NSCLC
National Senior Citizens Law Center
PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

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Delivered via e-mail to: TX-MedicareMedicaidCoordination@cms.hhs.gov

Re: Comments on Dual-Eligible Integration Proposal from Texas

Dear Director Bella,

Thank you for providing this opportunity to comment on the proposal submitted by Texas for its demonstration to integrate care for dual eligible individuals. The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults through advocacy, litigation, and the education and counseling of local advocates.

NSCLC has reviewed the extensive comments on the original state proposal submitted by organizations including AARP, the Center for Public Policy Priorities, Disability Rights Texas, and ADAPT of Texas. We endorse those comments, and submit our own separately in order to highlight several of the issues raised by the Texas proposal that have broader implications for demonstrations in other states.

Failure to Engage with Stakeholder Questions and Concerns

An overarching concern that we have about Texas' submission is the state's minimal revisions to the proposal it has submitted to CMS despite thorough comments and incisive questions from stakeholders to the state-level proposal. For instance, state stakeholders raised serious, thoughtful questions about Texas' quality and cost measurement process, asking for more details about the process and making a number of concrete suggestions for evaluation of the demonstration (see, e.g., comments by the Center for Public Policy Priorities). Yet the section on Quality and Cost Measurement ultimately submitted to CMS was virtually unchanged from that released earlier for stakeholder comment, with the except of an additional note that STAR+PLUS MCOs would continue to be required to comply with the Health Insurance Portability and Accountability Act (HIPPA).[1] Nor were these calls for more rigorous quality controls acknowledged in the "Stakeholder

[1] Texas Proposal at 28-30.

Engagement" section.[2]

> Recommendation: Where appropriate, CMS should require Texas (and other states) not just to solicit and accept stakeholder comments, but also to respond or engage with stakeholders about their comments and suggestions.

Passive Enrollment

Texas is proposing passive enrollment with an opportunity to opt out.[3] We believe that this process is unfair to beneficiaries, as it makes a decision for them (in some cases undoing a decision they have already made to enroll in a particular Medicare plan) and then forces them to go through administrative procedures to reverse a choice that they never made in the first place.

Enrollment procedures should be designed to honor beneficiary choice. Any transition into a managed care system should be voluntary, driven by a beneficiary's affirmative decision to have services provided through an integrated entity. Enrollment should occur only when a beneficiary affirmatively opts into a managed care system.

Furthermore, an opt-in only enrollment procedure would ensure that the demonstration project is kept to a manageable size, focused on those most motivated for integration, and thus increase the long term likelihood of success of the project.

We request that Texas' opt-out process be rejected, and that CMS require that Texas implement an opt-in process that truly honors consumer choice. STAR+PLUS plans should build their enrollment on meeting consumers' needs, not on taking advantage of the inertia and confusion inherent in an opt-out model. When and if experience shows that STAR+PLUS plans are able to deliver quality care, the question of whether passive enrollment best serves the needs of beneficiaries can be revisited. But no beneficiary should be passively enrolled into an experiment.

> *Recommendation*: Beneficiaries should not be enrolled without an affirmative choice. This will provide strong incentives to STAR+PLUS plans to meet beneficiaries' needs. If passive enrollment is allowed, however, beneficiaries should be allowed to preemptively decline passive enrollment.

Network Adequacy and Care Coordination Capacity

Texas' proposal needs further fleshing out on network adequacy standards and care coordination capacity. While the state generally states that the STAR+PLUS plans must have written contracts with a range of types of providers, the state never sets forth actual criteria for measuring network adequacy, such as specific acceptable wait times or

[2] Id. p. 21-23.
[3] Texas also indicates that it would "revisit" this policy in year two in order to determine whether a lock-in period would make sense. While we oppose lock-in periods which undermine beneficiaries' Medicare rights, we appreciate Texas decision to wait to make this decision.

minimum requirements for the number of providers that must be available for any covered service.

First, network adequacy standards should be based on a review of the needs of the members. There should be a requirement to conduct such reviews periodically and adjust networks to address unmet needs. The state has not established any ratios of providers to members (which would vary by type of service) or any patient load guidelines (which should include all patients served by the provider, not just those who are enrolled in the particular STAR+PLUS plan). Despite broad statements about the need to respond to members' linguistic, cultural, and physical needs, specific accessibility standards and language access criteria also have yet to be developed.

Despite the importance of care coordination to the purpose of the duals demonstration, there is nothing in the section of Texas' proposal on provider networks and services that addresses availability and quality of care coordination. This is particularly troubling because it is clear that taking on the high-needs dual eligible population would require a significant expansion of current STAR+PLUS plans' capacity to provide care coordination. According to an evaluation of STAR+PLUS plans, only twenty-three percent of members have a care coordinator to help arrange access to services.[4] And of those who had a care coordinator, only 56 percent indicated that they had been contacted by the coordinator in the past six months. Clearly, absorbing the dual eligible population, with its high needs for care coordination, will require plans to significantly expand their coordination capability.

> *Recommendation*: CMS should require Texas to add meaningful, substantive criteria to its proposed network adequacy standards.

Inadequate Quality Assurance Procedures

Texas' proposal states repeatedly that the state plans to work with CMS to develop quality goals and assessment, but lacks specifics about what the content of those goals or assessments will be.

There are a range of indicators that should be considered in assessing STAR+PLUS plans. These should include access to effective service coordination, ability to self-direct service, Because a network that meets the needs of plan members is the linchpin to a person-centered health delivery system, Texas must commit to devote adequate resources to monitoring the adequacy of STAR+PLUS plans with specific reference to the needs of dual eligibles. There must be intensive state monitoring, including secret shopper surveys and protocols that make it easy for plan members to report problems with getting appointments and that encourage such reports.

> *Recommendation*: CMS should require that Texas develop substantive quality measures, easily accessible to the public, that allow comparison of STAR+PLUS plans to other options available to dual eligibles. The systems should include quality of life measures identified by stakeholders as important.

[4] Texas STAR+PLUS Enrollee Survey Report, FY 2009, p. 22, available at http://www.hhsc.state.tx.us/reports/2010/Enrollee_Report_FY09.pdf.

Appeals

We note here an improvement made by Texas after the state-level comment period. Its original proposal would have maintained a 30-day standard for member appeals, despite the 60 days allowed by Medicare. The current proposal, however, does not contain the 30 day appeal deadline.

We thank Texas for eliminating this requirement, which would have resulted in a significant limitation on Medicare beneficiaries' due process rights.

Thank you for your attention to these issues, and for your continuing work in the development of dual integration programs that work for beneficiaries. Dual-eligible individuals in general are extremely vulnerable, in regards both to health care needs and finances. Safeguards are needed to ensure that managed care models provide the coordinated and comprehensive attention that dual eligibles need and deserve.

Thank you for the opportunity to submit these comments. Please let us know if you have and questions or would like to discuss our comments further.

Sincerely,

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Deputy Director

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