



INTERIM REPORT *to the 86th Texas Legislature*



HOUSE COMMITTEE ON HUMAN SERVICES

November 2018

**HOUSE COMMITTEE ON HUMAN SERVICES
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2018**

**A REPORT TO THE
HOUSE OF REPRESENTATIVES
86TH TEXAS LEGISLATURE**

**RICHARD PEÑA RAYMOND
CHAIRMAN**

**COMMITTEE CLERK
KYLE MAURO**



Committee On Human Services

December 10, 2018

Richard Peña Raymond
Chairman

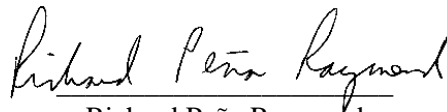
P.O. Box 2910
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The Honorable Joe Straus
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701


Dear Mr. Speaker and Fellow Members:

The Committee on Human Services of the Eighty-fifth Legislature hereby submits its interim report including recommendations and drafted legislation for consideration by the Eighty-sixth Legislature.

Respectfully submitted,

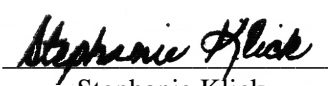

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Interim Charge

Study the impact of Hurricane Harvey and the response to the storm on individuals living in long-term care facilities, assisted living facilities, state supported living centers, licensed community group homes, and children in the foster care system. Identify and recommend necessary solutions to ensure appropriate disaster-related protocols are in place to keep vulnerable Texans protected. Also, identify any challenges state agencies experienced in responding to the storm or during recovery efforts.

Summary

The Committee held a joint hearing with the House Public Health Committee on November 1, 2017 and received testimony from state agencies, local health officials and other interested individuals to learn more about their experience during Hurricane Harvey.

Hurricane Harvey made landfall in Texas on August 26, 2017. The storm hovered over Southeast Texas for four days dropping record amounts of rain, with some areas receiving as much as 60 inches. Harvey was not only the deadliest hurricane to hit Texas since 1919, the storm also forced the evacuation of over 30,000 Texans.¹

The Department of Family and Protective Services (DFPS) and the Health and Human Services Commission (HHSC) engaged in emergency preparedness efforts to ensure individuals served by their programs knew what to expect and where to receive services.

In June, DFPS worked to ensure providers had updated their evacuation plans in case of severe weather. Additionally, all foster and adoptive families were contacted when the magnitude of the storm was realized to ensure they would be following emergency procedures. The agency also coordinated with Superior Health Plan who administers the STAR Health program.²

HHSC worked to ensure relevant information was relayed to nursing facilities and assisted living facilities so they would be ready to implement their disaster and evacuation plans if necessary. Over 400 individuals at the Corpus Christi State Supported Living Center, including residents and employees were evacuated prior to landfall.³

Preparation efforts helped mitigate potential issues however, the magnitude of the storm forced both DFPS and HHSC to close offices and facilities in affected areas making response efforts more difficult.

Partnerships between DFPS and local law enforcement ensured intakes, investigations and removals continued during the storm. The agency also monitored evacuations of provider facilities and maintained contact throughout the storm to ensure transitions were as seamless as possible.⁴

Both agencies remained flexible during the storm, mobilizing staff to assist with response efforts at shelters where impacted individuals needed their services.

HHSC remained in contact with regulated facilities throughout the storm. When emergencies were reported, agency staff notified the State Operations Center so local emergency personnel could intervene. In total, 104 assisted living facilities and nursing facilities reported evacuating nearly 4,500 residents. HHSC teams conducted on-site inspections to ensure facilities that had been damaged could safely resume operations. At the time of the hearing 39 of these facilities remained temporarily closed due to damage from the storm.⁵

Eighteen General Residential Operations, eight Residential Treatment Centers, and around 1,500 children in the care of the State were evacuated. Several providers experienced severe damage to their facilities and DFPS has been engaged with providers to determine the impacts on statewide capacity.⁶

HHSC worked with federal partners to secure waivers so that Supplemental Nutrition Assistance Program (SNAP) recipients continued to receive assistance during the storm and recovery period. Waivers allowed beneficiaries to purchase hot foods, to extend their certification periods, to receive their benefits early, and to replace benefits when Lone Star cards were lost or damaged. Replacement SNAP benefits were issued to approximately 693,000 households totaling \$91 million.⁷

Disaster SNAP, a program offering short-term food benefits to families not receiving SNAP benefits was distributed to families returning home after the storm. After securing the federal waiver to distribute D-SNAP, HHSC was able to issue more than \$530 million in benefits to over 500,000 families in 39 affected counties.⁸

One area of improvement for HHSC would be to improve communications and notifications with SNAP retailers when D-SNAP and replacement benefits are expected to be issued. This would improve preparation to serve Texans in need by allowing retailers to ensure the right products are on the shelves. When these types of benefits are issued in a concentrated area it can impact the ability of retailers to provide products to families.

HHSC received flexibility from the federal Centers for Medicare & Medicaid Services (CMS) to allow displaced individuals to access out-of-network Medicaid services and expedite the Medicaid enrollment process for out-of-state providers.

Providers in the long-term/post acute space focused on ensuring evacuations and relocations took place with the least impact to residents. These facilities had to determine whether to shelter in place or whether it made more sense to evacuate based on ever-changing storm conditions in their area. While there were isolated incidents of some facilities not following their emergency plans which resulted in negative outcomes, facilities were largely successful in keeping their residents safe and managing the storm situation.⁹

Medicaid health plans also known as Managed Care Organizations (MCOs) were heavily involved in trying to resolve Medicaid beneficiary issues during the storm. MCOs waived medical necessity reviews, prior authorization requests, and early refill requests in order to get beneficiaries care when they needed it. Health plans posted 24 hour assistance hotlines, mental health hotlines, and free telemedicine hotlines to provide the kind of flexible assistance needed by beneficiaries. However, MCOs had a difficult time contacting emergency management when beneficiaries needed to be evacuated.¹⁰

Recommendations

- An emergency coordinator position should be established at DFPS that would manage the agency's efforts to prepare for and react to disaster/emergency situations.
- HHSC should establish processes to pursue waivers early on when disaster situations are expected to allow providers the resources and flexibility to meet the needs of affected individuals.
- Providers who are highly involved with patient/beneficiary care such as long-term/post acute facilities and MCOs should be co-located with regulatory and commission staff responsible for provider coordination and more integrated into the agency disaster response process to help improve the efficiency of HHSC's communications during disaster situations.
- HHSC should study ways other states have streamlined the D-SNAP application process, potentially by offering a telephonic or online D-SNAP pre-registration process.

Interim Charge

Review the history and any future roll-out of Medicaid Managed Care in Texas. Determine the impact managed care has had on the quality and cost of care. In the review, determine: initiatives that managed care organizations (MCOs) have implemented to improve quality of care; whether access to care and network adequacy contractual requirements are sufficient; and whether MCOs have improved the coordination of care. Also determine provider and Medicaid participants' satisfaction within STAR, STAR Health, STAR Kids, and STAR+PLUS managed care programs. In addition, review the Health and Human Services Commission's (HHSC) oversight of managed care organizations, and make recommendations for any needed improvement.

Summary

Over the course of the interim the committee held four hearings and received testimony from nearly 150 witnesses. Testimony was received from Health and Human Services Commission (HHSC) staff, managed care organization (MCO) employees, health care providers, advocacy organizations and most importantly, Medicaid beneficiaries.

In Texas, Medicaid - the jointly funded state-federal program to provide health care to eligible needy individuals is primarily delivered through a managed care model. Texas has operated managed care programs since 1993, however over the last 18 years Texas has expanded the use of managed care significantly, increasing from a caseload of roughly 500,000 in 2000 to over 4 million today. Over 92% of the Texas Medicaid caseload is now served through the managed care model.

In traditional Medicaid, individuals may receive care from any enrolled Medicaid provider who is then paid a fee for the services they provided. In this system, the state sets Medicaid rates and contracts with an administrator to pay provider claims.

In a managed care system, the state pays MCOs a capitated rate per enrolled member. MCOs are then responsible for providing all covered Medicaid services through their network of providers. MCOs build their networks by contracting with providers for a negotiated rate; this is similar to the commercial insurance system. MCOs are responsible for paying provider claims and are incentivized to reduce unnecessary costs.

