

HEALTH AND HUMAN SERVICES COMMISSION

INTERAGENCY TASK FORCE FOR CHILDREN WITH SPECIAL NEEDS

TEXAS HEALTH SERVICES AUTHORITY

Sarah Kirkle, Project Manager

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.

Recent events support the need to reorganize the health and human services system.

- The Office of Inspector General (OIG) prevents, detects, and investigates fraud, waste, and abuse throughout the health and human services system.

In fiscal year 2013, the system agencies spent a combined \$34.5 billion, about 58 percent of which were federal funds and 42 percent was general revenue and other state funds. HHSC alone spent about \$23.4 billion that year, with its main expenditures related to Medicaid, the Children's Health Insurance Program, and integrated eligibility and enrollment services. In total, the system agencies had more than 54,000 staff in fiscal year 2013, including more than 12,000 staff employed by HHSC and OIG.

Two other entities subject to Sunset review are also included with this review of HHSC: the Texas Health Services Authority, a public-private partnership created to accelerate the adoption and secure sharing of health-related information through health information exchanges; and the Interagency Task Force for Children with Special Needs, which advises HHSC on ways to improve the coordination, quality, and efficiency of services for children with special needs.

Summary

The timing of the Sunset review of HHSC greatly influenced the Sunset Commission's vision for reshaping the system and improving services to the most vulnerable Texans. Not only was the Sunset Commission able to consider how well the system is working after 12 years' experience in the current configuration, it was also able to follow up on more recent events including the transition to managed care from direct fee for service in the state's Medicaid program, the integration of behavioral and physical health, and funding shifts and changes in federal law affecting program delivery.

The Sunset Commission built on the Sunset reviews of the four health and human services agencies to take a big step toward completing the vision of the 2003 consolidation, and with it, promoting accountability in the system, reducing fragmentation, and streamlining operations. The Sunset proposal would eliminate these agencies as separate entities and reconfigure them in a functional alignment under HHSC as discussed below. Much of DARS would transition to the Texas Workforce Commission (TWC), as discussed in the TWC section of this report. The Sunset Commission's recommendations specific to each system agency, however, continue to be needed whether the agency continues as currently organized or as reorganized. The recommendations for the other health and human services agencies follow this discussion of HHSC, and reflect each agency as currently organized, although the intent of the Sunset Commission is that they be aligned functionally in the reorganized system.

The Sunset Commission also took action to better position HHSC in its new environment to ensure the quality of programs and services, detailed in the issues below. In addition, the Sunset Commission addressed other entities under the HHSC umbrella or closely associated with HHSC. OIG came under the microscope for the first time in its current incarnation, revealing deep management and due process concerns, particularly in its efforts to detect and deter Medicaid fraud, waste, and abuse. Finally, two other entities with their own Sunset dates, the Interagency Task Force for Children with Special Needs and the Texas Health Services Authority, can still operate effectively, but under alternative approaches to their existing statutory arrangements. The following material summarizes the Sunset Commission's recommendations on HHSC and these related entities.

Issues and Recommendations

Issue 1

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

The Legislature expected the 2003 consolidation of human services agencies 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 administration, and unnecessary expenses. Regulatory functions may be too closely connected with the programs they regulate and lose the benefits of being housed 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 infrastructure 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.

Recommendations

Change in Statute

1.1 Reorganize the five health and human services system agencies into one agency called the Health and Human Services Commission, with divisions established along functional lines.

This recommendation eliminates DSHS, DADS, and DFPS as separate agencies, merging their functions into a newly constituted Health and Human Services Commission. In the case of DARS, only a few remaining functions would be merged into the new structure, as DARS' largest functions related to vocational rehabilitation and federal disability determination would transfer to TWC, as described in the TWC section of this report. 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 improves the delivery of health and human services by reducing the fragmentation and inefficiency of the current structure.

