FROM: LAWRENCE COLLINS, AMERIGROUP TEXAS

TO: MEMBERS OF THE TEXAS ASSOCIATION OF HEALTH PLANS EXECUTIVE BOARD

DATE: MARCH 3, 2021

SUBJECT: TAHP MESSAGING & COMMUNICATIONS TO THE LEGISLATURE

Dear TAHP Executive Board Members:

Thank you for the work you've done on behalf of Texas Medicaid.

Amerigroup and TAHP have recently asserted different policy positions to the Texas Legislature regarding the best path forward for the state's Medicaid program, the people who rely on it, and the taxpayers who pay for it. While Amerigroup respects and appreciates the opinions and perspectives of any party, including TAHP, we feel compelled to point out the factual inaccuracies and other bizarre turns of phrase — especially on such a consequential matter — in the Association's communications with public officials. Given that TAHP will testify under oath to the House Appropriations Subcommittee on Health & Human Services tomorrow morning, we believe it is important that TAHP argue its positions honestly, accurately, and transparently.

Specifically, we are concerned about TAHP's recent representations to legislators in a handout titled, "*TAHP Supports Senate Rider 21 & Opposes House Rider 22*" and other testimony to various committees. We hereby request that you correct them in advance of the tomorrow's subcommittee hearing. We also must express our concern about any potential oral representations by TAHP staff regarding these riders.

As you know, Amerigroup has briefed TAHP staff, all member plans individually (some several times), and the Texas Association of Community Health Plans staff regarding our proposals to strengthen competition in the Medicaid program on behalf of Medicaid members and Texas taxpayers. We also have presented these proposals in public forums and, most recently, to the Medicaid Workgroup at the Texas Conservative Coalition Research Institute (TCCRI, of which we are all members). TAHP and member plans are very well advised of our positions. Yet TAHP staff have consistently misrepresented the proposals themselves and the objectives they seek to achieve — and they have unfairly and inaccurately disparaged Amerigroup itself.

Factual Inaccuracies

1. ***Rider 22 prioritizes "profits over important patient outcomes."***

On March 1, TAHP staff testified in opposition to House Rider 22, alleging that it is "shifting managed care procurement criteria toward profits over important patient outcomes." This is an outright fabrication. This rider is clearly intended to help the legislature achieve longstanding goals (and current law) to protect Medicaid members and Texas taxpayers. TAHP can point to no objective evidence whatsoever that Rider 22 is intended to or actually does prioritize profit, because none exists. The plain language of the rider prioritizes cost, quality and customer satisfaction. The rider would measure performance by combining these three principles, which are revered in managed care as the Triple Aim. Further, Rider 22 is merely a broader and important application of Rider 43 from 2019, which the Texas Health & Human Services Commission has wholly adopted as its policy and which

TAHP has recently invoked, in both TCCRI Medicaid Workgroup settings and in official communications with legislators, as a strength of Texas' Medicaid program.

2. ***"The Rider is based on a single vendor's flawed methodology and conclusions about HHSC oversight."***

This statement is false and intentionally misleading. The plain language of the rider requires implementation of current law, passed by the Legislature in 2013, requiring cost, quality, and customer satisfaction benchmarks. Amerigroup does not now ask — nor has it ever asked — HHSC, the legislature, the MCO community, or other stakeholders to adopt any specific index; those that Amerigroup modeled were developed only to demonstrate the potential value of this proposal.

3. ***"We disagree with replacing HHSC's established methodology for assessing health plan performance with a proprietary methodology developed by one MCO."***

This is false and intentionally misleading. HHSC has no "established methodology" to assess the performance of MCOs. The only one available to the agency was developed by the University of California — and HHSC does not use this model in gauging MCOs' performance as part of the procurement process. More importantly, the plain language of the rider requires HHSC to develop cost, quality, and customer satisfaction indices on a certain timeline and through a public input process. The rider does not require the adoption of any specific index at all.

4. ***"Proposals that tilt procurement toward an unfair competitive advantage should be viewed skeptically, as should proposals that create barriers to new entrants and small community plans."***

This is false and intentionally misleading. The plain language of the rider says: "It is the intent of the Legislature that for both procurement and routine performance assessment, funds appropriated above for services provided through managed care in Goal A, Medicaid Client Services, and Goal C, CHIP Client Services, be expended only for: 1) high-performing managed care organizations (MCOs) that provide the best value to the state, and 2) a rate payment system that incentivizes high-performing MCOs." Again, HHSC currently has no objective means, process, or history for assessing the performance of health plans as part of the procurement process. This rider would ensure that high performers, whomever they may be, will earn contracts to serve Texans who depend on Medicaid services. Since HHSC has not yet developed the criteria or even commenced the public input process required by the rider, no plan can possibly know what the process is, let alone who may be in a better positioned. We invite the association and its members to consider the possibility that Amerigroup itself might end up disadvantaged through this process — the only clear winners will be HHSC, the people of Texas, and Texans who rely on Medicaid.

