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**Public Comment on:  
Pathways to Health: Medicare and Medicaid Integration Project in Washington State**

**To: Duals Project Team** [duals@dshs.wa.gov](mailto:duals@dshs.wa.gov)

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**Overview and Recommendations**

AARP supports the work of the Department and the Authority to craft new health care systems for the dual eligibles. We believe that this project holds great promise in eliminating the current fragmentation and improving the quality of care and health while adequately protecting the rights and benefits of this highly vulnerable population.

There are many aspects of this proposal that we fully support and there are also areas of concern. Accordingly, we urge the Department and the Authority to modify and expand the proposal in several areas before it is submitted to the Centers for Medicare and Medicaid Services (CMS).

On behalf of AARP Washington's nearly 1 million members, thank you for the thoughtful stakeholder engagement process and in particular for listening and responding to AARP's three major pieces of advice which can be summarized in the following sound bites:

- ***Proceed with Caution***
- ***Don't Throw the Baby Out with the Bath Water***
- ***Get something done***

The three proposed strategies embody the spirit of this feedback. Together they strike a balance between the desire for meaningful systems change and the concern that we not move too fast in too many areas of the state and or turn the clock backward on successful reform already achieved in the long term care sector.

To ensure success, AARP recommends four major areas for improvement in this proposal:

- A. **High Touch Care Coordination** – AARP recommends changes to ensure that the health home intervention is truly high touch and that it is appropriately designed to meet the needs of the duals population.
- B. **Consumer Protections** - Clearer and more specific consumer protections are necessary to counter balance the inherent incentive in capitated managed care to under service.
- C. **High Quality, Person Centered Care** - Stronger linkage to build on existing systems and successes in our long term sector.
- D. **Feasible Time Line and Structure** - A more realistic time line for implementation and greater flexibility to allow for testing of a fully integrated model.

Below are overall reactions to three strategies followed by more detailed comments related to the four major recommendations outlined above.

### **Strategy 1 –Health Homes for High Cost/High Risk Duals**

AARP strongly supports testing health homes as a means for improving care coordination for this population as outlined in Strategy 1. This strategy speaks to AARP's feedback that we urgently need to **get something done** for the duals population. Numerous studies illustrate that individuals who are dually eligible receive fragmented care that fails to take into account the full picture of their needs. Our major concern about this strategy, as outlined in this document is that the care coordination truly be "high touch" - with meaningful relationships between clients and coordinators and not just perfunctory box checking. In addition, we are concerned about funding for this strategy and continuity of the service after eight quarters if funding cannot be maintained. Finally, we question whether, in the absence of full financial alignment, coordinators will have the authority they need to achieve meaningful change.

### **Strategy 2 –Fully Financially Integrated Model through Health Plans**

AARP supports full capitation and the integrated model outlined in Strategy 2 and we appreciated that our feedback that we **proceed with caution** in this direction was taken into account. We agree with the assessment that we are not ready to implement this model statewide. We note, however, that the criteria for geographic areas may be too narrow and suggest loosening the restrictions to make it more likely that we will see experimentation with this model in more than just one or two geographic areas. Most importantly we recommend a number of specific ways that consumer protections under this Strategy and Strategy 3 should be strengthened. There is an inherent incentive under managed care to minimize care in order to maximize profit under a per member per month payment. Effective checks and balances such as those outlined in these comments are necessary to counter this. Finally, we are concerned that it is not feasible to implement this strategy by January 2013 and recommend this be pushed back to January, 2014.

### **Strategy 3 – Modernized Delivery System – mixed managed care and FFS + health homes.**

AARP supports testing managed care with a carve out for behavioral health and long term services and supports, woven together through a health home. While complex, Strategy 3 speaks to the feedback from AARP and others that we **don't throw the baby out with the bath water**. Limited capitation will integrate health care services without moving control or authority for long term care to entities with limited experience in managing these services. While it will be harder to achieve seamless coordination without full financial alignment, we support the concept of knitting these services together through the health home and through the use of performance measures and incentive pools. In addition, we support the proposals outlined in this strategy to modernize and simplify the current services delivery system. Our major concern with this strategy relates again to consumer protections and the need to more specifically spell these out both for Strategy 2 and 3.

The remainder of this document outlines our recommendations for improvement in more detail.

#### **A. High Touch Care Coordination**

The assumptions of what types of organizations can qualify to be health homes (outlined on pg. 58 of the Health Home Proposal) should be more narrowly defined. At least for a transition period, the entities qualified as health homes should be limited to community based organizations with proven expertise in serving the duals population. Examples could include Area Agencies on Aging familiar

with the needs of elders with long term care needs or mental health centers familiar with the needs of people with significant mental illness.