- **Require the governor to appoint an executive commissioner, with Senate confirmation, for a two-year term to lead the new agency.**
- **Establish divisions along functional lines as the basic organizational framework for the consolidated agency.**

Statute would require the executive commissioner to consider the following functional divisions in organizing the commission: medical and social services, state institutions and facilities, family and protective services, public health services, regulatory services, centralized services, and inspector general.

The graphic, *Health and Human Services Commission Example of Functional Organization*, on the following page depicts the organizational arrangement to be considered. The descriptions of divisions in the following graphic do not imply organization of sections within them. The executive commissioner would consider this organization chart as a starting point and fill in and adjust organizational details in developing the transition plan described in Recommendation 1.2.

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 similar to the authority that commissioners exercise now.

This recommendation would also remove structural components for entities that are administratively attached to the system. These entities are the Texas Office for the Prevention of Developmental Disabilities, and the Texas Council on Autism and Pervasive Developmental Disorders and Texas Autism Research and Resource Center. The recommendation would maintain the functions of these entities in statute, but would remove any structural components, such as administrative attachment, governing boards or appointment structures, or status as an independent entity, just as it removes the separate system agencies. The executive commissioner could create advisory committees in rule 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, would be retained in its current structure but its administrative attachment would move from DADS to HHSC.

- **Establish a Policy and Performance Office.**

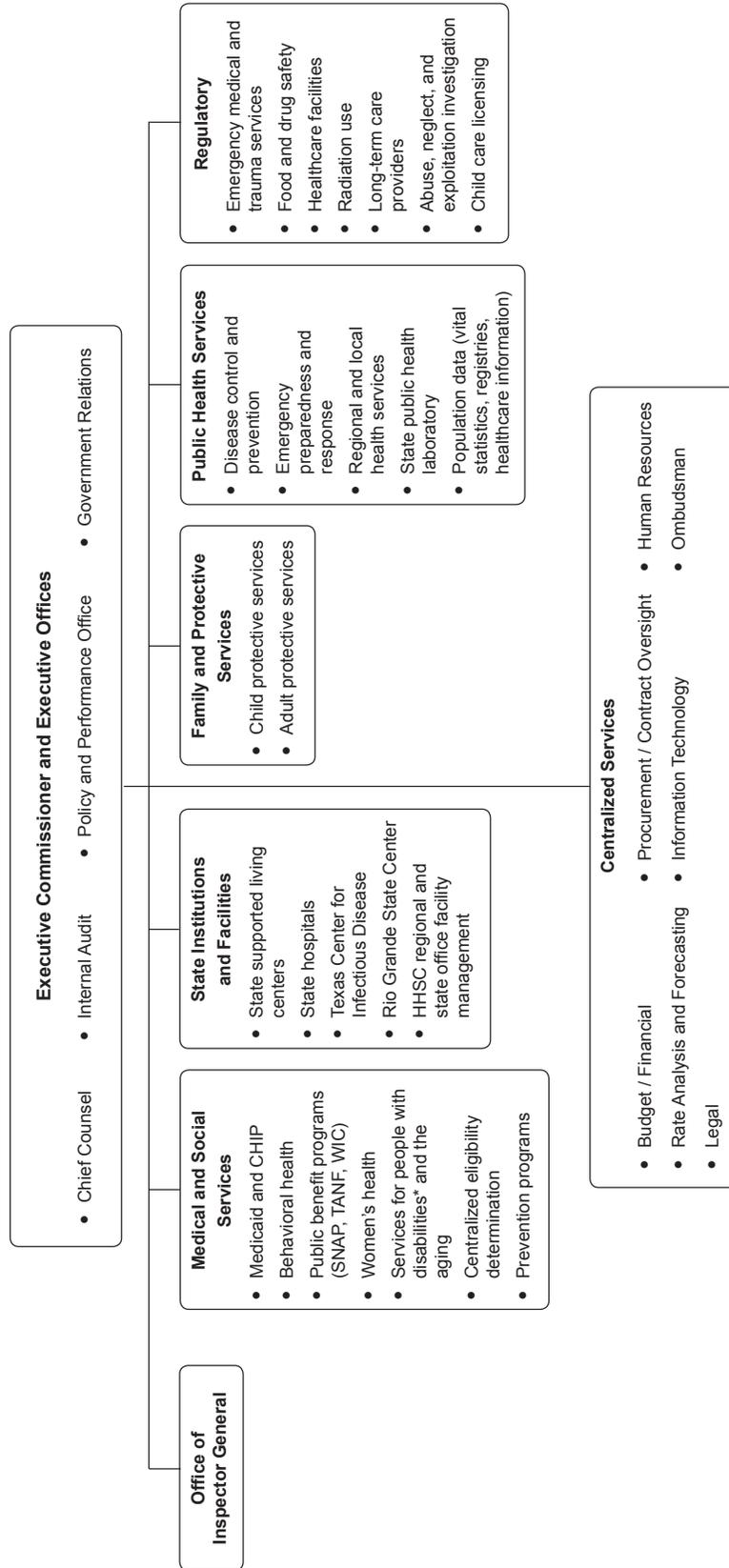
Statute would require HHSC to designate and maintain a high-level executive office to coordinate policy and performance efforts across the system. Specifically, the office would develop a systemwide performance management system, oversee data and analytics responsibilities, and oversee implementation 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 client population groups do not lose the visibility or attention they need in the new organization, including establishing cross-functional efforts or teams needed to improve coordination of services. Regarding system staff, the office would take the lead in managing change in the organization, including cultural aspects and needed communication with staff in the transition and on an ongoing basis to implement major policy changes, such as legislation and associated rule revisions. The office would also be a centralized “think tank” within the system to offer program evaluation and process improvement expertise.