The managed care model operates with the understanding that MCOs are allowed to earn a profit for the services they provide. The amount of profit they earn is primarily driven by their ability to reduce unnecessary costs. There are a variety of mechanisms to achieve this goal including ensuring the appropriate utilization of services, emphasizing preventive care, and improving health outcomes, among others.

MCOs are limited in the profits they earn through an experience rebate system, or profit sharing. Up to a certain amount MCOs are allowed to keep all profits. As profits increase as a percentage of their total capitation, the amount they are required to give back to the state also increases. As a way to mitigate unnecessary spending by MCOs to reduce profits, MCOs are limited in the amount of their capitation that can be used for administrative expenses such as employee compensation.

Medicaid managed care is delivered through six programs across the state: the STAR program which provides services mostly for children, newborns and pregnant women; STAR+PLUS which provides acute care and long-term services and supports (LTSS) for the elderly and individuals who have a disability; STAR Kids which provides acute care, LTSS and behavioral health services for children and young adults with a disability; STAR Health which provides acute care, LTSS and behavioral health services for children and young adults in state conservatorship; Children's Medicaid Dental Services which are provided for most children and young adults enrolled in Medicaid; and the Dual Demonstration or Medicare-Medicaid plan (MMP) which provides services for individuals who are eligible for both Medicare and Medicaid benefits who live in one of six counties where the demonstration operates.

Some of the managed care programs are statewide such as the dental program and STAR Health. The larger programs, however, such as STAR and STAR+PLUS are subdivided geographically into regional service areas. Each MCO in each program and each service area has a separate contract with HHSC. In total HHSC procures and manages over 40 separate managed care contracts. HHSC has responsibility for ensuring the terms of each contract are upheld and the agency engages in numerous contract oversight mechanisms to that end.

Those mechanisms include biennial operational reviews, utilization reviews, financial oversight as well as targeted reviews as necessary. Biennial reviews focus on a broad array of subjects such as claims processing, provider relations, data validity and complaints/appeals. Utilization reviews are performed to ensure MCOs are correctly enrolling members into home and community-based services as well as to ensure MCOs are providing services according to their enrollees' needs assessment. Financial oversight includes validation and audit of MCO self-reported data and claims.

Non-compliance identified through these oversight mechanisms can result in a number of remedies including corrective action plans, liquidated damages, suspension of default enrollment, and contract termination. HHSC has the authority to assess these remedies as they see fit and are not required to graduate from lower impact remedies to higher as an issue continues.

As required by Rider 61 of the General Appropriations Act - SB 1 (85R) HHSC commissioned an independent study to evaluate the managed care program's performance regarding cost and quality, among other things. The study was performed by Deloitte who presented their final report in August 2018.

Healthcare Effectiveness Data and Information Set (HEDIS) measures are frequently used to measure health care quality performance. The Rider 61 study analyzed 19 unique HEDIS measures against the national 50th percentile as well as other comparable states 50th percentile. According to the report, Texas's results were above the national benchmark for nine measures and below the national benchmark for ten measures. Additionally Texas scored highest out of all comparable states for some measures and lowest of all comparable states for some measures.¹¹

In their study of assumed cost savings Deloitte noted that when comparing actual historical managed care payments to hypothetical expenditures in a traditional Medicaid arrangement, from 2009 to 2017, managed care could have saved the state anywhere between \$600M to \$1.5B per year; or a savings of 4.7 to 11.5 percent.¹²

While cost and quality are certainly important when considering the potential benefit of a managed care system over a traditional Medicaid system, it is also important to consider patient and provider satisfaction with the program.

The following topics within the broader subject of the Texas managed care program reflect issues the committee and committee members have heard a great deal about from providers, patients and MCOs over the course of the interim.

Complaints and Appeals

In the Rider 61 study Deloitte analyzed managed care contract review and oversight. While opportunities for improvement were identified in all categories of contract oversight, grievances and appeals ranked lowest.¹³ Without strong complaints and appeals processes, achieving program improvement is more difficult and satisfaction with the program drops.

Medicaid recipients have the option of submitting complaints to a number of different access points including the agency and the HHS Office of the Ombudsman but are directed to first submit complaints directly to their MCO. MCOs are responsible for categorizing and tracking complaints and delivering this data to HHSC for review. Agency access points also track complaints data for analysis.

Having multiple entry points for complaints data makes it difficult to ensure data consistency. HHSC is working to improve data management and create consistent definitions across the agency and throughout the managed care program. Additionally, HHSC will be forming a complaint escalation team to trend complaints and improve data analysis. HHSC will also be making complaint data public. The committee is hopeful that improvements to complaint analysis and standardizing definitions will allow complaint data to be used to its fullest extent in improving the managed care system as it should.

Appeals are another point of contention within the managed care system. MCOs are responsible for providing eligible services and benefits to their members. MCOs may not be more restrictive in their criteria for determining eligibility for a benefit than set forth in the state Medicaid plan, state or federal law, or in the state's medical policy.

When Medicaid recipients are not satisfied by a medical necessity determination from an MCO, they have the right to an appeal as well as an HHSC fair hearing if the result of the MCO appeal is not satisfactory. While the process may be time-consuming and burdensome, one of the primary tenets of managed care is the MCO's ability to reduce unnecessary utilization. However, it should be the role of the state to ensure there isn't purposeful underutilization and beneficiaries are getting the care they need.

HHSC has requested and received approval for additional staff resources to support MCO oversight. Additional staff will be used to analyze trends and guide utilization reviews to ensure quality of care. The agency will also be expanding utilization review to the STAR Kids and Star Health programs to expand oversight in these programs and ensure these recipients are getting the care they need. HHSC will also be creating an expanded Chief Medical Officer position to focus on these efforts and ensure strong clinical oversight of the managed care program.

- HHSC should continue to improve the member complaint process by strengthening complaint tracking and analysis processes.
- The legislature should add a definition of "complaint" to statute that encompasses all types of grievances, concerns, and inquiries as well as a definition of "appeal" that encompasses all types of protests and objections. Additionally the legislature should direct HHSC to develop a complaints and appeals system in which all beneficiary and provider complaints, appeals and denials are shared with HHSC and OIG immediately and include the member's Medicaid identification number or provider's Medicaid identification number. MCOs should be required to update the complaints and appeals system with the progress of the complaint or appeal including whether or not the complaint was valid and why, steps being taken to resolve the issue, and final resolution. Denials should be updated with justification and appeal information which should include current status of the appeal and resolution. The complaints system should not be limited to providers who are contracted with an MCO, particularly if they are providing services to an MCO's beneficiary. The complaints and appeals system should be updated with complaints and appeals received by HHSC and OIG. HHSC and OIG should develop policies governing when to direct a complaint or appeal back to the MCO and when to investigate themselves, including consideration of when a beneficiary or provider wishes to remain anonymous.

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- HHSC's expanded Chief Medical Officer should be tasked with ensuring medical necessity determinations are appropriate, consistent, and are being made according to best clinical practices.
 - The Legislature should establish a Provider Ombudsman within HHSC to serve as an advocate for providers in the same way the traditional ombudsman serves beneficiaries.
 - HHSC should engage with an Independent Review Organization (IRO.) When a claims denial based on medical necessity is upheld by an MCO after the appeals process has been initiated, the IRO would provide an external review and make a binding decision on whether to uphold or overturn the MCO's medical necessity determination.

Office of Inspector General

The Office of Inspector General (OIG) was created to strengthen HHSC's capacity to combat fraud, waste and abuse in publicly funded state-run health and human services programs. In the traditional Medicaid model the OIG focused on fraud, waste, and abuse stemming from provider action. The OIG is statutorily required to focus their efforts on recoveries which would predominantly come from providers who billed for services they did not provide or provided unnecessarily.

Moving to managed care brings an additional set of risks to program integrity such as purposeful underutilization, inaccurate encounter data, submission of inaccurate self-reporting data and lack of access to subcontractor information. In the current system MCOs manage tens of billions of taxpayer dollars. Oversight of their contracts and whether the terms are upheld is left up to the state and giving additional entities oversight tools can only strengthen the program. With MCOs ensuring that fraud, waste and abuse are not occurring at the provider level, the OIG should be free to focus resources where they see the most opportunity to ensure program integrity and safeguard the nearly thirty billion dollars that flow through the Medicaid program each year.

