net fiscal impact to the state. Any recommendation that would have an associated cost would be offset by savings from a reduction in staff.

Although the agency has not yet fully staffed its new Medicaid data analytics area, comprehensive evaluation of Medicaid data and trends could require additional resources. While HHSC estimates providing further analysis would require three additional staff and have an estimated cost of about $221,000 per year, any associated costs would be offset by savings from the reduction of staff in the agency's prescription drug program. Also, HHSC should consider whether current data analytics contracts could aid in evaluating the Medicaid program.

Directing HHSC to develop a system to avoid manual data entry for reports would have a one-time cost, but this cost could not be estimated and any associated costs would likely be offset by savings from not manually entering data into reports, estimated at $160,000 in fiscal year 2013. Requiring HHSC to regularly evaluate the ongoing need for data and to develop a dashboard of key performance measures would not result in additional costs to the state.

Directing HHSC to redefine the role of its prescription drug program would repurpose resources and positions for 20 staff, whose annual salaries total about $1 million, including six regional pharmacists, eight regional pharmacy assistants, and six call center staff. Resources that have been dedicated to activities predominantly associated with fee-for-service would be available to take on new responsibilities overseeing managed care organizations. HHSC should repurpose these positions or resources to:

- provide oversight and monitor pharmacy drug-related contract provisions for managed care organizations and pharmacy benefit managers,

- evaluate prescription drug benefit data and trends for the agency's prescription drug program,

- expand the managed care call center to accommodate the increase in workload associated with expansions of managed care, and

- expand the agency's efforts to evaluate Medicaid data, as described in Recommendation 1.1.

Combining the Pharmaceutical and Therapeutics Committee and the Drug Utilization Review Board into a single advisory board could result in a small amount of savings from less staff time spent preparing for meetings and reduced travel expenditures for fewer board members. However, these savings will likely be offset by the increase in duties for the repurposed board. Consolidating the three vendor contracts that support the separate committees will likely result in savings, but these savings could not

be determined for this report. Total cost for these three vendor contracts is about $27.5 million for the life of the contracts.

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

¹    H.B. 7, 72nd Texas Legislature, First Called Session, 1991.

²    Texas Health and Human Services Commission, *Texas Medicaid and CHIP in Perspective*, Ninth Edition (Austin: Health and Human Services Commission, 2013), p. 7-1.

³    Ibid.

⁴    Subchapter E, Chapter 534, Texas Government Code.

⁵    *Texas Medicaid and CHIP in Perspective*, pp. 7-3 – 7-6.

⁶    HHSC may choose whether to provide all long-term services and supports through managed care, as specified in Section 534.202(c)(2), Texas Government Code.  Some recipients of long-term care services and supports through Medicaid waiver programs may choose to continue receiving benefits under the waiver program, instead of managed care, as specified in Section 534.202(c)(1)(B), Texas Government Code.

⁷    Section 531.102(a), Texas Government Code.

⁸    Sections 531.0082, 531.0214, and 531.02141, Texas Government Code.

⁹    Section 533.015, Texas Government Code.

¹⁰   S.B. 7, 82nd Texas Legislature, Regular Session, 2011.

¹¹   Section 531.074, Texas Government Code.

¹²   42 C.F.R. Section 456.716.

¹³   42 C.F.R. Section 431.12.

¹⁴   Sections 531.0082, 531.0214, and 531.02141, Texas Government Code.

# ISSUE 5

*Fragmented Provider Enrollment and Credentialing Processes Are Administratively Burdensome and Could Discourage Participation in Medicaid.*

## Background

All Texas healthcare providers who serve Medicaid clients must enroll with the state to receive payment for services.[1] The textbox, *Common Medicaid Providers*, lists the most common types of Medicaid providers. In fiscal year 2013, more than 114,000 providers were enrolled in Medicaid in Texas.

- **Enrollment.** To enroll in Medicaid, most providers must first enroll in Medicare with the Centers for Medicare and Medicaid Services.[2] Once enrolled in Medicare, providers submit an application to the Health and Human Services Commission's (HHSC's) provider enrollment contractor, which validates provider application information, verifies licensure or certification, checks to see if the provider has been excluded from programs like Medicare or Medicaid by another state or the federal government, and determines whether providers meet criteria to participate in the Medicaid program. Providers serving in multiple care settings or as multiple provider types may need to complete separate enrollment processes and receive operating authority from other health and human services agencies.

| Common Medicaid Providers |
| --- |
| • Physicians |
| • Nurses |
| • Pharmacists |
| • Therapists |
| • Dentists |
| • Behavioral health specialists |
| • Hospitals |
| • Nursing homes |

  Once enrollment applications are reviewed by the appropriate state agency, the Office of Inspector General (OIG) conducts background checks of Medicaid providers, including verifying licensure or certification, reviewing criminal history information, reconciling state and federal exclusion database hits, and performing onsite visits for moderate and high-risk providers.[3]

- **Credentialing.** In addition to enrolling in Medicaid, providers serving clients in managed care go through a separate credentialing process for each managed care organization with which they wish to contract to provide services.[4] Providers submit a standard application to either a centralized, third-party credentialing entity or directly to a managed care organization. Each managed care organization validates provider information and determines whether providers meet the organization's professional standards and network needs. Once credentialed, managed care organizations may contract with providers to serve their Medicaid clients. In fiscal year 2013, approximately 68,000, or 60 percent, of Medicaid providers were credentialed by one or more managed care organizations.

- **State and federal changes.** The federal Patient Protection and Affordable Care Act made several changes to the Medicaid enrollment process, including for the first time requiring providers to re-enroll in Medicaid; strengthening background check requirements, including fingerprinting, federal database checks, and onsite visits; and implementing stricter ownership and control interests for all Medicaid providers. The 83rd Texas Legislature also required HHSC to develop a plan to reduce administrative burdens for providers participating in Medicaid managed care by creating a prompt enrollment and credentialing process.[5]

# Findings

## Lengthy and cumbersome enrollment processes may well contribute to the growing unwillingness of providers to participate in Medicaid, to the detriment of client access to services.

Ensuring clients can access healthcare services through an adequate provider network is one of the basic tenets of the Medicaid program. However, an increasingly complex Medicaid system and associated administrative burdens, together with low reimbursement rates, make it difficult for the state to attract physicians to participate in the program. The state's lengthy enrollment and credentialing processes — which takes from three to nine months, and in some exceptional cases, over a year — also contribute to providers' unwillingness to serve Medicaid clients, which can impact clients' access to needed healthcare services. The chart, *Physicians Willing to Accept New Medicaid Clients*, shows the significant decrease in physicians willing to accept new Medicaid clients, decreasing from 67 percent in 2000 to 31 percent in 2012.[6]

**Physicians Willing to Accept New Medicaid Clients**

| | |
|---|---|
| 80% | |
| 60% | |
| 40% | |
| 20% | |
| 0% | |
| | 2000  2002  2004  2006  2008  2010  2012 |
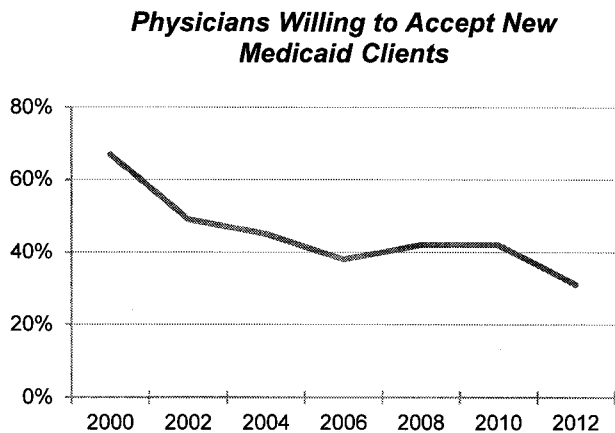
## Fragmentation and disconnects in the Medicaid enrollment and credentialing processes persist as efforts to eliminate burdens have stalled.

The state's enrollment process is fragmented across six different entities, as described in the textbox, *Provider Enrollment Entities*. Similarly, the managed care credentialing process is separated from the state enrollment process and required for each individual managed care organization. Agency efforts to address this fragmentation and associated inefficiencies have been continually delayed.

---

### Provider Enrollment Entities

- **Centers for Medicare and Medicaid Services** – Enrolls providers in Medicare

- **HHSC** – Enrolls pharmacies and oversees enrollment broker contract

- **Provider Enrollment Contractor** – Enrolls physicians, nurses, dentists, therapists, and durable medical equipment providers

- **Department of Aging and Disability Services** – Enrolls, licenses, and contracts with long-term care providers, such as nursing homes and home health agencies

- **Department of Assistive and Rehabilitative Services** – Enrolls early childhood intervention specialists

- **OIG** – Conducts background checks

---

● **Multiple enrollment processes.** Providers operating in different care settings or as multiple provider types must enroll separately for each type or setting, creating an administrative burden for both providers and the state. For example, a home health agency that provides services in both acute and long-term care settings must enroll as a provider through both HHSC and the Department of Aging and Disability Services (DADS). Similarly, a pharmacy that sells wheelchairs would enroll as a pharmacy with HHSC's prescription drug program and as a durable medical equipment provider through the state's provider enrollment contractor. Requiring providers to navigate the state's complex enrollment system and submit multiple applications containing similar information to different state agencies wastes resources and delays services to Medicaid clients.

*Provider information is not shared between enrollment and credentialing processes.*

● **Uncoordinated credentialing process.** Provider information is not shared between the state's enrollment and managed care organizations' credentialing processes, causing providers to submit the same information multiple times to participate in Medicaid managed care. In addition, not all provider information is shared within the managed care system for providers credentialed by managed care organizations. Fifteen of the 21 managed care organizations and dental maintenance organizations use a centralized, third-party credentialing database, which serves as a hub to collect, store, and share provider information so providers only have to submit their information once. However, for those managed care organizations that do not use a centralized credentialing database, providers must submit multiple applications to be able to contract.

● **Delayed improvements.** More than three years after HHSC first proposed changes to streamline the provider enrollment and credentialing processes, most of these changes have still not been implemented. In 2011, recognizing the strain and hassle the enrollment and credentialing processes place on providers, HHSC formalized a list of over 100 system and process improvements into a contract amendment for its provider enrollment contractor. The textbox, *Proposed Changes to the Enrollment and Credentialing Processes*, lists examples of improvements HHSC planned to make to these processes.

> **Proposed Changes to the Enrollment and Credentialing Processes**
>
> ● Create a centralized provider enrollment database for all provider types
>
> ● Hire additional staff to re-enroll current providers
>
> ● Implement electronic signature technology
>
> ● Improve an online provider directory

Constant delays, including waiting for federal funding, changes in the state's provider enrollment contractor, and 19 revisions to its contract amendment, have slowed efforts to eliminate administrative burdens and simplify the process for providers to participate in Medicaid. While many of these delays have now been resolved, the agency has still not made needed improvements and is currently reevaluating whether its list of enhancements continues to meet the functional and strategic goals of the agency. Meanwhile, providers are still stuck navigating the state's outdated and onerous enrollment and credentialing processes.

## OIG's criminal background check process lacks guidelines, duplicates efforts of state licensing boards, and unnecessarily delays the enrollment process.

- **Lacks criminal history guidelines.** OIG lacks criminal history guidelines to lay out considerations for staff in making decisions to ensure consistency in determining which violations or criminal offenses prevent providers from participating in Medicaid. Without guidelines, staff risks unfairly recommending different decisions for providers with the same violation. Providers may also be unaware of eligibility criteria for Medicaid participation before applying and lack a clear process for offering input.

- **Takes too long.** While HHSC estimates it takes OIG an average of 30 days to complete criminal background checks, OIG does not track the overall average length of time to complete this process. In contrast, other parts of the enrollment process, such as validation of applications by the provider enrollment contractor, are required to complete tasks in a specified period of time and track data to ensure compliance with those time requirements. Given the lengthy timeframe for the enrollment process overall, established timeframes would enable more efficient processing of provider applications. In some cases, lengthy timeframes result from factors outside of OIG's control. Additional requirements in the Affordable Care Act, such as for site visits and verification of provider ownership interests, can lengthen OIG's background check process, as does submission of incomplete applications by providers. Tracking the length of time for completing background checks will enable OIG and HHSC to identify when delays are due to backlogs as opposed to factors outside of OIG's control.

*Medicaid providers should not be held to a different standard than is required to practice their professions.*

- **Duplicates work of licensing boards.** OIG's screening of physicians, nurses, and many other providers duplicates criminal history checks performed by state licensing boards, delaying the enrollment process and wasting state resources. Licensing boards, such as the Texas Medical Board, Texas Pharmacy Board, and Texas Nursing Board, also must review criminal history information to determine if a provider meets minimum standards to practice their profession in the state. Unlike OIG, these boards use more advanced, fingerprint-based checks which largely provide automatic notice if providers commit a crime after initial review, ensuring providers continue to meet standards to practice in Texas. OIG already receives updates from major licensing boards on board actions, including actions based on criminal history information that affects providers' ability to participate in Medicaid. Medicaid providers should not be held to a different criminal history standard than healthcare providers the state deems fit to practice on the general population, including vulnerable populations such as children and persons with a disability. The process for checking a provider's criminal history should not be confused with separate OIG processes for checking exclusion lists for infractions specific to Medicaid or Medicare and disciplinary actions by licensing boards that would affect a provider's ability to participate in Medicaid.

Further, the state already relies on licensing processes to check criminal history information for long-term care facilities that are regulated and enrolled in Medicaid by DADS. Narrowing OIG's criminal history checks to providers not already screened by licensing boards, such as durable medical equipment providers, would enable the state to gain efficiencies by taking advantage of other state resources.

In addition to licensing boards and OIG, HHSC's provider enrollment contractor and managed care organizations also verify licensure and state and federal Medicaid exclusion lists, including OIG's open investigations list. Four layers of background checks are not necessary to ensure the state does not enroll providers prohibited from participating in Medicaid.

- **Does not review all revocation information.** Unlike an exclusion from the Medicaid program, which is a penalty barring participation, Medicare or state Medicaid programs may terminate a provider whose billing privileges have been revoked for a specified period of time. However, as part of its background check process, HHSC and OIG do not check the federal revocation list for terminated providers, as required by federal law.[7] As a result, providers prohibited from participating in Medicaid are still providing and billing for Medicaid services in Texas. Regular review of termination and revocation information is needed to comply with federal law and to avoid paying Medicaid providers for services that legally should not be provided.

> *The state does not review federally required revocation information.*

## Recommendations

### *Change in Statute*

**5.1  Require HHSC to streamline the Medicaid provider enrollment and credentialing processes by creating an enrollment portal and better linking data within the process.**

This recommendation would require HHSC to create a centralized enrollment portal and authorize the agency to share information with, or require managed care organizations to use, a centralized credentialing database in an effort to streamline and speed up the timeframes for a provider to participate in the Medicaid program.

- **Create an enrollment portal.** This recommendation would require HHSC to create a centralized, web-based portal for providers to enroll in Medicaid. Instead of applying to multiple agencies to participate in the program, providers would submit a single application through the front-end enrollment portal. Provider information submitted through the portal would interface with the appropriate health and human services agency for the provider's type and care setting. Providers needing to receive a license or contract with a state agency before enrolling in Medicaid would automatically be redirected from the portal to the appropriate agency. Provider applications would also be routed to OIG to verify background information as needed.

- **Streamline and centralize credentialing processes.** This recommendation would provide broad authority for HHSC to streamline the managed care credentialing processes. Specifically, it would authorize HHSC to share information directly from the state's provider enrollment database with

a centralized credentialing entity. With this change, providers would not have to provide their information to both the state for enrollment purposes and a third-party credentialing entity or managed care organization for credentialing. The recommendation would also authorize HHSC to require all managed care organizations to use the same centralized credentialing entity as a hub for collecting and sharing information to prevent providers from having to submit multiple managed care credentialing applications.

In addition, this recommendation would authorize HHSC to create a single, consolidated enrollment and credentialing process or contract with a third-party entity to perform this function, if cost effective. HHSC should develop a workgroup to determine the feasibility of creating a centralized enrollment and credentialing process for providers either through the state or by contracting with a third-party entity. The goal of the workgroup should be to create a process for providers to enroll in Medicaid and managed care simultaneously and without submitting the same information multiple times through two different processes. The workgroup should determine cost implications for these approaches and consider options to further streamline the provider enrollment and credentialing processes; reduce administrative burdens and costs for providers and the state; and address potential issues, such as the impact to managed care organizations' national accreditation. This recommendation would also provide for exempting Medicaid managed care organizations from the requirement in the Insurance Code to credential providers every three years, in the event HHSC consolidates the enrollment and credentialing process.[8] Under the Affordable Care Act, states must re-enroll providers in Medicaid every five years, which, through this consolidated approach, would provide for credentialing in the same time frame.

The workgroup should include staff of the agencies involved in the enrollment process, providers representing different types and care settings, managed care organizations, and other stakeholders familiar with the enrollment and credentialing processes. HHSC should begin this workgroup by January 1, 2015 and implement the workgroup's recommendations by September 1, 2016. Nothing in this recommendation would affect managed care organizations' authority to extend contracts only to providers they approve for inclusion in their networks.

## 5.2 Provide that OIG no longer conduct criminal history checks for providers already reviewed by licensing boards.

This recommendation would limit OIG's criminal history checks to providers not already subject to fingerprint-based criminal history checks by state licensing boards. Licensing boards are well equipped to review criminal history information. OIG should determine which providers do not have fingerprint-based criminal history checks and continue performing criminal history checks for those provider types. Licensed providers that pass fingerprint criminal history checks performed by a licensing board and are eligible to practice in Texas would still be subject to additional OIG screening related to federal or state exclusions, open OIG investigations, or other criteria that prohibits participation in the Medicaid program.

As part of this recommendation, OIG would reach out to licensing boards to verify licensure information and receive regular updates on board actions against providers, as it does for some professions now. Licensing boards would notify OIG if a provider is no longer in good standing or if the board has taken disciplinary action against a provider, such as for inappropriate sexual conduct or professional boundary issues. In these situations, OIG, in consultation with HHSC, would determine whether a provider remains fit to participate in Medicaid, as it does now. This recommendation is limited to fingerprint criminal history checks conducted for Medicaid provider enrollment or re-enrollment, and does not affect OIG or HHSC's authority to make interim determinations based on licensing board disciplinary actions.

As part of its background check process, OIG should also check the federal revocation list to ensure terminated providers are not allowed to participate in Medicaid because of a suspension of billing privileges for Medicare or other state Medicaid programs, as required by federal law.

The state's provider enrollment contractor and managed care organizations should also defer to OIG or licensing boards to ensure providers meet criteria to participate in the Medicaid program.

### 5.3 Require OIG to develop criminal history guidelines for provider types for which it conducts background checks.

For providers not subject to fingerprint-based criminal history checks by licensing boards, OIG would establish guidelines, in rule, for evaluation of criminal history information when determining an applicant's eligibility to participate in Medicaid. To ensure eligibility decisions are made consistently and fairly, OIG would define which offenses prohibit participation in the Medicaid program for each provider type. Criminal history offenses that prohibit participation in Medicaid should be related to the extent the underlying conduct relates to the provider's job, level of interaction with the client, or previous evidence of fraud, waste, or abuse. This recommendation would also require OIG to seek public input on the guidelines and publish its guidelines in the Texas Register.

### 5.4 Require OIG to complete provider background checks within 10 business days.

This recommendation would require OIG to complete all background checks within 10 business days for providers who submit complete applications. For providers not screened by state licensing boards, OIG would be required to conduct criminal history checks, review exclusion lists, and check for open investigations within 10 business days. For providers screened by state licensing boards, OIG would verify a provider's license is in good standing with the state, review exclusion lists, and check for open investigations within 10 business days. The 10-day requirement would not include completion of an on-site visit. OIG would also be required to develop performance metrics to measure the length of time for completing background checks for complete applications, as well as for completion of background checks for all applications.

## Fiscal Implication

These recommendations would have no significant fiscal impact to the state.

HHSC could not estimate costs associated with creating a web-based enrollment portal, but believes costs would be akin to other web-based projects estimated at $1 million. HHSC has received federal approval and funding for related provider enrollment projects that could be applied to this web-based portal. HHSC should try to maximize these federal funds to offset any costs associated with creating an enrollment portal.

Authorizing HHSC to share information with a third-party credentialing entity or requiring managed care organizations to use a centralized credentialing entity would have no fiscal impact to the state, as three-fourths of managed care organizations already use a centralized credentialing entity.

While requiring OIG to complete background checks within 10 business days could require more staff to process applications faster, any costs would be offset by a reduction in workload from limiting OIG's criminal history checks to providers not screened by state licensing boards. Instead of performing criminal history checks for all types of providers, OIG would redirect staff to focus on screening providers who

have not already gone through a criminal background check process as part of their licensing requirement and speeding up the background checks it does provide.

Requiring OIG to check the federal revocation list when conducting background checks would likely result in a small savings for the state because providers not eligible to bill Medicare or other state Medicaid programs would also not be reimbursed for Medicaid services in Texas.

1    T.A.C. Section 352.13.

2    42 C.F.R. Part 455, Subpart E; and 1 T.A.C. Chapter 371, Subchapter E.

3    42 C.F.R. Section 455.434; and 15 T.A.C. Subchapter E.

4    42 C.F.R. Section 438.214; and Chapter 1452, Subchapter A, Texas Insurance Code.

5    S.B. 1150, 83rd Texas Legislature, Regular Session, 2013.

6    Texas Medical Association, *Survey of Texas Physicians* (Austin: Texas Medical Association, 2012), p. 12.

7    42 C.F.R. Sections 424.535 and 455.416.

8    Section 1452.004, Texas Insurance Code.

# ISSUE 6

*The State Is Missing Opportunities to More Aggressively Promote Methods to Improve the Quality of Health Care.*

## Background

Over the past several sessions, the Legislature has significantly expanded efforts to measure the quality of health care and promote better healthcare outcomes for clients. Agencies across the health and human services system administer about 270 different initiatives intended to improve the quality and outcomes of their programs. Focusing on outcomes to improve quality of care helps to contain costs, better direct policy decisions, and ensure that the state's expansion of the managed care model in Medicaid does not inappropriately affect needed services to clients. The system's most significant quality initiatives include paying providers in new ways that encourage quality outcomes and applying various financial incentives and penalties to managed care organizations and hospitals that are tied to performance requirements.

In addition, in 2011, the state received a waiver from certain federal Medicaid requirements (the Texas Health Care Transformation and Quality Improvement Program 1115 Waiver) which allows Texas to expand its managed care efforts statewide and funds Delivery System Reform Incentive Payment (DSRIP) program projects. The 1115 waiver provides up to $11.4 billion in DSRIP funding for nearly 1,500 local healthcare projects, which aim to improve the quality of health care.[1] Examples of DSRIP projects designed to contain costs and improve quality are listed in the textbox, *DSRIP Project Examples*.

| *DSRIP Project Examples* |
| --- |
| • Use of a medical home to better coordinate a patient's care |
| • Emphasis on preventive care |
| • Establishment of triage or urgent care centers with longer hours to avoid unnecessary emergency department visits |
| • Integration of behavioral health and primary care services |
| • Use of apps and social media to communicate reminders and tips to promote preventive and follow-up care |

## Findings

### HHSC lacks a cohesive vision for improving the quality of health care, ultimately limiting its ability to accomplish meaningful change to improve healthcare delivery in the state.

The state's primary efforts to improve the quality of health care do not work together, creating missed opportunities for synergy, potentially duplicating effort, and impeding the broad change in healthcare delivery intended to improve the overall healthcare system. Health and Human Services Commission (HHSC) administers the three largest quality initiatives. These initiatives, administered in separate, uncoordinated areas of the agency, set up financial incentives or penalties tied to performance. The table on the following page, *HHSC's Separate Quality Initiatives*, describes in more detail quality initiatives for managed care organizations, projects funded with DSRIP funds, and hospital reimbursement rates.

---

### HHSC's Separate Quality Initiatives

**Managed Care Organizations**

Pay-For-Quality Program. Managed care organizations are subject to incentives and disincentives of up to 4 percent of the monthly payment, typically called a capitated rate, based on performance on a series of quality measures, which include potentially preventable health-related events. Some managed care organizations create programs or offer incentives to clients to improve their own health in an effort to improve the organization's overall performance.

Performance Improvement Projects. Managed care organizations must design projects to improve performance on specific initiatives designated by HHSC, often related to conditions driving costs in the different regions.

**DSRIP Projects**

Local providers choose projects from a state-selected menu of topics, subject to federal approval. Providers must demonstrate outcomes and quality improvement in local healthcare projects for continued funding.

**Hospital Reimbursement Rates**

HHSC lowers fees paid to hospitals for specific Medicaid services by 1 to 2 percent for poor performance related to potentially preventable re-admissions and by 2 to 2.5 percent for poor performance related to potentially preventable complications. The fee-for-service rate reductions for hospitals participating in managed care are reflected in reductions to the managed care organization's capitated rate.

---

- **Lack of coordination creates missed opportunities.** Given the size and complexity of the healthcare system, HHSC should coordinate its quality efforts to ensure all the components of the system are working toward the same shared vision. In every area of the state, managed care initiatives and DSRIP projects independently target overlapping populations to achieve the same goals, creating potential duplication and missed opportunities to collaborate on projects to achieve better outcomes.[2] Some of the most common overlapping projects aim to reduce use of unnecessary services or emergency room visits through efforts such as increased preventive care visits, expanded clinic hours, follow-up efforts to ensure adherence to medications, and implementation of chronic disease management techniques.

*The wide range of DSRIP projects presents difficulties in evaluating or comparing projects.*

The state has an opportunity to reduce such overlap and increase collaboration by seeking changes when renewing the 1115 waiver, which is assumed likely in 2016. DSRIP projects are locally selected from a very large, state-directed menu that includes 33 topic areas. While this approach provides local flexibility, the menu is too broad to focus the state on efforts most likely to transform the healthcare system to improve outcomes. The wide range of projects creates difficulties for the state in evaluating or comparing projects, determining which projects are most successful, and gleaning best practices to expand across the state. In addition, allowing local projects to select their own outcome metrics does not ensure project measures are in line with established standards for measuring quality and may not be best suited for analysis of statewide impact of similar projects.

- **Increased complexities and administrative burdens.** If not aligned, quality initiatives can increase the complexity of the healthcare system and the administrative burden for providers. When providers have different or conflicting targets for performance, providers struggle to appropriately adjust their practices and have difficulty achieving the targets. To improve quality of care in the most efficient manner, measures and reporting must be consistent across the initiatives if they are to move toward the same goal. As an example, potentially preventable re-admissions are measured at 15 days in some programs and 30 days in others.

  In addition, HHSC should consider the cumulative effect of various quality initiatives on providers. For example, performance requirements for managed care quality initiatives ultimately affect providers, including hospitals that are subject to their own, separate financial penalties for performance. HHSC must carefully craft its quality initiatives to ensure that the programs do not unfairly penalize participants involved in multiple programs.

## Most providers are not paid under managed care in ways that contain costs and incentivize quality of care.

*A fee-for-service approach can incentivize more — instead of better — care.*

While the state pays managed care organizations on a capitated basis, managed care networks continue to pay the large majority of providers a fee for services delivered. This approach can incentivize providers to bill based on volume, providing more care instead of necessarily better care and increasing costs.

Moving away from the fee-for-service approach is the final frontier of cost savings under the current managed care model. In 2013, HHSC amended managed care contracts to require managed care organizations to develop a plan to move away from strictly fee-for-service payments and use alternative payment structures to incentivize providers for quality improvement efforts. Incentive-based payments could decrease volume-based billings, creating cost savings for managed care organizations and the state, as well as incentivize providers to focus on outcomes and quality of care. The textbox, *Examples of Incentive-Based Payments Used by Managed Care Organizations*, lists different types of payment structures employed by various managed care organizations in lieu of traditional fee-for-service payments.

---

### Examples of Incentive-Based Payments Used by Managed Care Organizations

- Shared savings or shared risks between providers and managed care organizations

- Accountable care organizations in which providers are paid based on quality outcomes for clients

- Capitated payments to providers

- Bundled payments for common service packages, such as all services required for a knee replacement

- Bonuses for a provider's performance on quality initiatives

---

*Managed care organizations have little incentive to initiate payment reform on their own.*

HHSC's analysis of managed care organization's current use of incentive-based payments determined that the amount of money and number of members involved in incentive-based payment structures are low as compared to overall payments and membership. Managed care organizations are slow to implement incentive-based payments because of providers' reluctance to change payment methods, ultimately leading to managed care organizations' concerns about impacts to sometimes fragile Medicaid provider networks. Managed care organizations also may have little financial incentive to implement incentive-based payments of their own initiative for various reasons, such as difficulty in negotiations with providers, a lack of projected savings, or concern that any savings will be reflected in their financial experience and reduce the next year's payment from the state. Successful incentive-based payment reforms should incentivize a managed care organization by allowing both the organization and the state to save money while increasing quality.

While the state could benefit from requiring managed care organizations to more aggressively implement incentive-based payments, an uncoordinated approach could be disruptive for providers, clients, and managed care organizations. If managed care organizations in the same service areas do not coordinate their approaches, providers may participate in several different payment structures at once, which would be administratively burdensome. Further, if a managed care organization implements a more complex payment method than its competitor, providers may switch to another managed care organization, causing service disruptions for clients and placing the managed care organization at risk of not complying with requirements to maintain an adequate provider network.

## Recommendations

### *Change in Statute*

**6.1    Require HHSC to develop a comprehensive, coordinated operational plan designed to ensure consistent approaches in its major initiatives for improving the quality of health care.**

This recommendation would require HHSC to develop a plan to include broad goals for improving the quality of health care as a whole and Medicaid in particular. HHSC would be required to revise its major quality initiatives as necessary to ensure the initiatives work toward these common goals, including ensuring that the same measures are reported consistently across initiatives for better evaluation of statewide impact. The executive commissioner should develop this plan in conjunction with seeking renewal of the 1115 waiver.

In implementing this recommendation, when seeking renewal of the 1115 waiver, HHSC should use its experience to narrow the menu of DSRIP projects to those most critical for improving the quality of health care in the state, including behavioral health, consistent with the plan above. HHSC should be sure to take into account unique local and regional healthcare needs and diversity. HHSC may grandfather existing DSRIP projects excluded from the new menu, as long as they continue to meet their funding requirements and outcome objectives. HHSC could also include a category for other innovative projects if the agency is concerned that its menu may not be broad enough to allow for local flexibility or innovation. HHSC should also consider developing ways to incentivize coordination across

these various quality initiatives. For example, HHSC could seek approval to set aside or use remaining DSRIP funds to create a performance bonus pool to be spread among high-performing DSRIP providers that coordinate projects with managed care organizations in the region.

### 6.2 Require HHSC to develop a pilot project to promote increased use of incentive-based payments by managed care organizations.

This recommendation would require HHSC to develop a pilot project to increase managed care organizations' use of incentive-based payments to providers. HHSC should create a workgroup made up of managed care organizations and provider associations to develop the details of the pilot program, including, at a minimum, the following elements:

- identifying a managed care service delivery area and managed care programs to be included and requiring all managed care organizations in the service delivery model to participate in the program;

- determining which type of incentive-based payment structures to pilot and which services most appropriately fit in that payment structure; and

- determining timelines for implementation of the incentive-based payment pilot program to begin on or before January 1, 2017.

HHSC should use the pilot program to determine which types of incentive-based payment structures and services would be most appropriate for expansion statewide for inclusion in managed care contracts by September 1, 2018.

### *Management Action*

### 6.3 Require HHSC to include a requirement for use of incentive-based payments in managed care requests for proposals and better define types of incentive-based payments.

HHSC should include, as part of future requests for proposals for Medicaid managed care contracts, requirements related to incentive-based provider payment reform. HHSC could then evaluate how aggressively managed care organizations approach payment reform and score proposals to award more points to managed care organizations that commit a higher percentage of their funds to incentive-based payments.

To promote wider use of incentive-based payment structures, HHSC should also better define types of incentive-based payment structures to promote consistency in language and approach among managed care organizations. HHSC should also continue to require managed care organizations, as part of their contracts, to report types of incentive-based payment structures used and to what extent.

## Fiscal Implication

These recommendations would not result in additional costs to the state and could create long-term savings for both Medicaid and the healthcare system at large. Aligning quality initiatives could create more effective programs and collaborations to enhance existing efforts to reduce expensive costs, such as for emergency room care, through increased focus on preventative care. Similarly, incentive-based provider payments would decrease billing incentives based on volume by transferring that focus to improved quality of care for clients.

¹    Lisa Kirsch, Health and Human Services Commission, testimony before the House County Affairs Committee (Austin, May 15, 2014).

²    Several managed care performance improvement projects exist statewide.

# ISSUE 7

*HHSC Lacks a Comprehensive Approach to Managing Data, Limiting Effective Delivery of Complex and Interconnected Services.*

## Background

The five agencies in the Texas health and human services system collect and generate mountains of information while administering hundreds of programs. Used generically, human services "data" can mean detailed electronic records of an individual's benefits provided through programs such as Medicaid; or information compiled more broadly to monitor and improve public health, such as registries that record incidence of specific diseases like cancer. The textbox on the following page, *Examples of Human Services Information Collected*, provides a high-level overview of key data retained by the system. According to informal estimates, the total volume of information maintained by system agencies could top 200 terabytes of data. For comparison, a digitized version of the Library of Congress's 17 million printed holdings would total about 136 terabytes; while all data sent from the Hubble Telescope from its first 24 years was about 100 terabytes.[1]

The primary use of all of this information is to manage the day-to-day administration of diverse programs — determining who is eligible to receive services, identifying appropriate providers to deliver services, processing payments, and checking compliance with funding and contract requirements. The system's approximately 800 underlying data systems are decentralized among responsible programs and other state and federal agencies with primary control over the data, with maintenance often resting with information technology (IT) managers or contractors.

As technology and the volume of compiled data have evolved in recent years, so have the potential powerful uses of this information for more strategic purposes, as shown in the textbox, *Key Data Uses*. However, distilling so much data into information that can inform policy must be carefully managed to be meaningful. For example, administrative data collected when running a program can be used to better understand issues within client populations, such as incidence of conditions like diabetes or mental illness driving poor outcomes and higher costs, or other potential red flags indicating fraud or waste. The growing ease of collecting and transmitting so much information, much of it regulated by federal and state privacy laws governing who may use or disclose the information and how long it may be retained, has also increased the risk of its inappropriate use or disclosure and demands better management and control.

> ### Key Data Uses
>
> - **Measure performance**: Report on immediate program activity, such as goals required by the Legislature in the General Appropriations Act, or metrics developed internally to track service delivery and outcomes. Examples: applications received and processed; number of clients served; response time; disease rates.
>
> - **Measure progress**: Report on achieving program outcomes over time, requiring consistent data over longer periods to draw meaningful conclusions. Examples: improvement in time to process applications and determine client eligibility; improvement in quality of care based on measures such as infection rates.
>
> - **Assess impact of policy changes**: Analyze how recent or contemplated changes may impact program cost, client populations served, and outcomes. Examples: providing new medications to eligible populations; changing provider rates; adding or eliminating covered services.
>
> - **Plan for the future**: Forecast needed programs and resources over short- and long-term projections, impacting everything from provider networks to office space. Examples: caseload growth; client demographics.

