HOUSE COMMITTEE ON APPROPRIATIONS

INTERIM CHARGE 1:

Monitor and oversee the implementation of appropriations bills and other relevant legislation passed by the 86th Legislature. In conducting this oversight, the Committee will also specifically monitor implementation of appropriations for:

- *Human and sex trafficking legislation;*
- *Revenue projections for the Crime Victims' Compensation Fund; and*
- *Implementation of procurement and contracting reforms at state agencies.*

The following constitute responses to a request for information regarding the above interim charge posted on August 5, 2020.

September 30, 2020

The Honorable Giovanni Capriglione, Chair
The Honorable Oscar Longoria, Vice Chair
Committee Members
House Appropriations Committee
Capitol Building, Room E1.030
Austin, Texas 78701

Via email: Appropriations@house.texas.gov

Dear Chair Capriglione, Vice-Chair Longoria and Members of the Appropriations Committee:

My office is submitting information on Interim Charge 1, specifically regarding appropriations for the implementation of procurement and contracting reform at state agencies.

The Comptroller's office has a multi-faceted role in statewide procurement. Our Statewide Procurement Division connects vendors with state purchasers and contract opportunities. We assist state and local government with the procurement of non-IT goods and services through easily accessible contracts that meet their needs. Our e-procurement system, TxSmartBuy, lists vendors' goods and services for easy access and ordering by state and local government purchasers. We also manage and monitor hundreds of state contracts with over two million items and provide training for over 5,000 state purchasers and contract managers.

In addition, the Comptroller is a member of the Contract Advisory Team (CAT) and Quality Assurance Team (QAT). The CAT is responsible for assisting state agencies in improving contract management practices by reviewing the solicitation of contracts with a monetary value of $5 million or more and preparing recommendations to the Comptroller on revisions to the statewide *Procurement and Contract Management Guide* and on the Comptroller's oversight of the training of the state's contract managers. The solicitations reviewed by the CAT are submitted by virtually every state agency, with a few statutory exceptions. Members of the CAT include the Office of the Governor, the Comptroller of Public Accounts, the Department of Information Resources, the Health and Human Services Commission and the Texas Facilities Commission.

The QAT is responsible for implementing a consistent and repeatable approach for quality assurance review of technology projects. Projects are continually assessed to help reduce the likelihood that projects fail to deliver quality solutions based on the schedule, budget and scope commitments made to state leadership. The Comptroller was added to the Quality Assurance Team in 2017, and now comprises representatives of the Comptroller of Public Accounts, the Legislative Budget Board, the Department of Information Resources and the State Auditor's Office (SAO). The Comptroller generally takes the lead on contract-related questions that come to the QAT and our project management staff participate in discussions about all aspects of major information resource projects. The QAT focuses on working cooperatively with agencies to achieve better projects. As a result, agencies are becoming more willing to engage the QAT in areas such as planning and risk mitigation, resulting in better coordination between the QAT and other agencies.

The Comptroller has adopted three rules packages in response to SB 65 (86R). As directed by SB 65, the Comptroller has adopted rules to allow a procurement director to delegate the responsibility to certify that the contract file is complete and that the assessment of vendors was done according to written procedures

to an appropriate person on their staff. SB 65 also required the SAO to designate which large agencies require additional or reduced monitoring. In consultation with CAT, we developed guidelines for the monitoring of those agencies identified by SAO for solicitation development; contract negotiation and award; and contract management and termination. The Comptroller's office updated its Vendor Performance Tracking System reporting rule to mirror the SB 65 requirement of at least annual reporting on vendor performance for large contracts. The Comptroller's office also updated the *Procurement and Contract Management Guide* and training materials to help agencies implement the changes.

In addition, SB 65 recognized that different agencies face different levels of risk, allocating oversight to higher-risk agencies. The statute recognizes that increased administration can create ongoing costs in the planning, execution and management of procurement and contracting for all agencies, regardless of an individual agency's history or risk profile.

Anecdotally, we continue to hear that vendors find doing business with the state to be cumbersome and expensive. Vendors cite concerns with solicitations that are overly complex, unclear or that contain outdated specifications. Some agencies struggle with a variety of contracting and reporting thresholds and other procedural issues that take time away from drafting quality solicitations. This can discourage qualified vendors from issuing bids and potentially require agencies to delay projects or reissue solicitations. The Legislature may consider simplifying thresholds based on uniformity and risk and thus reduce administrative burdens that may not carry a corresponding benefit.

It is our belief that the Legislature has struck a good balance between ensuring appropriate oversight and reducing the administrative burden on low-risk contracts. Continued efforts to reduce the administrative burden on both agencies and vendors would be useful.

We appreciate the opportunity to provide information on this charge. If you have any questions, please do not hesitate to contact me.

Sincerely,

Glenn Hegar

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Texas Department of
Family and Protective Services

House Appropriations Committee

Request for Information
Contract Oversight

Interim Charge 1
September 30, 2020

TEXAS Department of Family and Protective Services

Introduction

DFPS has more than 2,000 contracts; these contracts are important tools that enable our agency to fulfill its mission to protect and serve children, vulnerable adults, and elderly who rely on us for help. These client service contracts provide children and their families with preventive or protective services in their communities – including 24-hour residential child care, substance abuse testing and treatment, and preparing the young people in foster care for the transition to life on their own as adults.

Through strong Legislative support, DFPS has been able to improve processes and resources to keep children safe while in care. Specifically, DFPS has matured its risk analysis tools and contract management.

With the infusion of funding, DFPS was able to hire more qualified staff to effectively manage contracts from beginning to end using improved tools. The next slide is a visual representation of all aspects of contracting at DFPS.

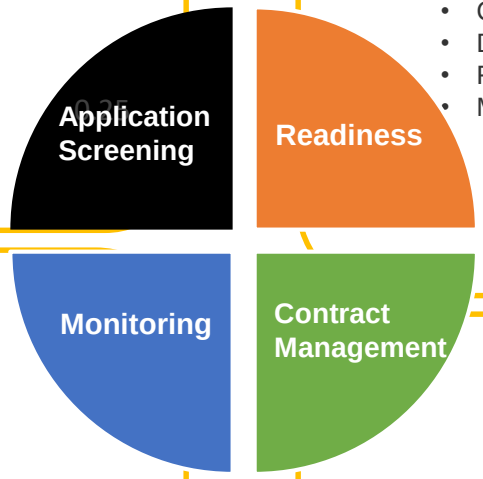
TEXAS Department of Family and Protective Services

Contracting Functions & Activities

APPLICATION PHASE:
Application Specialist & Fiscal Officer

Initial Compliance Screening:
- Required Checks:
- Legal name
- Debarment, divestment, federal excluded parties, vendor hold
- Insurance

Suitability against eligibility criteria:
- History and experience
- Financial capacity, stability and structure
- Evidence of a service delivery model through the
- achievement of Service objectives and Service Level Indicators



PROVISIONAL CONTRACTING PHASE:
Application Specialist

Anticipate critical elements or aspects of readiness and initial implementation that are more likely to pose challenges for the organization
- Performance
- Critical Processes Effectiveness
- Deliverables Compliance
- Financial Stability and Controls
- Monitoring:
  - On-site reviews
  - Quarterly performance results
  - Quarterly CQI progress
  - Complaint tracking
  - Financials

MONITORING:

Monitoring Specialist: Annual On-Site risk-based specialized monitoring

Heightened Monitoring Team: Enhanced monitoring using a multi-divisional monitoring team.

24-Hour Awake Supervision Contract Specialist: At least, monthly On-Site monitoring of awake and continuous supervision

Third Party Utilization Reviewer: Conducts a service level monitoring assessment to determine compliance with Service Level Standards.

Residential Contract Manager:
- Ad hoc monitoring
- Test/Manage Incentives & Remedies
- Investigate Complaints

CONTRACT MANAGEMENT:
Residential Contract Manager

- Completes Annual Risk Analysis
- Provides Technical Assistance
- Reports Performance Measures
- Certifies on-going compliance
- Processes Supplemental Payments
- Critical Processes Effectiveness
- Deliverables Compliance

TEXAS Department of Family and Protective Services

Resources

Generous appropriations through Senate Bill 781 and the budget have worked to strengthen and complement DFPS' existing contract oversight and administration in a number of ways.

SB 781 funded three Application Specialists, who provide increased oversight and technical assistance for new contractors during an 18 to 24-month provisional contract period.

Resources

Specifically, the Application Specialists enable DFPS to conduct pre-contract application reviews that ensure potential contractors:

- Meet required qualifications;
- Prepare operational plans and policies that align with their proposed services;
- Have sufficient fiscal capacity and controls; and
- Demonstrate readiness to begin providing care to foster children.

Resources

Application Specialists also provide intensified oversight and technical assistance following the application review stage and during the initial provisional contracting period, including:

- Reviewing monthly and quarterly Quality Improvement Reports to proactively provide frequent and focused on-site monitoring and compliance reviews; and
- Ensuring all contract terms are met for all provisional contracts.

TEXAS Department of Family and Protective Services

Resources

Moreover, the addition of monitoring staff and contract technicians through Exceptional Item funding has enabled DFPS to improve its oversight of residential care services and purchased client services from both a qualitative and quantitative focus.

Strengthened processes include expanding the scope of on-site monitoring based on risk elements specific to contracted services, including ensuring that Child Placing Agency (CPA) reviews are focused on the quality of foster care home studies and the CPA's supervision of homes.

Resources

General Residential Operation reviews will include additional child interviews and an analysis of critical indicators at frequent intervals during a contractor's provisional status.

Importantly, the specialized monitoring team has increased the number of contracts for specialized monitoring from 20% to 50% of the total number of contracts identified for monitoring through the strengthened annual risk analysis. Specialized monitoring occurs on-site, and this oversight continues until compliance is satisfied.

TEXAS Department of Family and Protective Services

Quality Improvement

Continuous Quality Improvement for CPS Regional Contracts allows DFPS to more effectively track and enforce performance measures to ensure children, families, and vulnerable adults receive quality services.

A reduction in caseloads through additional Residential Contract Managers has allowed staff a smaller span of control to provide more effective monitoring and technical assistance to providers. This greater focus improves performance and maintains critical relationships between DFPS and its providers.

TEXAS Department of Family and Protective Services

Quality Improvement

These improvements would not have been possible without the additional data positions, Contract Performance Analysts, which allows for an expanded and robust data infrastructure.

Contract Performance Analysts provide invaluable support to Residential Contract Managers as they:

- Use data to create intuitive and detailed reports that includes current and historical performance;
- Work directly with contract staff to interpret and use the analysis in contract oversight activities beginning with the application stage; and
- Build data tools/models to assist contract managers in proactively identifying residential operations that may benefit from additional oversight or assistance.

TEXAS Department of Family and Protective Services

Performance-Based Contracting

The infusion of these resources has also allowed Residential Contract Managers to further focus on the department's performance-based contracting efforts.

All DFPS client service contracts have performance measures; the more responsible a contractor is for client outcomes, the closer the contract gets to being truly performance-based.

The next few slides illustrate DFPS' performance measures on its service contracts.