As with many functions of the traditional Medicaid system, the role of the OIG must be updated to reflect the system that currently exists. In order to combat evolving forms of fraud, waste, and abuse the OIG should act as an independent health plan monitor studying trends in denials and complaints as well as other concerns of both beneficiaries and providers.

- Statute defining the role of the OIG should be amended, giving them additional authority to ensure program integrity in an evolving Medicaid landscape.
- The OIG should investigate referrals from HHSC regarding complaints, appeals and denials when patterns of abuse and purposeful underutilization are found through analysis of complaints and appeals data.

Timely Payment

Timely payment is vital to the ability of providers in the Medicaid program to remain in the program. With smaller than usual margins due to relatively low Medicaid rates, providers may face significant cash flow issues. For this reason the legislature has codified timely payment requirements for MCOs in situations where providers submit clean claims. However, if there are issues with claims, adjudication can drag out much longer. Accounts receivable balances for providers have grown significantly over the last several years which is a result of statute not addressing payment requirements for non-clean claims.

It is also important to consider how existing HHSC data systems may be an impediment to efficiency and prevent processes from working as intended. Agency data systems are out of date and don't interface or have the ability to communicate with each other to the fullest extent that current technology allows. Data sharing between programs, different functional areas within HHSC, and even with MCOs is a crucial step toward managed care optimization.

- The legislature should establish timely payment requirements for non-clean claims. Non-clean claims should be adjudicated within 30 days of the provider submitting additional information requested by the MCO. Additionally, claims projects to fix MCO claims processing systems should be adjudicated within 60 days, and pending claims resulting from claims projects should be adjudicated no later than 30 days after the claims payment system is fixed.
- The legislature should invest in HHSC data systems with expanded functionality helping to bring agency data technology capabilities up to date.

Care Coordination

Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.¹⁴ Care coordination is a benefit of Texas managed care programs that serve more medically complex populations in STAR+PLUS, STAR Kids and STAR Health. In their ideal form, care coordinators should be a liaison between the MCO, the beneficiary and their health care providers ensuring that the beneficiary is receiving the care they need.

The Legislative Budget Board studied care coordination in Texas Medicaid and produced a staff report in January 2017. According to the report, Most members in managed care programs receive minimal or no coordination services from their MCO. Many participants who meet eligibility requirements for care coordination do not receive a service plan or a named coordinator.¹⁵

Additionally, members who do receive care coordination services may not be realizing the full benefits care coordination can provide. The percentage of surveyed members of the STAR+PLUS program who are dissatisfied with care coordination services increased from 8 percent in 2008 to 26 percent in 2014. Plans to coordinate care aren't always shared with providers and contact between MCO staff and providers is often limited or does not occur. Members with the highest needs often experience the largest gaps in access to services that should be coordinated by their MCO.¹⁶

The value in care coordination comes from its ability to improve beneficiary satisfaction and improve quality outcomes. If a care coordinator is working as intended the beneficiary will receive services as needed without unnecessary administrative burden on the beneficiary or their providers. Quality outcomes improve and managed care efficiency increases when beneficiaries receive services appropriately.

Care coordination is one of the key components of managed care programs for disabled Medicaid members. In order for managed care to work for these populations care coordination must live up to its expectations.

- HHSC should look for opportunities to re-emphasize quality and patient satisfaction as goals of managed care with the understanding that care coordination inherently helps to achieve those goals.
- HHSC should implement requirements that health care providers be notified and given contact information for their patient's care coordinator.

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- HHSC should implement standards to require MCOs to respond to requests for post-hospital discharge services within 72 hours at least 95% of the time and provide specific reasons for denials of post-hospital discharge services. HHSC should monitor denials to ensure services are not being denied to meet timeframe requirements.

IDD LTSS Transition to Managed Care

Through legislation passed in 2013 - SB 7 (83R) and amended in 2017 - HB 3295 (85R), the Legislature directed HHSC to transition remaining Medicaid programs providing LTSS to individuals with intellectual or developmental disabilities (IDD) into managed care.

The Texas Home Living waiver program is set to transition to managed care in September 2020. The Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition program, the Home and Community-based Services, Community Living and Supports Services, and Deaf Blind with Multiple Disabilities waiver programs are set to transition in September 2021.

In that legislation, HHSC was authorized to implement a pilot program to test service delivery models involving a capitated managed care strategy to deliver LTSS to individuals with IDD. The legislation also established the Intellectual and Developmental Disability System Redesign Advisory Committee to ensure stakeholders had a voice in the development and implementation of this transition.

HHSC identified several risks and concerns during the development of the pilot program which contributed to delays in its implementation. Ultimately HHSC decided not to move forward with the pilot program, instead choosing to focus efforts on the transition occurring in 2020. HHSC did, however, engage Deloitte and the University of Texas School of Public Health-Houston to perform an analysis of the IDD LTSS transition that is to be completed by the end of 2018.

In July of 2018 the IDD System Redesign Advisory Committee submitted to HHSC recommendations regarding the transition. The committee strongly recommended that HHSC not move forward with the transition as it is currently scheduled. Among their rationale for making this recommendation were the fact that the committee considered the pilot program a necessary tool in understanding challenges to the overall support system and stakeholders. The committee also referenced the importance of reviewing the results of the Deloitte/University of Texas study prior to proceeding with the transition.

- The Legislature should delay the transition of IDD LTSS into managed care indefinitely. Additionally, statute should be amended requiring HHSC to carry out a pilot program, the results of which would be reviewed by the Legislature, along with the results of the Deloitte/University of Texas study, before the Legislature ultimately decides whether and when to continue with the transition.

Value-Based Contracting

Although Texas has chosen to move toward a managed care Medicaid model as opposed to a traditional or fee-for-service delivery system, payments to providers are still largely made following the fee-for-service pattern. Providers submit claims for services provided and MCOs pay the claims.

Alternative payment models that focus on value and quality instead of volume are becoming the new norm. Accordingly, the state's contracts with MCOs now include requirements that a minimum percentage of provider payments be linked to quality-based alternative payment models.

For 2018, 25% or more of all payments must be value-based and 10% or more must be risk-based. These targets increase over 4 years until 2021 when 50% or more of payments must be value-based and 25% or more must be risk-based.

Payments with a strong tie to value can help to incentivize more efficient delivery of health care services and higher quality outcomes. This is certainly the direction Texas Medicaid should be going considering the growing amount of the state's limited resources that are invested in the program. Payments based solely on volume are becoming outmoded and are seen to incentivize the wrong types of behaviors.

While some provider types and services may naturally fit into alternative payment model structures, others may not. In the Medicaid environment, provider rates are low to begin with and requiring providers to accept risk in their contracts may not be feasible for all provider types. Consequently, some MCOs have looked toward preferred provider arrangements in order to meet the value-based contracting requirements.

Preferred provider arrangements operate under the expectation that providers are willing to build risk into their payment structure in return for increased steerage, or a higher number of members being directed toward that practice. While preferred provider arrangements may be an acceptable way to meet value-based contracting requirements, they should not limit a member's free choice of provider.

It is important that HHSC closely monitor the application of alternative payment models in MCO/provider contracts, particularly for preferred provider arrangements, to ensure that member experience as well as network adequacy are not negatively impacted.

- HHSC should produce guidance for MCOs and providers regarding best practices, proven alternative payment model structures and rules regarding what will and will not be considered a qualifying value-based payment to reduce administrative burden and ensure all parties are prepared as MCOs move toward more complex models.
- HHSC should ensure that value-based contracts based on quality are linked to known quality measures and are based on credible data.
- HHSC should ensure that preferred provider arrangements include a reasonable opt-out provision for any reason or no reason at all, to allow for a member's free choice of provider. HHSC should also require that preferred provider arrangements prove an increase in quality or efficiency in order to continue.

STAR Kids

The STAR Kids program is the Texas Medicaid managed care program for children and adults up to age 20 who have disabilities. The program began in November 2016. STAR Kids members receive acute care, LTSS and behavioral health services along with Medically Dependent Children Program (MDCP) waiver services, if eligible.