**Examples of Human Services Information Collected**

| Health and Human Services Commission (HHSC) | |
|---|---|
| Medicaid | • Client and provider eligibility information<br>• Claims processing and managed care encounter data<br>• Vendor drug and medical transportation program client and billing information |
| Other benefit programs | Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF); and Children's Health Insurance Program (CHIP) eligibility, client, and claims information |
| **Department of State Health Services (DSHS)** | |
| State public health laboratory | • Newborn screening records<br>• Public health testing information (for example: water quality and infectious disease)<br>• Early screening and diagnosis information for Medicaid recipients |
| Health services programs | • Client, provider, and claims data for:<br>  – mental health and substance abuse programs, including state hospital client management systems<br>  – programs for children and women, including nutrition assistance and primary care |
| Population health information | Statewide information on incidence of immunizations, cancer, birth defects, and other reportable diseases collected for public health surveillance purposes |
| Vital statistics | Records of every Texan's birth, death, marriage, divorce, adoption, etc. |
| Hospital claims | Inpatient and outpatient discharge data (Texas Health Care Information Collection program) |
| **Department of Aging and Disability Services (DADS)** | |
| Individuals with intellectual and developmental disabilities and regulatory programs | • Long-term care and home living certification, case management, and billing<br>• State supported living center client management systems |
| **Department of Family and Protective Services (DFPS)** | |
| Protective services programs | Case management, eligibility, and billing for child and adult services including foster care and abuse/neglect investigations |
| **Department of Assistive and Rehabilitative Services (DARS)** | |
| Early childhood intervention | Case management, eligibility, and billing for services to children 0–3 with disabilities or developmental delays |

# Findings

**Ongoing efforts to develop a more outcomes-focused, efficient healthcare system require overcoming many challenges inherent to organizing and analyzing complex data.**

• **Data management increasingly important.** Promoting a more effective, performance-based healthcare system has been an interest of national and state healthcare policy for some time, and typically focuses on using significant government spending on health care to improve the overall quality and efficiency of delivered services. Effective data management and analytics are central to these efforts — programs to measure and increase quality are only as good as the underlying information being used for policy decisions, including sanctions and rewards placed on providers. For example,

the federal Centers for Medicare and Medicaid Services, which covers more than 100 million people, has developed rules tying hospital payments to measures such as re-admissions and hospital-acquired infection rates.[2] Texas has been implementing similar payment-based quality incentives in Medicaid for several years, and also recently began participating in a new, data-intensive federal program providing significant funds to local projects designed to better integrate patient care and improve quality (known as the Delivery System Reform Incentive Payment program, or DSRIP).[3] Another major federal payment incentive program promotes standardization, collection, and "meaningful use" of clinical data in electronic health records with the goals of improving care and better understanding population health trends.[4]

The Texas Legislature has also taken a number of recent steps indicating a clear commitment to data-driven healthcare policy. In 2011, the Legislature created the Texas Institute of Health Care Quality and Efficiency, an independent board attached to HHSC with a mission to improve the efficiency of health care delivery, including improving the reporting, organization, and transparency of healthcare information.[5] Last session, the Legislature also continued focusing Medicaid managed care expansion on integrating and improving quality of care for clients; clarified the authority of human services agencies to share data among system agencies for program purposes; directed the creation of a dedicated Medicaid analytics unit; invested millions in fraud detection analytics for the Office of Inspector General; and required expanded collection of hospital discharge data to better understand utilization of emergency rooms.[6]

- **Systemic challenges.** The challenges with better using significant healthcare data for these purposes are well documented and not unique to Texas. Interest and expectations regarding using administrative information for program design and analysis have increased with the amount of data collected, yet agencies struggle to implement the sophisticated systems, analytical tools, and necessary policy to meet this demand. As the Urban Institute recently noted, "lack of at least some regular basic analysis of the performance information is probably the major missing element today in many if not most performance measurement systems."[7] The Center for Digital Government concluded health and human services organizations "have little financial incentive or ability to integrate and share data. . . [making it] inherently difficult to deliver a single 'version of truth' that provides a holistic view of the recipient."[8] A recent workgroup of state Medicaid directors echoed similar challenges, stating "complex reforms that recast payment reimbursement and shift quality measurement to outcomes require data analytics capacity. . . [A]gencies reported that one of their major challenges was not a lack of data, but that they were awash in it . . . High level attention and leadership is needed to overcome these challenges."[9]

*Medicaid agencies are awash in data, requiring high-level attention to overcome challenges.*

**The Texas health and human services system's decentralized approach to data oversight creates risk and prevents basic, appropriate uses of information to measure performance and drive policy.**

- **Risks and lost opportunities.** Though data management is a critical element of current efforts to improve health care, HHSC has not yet developed the underlying infrastructure and policy needed to direct deliberate development of these resources and clearly understand the limitations and potential of what is currently collected. This lack of fully-formed procedures to govern the development of data systems and a clear, overall strategic approach to data management create both risks and lost opportunities. On a basic level, the system does not have a firm grasp on the universe of data collected, risking duplication of effort or potentially, inappropriate use. No centralized, clear inventory of data collected throughout the system exists. Such an inventory could promote understanding of potential uses, and provide more definitive answers to murky legal and privacy issues that delay efforts to more effectively use information.

*HHSC cannot easily identify costs associated with the same clients served in several programs.*

The system's fragmented data systems have developed piecemeal and contain multiple standards, resulting in data sets that are difficult to manipulate to extract meaningful information. As the state continues to invest millions of dollars in various systems, the lack of consistent data standards prevents fundamental planning such as common database definitions so that clients and providers can be more easily compared across programs and data systems. When basic policy questions arise, agency staff often must torturously assemble data cobbled together from different and poorly integrated systems, rather than query data sets that are strategically designed to work together to inform policy development and decision making. For example, even within one program, Medicaid, HHSC cannot easily identify all costs associated with one group of clients that may be receiving long-term services and supports through DADS in addition to acute care through HHSC. In other cases, the volume of information collected has expanded over time to be so massive that it thwarts consistent reporting and clarity around key issues, such as is the case with the hundreds of potential reasons captured for why a person is dropped from Medicaid enrollment. While HHSC has recognized these challenges and moved forward with a major project to better standardize Medicaid data in a single warehouse, this effort is incomplete and only addresses a small fraction of the data systems across the enterprise. The textbox on the following page, *Opportunities to Better Coordinate Services*, provides additional examples of how data could be used to identify links between various system programs to improve outcomes, but this analysis depends on careful data management and planning that is currently lacking. As Medicaid transformation and other policy changes continue, HHSC needs access to information based in reliable, valid data that can inform critical decisions with major impact on both individual clients and costs to the state.

*HHSC needs information based in reliable, valid data to make critical policy decisions.*

---

### Opportunities to Better Coordinate Services

- Client crossover between major benefit programs such as Medicaid, SNAP, and TANF

- Individuals involved with the child protective services system and involved in substance abuse programs

- Individuals dually diagnosed with mental health as well as intellectual and developmental disabilities being treated in various programs found in two or three agencies

- Medicaid and CHIP-covered mothers at risk of pre-term birth based on previous medical issues

- Immunization status of children covered by Medicaid

- Women and children transitioning or receiving services from Medicaid and other system safety-net programs such as family planning and primary care

---

The Sunset reviews of the health and human services agencies noted numerous other examples of programs struggling to effectively use data to support stated goals. For example, Issue 4 of this report describes how HHSC has struggled to use data analytics to comprehensively monitor the Medicaid program for fraud, waste, and abuse in the context of expanding managed care. Issues 8, 9, and 10 also raise significant doubts about the system's ability to use data to operate fragmented women's health programs between two agencies; administer the NorthSTAR behavioral health program in Dallas; and manage the Office of Inspector General's efforts to uncover fraud, waste, and abuse. While system agencies should retain control and basic oversight of day-to-day management and use of data systems needed to carry out administration, they also clearly need more direction and support to effectively use the information to direct policy and evaluate service outcomes in a more strategic way.

Finally, the lack of centralized coordination of these issues means that responsibility for data oversight, including important policy decisions, often falls on IT managers by default due to the technical aspects of the related systems and questions that may be posed. However, increasing demands on information analytics require higher-level policy direction and oversight than is appropriate to place with more operationally focused IT staff.

- **Lack of clarity on appropriate data sharing and use.** Absence of centralized standards and policy creates a situation that stymies innovative uses of data while increasing risk surrounding the data's appropriate use. Agency staff report an exponential growth in interest by state agencies, managed care organizations, research institutions, and other external parties for the valuable data the system maintains. However, without a single point of contact within the system to monitor and control data use and release, legitimate efforts stall indefinitely due to lack of clear policy direction, while other efforts to link and share information create discomfort and legal questions by some parties.

*Lack of a centralized data policy stymies innovative data uses and risks data's inappropriate use.*

For example, without clear policy direction, a request from managed care organizations to cross-check their enrollees with data on pre-term births available through vital statistics took more than two years to resolve. This delayed the managed care organizations' efforts to help identify at-risk enrollees and avoid additional pre-term deliveries, an outcome clearly in line with the state's priorities of improving patient outcomes and avoiding higher costs.

*A request for data needed to reduce pre-term births in Medicaid took two years to resolve.*

In another example, the lack of a centralized process for vetting research requests for data across multiple agencies created lengthy delays and frustration on the part of researchers conducting an innovative analysis of how people with severe and persistent mental illness use services across the system. As a result, the researchers recommended centralizing administration of state-level data sets to make cross-program analysis of publicly funded healthcare more straightforward, including developing a single process and access point for requesting data, developing data use agreements and protocols for data sharing, and completing required approvals for research on human subjects.[10]

### While HHSC has taken initial steps to improve data management and strategic use, current efforts are brand new and lack the organizational weight to ensure success.

- **Preliminary efforts.** Recognizing the need for a more centralized and strategic approach to managing system data, HHSC has begun implementing an "enterprise data governance" process, and hired a dedicated chief data officer within the financial services division in early 2014. This effort stems from the major, multimillion dollar effort to consolidate Medicaid data and reporting in an enterprise data warehouse, which has taken several years to get off the ground and raised significant issues with lack of standards between numerous existing systems holding Medicaid client data. While this governance effort is a positive step in the right direction, it is in its infancy, initially focused on Medicaid, and does not yet have the established resources and coordination needed to reach its full potential. The creation of this office also seems to merely add another layer to, not consolidate, other scattered data-related initiatives currently underway. As this office establishes its role, executive management needs to consider and clearly define responsibilities of the other data analytics groups in the enterprise, such as the Center for Health Statistics, the new Medicaid analytics unit, and other numerous efforts to evaluate quality initiatives.

*Lack of standards between Medicaid systems has caused issues for the enterprise data warehouse project.*

- **Authority unclear.** As with most system support services in the enterprise described in more detail in Issue 2 of this report, the current role of the new data governance effort is rooted in coordination and consensus-building, not clear authority to set standards and monitor results. While system programs needs to be directly involved in any new standards or processes, the office also needs a clearly defined role and authority to effectively carry out its mission.

# Recommendation

## *Management Action*

### 7.1 Direct HHSC to elevate oversight and management of data initiatives, including creation of a centralized office with clear authority to oversee strategic use of data.

HHSC should prioritize and provide additional attention to data oversight and use by designating a high-level executive office to coordinate these efforts. Following the concepts outlined below, the office should have authority to implement consistent plans and policies relating to data governance, monitor major data projects, promote strategic analysis of data following best practices, and coordinate between internal and external partners to ensure appropriate use.

- **Dedicated, high-level office.** HHSC should evaluate ongoing data governance and management efforts currently established in several offices within HHSC and other system agencies and consider combining these functions to the extent feasible into the new office, along with a closer link to executive management. However, day-to-day data management functions should remain within the programs owning and using the data. The office should have a close link with the enterprise information technology office, privacy office, legal services, and other areas of expertise as appropriate.

- **Standards-setting and monitoring.** The office should have clear authority to establish a system-wide approach to governing the development, use, and appropriate sharing of data and data systems and to monitor adherence to agreed-upon standards. The office should carry out these functions with an eye toward long-term strategic viability of data collected, and regularly report on status of its operations to executive management.

- **Inventory and strategic planning.** As one of its first functions, the office should conduct a detailed inventory of all major data sets and systems across the enterprise, authoritatively documenting their purpose; funding; uses; legal, regulatory, or other restrictions; current issues; and future potential. The office should then develop a strategic plan showing the results of this review, establishing data priorities for the enterprise and strategies for achieving them, identifying challenges or statutory barriers, and highlighting needed policy direction for executive management's and the Legislature's consideration.

  In developing this plan, the office should seek input from internal system staff working with key data sets, existing advisory groups such as the Texas Institute of Health Care Quality and Efficiency, and other external stakeholders such as providers, legislative offices, and research institutions. The plan should review and seek to implement best practices that balance appropriate controls and careful sharing of data with better use of information to improve system performance and quality. The plan should also consider whether any data collected or stored is duplicative or unnecessary and recommend streamlining initiatives.

- **Data sharing and dissemination.** Using the detailed data inventory as a basis, the office should be the system authority on data sharing and linking between system agencies, other state agencies, and external partners such as federal agencies and research institutions. The office should develop clear principles and policies governing whether, when, and how system data may be shared internally and externally, and should take the lead to secure permissions and negotiate data use agreements with external parties as needed. The office should develop consolidated procedures and policies setting out how interested offices and entities can share data, helping to make these at times convoluted processes clearer and more transparent. The office would be responsible for consolidating efforts to receive data

from other entities (such as Medicare data) as well as any data leaving the system. Finally, the office should serve as a single point of contact and tracking for satisfying legal requirements for research on human subjects, with related functions from other programs such as institutional review boards located within system agencies moved under its authority. To achieve these goals, the office should work closely with system information technology, privacy, and security officers; and legal services.

- **Special initiatives, technical assistance, and best practices.** While most daily management and use of data should remain with programs, the office should develop specialized expertise to offer technical assistance and cross-program coordination for priority projects as needed or requested. The office should seek out and distribute national best practices and promote their use, as resources allow.

## Fiscal Implication

This recommendation would not have significant implementation costs, as HHSC has already started developing a more centralized approach to data management and could add to these efforts within existing resources. The recommendation would encourage smarter data management and use, not more data collection or significantly more staff. A more streamlined, standards-based approach to managing and using system data would have significant positive impacts by more effectively targeting spending on better, and less costly, outcomes for clients. However, these results would depend on implementation and could not be estimated.

[1]    Lyman, Peter and Hal R. Varian, "How Much Information, 2003," University of California at Berkley School of Information Management and Systems, last modified October 27, 2003, http://www.sims.berkeley.edu/how-much-info-2003; and "Hubble Space Telescope," National Aeronautics and Space Administration, last modified April 25, 2014, http://www.nasa.gov/mission_pages/hubble/story/index.html.

[2]    Centers for Medicare and Medicaid Services, "CMS Issues Hospital Inpatient Payment Regulation," news release, August 4, 2014, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-08-04.html.

[3]    Ardas Khalsa, Director, Healthcare Transformation Waiver Operations, Texas Health and Human Services Commission, "Presentation to the House County Affairs Committee on the Healthcare Transformation Waiver," March 10, 2014, http://www.hhsc.state.tx.us/news/presentations/2014/House-County-Affairs-Committee.pdf.

[4]    "Meaningful Use Definition & Objectives," Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services, last modified March 18, 2014, http://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives.

[5]    S.B. 7, 82nd Texas Legislature, First Called Session, 2011.

[6]    S.B. 58, S.B. 1542, S.B. 7, and S.B. 8, 83rd Texas Legislature, Regular Session, 2013; and Rider 93, page II-80, Article II (S.B. 1), Acts of the 83rd Legislature, Regular Session, 2013 (the General Appropriations Act).

[7]    Hatry, Harry P., *Transforming Performance Measurement for the 21st Century* (Washington, D.C.: Urban Institute, 2014), p. 37.

[8]    Center for Digital Government, *A Data-Powered Approach to People-Centric Services* (2014), pp. 1–2.

[9]    National Association of Medicaid Directors, *Data Analytics for Effective Reform* (Washington, D.C.: 2014), pp. 4–6.

[10]    Rowan, Paul J., Robert Morgan, Charles Begley, Suja Rajan, and Thomas Reynolds, "Increasing the Power of State Data for Assessing Healthcare Programs and Policy: Recommendations to the Meadows Foundation and the Texas Institute for Health Care Quality and Efficiency," August 13, 2014.

# ISSUE 8

*Administration of Multiple Women's Health Programs Wastes Resources and Is Unnecessarily Complicated for Providers and Clients.*

## Background

Texas provides women's health and family planning services for low-income women through three programs: the Expanded Primary Health Care and Family Planning programs administered by the Department of State Health Services (DSHS), and the Texas Women's Health Program administered by the Health and Human Services Commission (HHSC). The programs share similar objectives to improve the reproductive health of low-income women and avoid unintended pregnancies. The programs also aim to reduce state expenditures for Medicaid birth-related costs. Key differences among the existing programs are described in the table on the following page, *State Women's Health Programs.*

The costs of providing women's health and family planning services are significantly less expensive than the cost of a Medicaid birth. In addition, the average monthly caseload of pregnant women in the state's Medicaid program is increasing. The textbox, *State-Funded Women's Health Care – By the Numbers*, provides specific data on numbers and costs associated with women's health care. State-funded women's health and family planning services help the state avoid the cost of unintended pregnancies; national estimates indicate every dollar spent on publicly funded contraceptive services yields $5.68 in Medicaid savings.[2]

Changes in policy and funding over the past four years have significantly altered the landscape of state-funded women's health services in Texas. The state and federal policy decisions listed below have transitioned the state's programs, developed separately using different funding sources and associated requirements, to predominantly state general revenue funding for the first time in fiscal year 2014.[3]

---

**State-Funded Women's Health Care – By the Numbers**

- **2.18 Million** – number of Texas women between 15–44 years old at or below 185 percent of the federal poverty level in 2012

- **162,335** – number of clients served through the Family Planning and Texas Women's Health programs in 2013[1]

- **207,058** – number of Texas births paid for by Medicaid (53 percent of all births in Texas) in 2013

- **7.7 percent** – increase in the average monthly caseload of pregnant women in the Medicaid program from 2012 to 2014, that caseload averaging 136,946 women monthly in 2014

- **$10,993** – average cost to the state for Medicaid prenatal care, labor, delivery, postpartum care and the first year of infant health care in 2013

- **$287** – average cost to the state per client of the Family Planning program in 2013

- **$277** – average cost to the state per client of the Texas Women's Health Program in 2013

---

- During the state's fiscal downturn in 2011, the 82nd Legislature decreased funding to the Family Planning program by $70.1 million, or 65 percent, for fiscal years 2012 and 2013. According to recent analysis, the decrease in funding contributed to the closure of a significant number of family planning clinics and likely resulted in additional Medicaid births.[4]

| State Women's Health Programs | | | |
|---|---|---|---|
| **Program** | **Texas Women's Health Program (HHSC)** | **Family Planning (DSHS)** | **Expanded Primary Health Care (DSHS)** |
| **Client Eligibility** | 185 percent federal poverty level<br><br>Women ages 18–44, seeking family planning services<br><br>U.S. citizen or eligible immigrant<br><br>Not sterilized or pregnant | 250 percent federal poverty level<br><br>Women and men seeking family planning services<br><br>Texas resident<br><br>Not sterilized or pregnant | 200 percent federal poverty level<br><br>Women ages 18 and older<br><br>Texas resident |
| **Claims Administration**<br>**Cost-Reimbursement** allows contracted entities to submit monthly expense statements, which can include administrative or other expenses beyond direct medical services, to receive a portion of their funding award.<br>**Fee-for-Service** is a set payment for each direct medical service to a client. | 100 percent fee-for-service, claims processed by HHSC's third-party claims processor | Up to 50 percent cost-reimbursement, administered by DSHS<br><br>50 to 100 percent fee-for-service, claims processed by HHSC's third party claims processor | Up to 25 percent cost-reimbursement, administered by DSHS<br><br>75 to 100 percent fee-for-service, claims processed by HHSC's third-party claims processor as of September 1, 2014 |
| **Infrastructure**[5]<br>Contractors are typically administrative entities such as Federally Qualified Healthcare Centers or community clinics.<br>Sites are physical locations.<br>Providers, such as doctors or nurse practitioners, deliver direct services. | 0 contractors<br><br>1,404 sites<br><br>3,853 providers, an estimated 1,828 of which are actively billing (point in time figure from June 20, 2014) | 18 contractors<br><br>89 sites<br><br>Unknown number of providers | 51 contractors<br><br>220 sites<br><br>Unknown number of providers |
| **Covered Services**[6] | Priority services across all programs include pelvic exams, screenings and treatments of certain sexually transmitted infections, HIV screenings, diabetes screenings, high blood pressure screenings, cholesterol screenings, clinical breast exams, pap tests[7], and reversible and permanent methods of birth control (not including emergency birth control) | | |
| | | | Additional priority services include mammograms, diagnostic services for abnormal breast or cervical cancer test results, cervical dysplasia treatment, case management, and prenatal medical and dental services |
| **Allowed Visits** | One visit permitted, plus follow-up visits related to client's chosen method of contraception | Multiple visits permitted, services provided based on client need | Multiple visits permitted, services provided based on client need |

- In 2012, rules prohibiting the affiliation of state-funded women's health service providers with abortion providers were deemed incompatible with federal Medicaid policy, resulting in a loss of federal match funds for the Medicaid Women's Health Program and the subsequent creation of the general revenue-funded Texas Women's Health Program in January 2013.[8]

- In 2013, the federal Title X Family Planning grant, previously used to support the state's Family Planning program, was awarded to a nonprofit entity. The Legislature appropriated general revenue funding to mitigate the loss of federal funds to the program.[9] The Legislature also created the Expanded Primary Health Care program, which provides comprehensive services, but is still focused on providing family planning services.[10]

Overall, the 83rd Legislature invested more than $215 million in women's health and family planning programs for fiscal years 2014 and 2015, a 17 percent increase from the 2010 to 2011 biennium, before budget cuts in 2012 and 2013.[11]

## Findings

### State-funded women's health programs comprise a patchwork of services that are difficult to navigate and result in unnecessary administrative costs.

Differences among state women's health programs create a confusing and fragmented system for clients, requiring the weaving together of different benefit packages to deliver necessary services to meet their needs. Meanwhile, separate administrative processes divert financial and other resources away from efficient service delivery for both providers and the state.

- **Clients face obstacles to receiving care**. Clients requiring more than basic family planning services must complete separate eligibility, screening, and enrollment processes for each program, sometimes changing provider locations to receive additional needed care. For example, the Texas Women's Health Program only covers office visits related to method of contraception, so if abnormal cervical cells are found through a pap exam provided by an initial visit the client must navigate another program's processes to receive a follow-up exam after treatment. Because the state lacks coordinated outreach efforts for women's health programs, clients are often unaware of other services for which they may qualify to address their needs.

  For locations that do not provide all three programs, clients may not receive needed services, as these providers often lack strong referral networks to clinics with more options. Ninety-six percent of Texas Women's Health Program providers do not provide the other state women's health programs. Because of this program's limited coverage, as noted above, many clients must find another provider for needed follow-up care. Considering the large majority, approximately 90 percent, of clients earn below 100 percent of the federal poverty level and have limited transportation options, their ability to get to a second provider at a different site is further limited.[12]

*Uncoordinated outreach for women's health programs makes clients unaware of needed services.*

● **Administrative burdens make provider participation onerous.** Women's health providers, especially providers participating in more than one program, report spending a disproportionate amount of time complying with administrative requirements for state programs when compared to administering similar services supported by other payer sources. For example, the 63 clinics participating in both the Family Planning and Expanded Primary Health Care programs complete separate grant application processes to the same agency for overlapping services. Providers must fill out different paperwork sometimes for each service, as each program has its own necessary documentation, a labor intensive process for professionals already in short supply. When providers submit for payment from the state, billing staff must navigate distinct billing and claims submission processes and report different metrics on different schedules to different agencies.

*Costs of managing multiple programs discourages clinics with less experience and fewer resources from participating.*

---

**Duplicative Program Components**

● Grant processes

● Funding distribution

● Enrollment processes and eligibility determinations*

● Claims processing

● Reporting requirements

● Audit and accountability processes

● Technical assistance

● Rulemaking

● Outreach efforts*

● Websites

● Clinic locator tools

● Support staff and administration

* Performed by clinic administrators for DSHS programs.

---

Administrative burdens associated with state women's health programs likely contribute to the fragility of the provider network. Established clinics report difficulty in navigating the programs, but feel compelled to participate in multiple programs to offer the full array of available services to clients. For newer or smaller clinics with less experience and fewer resources, the administrative costs of managing multiple programs is too great and ultimately discourages participation in the full scope of programs, limiting access to care.

● **Overlapping program infrastructure.** Operation of three similar but distinct programs through two agencies is inherently inefficient for the state. A long list of support functions, detailed in the textbox *Duplicative Program Components*, are duplicated across agencies or programs. The programs maintain separate contracts with the state's third-party claims administrator which is not cost-effective for the state. Important efforts to better coordinate women's health infrastructure have been initiated, such as the planned launch of a single website and clinic locator in October 2014. However, these tools will not eliminate the need for clients, providers, or the state to expend extra time and resources to effectively receive or administer services.

## State-funded women's health programs lack clear leadership and cohesive management.

● **Need for strategic oversight.** The state's women's health programs are administered in a piecemeal fashion, without an overarching policy or plan for how the state can best serve the health and family planning needs of low-income Texas women. HHSC's strategic plan describes a planned consolidated website, and HHSC hired a women's health coordinator in 2013.[13] However, the coordinator lacks the authority to direct programmatic changes, allowing for communication and coordination between the agencies

to remain fractured through continued operation in silos. More importantly, the agencies have not taken the initiative to establish, implement, or achieve a comprehensive vision for women's health across agency lines.

The Texas Women's Health Program lacks individual program leadership, having no dedicated staff or director, and is being supported by Medicaid policy staff even though it is no longer a Medicaid program. Challenges with maintaining the provider base during the quick transition from a Medicaid to state supported program were likely compounded by the lack of a dedicated leader for the program. The number of enrollees in the program gradually decreased after the transition in January 2013 to a low point in September of the same year for a cumulative decline of 11 percent over the nine-month period. A major outreach initiative was subsequently initiated in October 2013 to help the program regain its client base. The absence of a full-time staff person for the program is troubling given the demonstrated need for services, the potential for Medicaid cost savings, and significant legislative interest in women's health services.

*The absence of a full-time staff person for the Texas Women's Health Program is troubling.*

● **Incomplete or unavailable data sets prevent thorough analysis.** Basic data to compare the programs is often either incomplete or unavailable, as the programs operate completely independent of one another. The cost-reimbursement model used by the DSHS programs especially limits data collection for service utilization and cost because providers report services provided in the aggregate. Additionally, providers report numerous clients participate in multiple programs, yet the agencies are unable to provide the actual number of clients who do so or which services they used. Without the information, the agencies are unable to determine the scope and impacts of the current programs' limitations. Other key data sets like the number of providers for all programs are also not available, further limiting comparison and assessment of capacity.

*The agencies are unable to provide the actual number of clients who participate in multiple programs.*

Comparison of the programs over time is also impossible because of data quality issues. The list of providers participating in the Texas Women's Health Program, originally meant to encompass all billing entities, included indirect service providers such as labs and anesthesiologists, and even included billing addresses rather than provider service locations, skewing the list of primary providers of covered services. While this issue was addressed for the current program, the agency is unable to compare the current program trends with those before 2013.

● **No meaningful evaluation of outcomes and impact.** Data issues are compounded by a lack of leadership to cohesively examine the programs and meaningfully measure impacts across the three programs. In particular, limitations measuring client demand and program capacity make it difficult to judge the impact of significant program policies and investments or to find ways to improve the effectiveness or efficiency of the programs. Existing program performance measures are weak; the Texas Women's Health and Family Planning programs track only the average cost of services

per client and average number of clients served per month. Meanwhile, the newly created Expanded Primary Health Care program does not have any specific performance measures, demonstrating a lack of meaningful outcome measures and leadership to develop them.

- **Poor and uncoordinated communication.** Weak communication leaves service providers unclear about program administration and agency staff uninformed about parallel efforts in the other agency. Outreach efforts to overlapping service populations are wholly uncoordinated, with DSHS contractors responsible for undertaking their own localized communication efforts and HHSC conducting centralized program communication through activities like mass mailings to potentially eligible populations statewide. Meanwhile, providers report mixed messages from state staff regarding program policies and procedures, especially related to the rollout of the new Expanded Primary Health Care program and for policy changes to the other programs. In another example, confusion over eligibility to participate in the DSHS programs and the Title X grant program, now administered by a nonprofit entity, kept some providers from joining state initiatives. Given the nearly constant changes to state-funded women's health over the last four years, clear and coordinated communication from the state remains critical to ensuring provider participation and, ultimately, access to services for clients.

## Now is the time to revisit Texas' approach to state-funded women's health programs to improve service and efficiency for clients, providers, and the state.

*More time operating the current structure of programs will not prove one existing model better than the others.*

Women's health providers have grown weary of change after the significant events in women's health programs over the past four years. However, the independence of the programs from restrictions associated with federal funding allows the state, for the first time, to ease the administrative burden on providers and customize women's health services to best meet client needs. Additional time operating within the current structure of programs will not prove any one existing model better than the others, as each has clearly preferred components and drawbacks to clients, providers, and the state. Continuing the existing organization would simply carry on the current confusion, duplication, and inefficiencies for all stakeholders, without a means to effectively evaluate investments and measure impact. Consolidating the programs in a way that continues the preferred aspects of each could offer the following benefits.

- **A more comprehensive benefit package.** Across stakeholder groups, the Expanded Primary Health Care program is the preferred benefit package because it covers a broader range of screenings and treatment services. Yet, some low-volume clinics cannot participate because they do not have the resources to offer the program's additional benefits. In contrast, providers only participating in the Texas Women's Health Program

are uncomfortable with its limited benefit package, which discourages participation by professionals who have an ethical obligation to treat known conditions but cannot be reimbursed by the state for follow-up visits related to anything other than method of contraception.

A significant need exists for follow-up or additional services beyond basic family planning among clients. Thirty-nine percent of clients in the Family Planning program, not including subsequent visits following a Texas Women's Health Program visit, had two or more office visits covered by the program in fiscal year 2013. While family planning services are the primary goal of the state's women's health programs, a more comprehensive benefit package with increased flexibility for providers could encourage more provider participation, improving capacity for family planning services, and ultimately enhancing health outcomes and reducing costs.

> *A significant need exists for follow-up or additional services beyond basic family planning among clients.*

- **Increased service capacity through administrative efficiency.** Increasing the efficiency of women's health programs through a single, consolidated approach instead of through three separate programs would free up resources at both the state and provider level that could be used to provide additional services to more clients.

- **A single claims administration infrastructure.** With the exception of some low-volume clinics, which rely on cost-reimbursement allocations to cover basic infrastructure costs, service providers across the state prefer a fee-for-service claims administration model, like that used by the Texas Women's Health Program and private insurance plans. Providers of all sizes are better equipped to process claims using the fee-for-service model than by compiling and submitting vouchers for cost-reimbursement. Given the varied landscape of provider infrastructure in Texas, a single fee-for-service administration process with the flexibility to offer a limited cost-reimbursement benefit would eliminate the need for the state to manage three separate billing contracts and offer providers a more standard and efficient method to submit claims.

> *A single program and benefit network would promote continuity of care.*

- **Increased continuity of care.** Increased coordination among women's health services, including Medicaid, would better connect women with needed services. Offering a single program and benefit network would help retain women in programs offering cost-effective family planning and preventative care services, as well as strengthen necessary referrals among providers, promoting continuity of care. Recognizing the importance of continuity of care, HHSC already requires Medicaid managed care organizations to provide new mothers with transition services, such as help with program applications for women's health programs. HHSC is also considering the automatic transition of eligible new mothers from Medicaid to the Texas Women's Health Program, an initiative tentatively scheduled for 2015.

# Recommendations

## Change in Statute

### 8.1   Require HHSC to establish a single women's health and family planning program for the health and human services system.

This recommendation would integrate all three of the current programs offering women's health and family planning services for low-income Texas women into one administrative and benefits structure. The combined program would offer a single point of entry for clients and providers to state-funded services and consolidate the state's administrative functions. While statute would simply require HHSC to operate a single women's health and family planning program for the health and human services system, HHSC would be directed to establish specific program components in rule, as detailed below. The new program would include eligibility criteria and covered services most resembling the Expanded Primary Health Care program and administrative components most like the Texas Women's Health Program, as described below and in the table, *Proposed Women's Health Program*.

- **Client eligibility.** Client eligibility criteria for the new program would mirror the existing criteria of the Expanded Primary Health Care program, with two exceptions. First, the federal poverty level threshold would decrease from 200 percent to 185 percent, since most clients seeking services fall below 100 percent of the federal poverty level this change would have minimal impact. Second, the program would change age requirements from ages 18 and older to women of childbearing age actively seeking family planning services.

| Proposed Women's Health Program | |
|---|---|
| **Client Eligibility** | 185 percent federal poverty level<br><br>Women ages 15–44, seeking family planning services<br><br>Texas resident<br><br>Not sterilized or pregnant |
| **Claims Administration** | 100 percent fee-for-service<br><br>A limited cost-reimbursement benefit would be available only for providers who, without cost-reimbursement to help sustain their operations, can demonstrate a lack of client access to women's health services in their area |
| **Covered Services** | **Required services:** Pelvic exam, sexually transmitted infection screening and treatment, HIV screening, diabetes screening, high blood pressure screenings, cholesterol screenings, clinical breast exams, pap tests (initial and follow-up), and reversible and permanent methods of birth control (not including emergency birth control)<br><br>**Additional services:** Mammograms, diagnostic services for abnormal breast or cervical cancer test results, cervical dysplasia treatment and case management<br><br>**Additional primary care services are covered by the program, but only if need is determined as part of a family planning visit[14]** |
| **Allowed Visits** | Multiple visits permitted, services provided based on client need |

- **Eligibility determination and enrollment process.** Client enrollment for the new program would resemble the Texas Women's Health Program, requiring an application to the state for a client's eligibility determination. Eligibility determinations would no longer be made at the point of service by contractors. However, providers would be authorized to offer conditional eligibility for the program's services, as the Expanded Primary Health Care and Family Planning programs currently do, at their own financial risk. If a client is presumed eligible and receives services, those services would be covered by the program as long as eligibility is verified.

- **Covered services.** The new program would be a family planning focused program. The benefit package would be most similar to the Expanded Primary Health Care program, with the exclusion of prenatal medical and dental services, which would still be offered by the Medicaid, Title V Prenatal, and Children's Health Insurance Program perinatal programs. However, unlike the Expanded Primary Health Care program, the new program would require all clients to be seen for a family planning visit and primary care benefits would only be offered during a family planning or follow-up visit.