TEXAS Department of Family and Protective Services

Performance-Based Contracting

Residential Child Care Contract Performance Measures
% of children safe in Foster Care (All)
% of timely Texas Health Steps Medical/Dental Checkup (All)
Sibling Group Placements in foster homes (CPA only)
Child remains in a least restrictive setting (IPTP and Treatment Foster Care only)
% of timely CANS assessments (All)
% of positive discharges (All)
% of youth completing PAL (All)
Older Youth Placements in Foster Homes (CPA only)
Discharge to a Family placement (GRO only)
Successful Discharge from IPTP (IPTP only)
Timely Entry and Exit CANS (Treatment Foster Care only)
Successful Transition from TFC (Treatment Foster Care only)

Child Placing Agency (CPA)
Intensive Psychiatric Treatment Program (IPTP)
General Residential Operations (GRO)
Preparation for Adult Living (PAL)
Child and Adolescent Needs and Strengths Assessment (CANS)

TEXAS Department of Family and Protective Services

Performance-Based Contracting

Community-Based Care Performance Measures
% of children safe in care
Children/Youth obtain a Texas Health Steps exam timely
Children/Youth placed with their siblings
Children/Youth placed in a least restrictive setting
Children/Youth remain in their school of origin
Children/Youth placed in their home communities
Children/Youth placement stability
Youth turning 18 complete PAL training
Children/Youth placed with kin
Youth age 16 and older obtain driver's license or identification card
Children/Youth participate in service planning
Children/Youth attend court hearings
Caseworker turnover rate is maintain/improved

TEXAS Department of Family and Protective Services

Performance-Based Contracting

Purchased Client Services (PCS) Performance Measures *Examples of Contracts & Some Measures*	
PCS Contract Type	**Measures**
Task Centric Contract: Hospital Sitter	Critical Task: Timely scheduling and delivery of services
Information Centric Contract: Evaluation & Treatment (Assessment)	Critical Task: Timely evaluation for psychiatric evaluation Quality: Favorable caseworker reviews for services rendered
Condition Centric Contract: Evaluation and Treatment	Critical Task: Service plans contain correct information Quality: Favorable caseworker and client reviews for services rendered Client Outcomes: Clients achieve therapeutic goals
Multi-system: Post Adoption	Critical Task: Responds to the needs of clients timely Quality: Clinicians are trained in trauma-informed child welfare practices Case Outcomes: Child recidivism rate after receiving services

*Not an exhaustive list of contracts and measures

TEXAS Department of Family and Protective Services

Senate Bill 11 (85R) Incentives and Remedies Performance Outcomes

Through Senate Bill 11 (85R), the agency is able to monitor the effectiveness of residential child-care services, keeping children safe and improving their well-being, through:

- Specifying performance outcomes;
- Assessing financial penalties for failing to meet specified performance outcomes; and
- Offering financial incentives for exceeding any specified performance outcomes.

In addition to the staff resources we have been given, DFPS has automated the management of incentives and remedies with existing resources. The development of this interactive system has allowed for streamlining contractor response processes and will enabled DFPS to conduct quality assurance and reporting.

The next slide lays out the incentives and remedies for FY 2020.

TEXAS Department of Family and Protective Services

Senate Bill 11 (85R) Incentives and Remedies Performance Outcomes

Effective FY20	Performance Incentive	Methodology (based on IMPACT data)
Group 1. RTC and IPTP	Percent of discharges to a family placement	(1) whose next placement is in a(n): adoptive placement; foster home; treatment foster care home; GRO cottage home; relative (verified or kinship); own home; or noncustodial parent; OR (2) who exited DFPS conservatorship to: reunification; relative PMC; relative PCA; or adoption.
Group 2. Non-RTC GRO (excluding ES)		
CPA (non-TEP or TFC) By contractor	Ratio of older youth placements in foster homes	Any youth placed in a foster home who was 14 years or older at the time of the placement
	Percent of non-relative foster homes accepting a placement of sibling groups	(1) For sibling groups of two, both siblings are placed in the same home; OR (2) For sibling groups of three or more, three or more siblings are placed in the same home.

	Performance Incentive	Percent of Available Incentive Payments	When Initial Data will be Available
GRO, IPTP, CPA	PAL Performance *measure discontinued in FY20*	70%	December 2019
TFC	Less Restrictive Setting and Recidivism	30%	April 2020

TEXAS Department of Family and Protective Services

Senate Bill 11 (85R) Incentives and Remedies Performance Outcomes

This incentive and remedy structure has enabled DFPS to move the needle in several critical areas. Each of the remedies are tied to child safety and well-being.

It is extremely important for every child to receive a doctor's visit through Early Period Screening Diagnosis and Treatment (EPSDT), also known as Texas Health Steps. This has been successful as more children are receiving EPSDT since DFPS began imposing performance remedies.

Background checks for providers are essential for child safety. Like EPSDT, there was marked improvement as more providers are securing more background checks for their employees after imposition of remedies.

TEXAS Department of Family and Protective Services

Optimization of Resources

With the Legislature's generous support and partnership, DFPS will continue to optimize and leverage its resources. Specifically:

Use of Data - DFPS has transitioned from an annual qualitative assessment to using data analysis to identify potential emerging risks. This eliminates the time-intensive, manual information gathering in multiple systems, instead utilizing trend information and drawing upon real-time qualitative inputs to focus resources on residential contractors needing additional support.

TEXAS Department of Family and Protective Services

Optimization of Resources

Early Identification -DFPS is focusing resources on identification of issues early in the contracting process as potential risks emerge. Early identification triggers increased monitoring and technical assistance to improve quality and compliance.

Ongoing Efforts - DFPS will continue to conduct annual contract risk assessment and risk-based contract monitoring protocols based on trends and patterns. DFPS will also continue multi-disciplinary team assessments and reviews to manage contract compliance.

HOUSE FORMAL REQUEST FOR INFORMATION (RFI)

COMMITTEE: APPROPRIATIONS

INTERIM CHARGE 1: IMPLEMENTATION OF PROCUREMENT AND CONTRACTING REFORMS AT STATE AGENCIES

Interim Charge

Monitor and oversee the implementation of appropriations bills and other relevant legislation passed by the 86th Legislature. In conducting this oversight, the Committee will also specifically monitor implementation of appropriations for:

- Human and sex trafficking legislation;
- Revenue projections for the Crime Victims' Compensation Fund; and
- **Implementation of procurement and contracting reforms at state agencies.**

Background

Each day, the Health and Human Services (HHS) system connects millions of Texans to lifesaving assistance and services, primarily through contracts with providers and other vendors. The integrity, quality, and compliance of procurement and contracting activities at HHS is of paramount importance.

Over the past decade, HHS procurements and contracts grew significantly in number and complexity, with over 20,000 contracts currently valued at approximately $34 billion annually. These include contracts for a wide range of goods and services, including commodities, building construction, information technology, and managed care and other health services. A lack of clear processes and effective oversight measures to support the volume and complexity of contracts resulted in systemic issues that ultimately led to the cancellations of several complex, high-value procurements.

For the past two years, HHS has been heavily focused on reforming the procurement and contracting system to address the weaknesses that led to these cancellations and other shortcomings identified by internal and external reviewers, including the State Auditor's Office. Collectively, these reforms seek to serve the millions of Texans who depend on HHS services in an efficient and effective manner, restore public trust, and ensure the full compliance and accountability.

Progress to Date

Reforms to HHS procurement and contracting have been implemented continuously since late 2018, based on legislative direction (including Senate Bill 65, 86th Legislature, Regular Session, 2019), recommendations from third-party entities, and findings of the Health and Human Services Commission's (HHSC's) Internal Auditor (IA). These improvements have been bolstered by the legislature's significant investment during the 86th Regular Session to increase essential staff in the Procurement and Contracting Services (PCS) and Legal Divisions at HHSC, and to enhance the CAPPS Financials System which supports the procurement process. It is worth noting that the solicitations for Medicaid managed care products, which were cancelled in early 2020, were developed and posted prior to implementation of the most significant reform efforts.

Based on the insights and observations of internal and external reviews, HHS's reform strategy has focused on the following overarching goals:

1. Enhancing accountability, oversight, and compliance;
2. Establishing clear and effective policies, procedures, and processes;
3. Strengthening the procurement and contracting workforce;
4. Enhancing strategic and long-term planning for procurement and contracting functions; and
5. Improving communications and transparency internally and externally.

, Substantial progress has been made in these areas since 2018 with continuing improvement for the foreseeable future. Accomplishments in each of these areas include:

- **Enhanced accountability, oversight, and compliance:**
  - Developed and implemented a procurement risk assessment tool to make risk-based determinations concerning the levels of review and approval that will be required for all procurements.*[i]
  - Established a three-lines-of-defense risk management policy to better clarify roles and responsibilities for the identification, management, and mitigation of risk in the procurement and contracting process.*
  - Improved compliance and oversight through the establishment of the Compliance and Quality Control (CQC) Division, independent of PCS.
  - Created a Compliance division within HHSC's IA to track audit trends and reduce the frequency of repeat findings and disallowed costs.
  - Added capability to conduct evaluations within the CAPPS Financials system, which will strengthen the integrity of the evaluation process and improve efficiency when fully implemented.
  - Enhanced and standardized controls of procurement evaluation score sheets and added a secondary review of final score summaries.
  - Launched a vendor compliance checklist, guidance document and policy to provide clear direction for contract managers to improve the effectiveness of compliance checks on contractors.*
  - Developed and launched a contract file checklist and guidance for contract managers.

- **Established clear and effective policies, procedures, and processes:**
  - Published a comprehensive procurement and contract management handbook to serve as a single resource for HHS policies and procedures related to the procurement and contract lifecycle.*
  - Developed/updated checklists, forms, and templates to ensure legal compliance and best practices for all types of procurements.
  - Published updated standard operating procedures for complex solicitations to ensure compliance with statutes and provide clear guidance to PCS and program staff.
  - Conducted a comprehensive review of the complex procurement process, resulting in a reduction of the average time from requisition entry to contract mailout by up to 51 days.*
  - Developed a responsibility matrix for complex procurements to clearly define the responsible, accountable, consulted, and informed (RACI) parties during each step of the complex procurement process.*

- **Strengthened the procurement and contracting workforce:**
  - Reduced the vacancy rate in the PCS division from 26 percent to 4 percent, and reduced PCS supervisor-to-staff ratios by half, from 20:1 to 10:1.
  - Established specialized teams within PCS such as Construction, Information Technology, and Grants, to focus on high-value, specialized procurements.
  - Developed a long-term training strategy and enhanced training for PCS purchasers and staff across the agency*
  - Established a Contract Management Support Unit within PCS to develop standard tools, issue guidance and policies, and provide technical assistance to HHSC contract managers.*

- **Enhanced strategic and long-term planning for procurement and contracting functions:**
  - Published a revised operating model and a three-year strategic plan for the HHS procurement and contracting system.*
  - Implemented a Complex Procurement Planning Initiative in collaboration with program areas to plan and document all upcoming complex procurements through the end of the fiscal year and beyond.
  - Published the Procurement Action Lead Time Schedule that informs program of the timelines associated with each of the procurement types. This schedule details the procurement process, responsible parties, and estimated processing times for each step in the procurement timeline.
  - Established the Procurement and Contracting Improvement Project (PCIP) Executive Steering Committee to oversee and guide implementation of a portfolio of 16 projects aimed at strengthening

procurement and contracting, based on the analysis performed by Ernst & Young, LLP (EY).*

- **Improving communication and transparency internally and externally:**
  - Published the HHS Vendor Interaction Policy to promote and guide communications between the vendor community and HHS staff, while maintaining the integrity of the agency procurement process.
  - Published the PCS Communications Policy to enhance communications within PCS and between PCS and program areas within the agency.*
  - Posted a forecast of upcoming complex procurements and grants to the HHSC public-facing website to make vendors aware of upcoming opportunities to do business with the agency.
  - Redesigned PCS' internal-facing web page to more effectively share information, forms, templates, and guidance with PCS and agency staff.
  - Published a guide for vendors called "How to Do Business with HHSC" to foster more engagement with current vendors and to provide more information for prospective vendors.
  - Successfully completed a webinar for vendors seeking to do business with State Supported Living Centers (SSLCs) and State Hospitals, with over 150 vendors participating.
  - Updated Historically Underutilized Business (HUB) solicitation templates to provide better guidance to respondents, and expanded Post-Contract Award Meetings between HUB, PCS, and program to solidify the HUB Subcontracting Plan (HSP) and ensure compliance.
  - Implemented the first of several CAPPS Financials 3.0 enhancements to provide greater visibility into the status of procurements and provide associated outreach and training.*

Planning Ahead: Future Reforms

HHS embraces a continuous improvement approach to procurement and contracting. As described below, specific reforms are planned through 2020, while ensuring that procurement and contracting functions are more accountable and responsive to the needs of clients and the vendor community.