Since the transition to STAR Kids many parents have experienced issues with the program and expressed those issues to MCOs, HHSC, and to their legislators directly. Issues raised by parents related to care coordination, reduction or denial of services, specialists not being in-network, confusion between Medicaid and private insurance coverage, issues with the STAR Kids Screening and Assessment Instrument (SK-SAI) and more.

The Office of the Inspector General has initiated an audit to evaluate the effectiveness of MCO performance through STAR Kids. The results were not released at the time this report was submitted but they should be considered in depth by the legislature as they decide how to move forward with improvements to the program.

The populations served by STAR Kids, particularly the medically fragile children, have some of the more complex conditions and needs seen in the entire Medicaid program. Dealing with denials of services their physicians have deemed medically necessary and navigating the many layers of managed care with limited care coordination are burdens the legislature should work to alleviate for these parents.

- Medically fragile STAR Kids program members should choose the delivery system most appropriate for their child's needs. Parents should be allowed to opt-out of managed care and instead receive their services through the traditional fee-for-service model.
- Statute should be amended to ensure Medicaid beneficiaries receiving therapy services, particularly those in the STAR Kids program, are not subject to service denials or reductions based on lack of progress. Preventing regression should be the qualification for medical necessity.
- The legislature should consider removing the statutory requirement that MCOs use the state-developed SK-SAI allowing MCOs to use nationally recognized screening tools. Additionally the legislature should consider whether there is a functional need to administer the SK-SAI every year.

Claims Portal

Texas Government Code Sec. 533.00251(c)(7) already requires HHSC to ensure "the establishment of a portal...through which nursing facility providers...may submit claims to any managed care organization." The statute has been interpreted to mean that each MCO may operate its own portal. However, multiple portals results in a burdensome administrative process with each MCO's portal in order for facilities to submit, review and edit claims which can be costly when considering employee workload.

- The legislature should clarify statute to ensure nursing facilities can manage all claims processes by accessing a single portal administered by HHSC.

MMP

In 2015, HHSC began enrolling clients receiving both Medicare and Medicaid benefits into a six-county pilot program now known as MMP. Its purpose was to make it easier to get care, eliminate cost shifting between Medicare and Medicaid, and to achieve cost savings through improvements in care and coordination. Providers have suggested the goals of the MMP program are not being realized and there may even be a greater regulatory burden and cost on providers than before.

- HHSC should complete a study by January 1, 2020 to determine the efficacy of the MMP program. It should review costs to the state and to providers, provider and participant satisfaction, and lessons learned since implementation of the pilot. HHSC should only continue the MMP program if the study determines cost savings.

Third Party Liability

As the payer of last resort, the Medicaid program is not intended to fund health care services before an individual's Medicare, TRICARE or private coverage provider pays claims under their policies. Third party liability (TPL) is the cost recovery mechanism required by the Centers for Medicare and Medicaid Services (CMS) that ensures states make an effort to identify third party coverage and recover funds when they haven't been billed appropriately.

As states move from large, integrated Medicaid Management Information Systems (MMIS) to more modern, modular Medicaid Enterprise Systems (MES), HHSC will be considering new, more effective models for carrying out existing processes. The agency should look to other states for best practices and existing systems that are already proving efficiency in the Medicaid program.

Additionally, TPL recoveries could be increased significantly through the use of non-traditional data sources to determine primary liability. Data sources aside from commercial insurance files can supplement the files HHSC currently receives providing opportunities for recovery when previously undiscovered liability is identified. Existing sources of this data are available in the private sector and should be sought out.

The TRICARE DEERS match process presents another potential opportunity along those lines. The match process, which has been allowed to expire, helps identify individuals who are on Medicaid rolls and have TRICARE coverage. If the Department of Defense and CMS would re-initiate this data sharing agreement costs could be shifted from Texas back to the federal government.

- HHSC should follow the majority of other states and separate TPL and other cost containment initiatives from their MMIS.
- MCOs should be given additional time to identify and recover TPL. The state allows only 120 days from adjudication yet federal law allows three years for identification and another six years to complete recovery.
- HHSC should make efforts to identify additional data sources for TPL in order to supplement and enhance TPL recovery efforts. The State should urge TRICARE to fulfill their TPL responsibilities to state Medicaid programs by re-initiating the DEERS match process.

HHSC Transition to Managed Care

HHSC oversight of MCOs is one of, if not the most important responsibilities of the agency now that managed care has become the predominant delivery method of Medicaid in Texas. A significant portion of the HHSC budget that does not go to beneficiary services is dedicated to MCO oversight to ensure the health plans are carrying out the terms of their contracts with the state and that services are being provided as required.

As Texas has moved from a traditional Medicaid model into managed care, opportunities have arisen for the agency to build and improve oversight activities. Transforming one of the largest state agencies in the country from a service delivery agency into a procurement and contract oversight entity is not a simple undertaking. HHSC should take every opportunity to study best practices and adopt new, more efficient processes and technologies made available through the private sector.

For example, an accreditation process could provide an opportunity for HHSC to engage a proven private sector partner to determine MCO competency across a number of standards. Plans can also be accredited based on their functional role and the specific programs they serve in Texas Medicaid providing an additional level of oversight and functional testing.

Additionally, while HHSC streamlines their oversight processes they should also focus on ways to help plans streamline their administrative requirements so more resources can be focused on ensuring quality patient care. While an increasing number of MCO deliverables require additional MCO resources, they also saddle HHSC with additional information to review and analyze. Efforts to streamline and reduce MCO deliverables and ensure non-duplication should be a key effort moving forward and were identified as an opportunity for improvement by the Deloitte Rider 61 study.

Health care systems are moving from a model of simply providing care for individuals when needed into a model of determining what environmental factors cause good or bad health outcomes and trying to affect an individual's environment to improve health. These environmental factors are called social determinants of health and they affect a broad array of health outcomes. While preventive medicine and more forward-looking models of health care may require additional investment on the front end, they have consistently proven to provide far more in savings on the back end. It is imperative, as health care costs continue rising, that all entities engaged in providing state-funded health care including providers, MCOs, HHSC and the Legislature keep this in mind and look forward as they determine where to invest resources and how to bring health care costs down and improve outcomes.

- The Legislature should consider a requirement that all future MCO contracts include accreditation requirements to provide a cost-effective form of oversight through a proven accreditation organization.
- HHSC should engage in an administrative simplification project. Not only should the agency make efforts to prioritize and reduce MCO deliverables, they should simultaneously ensure that MCOs are not requiring a burdensome amount of paperwork from providers when not absolutely necessary. Increased efficiency and automation of processes should be the ultimate goal. Additionally, the agency should ensure non-duplication of efforts regarding validation of quality areas that accredited health plans have already proven.
- HHSC should remove the requirement that MCOs provide hard copy provider directories to their members which only increase administrative costs due to printing and shipping. Alternatively, HHSC should require that MCOs provide printed hard copy directories upon request.
- The Legislature should take steps to further focus resources on preventive health care ultimately saving resources and slowing Medicaid cost growth. Additionally, HHSC should seek out opportunities to engage private sector partners with solutions that will help move the agency forward into the era of managed care.

Interim Charge

Examine the survey process for nursing facilities to determine any duplication of government regulations. Consider recommendations to reduce duplication while ensuring patient safety is preserved.

Summary

The Committee held a hearing on December 13, 2017 and received testimony from interested parties and the Health and Human Services Commission which establishes and enforces regulations governing nursing facilities.