Nothing in this rider "tilts" procurement to any one plan's advantage. Indeed, the rider simply recalibrates the current process, which provides unfair competitive advantage to low and, worse, unknown and unproven performers. Amerigroup is pursuing these policy changes only because we are longtime partners in Texas' Medicaid managed care system, we can no longer ignore systemic deficiencies that prop up underperforming MCOs, and we feel confident in the services we provide and the value we create for the people of Texas.

5. ***"Evaluation of efficiency should not be solely based on a health plan's financial performance and whether the plan generated a profit or incurred a loss."***

This is false and intentionally misleading. The plain language of the rider requires performance to be measured through transparent cost, quality, and customer satisfaction metrics developed by HHSC with substantial public input. The House rider also contains accountability requirements.

6. ***"Withholding health plan premiums as outlined in the Rider would negatively affect provider payments and access to services for clients."***

This is false and intentionally misleading. MCOs have already agreed that premiums should be withheld if health plans do not meet prescribed standards. The rider simply underscores current MCO contract language: *"MCO understands and expressly assumes the risks associated with the performance of the duties and responsibilities under this Contract, including the failure, termination or suspension of funding to HHSC, delays or denials of required approvals, and cost overruns not reasonably attributable to HHSC."* TAHP seems to contradict itself by alternately praising the structure of Texas Medicaid contracts and, here, decrying efforts to enforce those contracts.

Bizarre Turns of Phrase

TAHP's handout concludes by disparaging Amerigroup's analysis of the state's rate-setting process: "Amerigroup's argument that MCOs that lose money drive up future cost is misleading." A similarly misleading comment (which did not mention Amerigroup) was made by a TAHP representative to the Senate Finance Committee on Feb. 26.

Please consider HHSC's own publication on this point*: "MCO capitation rates are derived primarily from MCO historical claims experience for a particular base period of time, also called encounter data. Rates are established each year based on actual MCO expenditures on medical services. Reductions in spending on medical services will have the effect of reducing future capitation rates"* (Texas Medicaid & CHIP Reference Guide, 12th Edition). The mere acknowledgement of this process, juxtaposed against the consistently poor performance of some of TAHP's member plans, raises questions about whether these particular plans are employing basic principles of managed care at all.

TAHP takes a bold and shaky position here on the nature of the MCO risk calculus and how it impacts our client, HHSC. It is outrageous, logically strained, and factually troublesome to suggest, "MCOs absorb losses in any given year, not the state," but then to acknowledge, "If an expense is counted toward rate setting in the next year, it is because it was for an actual service needed and provided to a client."

The latter clearly admits that these MCO expenditures are included in the rate-setting process. They do drive the community rate higher. Failing to acknowledge this basic logic and math seems either ill-informed, naïve, or calculated to keep Medicaid rates as high as possible, in spite of certain MCOs' unfulfilled promises to save taxpayers money and deliver quality care to Texans.

Finally, this concluding section of TAHP's handout has additional, if minor, problems.

· ***"Administrative costs are capped – if a plan is inefficient and spends over the administrative cap, the spending is not allowable and cannot count toward current or future expenses."***

Amerigroup agrees with this sentiment, but it reflects a misunderstanding of the rider language. The reference to administrative savings concerns savings HHSC can realize by managing fewer MCOs in

Medicaid, not the administrative costs of MCOs themselves. Amerigroup will work to clarify this language.

· ***"Eliminating an MCO for losses as a result of costs to deliver necessary care does not save money or create efficiency – the client will just move to another MCO, shifting their costs to the other plan and there will not be any improvement to the overall financial status of the program***."

> MCO contracts contain provisions allowing HHSC to terminate a plan for any reason. TAHP's argument, intentionally or not, appears designed to justify persistent financial losses by certain MCOs, despite systemic procedures and ongoing legislative efforts to promote competition and private-sector innovation. *All health plans are not the same*. Sendero, Christus, and Children's Medical Center Health Plan all lost significant amounts of money before going out of business — all of those funds could have been used to improve care to Medicaid members or to reduce costs for taxpayers.

Some incumbent plans are now in a similarly untenable financial posture. Amerigroup believes Medicaid members should be protected through policies and financial guardrails addressing MCOs with persistent losses — the state has appropriately and successfully used similar policies to prevent excessive MCO profits.

We respectfully ask you to reconsider how you represent certain facts and invoke Amerigroup's brand.

Please let us know if you would like to discuss these issues further. We would be happy to lay out the facts and the truth around our proposals to improve managed care — both for the Texans who rely on Medicaid and those who pay for it.

Amerigroup plan President, Greg Thompson, and Anthem general counsel, Stephen Ford, are copied here.

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