Building upon the foundational pieces of a sustainable operating model, moving forward, HHS is focusing efforts on the following key areas:

- Planning for the successful re-procurement of managed care products;
- Strengthening the efficiency and integrity of solicitation development and evaluation processes;
- Strengthening contract management effectiveness, efficiency, quality, and oversight; and
- Enhancing accountability throughout the procurement and contracting process.

Some of the key activities HHS intends to complete in the next 30, 60 and 90 days are as follows.

Next 30 Days:

- Publish updated Standard Operating Procedures for IT procurements.
- Develop a Standard Response Template and Quick Reference Guide for CQC to more efficiently interact with PCS and other internal partners.
- Publish a HUB Toolkit for vendors to assist with state HUB compliance.
- Create a standard Invoice Tracking Template and policy for contract managers to ensure consistent tracking of payments for deliverables.

Next 60 Days:

- Develop a risk-based methodology to determine the appropriate level of CQC procurement oversight activities at different stages of the procurement process.
- Launch the development of a three to five-year Procurement Road Map, building on the Complex Procurement Planning Initiative, to ensure the adequate planning and resourcing of major procurements, and to provide additional accountability for adherence to established timelines for procurement milestones.
- Require the use of the CAPPS Financials Evaluation tool for all eligible procurements to strengthen the integrity of the process and improve efficiency.

Next 90 days:

- Complete the comprehensive training plan to ensure critical training needs of PCS and program staff are addressed.
- Determine the role of CQC in providing oversight and quality control in the contract management phase of the procurement and contracting lifecycle.
- Further clarify roles for complex procurement activities with shared responsibility across departments, identify potential duplication of effort, and determine other opportunities for increased efficiency in the procurement process.
- Roll out additional improvements to CAPPS Financials to allow for better tracking of purchase orders and contracts.
- Repeal Title 1, Chapter 391 of the Texas Administrative Code and propose new rules through the agency rule-making process to ensure clarity and compliance.

Appendix A

Full Timeline of Reform

The items highlighted under “Progress to Date” in the document provide a snapshot of some of the most impactful improvements HHS has made in the past two years. Below is a comprehensive timeline, beginning in fiscal year 2018, of all improvements made by HHSC to reform procurement and contracting practices. Also included are audit findings, procurement and contract cancellations, and third-party reviews. Reforms are grouped into the five focus areas outlined in the “Progress to Date” section.

Fiscal Year 2018

Audit Findings, External Reviews, Cancellations

- State Auditor's Office (SAO) issued Report No. 18-038, An Audit Report on Scoring and Evaluation of Selected Procurements at the Health and Human Services Commission. All recommendations were reported complete as of December 31, 2018.
- HHSC Internal Audit issued Audit 18-01-023 of PCS Procurement Processes. As of June 2020, 16 of 22 items has been verified as completed and implemented, and 3 additional recommendations are complete and awaiting verification by Internal Audit.
- OIG issued a review of the HHS Procurement Process: 2013-2018, which helped guide reforms.
- Five contracts with Managed Care Organizations (MCOs) to provide STAR/CHIP services were cancelled due to errors in the evaluation tool.
- Ernst and Young, LLP (EY) began a review of the HHS procurement and contracting system.

Enhanced accountability, oversight, and compliance

- The Compliance and Quality Control (CQC) Division was created outside of the PCS chain of command to provide an additional layer of oversight.
- New management worked with multiple auditing entities and completed an extensive review of in-flight procurements and existing policies and procedures to ensure compliance and appropriate evaluation and scoring.
- Enhanced and standardized controls of evaluation scoresheet to prevent unallowable scores and required aggregation of individual scoresheets into final score summaries using appropriate and accurate formulas and logic.
- Implemented additional quality control reviews of the evaluation scoring process to ensure consistency and accuracy.
- Established CQC review of all complex procurement solicitations for compliance and quality, editing, and approval and/or posting for public response.
- Addressed key Internal Audit findings, including but not limited to:
    - Bringing PCS staff into compliance with agency-required training;
    - Standardizing procedures and checklists for procurement and contract files;
    - Establishing controls to improve the integrity of the bid room process, including bid opening and documentation, updated bid room procedures, and enforced mandatory bid room training of all buyers; and
    - Revising procedures for complex procurements and consultant solicitations to ensure compliance with legal authorities and best practices.

Established clear and effective policies, procedures, and processes

- In consultation with the Department of Information Resources (DIR) and the Comptroller of Public Accounts (CPA), HHSC developed and implemented a comprehensive procurement checklist to ensure all requirements from

solicitation development to contract award are completed in accordance with applicable legal authorities.
- Developed or updated checklists, forms, and operating procedures to ensure legal compliance and best practices for all types of procurements.

Strengthened the procurement and contracting workforce
- Reallocated existing resources and reassigned agency staff to assist PCS in completing timely procurements at the end of FY 2018.
- Provided targeted training to ensure staff correctly and consistently followed policies and procedures.

Enhanced strategic and long-term planning for procurement and contracting functions
- Established the Procurement and Contracting Improvement Project (PCIP) Executive Steering Committee to oversee and guide implementation of a portfolio of 16 projects aimed at strengthening procurement and contracting, based on the analysis performed by Ernst & Young, LLP (EY).

Fiscal Year 2019

Audit Findings, External Reviews, Cancellations
- Mercer Health was engaged to perform an assessment of the current Medicaid Managed Care procurement process led by the Major Procurements Office in the Medicaid CHIP Services Division.
- EY issued their final assessment, root cause analysis, and improvement plan.
- Dental, STAR+PLUS, and STAR/CHIP procurements, posted in October 2018, were cancelled due to issues with HUB requirements.

Enhanced accountability, oversight and compliance
- For all complex procurement solicitations, implemented practices to ensure adherence to statutory requirement to incorporate evaluation scoring language, criteria, and weights in the posted document.
- Enhanced accountability measures were implemented to ensure PCS staff complete required annual nondisclosure and conflict of interest statements.
- Expanded CQC responsibilities to include:
    - Review of all complex procurement solicitations for compliance and quality;
    - Approval of procurement solicitations prior to third-party review (e.g. Contract Advisory Team);
    - Review and approval of all addenda to active solicitations.
- Established performance measure to track the number of fatal flaws identified and corrected before posting solicitations.
- Established monthly spot audits of procurement files by CQC to ensure quality and compliance with statutory and procedural requirements.
- Completed rule review process for all procurement-related agency rules, as statutorily required at least once every four years.

- Implemented a process to achieve full compliance with statutory requirements related to posting of all fiscal year 2019 contracts and procurement documents on HHSC and Legislative Budget Board (LBB) websites.
- Began real-time publication of contracts and procurement documents to agency website in accordance with Senate Bill 20, 84th Texas Legislature, 2015; and began updating LBB reporting to include all required documentation.

Established clear and effective policies, procedures, and processes

- Began comprehensive review of end-to-end process for complex procurements in accordance with EY recommendations.

Strengthened the procurement and contracting workforce

- Provided additional targeted training for procurement staff to ensure compliance.
- Reduced vacancy rate of purchasers from 26 percent in August 2018 to 15 percent in August 2019.

Enhanced strategic and long-term planning for procurement and contracting functions

- Conducted extensive strategic planning to identify long-term goals and objectives for procurement and contracting improvements.

Enhanced communication and transparency

- Published HHS Vendor Interaction Policy to promote and guide communications between the vendor community and HHS staff, while protecting the integrity of the agency procurement process.

Fiscal Year 2020 to date

Audit Findings, External Reviews, Cancellations

- STAR+PLUS contract (RFP posted in October 2018) was cancelled due to evaluation and scoring issues.
- STAR/CHIP procurement, which was posted in October 2018, was cancelled due to evaluation and scoring issues.
- Mercer issued assessment and improvement recommendations for Medicaid Managed Care procurements.
- Completed a comprehensive review of the Mercer report to determine which recommendations should be implemented systemwide for major complex procurements.
- Received notification that the SAO will conduct an audit to determine if HHSC has administered procurement and other contract management functions for selected contracts in accordance with all applicable legal and agency requirements.
- Received notification from SAO that HHSC was rated as "Additional Monitoring Needed" based on an assessment of contract monitoring at certain state agencies.

Enhanced accountability, oversight, and compliance

- On September 1, 2019, began posting contracts and solicitation documents (awarded or amended) on the HHSC website in real-time, in accordance with SB 20, 84th Texas Legislature, Regular Session, 2015.
- Began reporting and submitting documentation on all contracts or amendments requiring attestation letters to the LBB in real-time, in accordance with the General Appropriations Act.
- Developed and implemented a series of initiatives in the HHS HUB Reform Plan, including:
    - New process to increase HUB utilization for certain spot purchases of less than $5,000;
    - Updated HUB solicitation templates to provide better guidance to respondents;
    - Began developing Standard Operating Procedures for the HUB Program Office; and
    - Expanded Post-Contract Award Meetings between HUB, PCS, and program to solidify the HUB Subcontracting Plan (HSP) and ensure compliance.
- Established a procurement risk assessment tool to determine approval workflow based on level of risk.
- Completed a comprehensive review of HHSC's procurement rules, Title 1, Chapter 391 of the Texas Administrative Code, to identify obsolete or outdated rules to be amended or repealed.
- Elevated the CQC Division to a Deputy Executive Commissioner-level office and moved to the Chief Policy and Regulatory Officer, a different chain of command to ensure independence and sufficient oversight of PCS.

- Conducted an evaluation of CQC's current role in the procurement process and provided recommendations for enhancing the oversight role and improving efficiency.

Established clear and effective policies, procedures, and processes

- Implemented the PCIP recommended improvements to the end-to-end process for complex procurements, including program responsibility for contract execution. In a pilot of these improvements, PCS and DSHS were able to reduce the time from requisition entry to contract mailout from 53 to 4 days.
- Through the PCIP process, established a clear understanding of each area that is responsible, accountable, consulted, and informed on each step of the complex procurement process; educated agency staff on these roles and responsibilities.
- Published a combined procurement and contract management handbook to be a single resource for HHS policies and procedures related to the procurement and contract lifecycle as recommended through PCIP.
- Published updated procedures for RFx solicitations to ensure statutory compliance and provide clear direction to PCS and program staff.
- Implemented CAPPS Financial 2.0 Enhancements, including:
    - Developed capacity to conduct evaluations in the CAPPS Financials system to improve efficiency and reduce risk;
    - Created a CAPPS Financials template library to standardize procurement and contract templates, forms, and exhibits;
    - Enhanced needs assessment intake questionnaire to better identify procurement objectives and determine procurement method; and
    - Created a vendor portal for submission of electronic responses to solicitations.

Strengthened the procurement and contracting workforce

- Completed a workload study of PCS, which guided the allotment of 32 additional FTEs authorized by the 86th Texas Legislature. This restructuring allowed PCS to: reduce supervisor-to-staff ratios from 20:1 in 2018 to 10:1 in 2020; increase the number of purchasers to reduce workloads; and increase the number of Level 1 support staff to complete procurements.
- Established a Grants team to improve the procurement process for grants by providing specific guidance to program and conducting a comprehensive review of the Request for Application (RFA) process from developing the statement of work through contract award.
- Established a Complex Construction team with expertise in construction solicitations. The team updated all construction procurement and contract documents and established a construction forecasting process to share with the vendor community about upcoming projects.
- Developed a comprehensive training strategy for PCS and program staff, as well as a process to identify future training needs.
- Determined roles, responsibilities, and structure of new PCS Contract Management Support unit.

