Center *for* Public Policy Priorities

TESTIMONY

February 28, 2005

Senate Bill 47 by Nelson:
Medicaid Biometric Finger Imaging Fraud Reduction Pilot Program

The Center for Public Policy Priorities appreciates this opportunity to comment on SB 47 by Chairman Nelson.

CPPP has approached the biometric imaging with a goal of promoting and protecting ease of access to health care for Medicaid clients. We also support ease of use by Medicaid health care providers, because access to care requires that we not to create disincentives for provider participation in Medicaid. CPPP strongly supported the inclusion of provisions in HB 2292 which allowed for the exemptions children, the aged, or the disabled, as well as the commitment to ensuing that enrollment (i.e., the collection of the initial finger image) be designed in a way that accommodates the transportation barriers and work schedules of Medicaid enrollees.

On behalf of CPPP, I have served since January 2004 as the sole client advocate representative on the Medicaid Integrity project's (MIP) Steering Committee, along with representatives from TMA, THA, and the Texas Dental Association. Through the Steering Committee, we have followed closely the progress of the pilots, and shared our concerns with all involved. We have also communicated with the Committee staff assigned to this bill about our hopes and concerns going forward.

We are testifying today "on", rather than for or against the bill. We very much appreciate Senator Nelson's additions to the bill as filed that have been laid out in this committee substitute, as they address some key concerns about the MIP project.

We would like to share with the Committee members some of our concerns about the work that remains to be done if this technology is to be extended for statewide use. We very much hope to work with Committee staff to propose additional perfecting amendments which we believe would strengthen the bill, by further ensuring that HHSC policies would minimize any disruption in access to care.

Based on our Steering Committee participation and the findings of the MIP Independent Evaluator, we think the expansion of this technology calls for 3 key elements:

1. A slow phase-in beginning with limited service areas, so that important policies which were not yet tested in the pilots can be developed and tested in a methodical, thoughtful and cautious manner;
2. A strong consumer and provider input process in the development of these policies for the next phase of the project; and
3. Clear oversight by and accountability to the Legislature for major policy decisions, with reporting required before major policies are implemented.

The report of the MIP's Independent Evaluator explains the limits of what the pilot has tested to date, and makes strong recommendations for how any expansion should proceed.

Pilot Limits (See pp. 2-3, report of the Independent Evaluator.)

- The pilot thus far has basically tested the rudiments of distributing cards to selected adults, the installation of equipment with selected providers, and the "enrollment" and subsequent use of biometric imaging when the selected clients visited a participating provider. ***There were no consequences for forgetting a card, losing a card, or failure to get a proper biometric match.***

- The pilots have not tested how the system would work in a setting in which clients and providers were mandated to participate. It has not developed or tested any protocols for what would occur in such a setting when a client failed to bring a card (due to loss, theft, or simply forgetting it).
- The pilots have not explored in any depth how special populations would be treated in a mandatory Biometric imaging mode, including whether they should be exempt from imaging. These groups include:
    - the elderly SSI and Medicare-related population;
    - the adult disabled SSI and waiver population;
    - persons with mental retardation;
    - persons with serious mental illness.
- The pilots also have not developed policy to resolve the challenges that will be involved if children, who make up more than 2/3 of Texas Medicaid, are to be involved in the Biometric imaging population. Of the 1.8 million children on Texas Medicaid in January, only a little over 165,000 (9%) were on TANF; thus about 1.6 million – the overwhelming majority – have parents who are not themselves enrolled in Medicaid. Decision points would include:
    - Whether to exempt children entirely;
    - Whether to image children themselves, or instead image their adult caretakers. If caretakers are imaged, families will need to be able to have multiple caretakers on the card, to enable more than one adult to take the child to the doctor.

Pilot Expansion Risks, Challenges, and Recommendations: (See pp. 8-12, report of the Independent Evaluator.)

- As noted above, the difficult policy development tasks involving what happens when a match is not reflected by the equipment, or when a card is lost or missing have not yet been tackled.