- **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 requests and other documents required in the state’s appropriations process, operation of agency programs, and other issues for the entire system. The executive commissioner would retain all decision-making authority. The committee would not be a “governmental body” as defined by the Open Meetings Act, given that these individuals would normally meet in the course of their daily work to discuss agency business. Executive council meetings should be publicly announced and held at least quarterly, with authority to call a special meeting when necessary.

**Health and Human Services Commission
Example of Functional Organization (including Sunset decisions on January 14, 2015)**

The following diagram is an *example* of an HHSC organization developed around functional lines. Statute would specify that the executive commissioner must consider reorganizing the agency around these seven large functional divisions, but statute would not include any of the bulleted detail under each of these functional divisions. The executive commissioner would use this chart as a starting point for preparing the transition plan for the reorganization. **Bullethead items are not intended to be an exhaustive list of all functions carried out in the seven large functional divisions.** Each of the seven functional divisions would be led by a high level executive who would have broad discretion to make decisions as delegated by the executive commissioner. Statute would require HHSC to establish a Policy and Performance Office, which is to develop cross-functional teams and processes between the functional divisions to ensure full collaboration of staff and coordination of related programs for optimal delivery of services.



* The Sunset Commission voted on January 14, 2015 to recommend transferring the Blind and General Vocational Rehabilitation programs, Business Enterprises of Texas, and federal Disability Determination Services from the Department of Assistive and Rehabilitative Services to the Texas Workforce Commission. These activities had been bulleted either separately or grouped conceptually with services for people with disabilities under Medical and Social Services in the Sunset Commission decisions on HHSC on December 10, 2014, but would no longer be considered under that functional alignment.

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.

This recommendation would require in statute that the executive commissioner submit a transition plan outlining the newly formed agency structure and a plan to carry out the reorganization to a newly created transition legislative oversight committee for its review and approval, and to the governor and Legislative Budget Board by December 1, 2015. 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.

As a management recommendation, the executive commissioner should submit to the transition legislative oversight committee a separate plan for consolidating administrative support services; report how the reorganized structure emphasizes information technology and contracting so that these functions receive ongoing high-level attention; as well as report how to satisfy federal requirements related to the organizational placement of programs. The executive commissioner should also report how the reorganized structure would ensure needed coordination for people served across system components.