Enhanced strategic and long-term planning for procurement and contracting functions

- Published a three-year strategic plan for the HHS Procurement and Contracting system to guide the agency's ongoing improvement goals and objectives.
- Implemented a Complex Procurements Planning Initiative which involves a coordinated approach with program to plan and document all upcoming complex procurements through the end of fiscal year 2020 and beyond.
- Published the Procurement Action Lead Time Schedule that informs program of the timelines associated with procurement types. This schedule details the steps in procurement process, responsible parties, and required processing times per step.
- Developed and implemented a Data Cleansing Road Map to identify and correct legacy data and other known data entry errors in CAPPS and SCOR.

Enhanced communication and transparency internally and externally

- Posted a forecast of complex procurements and grants to the HHSC public-facing website.
- Hired a PCS Communications Specialist and implemented a comprehensive strategy and framework to improve PCS communication with internal customers.
- Hired a PCS Internal Web Administrator to redesign PCS' intranet page to more effectively share information, forms, templates, and guidance with PCS and agency staff.
- Held a webinar for vendors seeking to do business with State Supported Living Centers (SSLCs) and State Hospitals.
- Developed and implemented the HHS Online Bid Room – an online option for submitting a response to a solicitation for HHSC, DSHS, DFPS, and TCCO.
- Began development of a guide for vendors to be completed by September 1, 2020, entitled "How to Do Business with HHSC," to foster more engagement with current vendors, and to provide more information for prospective vendors.

[i] *Indicates a deliverable or outcome associated with the Procurement and Contracting Improvement Plan (PCIP).

86th Legislature, Interim Charge 1, Request for Information

House Committee on Appropriations

September 30, 2020

Interim Charge 1.

Monitor & Oversight: Monitor and oversee the implementation of appropriations bills and other relevant legislation passed by the 86th Legislature. In conducting this oversight, the Committee will also specifically monitor implementation of appropriations for:

- *Human and sex trafficking legislation; and*
- *Implementation of procurement and contracting reforms at state agencies.*

Human and Sex Trafficking Legislation

Senate Bill 1219 – Relating to human trafficking signs at certain transportation hubs.

SB 1219 adds Section 402.0351, Texas Government Code, to require the Attorney General to require and enforce the posting of signage for services and assistance available to victims of human trafficking at certain transportation hubs as determined by the Attorney General (buses, bus stops, trains, train stations, safety rest areas, and airports).

SB 1219 requires the Attorney General, by rule, to prescribe the design and content of the sign, the manner for displaying the sign, and any exceptions to the posting requirements. SB 1219 also requires the Attorney General to consult with the Texas Department of Transportation (TxDOT) when adopting the rules regarding the design and content of the sign, which must include in both English and Spanish the telephone number and internet website of the National Human Trafficking Resource Center and the key indicators that a person is a victim of human trafficking.

TxDOT only has direct oversight and control of certain transportation hubs (rest areas) as defined by SB 1219. TxDOT operates 76 safety rest areas and an additional 12 Travel Information Centers, which also serve as safety rest areas. As part of human trafficking awareness campaigns prior to the passage of SB 1219, TxDOT posted signage in each rest area and Travel Information Center bathroom stall and other locations around the facilities. These signs provide information to potential human trafficking victims in English and Spanish and include the National Human Trafficking Hotline's phone number.

As required in SB 1219, TxDOT has held multiple coordination meetings with the Office of the Attorney General to share TxDOT's efforts and current signage, contacts around the state for transit operators and general aviation airports, and lessons learned while implementing TxDOT's human trafficking awareness campaigns.

Currently, TxDOT is awaiting final adoption of rules from the Attorney General. Upon final adoption, TxDOT will work to place the updated signage prominently in all safety rest areas and Travel Information Centers and engage other transportation hub operator contacts to ensure the entities are aware of the provisions of SB 1219.

In addition to SB 1219, Rider 49, TxDOT Bill Pattern, General Appropriations Act, 86th Regular Legislative Session (2019), appropriated $200,000 in General Revenue to install signage or to provide grants to install signage at locations determined in SB 1219. Because TxDOT can use other appropriated funds (State Highway Fund) from TxDOT's current budget to install signage at TxDOT facilitates, in response to the recent five percent

General Revenue budget cut request by the Legislative Budget Board, TxDOT proposed cutting the General Revenue funding for this program. Once the Office of the Attorney General adopts rules on signage design and rules, TxDOT will place the appropriate signs at its safety rest areas and Travel Information Centers.

SB 1593 –Relating to training by the Texas Department of Transportation on the recognition and prevention of smuggling and trafficking of persons.

SB 1593 adds Section 201.407, Texas Transportation Code, to require TxDOT to develop and make available to employees of TxDOT a training course on the recognition and prevention of smuggling and trafficking of persons. The bill requires TxDOT, in collaboration with the Office of the Attorney General, to establish the content of the training developed. Finally, SB 1593 requires TxDOT, on the date an employee begins employment with TxDOT, to provide notice to the employee of the availability of the training. Since September 1, 2019, when the training became a requirement, over 2,500 newly hired TxDOT employees have completed human trafficking training.

TxDOT began requiring all new hires to take human trafficking awareness training within 30 days of hire in December of 2018. TxDOT advises all new employees of their mandatory training requirements on the first day of employment during new employee orientation. The video training course is mandatory for new employees and is not a recurring requirement. TxDOT structured the human trafficking training around the Attorney General's existing human trafficking resources.

In addition to the required training, TxDOT makes all employees aware of the importance of recognizing the signs of human trafficking with the distribution of information on human trafficking. On April 12, 2019, TxDOT's executive director sent a video message to all TxDOT employees that detailed TxDOT's efforts regarding human trafficking and encouraged employees to be aware of the issue.

Ongoing TxDOT Efforts and Campaigns on Human Trafficking Awareness:

Beginning in 2019, TxDOT joined a statewide effort to encourage everyone to know, watch for, and report human trafficking signs. To end human trafficking, TxDOT launched its "On the Road to End Human Trafficking" initiative.

To raise awareness among employees, industry partners, and the public, TxDOT provides the following materials:

- Information cards for all TxDOT vehicles;
- Wallet cards that include details on what to look for and how to report suspected trafficking;
- Large posters; and
- Restroom stall signs for TxDOT's safety rest areas and TICs throughout the state.

These materials raise public awareness and provide human trafficking victims with critical information on how to reach out for help. The materials may be found on TxDOT's public website at the following hyperlink for

anyone to download and use as needed: https://www.txdot.gov/inside-txdot/media-center/psas/prevent-human-trafficking.html.

In addition to the previously mentioned new employee training and ongoing awareness campaigns, TxDOT's Austin District held a more in-depth, in-person training in January of 2020 for their maintenance and Highway Emergency Response Operator (HERO) employees. These employees are on the front lines every day and are best suited to recognize human trafficking signs on Texas' roadways. This training was developed in partnership with the Governor's Commission for Women. TxDOT has suspended further in-person training due to COVID-19 but is exploring ways to share this training virtually with other TxDOT districts moving forward.

TxDOT also works to ensure human trafficking awareness remains front and center by posting messages on its social media channels regularly. Most recently, TxDOT posted messages on July 30, 2020 in recognition of World Day against Trafficking in Persons.

Implementation of Procurement and Contracting Reforms at State Agencies

In accordance with Texas Government Code, Section 2261.258 (as added by Senate Bill 65, 86th Regular Session (2019), the State Auditor's Office (SAO) assigned contract monitoring ratings of additional monitoring warranted, no additional monitoring warranted, or reduced monitoring warranted to each of the 25 largest state agencies. Those agencies were determined by the Legislative Budget Board (LBB). That statute requires a report on those ratings to be submitted to the Office of the Comptroller of Public Accounts (CPA) and the Department of Information Resources (DIR) by September 1 of each year. The CPA and DIR are responsible for developing guidelines for additional and reduced monitoring.

For this statute, the SAO reviewed and analyzed relevant contracting-related information from multiple sources specified in Section 2261.258, Texas Government Code. Contracting-related information reviewed included audits conducted by the SAO, audits conducted by agencies' internal audit divisions, purchase audits conducted by the CPA, Quality Assurance Team reviews, Contract Advisory Team reviews, LBB reviews, Sunset Advisory Team reviews, and self-reported improvements and analyses provided by the agencies rated.

No single source was used to assign a rating of additional monitoring warranted or reduced monitoring warranted. The Texas Department of Transportation (TxDOT) was assessed a rating of "No Additional Monitoring Warranted (For Any Contracting Period)."[1]

[1] A Report on Contract Monitoring Assessment at Certain State Agencies, State Auditor's Office (April 2020); http://www.sao.texas.gov/SAOReports/ReportNumber?id=20-028

Texas Association of Health Plans
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September 24, 2020

House Appropriations Committee
via email to Appropriations@house.texas.gov

Chairman Capriglione and House Appropriations Committee Members,

The Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, health maintenance organizations, and other related health care entities operating in Texas. Our members provide health and supplemental benefits to Texans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid.

Thank you for the opportunity to comment on your RFI related to the implementation of procurement and contracting reforms at state agencies. We are encouraged by the recent Medicaid Managed Care Procurements Assessment conducted by Mercer for HHSC and are extremely supportive of the recommendations outlined in the report. The findings align with our member health plans' experience with the process as well as with best practices in other states.

We recommend that HHSC implement Mercer's recommendations before the agency moves forward with any additional managed care procurements. We also recommend that HHSC use the multi-consulting pool to contract with experts to help implement the recommendations and develop the STAR/CHIP and STAR+PLUS RFPs in a timely and successful manner. The agency has continually extended the existing contracts and should complete the new RFP process sooner rather than later.

The Medicaid managed care organization (MCO) contracts are the largest contracts in the state of Texas, so it is vital that HHSC has a transparent and fair process to award them. The health plans that administer the Medicaid program are responsible for providing services to the most vulnerable Texans, and it is important for the public to have confidence in the award process and in the managed care program. We support the implementation of all recommendations outlined by Mercer because we believe they will help strengthen the procurement process. There are a few recommendations we would like to emphasize as they will have the largest impact on creating a strong foundation for procurement.

We strongly support the recommendation that HHSC begin any procurement or re-procurement with a defined vision and leadership involvement. Over the past 20 years, the Texas Legislature tasked Medicaid MCOs with transforming what was a costly, outdated, and broken fee-for-service program into a modern, integrated health care delivery system that leverages private sector innovation and expertise. Recent evaluations of Texas' managed care program have shown that the program is achieving significant savings while improving quality of care. Reports have also highlighted that Texas' Medicaid managed care model is an efficient

system.[1] We are overdue, however, for HHSC and the Legislature to renew Texas' vision and goals for the future of the program.

A strong vision for Medicaid managed care will help align the agency in its procurement development, evaluation process, award decisions, and even in oversight of the contract once awarded. Clearly outlining organizational goals will not only help HHSC staff understand how to develop the elements of the draft RFP, but will also help them assign weight for evaluations and aid leadership in making final determinations on awards. A clear, transparent vision will set expectations and help health plans bidding on procurements understand the agency's goals. Finally, clear program goals will help the agency plan for the future while increasing transparency in the procurement process and in the program's overall progress, resulting in greater stakeholder confidence.