  "A balance between enforcement and facilitation is necessary in order to avoid alienating providers and clients while maintaining fraud prevention capabilities.….Biometric exceptions (non-match) can occur through absolutely no fault of the client or provider….Therefore the absence of a biometric match should never be used as the sole basis on which services are denied or claims not paid." (pp. 10-11)
- The pilots have only achieved 90% matching rates, and the Independent Evaluator states that rates for and expansion will need to "exceed 99%, with a low false accept rate." (p. 10)
- **Provider-based "enrollment" is a problem, because the minimally-trained staff don't get as good an initial image collected** (p.. 7). But, if HHSC proceeds as proposed to eliminate a high percentage of local offices, enrollment at the eligibility site will not be a good alternative. Moreover, the majority (about 80%) of the 1.8 million children on Medicaid are not subject to a face-to-face visit at either enrollment or renewal, and it would be expensive, cumbersome, and inconvenient to require a special visit to an office (that now may be a county away) to collect the initial image. Many aged or disabled clients are also exempt from face-to-face visits.
- "**Expansion requires systematic and comprehensive provider and client outreach.**" (p. 7.) The short time span for these pilots required minimal outreach before implementation. "A several-month process of outreach, consensus building, and education may have been sufficient to drive awareness and improve transaction volumes."
- **The massive scope of Medicaid would require a roll-out over an extended time** (p. 10.) enrollment would require :"a several month period or longer"…and hardware and software "would similarly be deployed in a phased fashion over an elongated time period…(resulting in a)…lengthy transition from its current state to a MIP-enabled state…it is not until a steady state is reached that the anticipated benefits of a MIP system will be most evident."

- **Recommended approach: "Limited and Conditional expansion of pilot with addition of critical functional elements."** The next phase would include "enhancing Medicaid-specific functionality within one or more circumscribed areas…to provide "an opportunity to address areas such as outlier populations, mandatory usage policies, and client and provider outreach."

Summation. Based on these findings, CPPP would like to work with the Committee staff to identify refining language which would further clarify:

- that the approach to initial enrollment would not create new administrative hurdles for Medicaid clients, and
- that policy development in the areas of exempting categories of clients and procedures for access to care in the case of a non-match or missing card will be carefully developed, tested, and resolved in small localized test prior to attempting statewide expansion of MIP. **We would suggest that HHSC be directed to report at two points to the Legislature on their rationale for exempting (or not) the aged, disabled and children, as well as their policy and procedures for dealing with missing cards and "non-match" situations: once prior to testing those policies in that pilot area or areas, and again after testing and before expanding those policies beyond the test pilot counties.**

We of course support a strong cost analysis to ensure that the MIP and IBC approaches adopted are truly cost effective, in additional to being feasible for both clients and providers.

(Read the Independent Evaluator's report at http://www.hhsc.state.tx.us/OIE/MIP/020105_MIP_EvalRpt.pdf)

Text from original enacting legislation related to Client and Provider Protections:

Government Code

Sec. 531.1063 (d) In implementing the program, **the commission may:**

(1) exempt recipients who are children or who are elderly or disabled; and

(2) obtain a fingerprint image from a parent or caretaker of a recipient who is a child, regardless of whether the parent or caretaker is a recipient.

(e) The commission must ensure that the procedures for obtaining fingerprint images of participating recipients and parents and caretakers who are not recipients are designed in a flexible manner that gives consideration to transportation barriers and work schedules of those individuals.

(f) To ensure reliability, the program and all associated hardware and software must easily integrate into participant settings and must be initially tested in a physician environment in this state and determined to be successful in authenticating recipients, providers, and provider staff members before the program is implemented throughout the program area.

Who is on Texas Medicaid

As of January 2005, 2.7 million Texans were enrolled in Medicaid:

- 1.8 million were children
  - about 78,000 of these children, or 4%, were receiving disability-related Medicaid (97% of these on SSI),
  - about 13,700 were pregnant teens;
  - 165,300 in TANF families (6.2% of total caseload)
- 862,500 were adults:

- 667,600 (77% of the adults) were elderly or disabled: (353,910 elderly, and 313,651 disabled or blind).
    - Adults on SSI account for 60% of the aged and disabled recipients (76% of blind/disabled are on SSI).
    - 316,677 of the aged and disabled were full Medicaid-Medicare dual eligibles (47% of the aged and disabled).
- Other adults: 87,700 maternity coverage; 45,100 TANF parents (1.7% of total caseload); 61,000 either TMA (Transitional Medicaid Assistance) or parents who are at or below TANF income, but not receiving TANF cash assistance

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