From: Sunset Advisory Commission
To: Cecelia Hartley
Subject: FW: Form submission from: Public Input Form for Agencies Under Review (Public/After Publication)
Date: Friday, October 17, 2014 4:48:40 PM

-----Original Message-----
From: sundrupal@capitol.local [mailto:sundrupal@capitol.local]
Sent: Friday, October 17, 2014 4:48 PM
To: Sunset Advisory Commission
Subject: Form submission from: Public Input Form for Agencies Under Review (Public/After Publication)

Submitted on Friday, October 17, 2014 - 16:48

Agency: HEALTH AND HUMAN SERVICES COMMISSION HHSC

First Name: Susan

Last Name: Murphree

Title: Sr. Policy Specialist

Organization you are affiliated with: Disability Rights Texas

Email: smurphree@drtx.org

City: Austin

State: Texas

Your Comments About the Staff Report, Including Recommendations Supported or Opposed:

Texas Sunset Advisory Commission
Comments on Health and Human Services Commission On behalf of Disability Rights Texas October 17, 2014

Thank you for soliciting public input during the Sunset process for Health and Human Service Commission. These comments are on behalf of Disability Rights Texas (DRTx) and are being submitted by Susan Murphree, Sr. Policy Specialist.
Federal law authorizes Disability Rights Texas, to both advocate and protect the rights of persons with disabilities. That is, Disability Rights Texas is involved in ensuring that individuals in the community (a) receive the services and protections that will enable them to function as independently as they possibly can, and (b) are given the opportunity to move to a less restrictive community-based placement. (See www.disabilityrightstx.org)

Issue 1 – Consolidation of Health and Human Services Agencies While we support organizing the services based on the function of service to be provided, we are concerned with how well putting all services, with distinct divisions, in one mega agency would work. Concerns on further consolidation arise from worry about volume and depth of the programs and services and loss of knowledge, values and program principles through attrition and reorganization. The span of control seems too large to effectively manage and the scope of expertise needed for best-practice, value based programs too broad.

We think finding a way to separate the conflict of interest when the State both operates and regulates programs is important and timely.

Issue 2 – Centralization of Support Services We support defining and strengthening contracting procurement and monitoring, but do not think that requires all contracting activities to be embedded within HHSC.

Issue 3 – Fragmentation of Medicaid Administration HHSC is already the lead and designated Medicaid state agency. We believe the shared vision should include individuals receiving services in the most integrated setting and, if that is clearly communicated, then policies and fixes to problems can be aligned. We are concerned that the effort may become too health and safety focused in the managed care medical model, with attention to self-determination, quality of life in the community and community engagement diminished. A shared vision with skills and knowledge to identify and fix problems requires coordination, but not necessarily further consolidation.

Issue 5 – Provider Enrollment and Credentialing Texas needs to improve access to health care providers to meet the requirements of the Medicaid Act. What new strategies can be put in place to increase Medicaid providers, regardless of the service delivery system? This should be a priority focus.

Issue 9 – Sub-issue, Medicaid Eligibility We do not believe Texas is meeting its obligations to assist with the maintenance of Medicaid eligibility for those who go to work, but should still qualify, and others, and instead spends time and other resources for individuals who could and should have continuous eligibility – particularly those in home community-based services. This is a fix that is overdue, not just for individuals who seek behavior health services. We recommend looking at how other states address this problem through policies or technology. We understand that Tennessee may have a grace period that is working for those who, either inappropriately or for a short period of time, "ping pong" in and out of eligibility.

Issue 13 – Advisory Committees
While there could be opportunity for removing duplication across advisory committees, we support determining which advisory committees should continue and maintaining a statutory obligation for those committees. The HHSC Commissioner should continue to be able to create additional committees and workgroups as needed; however, the Commissioner should not have full discretion without statutory direction regarding continuation and membership of key Advisory Committees. For example, the Children's Policy Council should be continued and the configuration of members that leverage family and self-advocate expertise to advise the Commissioner should be kept intact.
Furthermore, we do not support losing public representation on any Advisory Council for remaining agencies, divisions or on the HHSC Advisory Council.

Thank you for the opportunity to provide public input. For more information, please contact Susan Murphree at smurphree@drtx.org.

