For Electronic Submission: Submitted via www.regulations.gov
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-2408-P,
Baltimore, MD

Re: Docket Number CMS-2408-P, Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care

Dear Sir/Madam:

The Center for Public Policy Priorities (CPPP) submits these comments in response to a Proposed Rule by the Centers for Medicare & Medicaid Services (CMS), entitled "Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care," and published in the Federal Register on 11/14/2018.

The Benedictine Sisters of Boerne, Texas, founded CPPP in 1985 to advance public policy solutions to improve access to health care. We became an independent, tax-exempt organization in 1999, and over time our focus has expanded to include economic opportunity and fiscal policy. We are based in Austin, Texas, and work statewide. At CPPP, we believe in a Texas that offers everyone the chance to compete and succeed in life. Administrative advocacy is one important way we use data and analysis to enable Texans of all backgrounds to reach their full potential.

The Center's policy staff have been involved with the evolution of Texas' Medicaid Managed Care program since its inception in 1993, first as employees of the Medicaid program and later as external policy experts and advocates for Texas Medicaid beneficiaries. In Texas today, nearly all of our over 4 million (point in time) full Medicaid beneficiaries are enrolled in risk-based HMOs, including medically fragile children, nursing home residents, and other Texans with disabilities.

In June 2018, the Dallas Morning News began publication of a series of articles based on over a year of investigation of Medicaid Managed Care in Texas, which provided a disturbing record of individuals harmed and systemic breakdown in oversight and enforcement of quality, access, and safety standards. (*We attach to these comments the letter of concern submitted by 17 Texas organizations working on health care, children's issues, or policy related to people with disabilities to state leaders, expressing concern about Texans' struggles to access health care under the state's Medicaid managed care system.*)

Because of Texas' high-visibility and well-documented struggle to provide adequate access to care for children, pregnant women, seniors, and Texans with disabilities enrolled in Medicaid Managed Care, CPPP and other Texas advocates have a special concern about the need to maintain and improve current standards for oversight and enforcement of access to care. That concern is reflected in our comments below.

Retention of important 2016 provisions. The Center commends CMS for retaining important provisions of the 2016 CMS update to Medicaid Managed Care that establish enrollee rights and protections, set standards for program integrity, a provide for sanctions for contractors who fail to meet contract requirements in these November 2018 proposed rules. In 2017, the latest year for which full Texas Medicaid Managed Care financial statistical reports from Texas HHSC are available, Texas Medicaid Managed Care health plans reported over $616 million in net retained profits from their Medicaid business. Given this robust profitability, Texas Medicaid enrollees, consumer advocates, and taxpayers in general have

a right to demand contract compliance, access to care, and transparent and meaningful consumer information and supports from the Medicaid Managed Care industry.

Potential to Weaken Access to Care Standards. CMS proposes dropping the requirement for specific time and distance benchmarks as a minimum state standard, and allowing instead for states to develop their own alternative quantitative network adequacy standards. Based on Texas' 25 years of Medicaid Managed Care, we would observe that time and distance standards should not be dropped. They are a necessary but insufficient component of oversight of access.

Simply knowing that providers are within the required time and distance standards does not inform either program overseers or Medicaid enrollees about other equally critical factors, including how long they must wait for an appointment, whether or not they are accepting new patients, if they can serve non-English speakers, are accessible to public transportation, or are willing to serve enrollees with special needs. Rather than dropping the time and distance standards, CMS should be requiring states to develop additional benchmarks that can efficiently assess and communicate how well these additional factors are addressed by a Medicaid Managed Care plan. It's important to note that provider to enrollee rations remain ineffective, because many providers may belong not only to multiple Medicaid Managed Care plans but also to multiple commercial market plans; so that knowing how many Medicaid clients they have is useless data. Waiting time for appointments and acceptance of new Medicaid patients are far more valuable metrics.

Medicaid's federal laws combined with the reality of less than robust enforcement constitute a "weak leg" in Medicaid's foundation. Because there are no minimum standards for reimbursement, only minimal oversight of true access conditions, and Congressional reluctance to impose any specific requirements that will affect state budget needs, the temptation for state Legislatures to under-fund Medicaid will always be present, making creation and enforcement of meaningful access standards all the more important.

Indeed, if CMS intention with this proposal to eliminate the time and distance standards is to signal a low priority being given CMS' direct role in oversight and enforcement of network adequacy, it is all the more important to set a high bar in state-level standards so that protections can be strong at the state level. This is particularly true given the absence of standing for enrollees or providers to challenge adequacy of Medicaid rates in the courts.