  All participating providers would be required to offer the primary set of family planning services offered through the current programs, including a pelvic exam, sexually transmitted infection screenings and treatments, HIV screenings, diabetes screenings, high blood pressure screenings, cholesterol screenings, clinical breast exams, pap tests, and reversible and permanent methods of birth control, not including emergency birth control. This requirement would have the effect of limiting primary care benefits to only those providers offering this core set of family planning services. Women would not be able to access this program for their general primary healthcare needs not identified through a family planning visit. These same providers would not be *required* to offer additional services included in the new program, such as mammograms, diagnostic services for abnormal breast or cervical cancer test results, cervical dysplasia treatment and case management, or primary care services. Providers not offering all covered services would be required to refer clients to another provider within the new program for any services not offered. Primary care benefits would only be provided if need is determined as part of a client's family planning visit. Follow-up office visits for any services covered by the program and provided by a participating provider would be permitted.

- **Billing procedures and funding distribution.** All claims in the new program would be processed through a fee-for-service model through the state's third-party claims administrator, which would create a competitive market among providers to serve eligible clients and promote associated outreach efforts. HHSC would be directed to establish a limited cost-reimbursement benefit, by rule, for providers who can demonstrate that without their services, clients would lack access to women's health services in their area. Providers receiving the cost-reimbursement benefit would receive funds beyond the fee-for-service reimbursements to cover administrative and operational expenses.

- **Program administration.** The new program would be administered by HHSC. Consolidation of existing programs would eliminate the need for HHSC's women's health coordinator position. HHSC should instead hire a director to oversee integration of the existing programs and implement and administer the new program. HHSC would be directed to establish comprehensive performance measures designed to gauge program capacity, demand, and outcomes related to the program's goals and activities.

- **Annual evaluation of services.** HHSC would be required to annually assess the program in the context of budget capacity, covered services, population needs, and appropriateness of performance measures. If program demand exceeds or is forecasted to exceed budget capacity, HHSC should consult with state leadership and re-evaluate inclusion of high-cost primary care services to remain

within budget. Clinical standards would also continue to be set by the agency, in consultation with the public health experts in the health and human services system.

- **Transition.** HHSC would be directed to consolidate the programs and roll out the new program by January 1, 2017. HHSC should be sure to keep providers and other stakeholders informed of the agency's progress and offer technical assistance to assist providers with the program's transition. HHSC should automatically enroll providers in the existing programs into the new program unless they request not to be enrolled.

Current laws applicable to existing state-funded women's health programs would be applied to the new program.[15]

## *Management Action*

### 8.2  Direct HHSC to study the feasibility of automatically transitioning new mothers in Medicaid to the new women's health program.

To improve continuity of care, HHSC would be required to report feasibility, the potential costs and any projected savings of automatically transitioning new mothers in the Medicaid program, who are not eligible for general Medicaid coverage, to the new women's health program after giving birth. This transition would aid low-income mothers, who are most likely to have additional Medicaid-paid births, in accessing family planning services without making separate application to the state. HHSC should evaluate any potential confidentiality issues, costs, and savings and report conclusions and recommendations to the Legislature by December 31, 2014. Based on this information, the Legislature should evaluate whether automatically transitioning new Medicaid mothers into the new women's health program is cost-effective.

## Fiscal Implication

Consolidation of women's health programs into a single program would result in an estimated annual administrative savings to the state of $1.1 million, based on applying the current percentage of administrative costs for the Texas Women's Health Program to the combined current budgets of the three programs. Consolidation of claims administration contracts would also likely result in savings, but those savings cannot be estimated.

Estimated administrative savings from Recommendation 8.1 could be reinvested into the new program for cost-reimbursement benefits or additional capacity.

### Texas Women's Health Programs

| Fiscal Year | Savings to the General Revenue Fund |
|---|---|
| 2017 | $732,600 |
| 2018 | $1,100,000 |
| 2019 | $1,100,000 |
| 2020 | $1,100,000 |
| 2021 | $1,100,000 |

The new program's budget is based on consolidation of the current budgets for all three programs, which totals $107,600,000 and has the capacity to serve 326,129 clients within the proposed program structure and benefit package. Reinvesting the administrative savings into the new program would increase capacity by 3,647 clients for a total capacity of 329,776 clients.

1    The Expanded Primary Health Care program did not begin until fiscal year 2014.

2    Jennifer J. Frost, Mila R. Zolna, and Lori Frohwirth, *Contraceptive Needs and Services, 2010* (New York: Guttmacher Institute, 2013).

3    The Family Planning program at DSHS has $5,505,714 in federal and interagency contract funding in fiscal years 2014 to 2015, representing approximately 13 percent of the Family Planning program's budget and about 3 percent of the combined budgets of the Family Planning, Expanded Primary Health Care and Texas Women's Healthcare programs.

4    "Texas Policy Evaluation Project Family Data Finder," University of Texas Population Research Center, Texas Policy Evaluation Project, accessed August 8, 2014, https://www.prc/utexas/edu/txpep/#state.

5    Some sites and providers participate in multiple state-funded women's health programs.

6    The Expanded Primary Health Care program prioritizes family planning services listed in the chart, but can also cover primary care services as defined in Section 31.002(a)(4), Texas Health and Safety Code.

7    The Texas Women's Health Program offers only initial pap testing for cervical cancer; the Family Planning and Expanded Primary Health Care programs offer follow-up testing for abnormal pap tests.

8    25 T.A.C. Section 39.38(b)(1).

9    Rider 91, page II-79, Article II (S.B. 1), Acts of the 83rd Legislature, Regular Session, 2013 (the General Appropriations Act).

10   Rider 89, page II-79, Article II (S.B. 1), Acts of the 83rd Legislature, Regular Session, 2013 (the General Appropriations Act).

11   Article 1 (S.B.1), Acts of the 83rd Legislature, Regular Session, 2013 (the General Appropriations Act).

12   Ninety percent of Texas Women's Health Program clients are under 100 percent of the federal poverty level threshold, and while DSHS cannot provide data to show the poverty level for its clients, the agency reports anecdotally that the large majority of its clients also fall under 100 percent of the federal poverty level.

13   Health and Human Services Commission, *Health and Human Services Commission Strategic Plan — 2015–2019*, accessed August 11, 2014, http://www.hhsc.state.tx.us/about_hhsc/strategic-plan/2015-2019/.

14   Section 31.002(a)(4), Texas Health and Safety Code.

15   Section 32.024(c-1), Texas Human Resources Code.

# ISSUE 9

*NorthSTAR's Outdated Approach Stifles More Innovative Delivery of Behavioral Health Services in the Dallas Region.*

## Background

In 1999, the state created NorthSTAR to pilot a new approach to delivering integrated, publicly funded mental health and substance use disorder services — referred to as behavioral health services — for both Medicaid and indigent clients.[1] The NorthSTAR pilot sought to eliminate wait lists and improve client services by combining delivery systems and funding sources from Medicaid, state general revenue-funded indigent programs, federal block grants, and some local funds. Today, NorthSTAR provides behavioral health services through this unique model, different from the rest of the state, to Medicaid recipients and indigent persons residing in Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties.

- **Oversight.** The Department of State Health Services (DSHS) contracts with a behavioral health organization, currently ValueOptions, to administer the NorthSTAR program. NorthSTAR is the only Medicaid managed care contract not managed by the Health and Human Services Commission (HHSC).

  A locally appointed governing board, the North Texas Behavioral Health Authority, also provides guidance and input to NorthSTAR. This board, appointed by county commissioners in each of the seven counties, serves as the local behavioral health authority for the region, and is responsible for planning, oversight, and ombudsman services.[2]

- **Budget.** In fiscal year 2013, NorthSTAR operated on a total budget of $166 million, including about $69 million in Medicaid funds.[3] DSHS pays ValueOptions a monthly amount based on a fixed per member, per month rate for its Medicaid clients and on an annual budget for its remaining funding sources for indigent clients.

- **Population served.** Most Medicaid recipients residing in NorthSTAR's service area are automatically enrolled in NorthSTAR, while indigent individuals not eligible for Medicaid access services must meet income and clinical criteria.[4] The seven county area served by NorthSTAR has over 621,000 individuals enrolled in Medicaid and over 468,000 indigent persons who are counted as enrolled members due to current or previous participation in services. Of the almost 75,000 members actually receiving behavioral health services, a slight majority are indigent. Some clients lose their Medicaid eligibility throughout the year. During fiscal year 2013, about 27 percent of NorthSTAR's Medicaid population lost eligibility.

- **Services.** Covered services in NorthSTAR include visits to a psychiatrist, psychologist, or counselor; inpatient and outpatient care for serious mental illness; and substance abuse, crisis, residential, and employment services. Primary healthcare services are not included and are provided separately for Medicaid clients through a managed care organization or fee-for-service. The indigent population often lacks insurance coverage for primary healthcare needs and may receive these services from other programs such as community clinics or uncompensated care.

# Findings

## Clients in NorthSTAR may be left behind as the rest of the state moves toward integrating all aspects of health care to reduce costs and improve outcomes, especially in Medicaid.

● Behavioral and physical health integration is becoming a best practice. Wide support exists for ensuring a person's physical health is treated together with behavioral health issues. This link, described further in the textbox *Co-occurrence of Behavioral and Physical Health Problems*, demonstrates why coordination of both types of care can improve health outcomes and reduce unnecessary costs. An integrated approach can help more effectively treat mental illness by increasing access to care and reducing stigmas that may prevent treatment. Integration also helps ensure the higher incidence, severity, and cost of physical health issues in people with mental illness are addressed more effectively.

---

### Co-occurrence of Behavioral and Physical Health Problems

● Specific to the Medicaid population, psychiatric illness is represented in three of the top five most prevalent pairs of diseases among the highest-cost 5 percent of Medicaid-only beneficiaries with disabilities.[5]

● People with serious mental illness die, on average, 25 years earlier than the general population.[6]

● Co-occurring medical conditions such as cardiovascular, pulmonary, and infectious diseases lead to premature deaths in 60 percent of persons with mental illness.[7]

● Persons who suffer from a serious physical illness are more likely to suffer from depression or anxiety, which can interfere with medication adherence.[8]

● Thirty-one percent of potentially preventable readmissions to emergency rooms and 12 percent of potentially preventable admissions resulted from behavioral health or substance abuse conditions in fiscal year 2013.

● A recent Missouri Medicaid integrated pilot project resulted in a 13 percent reduction in hospital admissions and an 8 percent reduction in emergency room use, resulting in an overall cost savings of approximately $2.4 million for 12,000 enrollees over just 18 months.[9]

---

● **Texas is moving toward integrated care.** Medicaid participants in the NorthSTAR area lack coordinated access to behavioral health and primary care benefits.[10] Medicaid managed care outside the NorthSTAR region has structurally integrated primary care, mental health, and substance abuse benefits for some time. Last session, the 83rd Legislature transitioned the remaining Medicaid mental health services into the managed care model used in the rest of the state, including case management and rehabilitation services. While implementation of the more recent change is ongoing, the structural barriers are now removed with clear direction toward integrating care for the Medicaid population.

Beyond Medicaid, communities around the state are collaborating to integrate primary care and behavioral health for the indigent and other populations. The availability of additional federal funds through the new Delivery System Reform Incentive Payment (DSRIP) program has driven significant efforts toward this goal. Statewide, 54 DSRIP projects worth about $370 million are working specifically to integrate primary care and behavioral health, four of which are in the NorthSTAR region. However, these projects operate separately from the NorthSTAR model.

● **NorthSTAR model prevents integration.** Continuing NorthSTAR as a separate carve-out from the rest of Medicaid managed care moves in the opposite direction of the clear push to integrate mental health with primary care occurring in the rest of the state. While some providers within the NorthSTAR region have been able to participate in programs to promote integration, they have not done so through the NorthSTAR model. Widespread integration of behavioral health services with primary care within NorthSTAR would require a fundamental change to the NorthSTAR model and federal approval.

*The lack of coordinated treatment limits improvements in health outcomes and cost efficiencies.*

Medicaid clients in NorthSTAR with co-occurring mental health and physical health conditions are not currently receiving coordinated treatment to address their needs comprehensively, limiting the improved outcomes and efficiency the state hopes to gain through integrated care. Because the responsibility for physical and behavioral health is split between Medicaid managed care organizations and the NorthSTAR behavioral health organization, neither has access to clients' full medical information needed to effectively coordinate care. Clients must also keep track of two insurance cards and two sets of program requirements, one for primary care and one for behavioral health, which only complicates the system for persons with serious mental illness.

## The NorthSTAR model prevents a comprehensive evaluation of statewide behavioral health policies and outcomes in Medicaid.

The state cannot effectively administer and evaluate its Medicaid behavioral health benefits in a comprehensive manner because the Dallas area, one of the most populous regions of the state, is carved-out. Beyond the basic lack of a cohesive statewide behavioral health policy, fragmented administration results in the following concerns within Medicaid.

*HHSC cannot use NorthSTAR Medicaid data because it is reported in an incompatible way.*

● **No comprehensive data analysis.** NorthSTAR presents challenges in managing the Medicaid behavioral health system because it carves out a major part of the state from policy discussions and improvement efforts based on standard, comparable evaluation. For example, HHSC is unable to evaluate Medicaid's behavioral health benefit as a whole or track statewide performance because NorthSTAR reports its data in an incompatible way. Because NorthSTAR uses a separate personal identifier, HHSC cannot determine which persons receiving NorthSTAR services are Medicaid clients, and cannot use NorthSTAR claims data for

comprehensive evaluation of trends or utilization in Medicaid. While DSHS has a crosswalk for its own management purposes, this crosswalk does not interface with Medicaid systems.

- **Duplication in Medicaid claims.** In the NorthSTAR area, Medicaid clients may receive minor mental health services in a primary care setting, paid through a managed care organization, or by a behavioral health specialist, paid for by the behavioral health organization. Both types of services are paid for by Medicaid but neither are ever evaluated to identify duplicative claims for the same client. Payment disputes can also arise as long as separate managed care organizations with overlapping, but not integrated, coverage exist in the same program.

- **Client impacts.** In the Dallas area, clients must navigate a confusing web of access points to behavioral health services, including managed care organization services (which can include behavioral health treatment through primary care physicians), NorthSTAR behavioral health services, and most recently, the intended expansion of the Youth Empowerment Services (YES) program for youth with severe emotional disturbance.

  While NorthSTAR clients have options for providers within NorthSTAR's network, clients do not have a choice of plans. Clients must join NorthSTAR's sole behavioral health organization, ValueOptions. In the managed care model used in the rest of the state, Medicaid clients have a choice of at least two managed care organizations, each with its own network of providers in the service area. Choice allows clients options for service, and competition can create advantages for clients in the way of improved customer service and additional supports and benefits.

*DSRIP has changed the game for behavioral health funding.*

## NorthSTAR's structure interferes with opportunities and incentives for funding behavioral health in the Dallas region.

- **Inability to access new federal funds.** In the last few years, DSRIP funding has changed the game for how behavioral health services are funded and delivered in Texas, providing an influx of funding to locally designed projects, many of which are focusing on the integration of behavioral health and primary care. However, while all local mental health authorities in the rest of the state are actively participating in and benefiting from DSRIP, the Dallas region's participation is significantly lagging. The region cannot use the significant amount of state money provided to NorthSTAR as matching funds to secure the federal funds because NorthSTAR operates through a private vendor to coordinate services. Federal law requires a public entity to put up the public share of payments for the project for DSRIP.[11] In fact, no managed care organization is allowed to participate in these projects according to program rules because all DSRIP providers must be direct Medicaid providers.[12] A change in the basic NorthSTAR model itself and federal approval would be required for NorthSTAR to

be eligible for DSRIP funds. Specifically, a DSRIP provider would need to assume full financial risk for provision of behavioral health services for eligible persons in the NorthSTAR region, including if costs exceed the amount of the contract.

As a result, the Dallas area received significantly less funding than comparable metropolitan areas of the state. The chart, *Comparison of DSRIP Behavioral Health Projects and Value*, depicts this disparity. The Dallas region behavioral health-related DSRIP projects have potentially earned $300 million less than the Houston region, and about $100 million less than the Fort Worth region and other

**Comparison of DSRIP Behavioral Health Projects and Value: Five Largest Regions**

| Region | Number of Active Four-Year Projects | Estimated Project Value |
|---|---|---|
| Houston (Region 3) | 44 | $444 Million |
| Fort Worth (Region 10) | 26 | $229 Million |
| San Antonio (Region 6) | 34 | $216 Million |
| Austin (Region 7) | 36 | $197 Million |
| Dallas (Region 9) | 21 | $127 Million |

metropolitan areas of the state on average. Continued DSRIP funding in the future will be contingent on subsequent federal approval of the waiver, but the broad scope and critical nature of this funding makes it a reasonable assumption that federal funding will likely continue beyond 2016 in some form. The Dallas region should not miss out on this funding simply because of an outdated structure for its behavioral health services.

- **Local investment lacking.** The NorthSTAR model does not effectively incentivize local contributions for these services, leading to declining local funding invested in NorthSTAR, which now operates with little local funding support. Although local match funds are not required of the counties participating in NorthSTAR, four of the seven counties have historically contributed. However, two counties traditionally providing the largest amounts, Collin and Dallas, have stopped contributing, leaving only small investments from two rural counties, as shown in the table on the following page, *Local Funding Contributions to NorthSTAR*.[13]

In fiscal year 2014, Dallas County used the money it had contributed to NorthSTAR as match for various DSRIP projects to better leverage federal funds for the area. This additional federal funding may supplement the behavioral health services that NorthSTAR provides the region, including helping with hospital and jail diversions for persons in need of services. However, these DSRIP dollars came to the Dallas region despite NorthSTAR, not because of it, and as mentioned earlier, these projects operate separately from NorthSTAR.

*The Dallas region misses out on additional federal funds because of NorthSTAR's outdated structure.*

The withdrawal of local funding for NorthSTAR to use for other DSRIP projects in the area reflects a telling lack of support and commitment for the model because of its structural limitations. Local mental health authorities in other parts of the state have match requirements averaging 9 percent.

However, voluntary local matches dramatically exceed the required amount, ranging from 16 to 306 percent, and averaging 91 percent match.[14] In comparison, in the NorthSTAR region, local contributions now represent far less than 1 percent.

**Local Funding Contributions to NorthSTAR**
**FYs 2009–2014**

|  | FY 09 | FY 10 | FY 11 | FY 12 | FY 13 | FY 14 |
|---|---|---|---|---|---|---|
| Dallas | $4,040,000 | $3,715,083 | $3,715,083 | $3,343,576 | $3,342,576 | $0 |
| Collin | $560,000 | $560,000 | $560,000 | $0 | $0 | $0 |
| Rockwall | $22,500 | $22,500 | $22,500 | $25,000 | $25,000 | $25,000 |
| Navarro | $13,500 | $13,500 | $13,500 | $15,000 | $15,000 | $15,000 |
| Ellis* | $0 | $0 | $0 | $0 | $0 | $0 |
| Hunt* | $0 | $0 | $0 | $0 | $0 | $0 |
| Kaufman* | $0 | $0 | $0 | $0 | $0 | $0 |
| Total | $4,636,000 | $4,311,083 | $4,311,083 | $3,383,576 | $3,382,576 | $40,000 |

\* Ellis, Hunt, and Kaufman counties have never provided local funds to NorthSTAR.

**The time has come to draw conclusions from the NorthSTAR model and move forward with a new approach that better serves the Dallas region and the state.**

Through effective business strategies, the NorthSTAR model has provided broad access to behavioral health services for indigent clients at a much lower cost per client than the rest of the state. However, this commonly cited benefit of the model is not supposed to result from the inclusion of Medicaid funding, and in fact, federal law clearly requires that Medicaid rates be set to cover only Medicaid-eligible expenses.[15] If Medicaid rates are not set appropriately, or if the rates allow for expenditure of Medicaid funds beyond eligible Medicaid expenses, the state could be subject to federal penalties or recoupment of funds. Lax financial oversight of NorthSTAR in the past, particularly in relation to identifying and separating Medicaid and indigent costs, has helped create a perception that the success of the model depends on the inclusion of Medicaid funds to cover some of the cost of indigent care. Recently, the state has improved Medicaid rate setting for NorthSTAR to more accurately reflect Medicaid expenses, making potential separation of indigent and Medicaid funding sources more apparent from a financial standpoint.

*Improved rate setting makes separation of indigent and Medicaid populations more apparent.*

Despite reasonable questions about financial aspects of NorthSTAR and concerns that key aspects of the model's basic structure prevent taking advantage of opportunities for increased funding and integration of services, successful elements of NorthSTAR could be continued in a new model or applied statewide. These strategies include, for example, encouraging a competitive

provider market, increased outreach to clients, and use of a model that promotes cost efficiencies. Other elements to consider in a new model and in other statewide behavioral health approaches include the following.

- **Structure.** Use of a public entity eligible to put up the matching funds for federal DSRIP funds could allow for significantly greater funding opportunities and promote collaboration with other behavioral health and primary care efforts in the region.

- **Funding and services.** Studies have struggled to compare NorthSTAR to other behavioral health models because of its unique set up involving inclusion of Medicaid funds. The Legislative Budget Board concluded that NorthSTAR serves more clients with fewer overall services, while local mental health authorities in other parts of the state serve fewer people with a deeper array of services.[16] These differences result in wildly different costs per client — $1,587 in NorthSTAR compared to an average $3,684 in local mental health authorities in fiscal year 2013. Given that the NorthSTAR model cannot depend on Medicaid funding to pay for indigent behavioral health services, generally the same amount of funding currently provided for indigent services in the Dallas region would still be available for those services even if Medicaid funding was separated. Under this scenario, the level of services people receive, whether many people receive fewer services or fewer people receive more services, is ultimately a local policy decision. However, separating Medicaid funding from NorthSTAR would not automatically require cutting care currently given to the indigent population in the Dallas region.

- **Access to care.** A system open to participation by more providers expands the network, providing greater choice of providers and facilitating a competitive provider market. NorthSTAR enjoys a robust provider network because it pays providers on a fee-for-service basis, much like any managed care organization. Maintaining a fee-for-service approach or considering alternative payment methods, such as incentive-based payments as discussed in Issue 6, would benefit clients by promoting greater access to, and improving quality of, care.

- **Continuity of care.** Ensuring that current providers participate in a new model would enable clients to continue treatment without interruption. In addition, the NorthSTAR approach to assisting clients in obtaining or maintaining Medicaid eligibility provides significant health benefits from continuing to receive needed care. The loss of Medicaid status for those who are still eligible causes a much higher expenditure of state and local funds, as such expenses are not paid through the federal Medicaid match. The percentage of Medicaid recipients that lose eligibility and could regain it within the same year typically averages 5 percent of NorthSTAR's Medicaid population receiving services. Because the state does not have a clear effort to assist Medicaid recipients in maintaining their benefits, it is missing out on the benefits of ensuring greater continuity of care and cost savings that exists in NorthSTAR.

*Whether many people receive fewer services or fewer people receive more services is a local policy decision.*

*By not helping recipients maintain Medicaid benefits, the state misses out on continuity of care and related savings.*

- **Integration of mental health and substance abuse.** Despite NorthSTAR's success and elimination of statutory barriers to integration of mental health and substance abuse benefits, integration of these two benefits has not effectively occurred statewide.

- **Local input and participation.** Provision of indigent behavioral health services have historically been a largely local decision, as the state has traditionally delegated the planning, oversight, and delivery of services to local mental or behavioral health authorities. Local governments in the NorthSTAR area should continue to play a role in deciding how to administer behavioral health services for the indigent population. In addition, consideration should be given to developing a model that facilitates more, not less, local financial investments in the system over time.

# Recommendations

## *Management Action*

### 9.1 Transition provision of behavioral health services in the Dallas area from NorthSTAR to an updated model.

This recommendation would discontinue NorthSTAR as currently structured, separating the funding and administration of behavioral health services for Medicaid and indigent populations in the Dallas region. This change would allow for integration of primary care and behavioral health services for Medicaid clients, access to federal DSRIP funds for indigent services, and other innovative changes following best practices not feasible in the current model.

- **Medicaid.** This recommendation would transition behavioral health services for Medicaid clients to the managed care organizations responsible for their primary health care, as is currently occurring in the rest of the state. Subject to federal approval to discontinue the NorthSTAR waiver and move these services into the 1115 waiver, HHSC and DSHS would need to amend managed care contracts to transition clients from NorthSTAR to managed care organizations in the service area. HHSC and DSHS should ensure continuity of care for clients as they move from NorthSTAR to a managed care organization by requiring the organizations to extend contracts to any provider participating in NorthSTAR and treat them as significant traditional providers for three years. Managed care organizations have traditionally done this in other managed care transitions.

- **Local plan for indigent services.** DSHS, in consultation with HHSC, would be required to seek local input in selecting a new entity and model for providing behavioral health services to the indigent in the NorthSTAR area by soliciting proposals through a competitive bid. If DSHS does not receive sufficient local proposals to deliver indigent healthcare services, DSHS, in consultation with HHSC, should solicit local input in developing its own plan to transition indigent services to a new entity. In selecting an entity, DSHS and HHSC should give favorable consideration to proposals that most closely provide for the following:

  - experience or plan to provide and coordinate integrated care for mental health, substance abuse, and crisis services;

  - status as a public entity eligible to put up non-federal funds to match federal DSRIP funds;

- intent and ability to integrate behavioral health and primary care services;

- provider payment plan and mechanisms to ensure a competitive provider market and an adequate network of providers capable of providing broad access to services;

- plans to ensure quality of services provided to clients; and

- incentives or inclusion of local participation or match requirements.

DSHS, together with HHSC, should use a funding mechanism that incorporates outcome-based performance requirements and encourages cost efficiencies. DSHS should require the selected entity to submit the same metrics as the rest of the state to enable direct comparison with the rest of the state for behavioral health services. The selected entity would be required to offer contracts to all significant traditional providers currently delivering services in NorthSTAR for three years to ensure continuity of care for indigent clients.

- **Timeline.** DSHS would maintain its current contract for NorthSTAR until the agency is able to transition clients to the newly awarded model. DSHS, together with HHSC, should release its request for proposals by December 2015, and select an entity in time to begin services by September 1, 2016.

- **Impacts.** This recommendation would allow local governments and entities to propose a model that best suits their needs for provision of indigent behavioral health services that takes advantage of federal funding opportunities and allows for integration of behavioral health and primary care services. The new model could be a structure similar to local mental health authorities in the rest of the state, a public approach similar to NorthSTAR that includes only indigent and not Medicaid services for which any number of current Dallas-area or NorthSTAR participants could compete, or something new and innovative. For the state, this new model could provide an opportunity to experiment with best practices that, unlike the NorthSTAR model because it currently involves Medicaid funding, can easily be expanded across the state. Requiring both managed care organizations and the new entity to offer the same providers a contract would assist in continuity of care for clients if they gain or lose Medicaid eligibility.

## Change in Appropriations

### 9.2 The Sunset Commission should recommend that the Legislature include a rider to transition NorthSTAR funds to DSHS behavioral health funding strategies.

The Sunset Commission should recommend a change in appropriations in the DSHS bill pattern to transition funding from NorthSTAR to existing budget strategies used to fund other DSHS mental health and substance abuse programs in the rest of the state in amounts the appropriative committees see fit. The rider should discontinue funds to NorthSTAR at the end of fiscal year 2016 and transfer those funds to the strategies identified above in fiscal year 2017.

## Change in Statute

### 9.3 Require the state to assist with maintenance of Medicaid eligibility statewide.

This recommendation would apply statewide and require managed care organizations to work with Medicaid clients to assist with maintaining Medicaid eligibility. HHSC should continue to provide information in enrollment files for managed care organizations and require their assistance in maintaining eligibility. HHSC should also explore strategies to support continuity of Medicaid eligibility for individuals with social security income, if cost effective. Assisting clients in maintaining their eligibility

.is cost-effective for the state because it both ensures that the cost of services can be matched with federal funds, and can provide continuity of care to prevent lapses that result in more expensive admissions to emergency rooms or jails. Requirements for managed care organizations to assist clients with maintaining Medicaid eligibility would not only benefit persons with mental illness, but also other populations needing assistance such as individuals with intellectual and developmental disabilities.

## 9.4    Require HHSC to ensure behavioral health services are integrated into managed care organizations statewide.

This recommendation would require HHSC, as part of its contract monitoring efforts for Medicaid managed care organizations statewide, to ensure that behavioral health services are fully integrated into primary care coordination. HHSC should use performance audits and other oversight tools, especially in cases in which managed care organizations subcontract behavioral health services, to ensure clients receive coordinated behavioral health and primary care. HHSC would also be directed to establish performance measures to ensure effective integration of services. For example, HHSC could ensure an adequate number of behavioral health providers in a managed care organization's network, or review treatment plans to ensure that behavioral health services are incorporated into primary care or long-term services and support plans. The result of such integration would more effectively realize health benefits for clients and cost savings for state and local governments.

## Fiscal Implication

These recommendations would result in about $2.4 million in savings to the state in fiscal year 2017, but totaling almost $29 million over the first five years. Overall, provision of indigent behavioral health services in the Dallas area through a new model, serving the same number of people with similar services, could be accomplished with about the same level of funding as NorthSTAR currently uses for its indigent population. A new behavioral health model capable of accessing federal funds for indigent care in the Dallas area, while not increasing funds to the state, could also result in significant gain for the Dallas area of more than $40 million annually.

- **Local DSRIP funds**. Creation of an entity eligible for DSRIP funds would infuse a significant amount of federal funding into the Dallas area behavioral health system. Assuming the 1115 waiver continues upon waiver renewal in 2016 under the current structure and funding levels, and assuming that all of NorthSTAR's $68 million that currently qualifies as intergovernmental transfer funds is matched with a 60 percent federal funding for DSRIP projects, about $40.7 million in additional funds for the Dallas area could be secured annually.[17]

- **Indigent services**. Costs to administer behavioral health services for the indigent in the Dallas area will depend on the local approach to service levels. Sunset staff believes that an approach similar to the current model, minus Medicaid funding, can provide approximately the same level of services to the same number of people. However, if local proposals reflect a model more in line with the rest of the state, providing more services to fewer people, then fewer clients will receive services. Under this approach, providing more services to more people will result in additional costs.

  Based on recent pilots in other states, if local efforts promote increased integration of behavioral health and primary care for the indigent population, savings to local governments could be dramatic; however, potential savings would depend on the scope of implementation and could not be estimated for this report.

Separating Medicaid funds from funds for indigent services in the NorthSTAR region could result in the loss of some small administrative efficiencies, as administrative costs for both the Medicaid and indigent populations are currently combined. However, these costs would not be significant.

- **Medicaid services.** Removing Medicaid behavioral health services from NorthSTAR and integrating them with primary care services in Medicaid managed care in the Dallas area will result in an estimated $28.9 million in cost savings for the state over five years. Annual state savings of $107,367 from the reduction of about four staff will also result from more efficient administration of the Medicaid portion of the NorthSTAR contract.

- **Assistance with Medicaid eligibility.** Separating services for the Medicaid and indigent populations in the Dallas area, as recommended in Recommendation 9.1, could result in small increased costs in the Dallas area tied to indigent individuals losing their Medicaid eligibility. However, Recommendation 9.3 should reduce this financial impact in the Dallas area by improving maintenance or renewal of Medicaid eligibility. For the rest of the state, Recommendation 9.3 would result in savings associated with obtaining federal match funds for persons who are eligible for Medicaid, but forget to renew or otherwise lose coverage while still eligible for Medicaid. Those savings could not be estimated for this report.

### Savings to General Revenue

| Fiscal Year | Savings to the General Revenue Fund |
|---|---|
| 2017 | $2,438,901 |
| 2018 | $6,413,710 |
| 2019 | $6,547,469 |
| 2020 | $6,857,475 |
| 2021 | $7,191,510 |

.............................................

1      NorthSTAR is a 1915(b) Medicaid waiver of Title XIX, Social Security Act.

2      Section 533.0356, Texas Health and Safety Code.

3      Other funding sources include state funds, Mental Health block grant, Substance Abuse Prevention and Treatment block grant, Temporary Assistance for Needy Families block grant, Title XX, and a state hospital allocation.

4      Medicaid recipients in nursing homes, intermediate care facilities, and foster care do not participate in NorthSTAR and receive behavioral health services through fee-for-service.

5      *Morbidity and Mortality in People with Serious Mental Illness*, National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, October 2006.

6      Faces of Medicaid III: Refining the Portrait of People with Multiple, Chronic Conditions, Center for Healthcare Strategies, Inc. October 2009.

7      *Morbidity and Mortality in People with Serious Mental Illness*, National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, October 2006.

8      *Texas Learning Community on Integrated Health Care: Coming Together to Advance the Adoption and Acceleration of Integrated Health Care in Texas*, http://www.hogg.utexas.edu/uploads/documents/TLC%20Summary%20Report_final1.pdf, February 2013.

9      *Progress Report, Missouri CMHC Healthcare Homes*, Department of Mental Health and MO HealthNet.

10     S.B. 58, 83rd Texas Legislature, Regular Session, 2013.

11     42 C.F.R. Sections 433.50 and 433.51.

12     15 T.A.C. Section 355.8203(c)(1).

13     The Dallas County local match funds historically went to ValueOptions and the other rural county funds go to the North Texas Behavioral Health Authority.

14     Local match requirements for local mental health authorities range from 5 to 14 percent and are based on the per capita income of each local mental health authority's local service area.

15     42 C.F.R. Section 438.6(c)(4)(ii)(A).

16     Legislative Budget Board, *A Comparison of Behavioral Health Data Across NorthSTAR and Other Selected Service Delivery Areas, January 2011*, , accessed September 25, 2014, http://www.lbb.state.tx.us/Documents/Publications/GEER/GEER01012011. pdf#CompBehavioralHealthData, p. 81.

17     Eligible funds for DSRIP match include unmatched general revenue for indigent care, block grant maintenance of effort, and state hospital funds.

# ISSUE 10

*Poor Management Threatens the Office of Inspector General's Effective Execution of Its Fraud, Waste, and Abuse Mission.*

## Background

The Texas Legislature created the Office of Inspector General (OIG) in 2003 as part of its reorganization of the health and human services (HHS) system. In statute, OIG is a division of the Health and Human Services Commission (HHSC), but organizationally and practically, OIG operates with a large degree of independence and separation from HHSC.[1] The governor appoints the inspector general to a one-year term.[2]

OIG is charged with preventing, detecting, and investigating fraud, waste, and abuse throughout the HHS system.[3] To accomplish this mission, OIG engages in a wide variety of functions, performing 103,618 investigations, reviews, and audits in fiscal year 2013. OIG comprises five divisions, the functions of which are listed below.

- **Operations.** The operations division performs various administrative, business, and technological functions for OIG. The division maintains the business side of OIG, and houses actuarial staff who create statistically valid random samples for enforcement and audit divisions. The division also houses a data mining system used to identify and recover overpaid amounts in Medicaid claims and contains the third-party liability unit, which ensures that Medicaid is the payer of last resort on all claims. The division operates the fraud, waste, and abuse hotline, performs background checks on providers during Medicaid enrollment, and performs limited provider education. The division recently added a managed care unit to provide internal support to the rest of OIG on managed care issues and assist in OIG's interactions with managed care organizations.