In the State of Texas, all nursing facilities must be licensed. The state is responsible for issuance and renewal of licenses, as well as enforcement of licensing standards. Facilities aren't required to maintain federal certification, however, facilities who wish to participate in federally funded programs like Medicaid and Medicare are required to obtain this certification.¹⁷

State regulations covering nursing facilities closely mirror federal regulations. When a surveyor performs complaint investigations or surveys a facility, compliance with both state and federal regulations are determined. If a violation of a federal regulation is identified it likely also identifies a state violation. In this case, the surveyor informs the facility that the problem needs to be addressed to meet both federal and state standards. Federal regulators with the Centers for Medicare and Medicaid Services (CMS) review recommendations for penalties based on violation of federal regulations and make the determination whether or not to assess a monetary penalty. If a penalty is assessed on the federal side, statute prevents the state from assessing a penalty based on the same violation.¹⁸

While statute prohibits a monetary penalty from being assessed by both state and federal regulators, the state may still assess a licensure enforcement action on a facility when a monetary penalty is assessed federally. This dual citing can be burdensome to providers resulting in increased penalties, administrative responsibilities and lower performance scores on the rating system.¹⁹

For many violations, particularly those without actual harm to residents and those not categorized as immediate jeopardy violations, the facility has the opportunity to correct the problem. If the correction is held for twelve months the facility will not face a penalty.²⁰

The "right to correct" provision helps to mitigate the effect of being cited for a violation, however, unnecessary burden is created through complaints that result in investigations being performed without the complaint being substantiated. Less than 18% of complaints are substantiated by investigations.²¹

Facilities are also troubled by highly detailed and complex regulatory guidelines that confuse both surveyors and facility staff. Industry members believe the survey process is inconsistent and is subject to varying interpretation.^{22 23} In addition to issues with survey inconsistencies a workforce shortage in the long-term care field has created an environment where staff experienced with the survey process are becoming less readily available.²⁴

HHSC requires more substantial surveyor training than is required by CMS but in a state as large as Texas, consistency can be difficult and has been a point of focus for HHSC regulatory staff. Efforts have been undertaken to improve these inconsistencies including the creation of a system to share immediate jeopardy situations statewide which is expected to create a better understanding of regulations by surveyors.²⁵

Recommendations

- HHSC should review surveyor training requirements and processes to determine where additional improvements can be made to ensure more consistent interpretation of regulations
- HHSC should consider developing joint education opportunities for both surveyors and providers to improve communication between all parties and to help foster a consistent understanding of changing regulations
- The Legislature should consider taking action recommended by the Texas Council on Long-Term Care Facility Surveys and Informal Dispute Resolution related to increasing retention of surveyors/investigators through a career ladder and salary restructuring in their December 2016 Report as required by SB 914 (84R)

Interim Charge

Review the availability of prevention and early intervention programs and determine their effectiveness in reducing maltreatment of children. In addition, review services available to children emancipating out of foster care, as well as services available to families post-adoption. Determine if current services are adequately providing for children's needs and meeting the objectives of the programs. While reviewing possible system improvements for children, follow the work of the Supreme Court of Texas Children's Commissions' Statewide Collaborative of Trauma-Informed Care to determine how trauma-informed care impacts outcomes for children.

Summary

The Committee held a hearing on November 13, 2018 and received testimony from the Department of Family and Protective Services (DFPS), Health and Human Services Commission (HHSC), other governmental entities and numerous interested stakeholders. Testimony focused on the importance of a trauma-informed child welfare system.

Trauma-Informed Care (TIC) is a system or program that is knowledgeable and sensitive to the impact of trauma in a person or family and/or the vulnerabilities of those who have experienced traumatic events. Trauma-informed services are delivered in a way that prioritizes safety and avoidance of re-traumatization.²⁶

DFPS began implementing TIC training for caseworkers and caregivers in 2009 and over the course of the last 9 years expanded efforts to include training for residential providers, more robust training requirements, creation of a TIC program specialist position and implementation of the Child and Adolescent Needs and Strengths (CANS) assessment- a comprehensive, trauma-informed behavioral health assessment and screening tool.²⁷

As of 2014, a minimum of 8 hours of TIC training is required for an individual prior to being the only caregiver responsible for a child in care. Caregivers have the choice of curriculum to study and many use Trust Based Relational Intervention (TBRI), The Sanctuary Model, STAR Health trainings, or National Childhood Traumatic Stress Network (NCTSN) curriculum.²⁸

DFPS is currently prioritizing ways to strengthen TIC activity including updating CPS trauma-related staff trainings to promote TIC principles and reviewing policy and practices to incorporate TIC perspectives as needed. DFPS also participates in a number of stakeholder run community groups whose goal is to create a more trauma-informed system of care.²⁹

TIC can play a significant role in how a child placed with a family thrives in that placement, however it is also one of the key factors in preparing those children who do not exit to permanency for life outside of care, which is the reality for 7% of children in the state's conservatorship.

DFPS provides transitional living services for youth currently and formerly in foster care including experiential life skills training, preparation for adult living services, assistance with personal documents and credit reports, supervised independent living, and many others.³⁰

Under federal law, youth formerly in foster care receive Medicaid coverage up to age 26, as long as they were in the states conservatorship when they exited care. These individuals are automatically enrolled when they leave care, however many experience a disruption in coverage due to difficulty renewing their benefits annually.³¹

On average, just over 220 adopted children are returned to care each year. To reduce these numbers DFPS provides services to support adoptive families. Services include case management, support groups, parent training, therapeutic counseling, respite care, and residential therapeutic care. These services are provided to help the child and family adjust to the adoption, cope with any history of abuse, and avoid permanent or long-term removal of the children from the adoptive family setting.³²

While services provided to children who have been removed from their families can diminish the effects of lived trauma experiences, prevention and early intervention (PEI) services help strengthen families, preventing removals which are a form of trauma in themselves.

The state provides a number of services to individuals at risk of entering the child welfare system. Services to At-Risk-Youth (STAR) provide individual and family crisis counseling, youth and parenting skills classes, and short-term emergency respite care. DFPS provides this program statewide to families for 3-6 months at a time. DFPS has requested an exceptional item to serve an additional 6,000 families increasing the programs reach by 31%. The Community Youth Development program provides services in targeted zip codes to promote protective factors and prevent outcomes such as juvenile delinquency by funding existing local programs. DFPS has requested an exceptional item to fund an additional 4,000 individuals or a 24% increase, expanding the program into additional zip codes as well.³³

The Texas Nurse Family Partnership is a voluntary program in which registered nurses regularly visit the homes of low-income women pregnant with their first child. Families can receive services until the child reaches two years of age. DFPS has requested an exceptional item that would provide a targeted expansion, increasing the number of families served by 500 or 20%.³⁴ Evidence-based parent education programs such as the Nurse Family Partnership and others have proven to reduce child maltreatment by up to 50% reducing the need for costly child protective service and foster care.³⁵

The Statewide Collaborative of Trauma-Informed Care (SCTIC) is an initiative of the Supreme Court of Texas Children's Commission which launched in the Summer of 2017. Members of SCTIC include state agencies such as DFPS, HHSC and the Texas Juvenile Justice Department, attorneys, medical professionals, service providers, trauma-informed specialists and more. The purpose of SCTIC is to elevate trauma-informed policy in the Texas child welfare system by creating a statewide system reform.

The primary goals of the collaborative include ensuring that all children, youth and families engaged with DFPS and young adults exiting DFPS custody are served by a trauma-informed child welfare system; to ensure there is a culture of trauma-informed care, training, and tools within the child welfare system; to ensure that child welfare systems collaborate to create a consistent environment; and to ensure that trauma-informed efforts are data-driven, effective, and sustainable.

SCTIC is currently working to finalize their Texas Blueprint for a Trauma-Informed and Trauma-Responsive Child Welfare System and expects to publish by the end of January 2019.³⁶

Recommendations

- HHSC should develop a process to streamline the Medicaid renewal process for youth formerly in foster care to prevent any disruption in services, treatment or medication they need after leaving the state's conservatorship.
- HHSC and DFPS should collaborate to ensure contracted MCOs serving current and former foster youth, caseworkers, and caregivers facilitate information sharing to ensure primary care and treating physicians caring for children in the child welfare system have ready access to the child's trauma history in order to establish a baseline understanding of the child's exposure to trauma.
- The Legislature should invest in the creation and implementation of a strategic plan to maximize the opportunities made available through the federal Family First prevention Services Act, which provides an opportunity for states to draw down federal match for trauma-informed mental health, substance use, and in-home parenting support services for children at imminent risk of entering foster care and their families. Additionally the Legislature should fund PEI-related exceptional items requests from DFPS such as Texas Nurse Family Partnership.



State of Texas
House of Representatives

RICK MILLER

DISTRICT 26

November 19, 2018

We all know the high priority that was placed on fixing the DFPS/CPS (Foster Care) system during the 85th Legislative Session. Transforming DFPS/CPS is an issue that continues, and it remains a high priority for the 86th Legislative Session for my office.