In addition to setting the vision for the managed care program and its procurement process, we believe it is extremely important for HHSC leadership to be involved throughout the entire process. Historically, procurements that had significant involvement and oversight from leadership are more successful and see fewer legal challenges. Mercer highlights the need for leadership involvement in several places throughout its assessment. They note that while proposal scores are important, the calculation of scores is typically determined by mid-level staff and should not be the sole determinant of contract awards. Additionally, Mercer recommends that evaluation scores should inform award decisions, but *final decisions should reflect the judgement of agency leadership about how the achievement of program objectives and policy outcomes would be best achieved.*

We cannot emphasize enough the importance of dedicating highly skilled subject matter experts to the procurement process. HHSC staff who have a background in managed care should be assigned to participate in and prioritize the entire project — from the development of the RFP to the evaluation. The evaluation's quality is determined by the quality of staff working on the procurement as well as by the support, training, and expectations HHSC provides to them. We understand HHSC has limited resources and staff who are working on multiple projects at any given time, but the only way to ensure quality evaluations, consistent scoring, and defensible awards is to ensure staff with the most knowledge are participating in the process and provided with the necessary tools and time commitment for the entire process.

There are multiple recommendations throughout the assessment that, if adopted, would provide additional support to staff while improving the process. Several states, including Arizona, Kansas, and Indiana, have adopted some of the best practices outlined in the Mercer Report. Practices in other states have evolved to satisfy unique requirements within that particular state and to conform with state procurement laws. Texas procurement statutes were adopted to satisfy unique Texas requirements. Texas embraces a "best value" model that allows a state agency significant flexibility in its selection of vendors.[2] Rather than looking for a procurement model that has been successfully used in another state but may not be applicable to Texas, perhaps

[1] Rider 61 Evaluation of Medicaid Managed Care

[2] The Texas Government Code, Chapter 2155.074 establishes the best value standard for the purchase of goods and services. Procurement rules are further affected by the Texas Government Code, Section, Title 4, Subtitle I, Chapter 533, Medicaid Managed Care, 533.003, Considerations in Awarding Contracts.

Texas would be better served by looking at best practices for procurement processes in general. A summary of those best practices and our recommendations are outlined below.

Ensure Transparency and Develop and Adhere to a Published Timeline — Public confidence in the procurement process is bolstered when an agency is very clear in publishing and adhering to its procurement timeline, and focused efforts over a defined timeframe will result in fewer opportunities for error.

HHSC should use a transparent process that informs the procurement's timing and expectations on the front end. This should include what is included in the RFP and key dates throughout the entire process with the goal of having as few surprises as possible before, during, and after the procurement. Visible procurement processes provide respondents with a greater degree of predictability which, in turn, allows plans to better allocate resources and provide thorough, high-quality RFP responses. We recommend the state maintain a 90-day proposal turnaround schedule to attract more bidders, level the playing field, and improve bids through providing ample time for more thoughtful, detailed responses. **Additionally, HHSC should continue to release a draft RFP and allow for a 45- to 60-day comment period, specifically taking MCO recommendations into consideration.** This practice provides the state with valuable insight from stakeholders and enables the final RFP to include realistic and attainable requirements for a smooth implementation. Additionally, adjusting the RFP based on stakeholder feedback will ultimately result in fewer questions from bidders during the RFP process.

HHSC should clearly state the submission requirements and eliminate any superfluous information that is not truly needed to award a contract. The content of the RFP should be concise and focus on the population and the experience of the respondent. This level of transparency and clarity helps respondents provide more succinct and thorough responses.

HHSC should also maintain the greatest possible degree of transparency as to how the state will evaluate and score the RFP prior to submission and upon award. A clear explanation on scoring and evaluation is key to a successful contract award as it improves transparency, ensures evaluators are aware of the scoring rubric, and reduces potential protests and lawsuits.

Establish a Project Sponsor and Governance Structure — The senior manager who serves as the project sponsor should not be the procurement officer. Instead, it should be the person who has responsibility for the services being procured. While the procurement officer serves as the single point of contact, the procurement function is secondary to the mission-essential services being acquired. The project sponsor should establish a governance body that includes all areas within HHSC that are responsible for managed care, including procurement, legal, systems, operations, finance, etc. The governance committee would ensure that the project remains on track and that issues are identified and resolved or escalated to the HHSC Executive Commissioner for resolution.

Focus the RFP Requirements on Things that Matter — Compared to other states, Texas managed care procurements are incredibly complex. Among other extraneous requests that are evaluated and scored during procurement, Texas requires an inordinate amount of information relative to claims processing, and geo-access maps are required to demonstrate network adequacy. While important, these requirements and others like them could be included as

contract requirements and validated at readiness review rather than included, evaluated, and scored in the proposal. Rather than requesting and scoring so much information in the proposal, HHSC could simply state the requirement and associated level of expected performance. **The RFP could focus on those areas for which HHSC truly wishes to evaluate MCOs — cost, quality, and access.** These areas should be the primary focus of the evaluation criteria and best value in a managed care procurement. **Compliance with claims processing and network access should simply be validated during readiness review.**

The Arizona managed care procurement model is based on a relatively streamlined RFP and is largely scenario-based. Bidders are asked to respond in detail to a variety of scenarios presented for the population to be served. During oral presentations, vendors may be asked about additional details to support scenario responses. Bidders that have the best responses are awarded contracts. Other areas, such as claims administration, prior authorization, appeals, and grievances, are established as contractual requirements and not "scored".

Compete Based on Outcomes — The agency and Legislature should determine what value and outcomes they want to achieve through managed care and align the procurement process and scoring with those values. Texas should avoid overfocusing on one area of value — cost, for example. Evaluating health plans too heavily on cost can lead to perverse incentives and encourage plans to "underbid" their rates, which can result in rates that do not meet CMS actuarial soundness requirements and/or in a rate structure that cannot support the program. The basis for managed care competition should be based on multiple, measurable values including quality, outcomes, and ability to manage costs. HHSC can structure the procurement in a manner that allows non-incumbent plans to compete based on results of managing comparable lives in other states. **The values being used should be transparent and stated at the beginning of the process.**

One example of this is Florida's use of an Invitation to Negotiate (ITN) process. The ITN solicits plans that achieve a minimum score on proposals to negotiate for a potential contract award. Plans are scored based on traditional criteria and compete largely based on quality. For example, a plan may be required to bid on reductions in ED visits, hospitalizations, or readmissions. Plans are further assessed relative to performance on quality and cost containment.

Include Oral Presentations — HHSC should include a scored oral presentation with a specific set of questions provided at least 48 hours in advance of the meeting to allow for adequate preparation. The oral presentations should focus on the RFP and specific scenarios that show the MCO's knowledge and readiness. Oral presentations level the playing field for respondents and allow the state to ask questions and to gain insight and clarity about the proposals.

Improve the Process for Outlier Scores — HHSC should ensure that a discussion between scorers is built into the scoring process for outliers, at a minimum, but preferably all questions. As stated in the Mercer Report, allowing for discussion in cases where there are outliers gives evaluators the opportunity to explain their reasoning for scores and ultimately change the score if appropriate. This process was used in previous, successful RFPs, and the state should re-adopt this practice.

Thank you for your consideration of the recommendations in this letter. We believe they will strengthen and instill greater trust and transparency in the managed care procurement processes at HHSC. Please feel free to contact me if you have questions or need additional information.

Sincerely,

Jamie Dudensing, RN
CEO, Texas Association of Health Plans
jdudensing@tahp.org

Texas Appropriations Committee
Interim Charge 1: Implementation of procurement and contracting reforms at state agencies

Dear Chair Capriglione and Committee Members:

The Texas Association of Community Health Plans (TACHP) appreciates your interest in collecting feedback about state procurement and contracting reforms. Our comments will focus on the Health and Human Services Commission. As background about our organization, TACHP includes a consortium of 10 Medicaid health plans, also known as health insurance companies or Managed Care Organizations (MCOs). Our health plans are Texas companies that are regionally and locally based, and provide services throughout Texas with unmatched service in terms of cost competitiveness, consumer protections, and provider relations.

Procurements
Attached is the letter recently sent to the new HHSC Commissioner Cecile Young with our recommendations about how to improve the integrity and processes related to procurements. I apologize for not meeting the page limit, but believe it is important for the Committee to see the full letter.

Contracts
HHSC released a report in 2018 by the consulting firm Deloitte which evaluated HHSC's contract management practices in detail for MCOs. The report concluded HHSC does a good job in its contract management, and exceeds most states in some management functions. A summary of the report developed by TACHP is attached.

Please let us know how we can assist. Thank you.

TACHP MEDICAID MANAGED CARE PROCUREMENT RECOMMENDATIONS ATTACHMENT

Current state:

- Executive, legislative and marketplace anxiety driven by a lack of confidence in HHSC's ability to manage and make a quality decision regarding the awards.
- Financial commitment and risk – largest procurements in the state in terms of dollars and lives affected.
- Both require fundamental revisions to the award decision process and all processes and events that lead to that decision.

Future state:

- To restore trust and confidence in the procurement process and to ensure the best outcome for the states in awarding contracts.
- To assure that HHSC Medicaid resources are aligned with the level of risk associated with the number of lives and dollars affected by the procurements, and
- To assure HHSC balances its procurement regulatory and compliance roles with its responsibility to bring the expertise, knowledge and executive insight to purchase a massive health care delivery system.

Suggested solutions:

1. Developing Lessons Learned

The recent bid cancellation trend began in early 2017 with cancellation of the Hidalgo Service Area CHIP bid. The most recent cancellation occurred with the STAR+PLUS bid, which was originally released in November 2017, twice cancelled and re-issued, finally awarded in November 2019, and again canceled in March 2020 — 29 months following original RFP release. We recommend a close examination of these cancellations to develop lessons learned that may be applied to improve the effectiveness and integrity of future procurements. While Mercer identified some factors that likely contributed, the Mercer report pre-dated the most recent cancellations and therefore may not fully capture the factors that led to them.

It is unclear from the Mercer report how many HHSC staff were interviewed. If interviews did not include most of the staff who developed the RFPs and those who evaluated bids, as well as a cross-section of staff involved in managed care oversight who can speak to procurement process impact on oversight, we would recommend obtaining input from a broader group of staff. In any event, the input from those involved should be updated to consider the most recent cancellations.

Additionally, and perhaps most critically, Mercer's recommendations for improving the procurement process are based upon interviews only with HHSC staff. We strongly recommend obtaining additional input from:

- ***HHSC leadership**, including those involved in oversight of both the MMC Program and procurements. These individuals have a unique view of process implementation as well as the resource and agency reputation impacts of bid cancellations. Key areas for capturing HHSC leadership observations on issues with recent cancelled procurements include but may not be limited to:*

    - *Leadership involvement and oversight*
    - *Organizational distribution of responsibility*
    - *Effectiveness of cross-organizational and cross-functional collaboration*
    - *Process planning and execution*
    - *Evaluation criteria and process.*

2. Establishing a Strategic Vision for the MMC Program

Mercer identified the need for HHSC leadership to establish a vision and goals for MMC procurements. We have observed that HHSC uses very similar RFPs procurement after procurement, with minimal variation in goals and structure. While this is not unusual for states to do, it fails to capitalize fully on the opportunity to consider the strategic direction of the MMC Program and how procurement approach or the RFP may need to be re-engineered to take the Program to the next level.