- **Compliance.** Compliance performs financial and policy compliance audits and reviews of providers and facilities throughout programs in the HHS system, the largest of which is Medicaid. OIG spends the majority of its time on the following providers and facilities: hospitals, managed care organizations, nursing facilities, women's health providers, intermediate care facilities, vendor drug providers, and programs that receive federal money.

- **Internal affairs.** The internal affairs division investigates contractor fraud, waste, and abuse and employee misconduct, including criminal misconduct, internal to the HHS system. These investigations are largely of employees who may have violated human resources policies or who are suspected of misconduct involving a resident or patient of a state institution. The internal affairs division also investigates vital statistics fraud, such as misuse of birth and death certificates. Recently, OIG has begun investigating Department of Family and Protective Services (DFPS) employee actions in child fatality cases.

- **Enforcement.** The enforcement division investigates cases of suspected fraud, waste, and abuse by providers and recipients in various public assistance programs. The general investigations unit focuses on both retailers and recipients of the Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families. Examples of these investigations include underreporting income to obtain benefits fraudulently or improperly using the money provided by these benefit programs.

The Medicaid provider investigations unit pursues suspected fraud, waste, and abuse by Medicaid providers, including fraudulent or improper billing by providers. Suspected fraud cases are referred to the Office of the Attorney General's Medicaid fraud control unit for investigation.

- **Chief counsel.** The chief counsel division performs general legal functions for OIG, and completes the sanctions portion of the enforcement process. OIG does not handle criminal fraud cases, which are instead the responsibility of the Medicaid fraud control unit at the Attorney General's Office. The sanctions section represents OIG in administrative hearings and imposes administrative sanctions on providers who are in violation of their contracts. This division also performs collections, recovering overpayments from providers and payments related to audits, as well as funds resulting from a provider's criminal order requiring restitution.

- **Budget and staff.** OIG has grown significantly since its creation, particularly in recent years, as shown by the graph below. OIG's budget increased 30 percent from $37.9 million in fiscal year 2011 to $48.9 million in fiscal year 2014. In fiscal year 2014, 33 percent of these funds came from general revenue, another 45 percent from federal sources, and 22 percent from interagency contracts. OIG's staff increased from 655 to 774 over this same time period. Budget and employee growth occurred primarily in the enforcement section, as the Legislature appropriated more funds to strengthen OIG's efforts to combat fraud, waste, and abuse.

**OIG Budget and FTEs**
**FYs 2011–2014**
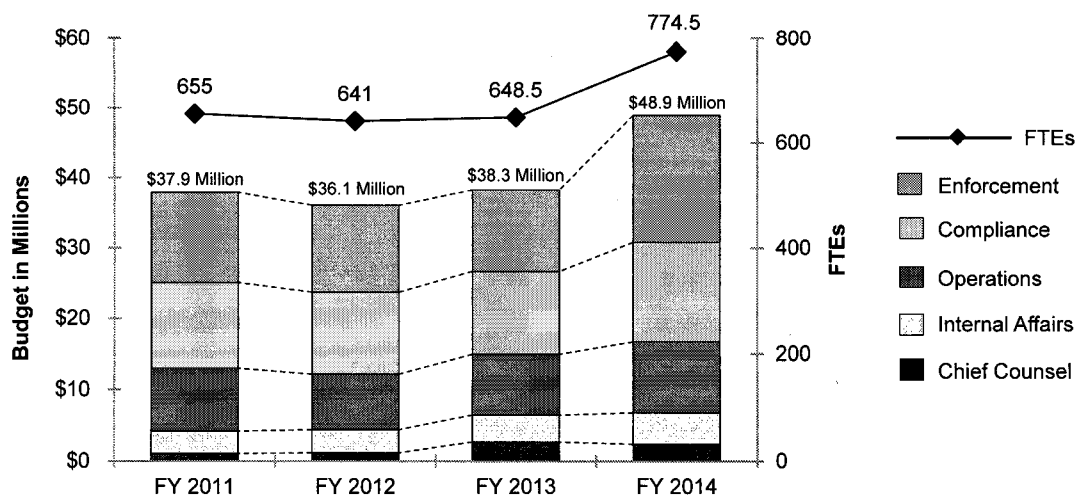


## Findings

The Office of Inspector General does not have an easy job. The expectations to root out fraud, waste, and abuse in public assistance programs like Medicaid in a state that has traditionally viewed such programs with suspicion creates a tremendous pressure on OIG to deliver results. Additional duties regarding possible abuse of clients in state institutions and possible criminal conduct within the HHS system add to this burden of expectations.

OIG's enforcement division has historically been fairly inactive. Before 2011, OIG had never brought a case before the State Office of Administrative

Hearings and both identification and recovery of overpayments to providers were considerably less than they are now. In recent years, OIG has finally taken an active role to ensure Medicaid program integrity. However, increased enforcement activity has also brought increased attention and scrutiny from the public on OIG's processes and results. This Sunset review, too, is the first comprehensive evaluation of OIG's operational efficiency and effectiveness since its creation in 2003.

The findings and discussion that follow regarding OIG present a rather harsh assessment, borne of a remarkable consistency of feedback from a range of interests and stakeholders and backed by the first-hand observations of Sunset staff, built over 11 months of review work. These conclusions are not made lightly, but are made instead in full recognition of the need for a strong and nimble OIG to ensure the integrity of these critically important HHS programs. No matter how one views the HHS system, it exists to serve a purpose, and the public must have confidence that it works properly. OIG is essential to the effort to instill that confidence.

*To question OIG's deficiencies is in no way to condone fraud or misconduct.*

However, OIG must serve this role the right way. OIG must have the proper mechanisms and approaches to effectively guide its efforts, to judge its own performance, and to accurately inform state leaders of the results of its work throughout the system. Much of what follows portrays aspects of bureaucracy that have become buzzwords in this business — a lack of priorities, criteria, processes, transparency, or accountability. However, behind these words is a real harm that can result when their basic tenets are missing. To question OIG's deficiencies is in no way to condone any level of fraud or misconduct. Ultimately, the discussion that follows relates to restoring trust to ensure that OIG is effectively serving this mission.

### OIG's investigative processes, especially Medicaid provider investigations, lack structure, data, and performance measures needed for overall management and evaluation, resulting in limited outcomes.

Throughout OIG's investigative areas, including internal affairs and especially Medicaid provider investigations, basic structural components needed to determine the overall effectiveness of investigative processes are lacking. Limitations, especially related to performance data, prevent Sunset staff, but more importantly, OIG management from fully evaluating specific areas for improvement within the investigative process. Strategies to help management better identify strengths and weaknesses of its process, including specific problems identified by Sunset staff, are detailed below.

- **Lack of criteria for opening or prioritizing cases.** OIG lacks written guidelines to ensure it is pursuing the most important, high-risk, high-dollar cases first. For internal affairs, OIG lacks clear criteria for designating a priority versus a non-priority case, each with different timeframes. Specifically, OIG staff lack a list of objective criteria to guide staff in determining which cases to open as full-scale investigations, how to

*OIG lacks a list of objective criteria to guide staff decision making.*

prioritize pursuit of those cases once opened, and when an investigator may administratively close a case. OIG's policies and procedures lay out the mechanics of OIG's work, such as how to use software and which documents to include in a case file, even including instructions on criteria to research when evaluating if a case merits a full-scale investigation. However, these policies and procedures do not provide an interpretive guide to staff on how to use that information in making decisions. A lack of decision-making guidelines based on objective criteria, such as volume of billings, history of noncompliance, or identified fraud trends, fails to ensure a fair and consistent approach to opening or prioritizing cases, allowing for providers with similar cases to be treated differently. OIG staff expressed concern that setting guidelines to prioritize cases most likely to provide the highest return to the state would tie the hands of investigators, limiting their flexibility to proceed with cases based on gut feelings. Such an approach feeds public perception that OIG engages in witch hunts against Medicaid providers, offering no defense through use of a transparent, standard, and objective approach to making these decisions. In 2006, for a different OIG program, the State Auditor's Office similarly recommended that OIG establish criteria for further pursuit and identify mechanisms to eliminate cases with no violations earlier in the process.[4]

Additionally, the agency's recent fraud initiatives for Medicaid provider investigations, together with a sophisticated new fraud identification system, Torch, compound the risk associated with a lack of priorities. Torch promises significant results for OIG, identifying $41 million in suspicious Medicaid payments for investigation in fiscal year 2014. However, the addition of such a substantial workload, without a demonstrated system for efficiently and effectively sorting and prosecuting cases in a way that maximizes monetary returns, jeopardizes the state's return on investment for these significant, and expensive, fraud identification efforts.

● **Poor use of data and performance measures.** Compounding the problems outlined above, OIG does not have basic performance data or a case management system to allow understanding of how efficient or effective its processes are, as described further in the textbox, *Performance Data Needed for Effective Case Management.* Where OIG has policies, such as a 60-day policy for completing full-scale investigations of Medicaid providers, it does not track its performance or come close to meeting its performance goals. Sunset staff's sample of investigations completed in fiscal year 2013 indicated OIG averaged three years to complete a full-scale investigation.

*OIG averages three years to complete investigations, well beyond its 60-day policy.*

Internal affairs, too, lacks a system to categorize and track types of complaints, resulting in difficulties evaluating how many employee investigations are related to managerial issues such as HHS staff sending personal emails on state computers as opposed to falsification of documents for public assistance benefits. Without a case management system capable of producing such data, OIG lacks management tools to proactively identify and address weaknesses in its investigative processes. While the 83rd Legislature appropriated funds for a case management system together with funding

---

### Performance Data Needed for Effective Case Management

- **Timeframes for resolution of cases.** Beyond total timeframes from receipt to resolution of a complaint or referral, an agency should also identify how long each stage of an investigation takes. For example, timeframes could measure from receipt to opening an investigation, from investigation to referral to sanctions, and from referral to sanctions to final resolution. Tracking external factors that delay cases, such as requests from law enforcement or lack of availability of expert reviewers, would help OIG understand which delays are within its control. Other changes in performance related to how fast cases progress can indicate inefficiencies or inform decisions related to workload or resources.

- **Caseload statistics.** An agency should be able to identify how many cases are in each stage of the investigative process. Knowing how many cases are in each stage of the process can help management pinpoint and address bottlenecks or backlogs. Also, tracking individual investigator caseloads helps manage case processing and serves as a valuable personnel management tool.

- **Trends in types of cases.** Identifying categories of cases can help establish which types of cases take longer to complete or commonly result in more serious findings or higher overpayments. This information can inform changes in prioritization criteria or allocation of resources.

- **Case dispositions.** Tracking the results of cases resolved, including whether dismissed, settled, or resulting in a final notice, and tracking outcomes of cases resulting in a sanction, informs management and the public of what OIG gets for its overall enforcement effort.

---

for a fraud identification system, difficulty reconciling different business processes across OIG's five divisions, combined with low funding estimates for the case management system, and OIG's decision to prioritize the fraud identification pieces of its project, have further delayed efforts to obtain a case management system for OIG.

Many of the statistics contained within this issue were compiled and calculated by Sunset staff with assistance from OIG. In several instances, data were simply unavailable or OIG staff struggled to provide the basic metrics requested by Sunset staff, requiring staff to manually hand count or individually calculate numbers. The textbox on the following page, *Medicaid Provider Investigations*, summarizes Sunset staff's analysis of a subset of data for this prominent area of OIG.

*In fiscal year 2013, OIG took 12 final actions resulting from Medicaid provider investigations.*

- **Limited outcomes.** For all the state's investment and media headlines, OIG takes little action, especially related to Medicaid provider investigations. In fiscal year 2012, OIG's sanctions division took 22 actions, 11 of which were for Medicaid provider investigations.[5] In fiscal year 2013, OIG took 17 actions, 12 of which were for Medicaid provider investigations. Additionally, some providers go out of business or bankrupt as a result of OIG action. Nine entities went out of business and one went bankrupt in fiscal year 2013, down from 13 out of business and three bankruptcies in 2012. Recovery of funds from providers that close or go bankrupt is difficult at best, often impossible. Pursuit of administrative sanctions is often the longest timeframe leading to case resolution in an investigative process, the result of lengthy due process procedures. OIG's limited outcomes are largely the result of the poor case flow and limited number of cases working their way out of the enforcement division and into the

## Medicaid Provider Investigations

OIG's Medicaid provider investigations are generally the highest profile investigations and contain the greatest potential for monetary recovery for suspected fraud, waste, and abuse. Below are findings illustrating key aspects of OIG's Medicaid provider investigation process and how limitations in the process compound for poor results. The information does not reflect 2014 data, for which OIG would hope to show improvement because of additional investigative resources. However, the timing of the recently concluded fiscal year and significant data limitations by OIG precluded an updated assessment.

**Lengthy timeframes.** The progression of a case through the enforcement process often takes years — more than a decade in some cases — likely the result of inadequate screening of the highest priority cases. The limited set of data below was hand-compiled by OIG and Sunset staff to obtain a flavor for the effectiveness of OIG's enforcement efforts. The data in the timeline represents the 73 investigations completed and referred from the OIG enforcement division to the sanctions division in fiscal year 2013.[6] Sunset staff manually traced back dates to establish the following timeline.

### Average Time Cases Stay in Enforcement Process
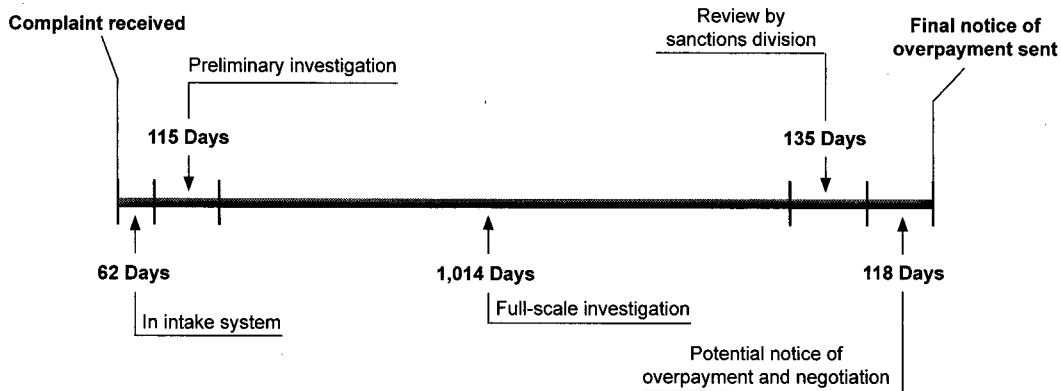


As seen in the graph, the longest lag in the process is the full-scale investigation stage, which takes nearly three years on average. Complaints may also sit in intake for months, an average of 62 days — twice the length of time required by statute — before they are even opened to determine whether they merit further investigation. Two cases sat lost in intake for more than seven years before they were opened for preliminary investigation. Sunset staff excluded these outliers for this analysis.

**Time from complaint receipt to final notice of overpayment, notice sent in FYs 2012 to 2014[7]**

*Fastest Time*: 421 days, more than one year

*Average Time*: 1,143 days, more than three years

*Slowest Time*: More than nine years, complaint originating in July 2004

*Comparison*: The Texas Medical Board averages 315 days to resolve a case, from complaint receipt to disciplinary action taken. The board's cases include complex, subjective determinations of whether a physician met an appropriate standard of care. The board is statutorily required to complete preliminary investigations within 45 days and full investigations within 180 days.[8]

**Cases languishing.** Cases languish for months to years, stuck in various stages of the investigative and sanctions processes. OIG's caseload consists of 1,156 open cases, 382 of which are more than three years old — a backlog dating back to 2001.

**Few cases resolved.** Because cases are not efficiently investigated, OIG takes action on very few complaints. In fiscal year 2013, OIG established overpayments on 12 cases, including 11 settlements, and one default. This represents only two percent of the complaints opened at intake for a preliminary investigation this same year.

**Limited cost recovery.** As a result of very few cases making it through the investigative process each year, in fiscal years 2012 and 2013, Medicaid provider investigations identified more than $1.1 billion of potential overpayments, but only collected a total of $5.5 million in overpayments.

sanctions process. OIG's sanctions division will face significant challenges as the large backlog of cases in Medicaid provider investigations makes its way through the administrative process toward case resolution.

## Absence of criteria to scale OIG's Medicaid payment recoupments to the nature of the violation contributes to large overpayment estimates and inconsistent results.

- **No scale for enforcement actions.** OIG does not differentiate between the gravity of violations of the Medicaid provider agreement. OIG can recoup payment for Medicaid claims or services provided that are not properly justified or documented, as required by the Medicaid provider agreement. After review by a subject-matter expert, OIG investigators determine whether an error justifies full recoupment from the provider of the state's payment for the service.

  A standard best practice for enforcement settings is to establish criteria to guide decisions on enforcement actions to ensure consistent decision making by agency staff and fair treatment to providers. However, OIG has not established categories of violations scaled to different actions. For example, OIG does not distinguish between clerical errors, lack of documentation, or not actually performing a service in setting the amount of the recoupment of state money or penalties for program violations. In most cases, OIG seeks to recoup the full payment amount for each service claim that includes an error, regardless of whether a service was fraudulently provided or whether the provider made a simple clerical error.

  Without published guidelines, investigators may apply judgment inconsistently, preventing OIG from ensuring providers receive the same penalty for the same violation in similar circumstances. Currently, OIG's attempts at consistency rest on staff's memory of investigations of similar types of cases. In practice, actual settlements rely more on a provider's ability to negotiate than any basis in medical necessity of services or financial harm to the state. OIG does have rules outlining criteria for assessing penalties, but OIG does not have a complete list of penalties it would apply or a decision-making guide for determining how those criteria apply to penalties. Providers are unaware of OIG's approach for recouping Medicaid payments, which does nothing to promote provider compliance by educating them about potential penalties. While OIG is authorized to recoup the full amount, taking the harshest approach without regard to whether a case involves fraud or simple clerical errors is misleading to the public about the prevalence of intentional fraud. Distinguishing between types of violations, especially for cases in which OIG establishes that some reimbursable level of service was performed by a provider, would be a more accurate and fair approach to recovering state dollars.

- **Extrapolation to large overpayments.** The practical result of seeking full recoupment of payments for all violations, including clerical errors, is that providers are routinely found to have extremely high error rates tied to

*OIG cannot ensure providers receive the same penalty for the same violation in similar circumstances.*

billings, resulting in very large overpayments that OIG does not even expect to recover. OIG uses the percentage of errors in a sample of Medicaid provider records to estimate the subsequent overpayment sought over the full audit time frame, usually several years. Certainly, trends or patterns of clerical errors can be an indicator of fraud. In addition, extrapolation can be a valuable tool for identifying problems and evaluating the potential for error; however, doing so without appropriately accounting for the nature of violations can cause identified overpayments to skyrocket. Actual settlement amounts well below the identified overpayment are a likely indicator of an inconsistent and unfair process for providers.

*Not accounting for the nature of violations can cause potential overpayments to skyrocket.*

OIG must also be careful that such eye-catching extrapolated amounts do not end up as a final result unless a provider can actually pay the amount or go out of business. The state must pay the federal government a portion of the final amount, regardless of whether the overpayment is collected from a provider, unless the provider goes out of business. In this context, extrapolating a very high error rate across a provider's entire Medicaid billing for a given period to arrive at a high overpayment amount can appear to give an incentive to OIG simply to put such a provider out of business. Such an outcome could well be appropriate in clear cases of fraud, but mixing minor program violations in the calculation makes such a judgment less clear.

*OIG should have stronger controls to evaluate the accuracy of sampling in its investigative process.*

- **Little oversight of sampling and extrapolation methodology.** OIG's extrapolation policy, which seemingly attempts to inflate dollars identified and attract headlines, places a great deal of pressure on its sampling methodology, an area without strong controls and oversight. OIG does not have quality assurance staff dedicated to ensuring that investigative work is done properly, in line with professional standards. The Association of Inspectors General's *Principles and Standards for Inspectors General*, commonly called the Green Book, suggests that an independent reviewer, external to the unit performing the review, should evaluate the accuracy of the investigative processes, such as the sampling and extrapolation processes.[9]

## OIG's wide array of responsibilities distract its focus from functions most critical to its mission.

OIG is charged with carrying out several activities placed at OIG during its creation after system consolidation that fit poorly with or distract from its mission. Narrowing OIG's scope of activities would help focus OIG on those functions presenting the greatest risk and that are most essential to preventing fraud, waste, and abuse, and realizing maximum recoupment of inappropriately spent funds. OIG management has previously attempted to narrow OIG's scope by discontinuing some of the activities mentioned below, but these attempts have been limited and ultimately unsuccessful.

- **Misplaced focus for investigations of system employees.** OIG investigates very serious allegations related to client welfare in state institutions and

fraud, waste, or abuse of public benefits, described further in the textbox, *Priority Investigations of System Employees*. Beyond these more critical investigations, HHS policy also charges OIG with investigating employee misconduct related to fraud, waste, or abuse.

OIG has interpreted its role broadly to investigate issues that can often be described as more managerial in nature. For example, OIG investigates violations of work rules; misuse of state resources, such as visiting social media or pornographic websites on computers, or sending personal emails; theft of state resources, such as computers; and even performing stakeouts in system parking lots to catch employees using illegal substances. Historically, OIG even spent time investigating lunches stolen from office refrigerators, though these investigations were discontinued under the current OIG administration.

> **Priority Investigations of System Employees**
>
> **Client harm.** OIG is required to employ peace officers to assist local law enforcement agencies in an investigation of a criminal offense involving a resident of a state supported living center or a patient of a state hospital.[10]
>
> **Program Integrity.** OIG also investigates HHS employee misconduct to ensure program integrity, especially related to fraud, waste, or abuse, for offenses such as inappropriate use or awarding of public benefits.[11]

While certainly wrong and inexcusable, these issues likely happen at every state agency, where managers address them, and if needed, refer them to local law enforcement. HHS has an OIG because of its unique position providing direct care to vulnerable people, such as in state hospitals and state supported living centers, and to ensure the integrity of public assistance programs. However, OIG cannot break its data into categories to show which types of investigations it spends its time on. The table below shows that OIG investigates most of the complaints it receives, ranging from 83 to 92 percent in the past three years, declining to investigate very few allegations of employee misconduct. Given the state's limited resources, narrowing OIG's focus and scope to the most pressing issues would enable OIG to focus on its high priority complaints.

### OIG Employee Investigations, Excluding State Institutions
### FYs 2011–2013

| Fiscal Year | Number Received | Investigations Opened | Percent Opened* | Investigations Completed | Percent Completed* | Summary of Disposition |
|---|---|---|---|---|---|---|
| 2011 | 654 | 600 | 92% | 521 | 80% | Substantiated – 102<br>Unsubstantiated – 419<br>Closed, No Investigation – 54 |
| 2012 | 928 | 780 | 84% | 805 | 87% | Substantiated – 122<br>Unsubstantiated – 653<br>Closed, No Investigation – 166 |
| 2013 | 801 | 665 | 83% | 758 | 94% | Substantiated – 132<br>Unsubstantiated – 626<br>Closed, No Investigation – 139 |

\* Data does not necessarily reflect cases from the same year. Many cases may cross over years.

Child fatality investigations. OIG also investigates the actions of DFPS' caseworkers and their supervisors to determine whether these individuals properly followed policy and applicable laws in cases resulting in a child's death. OIG's investigations are not well defined in their nature or scope; investigators look for missteps by investigating anything from policy violations to criminal offenses by caseworkers, even opening child fatality cases in which DFPS had no prior history.

OIG has conducted over 200 investigations to determine if DFPS employees acted appropriately in child fatality cases. Two indictments have resulted to date, both of which originated from outside sources and not from OIG's now standard reviews of caseworker actions. Certainly, OIG's independent investigation of allegations of DFPS employees' inappropriate or criminal actions involving a vulnerable child or adult provides needed accountability in these difficult matters. However, given the modest results from these more routine investigations, OIG's time would be better spent focusing on referrals with more serious allegations of employee misconduct, instead of looking at every case regardless of the merits. DFPS and external entities already have a series of review processes to evaluate individual errors and systemic problems that could contribute to these tragic deaths.

*OIG has seen only modest results from its routine investigations of child fatalities.*

In cases when OIG does investigate child fatalities, OIG should develop procedures to outline investigative roles and responsibilities to avoid duplication of effort. DFPS staff are unaware of OIG's procedures or scope of its investigation, contributing to a sense of confusion and anxiety in what is already an emotional and stressful situation. In comparison, OIG has developed procedures to guide its actions in complaints related to potential abuse, neglect, and exploitation in state hospitals and state supported living centers.[12] DFPS staff also expressed concern about not having the opportunity to review OIG draft reports to point out errors, as such reports may become part of the record in a criminal proceeding.

- **The Health Insurance Premium Payment program would fit better with Medicaid.** The Health Insurance Premium Payment program reimburses a Medicaid-eligible person or family for commercial insurance premiums when costs are less than the cost of Medicaid services. These clients often access additional Medicaid services, such as long-term services and supports, beyond acute care services provided by commercial insurance plans. In fiscal year 2013, the program covered 9,038 clients with Medicaid eligibility and was supported by one HHSC staff person.

*Because OIG's focus is not on program administration, the premium payment program is a questionable fit.*

The Health Insurance Premium Payment program operated under the direction of the Medicaid director until the program was transferred to OIG after HHS system consolidation in 2003. OIG's focus is not on program administration, but rather investigations and recoveries, making this program a questionable fit. Separated from Medicaid, OIG has a less direct forum for seeking program changes, such as remedying a statutory provision that prohibits individuals in the program from participating in Medicaid managed care. The intent of this provision was to make sure

the program did not pay premiums to two different insurers, and dates to 2001 when managed care was limited in scope.[13, 14] Today, most adults in Texas' Medicaid program must enroll in managed care, with planned expansions to include various Medicaid services for more populations. The statutory prohibition on enrollment of Medicaid clients in both the Health Insurance Premium Payment program and managed care creates a problem, as employer-based insurance programs do not provide long-term services and supports critical for many program participants.

Although a link exists between OIG's administrative identification of third-party insurance payers and the Health Insurance Premium Payment program, the program bears a more important connection to Medicaid services operated by HHSC's Medicaid staff. As the state is moving toward delivering long-term services almost entirely through managed care, the Medicaid program is a better fit to address this disconnect, preventing program participants from receiving the cost-effective delivery of a full range of needed services. Separation from Medicaid's program staff lessens the opportunity to integrate the program more seamlessly with Medicaid operations to better serve clients.

- **Cost report reviews are split between OIG and HHSC.** HHSC's rate analysis department uses reviews of cost reports to determine whether its Medicaid reimbursement rates, primarily for providers of long-term services and supports, appropriately reflect providers' costs, and to determine providers' compliance with legislatively required rate enhancements for attendants and nursing facility staff providing direct care to clients. OIG's responsibility for reviewing cost reports began after the HHS system consolidation. In recent years, because of increasing numbers of cost reports, fewer resources, and the scope of audits and reviews undertaken, OIG has been unable to address all cost reports collected. Rate analysis staff review cost reports not audited or reviewed by OIG, estimating that, for 4,600 reports covering fiscal year 2012 costs, its staff reviewed about 60 percent while OIG audited or reviewed the remaining 40 percent. Rate analysis completes its reviews with about 17 staff whose duties involve other functions, compared to the 64 staff OIG uses to perform either a desk review or full, formal audit, the latter of which is not necessarily required to effectively determine report accuracy.

*OIG uses 64 staff to perform desk reviews or full audits of its share of cost reports.*

Other than workload concerns, no strong philosophical reason exists for dividing cost report reviews and audits between the rate analysis department and OIG. OIG, with its primary interest in waste, fraud, and abuse, does not need to be preparing auditing reports for another division whose purpose is to set rates and ensure compliance with rate enhancements.

- **Single audit report reviews do not fit in OIG's mission.** The federal government requires recipients of more than $500,000 in federal assistance to prepare a single audit report.[15] In a typical scenario, an HHS system agency, such as the Department of State Health Services, receives federal assistance funding and passes it to a subrecipient, such as a local mental

health authority, to provide a service. Since consolidation, OIG has reviewed subrecipients' reports for HHS system agencies to ensure that the format and content meet federal standards and are without obvious mistakes; the entity submitting the report is financially viable; federal funds have been expended and reported properly; and required statements are disclosed. In fiscal year 2013, OIG performed 481 of these reviews and currently dedicates about five staff to the effort.

Again, with its mission to seek out and prevent fraud, waste, and abuse, and recover improperly spent funds to the maximum amount possible, OIG is not a good fit for this function. These reviews return no misspent money to the state. In addition, single audit reports do not require the review of auditors or personnel independent of the HHS program funding subrecipients.

- **Responsibilities to intermediate care facilities would be better placed at DADS**. State rules authorize the Department of Aging and Disability Services (DADS) to monitor trust funds of clients in intermediate care facilities and refer a program provider to OIG for audit if deemed necessary.[16] OIG reviews clients' trust funds and income applied to the client's cost of care when a facility changes hands or closes. OIG allocates about four staff to these audits and completed seven reports in fiscal year 2013, down from 15 reports in fiscal year 2012. This function also does not fit with OIG's primary mission of finding and preventing fraud, waste, and abuse.

*OIG's work is still primarily focused on fee-for-service.*

- **OIG should better define its role in managed care**. OIG has not clearly defined its role for overseeing fraud in managed care or overseeing managed care organizations' special investigative units. OIG's work is still primarily focused on fee-for-service, but is moving progressively into managed care claims, as 90 percent of clients and claims will likely be in managed care by 2017.

Federal law requires Medicaid managed care organizations to have a mandatory compliance plan designed to guard against fraud and abuse, which state law envisions through creation of special investigative units.[17] Special investigative units, while subject to periodic OIG audit, receive no regular oversight to ensure managed care organizations enforce their plan to prevent and reduce fraud and abuse, and they are not trained in advanced investigative tactics. By not providing regular oversight, OIG is missing a tool for expanding the office's reach. For example, when OIG discovers a new trend in fraudulent activity, OIG could rely on the special investigative units to quickly determine the prevalence of such fraud in the managed care organization and help stop it.

*OIG is well positioned to investigate providers participating in more than one managed care organization.*

OIG has also not defined its role versus special investigative units for provider investigations beyond requiring special investigative units to report fraud claims that exceed $100,000.[18] Because managed care organizations can only see within their own organization, OIG is well positioned to keep investigating providers that participate in more than one managed

care organization. However, such role distinctions have not been clearly defined, and both OIG and managed care organizations would benefit from clarity of roles and responsibilities.

## OIG's methods of communicating and sharing information need improvement.

OIG's role in the HHS system requires a difficult balance. On the one hand, OIG's mission requires a reasonable amount of independence to enforce against fraud, waste, and abuse in the system, including potential criminal investigations within HHS system agencies. On the other hand, OIG needs to work collaboratively with providers to help prevent fraud, waste, and abuse before it happens, and with HHS system agencies to get a clear understanding of system programs and share insights for improving these programs. Despite recent improvements in this area, OIG has not yet achieved an optimum balance, needing more attention on the side of communication and collaboration.

*Stakeholders and Sunset staff observed that OIG is not familiar enough with the programs it audits or investigates.*

- **Deficiencies in training.** Training is essential for OIG staff, especially to understand complicated HHS system programs. Beyond Sunset staff's own observations, both stakeholders and various HHS program staff suggest that OIG staff are not familiar enough with the programs they audit or investigate. OIG indicates that formal, ongoing training specifically covering the operation of HHS system programs, such as Medicaid, does not occur systematically. OIG relies primarily on large reference documents such as the 1,800-page *Texas Medicaid Provider Procedures Manual* or the 320-page *Texas Medicaid and CHIP in Perspective*, some high-level PowerPoints, and various rules, policies, and procedures to train its auditors and investigators. These documents are important, but do not replace more hands-on training by experts. Potential training resources sit untapped around the HHS system in the staffs running HHS programs. HHSC Medicaid staff, for example, have offered to help train OIG staff, but OIG has not taken them up on this offer.

  OIG has also not taken advantage of cross-training opportunities across its divisions and programs. For example, OIG does not investigate fraud, waste, or abuse across separate public assistance programs because separate funding sources for each program would require timesheets to properly document program resources. Lack of some cross-trained staff across provider and client investigations — currently structured as separate administrative sections — similarly reduces the enforcement division's ability to identify fraud, waste, and abuse across providers and clients. OIG's newest fraud identification system, Torch, which specializes in identification of relationships across programs, providers, and clients presents additional challenges to OIG's ability to adjust to effectively prosecute these fraud rings.

- **Poor communication.** Interviews with HHS system personnel, providers, and others indicate OIG does not communicate important information or procedures effectively within or outside the HHS system. In November

2006, the State Auditor's Office pointed out similar concerns to some of the examples noted below.[19] The size of the Medicaid program, with expenditures of more than $24.2 billion in fiscal year 2013, particularly argues for HHS system components and providers to work together well to protect taxpayer dollars and ensure quality services to clients. However, communication is a two-way street; action is needed from both OIG and HHSC to improve collaboration between the divisions. The following material highlights two areas where information sharing has been lacking.

*OIG does not use formal mechanisms to communicate fraud trends to Medicaid staff.*

Unshared trend information to inform policy changes. OIG, as the primary investigator and auditor of the Medicaid program, is positioned to identify trends pointing to fraud, waste, and abuse and need for program policy changes. However, OIG does not provide, in any formal sense, information gleaned from these sources to Medicaid staff. While OIG provides feedback on changes proposed by the Medicaid program through the Benefits Management Workgroup process, OIG does not have a reciprocal process to proactively share trend information and self-initiated suggestions for policy improvements to curb fraud. The Medicaid program lacks insight into problem areas that OIG is positioned to highlight, reducing the program's effectiveness in changing policy to fix problems and prevent them in the future.

No systematic fraud prevention efforts. OIG has emphasized programs to detect fraud, waste, and abuse *after* they occur, but has not developed a systematic, planned approach to focus educational efforts on prevention, perhaps out of concern of giving away its approach for combatting fraud. Such training could promote compliance and help prevent fraud, waste, abuse, and certainly errors, by educating providers on Medicaid policies and procedures and changes coming in these policies, clarifying standards used to judge appropriate decisions in difficult areas such as determining medical necessity for services, and identifying common areas for mistakes. Prevention and education efforts could improve provider performance in complying with standards and requirements for such matters as documentation and medical necessity. Such efforts could also improve OIG's relationship with providers by establishing cooperation and interaction with provider communities in non-investigative settings. OIG currently provides trainings or presentations on fraud prevention only upon request. An effective fraud prevention effort could save the state resources by reducing fraud on the front end, requiring less staff to chase fraud after it occurs and easing investigative processes when they do occur.