The real issue that we need to address is the children in the state's care and understanding the impact that trauma has had on the whole child...the brain, body, biology, behavior and belief system. Science has clearly shown these impacts, especially in the development of the brain and the effects trauma has on it. These children deserve the opportunity to live a fulfilling life and to understand their value in this world. As we know, giving these children (multiple) beds, (multiple) roofs over their heads, and food in their bellies is simply not doing enough. Many of these children are moved over 20 times and even more during their time in the Foster Care System. Therefore, it is the state's job, as well as mine as a State Representative, to make certain that these children are being healed and that their minds are not continuously being shattered while they are in our care.

Quoting one professional, "it is a high calling for us to think that we could move the entire child welfare system to embrace, learn and fully implement a trauma informed approach. But we cannot afford to shy away from this challenge, so I hope that you will consider taking the first steps to use the influence you are afforded to ensure that every person who comes in contact with children, youth and families with the system are trained in trauma informed care."

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It was a resounding, clear message, from every one of the 32 professionals at the hearing, in every vocation that touches the life of these children in foster care: 100 % of these children are suffering from trauma and we know scientifically that trauma on the brain exactly mirrors many diagnoses. They clearly stated that they have never seen a more potent intervention for the children and their parents than trauma informed care. The challenge is that it takes time and effort for caregivers to learn a method, so their responses become automatic. This approach requires a different mindset about what causes negative behaviors. It also requires caregivers to remain calm and focused on the needs of the child, a task that is difficult for those given top anger and coercive parenting styles. Having all members trained in a trauma informed approach brings tremendous focus and coordination to interactions. For caregivers to effectively implement a trauma informed approach, it is imperative that they learn a well-articulated model and have ongoing opportunities to practice and to receive feedback and coaching.

This is why I am proposing legislation that has the potential to be the most important bill proposed this coming session to truly transform the Foster Care System, and specifically, to change the lives of each child and family in the system in a positive way. If the measures outlined in my proposed legislation goes into law, the children and families in the Foster Care System will be given a new sense of purpose in their lives with positive outcomes realized in every child and family.

My legislation clarifies that the training provided must teach people skills and strategies that can easily be put into every day practice to help children heal from the Trauma all of them have experienced.

There are three key points in this discussion:

1. Expect everyone who touches the life of a child in the DFPS/CPS system to be trauma informed and trained in the implementation of an evidenced-based, transferrable trauma informed care practice
2. The expectation of a collaborative approach for each child (i.e., from the investigator who removes the child, to the court system, to the therapist, to the case workers, to the schools, to the foster or group homes...)
3. Leadership throughout the system must be held accountable to enforce the first two points

Our purpose with this legislation is to:

1. Institute Trauma Informed Care Training across the full spectrum of the DFPS/CPS network for every individual who interact with children in the Foster Care Program on a region by region basis.
2. Add definitions of *Trauma* and *Trauma Informed Care* into statute and then require the child welfare system to catch up with current research and train everyone who

touches the life of a child in an evidenced-based, transferable **trauma-informed care practice**.

3. Truly place the focus of the CPS system back on the children. This methodology of training places an emphasis on making the human connection with the children to provide a truly safe and trusting environment for them.
4. Follow the training with an implementation of Trauma Informed Care practices throughout the CPS system, region by region.

In response to the hearing agenda items regarding Trauma and Trauma Informed Care in the DFPS/CPS system on November 13, 2018, the following comments are provided based on testimony for the Interim Report of the Human Services Committee to the Speaker's Office regarding each charge:

- Review the availability of prevention and early intervention programs and their effectiveness in reducing maltreatment of children.

Testimony revealed that while there are programs being used very effectively in the prevention and early intervention of reducing maltreatment of children, the need to increase the availability of PEI services to parents and to invest in high quality treatment for adults suffering from trauma. In order to break the cycle of abuse, we cannot ignore the parents right in front of us who are struggling and need more help than what is currently being provided to them. The true keys to PEI lie heavily with drug and alcohol abuse programs, as well as mental health and psychiatric care. These programs need to be expanded to meet the needs of parents suffering from the effects of addiction and trauma. If the focus is on both the children and the parents with a continuum of care, working within CPS and Family-Based Services, through evidenced-based and trauma informed care practices, a significant improvement and greater results will be realized in making PEI more reliable and capable of reducing the maltreatment of children.

- Review services available to children aging out of foster care, as well as services available to family's post-adoption. Determine if current services are adequately providing for children's and families' needs and meeting the objectives of the programs.

The short answer to this charge is that the current services are not meeting the needs of the children and the families for those aging out of the system. Studies reveal with great clarity that the children are at a much higher risk for a whole array of negative outcomes, including homelessness, poverty, incarceration, substance abuse, teen pregnancy, suicide and sex trafficking. Many of these children leave the system much more damaged than when they entered, as their original trauma is compounded with each subsequent move or negative

experience and they leave the system completely unprepared to survive on their own in the real world. Everyone who is involved in caring for these children must be properly trained in trauma and equipped with the tools of trauma informed care that can be put in practice with the children. Another issue is that the splitting up of siblings is not working and that moving them frequently only creates more terror, fear, and behavioral issues resulting from the children being retraumatized with each move. The critical objective must be to never have a foster child “age out” of the system. This can be accomplished with the recruitment, training and retaining of better foster homes and parents who are fully supported by wraparound services, and with the requirement of trauma informed care training put into practice throughout the CPS system.

- Determine the need for system improvements, especially in the area of Trauma Informed Care, and how it impacts the outcomes for children and families.

The testimony of 32 professionals clearly revealed the essential need for training in an evidenced-based, trauma-informed approach for all parents, caregivers, teachers and childcare professionals...everyone who touches the life of the children in the Foster Care system. More than this, however, is that this approach must be a collaborative effort across the full spectrum of the DFPS/CPS system to put into practice trauma-informed care. If this is implemented, the consensus agreement by these professionals is that the system will be truly transformed, and the children will be healed in a way that allows them to connect, feel safe, trust and self-regulate with everyone they come into contact with in the system.

- Determine what training is necessary to achieve the intended results of a trauma-informed system of care. Evaluate the potential benefits of trauma-informed care training for all individuals who interact with children in the foster care system.

There is a clear desire across Texas for the child welfare system to become more trauma-informed and we believe that the notion, concept and desire for trauma-informed care is not a trend, but it is reflective of a deeper understanding of a complex problem. With the current capacity crisis in Texas and the clear need for better support for children with high needs, my legislation forces the child welfare system to catch up with current research and train people in practical ways about how to help and better serve this population. Simply maintaining the status quo with inadequate training and implementation on how to work with children who have experienced trauma will only further perpetuate the current problems Texas is experiencing. Requiring training that is not practical or evidence-informed is a

waste of time and energy for the state. My legislation clarifies that the training provided must teach them skills and strategies that can be easily put into every day practice to help children heal and feel that they have a sense of purpose in their lives.

- Analyze the current reimbursement methodology and rates for the assigned levels of care in the foster care system, with a focus on the impact the rates have on those agencies providing services and care for children.

The current reimbursement system, however well intentioned, can produce unintended consequences in the foster care system according to their assigned level of care. Both the agency and the foster parents are paid a significantly higher amount for a moderate or specialized rated child compared to a child who is rated as basic. This creates a perverse incentive to keep the children's rates at these higher levels of care. If the agency and foster parents are doing a good job with the children, and providing a stable, therapeutic placement, they are in essence penalized. One proposal would be to keep the same per diem rate at the same level for any child. Then institute a bonus system that would be given to the agency and the foster parents whenever they have a child in their care leveled down. The key point is that the system needs to be revised to provide an incentive to take the most difficult children to the lowest levels of care. This issue must be revisited in the next Session.

- Study the prevalence of mental illness diagnoses on children in the foster care system who have experienced trauma, the impact of these diagnoses on use of psychotropic medication, and the outcomes for these children.