Any Alternative or New Recommendations on This Agency:
In addition: We seek supports for Medicaid Managed Care beneficiaries through an Independent Ombudsman not embedded in a managed care company or a state agency and that has expertise and authority to navigate and represent individuals upon their request in negotiations and, when all else fails, administrative hearings.

My Comment Will Be Made Public: I agree

Susan Murphree

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Texas Sunset Advisory Commission

Comments on Health and Human Services Commission

On behalf of Disability Rights Texas

November 13, 2014

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We think finding a way to separate the conflict of interest when the State both operates and regulates programs is important and timely.

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Texas needs to improve access to health care providers to meet the requirements of the Medicaid Act. What new strategies can be put in place to increase Medicaid providers, regardless of the service delivery system? This should be a priority focus.

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We do not believe Texas is meeting its obligations to assist with the maintenance of Medicaid eligibility for those who go to work, but should still qualify, and others, and instead spends time and other resources for individuals who could and should have continuous eligibility – particularly those in home community-based services. This is a fix that is overdue, not just for individuals who seek behavior health services. We recommend looking at how other states address this problem through policies or technology. We understand that Tennessee may have a grace period that is working for those who, either inappropriately or for a short period of time, "ping pong" in and out of eligibility.

One of the biggest concerns SSI beneficiaries have about going to work is the possibility of losing Medicaid coverage. Section 1619(b) of the Social Security Act provides some protection for these beneficiaries. To qualify for continuing Medicaid coverage, a person must:

- Have been eligible for an SSI cash payment for at least 1 month;
- Still meet the disability requirement; and
- Still meet all other non-disability SSI requirements; and
- Need Medicaid benefits to continue to work; and
- Have gross earnings that are insufficient to replace SSI, Medicaid and publicly funded attendant care services.

This means that SSI beneficiaries who have earnings too high for a SSI cash payment may be eligible for Medicaid if they meet the above requirements. SSA uses a threshold amount to measure whether a person's earnings are high enough to replace his/her SSI and Medicaid benefits. This threshold is based on the:

- amount of earnings which would cause SSI cash payments to stop in the person's State; and
- average Medicaid expenses in that State.

If a SSI beneficiary has gross earnings higher than the threshold amount for his/her State, SSA can figure an individual threshold amount if that person has:

- Impairment-related work expenses; or
- Blind work expenses; or
- A plan to achieve self-support; or
- Personal attendant whose fees are publicly funded; or
- Medical expenses above the average State amount.

Under the provisions of Section 1619(b), the basis for the individual's eligibility for Medicaid changes from their status of actually receiving SSI payments to being "considered to be SSI recipients for purposes of Medicaid." In Section 1634 states, since the same standards and application process are used, for purposes of Medicaid eligibility, there is a seamless continuation of Medicaid eligibility for the individual without requiring additional steps (i.e., a new application and/or different rules). "Automatic" eligibility for Medicaid also applies to Section 1619(b) participants; "SSI recipients" who are no longer receiving any federal SSI cash benefits. Therefore, when an individual moves into Section 1619(b) status, in states with fully integrated SSI and Medicaid eligibility systems, **no review or additional steps regarding Medicaid eligibility are needed by those states.**

SSI Criteria States. A state also can provide "automatic" eligibility for Medicaid to individuals receiving federal SSI benefits but, in these states, the state requires a separate application for Medicaid. SSI criteria states must import data on SSI eligibility, which equates to Medicaid eligibility, from local and/or regional SSA office via the "state data exchange" or SDX file transfers. Compatibility and **translation of SDX files into state Management of Medicaid Information Systems (MMIS) is often a problem.** However, an additional barrier exists in the separate application process for Medicaid. Many states use a manual process for the Section 1619(b) group because of the small size. Eligibility workers, due to workloads, often overlook special procedures for this small but important cohort of workers with disabilities.

1619(b) Problems - Some SSI beneficiaries are having problems getting 1619(b) Medicaid after they are no longer receiving SSI cash benefits. Some of the problems are on the SSA side and some on the State Medicaid office side. Situations include: beneficiaries not being told about 1619(b), being told they would have to re-apply for state Medicaid and having a gap in coverage, not being told about other Medicaid options, and concerns about this in relation to receipt of Medicaid waivers for support. Last year we obtained information that the State Medicaid office is aware of problems with their computer system not coding 1619(b) eligibility correctly; however, they cannot address the computer problems because resources are being focused on other healthcare areas at this time. This continues to be problematic.

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