*OIG's emphasis is on detecting fraud, waste, and abuse after they occur.*

- **Lack of transparency in OIG processes and activities.** OIG's website offers information for the public and providers covering basic functions of concern to them, but this information is scanty and difficult to locate. In addition, the site's search function is inoperable; a search for the word "fraud" returns no results. The site also does not include publicly available final reports or audits, nor does it post OIG policies and procedures. In contrast, DFPS posts detailed policies and procedures for a variety of their programs, including programs aimed at protecting adults and children

and describing investigative procedures to be followed when necessary.[20] The Office of the Comptroller offers detailed procedures for many of its functions, including audit sampling and extrapolation methodologies for use in tax audits.[21] Such little information on OIG's website makes it difficult for the public and providers to understand OIG's functions, scope, procedures, and providers' rights for appeal.

## OIG's structure results in blurred accountability and little oversight of effectiveness in accomplishing its fraud, waste, and abuse mission.

- **Unclear accountability.** The structure for oversight of OIG does not clearly portray to whom OIG is ultimately accountable. While the governor appoints the inspector general, statute sets out OIG as a division of HHSC.[22] In practice, OIG operates independently as an administrative attachment to HHSC, reporting to the governor and not to the executive commissioner. While the governor's appointment authority provides for accountability and oversight of OIG on paper, the governor's incredible scope of duties running the state leave little time for day-to-day oversight of OIG. As a comparison to other OIGs within state government, the HHSC OIG is the only one that does not answer to either a board or a division underneath an executive director.[23]

  Not having OIG report to the executive commissioner could jeopardize HHSC's compliance with the single state agency requirement and could put federal funds at risk. Federal law requires that the Medicaid agency may not delegate the authority to supervise the state plan, including investigation of fraud, waste, and abuse, outside of a single state agency.[24] HHSC is the single state agency for administration of Medicaid in Texas.[25] In contrast, the Medicaid fraud control unit, which Texas houses in the Attorney General's Office, has a federal mandate to exist separate and distinct from the Medicaid agency.[26]

- **Little oversight to ensure effective performance.** The harm of this structural arrangement is a lack of oversight to ensure OIG is efficiently and effectively accomplishing its mission to combat fraud, waste, and abuse. As highlighted earlier in this issue, OIG's prevention efforts are minor and ad hoc at best; the agency lacks transparent processes and data to show efficiency of process or effectiveness; has limited outcomes; and lacks basic management practices such as decision-making guidelines and a case management system that provides metrics to inform management decisions. This frustrates OIG's ability to ensure purposeful allocation of resources to get the highest return for the state. The risk for the Legislature is not getting its expected return in dollars recovered for fraud, waste, and abuse. Within the last several years, the Legislature has made big investments in sophisticated tools to identify fraud and hiring staff to investigate it. However, additional staff and tools in no way translates to recovery or avoidance of fraud if OIG does not have the processes in place

*The HHSC OIG is the only one in Texas not answering to a board or agency director.*

to prosecute those findings. Ultimately, what is at stake is faith and trust that OIG is actually making a difference in ensuring the integrity of the state's public assistance programs. More specific issues related to OIG's cost-recovery efforts are below.

Questionable return on investment. Cost-recovery data from OIG does not show that the state is receiving an appreciable return on its investment in OIG. Specific to Medicaid provider investigations, OIG reports that it identified $1.1 billion in Medicaid provider overpayments in fiscal years 2012 and 2013, but only $5.5 million in provider overpayments was collected in that period of time. Overall, almost 80 percent of OIG's $273 million total money recovered in fiscal year 2013 came from third-party liability collections, a data-matching function for other insurance payers that is not related to fraud, waste, or abuse and that, in many states, is housed within the Medicaid program, not an OIG. Minus third-party liability figures, OIG's cost-recovery efforts struggle to recover OIG's costs, and the significant increase in OIG's budget for fiscal year 2014 will only exacerbate this difficulty. Certainly, OIG benefits the state by deterring wrongdoing and encouraging compliance, but the tremendous investment begs the question of what the state gets, or could get, in return.

> *OIG has only collected $5.5 million in the same period it identified $1.1 billion in overpayments.*

Incentives may not encourage recovery of dollars. OIG's performance measures may unintentionally create a perverse incentive for OIG to focus on dollars identified instead of avoided or recovered. Focusing on a dollar amount of fraud identified, not substantiated or recovered, could incentivize OIG to apply a harsh, exaggerated approach, such as to penalize providers for paperwork mistakes and extrapolate those errors to millions of dollars, in an effort to appear to be effectively combatting fraud. If applied in an overzealous manner, focus on dollars identified can be to the detriment of actual monetary recoveries because providers go out of business or stop providing services to Medicaid clients without ever being found to have engaged in fraud.

## Recommendations

### *Change in Statute*

**10.1    Remove the gubernatorial appointment of the inspector general and require the executive commissioner to appoint and directly supervise the inspector general.**

This recommendation would remove the one-year gubernatorial appointment of the inspector general and require the inspector general to serve at the pleasure of and report directly to the executive commissioner, who is a gubernatorial appointee. The executive commissioner would maintain full oversight responsibility for OIG's functions. This recommendation would remove any questions about the executive commissioner's authority and make the executive commissioner clearly accountable for OIG's performance, as is common in other state offices of inspector general.

In cases in which OIG perceives a conflict of interest in reporting to the executive commissioner, such as related to an employee investigation of a high-ranking official, or if OIG receives criminal allegations

involving the executive commissioner, OIG would refer those allegations to the Texas Rangers for investigation through the same mechanisms that are available to other state agencies.

## 10.2    Require OIG to undergo special review by Sunset in six years.

Given the lack of data to fully evaluate OIG's performance, especially related to investigations, this recommendation would subject OIG to a special review by the Sunset Advisory Commission in six years, with agencies with a Sunset date of 2021. This recommendation subjects OIG to review, but not abolishment, as OIG does not have its own Sunset date. Within six years, OIG should have a case management system and the ability to track data to better illustrate its overall performance and the effectiveness and efficiency of its processes.

## 10.3    Require OIG, by rule, to establish prioritization and other criteria to guide its investigation processes.

This recommendation would require that OIG develop criteria, by rule, for opening a case, and, once opened, for prioritizing cases to help manage workload efficiently across the agency. Provider cases should, at a minimum, be prioritized by highest potential for recovery or risk to the state through volume of billings, history of noncompliance, or identified fraud trends. Client cases should, at a minimum, be prioritized by highest potential for recovery balanced with federal timeliness requirements. Internal affairs investigations should prioritize allegations presenting the most serious threat to resident or patient safety or risk to program integrity, such as amount or scope of fraud, waste, and abuse activities.

This recommendation would also require OIG to establish, in rule, criteria to guide field investigators in closing cases that are not worth pursuing through a full-scale investigation. This recommendation also directs OIG to widely communicate this policy to staff and train its field investigators on what warrants pursuing or closing a case.

## 10.4    Require OIG to complete Medicaid provider preliminary investigations within 45 days and full investigations within 180 days.

This recommendation would require OIG to complete preliminary investigations in its Medicaid provider investigations division within 45 days after the complaint or referral is received. In cases of suspected Medicaid fraud, this preliminary investigation would provide time for OIG to determine whether to refer the matter to the Medicaid fraud control unit for criminal prosecution. Further, OIG should complete full-scale investigations within 180 days, starting from the time the preliminary investigation ends and a full-scale investigation begins, and ending when the case is referred to the sanctions division of OIG. If an investigation exceeds the 180 day limit, OIG would be required to provide notice to the provider. The notice must include an explanation of the reason why the investigation has not been completed, unless the notice would jeopardize an investigation. As a management action, OIG should establish a performance measure, incorporating the timelines above, for full resolution of its cases.

## 10.5    Require OIG, by rule, to establish criteria for scaling its enforcement actions for Medicaid provider investigations to the nature of the violation, including penalties.

This recommendation would require OIG to establish, in rule, criteria to use when determining enforcement and punitive actions for providers who have violated state law, program rules, or the Medicaid provider agreement. Provider violations should be categorized and scaled to the nature of the violation, including additional penalties, taking into account factors such as the prevalence of errors, the seriousness of the violations, the financial or other harm to the state or clients resulting or potentially resulting from the

errors, and mitigating factors. For example, clerical errors or inadequate documentation would likely result in a low level of recoupment, but not performing a service at all or performing a service that is not medically necessary would likely result in full payment recoupment for those services. The criteria must include a specific list of potential penalties and amounts, such as for fraud or other program violations. In situations where OIG finds patterns of errors resulting from inadequate or lacking documentation, OIG could use its existing penalty authority to assess additional fines, including fraud in cases in which OIG finds gross negligence on the part of the provider.

While adopting criteria will help OIG make consistent, fair decisions, the criteria should not be used as a one-size-fits-all approach; OIG would maintain flexibility in determining the most appropriate sanction for each violation, based on the factors above. Publicly adopting criteria to offer guidance to OIG staff would help ensure fair and consistent treatment of providers, provide the public with the opportunity to comment on the development of the criteria, and educate providers by allowing them to better understand the potential consequences of violations, while also ensuring that the state gets money back when providers inappropriately bill the state.

### 10.6  Require OIG to conduct quality assurance reviews and request a peer review of sampling methodology used in its investigative process.

This recommendation would require OIG to independently review aspects of its investigative process, including sampling and extrapolation of Medicaid provider records, by staff not directly involved with an investigation. Such a quality assurance review will help ensure aspects of the investigative process are performed in accordance with professional standards and ensure the integrity of the process. As a management recommendation, OIG should formally request the Association of Inspectors General, or a comparable resource, to conduct a peer review of OIG's sampling techniques according to the Association's standards laid out in the *Principles and Standards for Inspectors General*, commonly called the Green Book.

### 10.7  Define OIG's role in managed care, including strengthened oversight of special investigative units.

This recommendation would define OIG's role in managed care to include:

- investigating fraud, waste, and abuse within managed care organizations, including regular audits;

- investigating fraud, waste, and abuse across managed care organizations;

- establishing minimum requirements, providing training and regular oversight for, and approving fraud, waste, and abuse plans for managed care organization special investigative units;

- defining in rule, the investigative role of OIG versus a special investigative unit, including OIG's role reviewing special investigative unit findings; investigating cases that exceed $100,000 in overpayments; and investigating providers enrolled in more than one managed care organization;

- evaluating statewide fraud, waste, and abuse trends across the Medicaid system and communicating those trends to special investigative units to determine their prevalence; and

- assisting managed care organizations in other circumstances related to fraud, waste, and abuse as needed.

## 10.8    Remove the prohibition on participation in both the Health Insurance Premium Payment program and Medicaid managed care.

This recommendation would remove the outdated prohibition, which OIG has not had a direct forum from which to remedy, on participation in both the Health Insurance Premium Payment program and managed care to allow Medicaid clients in the Health Insurance Premium Payment program to access long-term care services and supports through Medicaid managed care.

## 10.9    Allow OIG to share confidential drafts of investigative reports concerning child fatalities with DFPS.

This recommendation would allow OIG to share confidential drafts of investigative reports that concern child fatalities with DFPS. In implementing this recommendation, OIG should allow knowledgeable DFPS staff to review any draft investigation reports on child fatalities, not to change conclusions, but to help ensure that any errors in facts or interpretation of DFPS policy do not occur and become part of the permanent record. The drafts would remain confidential in the custody of DFPS.

## *Management Action*

## 10.10   Direct OIG to narrow its employee investigations to focus on high priority allegations, such as those at state institutions and related to program integrity, and develop guidelines for investigations of child fatalities.

This recommendation would focus OIG's employee misconduct investigations to those involving a resident of a state supported living center or patient at a state hospital, or involving fraud, waste or abuse in administration of a public benefit or other program that threatens the program's integrity. OIG would still be authorized to investigate employees across the entire HHS system, and to investigate referrals of serious allegations or special requests of the executive commissioner. However, OIG would no longer spend time investigating general employee misconduct, regardless of whether the actions could be criminal in nature, for allegations that can be handled by an agency manager or referral to a local law enforcement agency. For example, OIG would no longer investigate misuse of state property or theft of a computer, but would investigate an employee's intentional falsification of eligibility documents.

This recommendation would also direct OIG to discontinue regular review of every Department of Family and Protective Services case involving a child fatality. OIG would continue to investigate special cases with specific and serious allegations related to DFPS employees, or investigate cases at the discretion of the executive commissioner. OIG should also develop written policies and procedures outlining how these investigations are to proceed, and ensure that DFPS understands the procedures OIG will follow in its investigations.

## 10.11   Direct OIG to actively take steps to improve training for its staff and communication with HHS system programs and providers.

- **Improve internal training.** OIG should seek out opportunities to cross train its staff in areas where missions are related and cross-section knowledge can improve staff's ability to identify trends in fraud, waste, and abuse that extend across programs or providers and clients. OIG should also develop active and ongoing training for its compliance, enforcement, and internal affairs staffs to inform them of policies and operations of critical programs they are involved in, internal policies and procedures staff should follow in carrying out their functions, and basic business practices of the providers they investigate. OIG should reach out to HHS system program staff, such as HHSC's

Medicaid staff, to assist in such training. These staff have in-depth knowledge and expertise in the policies and operations of their programs, the providers that serve those programs, and the clients of those providers.

- **Communicate and share information on Medicaid.** OIG should actively engage HHSC Medicaid staff to set up ways to share trend information, whether through formal or informal means. In particular, OIG has information systems and investigative experience at its disposal to identify trends in Medicaid fraud that would inform changes in policy to fix problems identified. OIG should also work cooperatively and proactively with Medicaid staff and, to the extent necessary, providers, to work out disagreements in Medicaid policy when they arise. Because communication requires both parties, HHSC's Medicaid division should also make efforts to improve its end of communication and collaboration with OIG.

- **Establish ongoing prevention efforts.** In an effort to prevent fraud, waste, and abuse, OIG should establish regular, ongoing ways to inform Medicaid providers of standards by which OIG holds providers accountable; problematic trends OIG sees in utilization of Medicaid services or areas likely to result in fraud, waste, or abuse; and basic procedures and operating philosophy of OIG. Ongoing prevention efforts would enable the state to stop fraud before it happens, instead of waiting to expend resources to prosecute it after it occurs.

- **Increase transparency.** OIG should offer more robust and better information related to its functions and activities on its website, including full explanations of basic functions of concern to the public and providers, an operational search function, links to its reports, and policies and procedures for its processes and investigations.

## 10.12 Direct HHSC and OIG to work together to transfer certain OIG functions to other areas of the HHS system where they would fit more appropriately.

This recommendation would make the following transfers. OIG should work with the executive commissioner to transfer any budget and staff who perform these activities.

- **Operation of the Health Insurance Premium Payment program.** This program should be transferred to the Medicaid program in HHSC, so that the program's operation would be grouped more closely with other Medicaid programs, helping better integrate services.

- **Review of cost reports.** The review of cost reports used in the rate setting process should be consolidated entirely within HHSC's financial services division rate analysis department. Staff performing cost report reviews should be separated from those calculating rates to help ensure independence in carrying out both functions. The Rate Analysis Department would continue to refer any suspected fraud, waste, or abuse to OIG for investigation.

- **Review of single audit reports.** This OIG review of reports by recipients of federal assistance to ensure proper spending and reporting of federal funds should be left to the HHS system agencies that run the programs requiring these reports.

- **Handling of residents' funds in intermediate care facilities.** Reviews of an intermediate care facilities' handling of residents' trust funds and income are infrequent and fall outside the primary mission of OIG to pursue fraud, waste, and abuse and maximize return of misspent funds to the state. This function should be carried out by DADS.

### 10.13  OIG should track basic performance measures needed to monitor the efficiency and effectiveness of its investigative processes.

OIG should establish metrics and measure performance, at a minimum, to gauge timeframes, caseload statistics, and dispositions, outcomes, and trend information on its cases. Tracking this information will enable OIG management to ensure efficiency of its processes, to ensure more effective outcomes, and more quickly identify problems caused by growing backlogs or bottlenecks.

### 10.14  OIG should establish a formal plan for reducing its backlog and improving inefficiencies in the process.

Under this recommendation, OIG should develop and implement a formal plan to clear out the backlog of its oldest cases by December 31, 2015, to recover the lingering unpaid overpayments on those cases and refocus its efforts on cases that are more current. While OIG has already begun work on strategies to help clear this backlog, OIG should compile such strategies into a formal plan and submit it to the executive commissioner for review by December 31, 2014. In implementing this recommendation, OIG should identify stages of its investigative process in which cases get caught for extended periods of time and implement changes to address the bottlenecks or backlogs in those stages.

## Fiscal Implication

Overall, these recommendations would result in about $898,000 in overall savings each year to the state through staff reductions associated with review of cost reports and narrowing the focus of OIG's employee investigations. Many of these recommendations would also result in better OIG management, resulting in administrative efficiencies, but those savings cannot be estimated.

Consolidation of cost report reviews in HHSC's rate analysis division would result in savings of about $261,000 in state funds annually, as HHSC could perform reviews of all cost reports with 14 fewer employees than OIG's 64 budgeted staff by conducting only that level of review required to ensure accurate rate setting and compliance with legislatively required rate enhancements for attendants and nursing facility staff providing direct care to clients. Budgeted amounts for travel costs, professional fees, and service contracts, which HHSC staff estimates to be just over $3 million, would also transfer to HHSC with these staff.

Narrowing the focus of internal affairs investigations to only those at state institutions and those needed to ensure program integrity would result in about $637,000 in annual savings to the state through a reduction of staff. The elimination of routine investigations of child fatality investigations and general employee waste and abuse in office settings would result in a decrease in workload of an estimated 30 percent, or 14 staff.

Requirements to add structure to the investigative processes, such as establishing criteria for prioritization would create a more efficient process that likely would result in an increase in overpayments to the state sooner. Requirements for establishment of time frames for completion of investigations could require additional resources to complete work faster, but the increase would be offset by not opening low-priority cases and more efficient processing of cases.

Other recommendations would not have a fiscal impact to the state, but would result in transferring staff and funding from OIG to other HHS agencies as follows.

- The Health Insurance Premium Payment program's one staff person and associated budget would transfer to HHSC's Medicaid program.

- Responsibility for review of single audit reports would transfer from OIG back to the HHS system agencies whose programs require such reviews. The five staff performing the function at OIG would transfer to those programs, to the extent possible, along with their associated budget.

- OIG's responsibility for reviewing residents' trust funds and personal funds applied to their cost of care would transfer to DADS, along with about three staff and associated budget currently used to perform the function.

### Office of Inspector General

| Fiscal Year | Savings to the General Revenue Fund |
|-------------|-------------------------------------|
| 2016        | $898,000                            |
| 2017        | $898,000                            |
| 2018        | $898,000                            |
| 2019        | $898,000                            |
| 2020        | $898,000                            |

.................................................

1    Section 531.008(c)(2), Texas Government Code.

2    Section 531.102(a-1), Texas Government Code.

3    Section 531.102(a), Texas Government Code.

4    State Auditor's Office, *An Audit Report on the Office of Inspector General at the Health and Human Services Commission*, report no. 07-004 (Austin:  State Auditor's Office, 2006), pp. 6 and 10.

5    Internal affairs investigations result in reports and recommendations and are not counted in these totals.

6    This data reflects the 73 cases referred to sanctions in FY 2013, as well as a subset of those cases that also reached potential, and final, notices of overpayment.  Of the 73 cases referred to sanctions, 33 received a potential notice of overpayment, which were used to calculate the 135-day average for that portion of the process.  Of these 33, five received a final notice of overpayment, which were used to calculate the 118-day average for that portion of the process.  In reality, these averages are likely to be much higher, but a complete set of data regarding 2013 cases was unavailable.

7    This data reflects cases Sunset reviewed in which a final notice of overpayment was sent during fiscal years 2012 to 2014, totaling 27 cases.  Final notice of overpayment does not represent resolution of a case; cases must still go to hearing or reach settlement and agreement for repayment if the case is not dismissed.

8    Sections 154.057(b) and 164.00(b)(1), Texas Occupations Code.

9    Association of Inspectors General, *Principles and Standards for Offices of Inspector General*, accessed September 25, 2014, http:// inspectorsgeneral.org/files/2012/06/IGStandards_revised_july2012.pdf.

10   Sections 552.101 and 555.101, Texas Health and Safety Code.

11   Direction to investigate employee misconduct comes from HHS Circular C-027.

12   Memorandum of Understanding Regarding Investigations of Abuse, Neglect, and Exploitation in State Supported Living Centers and State Hospitals between the Health and Human Services Commission, the Department of Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of Inspector General of HHSC.

13   Section 32.0422(k), Texas Human Resources Code.

14   H.B. 3038, 77th Texas Legislature, Regular Session, 2001.

15   New rules going into effect in December 2014 change the dollar threshold triggering a recipient's preparation of a single audit report from $500,000 to $750,000 in federal funds received.

16   40 T.A.C. Section 9.262(a) and (b).

17   42 C.F.R. Section 438.608; and Section 531.113, Texas Government Code.

18   Section 531.1131(b), Texas Government Code.

19   State Auditor's Office, *An Audit Report on the Office of Inspector General at the Health and Human Services Commission*, report no. 07-004 (Austin:  State Auditor's Office, 2006), p. 12.

20   "DFPS Program Handbooks," Texas Department of Family and Protective Services, accessed September 25, 2014, http://www.dfps. state.tx.us/handbooks/.

21   Comptroller of Public Accounts , *Sampling Manual*, accessed September 25, 2014,,. http://www.window.state.tx.us/taxinfo/audit/ sampling/sampling.pdf.

22   Sections 531.008(c)(2) and 531.102(a-1), Texas Government Code.

23   Inspector general-related operations in major agencies such as the Department of Public Safety, Texas Department of Criminal Justice, and the Texas Juvenile Justice Department answer to the boards of those organizations. The Texas Workforce Commission operates an office of investigations within one of its divisions that answers to the executive director. Other agencies may have such functions contained within their divisions.

24   42 C.F.R. Section 431.10, Subpart A.

25   Section 531.021, Texas Government Code.

26   42 C.F.R. Section 1007.9(a).

# ISSUE 11

*Credible Allegation of Fraud Payment Hold Hearings Do Not Achieve the Law's Intent to Act Quickly to Protect the State Against Significant Cases of Fraud.*

## Background

A payment hold is an administrative and enforcement tool used by the Office of Inspector General (OIG) to stop the flow of Medicaid payments from the state to a provider. Since OIG was first established, it has been authorized to place payment holds under the state Medicaid program to compel production of records or in circumstances involving fraud or wilful misrepresentation.[1] A new spin on the payment hold came in 2011 under the Patient Protection and Affordable Care Act, which requires states to "suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending."[2] This mandatory payment hold is known as a credible allegation of fraud hold, or CAF hold.

When OIG has what it believes is a credible allegation of fraud against a Medicaid provider, it must immediately suspend Medicaid payments to that provider and send notice of its action. OIG continues to hold payments for as long as it is investigating the alleged fraudulent payments that precipitated the hold. However, providers have the opportunity to appeal the CAF hold and, if the appeal succeeds, continue to receive payments while under investigation. If the provider does not appeal the CAF hold, the case investigation proceeds to a determination of an overpayment. The CAF hold automatically ends when the overpayment is either settled or decided through a separate administrative hearing. The chart on the following page, *Credible Allegation of Fraud Payment Hold Process*, illustrates the flow of these cases.

Last session, the 83rd Legislature passed Senate Bill 1803, intending to clarify the CAF hold appeal process. The legislation took major strides in improving transparency, but did not streamline the process. The textbox, *Senate Bill 1803*, provides additional detail on the bill's provisions.

---

### Senate Bill 1803

Senate Bill 1803 attempted to increase transparency and due process in OIG's enforcement practices. Along these lines, S.B. 1803:

- improved OIG's notices to providers, requiring them to include a sample of documents that form the basis for the hold;

- required OIG to adopt rules establishing criteria for initiating and conducting full-scale fraud and abuse investigations;

- required OIG to establish minimum investigator training requirements; and

- gave providers a right to two informal resolution meetings.

Hearing procedures outlined in the bill largely reflected OIG's existing processes. The bill codified these processes to make them more apparent to providers and other stakeholders.

---

## Credible Allegation of Fraud Payment Hold Process

```
┌─────────────────────────────┐              ┌─────────────────────────────┐
│   Medicaid payments withheld │              │  Overpayment investigation   │
│        from provider;        │─────────────▶│            ends;             │
│  provider receives CAF hold  │              │  OIG sends notice of         │
│           notice             │              │        overpayment           │
└─────────────────────────────┘              └─────────────────────────────┘
              │                                            │
              ▼                                            ▼
┌─────────────────────────────┐              ┌─────────────────────────────┐
│ Provider requests expedited  │              │ Provider requests overpayment│
│           hearing            │              │           hearing            │
└─────────────────────────────┘              └─────────────────────────────┘
              │                                            │
              ▼                                            ▼
┌─────────────────────────────┐              ┌─────────────────────────────┐
│ Optional informal resolution │              │        SOAH hearing          │
│          meetings            │              │                              │
└─────────────────────────────┘              └─────────────────────────────┘
              │                                            │
              ▼                                            ▼
┌─────────────────────────────┐              ┌─────────────────────────────┐
│        SOAH hearing          │              │   SOAH issues proposal for   │
│                              │              │  decision on overpayment     │
└─────────────────────────────┘              └─────────────────────────────┘
              │                                            │
              ▼                                            ▼
┌─────────────────────────────┐              ┌─────────────────────────────┐
│   SOAH issues proposal for   │              │   HHSC issues final order    │
│    decision on CAF hold      │              │     on overpayment           │
└─────────────────────────────┘              └─────────────────────────────┘
              │                                            │
              ▼                                            ▼
┌─────────────────────────────┐              ┌─────────────────────────────┐
│ HHSC issues final order on   │              │  Hold released upon payment  │
│          CAF hold            │              │         by provider          │
└─────────────────────────────┘              └─────────────────────────────┘
              │
              ▼
┌─────────────────────────────┐
│   Provider may file appeal in│
│        District Court        │
└─────────────────────────────┘
```

In addition to its own investigation, OIG sends each CAF hold to the Office of the Attorney General for potential criminal prosecution. OIG also places CAF holds when the U.S. Attorney, the Attorney General's Office, or another entity with jurisdiction indicts a provider for a criminal Medicaid offense. The table, *Number of CAF Holds by Source*, details the total number of CAF holds OIG placed on its own initiative, and on referral based on a criminal indictment.

### Number of CAF Holds by Source
### FYs 2011–2013

| Fiscal Year | Based on an OIG Investigation | Based on a Criminal Indictment | Total |
|-------------|-------------------------------|--------------------------------|-------|
| 2011        | 5                             | 1                              | 6     |
| 2012        | 54                            | 22                             | 76    |
| 2013        | 18                            | 12                             | 30    |

# Findings

## OIG actions go beyond the intent of a CAF hold, which is to prevent financial risks to the state posed by ongoing Medicaid payments to fraudulent providers.

- **Intent of a CAF hold.** CAF holds are meant to be "a very serious action" to proactively address a credible allegation that a provider is defrauding the Medicaid program.[3] The hold in these cases is meant to mitigate the state's financial risk associated with continuing to pay out money to a fraudulent provider. Beyond impact to the state, CAF holds also have a significant impact on providers. While providers on a CAF hold may continue to care for Medicaid clients, their pay for any Medicaid work they perform is reduced by the amount of the payment hold. For example, a 100 percent payment hold cuts off all Medicaid payments for that provider. Some providers simply choose to stop accepting Medicaid clients altogether, which affects Medicaid's network of providers. Because of the potential impact on the provider network, OIG consults with HHSC to ensure that holds will not jeopardize client access to care. In other cases, an inability to bill for Medicaid services may put providers out of business altogether.

  *Payment holds are meant to mitigate the state's financial risk.*

  The state has a significant interest in protecting the Medicaid program from those who would defraud it and ensuring taxpayer money is used in a responsible manner. The federal statute requiring CAF holds draws a clear connection between the payment hold and a pending fraud investigation.[4] Likewise, OIG refers all CAF holds to the Attorney General's Office for criminal investigation and potential indictment. The nature of the hold, then, relies on a credible allegation that *fraud* has occurred, and not just a credible allegation that any overpayment, regardless of its fraudulent nature, has occurred.

- **Improper use of payment holds.** Despite the intended serious nature of payment holds, OIG uses payment holds as a negotiation tactic or bargaining tool, even for cases that do not pose significant financial risks to the state. Payment holds, including CAF holds, should be reserved for significant events, such as fraud and to compel production of records.[5] Despite this, Sunset staff found during a review of OIG case files that OIG has used payment holds as a bargaining chip to promote settlement in cases that involve just $4,000–$6,000 in overpayments spread over several years, and to discourage providers from appealing certain aspects of their case. Further, some recipients of CAF holds claim that OIG uses holds for cases of non-fraudulent billing and documentation errors. Although OIG believes that it is required to place a hold in such circumstances, federal guidance provides for flexibility on cases involving non-fraudulent billing errors, and the current approach is not consistent with the intent of a CAF hold.[6]

  *Federal guidance provides for flexibility on cases involving non-fraudulent billing errors.*

## CAF hold hearings have exceeded their narrow scope, contributing to lengthy and costly hearings that duplicate the function of an overpayment hearing.

CAF hold appeal hearings are not intended to determine whether an overpayment has actually occurred. The question of whether an overpayment has occurred should be adjudicated at an overpayment hearing later in the process, if necessary. Rather, CAF hold hearings are meant to determine whether the allegation that the provider has committed fraud is credible, to the extent that it justifies stopping payments to a provider until the determination of a fraudulent overpayment is actually made.

- **Lengthy hearings.** In statute, payment hold hearings are referred to as "expedited" hearings, but in practice, these hearings have been far from expedited. In the two CAF hold hearings that have been held thus far, the breadth and complexity of evidence presented was at a level commensurate with a hearing meant to actually adjudicate the occurrence of a fraudulent overpayment. Both sides gave hours of testimony with multiple experts over several days, presenting full ranges of evidence intended to prove that the providers had actually defrauded the state — or not. However, at the end of these hearings, a determination was made solely on the validity of the payment hold, and the question of a fraudulent overpayment has yet to be settled at an overpayment hearing for either case, years after they both began. These hearings have greatly exceeded is the content needed to determine whether a credible allegation of fraud exists, meaning that the state and providers essentially have two full-blown processes, doubling both the time and resources required to conclude the overpayment case.

*Conflicting definitions and interpretation have confused what must be proven in a CAF hold hearing.*

Meanwhile, as CAF hold cases stall in this lengthy process, the state is unable to recover overpaid money and providers cannot receive payment for services to Medicaid clients. The amount of time by which CAF hold hearings lengthen the enforcement process — months to years — also delays resolution, which is desired by all parties.

- **Evidence and standard of proof.** A number of conflicting definitions and interpretations of "credible allegation of fraud" have confused what must be proven in a CAF hold hearing. Because "credible allegation of fraud" is a nebulous term that does not correspond to any widely accepted legal standard, a number of supporting documents and definitions have been created to help clarify this term for participants in the CAF hold process. The fact that parties are attempting to fully adjudicate the occurrence of fraud at CAF hold hearings is indicative of this confusion.

Federal and state guidelines define a credible allegation of fraud as one that has an "indicia of reliability." The Centers for Medicare and Medicaid Services has declined to further clarify this language, although it has recognized that states will have "different considerations in determining what may be a 'credible allegation of fraud'" and "differing standards...with respect to what may be considered an 'indicia of reliability.'"[7,8,9] Additional

interpretation and guidance is not only permissible, but necessary at the state level to appropriately execute the CAF hold requirement. Guidance on mitigating factors that affect when a CAF hold is appropriate, and at what level, would also further aid adjudication of these cases. Such factors providing good cause for not suspending payments or suspending payments only in part are established in federal regulations as a way of addressing due process concerns about the effect of lengthy payment holds on non-fraudulent providers.[10]

The standard of proof that the state must meet in these cases should be low, tailored to the narrow and specific aim of the hearing. For the two CAF hold cases heard so far, State Office of Administrative Hearings (SOAH) has required a prima facie showing of a credible allegation of fraud and applied a less-than-preponderance standard of proof to the OIG's evidence. Although language referring to a prima facie showing was deleted in S.B. 1803, this deletion was not immediately replaced with any language concerning the evidentiary burden, leaving something of an interpretive vacuum. The inspector general has testified that an "indicia of reliability" is not absolute proof or preponderance but "closer to probable cause or reasonable suspicion."[11] Establishing a clearer standard along the lines of probable cause would go a long way toward unsticking these payment hold proceedings.

*The standard of proof should be low, tailored to the narrow aim of the hearing.*

## CAF hold hearings provide for excessive process and undue burdens on providers as compared to cases presenting more serious risks to the state and public.

The following elements allow other types of hearing processes to quickly address questions of significant and ongoing risk. Application of these elements to the CAF hold hearing processes would benefit both the state and providers.

- **Expedited hearings.** Other entities that deal with serious situations presenting significant risk to the state or the public have hearing procedures in place to mitigate risks very quickly. Licensing agencies, like the Texas Medical Board and Texas Board of Nursing, have emergency suspension authority to temporarily suspend these practitioners' license while an investigation is pending. While Medicaid provider contracts and medical licenses are different legal arrangements, the concept at play in emergency suspensions is the same as that in CAF holds: the state must take swift action to prevent further harm while an investigation proceeds.

  Temporary suspension hearings have a number of features that ensure their efficacy and keep the hearing focused on its intent, addressing the same problems inherent in the CAF process.

  - Hearings are truly expedited and must be held quickly. Medical Board final suspension hearings are generally held within one or two months of the board's temporary suspension action. Board of Nursing suspension hearings are held within 17 days of board action.

*The concept behind emergency suspensions for licensing agencies is the same as for CAF holds.*

— The standards of proof are low — a preponderance of evidence for the Medical Board and probable cause for the Board of Nursing — but the agencies must also prove that the provider's continuing to practice "constitutes a continuing threat to the public welfare."[12, 13]

— To ensure that they remain narrowly focused, Medical Board hearings are limited to eight hours, with four hours for each side to present their case, plus time for questions from the deciding panels.[14]

*The impact of being prohibited from practicing is more severe than that of a payment hold.*

— Because of the serious consequences associated with suspending a professional license, the ensuing investigations and associated hearings on the merits of the case are time-limited. For the Medical Board, the investigation must be complete within 180 days. Board of Nursing hearings on the merits must be held within 61 days.[15]

While Medicaid contractual arrangements imply a different universe of rights and responsibilities than occupational licensing, other similarities make these hearing procedures right in line with the CAF process. The potential harms arising from an improperly practicing physician are at least as severe, if not more, than the harms from a provider who is defrauding Medicaid. The two issues should be resolved with a similar amount of strictness and swiftness. Likewise, the impact on a physician or nurse who is actually prohibited from practicing during the license suspension is more severe than the impact on a Medicaid provider subject to a payment hold. As such, the hearing process for a payment hold does not need to be more complex or burdensome than the process for temporary suspension of a license to practice nursing or medicine.

● **No appeal or opportunity to overrule decisions**. As preliminary actions in a larger investigation, the decisions in temporary suspension cases are not appealable to district court. While a panel of the Medical Board decides temporary suspensions of physicians, SOAH decides whether temporary suspensions should remain in place for the Board of Nursing. In both proceedings, the decision is not appealable. For the Board of Nursing, an order is entered by the SOAH judge, in lieu of its more traditional approach of submitting a proposal for decision back to an agency for final determination. This is done to ensure independence and avoid the appearance of bias by the agency. Significant concerns about the opportunity for bias have cast doubt on the fairness of CAF hold hearings. Because of the nature of OIG and HHSC's roles and the often significant amounts of money involved, CAF hold cases would benefit from this arrangement, to assuage concerns about potential bias.