Inadequate Notice of Providers Leaving Networks. CPPP opposes the proposed rule's provision to allow a Medicaid Managed Care plan to delay notification of patients that their physician or other provider is leaving the network until 30 days before the provider leave s the network, ***even if the Medicaid Managed Care plan has been notified of the departure months in advance.*** Because children on SSI and in Texas' Medically Dependent Children's Waiver are now enrolled in risked based Medicaid Managed Care HMOs (along with seniors and other adults with disabilities), this provision would rob patients and their families of precious time needed to re-establish new links to specialty care providers. Many families take years to assemble appropriate care teams for their loved ones, and need the prompt notifications required under the current standard. For enrollees with more typical needs, denying families the chance to promptly begin a search for a new pediatrician or obstetrician as soon as possible it would create an avoidable strain not only on the individuals affected, but on the providers who will need to accommodate the beneficiaries who have lost access to a provider.

FFP, Consistency of capitation rates, Supplemental payments, and IGT. The proposed rule includes several provisions that appear to be intended to eliminate the possibility that states could provide higher Medicaid Managed Care capitation rates on provider reimbursements by Medicaid Managed Care plans, based on the

relative availability of IGT. Likewise, the rule appears to be designed to eliminate the possibility of more robust rates for Medicaid Managed Care services to adults covered under state Medicaid expansions for adults under the ACA, or similar coverage for adults provided under 1115 waiver authority.

CPPP generally supports these provisions. In Texas Medicaid today, access—or lack thereof—to IGT has created winners and losers within (or outside of) our 1115 Transformation Waiver, and the development of Uniform Hospital Rate Increase Program (UHRIP) enhancements funded by either IGT or "Local Provider Participation Funds" has added a new layer of complexity to Texas Medicaid reimbursement transparency, equity, and raised questions about true "statewideness." Given extreme variations in average incomes, poverty rates, and fiscal capacity across Texas, guarding against allowing the establishment of a less robust Medicaid program in lower-income regions and cities is a very real priority.

We further support the general principle that enhanced reimbursement rates/capitation rates limited to the expansion population that is eligible for 90% Federal Financial Participation, while of understandable appeal to states, cannot be justified based on the inequitable advantage in access to care it would provide to those beneficiaries, compared to children, pregnant women, seniors, and Texans with disabilities served by Medicaid.

Paper Provider Directories-or a non-web based alternative--are still needed by some. While the population for whom paper directories are preferred is indeed shrinking, CPPP agrees with other commenters that many low-income and senior beneficiaries still lack access to online search capacity. Medicaid Managed Care plans that do not wish to publish a monthly paper directory version should be required at minimum to provide a monthly update flyer on request, and/or to offer a promptly-answered customer support phone line with after-hours capacity that will not only provide enrollees with contact information for a provider, but also will outreach to the provider to make an appointment, thereby ensuring that the provider is in fact available, and also granting the Medicaid Managed Care plan data to further update their network records.

Information Access for non-English speakers and visual disabilities may be compromised. CPPP shares the concerns voiced by other expert analysts that the changes to required non-English Tag lines and to Font sizes may have unintended negative consequences for the disability and non-English proficient populations. We suggest CMS withdraw this section of the proposed rule and revise it based on detailed input from multiple experts on language access and visual disability needs.

Changes to standards for Medicaid Fair Hearings. CPPP shares CMS' concern that a request for and appeal of a Medicaid Managed Care plan adverse decision to deny or reduce a benefit should be adequate to trigger an appeal. However, in Texas we have encountered instances in which Medicaid Managed Care plans have failed to accurate register those requests, including failing to note requests for continuation of benefits pending outcome of appeals and fair hearings. We are encouraging Texas Medicaid to create a system in which an appeals request (and requests for continuation of benefits) are registered simultaneously with the Medicaid agency and the individual Medicaid Managed Care plan. We recommend that CMS require states to create a similar "redundancy" protection to ensure that oral requests for appeals are fully an accurately recorded. Having a real-time record of these request should also benefit the state Medicaid agencies in their Medicaid Managed Care quality oversight role.

CPPP opposes the CMS proposal to drop the allowed time for requesting fair hearings from 120 to 90 days. As demonstrated in the Dallas Morning News series, Texas Medicaid's current levels of client education and supports for understanding the appeals and Fair hearing processes are inadequate, and few beneficiaries

have support in the process, while Medicaid Managed Care plans may enlist a number of staff in a hearing. Rather than reducing the time available for beneficiaries—many of them medically fragile, frail, or actively ill or injured—to initiate a request for Fair hearing, CMS should be proposing steps to ensure state Medicaid programs fully educate their beneficiaries about the steps required and timing of Medicaid Managed Care plan internal appeals and Medicaid Fair hearings, and provide meaningful enrollee supports to ensure the deck is not stacked against the beneficiary in the process.