Statute would require that the transition legislative oversight committee have the following composition: 11 voting members including four members from the House appointed by the speaker, four members from the Senate appointed by the lieutenant governor, and three public members appointed by the governor; and the executive commissioner as an ex officio nonvoting member. The lieutenant governor and speaker would each name a co-chair from among their appointees. The committee would be required to meet at least quarterly or at the call of the co-chairs through 2016 and then at least once a year through 2023, at which point the committee would disband. Committee meetings would be subject to the Open Meetings Act and the committee would be required to report to the lieutenant governor, speaker, and governor on progress and issues related to the transition not later than December 1 of even-numbered years.

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.

Unless specified in other decisions of the Sunset Commission, the need for all system functions would continue and the reconstituted HHSC would have a Sunset date of September 1, 2027. In addition to this full Sunset review, the reorganized agency would undergo a limited Sunset review for the 2022 – 2023 biennium, but would not be subject to abolishment at that time. The review would be limited to providing an update on agency progress in meeting reorganization requirements and identifying any other changes deemed appropriate.

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. Twelve years later, administrative consolidation is still incomplete, resulting in lost opportunities for efficiencies and cost savings. The Sunset Commission found that information resources, contracting, and rate setting support functions, remain decentralized in various degrees within and outside HHSC affecting needed oversight of these essential services. Of particular interest, HHSC lacks high-level attention to provide needed sophistication in its overall

approach to contracting to meet so many of its critical responsibilities through outside parties. While support services would centralize as a consequence of the overall system reorganization in Issue 1, their treatment here is intended to elevate their importance regardless of the outcome of reorganization.

Recommendations

Management Action – Nonstatutory

2.1 Direct HHSC to further consolidate administrative support services.

HHSC, in consultation with other system agencies, should develop a consolidation plan, including a schedule with milestones, for reviewing and implementing consolidation changes. The consolidation plan should use principles, such as ensuring clear lines of responsibility for providing services and responsiveness to the system's needs for support services to help guide decisions as to the desirability of further consolidation. As a statutory change, individual system agencies should be clearly exempted from the requirement that all state agencies have an internal audit, to allow for possible internal audit consolidation.

2.2 Direct HHSC to take steps to improve the accountability for, as well as the planning and integration of, information technology and information security in the health and human services system.

HHSC should consolidate within HHSC IT the system agencies' information resource managers, information security officers, and related staff, while still ensuring that system agencies have sufficient and readily available IT support to meet their needs. HHSC should clearly define and direct in policy that HHSC IT sign off on and monitor any IT-related procurements, regardless of the originating agency. HHSC guidelines should require that HHSC IT, in consultation with system agencies, develop a comprehensive plan of IT projects looking forward a minimum of three years that aligns with the program's vision, strategy, needs, and priorities. The executive commissioner should adopt guidelines setting out the responsibilities of HHSC IT and system agencies for IT. HHSC should also consolidate authority for system networking and customer support and put in place a security system meeting consistent minimum standards. As a statutory change, this recommendation would exempt system agencies from the general state requirement that each state agency's information resource manager report to the executive head of the agency.

2.3 Require HHSC to better define and strengthen its role in both procurement and contract monitoring.

HHSC should clarify and standardize its role over enrollment contracts and complete, maintain, and update the statutorily required contract management handbook, risk analysis procedure, and central contract management database. In addition, HHSC should require the executive commissioner's signature on large or complex contracts managed by any of the system agencies; 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.

2.4 Direct HHSC's procurement and contract office to improve assistance to and communications throughout the system.

HHSC should strengthen technical assistance by designating points of contact within HHSC and throughout the system. HHSC should also ensure HHSC procedures establish contract training requirements for contract development, or contract management staff and system leadership, and coordinate any required contract-related training.