- *…focus on **determining where HHSC wants to take the MMC Program** over the course of the upcoming procurement and the objectives and best value criteria (BVC) that will drive the process and RFP to achieve the vision. Key areas of discussion would include but may not be limited to:*
- *What are HHSC's **top priorities for outsourcing** to MCOs? Examples might include access, quality, cost savings, member or provider satisfaction, reducing HHSC administrative burden,* ensuring truly competitive market for Provider and Member choice.
- *What are the most **critical areas for improvement** in the MMC Program over the next contract period? Examples might include preventive care measures, access to BH services,* Social Determinants of Health initiatives and community engagement.
- *What does HHSC want to **encourage MCOs to deliver**? Examples might include performance improvement, innovation, use of best and evidence-based practices, collaboration with other MCOs, collaboration with other stakeholders.*
- *What does HHSC want to **avoid** in the MMC Program and in the upcoming procurement? Examples might include protests, delays in implementing new contracts due to lack of MCO readiness, member disruption, provider complaints, market instability.*

3. Overhaul RFP

Focus RFP to elements essential to receive quality, innovative bid responses that address Texas Medicaid Member and Provider needs with a high level of accountability

- Reduce duplicative requirements
- Write an RFP that allows respondents to differentiate
  - Solicit robust Executive Summary
  - State the purpose (desired results sought) in each major section
- Require proof / documentation rather than simple attestations
- Embed evaluation criteria by major section
- ***Questions should not ask bidders to demonstrate understanding of the SOW or how they will implement SOW requirements that represent standard managed care processes****. Most SOW requirements relate to industry standard processes that are important but performed similarly across MCOs. Requiring bidders to describe basic operational processes leaves little opportunity for presenting their best solution. It also results in long narrative that is time-consuming to review and makes it more difficult for evaluators to tease out the truly differentiating information in each bid.*

  Program descriptions and manuals, which are required at readiness review and as contract deliverables, provide detailed descriptions of how these requirements are implemented. Particularly in a mature managed care market, such basic operating requirements are more efficiently addressed through readiness review (which could be modified to add sanctions for failure to meet requirements) and contract monitoring.
- ***Questions should be focused to elicit information that allows evaluators to differentiate bidder solutions in meeting the procurement BVC****, such as :*
  - *Where a bidder's solution goes beyond requirements*
  - *How a bidder will meet new requirements*
  - *How a bidder will address specific HHSC priorities*
- ***Questions regarding MCO experience and performance should ask for information available in public record that can be evaluated using an audit style approach, rather than requiring narrative****. Basing evaluation of experience and performance on a specific list of quantifiable metrics (such as fines and sanctions, litigation, and HEDIS scores, and other contract performance metrics in Texas and/or in other states) would yield an objective comparison of bidder qualifications in this area.*
- ***Page limits should be short.*** *Long responses increase not only the time needed for evaluation, but also the challenge of separating important differentiating information from unnecessary details or spin. Once the need to describe basic processes for meeting SOW requirements is eliminated, we believe most questions requiring a narrative response should be limited to no more than five pages. This would force bidders to be succinct and focused on the most important differentiating information and also enable evaluators to review all respondents more quickly and effectively.*

- ***The number and complexity of questions should be limited****. The more questions the RFP asks, the longer the response and the longer it takes to evaluate. Question complexity also increases the length of a response and is more challenging to evaluate. We recommend using the procurement BVC as the starting point and developing one or a small number of questions for each criterion to elicit information targeted to differentiation of bidders. Questions should be crafted carefully and clearly convey the information being requested without being overly long with numerous subparts.* The amount of questions and the level of detail required in previous RFPs did not necessarily allow evaluators to clearly and fairly determine bidder capacity to meet and deliver program goals and healthy quality outcomes for Members.
- ***Evaluation criteria/tool should be released publicly as part of the RFP.*** *Mercer recommended releasing BVC and procurement vision but not the evaluation tool. We disagree that the evaluation tool should be held back. Transparency in how bids will be evaluated not only increases stakeholder confidence in the integrity of the process, but also gives bidders the clearest understanding of what HHSC values and wants to see in responses.*

4. Refine Best Value Criteria

- Explicitly state best value criteria in the RFP to assure that critical factors such as Member and Provider choice, competitive respondent field, strong service area commitment, and other value-based criteria are included in the executive award decision process that addresses key strategic and program goals
- Used as a fundamental executive award decision-making principle
- Staff and respondents both understand the statutory requirements of a best value decision and the rationale behind this fundamental requirement
- Scoring the RFP is a critical component of best value but cannot be the only component in ranking bid responses and awarding contracts

5. Assign internal resources within Medicaid and CHIP Services and engage an external vendor to manage the RFP rewrite and the evaluation process, which require dedicated resources and expertise. To ensure an RFP that reflects national best practices, and accurately reflects HHSC program goals, a vendor with expertise in advising key HHSC staff in drafting Medicaid managed care RFPs, and in best evaluation practices is a key reform. The RFP that HHSC issues should encourage and leverage current market solutions and offer clear choices to Members for the type of plans and services that best meet their unique needs. An external perspective and associated expertise is the best solution to achieving this end. Dedicated HHSC staff working collaboratively with the external vendor would allow all to focus the time the MCO awards demand and to expand HHSC knowledge and expertise.

- Within HHSC, reorganize functions so that Medicaid/CHIP staff lead managed care procurements, with Procurement staff serving in a supportive role. The procurement of MCOs is more complex than any other contracts in HHSC and includes the entire service delivery system of Medicaid/CHIP services for most recipients in Texas.
- Commit best staff to serve on development and evaluation teams
- Tally final evaluation results only after interactive deliberation among evaluators

- Eliminate outlier evaluation scores through a consensus process that incorporates quality control principles and thorough discussions among evaluators to address wide variations in scoring and any discrepancies among the evaluation team.

6. **Procure by Service Area** to ensure competitive procurement and contract award process and to allow for a level playing field in which respondents are judged fairly. Respondents must demonstrate commitment by Service Area to include network, staffing, value adds and community knowledge. Comparing single Service Area respondents using statewide bidding criteria does not allow for an apple to apple comparison.

    - TACHP recommends the consolidation of Harris/Jefferson and Nueces/Hidalgo Service Areas. In TACHP's comments on HHSC's request for information (RFI) on service area consolidation, TACHP recommended HHSC pilot our suggested consolidation before any further consolidation. Texas now has almost 30 million residents. Our population has differing needs that vary by geography, and the number of Medicaid service areas seems appropriate for the size of our state.

7. Suggested Timeline

Below we provide a suggested timeline for making changes to the procurement process and RFP and completing the next re-procurement. Understanding the need to work around agency demands related to the legislative session, we suggest a two-phase approach, with the first phase occurring prior to the 2021 Legislative Session and the second procurement phase occurring afterward. We suggest a 90-day separation between the STAR/CHIP and STAR+PLUS RFPs. A 90-day separation would best accommodate the significant resources required for both the MCOs to respond and for HHSC to evaluate. Additional time would aid the substantial workload that readiness requires.

Note: We are not aware of whether or how HHSC has already begun implementing Mercer recommendations but understand that our recommendations would need to be coordinated with any work already planned or underway.

Phase 1: Assessment of recent RFPs and Process re-design	
September 2020	Engage external vendor to manage writing draft RFP and designing and leading the evaluation process; assign core HHSC project team inside Medicaid and CHIP Services
October – November 2020	External Vendor and HHSC program project team to facilitate vision setting with key executives and stakeholder input, develop procurement objectives and establish best value criteria Produce recommended plan to include any lessons learned, Mercer Recommendations and national best practices as part of plan for RFP priorities and process revisions
November 2020	Present plan to HHSC leadership for sign off and share with stakeholders

December 2020 – January 2021	Draft revised RFP and develop associated evaluation criteria. Include external and internal evaluation staff in the process to ensure clear understanding and alignment with program goals as articulated in the RFP.
Phase 2: Implement Re-Procurement RFP #1	
June – July 2021	Draft RFP released and public comments reviewed, RFP revised accordingly
September - October 2021	Final RFP released
February 1, 2022	Bids due to HHSC
April-May 2022	Evaluation and awards
June 2022	Contracts signed
September 1, 2022	Contract Start Date
Phase 2: Implement Re-Procurement RFP #2	
September – November 2021	Draft RFP released and public comments reviewed, RFP revised accordingly
December 2020 - January 2021	Final RFP released
May 1, 2022	Bids due to HHSC
July - August 2022	Evaluation and awards
September 2022	Contracts signed
December 1, 2022	Contract Start Date

** All italic text comes from a separately submitted document "Recommendations to Improve Efficacy of HHSC MMC Procurement," written by Morrison and Donovan, dated May 2020.*

HHSC Rider Report 61 Final Comprehensive Report Rider 61 (b):
Evaluation of Medicaid and CHIP Managed Care Review of Managed Care Contract Review and Oversight Function Summary of Findings, August 3, 2018

Background

This report was completed at the direction of the 85th Texas Legislature, who directed that HHSC conduct a review of the agency's contract management and oversight for their Medicaid and CHIP managed care contracts. HHSC's contractor conducted the assessment based on two frameworks:

1. CMS' Final Rule for Medicaid & CHIP Managed Care, released May 2016; and
2. the National Contract Management Association's 2005 Contract Management Maturity Model (CMMM), designed to help organizations assess the maturity of their contract management processes.

HHSC's contractor performed the assessment during the winter and spring of 2018, and included nine functional areas in their review. Information gathered for the assessment included staff interviews, several sessions with HHSC leadership and staff, review of documents and use of relevant benchmarks from other states. Based on the information collected and reviewed, a CMMM maturity level was assigned for each functional area. The five CMMM levels of maturity in this assessment are:

- **Ad-Hoc** – some processes are established and exist, but are ad-hoc
- **Basic** – disciplined process capability
- **Structured** – fully established and institutionalized process capability
- **Integrated** – processes are integrated with other enterprise processes
- **Optimized** – all processes are optimized, focused on continuous improvement and adoption of lessons learned and best practices

***Notes on CMMM Maturity Levels**:*

- *(excerpt, page 12 of the report)* "The typical CMMM assessment covers six contract management key processes: procurement planning, solicitation planning, solicitation, source selection, contract administration, and contract closeout. However, since this is a review of managed care contract review and oversight function, the tool was adapted to cover the functional areas described in **Section 2.1.1 CMS Medicaid and CHIP Managed Care Final Rule**."
- *(excerpt, page 17 of the report)* "*T*he National Contract Management Association indicates that, based on their industry analysis of 200 companies across 12 industries, 72 percent of the companies were operating at a maturity level of between "Basic" and "Structured". None of the companies surveyed and evaluated were operating at a contract management maturity above Integrated."

Summary of Findings

HHSC functional areas reviewed and their assessed levels of CMMM maturity include:

Areas of Review	Assessed CMMM Maturity Level
1. State Monitoring Standards *[p 19] "Structured" designation based on the fact that process and standards are well established, institutionalized, and managed throughout MCS. However, there is still significant manual effort which should be alleviated by the new portal for deliverables submission.*	**Structured**
2. Quality of Care *[p 29] This functional area received a "Structured" designation, but noted some variability across elements within this area. It noted the used of the EQRO to validate encounter data as "Optimized". It also noted that a number of quality programs are new or recently redesigned.*	**Structured**
3. Network Adequacy and Access to Care *[p 45] "Structured" designation based on the fact that processes and standards for monitoring are fully established. More automation is needed.*	**Structured**
4. Program Integrity *[p 52] "Integrated" designation based on the fact that processes and standards are well coordinated and integrated by the OIG in coordination with MCS.*	**Integrated**
5. Grievances and Appeals *[p 60] "Basic" designation based on the fact that the process for logging complaints is not structured or standardized. Technical definitions and processes related to complaints are not standardized.*	**Basic**
6. Marketing and Communication Activities *[p 70] "Structured" designation based on the fact that there is formal documentation related to marketing and communication activities, and there are established procedures for reviewing member and provider materials. The UMCC and UMCM clearly define standards.*	**Structured**
7. Enrollments and Disenrollment *[p 79] "Structured" designation based on the fact that processes and standards are well established, documented and institutionalized across HHSC. Process automation exists.*	**Structured**
8. Rate Development Standards *[p 83] "Integrated" designation based on the fact that the process for validation of MCO reported financial data is a well-coordinated and integrated process across HHSC divisions and departments.*	**Integrated**
9. Contract Amendments and Procurements *[p 74] "Structured" designation based on the fact that process and standards are well established.*	**Structured**

(excerpt, pp 5-7 of report)

Activities for HHSC to Continue

The findings relative to the activities that HHSC should continue to execute, indicate that HHSC has built a strong foundation for its oversight of Medicaid and CHIP managed care programs **(Figure 2)**. The findings fall into four broad categories that emphasize some of the key accomplishments of HHSC's Medicaid and CHIP managed care oversight efforts:

1. **Adherence to standard processes**: HHSC has developed and documented processes for its core managed care contract management and oversight functions. Staff are aware of these processes and follow them.

