CENTER *for* PUBLIC POLICY PRIORITIES

WORKING FOR A **BETTER** TEXAS™

Billy Millwee
Deputy Executive Commissioner for Health Services
Texas Health and Human Services Commission
Brown-Heatly Building
4900 N. Lamar Blvd.
Austin, TX 78751-2316

May 13, 2012

Dear Mr. Millwee:

Please accept my apologies for these tardy comments, submitted after the 5/11/2012 deadline.

The Center for Public Policy Priorities (CPPP) appreciates the opportunity to comment on the HHSC April 2012 draft application for a Texas Dual Eligibles Integrated Care demonstration Project. Like many other Texas stakeholders, we support HHSC and CMS' goal of better- coordinated care, improved health outcomes, and a more cost effective care delivery model for Texans enrolled in both Medicare and Medicaid (Dual Eligibles). We, too, stand ready to work constructively with HHSC to promote policies that improve care and satisfaction for this vulnerable population.

We do have a number of concerns and recommendations for improvements to the demonstration proposal, which we have provided below.

Enrollee Choice and Timing

CPPP strongly supports CMS' opt-out requirement. We believe that if the state and CMS conduct an adequate and intensive education and outreach campaign for all STAR+Plus (S+) duals, the state will be able to draw a robust enough enrollment pool despite voluntary participation. Requiring that enrollees be allowed to opt out is a strong tool to ensure that states do the appropriate "leg work" in client education.

We join other Texas commenters in suggesting that HHSC add or CMS require that enrollees be given the ability to prospectively opt out of auto-enrollment; that is, to avoid going through passive enrollment necessitating a request for return to their MA/SNP plan of choice. The description of the process in the draft document is not sufficiently detailed to allow us to understand whether this may already be HHSC's intention.

Setting the Bar High for Quality of and Access to Care

The center urges HHSC to fully eliminate the risk of either a perception or a reality that our Medicaid program is experimenting with service delivery on a poor population. We can do this by setting high standards of care and access, and strong protections against intended or unintended barriers to functionally and medically needed care.

Texas' and other states' dual integration projects could play a key role in establishing a positive track record for how health plans can provide high-quality, cost-effective care and also be self-sustaining or profitable in a market where risk cannot be avoided. To deliver on that promise, dual integration projects must be vigilant to identify and remedy any

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loopholes that allow plans to "cherry-pick" or limit access to needed care despite the "guaranteed issue" nature of this population.

To this end, we agree with other commenters that HHSC and CMS should adopt strong minimum standards for quality ratings for MA/SNP plans as a condition of participation in the demonstration project.

We also call on HHSC to clearly detail the interaction between the Texas Medicaid program's recent policy to pay only Medicaid scale for most services to dual eligibles (i.e., with selected exceptions for oncology, psychology, and renal dialysis) and the duals integration proposal.

We strongly recommend that HHSC require detailed mapping of the availability of adequate PCP network in the affiliated MA/SNP plans, to eliminate plans with inadequate supplies and avoid PCP access crises. HHSC and/or CMS should consider the following steps:

- Verify that PCPs are accepting new enrollees, if necessary via secret shoppers;
- Map, measure and report (even if opt-out policy eliminates top access hazards for clients) the differences in provider networks across the affiliated MA/SNP plans and the non-affiliated plans to record any loss of access to PCPs or specialty care for evaluation purposes;
- Monitor aggressively and enforce compliance with Medicaid managed care contract access standards as (see p 13 C. i.)
- In 1995, Texas established state law requiring a Medicaid managed care help line for clients experiencing barriers to care, and this function was provided by an independent non-profit for a number of years. While HHSC chose several years ago to take this function in-house, the Dual integration projects along with the general expansion of Medicaid managed care suggest that HHSC at this time should clearly identify for enrollees a dedicated unit at HHSC Ombudsman's office for this purpose. The dedicated access help line could also serve as an independent monitor of access problems, since MCOs may have a conflict of interest in self-policing and self-reporting client access complaints and issues.
- Deep evaluation of S+ MCO/MA care coordination activities should identify who gets coordination services and who does not in terms of the enrollees' functional needs and diagnoses, as well as reporting the statistical frequency of care coordination, the intensity of care coordination services, and any correlation with diagnoses. This analysis should look for any biases in terms of access to care coordination or PAS based on diagnosis or functional disability, for example related to behavioral health related functional disability as opposed to physical functional needs.

Additional Comments

B. iv. P 9 of 29: the bullet providing examples of populations not eligible for full Medicaid benefits concludes with a reference to "undocumented aliens." Because the Texas Legislature has directed Texas Medicaid to exclude both legal and undocumented immigrants (except those under age 19), from the program, and the best expert estimates of Texas' non-citizen population indicate roughly one-third are lawfully present immigrants, in the interest of consistently promoting an accurate portrayal of the Texas Medicaid population to the public, we suggest that the reference be edited to say **"Emergency Medicaid for legal and undocumented aliens."**

C.ii. Top of page 15, first paragraph needs editing for clarity. Literal reading implies that Medicaid will pay all Rx benefits. We understand from discussion at the HHSC May 2 public forum that this is not the intent, but the clarification should be made in the final version.

C.ii. On page 15 of 29, Long Term Care Services and Supports for all enrollees, the text says enrollees "may" get medically and functionally needed PAS and DAHS. Shouldn't this be "shall?"

C.ii. On page 21 of 29; we support the HHSC proposal to maintain 30-day appeal resolution standard compared to the 60-day Medicare standard.

E. i. The final proposal should explain in greater detail how the 3rd contractual add-on (i.e., the contract in addition to the S+ and the MA/SNP contracts as identified in #6 on page 23 of 29) will truly result integrated clinical and financial outcomes and not simply the same entity holding 2 parallel but uncoordinated contracts.

E. i. CPPP also supports HHSC's continuation of a 5% at risk policy in MCO contracts, and its intention to develop a similar system for the demonstration projects (page 24 of 29). We strongly support inclusion of financial incentives that can reinforce superior care coordination, enrollee satisfaction, and clinical outcome improvement.

Thank you again for the opportunity to comment. Please let me know if I can provide any additional information.

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