Comments on Sunset Commission Staff Report – Health and Human Services Commission
October 16, 2014

Issue 4 and Issue 6: AARP supports the Sunset Commission Staff Report findings that HHSC has not fully adapted to the managed care environment and that HHSC can do more to improve the quality of care for Medicaid clients, who are now mostly served by Medicaid managed care models.

AARP has long advocated for improved Medicaid managed care contract management and for more Medicaid health plan accountability for quality outcomes. While some progress has been made, HHSC has not been able to demonstrate that the managed program, as a whole, is delivering on two basic, core business deliverables –

- Adequate provider networks, particularly specialist networks, and;
- The diversion of Medicaid managed care members with non-emergent health conditions from hospital emergency rooms.

These two items are core contract deliverables of the now $10 billion a year Texas Medicaid managed care program and the basis for why the state moved to managed care in the first place. As HHSC does adapt its systems to better reflect the contract management demands of this large managed care system, it needs to focus first on these two key elements.

These two issues are outlined in more detail below.

HHSC Needs to Adopt and Enforce Stronger Medicaid Managed Care Network Adequacy Standards

<u>Recommendation</u> - There are better standards for network adequacy that are in current use in managed care models. The Medicare Advantage standards (for Medicare HMOs) address most of the problems that exist in HHSC standards:

- Medicare **differentiates between the type of area** (Large Metro, Metro, Micro, Rural, etc.)
- Based on the area type, **minimum provider ratios** are set by type or provider
- **Minimum travel distance and travel times are set** based on the area type
- **Medicare permits exceptions** based on a reasonable exception process

Background

- Medicaid HMOs promise, in their contracts with the state, to deliver a network that provides reasonable access to care for Medicaid members.

- **Many managed care members struggle to locate providers who are actually accepting new Medicaid patients** or are forced out of (inadequate) networks to confusing out of network services. Provider directories often list providers that are not actually taking new Medicaid patients, which results in a difficult and frustrating "hunt" on the consumer's part.

- If consumers have a hard time finding specialist care or urgent care, they will end up being treated in the ER – an expensive outcome for the state and federal budgets and one that managed care is supposed to help prevent (see next issue).

- The Medicaid Managed Care Advisory Committee has taken up the network adequacy issue as major problem area and will be meeting in October to develop recommendations to HHSC. There are general concerns about health plans not being held accountable by HHSC on network adequacy. HHSC is studying the issue via an internal work group.

- There are a number of findings in HHSC's most recent External Quality Review Organization studies that directly or indirectly illustrate network problems in STAR+PLUS. The link to the EQRO studies is provided below.

  http://www.hhsc.state.tx.us/reports/2012/EQRO-StarPlus Addendum.pdf

  http://www.hhsc.state.tx.us/reports/2012/EQRO-Texas-STARPLUS-Audlt-Member-Survey-FY2011-Attachment-1.pd

- HHSC relies on a dated TDI standard for specialist access - **specialists can be up to 75 miles away from a member**. This standard in not appropriate for an aged and disabled population, makes little sense in the state's large metro areas, and is likely impossible to comply with in many rural areas of the states. TDI is in the process of reviewing this standard, as it updates its commercial HMO regulations.

- **No measurable/enforceable standard for network adequacy is set**. HHSC's standard only says that the network must be "sufficient" and there is not a definition of what "sufficient" means.

- **HHSC relies on self-reported HMO information and complaints from STAR+PLUS members - who are by definition aged and disabled, to monitor networks.** This is an inadequate approach to ensuring network adequacy. Expecting this membership to navigate an HMO complaint process and hoping that their complaints find their way to the HHSC health plan oversight staff is not an effective approach. It is unreasonable to expect STAR+PLUS members to, in effect, do HHSC's HMO contract monitoring work.

HHSC Needs to Routinely Measure and Publicly Report on Non-emergent Use of Emergency Room by Managed Care Members, by Health Plan, by Region

Recommendation: HHSC should publish this data, at least annually, for quality reporting and consumer information purposes. This should also be a fundamental and key metric for HHSC's quality incentive program.

Background

- Reduced use of the ER for non-emergency conditions was one of the major selling points of doing managed care in the first place and appropriate use of the ER is a potential indicator of how robust a plan's provider network might be.

- A 2011 Legislative Budget Board (LBB) study showed essentially **no statistical difference between the legacy fee for service Medicaid programs and Medicaid Managed care on non-emergent use of the ER**. **The STAR+PLUS difference was a statistical dead heat.**

- That LBB study is obviously old by now and there is not much fee for service left for a comparison. New data should be collected and published by HHSC that compares health plan to health plan on this metric and to national standards. This will provide an important measure for each plan and help HHSC to see if the state is really getting the service coordination (STAR+PLUS) and the network adequacy that its paying for and that the plans are contractually obligated to provide.

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Testimony - Sunset Commission Staff Report
Health and Human Services Commission
November 13, 2014

Trey Berndt, Associate State Director - Advocacy

Issue 1 (Consolidation of HHS Agencies)

The Sunset Commission should ensure a strong, formal consumer input process for HHS policy development, rulemaking, and other proposals that impact consumers.

- The health and human services enterprise currently has a formal input process at each existing agency, which offers stakeholders an opportunity to provide public comment on agency rulemaking and other issues. This process captures regulatory issues for all Medicaid services as well as non-Medicaid programs.

- AARP believes the Sunset Advisory Commission should go further than the staff report and specify broad areas where public input is essential. For example, long term care services, behavioral health services, public health services, etc.

- Given the sheer scope of Medicaid managed care, HHSC needs specific, structured consumer and provider input on what is or is not working in HHSC's multiple managed care programs. The State Medicaid Managed Care Advisory Committee or a similar group should be explicitly continued in the Sunset Commission's final recommendations.

Issues 4 and 6 (Managed Care Oversight and Quality of Care)

AARP supports the Sunset Commission Staff Report findings that HHSC has not fully adapted to the managed care environment and that HHSC can do more to improve the quality of care for Medicaid clients, who are now mostly served by Medicaid managed care models.

AARP has long advocated for improved Medicaid managed care contract management and for more Medicaid health plan accountability for quality outcomes. While some progress has been made, HHSC has not demonstrated that the managed program, as a whole, is delivering on two basic, core business deliverables –

- Adequate provider networks, particularly specialist networks, and;

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These two issues are outlined in more detail below.

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- If consumers have a hard time finding specialist care or urgent care, they will end up being treated in the ER – an expensive outcome for the state and federal budgets and one that managed care is supposed to help prevent (see next issue).

- The Medicaid Managed Care Advisory Committee has taken up the network adequacy issue as major problem area and met in October to develop recommendations to HHSC. Six specific recommendations related to network adequacy were adopted. These recommendations reflected general concerns about

health plans not being held accountable by HHSC on network adequacy. HHSC is also studying the issue via an internal work group.

- HHSC relies on a dated TDI commercial standard for specialist access - **specialists can be up to 75 miles away from a member**. This standard in not appropriate for an aged and disabled population, makes little sense in the state's large metro areas, and is likely impossible to comply with in many rural areas of the states. TDI is in the process of reviewing this standard, as it updates its commercial HMO regulations.

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