   Report findings: **Continue: Activities well-aligned to the managed care oversight function**

   - **Continue Accountability through the Strengthened Graduated Remediation Process and Liquidated Damages (LDs)**

     *[excerpt p 23] "HHSC may impose remedies for material non-compliance and determine the scope and severity of the remedy on a case-by-case basis in accordance with Attachment B-3 Deliverables/LDs Matrix of the Uniform Managed Care Contract (UMCC). In SFY2016, HHSC assessed $5.2 million in LDs13, which represented 0.03 percent of the $18.8 billion in total payments to MCOs in SFY2016. For the first two quarters in SFY2017, HHSC has assessed $9.7 million in LDs, which represented 0.04 percent of the $21.9 billion in total payments to the MCOs in SFY2017. The increase in LDs is a result of HHSC strengthening its oversight of non-compliance with the UMCC. Refer to **Appendix 5.1.5** for LDs assessed."*

     [excerpt, p 28] "…In the last four months, MCS formalized the process for issuance and approval of LDs, which documents the approval process and clarifies which authority can issue the LDs depending on the amount of LDs assessed."

   - **Continue to Improve Grievances and Appeals Data Aggregation and Identification of Trends**
   - **Continue Recovery Activities**

2. **Collaboration within and outside of HHSC**: HHSC works across divisions and with other entities in executing a wide range of contract management and oversight functions.

   Report findings: **Continue. Activities well-aligned to the managed care oversight function**

   - **Continue to Enhance Coordination of Audits and Reviews**

     [p 21] The report finding encouraged further enhancing coordination to make audits more efficient and effective.

   - **Continue with Integrated Managed Care Compliance and Operations (MCCO) Teams**
   - **Continue to Strengthen Integration of Managed Care Oversight Across Divisions**
   - **Continue Elevation of the Medicaid and CHIP Services (MCS) Major Procurement Office**

     [excerpt p 74] "In the spring of 2018, MCS elevated the Major Procurements Office (MPO) to be part of the Results Management Section. This move shifts the Managed Care Organization (MCO) procurement process to a position that is closer to the State Medicaid Director, provides more visibility across all sections, and fosters cross-section collaboration."

   - **Continue the Texas Fraud Prevention Partnership**

3. **Validation of information utilized for oversight**: HHSC has established processes to validate and audit much of the data provided to them for oversight purposes.

Report findings: **Continue. Activities well-aligned to the managed care oversight function**

- **Continue the MCO Risk Assessment Instrument**

  [p 20] Report identifies opportunity to incorporate complaints and appeals into the Risk Assessment Instrument to better inform upcoming reviews and/or audits.

- **Continue to Enhance Validation of Encounter Data**

  [p 32] Report suggests that HHSC build a monitoring tool and enhance the process to monitor encounter data and other data sources on a routine, regular basis to identify potential data outliers and issues.

- **Continue Use of the External Quality Review Organization (EQRO)**
- **Continue to Enhance the Texas Healthcare Learning Collaborative (THLC) Portal**
- **Continue Efforts to Automate Deliverable Submissions**

  [excerpt, p 20] "MCS is developing a portal to automate and integrate deliverable submissions from MCOs and communications with MCOs. The portal aims to alleviate the manual effort required in tracking and routing deliverables received from MCOs and to serve as the central document repository for MCO deliverables. Launching in April 2019, this portal will enable resources to be more focused on analysis and resolution of issues related to MCO performance. MCS plans to complete the review of deliverables prior to the portal launch."

4. **Provision of guidance**: HHSC has developed written guidance for Managed Care Organizations (MCOs) for many of the elements of the various Medicaid programs.

   Report findings: **Continue. Activities well-aligned to the managed care oversight function**

   - **Continue Ongoing Effort to Streamline MCO Deliverables**

     [excerpt, pp 19-20] "Due to the large volume and frequency of deliverables received from MCOs, it can be difficult to adequately review and utilize each deliverable for program improvement and compliance purposes. Prioritizing and possibly reducing the number of separately required deliverables could enable MCS to focus on in-depth reviews, target resources to address root causes, and study trends across MCOs. MCS is reviewing deliverables from MCOs as required by Rider 26 of the 2016-2017 General Appropriations Act, Regular Session, 2015, to determine if a flat-file format would better facilitate the deliverable submission process."

   - **Continue the Newly Redesigned Pay-for-Quality (P4Q) Program**
   - **Continue to Improve Guidance on Utilization Management and Medical Necessity Determinations**
   - **Continue the Consumer (Member) Information Toolkit**
   - **Continue to Provide Financial Reporting Transparency**

Opportunities for HHSC to Consider

Opportunities include new activities that HHSC may wish to implement to improve the oversight function **(Figure 3)**. These opportunities fall into five broad categories:

1. **Increase efficiency and automation of processes:** There are number of opportunities to take existing processes and make them less time and/or labor-consuming.

   Report findings: **Opportunity. Findings to enhance the managed care oversight function**

   - **Opportunity to Introduce a Summary Compliance Framework**

     [excerpt, p 23] "The length and complexity of the contracts make it challenging for MCOs to ensure they are compliant with every requirement. A summary compliance framework to guide MCOs in their efforts to

comply with the contract requirements could be a useful supporting tool. HHSC has an opportunity to update and build out Section 5.0 of the Uniform Managed Care Manual (UMCM), called the Consolidated Deliverable Matrix, into a comprehensive compliance matrix that maps policies and contract requirements to deliverables to aid MCOs and MCS in ensuring that MCOs are meeting contract policies. The framework would not relieve the MCOs of their duties required in the contract terms and conditions; however, it could serve as a useful tool to manage compliance and communicate contract policies and requirements."

- **Opportunity for Process Automation**
- **Opportunity to Align Entry Points for Grievances**
- **Opportunity to Streamline Planning and Development Procurement Phase**

  [excerpt, p 74] "The MCS procurement pre-solicitation phase lasts for approximately 15 months and accounts for about 40 percent of the entire procurement cycle. In the survey results for the comparative group, the pre-solicitation stage ranged from seven months to 18 months. While pre-solicitation activities are important, an opportunity exists for HHSC to shorten the planning timeline since a long planning phase can lead to rework and more changes downstream."

- **Opportunity to Improve the Manual Contracting Process**
- **Opportunity to Improve Contract Amendment Guidance**

2. **Share information across organizational units:** HHSC has opportunities to enhance sharing of information gathered for one oversight function to another oversight function to strengthen oversight efforts using information that already exists.

   Report findings: **Opportunity. Findings to enhance the managed care oversight function**

   - **Opportunity to Align Network Adequacy and Access to Care Efforts**
   - **Opportunity to Introduce Additional Factors into the Default Enrollment Methodology**

     [excerpt p 80] "According to the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, states may consider additional criteria to conduct the default/passive enrollment process when an individual does not self-select a MCO, including: the previous plan assignment of the member; quality assurance and improvement performance; procurement evaluation elements; accessibility of provider offices for people with disabilities (when appropriate); other reasonable criteria that support the objectives of the managed care program."

3. **Improve data integration:** Merging existing data sources or pulling in additional data sources could offer HHSC more insights on addressing certain oversight functions.

   Report findings: **Opportunity. Findings to enhance the managed care oversight function**

   - **Opportunity for Network Adequacy Standards for Long Term Services and Supports (LTSS) provider types**
   - **Opportunity to Introduce Additional Factors in Network Adequacy Analysis**

     [excerpt p 47] "The current network adequacy assessment process results in a binary "pass/fail" assessment by provider type, county, and MCO. Currently, the report provides the total number of providers contracted with any MCO in each county. Other reports are available to MCOs upon request with details on those providers, with which MCO(s) they are contracted, or how MCOs could contact the providers. By enhancing the reporting going back to the MCOs with additional details on providers who are available but not in the MCO's network, MCS can more directly help MCOs identify potential providers to add to their networks and in turn improve compliance with network adequacy standards. There are additional opportunities to enhance monitoring of network adequacy and take corrective action by reviewing complaints from members and providers, patterns of out-of-network provider utilization, and

single case agreements between MCOs and non-contracted providers. HHSC could also strengthen their monitoring of the MCO's provider directories, for example, by validating provider directories with HHSC's listing of all certified providers."

- **Opportunity to Leverage Performance Metrics to Make Data-Driven Decisions**

4. **Improve the effectiveness of priority functions:** HHSC has opportunities to strengthen some key oversight efforts.

   Report findings: **Opportunity. Findings to enhance the managed care oversight function**

   - **Opportunity to Increase Utilization Review Resources**
   - **Opportunity to Update the Methodology for Measuring Program Integrity**

     [p 54] The report suggests that the methodology for measuring program integrity efforts was developed for a FFS environment, and notes that OIG is exploring different options to update the methodology going forward.

   - **Opportunity to Enhance Education on the Issue Resolution Process**
   - **Opportunity to Validate New Member Onboarding**
   - **Opportunity to Enhance Data Validation with Financial Subject Matter Expertise**

5. **Increase transparency of relevant information:** While HHSC makes a significant amount of information available to the public, there are additional opportunities to provide more information to policy makers and consumers.

   Report findings: **Opportunity. Findings to enhance the managed care oversight function**

   - **Opportunity to Enhance the HHSC website**
   - **Opportunity to Enhance Managed Care Report Cards**

     [p 79] The report identifies an opportunity to incorporate complaint information into Managed Care Report Cards.

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Date: 9/24/2020
To: House Appropriations Committee Appropriations@house.texas.gov
From: Don Langer, CEO UnitedHealthcare Community Plan of Texas
don_langer@uhc.com
Re: Response to RFI HAC request

Chairman Capriglione,

UnitedHealthcare greatly values our partnership with the State and treats our responsibility to the Medicaid and Children's Health Insurance Program (CHIP) members we are entrusted to serve with the utmost importance. Over the last several months we have been working to identify any suggestions we could offer to strengthen HHSC's procurement and contracting process based on our experiences both in Texas and in other state Medicaid programs.

Thank you for the opportunity to comment on your RFI related to the implementation of procurement and contracting reforms at state agencies under Interim Charge 1. We are encouraged by the recent Medicaid Managed Care Procurements Assessment conducted by Mercer for HHSC. After reviewing the current process, and studying the December 2019 Mercer report, we developed the following recommendations that we respectfully submit for your consideration as you prepare recommendations to improve upon both the Texas Health and Human Services procurement process for Medicaid and CHIP contracts and the states's procurement and contracting processes in general.

1. Metrics that are going to be used to score and award contracts should be transparent and clearly outlined in Requests for Proposals (RFPs).

In order to accurately respond to RFPs, respondents must be aware of all metrics that will be used to score responses. For example, if market share caps are going to be included in the evaluation criteria, that should be clarified in the RFP, as that information could impact which service areas and/or programs a plan chooses to bid. We also agree with Mercer's observation that clearer instructions on how information will be scored will increase the quality and uniformity of responses.