*CAF hold cases would benefit from an arrangement that assuages concerns about potential bias.*

While allowing an administrative hearing agency like SOAH to make decisions in CAF hold cases is not specifically addressed in federal requirements for the Medicaid program to be administered by a "single state agency," the federal waiver process provides an opportunity to obtain clear federal approval. The Centers for Medicare and Medicaid Services has recognized that states will have varying administrative review processes

for payment holds and has expressed reluctance to limit states as to who or what other agencies may assist in validating credible allegations of fraud.[16] At least one state has delegated this authority. North Carolina has been granted a federal waiver for its administrative hearings office to make final decisions on Medicaid fraud overpayment hearings.[17]

- **No deposits for hearing costs.** The requirement that providers pay an upfront deposit for their CAF hold hearing at SOAH is a rare exception in state government and financially burdensome for providers from whom the state is already withholding payments. In almost all types of hearings, the administrative costs for holding a hearing at SOAH are paid by the state agency, with two exceptions:

  - contract claims cases brought by state contractors for an alleged breach of contract; and

  - appraisal review board appeals brought by property owners who disagree with the appraised value of their property, for property valued more than $1 million.

  In both of these cases, deposits paid by the appellants are much lower than deposits paid by providers who have appealed CAF holds. Contract claims appellants have paid an average deposit of $4,000 over the last three years, while appraisal review board cases always require a flat deposit of $1,500. In contrast, CAF hold hearing deposits have ranged from $10,400 to $46,270 for the total SOAH costs alone, not including the required deposits for court reporter and other fees and their own legal costs.

  Likewise, contract and appraisal cases are much shorter, lasting less than half a day on average, with the longest ever lasting less than two days. CAF hold hearings, on the other hand, have been lengthy affairs, taking several days to complete. Requiring clients to pay a deposit for CAF hold hearings places an unreasonable financial burden on the provider, especially when the state is already withholding Medicaid payments from a provider.

> *CAF hold hearing deposits have ranged from $10,400 to $46,270.*

## Recommendations

### *Change in Statute*

### 11.1 Streamline the CAF hold hearing process to more quickly mitigate state financial risks.

This recommendation would streamline and reform the CAF hold hearing process to encourage faster resolution of appeals so that overpayment cases may proceed more efficiently. The CAF hold process would undergo the following reforms.

- **Notice of a payment hold.** OIG would be required to send notice to providers within five days of placing a CAF hold. If the provider requests a hearing within 10 days of receiving notice, OIG would have three days to request a hearing with SOAH. SOAH would be required to hold the CAF hold appeal hearing within 30 days of the request for hearing. Holds would continue to take immediate effect.

- **Hearings.** Hearings should be held at SOAH and be limited to four hours for each side, plus time for any questions from the administrative law judge. The parties should be limited to two continuances for reasonable circumstances.

- **Standard of proof.** OIG would be required to show probable cause that the allegation of fraudulent activity has an indicia of reliability and that continued payment to a Medicaid provider presents an ongoing significant financial risk to the state and threat to the integrity of the Medicaid program, such as through a pattern of billing behavior or practices that indicate fraud. This guidance is expected to work within the expected variation in state interpretation without contradicting federal guidance.

- **Decisions and appeals.** The final decision on the payment hold would be made by an administrative law judge at SOAH, not by OIG or HHSC, and would not be appealable to district court. The final decision on the payment hold would merely determine whether the CAF hold should continue or not; SOAH should not have the ability to adjust the level or percent of the payment hold.

- **Resolution of the case.** As provided in Recommendation 10.4, OIG should complete the investigation of an overpayment case underlying a CAF hold within 180 days of beginning the full-scale investigation.

- **Informal resolution meetings.** Providers and OIG would have the option to have informal resolution meetings before a CAF hearing, but they would no longer have a statutory right. These informal resolution meetings would run concurrently with the CAF hearing process. This would aid in streamlining the hearing process and reducing the timeline, and would bring the process more in line to comparable processes before Medical Board and Board of Nursing hearings. A provider would still have a right to two informal resolution meetings before proceeding to the overpayment hearing. Procedures for the overpayment hearing would continue as currently structured.

If necessary, OIG should work with HHSC to apply for an appropriate Medicaid waiver or seek an amendment to the state plan from the Centers for Medicare and Medicaid Services to implement the recommendations.

These provisions are intended to strike a balance between fair and timely hearings, while ensuring that both the CAF hold and the overpayment case proceed within a reasonable timeframe. The effect would be a more efficient process and use of state and provider resources.

### 11.2 Clarify good cause exceptions for OIG's application of a credible allegation of fraud payment hold.

This recommendation would require OIG to consider the following findings or mitigating factors, as outlined in federal regulations, for not applying a payment hold, or applying a payment hold only in part, when it receives a credible allegation of fraud.[18]

- Law enforcement officials specifically request that a payment hold not be imposed because it may compromise or jeopardize an investigation.

- Other available remedies implemented by the state more effectively or quickly protect Medicaid funds.

- OIG determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment hold, that the hold should be removed.

- Medicaid client access to items or services would be jeopardized by a payment hold because of either of the following:

    — an individual or entity is the sole community physician or the sole source of essential specialized services in a community; or

    — the individual or entity serves a large number of Medicaid clients within a designated medically underserved area.

- The attorney general declines to certify that a matter continues to be under investigation.

- OIG determines that payment suspension is not in the best interests of the Medicaid program.

Specifying these factors in state law would help ensure that OIG fully considers the need to apply a payment hold.

### 11.3 Clarify OIG's authority to place payment holds only in serious circumstances.

This recommendation would clarify that OIG's payment hold authority applies only in circumstances requiring a serious enforcement tool to mitigate ongoing financial risk to the state, such as a pattern of billing behaviors or practices that indicate fraud. These circumstances would be limited to:

- credible allegations of fraud,

- situations in which OIG needs to compel the production of records from a provider, or

- at the request of the attorney general.

Payment holds would not be authorized for standard overpayment cases or non-fraudulent errors. OIG would not be authorized to apply payment holds to aid in bargaining and settlement negotiation. This recommendation would not affect OIG's existing authority to pursue and recover overpayments.

### 11.4 Require OIG to pay all costs of CAF hold hearings at SOAH.

This recommendation would require OIG to pay the full hearing costs for CAF hold appeals at SOAH, instead of requiring providers to pay half of the costs. Providers would still be responsible for any of their own costs incurred in preparing for the hearing. This recommendation would align CAF hold hearings with standard state practice of requiring the agency to pay for SOAH hearings.

## Fiscal Implication

These recommendations, once fully implemented, will likely have a positive fiscal impact to the state. While requiring OIG to pay the full cost of SOAH hearings will shift costs to the state, these costs will be offset by a reduction in hearing costs due to limitations on the length of the CAF hold hearings. Currently, the state's half of CAF hold hearings have ranged between $5,785 and $23,135. SOAH estimates the proposed streamlined hearings will cost a total of approximately $5,800 per hearing. Total SOAH costs for the state per hearing will decrease or remain the same, but the number of CAF hold hearings per year cannot be estimated. OIG has only had two CAF hold hearings since the CAF holds were first implemented.

Reducing the length of time for a case to proceed to an overpayment hearing will speed up collections of overpayments, using fewer resources, returning money to state coffers much sooner than the current process. Movement of cases to collections more quickly will also likely result in fewer providers going out of business or filing for bankruptcy, maximizing the amount the state is able to recover from providers.

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

1   Section 2.19(a), Chapter 198, (H.B. 2292), Acts of the 78th Texas Legislature, Regular Session, 2003.

2   42 C.F.R. Section 455.23(a)(1).

3   76 *Federal Register* 22, p. 5933.

4   42 C.F.R. Section 455.23(a)(1).

5   Section 531.102(g)(2), Texas Government Code.

6   76 *Federal Register* 22, p. 5936.

7   42 C.F.R. Section 455.2; Section 531.1011(3)(A), Texas Government Code.

8   76 *Federal Register* 22, p. 5935.

9   Ibid., p. 5936.

10   Ibid., p. 5940.

11   Douglas Wilson, CPA, Inspector General, Texas Health and Human Services Commission, testimony before the House Government Efficiency and Reform Committee (Austin, February 18, 2013).

12   Section 164.059(b), Texas Occupations Code.

13   Nursing Board hearings are further expedited and more easily adjudicated because statute provides very clear guidance on what constitutes a "continuing threat to the public welfare."

14   Texas Medical Board, February 6, 2009, meeting minutes.

15   Sections 164.003(b)(1) and 301.455(d) , Texas Occupations Code.

16   76 *Federal Register* 22, pp. 5937 and 5940.

17   North Carolina first received CMS approval of a state plan amendment in 2012, giving final decision-making authority to its Office of Administrative Hearings for Medicaid fraud overpayment cases. See North Carolina General Statutes, Section 108C-12, Appeals by Medicaid providers and applicants. This waiver was granted under previous federal regulations relating to the authority of the single state agency. See 42 C.F.R. Section 431.10(e)(3); 44 *Federal Register* 17930, March 23, 1979, stating in pertinent part:

> In order for an agency to qualify as the Medicaid agency — If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

The federal regulation regarding the authority of a single state agency has since been amended by deleting the language above and providing simply: "The Medicaid agency may not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules and regulations on program matters." (42 C.F.R. Section 431.10(e), amended 77 *Federal Register* 17202, March 23, 2012; 78 *Federal Register* 42300, July 15, 2013).

18   42 C.F.R. Section 455.23(e) and (f).

# ISSUE 12

*HHSC's Uncoordinated Approach to Websites, Hotlines, and Complaints Reduces Effectiveness of the System's Interactions With the Public.*

## Background

At its core, the Texas health and human services system is about serving people in need, some of whom are in crisis situations relating to health issues, mental illness, abuse and neglect, and other serious problems. In fiscal year 2013, the system provided almost 11 million services to individuals through hundreds of diverse and complicated programs. People learn about services and get help navigating issues through many websites and hotlines operated by system agencies, and through a centralized ombudsman's office administered by the Health and Human Services Commission (HHSC).

State law requires HHSC to ensure the public can easily find information and interact with health and human services programs through the Internet.[1] Accordingly, the five system agencies have developed about 100 websites offering information on a variety of services and topics. Agencies also maintain 28 separate hotlines to give additional information or to take reports from the public. The textbox, *System Websites and Hotlines*, provides some examples.

In 2003, the Legislature required HHSC to establish an ombudsman's office to provide dispute resolution and consumer protection services for the system.[2] The office provides information about complaint procedures and helps people navigate various processes at each agency. The office also collects data on complaints and inquiries received by system agencies and reports trend information to the executive commissioner.

> ### *System Websites and Hotlines*
>
> About 100 system websites, for example:
>
> - HHSC — "Your Texas Benefits": www.yourtexasbenefits.com
> - DADS — "Long Term Care Quality Reporting System": http://facilityquality.dads.state.tx.us
> - DFPS — "Help for Parents, Hope for Kids": www.helpandhope.org
> - DSHS — "Speak Your Mind": www.speakyourmindtexas.org and "Healthy Texas Babies": www.healthytexasbabies.com
>
> About 28 system hotlines, for example:
>
> - DADS — consumer rights and services
> - DFPS — statewide intake for abuse, neglect, or exploitation
> - DSHS — numerous public health hotlines such as partnership for a drug free America, vaccine questions, and helplines for health services programs like women's health
> - HHSC — many hotlines for services, including 2-1-1, eligibility questions, ombudsman, and fraud reporting

## Findings

### Numerous uncoordinated websites and hotlines create barriers to navigating the complex health and human services system.

System agencies have appropriately established many websites and hotlines needed to communicate with the public on a broad range of topics, from eligibility for specific programs to more general promotional public health efforts. However, the system has taken an overall piecemeal approach to

developing these resources, preventing a comprehensive understanding of the tools available and the best way to coordinate their use. The ever-expanding number of options requires users to navigate an increasingly complex network of information, making even savvy stakeholders familiar with the system frustrated, as frequently mentioned in open-ended responses to a Sunset survey.

- **Disjointed websites.** Statute directs HHSC to create and implement policies to ensure the public can easily access information online and specifies that creation of such technologies be developed through HHSC's planning process.[3] However, HHSC has not created any formal policies, leading to agencies having several websites, divisions of agencies having websites, and even programs within divisions having websites. This approach has resulted in nearly 100 program-specific supplemental websites, mostly for DSHS and HHSC, existing outside of the agencies' main websites. The supplemental sites do not use a standard format or shell, and often do not indicate which agency manages the site or link to agency home pages or standard agency resources. Furthering the difficulties, some of the supplemental websites do not come up on simple web searches for the topic, indicating they are not set up for basic search engine optimization. Valuable information is only valuable if the website is easily found and used.

*A disjointed approach to system websites confuses and frustrates the public and wastes resources.*

Agencies contract out development of nearly half of all websites and often do not notify or seek input from information technology or communications staff during the contracting process. This disjointed approach creates inconsistency in formatting and sophistication, resulting in confusion and frustration for the public and potential duplication of efforts thus wasting resources. HHSC recently began efforts to standardize the system's websites, but could not reach agreement with the health and human services agencies, resulting in continued disorganization.

- **Piecemeal approach to hotlines.** The system's 28 hotlines, including 2-1-1, were either legacy systems in existence before the 2003 reorganization under House Bill 2292, mandated by the Legislature, or developed internally as agencies identified the need. Together, these hotlines receive millions of calls annually, but HHSC does not collect any data to show how often a member of the public reaches the correct program or call center on their first attempt, making evaluation of effectiveness difficult. Open-ended responses to a Sunset survey repeatedly indicated frustration and difficulty among stakeholders in knowing which number to call and having to make multiple phone calls to get to the right place.

HHSC has not inventoried all the hotlines that exist throughout the system and has not created policies or standards for hotlines and call centers. The agency also has not evaluated whether the hotlines are necessary and whether any could be merged. This piecemeal approach results in several incompatible phone systems with different contract requirements. Not only is this approach inefficient, but incompatible phone systems can mean

that staff answering calls cannot simply transfer callers to the right place, forcing callers to hang up and try another number and limiting the goal of getting people to the information they need in the most straightforward manner possible.

## The HHSC ombudsman's office lacks basic authority and clear guidelines needed to identify problems through accurate complaints data.

The ombudsman office's important mission to help resolve and track issues people encounter in the system relies in large part on the public's understanding of what an ombudsman is as much as its statutory authority. As the system's neutral party, the office is well positioned to assist parties throughout the system to get their complaints and inquiries answered. However, the office's role in this regard is not well developed perhaps because of confusion about its strange sounding name. The office lacks visibility as a point of escalation when parties have difficulty being heard or obtaining information through complaint processes at system agencies. With such an important role to play, the office needs to be easily accessible to the people who need help the most in dealing with such a large, complex system.

Just as importantly, the office needs to understand and track trends to facilitate policy changes needed to address underlying problems. However, the office has difficulty collecting data and information from system agencies, preventing it from gaining a comprehensive understanding of the challenges faced by stakeholders, systemwide problems, and whether consumer complaints are actually resolved.

For example, the office has no authority to require system agencies to provide uniform and timely complaint information, or to access the agencies' programs, databases, and spreadsheets used to track complaints and inquiries. Although the office has established guidance to agencies that standardizes definitions and criteria for complaints and inquiries, the office does not have the authority to require their use. As a result, the agencies do not always follow these standard definitions or criteria, compromising the usefulness of the data. While all agencies use the Health and Human Services Enterprise Administration Report Tracking System, or HEART, to track *some* complaints and inquiries, not all divisions within each agency use the database. Some divisions have opted to continue using databases from previous legacy agencies, while others track the information in simple spreadsheets. Meanwhile, data that does arrive at the office is often incomplete, as the agencies only collect and share a portion of the complaints made. Further, agencies make no effort to collect complaints that originate in regional offices; such complaints are not centrally tracked by the system and simply handled at the discretion of managers in the field. These issues all prevent the ombudsman's office from effectively carrying out its mission.

> *The ombudsman's office needs to be easily accessible to people who need help the most.*

> *The ombudsman's office has no authority to require system agencies to provide information.*

# Recommendations

## *Change in Statute*

### 12.1 Require HHSC to create an approval process and standard criteria for all system websites.

This recommendation would require HHSC to create a standard process to ensure websites across the system are developed according to standard protocols. Agencies would be required to provide HHSC's communications and information technology offices information on all existing websites and gain approval from HHSC for any new website projects. HHSC would inventory and evaluate the ongoing need for existing separate websites and how to improve uniformity and efficiency of the sites. Program staff developing websites among system agencies and HHSC communications and information technology staff would need to work together during the early stages of planning according to criteria such as those listed below.

**Communications**

- Creating criteria for a uniform look and feel for all main agency home pages. These websites should have common layouts and features and provide obvious links to all other system agency home pages and key system resources.

- Creating criteria for a look and feel for all supplemental websites, including obviously placed links to the responsible agency's home page and other appropriate topical system resources.

- Using consistency of message wherever possible.

**Information Technology**

- Creating criteria for the technical aspects of sites, such as the types of platforms to be used and analytics to be tracked.

- Ensuring accessibility to people with disabilities.

- Ensuring search engine optimization for all websites.

- Ensuring internal website search capabilities.

- Maximizing use of software and contracts for website development.

- Developing requests for proposals when contracting for any business services that include the creation of a website, as also discussed in Issue 2.

### 12.2 Require HHSC to create policies governing hotlines and call centers throughout the health and human services system.

This recommendation would require HHSC to complete a comprehensive inventory of all hotlines and call centers that exist throughout the system and create criteria for assessing whether each is needed. HHSC must assess this inventory with an eye toward merging related hotlines and call centers where appropriate, and maximizing use of the 2-1-1 call system. HHSC should complete the inventory and assessment by March 1, 2016. HHSC must also create policies establishing criteria for any future hotlines or call centers, including an approval process for both establishing a hotline and the contracts and phone systems to be used.

HHSC is well positioned to use its information technology staff to help establish hotline criteria, including compatible phone systems and metrics to be tracked. Additionally, HHSC should ensure all agencies work with HHSC information technology staff when developing requests for proposals to procure contracts for new hotlines and call centers and reprocuring contracts for existing and needed hotlines and call centers, as also discussed in Issue 2. Establishing standard criteria and unifying the contracting process will move the system toward a seamless experience for the public and should result in cost savings over the long run.

### 12.3 Clarify the role and authority of the HHSC ombudsman's office as a point of escalation for complaints throughout the system and to collect standard complaint information.

This recommendation would provide the office with clear responsibility and authority to help interested parties raise matters if they feel they are not being heard or getting information regarding complaints with system agencies. This change would provide an avenue for helping the public better navigate the system, but would not establish a separate mechanism for resolving complaints or appealing agency decisions.

The recommendation would also clarify the office's authority for collecting inquiry and complaint data from all system agencies, including authority to access agency systems for logging complaints and inquiries. The executive commissioner would be required to adopt policies for a standard process to track and report inquiries and complaints among all system agencies. These policies must include centralized tracking of complaints submitted to field or regional offices to more accurately reflect issues originating in the field. This recommendation would ensure the office has the tools needed to fulfil its mission to monitor problems across the system and ultimately, help improve services. In the future, HHSC should assess the feasibility of a technology solution to allow for consistent reporting and tracking of complains and inquiries.

## Fiscal Implication

These recommendations would result in improved systems for better and more meaningful communications with the public and should produce savings from streamlined websites and hotlines and potentially fewer consumer contacts and complaints. However, exact savings would depend on the results and timing of implementation and could not be precisely estimated. Any costs associated with producing inventories and expanding existing systems would be negligible and could be accomplished within existing resources.

---

1    Sections 531.0162(a)(1) and 531.0162(a)(2), Texas Government Code.

2    Section 531.008(c)(3), Texas Government Code.

3    Section 531.0162, Texas Government Code.

# ISSUE 13

*HHSC's Advisory Committees, Including the Interagency Task Force for Children With Special Needs, Could be Combined and Better Managed Free of Statutory Restrictions.*

## Background

To obtain stakeholder input related to rules and policies for its programs, the Health and Human Services Commission (HHSC) oversees 41 advisory committees, 35 of which are in statute and briefly described in Appendix D.[1] Advisory committees are designed for stakeholders and members of the public, either through membership on a committee or during the public input period of a meeting, to advise or provide certain perspectives or expertise to the agency on its responsibilities. One of HHSC's advisory committees, the Interagency Task Force for Children With Special Needs, is currently under Sunset review.

While state law requires agencies to meet basic standards for public input to ensure open and responsive government, the Legislature has also acknowledged the need to regularly assess whether such input is effective. The Texas Sunset Act and other laws and HHSC policies require ongoing evaluation and review of advisory committees, as shown in the textbox, *Key Advisory Committee Laws and Policies.*

> ### Key Advisory Committee Laws and Policies
>
> - **Section 325.011, Texas Government Code:** Outlines criteria for the Sunset review of agencies and their advisory committees.
>
> - **Chapter 2110, Texas Government Code:** Requires regular evaluation of agency advisory committee costs, effectiveness, and duration.
>
> - **Section 531.012, Texas Government Code:** Authorizes the executive commissioner to appoint advisory committees in rule as needed.
>
> - **HHSC Circular C-022:** Establishes system-wide guidelines for all health and human services agencies' advisory committees, including a biennial report to evaluate continued usefulness of committees.

## Findings

**Statutory advisory groups are difficult to administer, inflexible, and not fully accessible to the public.**

- **Statutory restrictions.** Some of HHSC's advisory committees may continue to be useful, but would function better in rule than in law. Establishing advisory committees in statute can lock agencies into narrowly defined ways of obtaining input without the flexibility to change or abolish groups as needs, priorities, and conditions evolve. The executive commissioner has general authority to appoint advisory committees by rule, which allows the agency to create groups as needed without the perpetuity and limitations imposed by statutory requirements.[2] Re-establishing these committees in rule, instead of statute, would provide HHSC with more flexibility to structure the committees in the best way to meet the agency's current needs.

*Statutorily required advisory committees prevent the agency from responding to evolving needs.*

*In fiscal year 2013, staff spent 16,700 hours at a cost of $800,000 supporting advisory committees.*

*HHSC does not provide working access to the Internet in its hearing rooms.*

- **Burden to administer so many committees.** The large number of committees causes administrative burdens, as the agency has difficulty staffing and managing so many active committees. The agency estimates it conducted 189 meetings of advisory committees in fiscal year 2013, conservatively representing more than 16,700 staff hours at a cost of approximately $800,000. Although the committees' value cannot be similarly estimated, 630 committee members also take time away from their day-to-day activities and often pay their own travel costs to provide feedback. In addition, many advisory committees have their own statutorily required reporting requirements that can add to the administrative burden. Obtaining stakeholder input through advisory committees is an important tool for an agency, but advisory committees must be well managed to ensure their efficiency and effectiveness. Better management of advisory committees can open the system to improved channels of advice and public input.

- **Access to advisory committees is not friendly to the public.** The health and human services system lacks a master calendar of advisory committee meetings, causing conflicts for double-booked stakeholders and making it difficult for the public to know when meetings are happening, reducing their ability to easily attend or provide input to the agency. System agencies also stream very few of their advisory committee meetings, a common practice among other state agencies, further limiting public involvement. Because HHSC's stakeholders may have disabilities that pose additional challenges to physically attending meetings, the health and human services system should make a better effort to accommodate stakeholders and members of the public to obtain their input. HHSC also does not provide working access to the Internet in its hearing rooms, leaving members of the public unable to access meeting materials that staff posts on the agency's website.

### Several of HHSC's advisory committees are unnecessary or duplicative.

- **Unnecessary committees.** A group of regional advisory committees does not fulfill its purpose and could be abolished. When managed care was in its infancy, the Legislature established Medicaid and CHIP Regional Advisory Committees to provide recommendations to HHSC on the improvement of Medicaid managed care in their region.[3] The committees operate from field offices under the division overseeing eligibility services, not the Medicaid/CHIP division, which means that both staff and members of the committee are uninformed about administration and operations of the Medicaid program or managed care. Stakeholders who attend these meetings to receive updates or provide feedback cannot receive answers to their questions right away and must wait for advisory committee members to get the answer from the agency in several days or even weeks. Moreover, the Medicaid/CHIP division does not use the regional advisory committees to communicate with stakeholders. During the agency's efforts to provide information on the most recent expansion of managed care, the Medicaid/

CHIP division instead conducted a separate series of stakeholder meetings throughout the state.

In addition, four committees are inactive, having fulfilled their purpose, but remain in statute. Those four committees are the Guardianship Advisory Board, Renewing Our Communities Account Advisory Committee, Volunteer Advocate Program Advisory Committee, and the Work Group on Uncompensated Hospital Care.

● **Duplicative committees.** HHSC also has several groups of committees that could be combined to more efficiently discuss overlapping subject matters. HHSC's number of advisory committees with overlapping jurisdictions is uncommon among other state agencies. A best practice is to use a smaller number of standing advisory committees that have broad jurisdiction over certain functions, programs, or related topics. This approach allows agencies to assign an appropriate number of specific topics to one standing advisory committee, enabling the committee to consider the cumulative impacts of related topics on both the agency and its stakeholders. Advisory committees often establish subcommittees within the standing advisory committee, if more specific input or expertise is needed. Some examples of duplicative committees are below.

*HHSC's number of overlapping advisory committees is uncommon.*

Managed Care Committees. The Legislature created both a general managed care advisory committee as well as a separate committee for each recent or upcoming managed care transition, including the following:

– State Medicaid Managed Care Advisory Committee,

– STAR Kids Managed Care Advisory Committee,

– Intellectual and Developmental Disability System Redesign Advisory Committee,

– Behavioral Health Integration Advisory Committee,

– STAR+PLUS Quality Council, and

– STAR+PLUS Nursing Facility Advisory Committee.

While program eligibility may vary, each managed care program has common elements and challenges. Members of each committee have expressed interest in addressing the same managed care topics, such as network adequacy and quality. While HHSC staff try to update the committees on other committees' actions to avoid duplication, their efforts reinforce the inefficient approach of managing several overlapping committees. One managed care committee could serve to address all managed care concerns, with subcommittees to evaluate issues specific to certain managed care programs.

Quality Committees. The Legislature has also created multiple committees to evaluate and recommend quality initiatives in the healthcare system.

Beyond the managed care committees listed above, which often discuss quality as it relates to managed care, HHSC supports several other committees focused on quality-related topics, including the following:

- Medicaid and CHIP Quality-Based Payment Advisory Committee,

- Perinatal Advisory Council,

- Telemedicine and Telehealth Advisory Committee,

- Public Assistance Health Benefit Review and Design Committee, and

- Texas Institute of Health Care Quality and Efficiency.

HHSC would benefit from aligning these committees to avoid unnecessary duplication.

## The Interagency Task Force for Children With Special Needs has overlapping jurisdictions with several other groups focused on children's needs.

The Interagency Task Force for Children With Special Needs, currently under Sunset review, provides another example of a duplicative committee because it is one of four advisory committees on children's issues, three of which specifically focus on special needs children. In addition to the Task Force, the Children's Policy Council, the Council on Children and Families, and the Texas System of Care Consortium are also concerned with children's issues. A description of each entity's charge can be found in the chart, *Advisory Committees on Children's Issues*.

### Advisory Committees on Children's Issues

| Interagency Task Force for Children With Special Needs | Improves coordination, quality, and efficiency of services for children with special needs. Develops a five-year strategic plan to address the needs of children with chronic illnesses, intellectual or other developmental disabilities, or serious mental illness. This committee reports to state leadership. |
|---|---|
| Children's Policy Council | Assists and advises health and human services agencies in developing, implementing, and administering family support policies, and related long-term care and health programs for children with disabilities. This committee reports to the Legislature and HHSC. |
| Texas System of Care Consortium | Provides oversight to state efforts to provide a comprehensive approach of community-based services and supports to meet the challenges of children and youth with serious mental health needs and their families. This consortium reports to the Legislature and the Council on Children and Families. |
| Council on Children and Families | Collaborates and leverages resources in the pursuit of efficient delivery of health and education services to children, youth, and their families. This committee advises state leadership. |

Although children with special needs are a small part of the Medicaid population, their health issues are often complicated and they incur a disproportionate amount of the costs, meriting a continuing focus on improving service coordination and outcomes for this population. However, because the Children's Policy Council and System of Care Consortium share the Task Force's focus on children with special needs, confusion exists among HHSC staff, committee members, and involved stakeholders as to which body is intended to accomplish what purposes. In practice, all three committees, along with the Council on Children and Families, address service coordination for these children and bring forward policy recommendations. The Council on Children and Families, which has a broader jurisdiction than children with special needs, spends a significant portion of its time discussing issues related to children with special needs, as services for these children typically require more coordination and resources.

*Confusion exists as to which children's advisory committee is intended to accomplish what purpose.*

While the committees' compositions are different, the committees' jurisdictions are difficult to distinguish as they often overlap. In fiscal year 2013, HHSC staff spent over 2,600 hours providing support to the four advisory committees at a cost of $153,271.

## Advisory committees with Sunset dates do not need separate evaluation.

Six advisory committees have independent Sunset dates, described further in the textbox, *HHSC Advisory Committees Subject to Sunset Review*. The Texas Sunset Act directs the Sunset Commission and staff to consider the effectiveness and efficiency of advisory committees as part of every agency's Sunset review, making independent Sunset dates and evaluation for these advisory committees unnecessary.[4] Moreover, Sunset staff has evaluated these advisory committees in concert with review of other HHSC advisory committees for effectiveness and potential duplication. Removing these committees from statute, along with their independent Sunset dates, would allow HHSC to better manage its processes to obtain stakeholder input.

---

### HHSC Advisory Committees Subject to Sunset Review

2015 – Interagency Task Force for Children With Special Needs

2017 – Texas Institute of Health Care Quality and Efficiency

2019 – Council on Children and Families

2019 – Texas Nonprofit Council

2021 – Advisory Committee on Qualifications for Health Care Translators and Interpreters

2025 – Perinatal Advisory Council

---

# Recommendations

## *Change in Statute*

### 13.1   Remove advisory committees from statute, including those with Sunset dates, and allow the executive commissioner to re-establish needed advisory committees in rule.

This recommendation would eliminate from statute HHSC's 32 of the 35 advisory committees listed in Appendix D, including several unnecessary, duplicative, or inactive advisory committees. The three remaining committees, the Pharmaceutical and Therapeutics Committee, Drug Utilization Review Board, and Medical Care Advisory Committee, would not be affected by this recommendation, as those committees are addressed in Issue 4. The recommendation would also remove the Sunset dates of those advisory committees scheduled for Sunset review. All statutory provisions associated with those committees, including reporting requirements as shown in Appendix E, would be removed from law.

This recommendation would abolish all regional advisory committees established under Subchapter B, Chapter 533 of the Texas Government Code and remove the statutory language requiring the Commission to establish regional advisory committees. These committees should remain abolished because they do not properly fulfill their purpose and HHSC uses other mechanisms to receive statewide input into managed care initiatives.

The executive commissioner would continue to create or re-create advisory committees in rule, as necessary, to advise the agency. As part of this recommendation, HHSC should restructure and reduce its number of advisory committees to move from a multitude of committees with overlapping jurisdictions to a smaller number of standing committees with broad-based jurisdiction. Restructuring the agency's advisory committees to be more efficient and effective would reduce the number of committees, and the number of stakeholders serving on advisory committees. However, the result would be increased focus and quality of stakeholder input, more easily managed by agency staff.

Committee appointments by the governor, lieutenant governor, and speaker would be removed with the statutory language and all committee members would be appointed by the executive commissioner. All committees would report their recommendations to the executive commissioner, and HHSC would publicly distribute reports or recommendations to state leadership, legislative committees, and members of the public through existing mechanisms.

### 13.2   Remove the Task Force for Children With Special Needs, the Children's Policy Council, the Council on Children and Families, and the Texas System of Care Consortium from statute.

This recommendation would remove all four committees from statute, including removing Sunset dates. In implementing this recommendation, the executive commissioner, by rule, should combine and reorganize as one advisory committee, the Task Force, the Children's Policy Council, the Council on Children and Families, and the Texas System of Care Consortium in such a way that their membership, purpose, and initiatives most effectively direct state resources to improve services and better coordinate advisory efforts for children with special needs. HHSC would determine the composition of the new committee, making sure to balance input from relevant state agencies with input from parents or families of children with special needs. The new committee could use subcommittees to focus on specific initiatives under jurisdiction of the committee.

## 13.3 Require HHSC to create a master advisory committee calendar, stream advisory committee meetings, and ensure access to online meeting materials.

HHSC should create a master calendar on its website of all advisory committee meetings across the health and human services system. A master calendar would inform stakeholders and the public of upcoming meeting and prevent affected stakeholders from having to choose between meetings of committees with overlapping stakeholder groups. HHSC should also stream its advisory committee meetings online to encourage public participation. HHSC should ensure that members of the public can access the Internet in its public hearing rooms to ensure meeting materials are available for review.

# Fiscal Implication

Overall these recommendations would result in savings to the State of at least $39,000, but additional savings through more efficient administration of fewer advisory committees cannot be estimated. Abolishing the Medicaid and CHIP Regional Advisory Committees would result in annual savings of $39,481 in staff travel and time dedicated to supporting the committees. By reducing the number of advisory committees, the agency would realize savings in staff time and travel cost, but these savings would depend on the number of advisory committees that are not re-created in rules. Streaming advisory committee meetings and ensuring online access to meeting materials should have minimal cost that could be offset by savings created through more efficient management of HHSC's advisory committees. Ultimately, these recommendations would result in more effective and efficient systems for better and more meaningful communications with the public.

### Savings to General Revenue

| Fiscal Year | Savings to the General Revenue Fund |
|---|---|
| 2016 | $39,481 |
| 2017 | $39,481 |
| 2018 | $39,481 |
| 2019 | $39,481 |
| 2020 | $39,481 |

--------------------------------------------------

[1]   Advisory committees required by federal law include the Medical Care Advisory Committee and Drug Utilization Review Committee.

[2]   Section 531.012, Texas Government Code.

[3]   Subchapter B, Chapter 533, Texas Government Code.

[4]   Section 325.111, Texas Government Code.

# ISSUE 14

## HHSC Statutes Do Not Reflect Standard Elements of Sunset Reviews.

## Background

Sunset reviews include a number of standard elements that have resulted either from direction provided by the Sunset Commission, from statutory requirements added by the Legislature to the criteria for review in the Sunset Act, or from general law provisions typically imposed on state agencies. The following material summarizes Sunset staff's analysis of applicable standard elements for the Health and Human Services Commission (HHSC).

- **Sunset across-the-board provisions.** The Sunset Commission has developed a set of standard recommendations that it applies to all state agencies reviewed unless an overwhelming reason exists not to do so. These across-the-board recommendations (ATBs) reflect an effort by the Legislature to place policy directives on agencies to prevent problems from occurring, instead of reacting to problems after the fact. ATBs are statutory administrative policies adopted by the Sunset Commission that contain good government standards for state agencies. ATBs reflect review criteria contained in the Sunset Act designed to ensure open, responsive, and effective government.