Effective high touch care coordination is not possible without a meaningful relationship between care coordinator and client. The general requirements, service definitions and standards support this concept but are not sufficiently specific. To ensure a high touch intervention, care managers should be required to make a minimum number of in person touches. Currently the proposal calls for in person beneficiary assessments but is vague on whether support would continue to be in person or strictly telephonic. Ongoing, in person meetings, particularly in the beginning phases of the intervention will be essential to build the personal relationship and rapport needed to drive meaningful change.

Too many clients per care coordinator will weaken the effectiveness of the intervention. On pg. 64, the Proposal sets the standard that the ratio not exceed 50:1. AARP questions whether this ratio will allow for true client to coordinator relationship building. While standard for other populations, we believe that this ratio is insufficient for the high risk, high need duals population with their complex range of service needs. We recommend that a lower ratio and specific language to encourage health homes to leverage direct care workers and the personal relationship and proximity to clients. While a ratio of for example 30:1 will be more expensive in the short run it may pay for itself in generating greater cost savings than a 50:1 ratio under which care coordinators fail to truly get to know their client and effectively coordinate their care.

## **B. Consumer Protections**

The consumer protections outlined in the Proposal are conceptual and principle-based, but critical details are lacking. The Proposal is silent on the consumer protection requirements that the State will hold health plans and providers accountable to under all three delivery models. Specifics are not included on member communications, consumer services, and a unified appeals and grievance processes. Requirements and expectations of health plans for meaningful beneficiary input and participation on Governing and Advisory Boards is not mentioned.

The need for consumer protections increases as the individual's ability to self-advocate decreases. The dual population is exclusively comprised of poor individuals who are over 65 and/or disabled. As the proposal documents, over 60% of the 65+ population qualifies for Medicaid long-term services and supports because of their medical condition and need for assistance with activities of daily living. High portions are being treated for mental health issues (psychosis, dementia, mania/bipolar disorders, etc.). A portion of the duals who are unable to make informed medical and support services decisions on their own do not have family or others actively involved in medical and service decisions.

To protect this unique population, their rights, and their health and safety will require standards for proactive oversight and advocacy of the highest level — that equal or exceed consumer protection standards found in any other health care or coverage system.

## **Enrollment**

The Proposal provides scant detail on the passive enrollment, assignment to a specific health home within a plan or the opt-out process. The proposal also lacks information on the planned beneficiary notification process and timelines.

### ***Proposed Modifications***

The passive enrollment system should provide prospective enrollees with advance notice and a reasonable election period to select a plan of health home or to opt-out. For purposes of minimizing beneficiary confusion, we suggest that the State align with CMS' Medicare Advantage open enrollment period, October 1, 2012 through December 31, 2012. With this population and such a major change in the health care delivery system, outreach and education should start as early as possible.

As with all communications under this proposal, pre-enrollment materials should be made available alternative languages and formats for individuals with limited English proficiency and disabilities.

Consumers will need information to help them select the provider that best meets their individual needs. Advance notices should include information on all available options, details on provider networks, and objective quality and credential data on the plans and their provider networks and health homes. This notice should also list the health care providers the prospective enrollee has used during the preceding 12 months drawn from Medicaid and Medicare claims data and indicate which options would and would not include access to each of their providers.

Auto assignment decisions should be based solely on the best interests of the individual. Factors should include continuity of care, particularly with the primary care and long-term care providers and specialists providing ongoing treatment; and the quality of the providers available as to prospective needs. For example, if the individual will soon need surgery, the assignment process should consider which network includes the surgeons and hospitals that have the best outcome history for that particular surgery.

### **Continuity of Care and Transitions**

Health care consumers in general and the dual population in particular rarely change health care providers. Long-term patient-provider relations improve the quality of care and health outcomes and provide a level of experience and understanding that medical records alone do not. For consumers under this proposal, continuity of care will likely be the single most important issue in their decisions as to provider/plan selections or opting out.

Unlike the proposals in other states, such as Illinois, New York and Massachusetts, Washington's Proposal lacks specifics on health plans and health home provider requirements to ensure continuity of care and to avoid disruption of services as consumers transition from fee-for-service to managed care or from one managed care plan to another. The Proposal is silent on the process for assigning beneficiaries to a health home provider under Strategy 1. This will have implications for continuity of care for current primary care providers who do not participate in the health home system. There is no mention of continuity of care with regard to the 14 Regional Service Networks (RSNS) that are now responsible for providing mental health services or the Area Agencies on Aging that today provide case management services for individuals eligible to receive Long-Term Services and Supports and who reside in their own homes.