Thank you for your full consideration of our comments. If you have any questions about these comments, please contact Associate Director Anne Dunkelberg at dunkelberg@cppp.org.

Sincerely,

Anne Dunkelberg, Associate Director
Center for Public Policy Priorities
7020 Easy Wind Dr., Suite 200
Austin, TX 78752

Appendix: 17 Texas Groups Urge State Leaders To Fix Medicaid Managed Care

June 26, 2018

Dear Texas Legislative Leaders:

Like many Texans, we were deeply disturbed by the stories and systemic breakdown described in the recent Dallas Morning News investigative series on Medicaid managed care in Texas. The series reinforces three facts that have come to light in past legislative hearings, research, and conversation with Texans enrolled in the state's managed care programs. Our organizations represent a long history of advocacy for access to health care and long-term services and supports, working alongside and on behalf of Texans in the Medicaid program.

First, Medicaid is a critically important health insurance program providing preventive care, acute and long term services for many Texans. In fact, a recent survey by the Kaiser Family Foundation and the Episcopal Health Foundation found that 71 percent of Texans have a very or somewhat favorable view of the health insurance program.

Second, we recognize there are benefits to managed care *if the system is adequately funded and properly managed*. We have seen positive benefits when services are coordinated and health plans use innovative solutions, such as after-hours care and value-added services that are meaningful and improve health outcomes. However, the current managed care system has deep structural problems that are hurting children, people with disabilities, and other Texans. Our organizations can attest that the issues described are not isolated incidents, but recurring systemic flaws. Even putting aside the specific stories brought to light in the Dallas Morning News series, there is ample evidence of the gut-wrenching results of chronic underfunding and structural problems in Texas Medicaid managed care.

Third, the Legislature, Governor, Health and Human Services Commission (HHSC), and Managed Care Organizations (MCOs) must engage in an urgent, vigorous, and sustained effort to ensure that Texans enrolled in Medicaid managed care programs receive the care they need. We recognize and appreciate that state leaders have already scheduled hearings, communicated concerns to HHSC, and taken other steps to shed light on and address this problem, but much more work is needed.

Medicaid is a lifeline for many Texans, a program that deserves to be protected, adequately funded, and effectively managed. We urge state leaders to take steps to improve the following issues in Medicaid managed care, noting that the most fundamental problem is that chronic underfunding of the state's health care and community services system has devastating consequences for everyday Texans:

Funding and revenue: State leaders have cut back on sources of revenue for the state budget, underfunded Medicaid, and insisted on finding more "savings" and "cost containment" even when there is no clear way to make cuts without compromising health care and services for children, people with disabilities, pregnant women, and seniors. This approach is not only short-sighted but is also out of tune with the views of many Texans. The recent survey by the Kaiser Family Foundation and the Episcopal Health Foundation found that Texans were adamant about the Legislature prioritizing health care in the state budget, with 54 percent of Texans saying they favor increased spending on health care programs, while only 12 percent support decreased state spending on health care. We urge state leaders to fully fund the state's health care programs and to keep in mind the stories brought to light in the Dallas Morning-News series the next time they consider cutting back on sources of revenue for the state budget or shortchanging Medicaid.

Provider rates: Many provider types are paid rates that reflect only a portion of the costs of care. The Legislature sets provider rates for doctors and specialists so low that many professionals who want to serve Medicaid clients cannot financially justify participating in the program. Rate cuts by the Legislature to some

community care waiver providers and inadequate wages and benefits for personal attendants who provide critical support for Medicaid clients with disabilities and seniors seriously undercut a critical workforce in our state. In past years, the Legislature significantly cut reimbursement rates for life-changing therapies for kids with disabilities -- and only restored 25 percent of these Medicaid pediatric therapy rate cuts after families and professionals stressed the real-life, devastating impact on kids. In contrast, payment formulas for Texas Medicaid managed care organizations generally not only cover all costs, but often gain substantial retained profits, even as clients struggle to access service providers.

Texas needs to create a sustainable process in which provider payments match the cost of delivering care and ensure provider networks are adequate to meet the needs of enrollees. Further, where possible, it is vital to incentivize consumer-directed services as part of the long term services and support (LTSS) delivery system.