- **Reporting requirements.** The Sunset Act establishes a process for state agencies to provide information to the Sunset Commission about reporting requirements imposed on them by law and requires the Commission, in conducting reviews of state agencies, to consider if each reporting requirement needs to be continued or abolished. The Sunset Commission has interpreted these provisions as applying to reports that are specific to the agency and not general reporting requirements that extend well beyond the scope of the agency under review. In addition, the Commission will not consider reports required by rider to the General Appropriations Act under a presumption that the appropriations committees will decide on these requirements each biennium. Nor will the Commission consider reporting requirements with deadlines or expiration dates, routine notifications or notices, posting requirements, or federally mandated reports.

## Findings

**The Health and Human Services Commission's enabling statute does not reflect standard language typically applied across the board on Sunset reviews.**

HHSC's enabling statute does not include standard provisions relating to conflicts of interest and alternative rulemaking and dispute resolution that the Sunset Commission applies in across-the-board fashion to agencies under review.

- **Conflicts of interest.** While the agency's governing statute does contain some language to prevent potential conflicts of interest with trade associations, the language only applies to the executive commissioner and to entities with a financial interest in the former Texas Department of Mental Health and Mental Retardation and local mental health and mental retardation authorities.[1] The agency's statute does not include standard language that

> *Statute does not include language to help prevent potential conflicts of interest.*

would help prevent potential conflicts of interest between high-ranking agency employees and professional trade organizations associated with the health and human services agencies' myriad functions, as a way of ensuring that agency decisions are made solely in the public's interest.

- **Alternative rulemaking and dispute resolution.** The HHSC governing statute does not include all of the standard provisions relating to alternative rulemaking and dispute resolution that the Sunset Commission routinely applies to agencies under review. Without the complete provision, the agency could miss ways to improve rulemaking and dispute resolution through more open, inclusive, and conciliatory processes designed to solve problems by building consensus rather than through contested proceedings.

*Report requirements by agency advisory committees are addressed in Issue 13.*

## HHSC has four reporting requirements that are no longer necessary.

As required by the Sunset Act, Sunset staff reviewed HHSC's statutory reporting requirements and found that the agency is required to produce 42 reports, many of which continue to be useful. Eight of HHSC's reporting requirements are the ongoing responsibility of the agency's advisory committees and are addressed in Issue 13. Appendix E, *Health and Human Services Commission Reporting Requirements*, provides a comprehensive list of all reporting requirements and Sunset staff's analysis of their need. Of the reports related directly to the agency, four reporting requirements are no longer necessary and should be eliminated.

- *2-1-1 Electronic Access to Child Care and Education Services Summary Referrals.*[2] Statute requires HHSC to produce an annual report for the Legislature on the number of referrals made through the commission's website to child care and educational services, including information on the number of referrals to head start programs, local workforce boards, and local school districts. Since being established in 2005, the report has not sparked much legislative or stakeholder interest and the data could easily be provided to stakeholders on an ad hoc basis.

- *Medicaid Expenditures Report.*[3] Statute requires the agency to prepare a quarterly report detailing each health and human services (HHS) agency's Medicaid expenditures for the Comptroller's Office, State Auditor's Office, and the Legislature. However, the agency has not published this report in several years because both the monthly financial report, required by rider, and the federally required *Medicaid History Report* more comprehensively fulfill the requirements of this report.

*A more recent and comprehensive reporting requirement makes the Report on Overpayment Claims unnecessary.*

- *Report on Overpayment Claims.*[4] Statute requires that HHSC produce an annual report for the Legislative Budget Board and the governor describing the agency's progress in reducing the time to establish an overpayment claim for the Supplemental Nutrition Assistance Program (SNAP). This report, however, has been replaced by a more recent reporting requirement known as the S.B. 30 Report that provides more comprehensive information on the agency's attempts to collect overpayments of SNAP benefits.

- **Report on Procurement and Contracting Practices.**[5] Statute requires HHSC to produce a report assessing each health and human services agency's compliance with HHSC procurement requirements for the governor, lieutenant governor, and the speaker. Recently, HHSC centralized all HHS procurement at the agency, making the reporting requirement unnecessary.

# Recommendations

## Change in Statute

### 14.1 Update two standard Sunset across-the-board recommendations for HHSC.

- **Conflict of interest.** This recommendation would define "Texas trade association" and prohibit an individual from serving as a high-level agency employee if the person or the person's spouse is an officer, employee, or paid consultant of a Texas trade association in the health and human services field. The provision would also prohibit anyone registered as a lobbyist from serving as the agency's general counsel.

- **Alternative dispute resolution.** This recommendation would update statute to ensure that HHSC coordinates implementation of its alternative dispute resolution policy, provides training as needed, and collects data concerning the effectiveness of its use of alternative procedures for rulemaking and dispute resolution.

### 14.2 Eliminate four unnecessary reporting requirements, but continue others that serve a purpose.

This change will remove the following reporting requirements currently in statute:

- *2-1-1 Electronic Access to Child Care and Education Services Summary Referrals*

- *Medicaid Expenditures Report*

- *Report on Overpayment Claims*

- *Report on Procurement and Contracting Practices*

HHSC's other reporting requirements would continue in effect, with the exception of those addressed in Issue 13. Appendix E, *Health and Human Services Commission Reporting Requirements*, provides detail on each reporting requirement and Sunset staff's recommendation on whether to eliminate or continue the requirement.

# Fiscal Implication

These recommendations would not have a fiscal impact to the state.

....................................

1    The term mental retardation has generally been replaced with intellectual disability.

2    Section 531.03131(f), Texas Government Code.

3    Section 531.02112, Texas Government Code.

4    Section 22.0251(b), Texas Human Resources Code.

5    Section 2155.144(o), Texas Government Code.

# ISSUE 15

*Allow the Texas Health Services Authority to Promote Electronic Sharing of Health Information Through a Private Sector Entity.*

## Background

Technology has enabled medical personnel to create electronic files for patients and share that information over secure networks called health information exchanges. This advancement offers the promise of better medical outcomes for patients when the need arises for providers to quickly share medical history information. The textbox, *Health Information Exchanges*, explains structures for sharing health information through these networks.
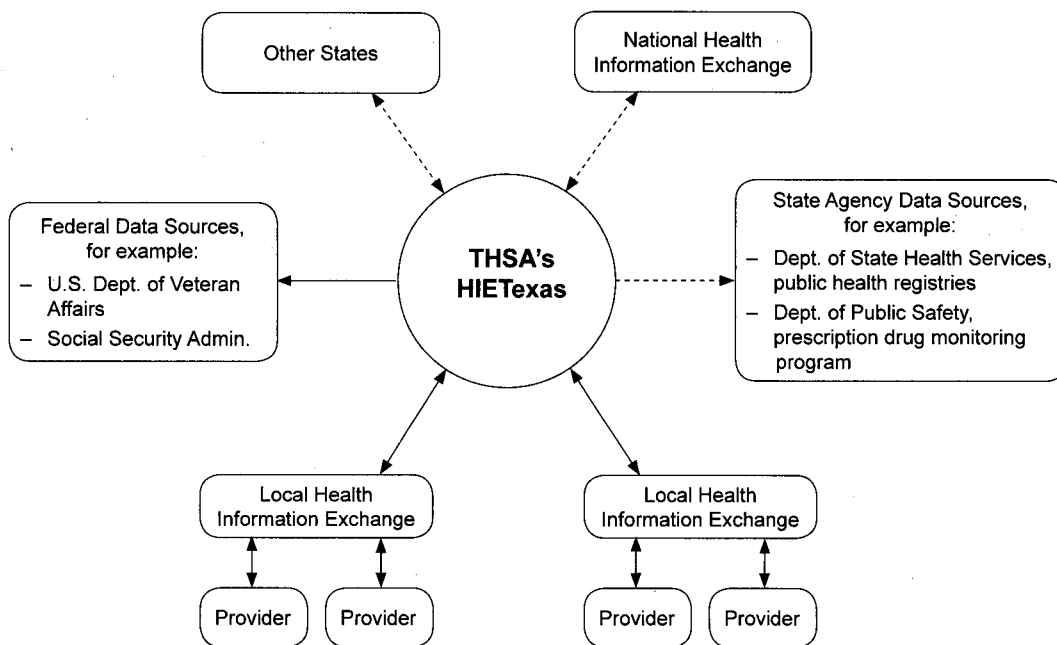
- **Creation.** Both the state and federal governments have promoted the development of electronic medical records and health information exchanges over the last decade.[1] As part of this movement, the Legislature created the Texas Health Services Authority

> ### Health Information Exchanges
>
> Health information exchanges allow healthcare providers, such as hospitals and physicians, to quickly share patient medical information electronically. As an example of the benefits of such information, quick electronic access to an unconscious accident victim's medical history could help a physician avoid administering drugs the patient is allergic to.
>
> Health information exchanges can be set up in a variety of ways. An exchange can connect a hospital and its affiliated offices and physicians together to electronically share patient medical records. On a broader scale, an exchange can also be local or regional, connecting physicians and institutions who agree to share information. Ultimately, exchanges can be linked together to share information across a state or beyond state lines.

(THSA) in 2007 to accelerate the secure sharing of electronic medical records through an integrated network, which was already occurring to some extent in the state — primarily among hospitals in the same corporate system.[2]

- **Structure.** Deciding to base its initiative largely on market forces and private interests, the Legislature created THSA as a nonprofit, public-private partnership.[3] THSA is governed by an 11-member board appointed by the governor and representing consumers, providers, hospitals, and other health information technology stakeholders.[4] The governor also appoints two ex officio, nonvoting members to represent the Texas Department of State Health Services.[5] At the request of the board, a representative from the Health and Human Services Commission (HHSC) also participates in quarterly meetings and serves as a nonvoting member. Although statutorily created as a nonprofit corporation, THSA is subject to the Texas Open Records Act, the Open Meetings Act, and the Sunset Act.[6] Statute authorizes THSA to fund its operations with general revenue, grants, user fees, and other ways consistent with its statutory purpose.[7]

- **Funding.** THSA received no funding when initially created, operating in the governor's office as an advisory board on health information technology and health information exchanges.[8] This situation changed after enactment of the federal American Recovery and Reinvestment Act, which included provisions to promote health information exchanges through grants to states.[9] In 2010, HHSC received a four-year, $28.8 million grant through these federal stimulus funds.[10] HHSC then contracted with THSA to develop a state plan and promote the development of health information exchanges in Texas, after which THSA separated from the governor's office to carry out this initiative.

Through its HHSC contract, THSA received about $1 million to develop a state health information exchange plan; $6.4 million to promote exchange activities; and another $18.8 million for grants that assist in the formation and support of health information exchanges. Federal funding for THSA ran out in fiscal year 2014, and THSA receives no ongoing state appropriation. The Legislature distributed $5 million to THSA from the Texas Health Insurance Pool in fiscal year 2014 that THSA believes will sustain its operations through at least 2017.[11] Also, statute requires HHSC, in consultation with THSA, to apply for and actively pursue federal funding to support health information exchange initiatives.[12]

- **Health information exchanges.** Federal funding enabled HHSC, with support from THSA, to spread grants among 16 local networks picked through a competitive process. These grants encouraged health information exchanges to develop their infrastructures and connect local hospitals, physicians, and clinical staff to their regional networks. Of the 16 health information exchanges that received funding, six are fully operational and transmitting information, four are in various stages of implementation, and six have either merged with other local networks or no longer exist. In fiscal year 2013, more than 4.2 million patient medical records were sent and received by the 30,000 clinical and administrative staff who participate in one of the remaining 10 local exchanges.

THSA also used a portion of its federal funding, passed through HHSC, to create a "state health information exchange," called HIETexas, with the goal of connecting local exchanges in Texas to each other and eventually to state data sources, such as the Department of State Health Services' public health registries, and to other federal and out-of-state networks. The state health information exchange is planned as the hub of the wheel connecting these networks together. As of September 2014, two of the 10 local health information exchanges have connected to HIETexas and are able to share electronic medical records with other local networks. The diagram, *Sharing Electronic Medical Records*, illustrates how information can be shared through HIETexas.

### Sharing Electronic Medical Records*



\* This diagram is intended to illustrate an example of how health information can be shared between providers, state and federal governments, and other entities, and does not show all possible connections to HIETexas or health information exchanges. The solid lines represent connections that are occurring and sharing information. The dotted lines represent connections that are still in the development and testing phase.

THSA has created an accreditation program that requires all local health information exchanges to operate under the same set of standards when connecting to HIETexas, thus ensuring a successful connection and interoperability. Also, under a separate program, statute requires THSA to develop privacy and security standards for sharing protected health information electronically and requires HHSC to review and adopt these standards in rule.[13] THSA has established a voluntary certification program that certifies providers' past compliance with these privacy and security standards.[14] By statute, the certification program mitigates against civil or administrative penalties that could be levied on certain entities such as healthcare providers for actions related to the disclosure of individually identifiable health information.[15] The certification program is intended to demonstrate providers' ability to comply with Health Insurance Portability and Accountability Act (HIPAA) and other state privacy laws, helping to gain the confidence of patients whose records are electronically transferred. THSA expects that one-time implementation and annual membership fees to connect to HIETexas, and user fees from its accreditation and certification programs will make it financially self-sufficient in the near future in the absence of ongoing appropriations.

- **Coordination.** THSA is statutorily responsible for collaborating with other state entities on various topics. THSA sits on the Electronic Health Information Exchange System Advisory Committee, a group made up of various types of providers, organizations, and state agencies whose purpose is to inform HHSC about topics related to electronic health information.[16] Along with the attorney general and the Texas Department of Insurance, THSA also coordinates with HHSC on activities related to audits of providers' compliance with HIPAA privacy requirements for health records.[17]

THSA is subject to the Sunset Act and is abolished September 1, 2015, unless continued by the Legislature.[18] The Sunset Act requires a determination of public need to continue an agency and whether alternative methods would adequately serve its functions. This issue examines the continuing need for THSA and its functions.

## Findings

### The state does not need a statutorily authorized entity to support health information exchanges.

While the people of Texas have a clear interest in the development of health information exchanges for the improvements they bring to the overall healthcare system, a governmental role as currently structured in statute is not needed to serve this interest. The state has already recognized the advantages of a non-governmental approach to supporting health information exchanges.[19] By establishing THSA as a public nonprofit corporation, the state has embarked on an approach to fostering health information technology through market-based strategies that rely on providing services and value to encourage participation and support instead of a top-down, governmental approach. The following material highlights key aspects of THSA's operations, reflecting why statutory authority is not needed to support health information exchanges.

- **Current set up as a nonprofit.** Statute already sets THSA up as a nonprofit entity, and THSA operates under a set of bylaws outlining its structure.[20] The structure gives THSA a framework for continuing as a private corporation without statutory underpinnings. As a purely private entity, THSA would have all the powers and duties it currently has under the Business

*THSA could continue to operate as an independent nonprofit entity.*

Organizations Code. Free from state control, however, THSA would have greater flexibility to operate, establish services, and deliver value than it currently does. For example, unlike THSA, a private corporation would be able to review computer security systems and security audits to certify compliance with privacy and security standards for sharing protected health information electronically without making these very security systems and audits subject to public disclosure under the Public Information Act, potentially jeopardizing the security of health information that was intended to be protected. The governor-appointed board of directors would no longer exist, but like any private corporation, the new organization would establish its own oversight board to meet its needs as a successful operation.

*The market should drive the development of health information exchanges.*

- **Private sector, market-based focus.** THSA exists primarily to assist local health information exchanges and their provider members link together for their providers' and patients' benefit. Literature surrounding THSA's creation also emphasizes that market forces should drive development of health information exchanges as much as possible, suggesting their success should depend on a real need supported by funding from providers who want to connect electronically.[21] The 2014 State Health Information Exchange Strategic Plan highlights the importance of market-based solutions as a guiding principle, recognizing the economic value of the electronic health information infrastructure, while noting that "government participation should generally be limited to catalyzing relevant markets, facilitating collaborations, easing regulatory burdens, and assisting the appropriate alignment of incentives."[22] THSA has operated with this goal in mind, working to be self-sustaining without government funding and to promote the exchange of health information with a strong business focus.

- **Transferable core duties.** As an independent nonprofit entity, THSA could continue performing its core functions without the need of state statute if health information exchanges see the nonprofit's worth and are willing to support THSA with funding from user fees or other funding sources. These services include promoting the development of health information exchanges, acting as a hub to connect health information networks, developing standards to enable interoperability between networks, and certifying that participating entities comply with privacy and security standards.

  THSA and HHSC have already carried out their respective charges to develop, and then adopt as rules, privacy and security standards for the electronic sharing of protected health information. Statutory authority for HHSC to adopt these standards in rule can be maintained elsewhere in statute apart from THSA's enabling law and, if necessary, THSA could continue assisting in developing or refining standards at HHSC's request. In addition, statutory provisions in THSA's statute and elsewhere offering certain protections for providers meeting these standards can and should be maintained in law.

A separate recommendation in this report would remove the Electronic Health Information Exchange System Advisory Committee from statute, allowing the HHSC executive commissioner to re-establish an advisory body, as needed, with the representation appropriate to reflect THSA's expertise. THSA's current involvement in joining with the attorney general and the Texas Department of Insurance to collaborate with HHSC in federally-related privacy audits is incidental and could be discontinued. As a nonprofit independent entity with no state ties, THSA could continue to receive federal grant money through HHSC if more becomes available.

**Through its market-based approach, a corporation like THSA should depend on participation by the private sector for its financial support, and not the largesse of the state.**

Statute permits THSA to be funded through the General Appropriations Act, as well as other sources.[23] The Legislature has used this authority, distributing $5 million to THSA to tide it over until it receives sufficient funding from its own private funding sources, primarily through the certification and accreditation of entities seeking to connect to the exchange.[24] Just as the sustainability of health information exchanges in Texas depends on services and value, driven by the number and type of data sources connected to these exchanges, so too should THSA depend on the market for its financial support. In this way, THSA's success would depend on the success of health information exchanges. Providing in statute for the Legislature to fund THSA waters down the principle of letting the market decide whether an organization with THSA's functions sinks or swims.

*THSA should depend on the market for its financial support.*

# Recommendation

## *Change in Statute*

### 15.1   Remove the Texas Health Services Authority from statute, allowing its functions to continue only in the private sector.

This recommendation would remove THSA's statutory authority, eliminating THSA as a statutory nonprofit corporation on September 1, 2015. Under this recommendation, THSA could transition to an independent nonprofit organization, appointing its own board of directors and providing whatever duties it determines necessary to support health information exchanges in Texas. This change would not affect the new organization's ability to maintain THSA's voluntary privacy and security certification process or accreditation process for entities connecting to HIETexas. Statutory provisions for privacy and security standards and HHSC rules relating to standards for sharing protected health information electronically would need to be preserved elsewhere in state law. Mitigating factors that currently exist in law to protect entities certified through THSA's privacy and security program would also be maintained in statute.

Under this new approach, statutory language prohibiting THSA from engaging in specified activities would be removed. However, the powerful incentive to develop a successful market for health information exchanges should prevent THSA from engaging in activities that would divert it from its primary mission

or antagonize the very participants, such as physicians, that the organization relies on for successful exchanges. THSA's statutory responsibility to collaborate with HHSC and the Texas Department of Insurance on federal audit-related duties concerning privacy laws would be eliminated.

This recommendation would allow the private sector nonprofit organization to retain the funding distributed to THSA last session to bridge the gap until it achieves self-sufficiency. Ongoing funding for that entity would be tied more directly to the health information exchanges and their provider members' conviction that these duties are worthwhile.

## Fiscal Implication

This recommendation would have no fiscal impact to the state. Currently, THSA does not receive an ongoing appropriation or have other regular, predictable funding sources such as federal grants.

1    Texas Health Information Technology Advisory Committee, *Roadmap for the Mobilization of Electronic Healthcare Information in Texas* (Austin: Texas Health Information Technology Advisory Committee, 2006), p. 29; House Research Organization, *House Bill 1066 Bill Analysis, 80th Texas Legislature, Regular Session, 2007* (Austin: House Research Organization, 2007), p.4.

2    Section 182.001, Texas Health and Safety Code.

3    Section 182.051(b), Texas Health and Safety Code.

4    Section 182.053(a), Texas Health and Safety Code.

5    Section 182.053(b), Texas Health and Safety Code.

6    Section 552.002, Texas Government Code; Sections 182.051(e) and 182.052, Texas Health and Safety Code.

7    Section 182.107, Texas Health and Safety Code.

8    Texas Health Services Authority, *Texas Health Services Authority Self-Evaluation Report* (Austin: Texas Health Services Authority, 2013), p. 1.

9    Ibid., p. 2.

10    Ibid., p. 22.

11    S.B. 1367, 83rd Texas Legislature, Regular Session, 2013.

12    Section 181.207, Texas Health and Safety Code.

13    Section 182.108(a), Texas Health and Safety Code.

14    Section 182.108(d), Texas Health and Safety Code.

15    Section 181.205, Texas Health and Safety Code.

16    Section 531.904, Texas Government Code.

17    Section 181.206, Texas Health and Safety Code.

18    Section 182.052, Texas Health and Safety Code.

19    *Roadmap for the Mobilization of Electronic Healthcare Information in Texas*, p. 29; *House Bill 1066 Bill Analysis, 80th Texas Legislature, Regular Session, 2007*, p.4.

20    Section 182.051(b), Texas Health and Safety Code; Texas Health Services Authority, *Amended and Restated Texas Health Services Authority Bylaws*, accessed June 30, 2014, http://www.hietexas.org.

21    Texas Health Information Technology Advisory Committee, *Roadmap for the Mobilization of Electronic Healthcare Information in Texas*.

22    Texas Health Services Authority, *Texas State HIE Strategic Plan* (Austin: Texas Health Services Authority, 2014) p. 4.

23    Section 182.107, Texas Health and Safety Code.

24    S.B. 1367, 83rd Texas Legislature, Regular Session, 2013.

# APPENDICES
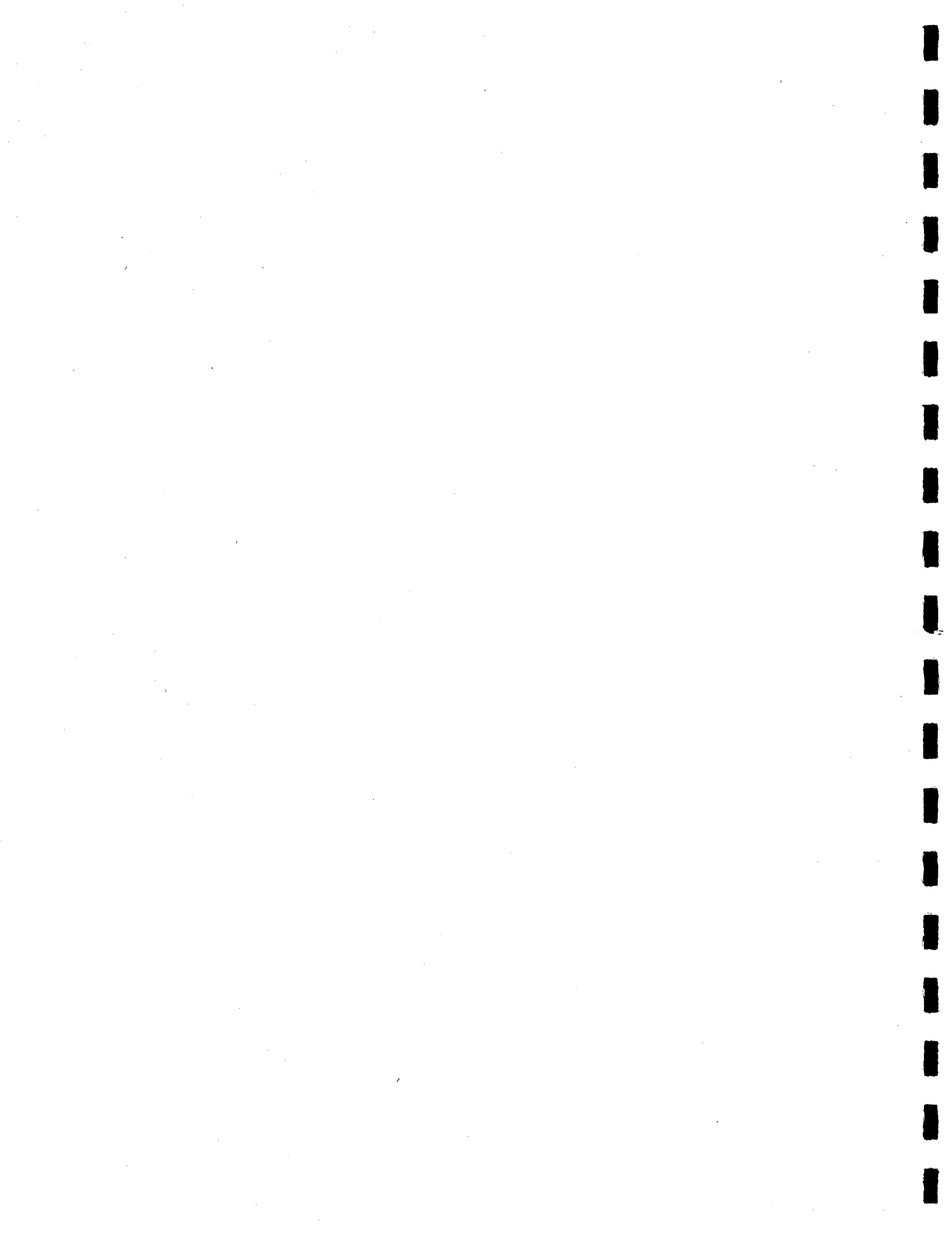
# APPENDIX A

## Historically Underutilized Businesses Statistics
## 2011 to 2013

The Legislature has encouraged state agencies to increase their use of historically underutilized businesses (HUBs) to promote full and equal opportunities for all businesses in state procurement. The Legislature also requires the Sunset Commission to consider agencies' compliance with laws and rules regarding HUB use in its reviews.[1]

The following material shows trend information for the Health and Human Services Commission's (HHSC) use of HUBs in purchasing goods and services. The agency maintains and reports this information under guidelines in statute.[2] In the charts, the dashed lines represent the goal for HUB purchasing in each category, as established by the comptroller's office. The diamond lines represent the percentage of agency spending with HUBs in each purchasing category from 2011 to 2013. Finally, the number in parentheses under each year shows the total amount the agency spent in each purchasing category.

With the exception of commodities, HHSC fell below all state HUB purchasing goals for each category for which it had expenditures. The agency indicates it has difficulty meeting HUB goals because facility lessors are responsible for hiring their own contractors — who are often not HUBs — to maintain and repair buildings, and because HHSC has difficulty finding HUBs to provide professional services. The agency has met other HUB-related requirements, such as appointing a HUB coordinator, establishing a HUB policy, and developing a mentor-protégé program.
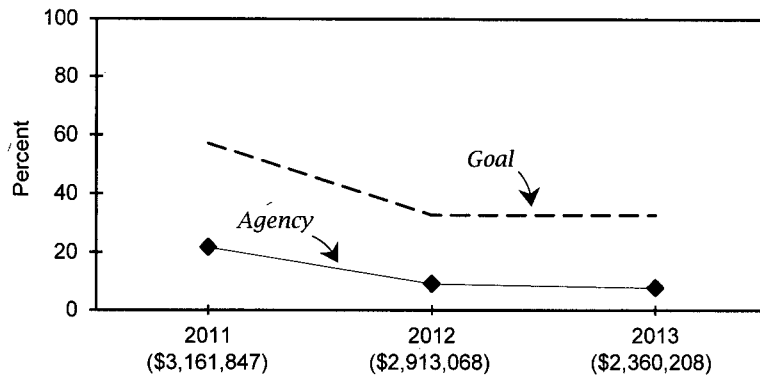
### Building Construction
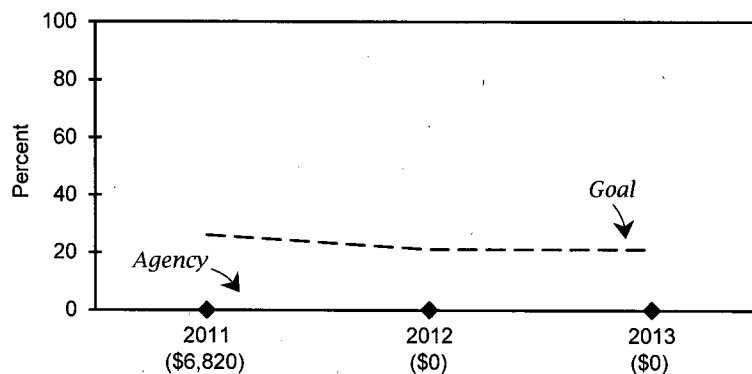


HHSC did not meet purchasing goals for building construction in 2011, the only year the agency had expenditures for this category.
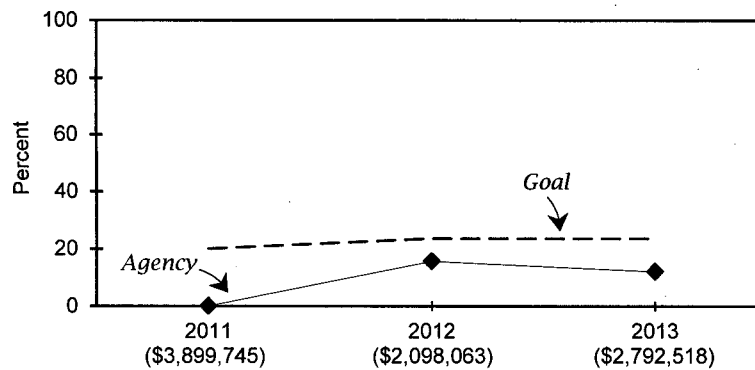
## *Appendix A*

### Special Trade



HHSC fell below the state's purchasing goals for the special trade category for fiscal years 2011 through 2013.
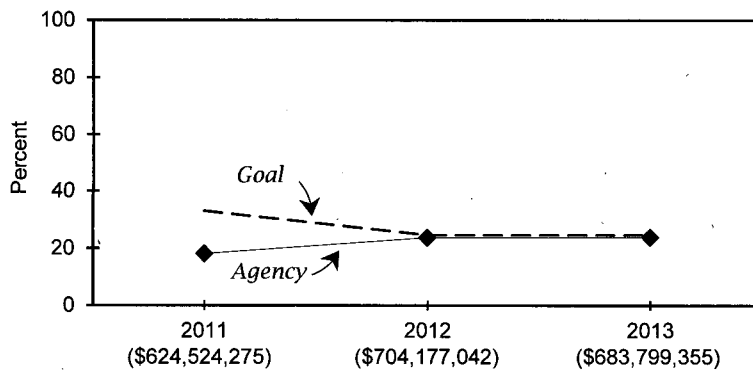
### Professional Services



The agency fell below the purchasing goal for professional services for each of the last three fiscal years.
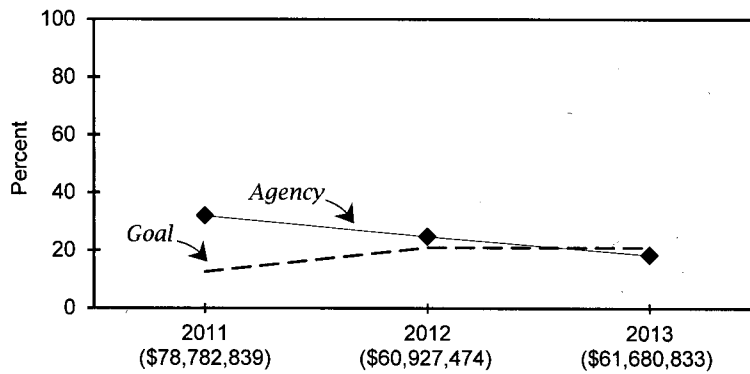
## Appendix A

### Other Services



In fiscal year 2011, the agency fell below the state's purchasing goal for other services, but exceeded the goal in fiscal years 2012 and 2013.

### Commodities



HHSC exceeded the state's goals for spending for commodities in fiscal years 2011 and 2012, but fell short of the goal in 2013.

..........................................

1     Section 325.011(9)(B), Texas Government Code.

2     Chapter 2161, Texas Government Code.

# APPENDIX B

## Equal Employment Opportunity Statistics
## 2011 to 2013

In accordance with the requirements of the Sunset Act, the following material shows trend information for the employment of minorities and females in all applicable categories by the Health and Human Services Commission (HHSC).[1] The agency maintains and reports this information under guidelines established by the Texas Workforce Commission.[2] In the charts, the dashed lines represent the percentages of the statewide civilian workforce for African-Americans, Hispanics, and females in each job category.[3] These percentages provide a yardstick for measuring agencies' performance in employing persons in each of these groups. The diamond lines represent the agency's actual employment percentages in each job category from 2011 to 2013. Generally, HHSC exceeded civilian workforce percentages for minorities and females for all job categories.