The critical issue is the focus that must be applied to the trauma that the children experience in their lives. The symptoms for several mental health disorders overlay with symptoms related trauma exposure, therefore, mental health professionals who are unaware often misdiagnose children who have experienced trauma and incorrectly prescribed psychotropic medications for these misdiagnosed conditions. In addition to misdiagnosis and misuse of psychotropic medications, failure to correctly evaluate and treat symptoms related to trauma can cause foster children to be retraumatized and blamed for their behavior, leading them on a downward spiral of harm. When professionals lack the understanding of the effects of trauma and appropriate methods for meeting the needs of traumatized children, they focus on trying to correct the child's behavior, rather than helping the child heal from trauma. There is much more to this issue

than could be written in this report that is available in my office. It does reflect the need for training and understanding of trauma and trauma informed care.

In summary, the implementation of evidenced-based, transferrable **Trauma Informed Care** throughout the system will truly transform it by healing the children and giving them **connection, safety, and trust** with others and the **ability to self-regulate** in this environment. We must get this right, now, for the children!

Respectfully,

A handwritten signature in black ink that reads "Rick Miller". The signature is written in a cursive, flowing style with a long horizontal stroke at the end.

Representative Rick Miller
House District 26

Interim Charge

Analyze the prevalence of children involved with Child Protective Services (CPS) who have a mental illness and/or a substance use disorder. In addition, analyze the prevalence of children involved with CPS due to their guardian's substance abuse or because of an untreated mental illness. Identify methods to strengthen CPS processes and services, including efforts for family preservation; increasing the number of appropriate placements designed for children with high needs; and ensuring Texas Medicaid is providing access to appropriate and effective behavioral health services.

Summary

The Committee held a joint hearing with the House Public Health Committee on August 9, 2018. The committees received testimony relating to substance use and mental illness in the Child Protective Services (CPS) program. Testimony was received from the Department of Family and Protective Services (DFPS), the Health and Human Services Commission (HHSC) and other interested parties.

Mental illness and substance use are both prevalent in adults and children involved in CPS programs. When investigating a family, investigators find when abuse or neglect occurs it is often a result of a parent's impairment through substance use. While substance use alone is not a reason for removals, it is a factor in nearly 65% of all removals in Texas.³⁷ This figure represents about twice as many removals due to substance use than the national average. This is significant considering the lower rates of family reunification in substance use cases. While about one-third of all children in the child welfare system who are removed return home, when substance use is a factor only about one-fifth of children removed return home.³⁸

Caseworkers have found that when parents have substance use issues there are typically underlying mental health issues. When this is the case, DFPS focuses on addressing substance use first since it is known to be more of a danger to the child. DFPS can drug test families, and if necessary coordinate inpatient/outpatient treatment services.³⁹

In FY17, 52% of child fatalities caused by abuse or neglect involved a parent or caregiver who was under the influence of one or more substances at the time of the incident. Over the same time period, child fatalities involving a parent or caregiver with a reported or confirmed mental health concern was close to 23%.⁴⁰

A nationwide study by the U.S. Department of Health and Human Services shows that removals with opioid abuse as a factor are increasing across the country. While Texas is experiencing an increase it is not as significant as the national increase. Marijuana is the substance most commonly identified as a factor in child abuse and neglect fatalities representing over half of all cases.⁴¹

Children who have experienced substance use or mental health issues typically have a higher level of need and require more intensive services to achieve permanency than other children in the child welfare system.

DFPS is working to build capacity for high-needs children in the child welfare system. The therapeutic foster care program is based on a new model of treating high-needs children in a foster family setting with parents who have received a high level of training and have only a small number of children in the home. Legislation from the 85th Legislative Session reclassified cottage homes as a least restrictive setting, creating new capacity for children who no longer need intensive treatment but aren't yet ready to move into a foster home setting.⁴²

SB 11 (85R) expanded community based care and created the family-based safety services pilot program. This pilot includes a performance-based contract to provide evidence based or promising practices case management services, and requires that removals of children be reduced along with recidivism.⁴³

Barriers to treatment for substance use include waiting lists for inpatient and outpatient treatment services and the lack of services in particular regions of the state. However, DFPS does execute contracts for counseling and education programs in instances when a waiting list is preventing a family from receiving the services they need.⁴⁴

STAR Health, a comprehensive, statewide managed care delivery model is the program designed to meet the health care needs of children in foster care. Along with standard Medicaid benefits, STAR Health also provides additional benefits tailored to the needs of children in the child welfare system including an increased focus on mental health and substance use services. The increased focus is due to the higher prevalence of issues in STAR Health than in the traditional STAR program. Over 50% of children enrolled in STAR Health struggle with mental illness or substance use disorder compared to about 7% of children on the STAR program.⁴⁵

Children entering DFPS conservatorship are immediately eligible to receive benefits through the STAR Health program. HHSC's contract for STAR Health requires the contracted health plan to develop network expertise and clinical capacity in trauma informed care through the use of programs and incentives. Networks must include behavioral health providers who are experienced in working with children with a background of complex and multiple traumas. HHSC added new network adequacy standards for behavioral health providers in the fall of 2017.⁴⁶

Despite the level of need of individuals in the STAR Health program only 1 in 6 foster youth who age out of the program regain Medicaid coverage, for which they are eligible until age 26. HHSC does not utilize auto-enrollment for individuals aging out of STAR Health.⁴⁷

Increases in the number of children in care who are older and have higher, more complex needs demonstrate the need to focus on prevention services which impact families before they enter the child welfare program.⁴⁸ The federal Family First Prevention Services Act is intended to increase the availability and use of prevention services while decreasing the use of congregate care facilities. Implementation of the legislation can be done at the state's pace but will require a great deal of planning by DFPS to ensure readiness.

National research shows that family drug courts help parents successfully navigate the child welfare system and improve outcomes. Parents involved with family drug court programs are more likely to initiate and complete treatment which results in higher instances of reunification. There are family drug courts in several counties around the state.⁴⁹

Other programs and techniques are being used to address the prevalence of substance use and mental illness in families in the CPS program. Programs that allow women to keep their children with them while in residential treatment remove barriers to treatment these women face. These centers teach women how to balance their recovery with meeting their children's needs and help keep children out of foster care.⁵⁰

Peer recovery coaches connect parents to needed services and resources and help them navigate the child welfare system. These coaches are in recovery themselves and serve as role models to other parents helping them see that recovery is a realistic goal.⁵¹

Recommendations

- The state should make efforts to expand the use of programs and techniques that sustain families through innovative treatment such as family drug courts, motivational interviewing, peer recovery coaches, parent/child residential treatment, and services to support parents' sobriety when children are returned home.

- DFPS should target specific regions of the state where substance use in families is most prevalent and establish specialized caseworkers with additional training in best practices for family engagement, focusing on families where substance use is present.

Interim Charge

Monitor the HHSC's implementation of Rider 219 in Article II of the General Appropriations Act related to prescription drug benefit administration in Medicaid. Analyze the role of pharmacy benefit managers in Texas Medicaid.

Summary

On December 13, 2017 the Committee held a hearing to receive testimony regarding Rider 60 (Conference Committee Report Rider 219) and the Vendor Drug Program. The committee also studied the role of Pharmacy Benefit Managers (PBMs) in Texas Medicaid. The Committee received testimony from the Health and Human Services Commission (HHSC), several trade associations and other interested parties. Additionally, the committee reviewed the Rider 60 Report and considered it along with the testimony presented to draw conclusions about this interim charge.

In Texas, just over 90% of the Medicaid population and all of the CHIP population receives services through a managed care model. In March 2012 the prescription drug benefit was carved-in to managed care, allowing managed care organizations (MCOs) to administer the benefit for all beneficiaries in managed care programs.⁵²

When studying Rider 60 it is important to understand the structure of the current prescription drug benefit, as well as which functions are maintained by the state and which are delegated to MCOs.

Prior to the carve-in, the prescription drug benefit was administered as a fee-for-service (FFS) program. The state's Vendor Drug Program (VDP) within HHSC administered the prescription drug benefit and was responsible for all aspects of administering the benefit including formulary and preferred drug list (PDL) management, management of the rebate program, management of prior authorizations, drug utilization review (DUR), claims processing, and more.

