Center *for* Public Policy Priorities

TESTIMONY

December 20, 2004

Testimony to the Transition Legislative Oversight Committee on the Draft Report on Health and Human Services Reorganization

The Center for Public Policy Priorities offers the following comments to the Transition Legislative Oversight Committee on its draft report to the 79th Legislature.

General

Public Input

The changes mandated by this consolidation have affected and will continue to affect millions of Texans and billions of taxpayer dollars. Involving all stakeholders and advocates, keeping the entire process transparent, and building consistent, open, two-way communications are more important than any other aspects of the reorganization and critical to the long-term success of this endeavor. In general, the Health and Human Services Commission has provided adequate opportunity to stakeholders to comment on the reorganization. We commend HHSC for holding extensive public hearings, the E-update, and giving the public the ability to comment via its web site. In the case of the agency structures and the role of the new agency councils, in particular, HHSC did a great job incorporating the advice from stakeholders in its planning process.

At times, however, communication with the commission has been one-sided. A good example are the public hearing held on the integrated eligibility initiative. A total of 12 hearings occurred; at not one of them was an HHSC official with responsibility for the initiative available to response to questions. This kind of one-way communications gives stakeholders the impression that their concerns are disappearing into a black hole. The absence in this report of a summary of the thousands of comments received in conjunction with the consolidation is another example. We strongly urge the committee to revise its draft report to include a summary of public comment related to the reorganization and the integrated eligibility initiative.

We also urge HHSC to revamp its communications process to better enable the direct engagement, involvement, and counsel of the many stakeholders and advocates who have worked in and on these programs for years. A more interactive public involvement process is needed, particularly as the integrated eligibility initiative goes forward. We urge this committee to recommend that HHSC schedule regular, informal briefings or Q&A sessions. This process worked very well during the development of the TIERS project. Staff of the TIERS team held periodic meetings (roughly once a quarter) for an "Advocates Working Group" that the center helped to coordinate. The center was responsible for organizing a broad group of advocates and informing them of scheduled meetings and documents the TIERS team was asking us to review. At key points in the process members of the workgroup also worked directly with TIERS team members in developing RFPs, reviewing proposals, and responding to policy options.

Access to information

In general, it has become more difficult to get routine caseload and administrative data from HHSC. We hope this is more the result of the shuffling of personnel who used to answer these data requests than it is a

cultural or ideological shift away from keeping advocates and the public informed. We urge this committee to include a recommendation in this report directing HHSC to make readily available, at a minimum, the same kind and amount of data as before the reorganization.

Cost savings
When the Transition Plan was released last fall, it emphasized the importance of identifying and tracking cost savings and cost efficiencies as the reorganization and consolidation progresses. We believe that transparency in these key budget issues is critical to the public accountability and success of this endeavor. This committee has recommended that savings achieved through the consolidation be reinvested in services. To this end, we encourage HHSC is develop a process for tracking these savings and efficiencies that is regularly summarized for the public through the agency's website. It is also critical that HHSC indicate whether the savings achieved are actually available to be redirected into services. If this committee and the legislature are sincere in wanting specific savings related to the reorganization to be redirected to health and human services, than this kind of tracking is imperative.

Comments on the Committee's Recommendations

Provide more flexibility to HHSC's executive commissioner to transfer funds between health and human services agencies.

The legislature should take care in expanding this authority to ensure continued and adequate oversight over HHSC's budget decisions and maintain their transparency. No other state agency head has the authority to make significant budget decisions without the approval of the governor's office and the Legislative Budget Board. If the legislature does grant this additional flexibility, the executive commissioner should still be required to submit proposals for fund transfers to the LBB and the governor.

Expand the Medicaid finger imaging pilot statewide (based on an assessment of the pilot) and explore the feasibility of a 'Universal Benefits Card' that could be used to establish client identity (via finger imaging or other use of biometrics), verify eligibility, and deliver benefits to clients in all major benefits programs.

CPPP has been a member of HHSC's Medicaid Integrity Project (MIP) Steering Committee for over one year. We recognize that smart card technology has the potential to benefit providers, clients, and taxpayers alike. HHSC will present its report on MIP pilot findings to the legislature in February. This report will detail the viability of the technology and the experiences of providers and clients in this first phase of study. It will also explain the numerous additional steps in developing policy and resolving remaining technological and logistical issues that need to be taken before statewide implementation. A careful and methodical approach will be needed to ensure that smart card technology is launched in a way that:

- truly reduces fraud;
- provides useable data that can be analyzed;
- provides advantages to, and does not create barriers for elders, persons with mental illness, persons with mental retardation, persons with physical disabilities, or children;
- provides a benefit to, and does not inconvenience, Medicaid providers or other vendors; and
- is designed in a way that can be fully integrated with other smart card functions which may be added later.

If done well, this initiative could be a model; if done poorly, it could become a cautionary tale encouraging states to avoid these new technologies.

Reinstate the School Health Advisory Committee and the Indigent Health Care Advisory Council.

We support this recommendation. HB 2292 arbitrarily abolished all non-federally mandated advisory committees. We urge the committee to consider amending its recommendation to direct the legislature to consider reinstating other advisory committees as well.

Maintain the more restrictive six-month coverage period HB 2292 imposed for CHIP.

The decision about 6- or 12-month coverage must be considered as part of the entire package of CHIP restorations. Years of research and Texas CHIP's actual experience in FY 2004 and 2005 show that more frequent renewal periods depress enrollment; CHIP caseloads are now 33% lower than in September 2003.