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

HHSC executive management should focus needed resources and attention on contracting to promote ongoing improvement, consistency, and accountability on major contracts. For example, reinstating some form of the disbanded enterprise contract council could provide a place to spearhead discussion of contracting issues and solutions.

2.6 Consolidate rate setting for the health and human services system at HHSC.

HHSC should establish this consolidation in policy, determining a transition schedule for moving different types of rates and associated staff to HHSC in stages, as well as identifying contracted services in agencies whose underlying payments are not based on standard rates and thus not appropriate for rate analysis.

2.7 Improve transparency in setting capitated rates.

HHSC should consider providing additional information and time to managed care organizations so that these entities can independently calculate various factors making up their capitated rates.

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.

Recommendation

Management Action – Nonstatutory

3.1 Consolidate administration of Medicaid at HHSC.

This recommendation would move all pieces of the Medicaid program administered by DSHS and DADS to HHSC in accordance with the overall system reorganization in Issue 1. HHSC should 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, with consolidation occurring no later than September 1, 2016.

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 requires increased sophistication. Meanwhile, having a separate Pharmaceutical and Therapeutics Committee and Drug Utilization Review Board impedes a unified approach to ensure the safe and cost-effective use of prescription drugs.

Recommendations

Management Action – Nonstatutory

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

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.**

Management Action – Nonstatutory

- 4.3 HHSC should develop a system to automate data entry.**

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.**

Management Action – Nonstatutory

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

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.**

The repurposed board's membership would include two representatives from managed care organizations, a pharmacist and physician, to serve as non-voting members.

- 4.7 Expand the Medical Care Advisory Committee’s membership to include a managed care representative.**

Management Action – Nonstatutory

- 4.8 Direct HHSC to report to the Sunset Commission recommendations related to network adequacy for Medicaid managed care organizations.**
- 4.9 Direct HHSC to routinely measure and publicly report on non-emergent utilization of the emergency department by managed care members, by health plan, by region.**

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.

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 also authorize creation of a single, consolidated enrollment and credentialing process, if feasible.

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

OIG’s criminal history checks would be limited to providers not already subject to fingerprint-based checks by state licensing boards. 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.

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

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

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 all applications.

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 under managed care, the Delivery System Reform Incentive Payment (DSRIP) program, and other efforts 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.

Recommendations

Change in Statute

6.1 Require HHSC to develop a comprehensive, coordinated operational plan designed to ensure consistent approaches 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 and revise its major quality initiatives to ensure the initiatives work toward common goals and measures are reported consistently. In implementing this recommendation, in conjunction with seeking renewal of the 1115 waiver, HHSC should narrow the menu of DSRIP projects and consider developing ways to incentivize coordination across these various quality initiatives.

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

Management Action – Nonstatutory

6.3 Require HHSC to include incentive-based payments in managed care contracts and better define types of incentive-based payments.

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. The system's highly decentralized approach prevents appropriate use of information to measure performance and inform key decisions and creates compliance risk given the complicated privacy laws and other regulations governing the data.

Recommendation

Management Action – Nonstatutory

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 with clear authority to coordinate data governance and management efforts throughout the system. The office should establish systemwide policies governing the development, use, and appropriate sharing of data and data systems and to monitor adherence to agreed-upon standards. The office should conduct a detailed inventory of all major data sets and systems across the enterprise, and should then develop a strategic plan establishing data priorities for the enterprise and strategies for achieving them, incorporating feedback from system staff and stakeholders. The office should also develop specialized expertise to offer technical assistance and cross-program coordination for priority projects.

Issue 8

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

HHSC and DSHS provide women’s health and family planning services 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 comparisons to measure the impact of significant legislative investments, problems compounded by the lack of a comprehensive vision for women’s health across agency lines.

Recommendations

Management Action – Nonstatutory

8.1 Consolidate the existing Texas Women’s Health and Expanded Primary Health Care programs into one program at HHSC and continue the Family Planning program unchanged, but also at HHSC.