## Administration
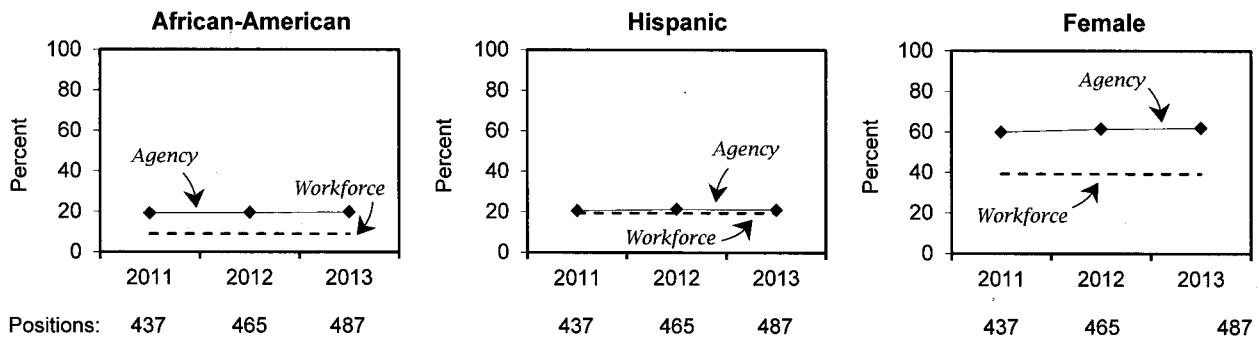


HHSC met or exceeded civilian workforce percentages for all three groups for each of the last three fiscal years.
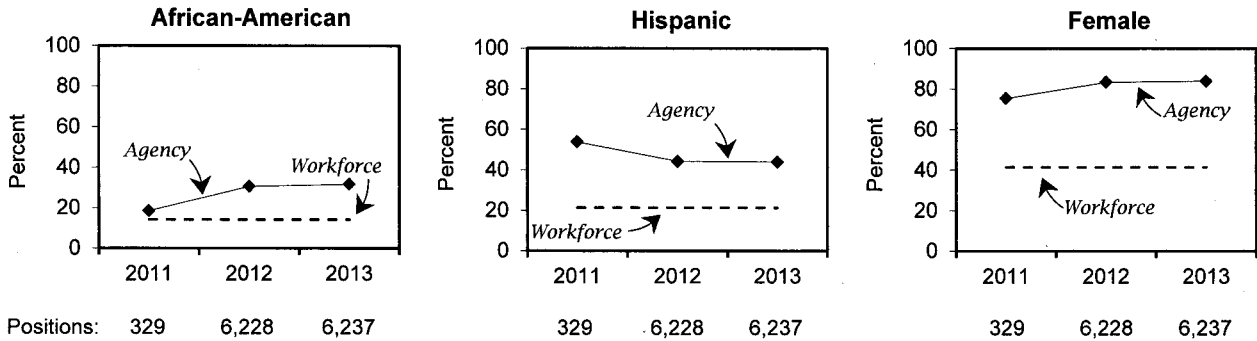
## Professional
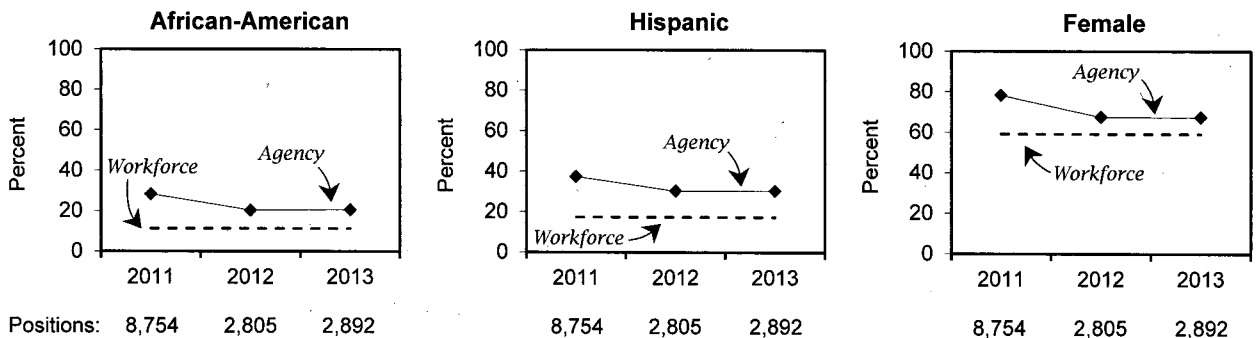


In the last three fiscal years, HHSC exceeded the civilian workforce percentage for all three groups.

# *Appendix B*

## Technical

| African-American | Hispanic | Female |
|---|---|---|



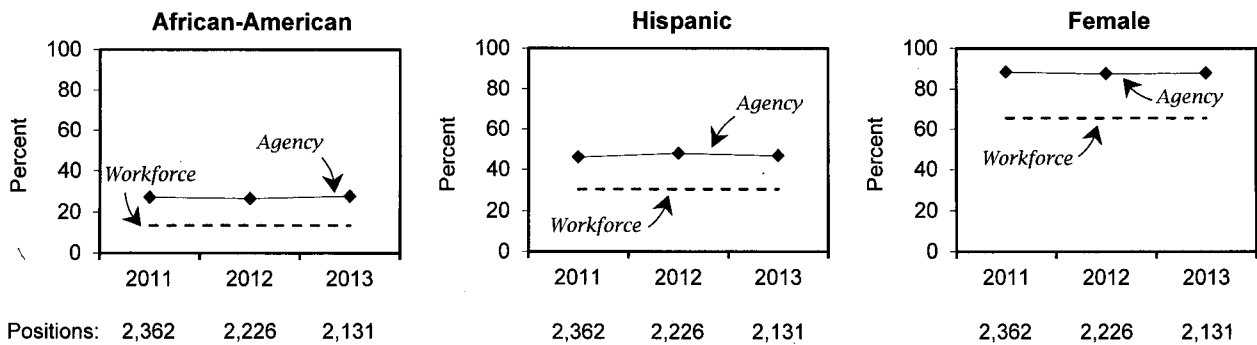| Positions: | 329 | 6,228 | 6,237 | | 329 | 6,228 | 6,237 | | 329 | 6,228 | 6,237 |

In the category with the most staff, HHSC exceeded the workforce percentage for all three groups.

## Administrative Support

| African-American | Hispanic | Female |
|---|---|---|



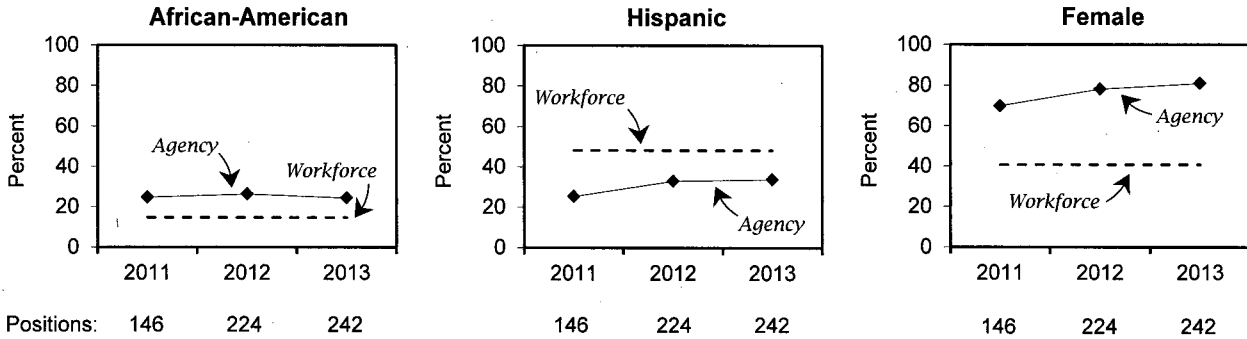| Positions: | 2,362 | 2,226 | 2,131 | | 2,362 | 2,226 | 2,131 | | 2,362 | 2,226 | 2,131 |

HHSC exceeded civilian workforce percentages for all three groups for each of the last three fiscal years.

# Appendix B

## Service/Maintenance[4]

### African-American



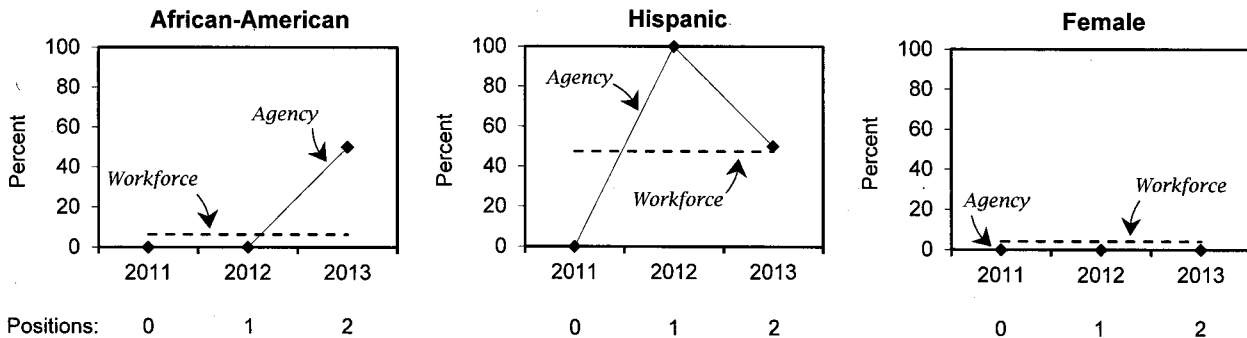| Positions: | 146 | 224 | 242 |

### Hispanic



| 146 | 224 | 242 |

### Female



| 146 | 224 | 242 |

HHSC fell below the civilian workforce percentage for Hispanics in the last three fiscal years, but exceeded percentages for African-Americans and females.

## Skilled Craft

### African-American



| Positions: | 0 | 1 | 2 |

### Hispanic



| 0 | 1 | 2 |

### Female



| 0 | 1 | 2 |

HHSC did not meet civilian workforce percentages for females in any year, and did not meet percentages for African-Americans until 2013. Also, HHSC exceeded percentages for Hispanics in 2012 and 2013, the only years the agency had staff for this category.

........................................

[1]  Section 325.011(9)(A), Texas Government Code.

[2]  Section 21.501, Texas Labor Code.

[3]  Because the Texas Workforce Commission has not released statewide civilian workforce percentages for fiscal years 2012 and 2013, this analysis uses fiscal year 2011 percentages for those two years.

[4]  The service/maintenance category includes three distinct occupational categories: service/maintenance, para-professionals, and protective services. Protective service workers and para-professionals used to be reported as separate groups.

# APPENDIX C

## Income Limits for Medicaid and CHIP Programs*



Legend: Pre-ACA Texas Income Limit · MAGI Adjusted Income Limit · Federal Income Disregard
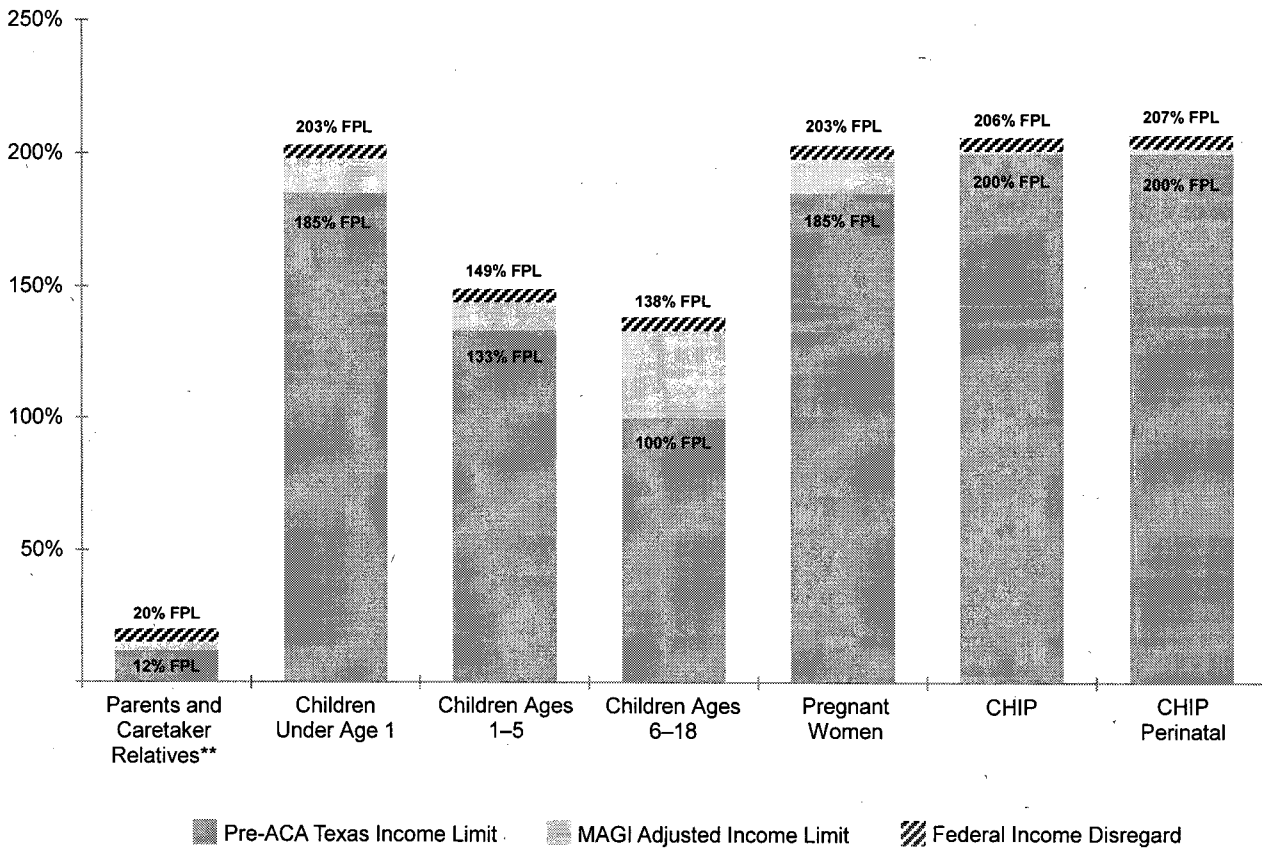
| 2014 Federal Poverty Levels: Monthly Dollar Amounts | | | |
|---|---|---|---|
| | 100% FPL | 133% FPL | 200% FPL |
| Family Size of 3 | $1,650 | $2,194 | $3,299 |

\* Effective January 1, 2014, the Affordable Care Act (ACA) required states to: (1) use Modified Adjusted Gross Income (MAGI) methodologies to determine eligibility for most Medicaid programs and the Children's Health Insurance Program (CHIP); (2) eliminate most income disregards, such as dependent care expenses; (3) adjust income limits to account for MAGI changes; and (4) apply a new federal income disregard equal to 5 percentage points of the federal poverty level.

\*\* Based on two-parent family, family size of three.

# APPENDIX D

## Health and Human Services Commission
## Statutory Advisory Committees

| Committee | Purpose |
|---|---|
| Advisory Committee on Medicaid and CHIP Program Rate and Expenditure Disparities | Advises the Health and Human Services Commission (HHSC) on efforts to eliminate disparities in payments for Medicaid and the Children's Health Insurance Program (CHIP) services between the Texas-Mexico border region and other areas of the state. |
| Advisory Committee on Qualifications for Health Care Translators and Interpreters | Develops strategies for HHSC to implement regulations and qualifications for health care interpreters and translators. |
| Behavioral Health Integration Advisory Committee | Advises HHSC on planning and development needs to integrate Medicaid and behavioral health services, including targeted case management, mental health rehabilitative services, and physical health services. |
| Children's Policy Council | Assists the health and human services agencies in developing, implementing, and administering family support policies and related long-term care programs for children with disabilities. |
| Consumer Direction Work Group | Advises HHSC on the delivery of services through consumer direction for long-term services and support programs. |
| Council on Children and Families | Advises state leadership on ways to improve coordination between state agencies and leverage resources to ensure children and their families have access to needed health and education services. |
| Drug Utilization Review Board | Recommends clinical and utilization restrictions, such as clinical edits and educational interventions, for prescription drugs to HHSC's executive commissioner. |
| Electronic Health Information Exchange System Advisory Committee | Advises HHSC regarding the development and implementation of a health information exchange network to improve the quality, safety, and efficiency of healthcare information. |
| Guardianship Advisory Board* | Recommends improvements to the statewide guardianship program to HHSC and the Department of Aging and Disability Services (DADS). |
| Hospital Payment Advisory Committee | Advises HHSC and the Medical Care Advisory Committee on ways to provide reasonable, adequate, and equitable payments to rural and urban hospital providers. |
| Information Resources Advisory Committee | Reviews information resource management plans and makes recommendations to HHSC relating to the consolidation and improved efficiency of information resource functions. |

# *Appendix D*

| Committee | Purpose |
|---|---|
| Intellectual and Developmental Disability System Redesign Advisory Committee | Advises HHSC and DADS on implementation of the acute care and long-term services and supports system redesign. |
| Interagency Coordinating Council for HIV and Hepatitis | Coordinates with HHSC and the Department of State Health Services on ways to improve awareness and prevention of HIV, AIDS, and hepatitis. |
| Interagency Coordinating Group for Faith- and Community-based Initiatives | Reports to the Legislature on ways to strengthen relationships and remove barriers between the state and faith and community-based organizations to provide charitable and social services to Texans. |
| Interagency Task Force for Children With Special Needs | Recommends to state leadership ways to improve coordination, quality, and efficiency of services for children with special needs; identifies delivery gaps, system entry points, and obstacles for children needing services; and develops a strategic plan to address the needs of children with chronic illnesses, intellectual or developmental disabilities, or serious mental illness. |
| Interagency Task Force on Ensuring Appropriate Care Settings for Persons with Disabilities | Assists the health and human services agencies in developing a comprehensive plan to ensure appropriate care settings for persons with disabilities. |
| Medical Care Advisory Committee | Reviews and makes recommendations to HHSC on proposed rules for the Medicaid program. |
| Medicaid and CHIP Quality-Based Payment Advisory Committee | Advises HHSC on programs and reimbursement policies that encourage high-quality, cost-effective health care delivery models that increase provider collaboration, promote wellness and prevention, and improve health outcomes. |
| Medicaid and CHIP Regional Advisory Committees | Advises and recommends to HHSC on how to improve Medicaid managed care across the state. |
| Perinatal Advisory Council | Advises HHSC on developing a process to improve and designate levels of neonatal and maternal care. |
| Pharmaceutical and Therapeutics Committee | Recommends to HHSC's executive commissioner which pharmaceutical drugs should be added to the state's preferred drug list. |
| Public Assistance Health Benefit Review and Design Committee | Recommends changes to HHSC to covered health benefits for Medicaid, CHIP, and other healthcare programs. |
| Renewing Our Communities Account Advisory Committee* | Makes recommendations to HHSC's executive commissioner regarding the powers and duties of the Renewing Our Communities account. |
| STAR+PLUS Nursing Facility Advisory Committee | Advises HHSC on the STAR+PLUS Medicaid managed care program, including Medicaid benefits for eligible nursing facility residents. |
| STAR+PLUS Quality Council | Advises HHSC on how to ensure eligible clients receive quality, person-centered, consumer-directed acute care and long-term services and supports in an integrated setting under the STAR+PLUS Medicaid managed care program. |

# Appendix D

| Committee | Purpose |
|-----------|---------|
| STAR Kids Managed Care Advisory Committee | Advises HHSC on how to implement and operate the STAR Kids managed care program. |
| State Medicaid Managed Care Advisory Committee | Recommends and provides input to HHSC on the statewide implementation of Medicaid managed care. |
| Task Force on Domestic Violence | Examines the impact of domestic violence on maternal and infant mortality and health; identifies methods to include domestic violence information in educational standards for educators and healthcare providers; and makes recommendations to state leadership relating to coordinating healthcare services for children and pregnant women who are victims of domestic violence. |
| Telemedicine and Telehealth Advisory Committee | Assists HHSC in evaluating telemedicine, telehealth, and tele-home monitoring policies and ensuring the efficient use and reimbursement of these services. |
| Texas Institute of Health Care Quality and Efficiency Board of Directors | Recommends to the Legislature ways to improve healthcare quality and contain costs by encouraging collaboration between healthcare providers and coordinating health care services. |
| Texas Nonprofit Council | Assists the Interagency Coordinating Group for Faith- and Community-Based Initiatives in creating partnerships between state agencies and faith- and community-based organizations. |
| Texas System of Care Consortium | Reports to the Legislature and oversees efforts to provide a comprehensive approach to community-based services and supports that meet the challenges of children with serious mental health needs and their families. |
| Texas Traumatic Brain Injury Advisory Council | Recommends to state leadership policies, programs, and innovative approaches to serving persons with brain injuries, their families, and caretakers. |
| Volunteer Advocate Program Advisory Committee* | Advises HHSC's executive commissioner on developing a pilot program that advocates for the elderly. |
| Work Group on Uncompensated Hospital Care* | Assists HHSC in developing a standard methodology for calculating and reporting uncompensated care costs for hospitals. |

*Inactive committees

# APPENDIX E

## *Health and Human Services Commission Reporting Requirements*

| Report Title | Legal Authority | Description | Recipient | Sunset Evaluation |
|---|---|---|---|---|
| 1. Data Analysis Unit, Report of the | Section 531.0082(d), Government Code | Requires the Health and Human Services Commission's (HHSC's) data analysis unit to report on its activities related to improving contracts, detecting trends, and discovering anomalies related to contracts for Medicaid, the Children's Health Insurance Program, and fee-for-service. | House Appropriations Committee, Lieutenant Governor, Governor, Senate Finance Committee, Senate Health and Human Services Committee, Speaker | Continue |
| 2. Colonias, Report on Assistance to | Section 531.0141, Government Code | Requires HHSC to submit a report detailing the number of projects providing assistance to the colonias, including the location of the projects, the number of people served, and the cost or anticipated cost of each. | Secretary of State | Continue |
| 3. Medicaid Expenditures Report | Section 531.02112, Government Code | Requires HHSC to provide detailed information on Medicaid expenditures for all programs within health and human services agencies, including the amount spent on indirect cost such as eligibility determination, claims processing, case management, and other administrative costs. | Comptroller, Governor, Legislature, State Auditor | Eliminate – See Recommendation 14.2 |
| 4. Telemedicine, Telehealth, and Home Telemonitoring, Report on | Section 531.0216(f), Government Code | Requires HHSC to report on the impact of telemedicine, telehealth, and home telemonitoring services on the Medicaid program, including the number of health care providers and facilities providing the services, the number of patients receiving these services, and the associated costs. | Lieutenant Governor, Speaker | Continue |
| 5. Persons With Disabilities Plan, Report on the Appropriate Care Setting for | Section 531.0244(g), Government Code | Requires HHSC to report on the implementation status of its plan to increase independent living for people with disabilities. The report also includes recommendations for statutory changes or other actions necessary to implement the plan. | Legislature, Governor | Continue |
| 6. Young Texans, Report on the Delivery of Health and Human Services to | Section 531.02492(b), Government Code | Requires HHSC to report on the health and human services agencies' efforts to provide services to children age six and under. The commission may provide recommendations to better coordinate state agency programs relating to the delivery of health and human services to this group. | Comptroller, Governor, House Committee on Public Health, Legislative Budget Board, Lieutenant Governor, Senate Health and Human Services Committee, Speaker | Continue |

# Appendix E

| Report Title | Legal Authority | Description | Recipient | Sunset Evaluation |
|---|---|---|---|---|
| 7. Coordinated Strategic Plan for Information Resources Management | Section 531.0273, Government Code | Requires HHSC to develop a five-year strategic plan for all information resources at all health and human services agencies. | Maintained internally | Continue |
| 8. Federal Funds Report | Section 531.028(c), Government Code | Requires HHSC to report on the implementation of a system to coordinate and monitor the use of federal money by all health and human services agencies. The report also identifies strategies to maximize the receipt and use of federal funds. | Lieutenant Governor, Speaker | Continue |
| 9. 2-1-1 Electronic Access to Child Care & Education Services Summary Referrals | Section 531.03131(f), Government Code | Requires HHSC to report on the use of its website to provide referrals for child care and education services. The report includes the number of referrals made to Head Start, the local workforce development centers, and to each school district. | Legislature | Eliminate – See Recommendation 14.2 |
| 10. Activity Report | Section 531.052(g), Government Code | Requires the Consumer Direction Workgroup to report to the Legislature regarding research on increasing consumer directed models and expanding this philosophy into other health and human services programs. | Legislature | Eliminate – See Recommendation 13.1 |
| 11. Medicaid Drug Utilization Review Program, Annual Report (State) | Section 531.0691(d), Government Code | Requires HHSC to report on the activities of the Medicaid Drug Utilization Review Program and any anticipated estimates of cost savings resulting from the program's performance of prospective and retrospective drug use reviews. | Not defined | Continue |
| 12. Drug Expenditure Data | Section 531.0693, Government Code | Requires HHSC to identify the therapeutic prescription drug classes and individual prescription drugs that are most often prescribed to patients or that represent the greatest expenditures. | Not defined | Continue |
| 13. Protected Health Information, Report on New Developments in Protecting | Section 531.0994(b), Government Code | Requires HHSC to report on new developments in safeguarding health information and provide recommendations to implement new safeguards within the commission. | Legislature | Continue |

# Appendix E

| Report Title | Legal Authority | Description | Recipient | Sunset Evaluation |
|---|---|---|---|---|
| 14. Fraud and Abuse in Medicaid or Other Health and Human Service Programs, Report on | Section 531.103(c), Government Code | Requires the HHSC – Office of the Inspector General and the attorney general to jointly prepare a report highlighting their activities in detecting and preventing fraud, waste, and abuse of the state's Medicaid program or other programs administered by the health and human services agencies. | Governor, Lieutenant Governor, Speaker | Continue |
| 15. Fraud Prevention, Report on | Section 531.108 (e), Government Code | Requires HHSC – Office of the Inspector General to produce an annual report on the results of computerized matching of the commission's applicants for public assistance with information from neighboring states and from the Texas Department of Criminal Justice. Also known as S.B. 30 report. | Governor, Legislative Budget Board | Continue |
| 16. Fraud Payment Recovery, Report of Managed Care Organizations | Section 531.1132, Government Code | Requires HHSC – Office of the Inspector General to report the amount of money recovered during the preceding 12-month period as a result of investigations and recovery efforts by managed care organization special investigative units. | Legislature | Continue |
| 17. Children in State Institutions, Report on | Section 531.162(b), Government Code | Requires HHSC to report on the number of children currently institutionalized and of those, the number identified for transition into a community setting. The report also includes the number of children that had been institutionalized at one time but are now reunited with their family. | Governor, House Committee on Public Health, and the Senate Health and Human Services Committee | Continue |
| 18. Texas System of Care Consortium, Report on the | Section 531.251(b-1), Government Code | Requires HHSC, along with a consortium of other health and human services entities, to report on its evaluation of the Texas System of Care for minors who are receiving mental health services and provide recommendations on strengthening state policies and practices that support local systems of care. | Legislature, Council on Children and Families | Eliminate – See Recommendation 13.2 |
| 19. Nurse Family Partnership Competitive Grant Program, Report on the | Section 531.659(a)(3), Government Code | Requires HHSC, with the Nurse-Family Partnership National Service office, to report on the performance of each Nurse-Family Partnership grantee over the preceding fiscal year. | Human Services, Senate Health and Human Services Committee | Continue |

# *Appendix E*

| Report Title | Legal Authority | Description | Recipient | Sunset Evaluation |
|---|---|---|---|---|
| 20. Legislative Appropriations Request Analysis | Section 531.803(a)(1), Government Code | Requires the Council on Children and Families to report on recommended modifications to council members' legislative appropriations requests that, through coordination of council members, could eliminate waste or increase services provided to children and their families. | Department of Aging and Disability Services, Department of Assistive and Rehabilitative Services, Department of Family and Protective Services, Department of State Health Services, HHSC, Juvenile Justice Department, Texas Education Agency, Texas Workforce Commission | Eliminate – See Recommendation 13.2 |
| 21. Child Welfare Report | Section 531.804, Government Code | Requires the Council on Children and Families to report on any requests, plans, and recommendations needed to further develop and maintain a statewide system of quality health, education, and human services for children and families. The report also includes information regarding the implementation of any processes, policies, or recommendations. | Governor, Legislature, Lieutenant Governor, Speaker | Eliminate – See Recommendation 13.2 |
| 22. Home Visiting Programs, Report on | Section 531.9871, Government Code | Requires HHSC to provide a report on state-funded home visit programs, including data on the number of families served and the cost per family. | Human Services Committees, Senate Health and Human Services Committee | Continue |
| 23. Utilization Review for STAR+PLUS MCOs, Report on | Section 533.00281(d), Government Code | Requires HHSC, in conjunction with its Office of Contract Management, to report on the results of its utilization review of the STAR+ Plus Managed Care program, including errors made by managed care organizations and any recommendations to improve the efficiency of the program. | House Committee on Public Health, Senate Health and Human Services Committee | Continue |
| 24. Acute Care Services and LTSS System, Report on Implementation of | Section 534.054, Government Code | Requires HHSC to submit an annual report to the Legislature regarding the implementation of the system designed to provide acute care services, long-term services, and supports system for individuals with intellectual and developmental disabilities. | Legislature | Continue |

# Appendix E

| Report Title | Legal Authority | Description | Recipient | Sunset Evaluation |
|---|---|---|---|---|
| 25. Interagency Coordinating Group, Annual Report of the | Section 535.054, Government Code | Requires the Interagency Coordinating Group for Faith- and Community-based Initiatives to report on the details of its activities, goals, and processes in developing partnerships between the health and human service agencies and faith-based and community-based initiatives. | Governor | Eliminate – See Recommendation 13.1 |
| 26. Texas Nonprofit Council, Report of the | Section 535.055(d), Government Code | Requires the Texas Nonprofit Council to report on its work on improving the relationship and coordination between state agencies and faith-based and community-based organizations. | House Committee on Public Health, Senate Health and Human Services Committee | Eliminate – See Recommendation 13.1 |
| 27. National and Community Service, Report of State Commission on | Section 535.106(c), Government Code | Requires HHSC to provide an annual report of information on any contract or grants the commission made through the State Commission on National and Community services. Includes information on grantees and the purpose grants were awarded. | Governor, Legislature, Lieutenant Governor | Continue |
| 28. Quality-Based Outcome and Process Measures, Report on | Section 536.008, Government Code | Requires HHSC to report on quality-based outcomes and process measures for compensating health care providers who participate in the Children's Heath Insurance Program and Medicaid program. | Legislature | Continue |
| 29. Procurement and Contracting Practices, Report on | Section 2155.144(o), Government Code | Requires HHSC to prepare a report assessing the compliance of each health and human services agency with the commission's policies on procurement. | Governor, Lieutenant Governor, Speaker | Eliminate – See Recommendation 14.2 |
| 30. Biennial Progress Report | Section 115.006, Health and Safety Code | Requires the Task Force for Children With Special Needs to report on the progress of each agency in accomplishing the goals set by the task force on improving the coordination, quality, and efficiency of services for children with special needs. | Governor, Lieutenant Governor, Speaker | Eliminate – See Recommendation 13.2 |
| 31. Newborn Resource Guide Evaluation | Section 161.502(d), Health and Safety Code | Requires HHSC to report on the effectiveness of the resource guide given to caregivers on the development, health, and safety of a child from birth to five years old. | Legislature | Continue |

# Appendix E

| Report Title | Legal Authority | Description | Recipient | Sunset Evaluation |
|---|---|---|---|---|
| 32. Audits of Entities Covered by HIPAA and Privacy Standards, Report on | Section 181.206 (c), Health and Safety Code | Requires HHSC to report the number of federal audits and audits conducted by state licensing agencies regarding the compliance of a covered entity with the Health Insurance Portability and Accountability Act and privacy standards. | House Committee on Public Health, Senate Health and Human Services Committee | Continue |
| 33. Boarding Home Regulation | Section 260.010(b), Health and Safety Code | Requires HHSC to provide information compiled from counties and municipalities that require permitting of boarding house facilities. The information includes the number of permitted facilities as well as the number of permits that were denied. | Legislature | Continue |
| 34. Investigation of Criminal Offenses at State Hospital, Report on OIG Activities Relating to | Section 552.103, Health and Safety Code | Requires HHSC – Office of Inspector General to annually report on activities involving investigations at state mental health hospitals, including the number and type of investigations and those involved. | Comptroller, Department of Family and Protective Services, Department of State Health Services, Governor, HHSC, House Committee on Public Health, Lieutenant Governor, Senate Health and Human Services Committee, Speaker, State Auditor's Office | Continue |
| 35. State Center Investigations, Annual Report of | Section 555.103, Health and Safety Code | Requires HHSC – Office of Inspector General to annually report on activities involving investigations at State Supported Living Centers, including the number and type of investigations and those involved. | Department of Aging and Disability Services, Department of Family and Protective Services, Comptroller, Governor, HHSC, Human Services, Lieutenant Governor, Senate Health and Human Services Committee, Speaker, State Auditor's Office | Continue |
| 36. Overpayment Claims, Report on | Section 22.0251(b), Human Resources Code | Requires HHSC to produce an annual report describing its progress in reaching its goal to reduce the amount of time it takes to establish an overpayment claim for the Supplemental Nutrition Assistance Program. | Governor, Legislative Budget Board | Eliminate – See Recommendation 14.2 |

# Appendix E

| Report Title | Legal Authority | Description | Recipient | Sunset Evaluation |
|---|---|---|---|---|
| 37. Telephone Collection Program, Report on the | Section 22.0252, Human Resources Code | Requires HHSC to report on attempts to collect reimbursements when food stamp and financial assistant benefits were granted in error. | Governor, Legislative Budget Board | Continue |
| 38. EBT, Report on Monitoring of | Section 22.028, Human Resources Code | Requires HHSC to report monthly on enforcement action taken on Supplemental Nutrition Assistance Electronic Benefits Transfers. | Comptroller | Continue |
| 39. Info Matching System Immigrants & Foreign Visitors, Report on the | Section 22.0292, Human Resources Code | Requires HHSC to report on the operations and success of information matching programs meant to prevent immigrants and visitors to the United States from receiving public benefits illegally. | Governor, Legislative Budget Board | Continue |
| 40. Children's Policy Council, Report of | Section 22.035(k), Human Resources Code | Requires the Children's Policy Council to report its findings and recommendations on developing, implementing, and administering family support policies to families of children with disabilities. | HHSC, Legislature | Eliminate – See Recommendation 13.2 |
| 41. Family Violence Program Statewide Report | Section 51.006, Human Resources Code | Requires HHSC to provide a summary of reports from family violence centers providing services under contract and an analysis of the effectiveness of those contracts. | Governor, Legislative Budget Board, Lieutenant Governor, Senate Health and Human Services Committee, Speaker | Continue |
| 42. Transition of Medically Dependent Children Waiver Program to STAR Kids, Ongoing Report on | Senate Bill 7, Section 2.12, 83rd Legislature, Regular Session | Requires HHSC and the Department of Aging and Disability Services to report on a review and evaluation of the transition of children who were recipients of the Medically Dependent Children's Program waiver to the STAR Kids Managed Care program. | Legislature | Continue |

# APPENDIX F

## *Staff Review Activities*

During the review of the health and human services system, Health and Human Services Commission, Texas Health Services Authority, and the Interagency Task Force for Children With Special Needs, Sunset staff engaged in the following activities that are standard to all Sunset reviews. Sunset staff worked extensively with agency personnel; attended board and committee meetings; met with staff from key legislative offices; conducted interviews and solicited written comments from interest groups and the public; reviewed agency documents and reports, federal and state statutes, legislative reports, previous legislation, and literature; researched the organization and functions of similar state agencies in other states; and performed background and comparative research.

In addition, Sunset staff also performed the following activities unique to the review:

- Toured several regional administrative offices for system agencies and client eligibility offices around the state.

- Visited urban and rural hospitals, other healthcare facilities and providers, and clients in home settings who participate in health and human service programs.

- Accompanied field staff on pharmacy inspections.

- Performed onsite visits of medical transportation providers, facilities, and call centers.

- Toured colonias in the Rio Grande Valley.

- Toured several state supported living centers and state hospitals throughout the state.

- Toured Delivery System Reform Incentive Payment (DSRIP) projects in the Dallas and Panhandle areas.

- Participated in a ride along with an investigator from the Office of Inspector General in the Rio Grande Valley.

- Visited and interviewed staff at different sized clinics accepting different combinations of women's health programs across the state, including women's health provider void areas.

- Observed agency staff audit a managed care organization.

- Visited regional health information exchange networks.

# Sunset Staff Review of the
# *Health and Human Services Commission*
# *and System Issues*

—————— *Report Prepared By* ——————

Sarah Kirkle, *Project Manager, HHSC*

Karl Spock, *Project Manager, HHS System Issues*

Anne Allensworth

Carrie Holley-Hurt

Danielle Nasr

Joey Reed

Katharine Teleki

Amy Trost

Cee Hartley

Joe Walraven, *Project Supervisor*

Ken Levine
*Director*