Network adequacy: While the state has taken some steps in prior legislative sessions to address Medicaid provider networks, much more work is needed. A doctor who is not taking new patients or who is not participating in Medicaid is of no help to a parent trying to find a specialist for her son or daughter. Children, pregnant women, seniors, and people with disabilities deserve to be able to find a health professional in their area – and in their health plan's network – who is available to provide care they need. The lack of a sufficient number of providers – especially psychiatrists – for vulnerable children in foster care is a major concern and runs counter to the state's recent focus on mental health and foster care. The challenge is more than just inaccurate provider directories. State leaders must work to ensure Medicaid plan networks include a sufficient number and geographic distribution of health and community service providers that are available to meet the needs of Medicaid clients. This includes primary care, specialists for children and adults, hospital systems, and a robust network of personal attendants, among others.

Care coordination: According to a January 2017 Legislative Budget Board (LBB) report, "[m]ost members in managed care programs receive minimal or no coordination services from their managed care organization. The low utilization of care coordination services delivered by managed care organizations may limit access to and coordination of key health services." We encourage state leaders to consider options presented in the January 2017 LBB staff report. These include funding strategies to increase care coordination utilization, as well as simplifying and clarifying requirements for benefits related to care coordination across Medicaid programs.

Complaint and resolution system: Texas needs a true system of appeals that facilitates due process and prioritizes keeping people healthy. As a Medicaid client's complaint or appeal is moving through the process, continued access to medications and medical care are critical and even life-saving. If a needed service is denied, Medicaid clients are told to go to different places -- their health plan, HHSC, and the HHSC Ombudsman's office, among others -- to make a complaint or resolve a dispute. This patchwork of different processes is not only confusing for clients, it doesn't resolve issues effectively for plans, consumers, and providers. Texas needs to prioritize a stronger system for complaints, appeals, and resolution, including an adequate level of staffing to ensure complaints are followed from beginning to end, until they are resolved.

Accountability of managed care organizations: The state should hold health plans accountable if they have done wrong or failed to meet program obligations. This includes enforcing penalties like liquidated damages and freezes on new enrollment. Texas' Medicaid program deserves an appropriate team of program surveyors that check on services and unmet needs experienced by children, pregnant women, seniors, and people with disabilities in Medicaid. We have seen the positive health benefits when plans promote after-hours care and value-added services that are meaningful and improve health outcomes. This innovation should continue. On the other hand, when health plans do not properly manage care and cut off medically necessary services, some of our most vulnerable Texans are left without vital medications or medical care – with potentially damaging and gut-wrenching results.

Proactive agency oversight must be backed by Legislative openness to bad news: The recent reports include stories of dangerous MCO policies that should have been stopped before ever taking effect, and of agency findings of threats to health and safety that never became public. If this is to change, our Texas Legislative culture must welcome hard truths about problems and challenges state agencies face, including those that will require appropriations as part of their solutions. A culture of transparency and high performance—one that does not encourage agencies to obscure problems but rewards them for confronting them—could have identified and prevented many of the issues raised in the Dallas Morning News series.

If you have any questions regarding this letter, we invite you to contact Dennis Borel, Executive Director of Coalition of Texans with Disabilities, at dborel@txdisabilities.org. We appreciate your attention and look forward to working with you on these critical issues.

CC:
Governor Greg Abbott
HHSC Executive Commissioner Cecile Young
Texas Association of Health Plans, Jamie Dudensing

Sincerely,

Anne Dunkelberg
Associate Director
Center for Public Policy Priorities

Dennis Borel
Executive Director
Coalition of Texans with Disabilities

Greg Hansch
Public Policy Director
National Alliance on Mental Illness (NAMI) Texas

Cathy Cranston
Personal Attendant Coalition of Texas (PACT)
ADAPT of Texas

Adriana Kohler
Senior Health Policy Associate
Texans Care for Children

Mary Faithfull
Executive Director
Disability Rights Texas

Jolene Sanders
Advocacy Manager, Easterseals Central Texas

Frederick W. Hines
President & CEO
Clarity Child Guidance Center

Patrick Bresette
Executive Director
Children's Defense Fund-Texas

Grace Chimene
President
League of Women Voters of Texas

Miriam Nisenbaum
Executive Director
National Association of Social Workers-Texas Chapter

Simone Nichols-Segers
Senior Manager, Advocacy
National Multiple Sclerosis Society

Bee Morehead
Executive Director
Texas Impact

Christine Yanas
Director of Governmental Affairs
Methodist Healthcare Ministries

Ann Williams Cass
Executive Director
Proyecto Azteca, San Juan, TX

Kyle Piccola
Chief Government and Community Relations Officer
The Arc of Texas

Frankie Robertson
Regional Director, Advocacy and Government Affairs
Southeast Region
March of Dimes