This recommendation directs HHSC to work with the Senate Finance Committee and the House Appropriations Committee to determine eligibility criteria and a benefit package for the consolidated program that will increase the state’s capacity to serve women and emphasize family planning services within available resources. HHSC should address other aspects of the program relating to billing procedures and funding distribution, program administration, and the periodic evaluation of services, largely on the direction provided through the appropriations process. HHSC should use the same processes in the two programs, where feasible, to gain administrative efficiencies.

HHSC is directed to consolidate the two programs and roll out the newly consolidated program by January 1, 2017. Current laws applicable to existing state-funded women’s health programs would be applied to the new program.

8.2 Direct HHSC to study the feasibility of automatically transitioning new mothers in Medicaid to the new women's health program.

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. However, successful elements of the NorthSTAR model could be continued in a new model or applied statewide.

Recommendations

Management Action – Nonstatutory

9.1 Transition provision of behavioral health services in the Dallas area from NorthSTAR to an updated model.

This recommendation would allow the local communities that comprise NorthSTAR to work with HHSC to develop a mutually agreed upon solution, within certain timelines, to move the current NorthSTAR model into one that meets the state's priorities and maintains the strengths of the NorthSTAR model, as described below.

- **Medicaid.** Subject to federal approval, 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. 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.
- **Local plan for indigent services.** Each of the counties that comprise NorthSTAR, either as an individual county or in partnership with other counties, would be required to submit a local plan to DSHS, in consultation with HHSC, for provision of indigent services. The agencies must dedicate a direct liaison to assist the local communities in developing their local plans. The local plan must be agreed to by a majority of the county commissioners, and the board of directors of the local mental health community center, in each county covered by the local plan. Counties who do not want to remain within NorthSTAR may adopt the current DSHS model of behavioral health service delivery found in other parts of the state outside of NorthSTAR.

Local plans must demonstrate the following criteria: 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.

If DSHS does not receive sufficient local proposals to deliver indigent healthcare services within required timelines, DSHS, in consultation with HHSC, should solicit local input in developing its own plan to transition indigent services to a new entity through a competitive bid. In selecting an entity, DSHS and HHSC should give favorable consideration to proposals that most closely provide for the criteria listed for local plans above.

- **Timeline.** For Medicaid, funding for children should be transitioned to STAR and STAR Kids plans no later than September 1, 2016. All other Medicaid and indigent behavioral health services must go into effect no later than January 1, 2017.

Change in Appropriation

- 9.2 The Sunset Commission should recommend that the Legislature include a rider to transition NorthSTAR funds to DSHS behavioral health funding strategies.**

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 assist clients in maintaining Medicaid eligibility. HHSC should also explore strategies to support continuity of Medicaid eligibility for individuals with social security income, if cost effective.

- 9.4 Require HHSC to ensure behavioral health services are integrated into managed care organizations statewide.**

HHSC should use performance audits and measures, especially in cases in which managed care organizations subcontract behavioral health services, to ensure clients receive coordinated behavioral health and primary care.

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 health and human services 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. 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 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.

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.

In cases in which OIG perceives a conflict of interest in reporting to 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.

10.3 Require OIG, by rule, to establish prioritization and other criteria to guide its investigation processes.

10.4 Require OIG to complete Medicaid provider preliminary investigations within 45 days and full investigations within 180 days.

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.

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

10.7 Define OIG's role in managed care, including strengthened oversight of special investigative units.

10.8 Remove the prohibition on participation in both the Health Insurance Premium Payment program and Medicaid managed care.

10.9 Allow OIG to share confidential drafts of investigative reports concerning child fatalities with DFPS.

Management Action – Nonstatutory

10.10 Direct OIG to narrow its employee investigations to focus on high priority allegations.

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 system, but not general employee misconduct for allegations that can be handled by an agency manager or referral to a local law enforcement agency. This recommendation would also direct OIG to discontinue regular review of every DFPS case involving a child fatality and focus instead on special cases with specific and serious allegations related to DFPS employees, or other cases at the discretion of the executive commissioner.