Today, some aspects of administering the benefit for populations served under the managed care model are maintained by the VDP while other functions have been transferred to MCOs. Major functions of managing the prescription drug benefit are controlled by the VDP including development and management of the formulary and PDL, and management of rebates. The drug formulary is a list of drugs covered by a particular program. Medicaid programs must cover drugs for which the manufacturer holds a national rebate agreement with the federal Department of Health and Human Services (HHS). The PDL is a list of drugs that are available to beneficiaries without prior authorization. Drugs are placed on the PDL based on a number of factors including clinical efficacy and cost. VDP negotiates supplemental rebate agreements with drug manufacturers in return for preferred drug status and placement on the PDL.⁵³ All MCOs are required to adhere to the VDP-developed formulary and PDL, a policy decision the state reinforced through passage of HB 1917 (85R) which extended this requirement into the year 2023.

Functions transferred to MCOs include prior authorization processing, DUR functions, utilization management, pharmacy network contracting and claims processing. Prior authorization requirements are a management tool used to ensure the appropriateness of a drug prior to dispensing. While the state requires certain prior authorizations be applied by MCOs, there are a list of optional, DUR Board-approved prior authorizations MCOs may apply to their membership. DUR functions include a number of measures used to ensure appropriate use of drugs as well as to reduce inappropriate or medically unnecessary prescriptions.⁵⁴

In administering the prescription drug benefit, MCOs are required by the state to use a PBM to process prescription claims. However, MCOs are permitted to, and predominantly do, contract with PBMs to carry out the remaining functions of administering the prescription drug benefit for which MCOs are responsible.

While VDP is not responsible for certain aspects of prescription drug benefit administration relative to the managed care population, VDP maintains complete responsibility for the administration of the benefit for the remaining FFS population. This requires VDP to perform or contract with vendors to perform the same functions MCOs are responsible for performing for their members.

It is also important to understand the way HHSC currently prices the prescription drug benefit. MCO payments for the benefit are made up of a number of components including expected pharmacy claims costs, administrative costs, a risk margin, and reimbursement for certain fees and taxes.

HHSC develops an estimate for actual pharmacy claims based on historical claims experience, trend rates and other data. A risk margin is applied to the expected claims so MCOs can cover costs if actual claims costs exceed expectations. The risk margin for FY18 and beyond is 1.5% or 1.75% depending on which program the member is enrolled in. The amount paid to MCOs also includes an administrative fee of \$1.80 per member per month. The state collects a 1.75% insurance premium tax from a number of insurance provider types including MCOs. HHSC reimburses MCOs for this amount but because it is included in the capitation the federal government funds a portion of this reimbursement at the FMAP (federal medical assistance percentage) rate. This federal portion represents a net gain to the state. Finally, the state includes a reimbursement for the federal ACA Health Insurance Providers Fee which is based on the total premium the insurer collects.⁵⁵

Rider 60 of the General Appropriations Act - SB 1 (85R) asked HHSC to study a different model for administration of the prescription drug benefit and provides some specific factors for the agency to consider:

Prescription Drug Benefit Administration in Medicaid, CHIP, and Other Health-Related Services. Out of funds appropriated above in Strategy L.1.1, HHS System Supports, the Health and Human Services Commission (HHSC) shall study potential cost savings in the administration of prescription drug benefits. In studying potential cost savings, HHSC may consider savings achieved from, but not limited to: a single statewide claims processor model to deliver prescription drug benefits in the Medicaid, CHIP, Women's Health, Children with Special Health Care Needs, and Kidney Health Care programs; reduction of the Affordable Care Act Health Insurance Providers Fee, guaranteed risk margin, and administrative services fees from decreasing capitation related to pharmacy benefits; and transitioning to a prescription pricing methodology based on National Average Drug Acquisition Cost (NADAC) with a professional dispensing fee commensurate with the most recent study commissioned by HHSC.⁵⁶

HHSC commissioned an independent study to carry out the requirements of Rider 60. The study was performed by Deloitte who presented their final report in August 2018.

Deloitte considered eight possible scenarios with variables consisting of potential changes to utilization rates, a change in administrative costs, and the potential elimination of the ACA health insurance providers fee at the federal level. Each scenario included the impact of not funding the guaranteed risk margin, moving to a new pricing methodology, and the loss of the federal share of the state premium tax as constants.

The scenario results ranged from a 4.9% savings of \$90.3M to a 4.1% additional cost of \$75.3M.

The study also considered other less quantifiable factors. In the single claims processor scenario HHSC would have access to additional data in a shorter timeframe than it currently does. This could allow HHSC to make decisions about prescription drug benefit policies that could impact costs, member experience or quality outcomes positively. The state could also achieve increased adherence to the PDL thereby increasing supplemental rebate dollars earned by the state to offset the cost of the prescription drug benefit.

The report considers the potential for MCOs to lose the ability to integrate and coordinate care as effectively as they might be able to currently. However it does not consider that in practice, MCOs receive their pharmacy data used to make care decisions from their PBM contractors. This is a relationship that could be mirrored in their relationship with a state-contracted pharmacy benefit administrator.

The report also considers the impact of shifting risk from MCOs to the state. In the current capitated model, the MCO takes a fixed payment from the state placing them at risk if costs come out higher than the fixed payment. However, the study shows that the pharmacy benefit has not proven to be very risky for MCOs. For FY15, FY16 and FY17 when comparing the expected claims component of the capitation rate along with the risk margin to the total cost of claims for MCOs the result is an overpayment for the prescription drug benefit of \$17.2M, \$16M and \$263.4M respectively.

The potential for utilization rates to change was included as a variable in the study. An increase in utilization would increase future costs of the prescription drug benefit. However, according to the study, because of the restrictions currently placed on MCOs in their ability to control utilization, and because the state could implement techniques through its contracted pharmacy benefit administrator that are similar to those currently used by MCOs, an impact to utilization may not be experienced at all.

The potential for administrative expenses to increase the cost of the prescription drug benefit also seems unlikely. The amount currently paid to MCOs to cover administrative costs is \$1.80 per member per month. According to the study this is a reasonable amount to assume the state would pay a contracted pharmacy benefit administrator for the potential 4.7M member pool based on existing contracts between MCOs and PBMs. The study considers that administrative costs might rise to \$2.20 per member per month, however this is unlikely, and due to the impact of economies of scale realized by the state, it is more likely the state will achieve a per member per month administrative cost of less than \$1.00 saving the state an additional \$40M per year or more.

The study considers the effect of not paying the state premium tax a loss to the state under the new model. For FY17 this loss of the federal share of the state premium tax would have cost the state \$36M. However it may be possible for the state to assess its premium tax on a contracted statewide pharmacy benefit administrator which would allow the state to retain the federal share of that tax payment.

The most likely scenario of the eight presented in the study seems to be the scenario in which the state's pharmacy benefit administrator can manage utilization as effectively as the MCO's PBMs, administrative costs stay the same, and the ACA health insurance providers fee continues to be assessed at the federal level. This scenario resulted in a cost savings of \$90.3M when compared to the existing program in FY17. When considering the potential for the state to continue to receive the benefit of the state premium tax and the potential for achieving an administrative component of less than \$1.00 per member per month, state savings of \$160M per year or more seem likely. This level of savings would more than make up for the potential one-time cost of \$30-50M for transitioning the program to a new model. In addition to the economic benefit the state would also benefit from increased control of the program, increased data availability, and full transparency of the prescription drug spend in a changing environment.

The current landscape of the retail pharmaceutical industry leaves the issue of true transparency in question. Mergers between pharmacies, PBMs and health insurance companies are becoming more commonplace. The effect of this vertical integration on a capitated, taxpayer funded healthcare program such as Texas Medicaid should be fully understood as this trend increases. While MCOs' administrative expenses are capped, there may be a disincentive to seek maximum cost efficiency between MCOs, PBMs and pharmacies when they are owned by the same entity and when profit sharing with the state exists as a disincentive to maximize the economic benefits of vertical integration.

Recommendations

- The legislature should amend statute to create a new, non-capitated, consolidated prescription drug benefit delivered by a single pharmacy benefit administrator that is developed and procured in a manner that: allows the state to benefit from collection of the state premium tax, achieves an administrative cost less than the existing rate paid in managed care, and allows MCOs to holistically manage care by delivering them real-time data.

Endnotes

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