CENTER *for* PUBLIC POLICY PRIORITIES

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Testimony: CSSB 200, Senate Health & Human Services Committee

The Center for Public Policies (CPPP) appreciates the opportunity to comment on the Committee Substitute for SB 200 by Nelson. CPPP is an independent public policy organization established in 1985 that uses data and analysis to advocate for solutions that enable Texans of all backgrounds to reach their full potential. We believe in a Texas that offers everyone the chance to compete and succeed in life, and we dare Texas to be the best state for hard-working people and their families. Improving access to health care for Texans has been at the core of our mission and activities since our founding.

There are more important topics and issues related to CSSB 200 than can be covered in a 2-minute comment. In addtion to the highlights from this oral testimony, I am submitting other more detailed issues in the written version you have before you.

CPPP Key Concerns with HHSC Consolidation and CSSB 200

The October 2014 HHSC Sunset Report included some excellent research and correctly observed many areas where HHSC and the "HHS enterprise" has failed to coordinate and integrate policy. But, like many other older observers who have witnessed agency transitions–in my case back to the late 1980s—we caution that reorganization in general, or consolidation in particular, is not a panacea for poor coordination or performance. Instead, the expectations communicated and culture created by Executive Branch and Agency Leadership have in our observation consistently been the most powerful indicators of whether agencies consistently strive for excellence, coordination, and improved quality.

As other commenters have noted, The Department of Protective and Regulatory Services (FPS predecessor) was created precisely because the treatment of vulnerable children and seniors had been buried in the massive DHS enterprise. We also share concerns about the effect this meg-agency strucutre will have on attracting and retaining top notch executives. We are glad to see that the revised timeline allows more time for a thoughtful transition, but it still appears that the transition plan must be submitted by 12/1/2015 and it is difficult to understand how the demands of these transitions will not detract from critical work like oversight of Medicaid Managed Care for nursing home residents and dual eligibles, and renewal of the 1115 Transformation waiver.

CPPP is concerned about the lack of clarity thus far about how the newly-structured HHS enterprise will engage robust citizen and stakeholder input. The elimination of agency councils compounds the loss in 2003 of governing boards, which had been required to include statewide representation.

- (Section 1.01, Sec. 531.0204 (b) on p. 9, line 3. The series of public hearings before the Executive Commissioner finalizes a Transition Plan should be fleshed out to ensure it is meaningful This will require providing the public with a draft plan to respond to, and the formal collection of public comments. Along with responses, those public comments and concerns should be published and submitted to the TLOC for their consideration as they consider the Executive Commissioner's draft plan.
- How will HHS ensure ongoing regional representation? In Section 1.03 p. 16, the Executive Council does not specify inclusion of any members other than Division chiefs.

- Changes to make advisory committees public in section 3.02 are all very positive, yet it remains unclear under sections 3.50 and 3.51 whether, how, and when the Executive Commissioner will reestablish these advisory functions. In their absence, there appears to be no process for detailed topical policy discussions or meaningful public or stakeholder input. Will the work of these committees simply be halted for a year or more? **CPPP recommends the bill be amended to provide a clear narrative prescribing a timeline for the Executive Commissioner to announce which advisory functions will be eliminated, or to define the new advisory body to which each item in the 3.50 or 3.51 will be transitioned. No advisory body should be eliminated until this accounting has first been accomplished, and there should be no gap in the ongoing work of these bodies between now and when they are either retired or transitioned.**

Detailed Comments:

- Section 1.15(p. 45): The practical effect of the repealer of DSHS, FPS code portions effective 9/1/2016, with others in section 1.16 not until 9/1/2019 is unclear. How does this mesh with the 2018-2019 schedule laid out in Section 1.01?

- Section 2.06 p. 52; Sec 531.0171 (b): The Ombudsman's office has no authority "to provide a separate process for resolving complaints or appeals." It is not at all clear what is meant here, i.e. separate from what?

- Section 2.07 Hotlines/Call centers: This list of criteria seems to lack a referecne to standards for effectiveness, ability to reach full resolution of client complaints, or evidence of adequate staffing levels.

- Section 2.18 p 68: Promotion of maintenance of eligibility: We appreciate and support this effort.

- Section 3.14 p 94: The language calling for the methodology to "account(s) for" non-patient-specific funding streams used to offset the hospital's initially computed amount of uncompensated care seems to be ambiguous.

Thank you for the opportunity to testify. Questions related to this testimony may be addressed to:
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