10.11 Direct OIG to actively take steps to improve training for its staff and communication with health and human services system programs and providers, including strengthening prevention efforts.

OIG should improve internal training for staff to better inform them of policies, operations, and basic business practices of providers and critical programs they investigate. OIG should better communicate and share information with Medicaid policy staff and establish regular, ongoing prevention efforts among Medicaid providers. OIG should also increase transparency by offering more robust and better information on its website. Finally, upon finding state employee fraud, including by OIG employees, OIG should promptly notify any affected or harmed providers.

10.12 Direct HHSC and OIG to work together to transfer certain OIG functions to other areas of the health and human services system where they would fit more appropriately.

This recommendation would make the following transfers: the Health Insurance Premium Payment program to the Medicaid program in HHSC; review of cost reports to HHSC's financial services division rate analysis department; review of single audit reports to the system agencies that run the programs requiring these reports; and reviews of an intermediate care facilities' handling of residents' trust funds and income to DADS.

10.13 OIG should track basic performance measures needed to monitor the efficiency and effectiveness of its investigative processes.

10.14 OIG should establish a formal plan for reducing its backlog and improving inefficiencies in the process.

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. The process for CAF hold hearings is excessive and creates undue burdens on providers as compared to cases presenting more serious risks to the State and public. In addition, aspects of the overpayment hearing process affect the fairness of these cases for both providers and the State.

Recommendations

Change in Statute

11.1 Streamline the CAF hold hearing process to more quickly mitigate state financial risks.

- **Notice of a payment hold.** OIG would be required to send notice to providers within five days of placing a CAF hold, which would continue to take immediate effect. If the provider requests a

hearing within 10 days of receiving notice, OIG would have three days to request a hearing with the State Office of Administrative Hearings (SOAH), and SOAH would be required to hold the CAF hold appeal hearing within 45 days of the request. OIG would be required to provide a detailed summary of all its evidence as to the credible allegation of fraud along with this notice.

- **Hearings.** Hearings would 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 would 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.
- **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. SOAH would not have the ability to adjust the 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.
- **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.

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 certain 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.

11.3 Clarify OIG’s authority to place payment holds only in serious circumstances.

This recommendation would clarify that OIG’s payment hold authority is 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 or to aid in bargaining and settlement negotiation.

11.4 Disallow CAF holds for services that have received prior authorization but lack additional evidence of fraud.

CAF payment holds should not be placed on providers for services that have received prior authorization by HHSC or its contractor as “medically necessary” unless additional evidence is presented that the provider has materially misrepresented documentation for the proposed medical or healthcare services. OIG would retain the ability to pursue all overpayments regardless of whether a claim received a prior authorization.

11.5 Amend the statutory definition of fraud.

This recommendation would amend the statutory definition of “fraud” to clarify that the term does not include unintentional technical, clerical, or administrative errors.

11.6 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.

11.7 Require OIG to pay all costs of overpayment hearings at SOAH.

This recommendation would require OIG to pay costs associated with overpayment hearings at SOAH, excluding provider attorney's fees, just as Recommendation 11.6 would do for CAF hold hearings.

11.8 Remove the statutory right to two informal resolution meetings before overpayment hearings.

Providers would maintain a right to one informal resolution meeting at the provider's request, but this and any subsequent meeting that may be granted would run concurrently with the overpayment process to not delay the timing of the overpayment hearing.

11.9 Provide pharmacies audited by OIG or a federal contractor and not accused of fraud the right to an informal hearing.

The recommendation would move informal hearings currently held at OIG to the HHSC Appeals division to remove OIG staff from making decisions on matters it originally developed. Vendor drug program staff would remain on the decision-making panel to ensure needed expertise. OIG would also be required to provide information to pharmacies related to methods used to determine the overpayment and any extrapolation of audit findings.

Issue 12

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

Collectively, the five health and human services agencies have developed about 100 websites and maintain 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. In addition, HHSC's ombudsman's office lacks adequate authority and visibility to 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.