However, families are renewing CHIP coverage at the same rate as always, and the same percentage of children is terminated each month for failure to renew as always. The only change is that now families must renew their children's coverage twice a year instead of once. Doubling the number of children required to renew every month also doubled the number terminated for failure to renew. HHSC recommended and the legislature adopted the more frequent renewal policy to achieve this very result. The impact of simultaneously cutting key benefits (with substantial out-of-pocket costs) and increasing premiums and co-payments may have exacerbated the decline in enrollment.

On the other hand, children's Medicaid enrollment, with a 6-month coverage period, continues to grow thanks to a less burdensome enrollment and renewal process coupled with 6-month coverage. The legislature's final decision regarding CHIP and Medicaid coverage periods must be made as part of a larger decision on all of the potential restorations and policy changes that may be adopted.

Maintain the new CHIP asset test allowed by HB 2292.

This recommendation seems premature given that HHSC implemented the limit the last week of August 2004, and has only released 10 weeks of program data on the new CHIP asset test. Texas is one of only 6 states imposing an assets test on EITHER child Medicaid or CHIP (the other states are CO, OR, UT, MT, ID). CMS has encouraged states to drop these tests because they tend to simply create paperwork barriers. CPPP recommends Texas eliminate the CHIP asset test entirely. At the very least, the Legislature and HHSC should re-vamp the policy so that it makes sense for the population it's being applied to (above 150-200% FPL). The current limit was designed for the Food Stamp program (a much poorer population, mostly below poverty) AND is actually stricter on vehicles than children's Medicaid! It is important not to penalize low-income working families for savings for home ownership, higher education, or retirement. The ability to invest helps build the middle class and prevents families from relying on government in other ways.

Restore vision and dental benefits to the CHIP benefit package, which were removed by HB 2292, but charge extra premiums for the benefits.

CPPP agrees that restoring these important CHIP benefits should be a high priority. Families have had difficulty reconciling premium increases being imposed at the same time as benefit cuts, particularly when those benefits include critical well-child dental care and out-of-pocket vision care costs. The recommendation does not fully explain what is being proposed in the way of "an added coverage basis with a sliding scale." We refer the committee to, and we endorse, the Texas CHIP Coalition's Principles for the 79th Legislature, which state that:

"reasonable premiums and co-payments must be commensurate with families' ability to pay. CHIP cost sharing requirements (should be revised) to ensure that they are appropriate to families' income levels, and to include convenient options for families who do not have bank accounts."

Increase CHIP co-payments further (beyond the increases already imposed under HB 2292), and replace monthly premiums with an enrollment fee (presumably paid every 6 months).

CPPP does not support co-payment increases in the near future for CHIP. The program has undergone so many policy changes over the last 16 months, at the same time that state outreach, education and marketing to families nearly disappeared. Benefit restorations and re-thinking of the asset test policy as well as premium costs, timing, and payment option policies should be implemented, outreach done, and program enrollment stabilized before additional new cost increases are implemented. Cost sharing increases should be studied in advance, rather than implementing in haste and studying the impact later.

Proceed with the plan to use privatized call centers for eligibility determination and enrollment in Medicaid, CHIP, TANF cash assistance, and Food Stamps.

A lot of good work has been done to explore the use of call centers as an alternative to local eligibility offices and HHSC has presented a compelling model for change. However, many critical details related to how the proposed will function—and whether it will meet the needs of ALL clients—needs to be worked out before a contract is awarded. The ultimate success of the model depends entirely on the accuracy of several assumptions that have not been tested, including

- the ability of the 211 network to handle the increased call volume,
- the capacity of community-based organizations and their volunteers to assist clients, the potential of clients to access a computer and apply for benefits online,
- the ability of the system to serve "hard-to-serve" clients or screen clients for disability or domestic violence issues;
- the availability and reliability of certain technology (including TIERS, which has not yet proven itself a viable tool for determining eligibility in the current environment and must be tested prior to adding new features to the system).

The most important assumption—how many staff will be needed—is also the most flawed, in that it ignores the staffing shortages that currently plague local eligibility offices. The business case offers no proof that the system will be able to function with so few staff, and offers no recommendations for policy simplifications that would support a more automated model.

The RFP is based on the assumptions in the business case. The ability of a private company to run the eligibility determination system more cost-effectively rests on the accuracy of these assumptions, which all support the aggressive assumption that the system will be able to functions with half as many staff. Awarding a huge, five-year contract before the business case has been tested could expose the state and taxpayers to significant cost and liability.

In addition to the devastating impact that an untested and poorly designed system could have on the 3 to 4 million clients who rely on these benefits, billions of dollars in federal funding for Texas are contingent on the lawful and effective administration of these programs. Finally, changes of this magnitude are difficult to undo once set in motion, and the decisions made today will affect these programs and the people who rely on them for years to come.

For these reasons, we urge the committee to revise its recommendation to the legislature to reflect a slower approach that involves adequate testing and evaluation of the new model before shutting down local offices or reducing staff significantly. We also urge the committee to consider recommending that the state auditor evaluate the business case before further implementation.

Reorganize the delivery of local services so that the local service delivery system is compatible with the new state health and human services system.

CPPP defers to the disability community and mental health advocates and stakeholders on this recommendation. However, we urge the committee to amend its recommendation to reflect the importance of consulting with the local entities and communities who will be affected by it.