Recommendation:

Ensure metrics and scoring criteria are clearly outlined in the RFP, which is precisely aligned with Mercer's recommendation to "[f]urther clarify any factors awards will be based on in the RFP document." We believe this will not only assist plans in providing thorough responses, but will also provide more uniform guidelines to evaluators. We also support including the following Mercer recommendation:

Provide instructions to the vendors on the type and quality of proposals the State expects. For example, in order to receive a high score for a proposal, each answer must include information about what the vendor will do, how they will do it, and how they will hold themselves accountable. This will reduce proposals that simply restate SOW language. This approach must be supported by giving evaluation teams the same guidance when scoring a proposal.

2. Address outlier scoring by requiring evaluators to justify their scoring and eliminate scoring that does not have a reasonable basis.

The need to address outlier scoring was a recurring theme in Mercer's report, and it was clear from the assessment that multiple factors built into the current RFP process can contribute to sizeable disparities in evaluators' scores. When evaluators are clear outliers in scoring, or render scoring that is arbitrary and against reasonable standards of evaluation, HHSC must be both equipped and empowered to address such scoring before awards are made.

Recommendation:

Multiple recommendations in Mercer's report would help to address outlier scoring, both in terms of strengthening front-end processes to reduce the opportunities for significant outliers, and in how best to address such scores. We support these recommendations, which include reducing the number of participants on the evaluation teams; increased training for evaluators; implementing uniform standards as to how and when evaluations are completed (i.e. reducing the evaluation timeline); reducing the number of possible scores (i.e. 1-5 scale rather than 1-10); clarifying questions and criteria; and moving to an overall consensus, or team, score.

3. Ensure no plan is given an unfair advantage or disadvantage through the reporting and scoring of past performance.

It appears that previous RFP scoring advantaged MCOs with either small amounts of business in Texas Medicaid, or no Texas business at all.

Because Texas' managed care business is complex, and covers many populations, current MCOs have their performance vetted over a number of years. MCOs that have not operated in Texas, or those that only possess small Texas Medicaid operations, have not been subject to the intensive, day-to-day review of their operations.

Incumbent MCOs, on the other hand, have been subject to intensive review over may years.

Advantaging MCOs that have not had their operations scrutinized and reviewed by HHSCs process over many years, may yield the result of awarding MCOs with limited capabilities and experience prevailing, when a proven, experienced MCO would execute the business more effectively. Mercer recognized this risk in its assessment of HHSC's current procurement and contracting process and recommended that the State develop questions regarding past performance, in both Texas and other states, that level the playing field for all RFP respondents.

Recommendation:

Do not score evaluation questions regarding past state performance on a binary scale (i.e. zero score for no past fine or 10 for any past fines), as doing so automatically favors respondents that have no past performance history without ensuring the State is awarding contracts based on best value criterion. We agree with Mercer's recommendations to better level this playing field by looking at past performance in the context of what was involved in any former compliance issues. We recommend that HHSC require responding MCOs to provide a listing of any relevant performance issues over the past 12 months along with information on how such issues were addressed, and whether the MCO's actions satisfactorily resolved the issues. Evaluators can then use this more thorough review to develop an overall score of past performance that more accurately aligns with best value criteria.

Conversely, rather than only looking at past negative performance, the State should consider also looking at past positive performance (i.e. quality metrics, member satisfaction, timeliness and accuracy of reports) in helping to determine overall best value factors.

The key purpose of this recommendation is to ask that HHSC give serious consideration as to how the weight of one question could influence the outcome of an entire contract award. We believe that Medicaid

members and the State will be best served if each MCO is evaluated on the totality of its performance and merits, using a more complete picture to help determine the overall impact on procurement awards.

4. Ensure RFP reporting requirements of contractual violations reflect the true performance of MCOs.

HHSC has rightfully implemented a variety of remedies for violations of contractual requirements. These remedies range from small fines for minor programmatic infractions to significant assessments for serious violations resulting in member harm or failure to execute major program requirements.

Reporting of fines, corrective action plans and liquidated damages should truly identify MCOs that operate in a manner that meets major program goals and requirements, and also identify MCOs with deficient practices that resulted in truly negative outcomes for the program. The RFP should encourage full reporting of all violations, but also allow for evaluators' utilization of reasonable judgment in scoring.

Recommendation:

Remove damages and fines from scoring criteria and instead allow evaluators to take such actions into account in assessing overall past performance to determine best value for the State. Looking at past administrative fines or damages in a more wholistic manner, rather than a binary score, will allow evaluators to better assess a plan's overall past performance. This change also supports the Mercer report's recommendations to further "modify how past performance is used in evaluation and awards," and to more clearly define best value criteria.

5. Include community and provider feedback in determining best overall value.

Consumers and medical service providers have actual experience with the day-to-day operations of MCOs. Their experiences go beyond many of the empirical measures used to judge performance, such as how timely are claims paid.

For example, one MCO may deem a claim "incomplete" for a variety of administrative technicalities, and not pay the claim for many days, even months after the service was provided. The MCO may then require the provider to "jump through hoops" in order to have a valid claim paid. Even after these delays and administrative hassles, the claim would be determined to have been paid "on time" by the current standards because it was not submitted "correctly" according to the individual MCO's rules.

Alternatively, another MCO may work with providers to ensure administrative requirements are met, or even assist in correct submission of the claim in "real time," assuring that the claim is paid quickly after the service is rendered.

Without input from consumers and providers, evaluators of responses may not have an accurate representation of MCO performance from only empirical measures, which can be manipulated by processes.

Recommendation:

Develop a process to collect and consider feedback from providers and community stakeholders regarding their experiences with RFP respondents. Because this information could advantage or disadvantage incumbent plans, depending on feedback provided, this input should not be given a numerical score, but rather taken into consideration in determining a plan's best overall value to the State. Such information from providers and stakeholders could be provided in the form of letters of reference for respondents and/or in completing independent reference checks on responding plans.

6. Ensure that mandatory contracting status for Hospital-Based Plans requires that all eligible plans meet minimum regulatory and operational criteria.

In 1997, the Texas Legislature established mandatory Medicaid managed care contracting requirements for certain hospital-based health plans. Texas Government Code § 533.004(a) requires HHSC to contract with health plans owned and operated by hospital districts, and nonprofit health plans that contract with hospital districts or municipalities for indigent care services. Under § 533.004(b), these hospital-based plans are still subject to all contractual, regulatory, and statutory requirements. HHSC

has historically interpreted this to mean that a proposal from hospital-based health plan must demonstrate the organization has ability to meet all contract requirements by satisfying the best value criteria. In recent managed care procurements, hospital-based plans with low-scoring or deficient proposals have argued against this interpretation in bid protests and lawsuits with varying degrees of success.

Texas Medicaid programs have evolved over time, increasingly serving more complex populations. When the Texas Legislature enacted the mandatory contracting requirement in 1997, the agency was still in the early stage of STAR program implementation. The STAR program focuses on preventative and acute care services for children and pregnant women, a relatively low-risk population. As of 2020, HHSC operates four managed care models focused on high-risk populations with specialized needs – STAR+PLUS, STAR Health, STAR Kids, and the Medicare/Medicaid demonstration program. As managed care populations and services have become more and more complex, so have managed care contract requirements. HHSC must carefully vet health plans to ensure they have expertise and resources needed to serve vulnerable populations.

Recommendation:

RFPs and evaluation and scoring criteria should clarify that, in order for the mandatory contracting status to apply to a Hospital-Based Plan, the plan must first demonstrate that it meets all minimum regulatory and operational criteria necessary to successfully execute the contract. Changes may be needed to the current statute to ensure clarity regarding this recommendation.

7. Examine the most efficient alignment of Medicaid managed care service areas.

As noted in the aforementioned issue on the evolution of mandatory contract awards, the Medicaid managed care program has matured significantly over the years. When the Texas Medicaid program began to transition to statewide managed care, community-based plans operated on a very regional basis. Due to the limited number of plan offerings in various areas of the State, it made sense at the time to remain divided into 13 service areas and award contracts accordingly.

Today, however, more plans are operating in various service areas and even many community-based plans have expanded beyond their initial geographic regions. With the upcoming Medicaid/ CHIP reprocurements, coupled with the Mercer recommendation to determine a minimum and maximum number of plans per service area prior to RFP release, we believe this is an ideal time to look at the current service area make-up and whether any realignments should be made.

Recommendation:

The State should study enrollee referral and utilization patters, in addition to caseload and the optimal number of MCOs for each service area, to determine if any areas should be realigned and/or combined. Based on our analysis of this information, we believe that the current 13 service areas could be realigned to seven relatively easily and with minimal disruption. This reduction in service areas will benefit not only the MCOs responsible for facilitating member care across the state, but also provide greater efficiencies to HHSC operations. A smaller number of SAs to manage will result in simplified administrative processes for both the MCOs and HHSC, as plans and HHSC are able to consolidate operations within larger geographic regions. This should also create opportunities for HHSC to reduce the administrative burden associated with managing 13 SAs and the multiple health plan operations within each area.

8. Experiences and lessons learned from procurement processes in other states.

UnitedHealthcare has had the benefit of working with other state Medicaid programs and participating in their procurement and contracting processes. We would like to offer the following recommendations for HHSC's consideration of what has, and has not, worked well based on our experiences. Other states such as Arizona, Kansas and Indiana use some of these processes and several mirror the Mercer report:

Recommendations:

- Utilize a transparent process that informs the procurement's timing and expectations on the front

end. This should include what is included in the RFP and key dates throughout the entire process, with the goal of having as few surprises as possible before, during, and after the procurement. One state lays out and communicates its approach to procurements years in advance, updating stakeholders of major decisions on populations, benefits and other changes. Companies spend a great deal of both time and monetary resources on each RFP (upwards of $100,000 per response) and must align resources as RFPs are released in each state. Visible procurement processes provide respondents with a greater degree of predictability which, in turn, allows plans to better allocate resources and provide more thorough and high-quality RFP responses.

- Maintain the greatest possible degree of transparency as to how the state will evaluate and score the RFP both prior to submission and upon award. A clear explanation on scoring and evaluation is key to a successful contract award.

- Clearly state the submission requirements and eliminate any superfluous information that is not truly needed to make a contract award. The content of the RFP should be concise and focus on the population and the experience of the respondent. This level of transparency and clarity helps respondents to provide more succinct and thorough responses:
    - Describe which attachments are needed and why, so that respondents may ensure attachments are responsive for the intended purposes;
    - Specify what should be included in attachments;
    - Describe any pre-RFP requirements concerning network and other administrative requirements;
    - Explain any financial submissions and what is needed for review of the RFP.

- Remain responsive to vendor questions during the RFP process by responding to questions that arise within a short timeframe or even publicly posting answers that apply to all respondents. Good communication is key to a clean RFP response.

- Provide enough flexibility that, in the event of an unclear response, evaluators may choose to follow up with the respondent for clarification rather than simply penalize the response.

- Describe any oral presentations that are specific in their request, including how they will be evaluated and scored.

- Focus the RFP and oral presentations on specific scenarios that show the knowledge and readiness of the MCO.

- Do not use a competitive cost proposal as a means for evaluating a health plan to determine procurement outcomes. This can lead to a perverse incentive for plans to “underbid” their rates, which can result in rates that do not meet CMS actuarial soundness requirements and/or in a rate structure that cannot ultimately support the Medicaid program.

Thank you for taking the time to consider these recommendations and for your commitment to strengthening the integrity of the Medicaid/CHIP procurement process. We stand ready to support HHSC in any way we can to help further improve Texas’ Medicaid program. Please do not hesitate to contact me if I, or anyone on my team, can be of assistance.

Sincerely,

Don Langer
CEO
UnitedHealthcare Community Plan of Texas