Recommendations

Change in Statute

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

This recommendation would require approval from HHSC for any new website projects throughout the system. HHSC would inventory and evaluate the ongoing need for existing websites and improve uniformity and efficiency, including creating a uniform look and feel for all main agency home pages and ensuring search engine optimization and other technical aspects for all websites.

12.2 Require HHSC to create policies governing hotlines and call centers throughout the system.

This recommendation would require HHSC to inventory and develop criteria to assess the need for all existing hotlines and call centers and create an approval process for new hotlines and call centers. 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.

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. The recommendation would clarify the office's authority for collecting inquiry and complaint data from all system agencies, and require the executive commissioner to adopt policies for a standard process to track and report inquiries and complaints among all system agencies.

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's 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.

Recommendations

Change in Statute

13.1 Remove advisory committees from statute, including those with Sunset dates, and require the executive commissioner to re-establish in rule advisory committees to consider all major areas of the agency.

This recommendation would eliminate from statute 32 of 35 advisory committees, including several unnecessary, duplicative, or inactive advisory committees. The three remaining 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, would be removed from law.

The executive commissioner would re-create advisory committees in rule that cover all major areas of the agency, including Medicaid and other social services programs; managed care; quality initiatives; aging; individuals with disabilities, including autism; rehabilitation, including brain injuries; children's

issues; public health; behavioral health; regulatory matters; protective services; prevention efforts; and faith and community-based matters. Through 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.

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 the four committees as one advisory committee in such a way that its membership, purpose, and initiatives most effectively direct state resources to improve services and better coordinate advisory efforts for children with special needs.

13.3 Apply advisory committee requirements outlined in Chapter 2110, Government Code, to advisory committees appointed by the executive commissioner.

13.4 Require HHSC to create a master advisory committee calendar, stream advisory committee meetings, and ensure access to online meeting materials.

Management Action – Nonstatutory

13.5 Direct the executive commissioner to seek stakeholder and public input in evaluating the need for and restructuring its advisory committees and post that plan on the agency’s website.

Issue 14

HHSC Statutes Do Not Reflect Standard Elements of Sunset Reviews.

HHSC’s statutes do not include standard provisions relating to conflicts of interest and alternative rulemaking and dispute resolution. Additionally, the Sunset Commission found that four of 42 required reports are no longer necessary and should be eliminated, and eight others required by advisory committees would be removed from statute under Issue 13.

Recommendations

Change in Statute

14.1 Update two standard Sunset across-the-board recommendations, related to conflicts of interest and alternative dispute resolution, for HHSC.

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*; and the *Report on Procurement and Contracting Practices*. HHSC’s other reporting requirements would continue in effect, except those addressed in Issue 13.

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.

Recommendation

Change in Statute

15.1 Remove the Texas Health Services Authority from statute in six years, 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, 2021. THSA would 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. Statutory provisions for privacy and security standards, HHSC rules relating to standards for sharing protected health information electronically, and mitigating factors to protect entities certified through THSA's privacy and security program would be preserved elsewhere in state law. This recommendation would also clarify that two ex officio non-voting members of THSA's board represent state health and human services agencies instead of just DSHS, and add one member to represent Texas local health information exchanges. The Sunset Commission also recommends to the Senate Finance and House Appropriations committees that THSA receive no state appropriation for the upcoming biennium.

Fiscal Implication Summary

The recommendations would result in savings to the General Revenue Fund of about \$1.7 million in fiscal year 2016, and \$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 be additional funds to local entities, not the State.

Issue 1 — Reorganizing the health and human services 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. Costs associated with the reorganization 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, and would likely offset savings in large part over the first few years.

Issue 8 — Consolidation of women's health programs would result in an estimated administrative savings to the State of \$1.1 million annually.

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, 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 the reduction of 28 staff 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 support and travel costs.

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

Fiscal Year	Savings to the General Revenue Fund	Change in 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