### ***Proposed Modifications***

The continuity of care requirements during the 90 day retention period – under both Strategy 2 and 3 – should be more clearly defined.

During this period, plans should be required to allow consumers to continue to receive care and treatment with the same health care providers during that period and, as to non-network providers, required to maintain current payment rates if necessary to maintain continuity of providers and treatment.

Plans and health homes should be prohibited from imposing involuntary changes in providers of ongoing treatment until treatment is concluded and in providers of long-term services and supports for at least six months.

In all cases, plans and health homes should be required to provide advance notice of proposed changes in providers, with transition plans, and subject to the consumer's right to appeal the proposed change. This will give plans and health home providers the opportunity to persuade the individual that a proposed change is advantageous. This should include any changes in case management services being provided by Area Agencies on Aging or in mental health services provided by Regional Service Networks. Advance notice should also inform consumers on their options to maintain continuity of care and providers if they opt out of the coverage available under this Proposal.

As noted above, any auto assignment of consumer to a health home should be based on the consumer's best interests, including continuity of care by the individual's current primary care providers.

While the Proposal specifies that participation of those receiving PACE services is optional, it is not clear how individuals currently enrolled in a Medicare Advantage Special Needs Plan (SNP) would be impacted if their current SNP is not a participating health plan under Strategy 2 and 3. It is also not clear whether the person can continue to receive their Medicare services through the SNP if they opt out of Proposal's integrated model for Medicare. Health plans need to demonstrate that they meet the State Medicaid access standards for LTSS and Medicare Advantage access standards for medical services and prescription drugs prior to the go-live date.

### **Choice, Lock-In and Disenrollment**

The most highly valued protection in any consumer situation is the ability the dissatisfied to take their business elsewhere. With the health and safety of highly vulnerable citizens at stake, the right to change providers or return to fee-for-service coverage should be unfettered. The Proposal lacks specifics on the important issues of choice and disenrollment other than the mandatory 90 day retention period.

### ***Proposed Modifications***

Whenever continuity of care is not assured, consumers should be free to change plans or health homes or to opt out. This will incent providers to provide high quality medical and support services and good customer service. Notice of the right to change plans or health homes or opt-out should be provided during the enrollment and renewal processes. Consumers should have the right to disenroll at any time for cause, e.g., denial of care, a proposed reduction of the quantity or quality of care, or an involuntary change in the provider of long-term services and supports.

The Department, Authority and CMS will want to guard against any managed care provider that might attempt to encourage disenrollment by consumers who are medically challenging and expensive to care for. Washington's agencies or an independent entity should conduct exit interviews of those who disenroll and plans should be required to take corrective action when appropriate. Enhanced oversight and a system of prior authorization for potentially adverse changes in care or providers would help identify incidences of network inadequacy, poor customer service, or "lemon dropping." The Proposal should include incentives for plans with high retention rates and should consider disincentives or financial sanctions for those with low retention rates. Data on plan retention rates should be supplied to prospective enrollees and current enrollees at renewal time.

The responsibility of the plans and their networks should not end with disenrollment. They should be required to develop and implement a transition plan to ensure continuity of care.

### **Network Adequacy and Health Care Provider Selection Criteria**

While the Proposal emphasizes Washington's experience and reliance on evidence-based practices as a successful tool to attaining improved quality and outcomes, it fails to incorporate this approach in the selection of plans and the health care providers and facilities that make up their networks and health homes. The Proposal focuses on the number, size and capacity of the networks and health homes to serve the dual population, but not on their quality.

### ***Proposed Modifications***

The Proposal should establish minimum accreditation and quality standards for all plans and providers. An exception should be made for consumer directed care where care and support services are provided by paid family, informal caregivers, or personal care attendants selected by the consumer.

The proposal appropriately seeks to improve health outcomes and to reduce the use of acute care and institutional services. Adoption of standards that, for example, exclude the practitioners with the worse track records for avoidable hospitalizations and readmissions could only help in attaining this result. CMS maintains quality data on nursing including rates of infections, pressure sores, and deficiencies documented by state health departments. This and other objective quality data could be used in building a network of providers with established records of minimizing preventable hospitalizations, reducing the duration of nursing home stays, and promoting the medical progress that will make the transition to a community-based setting possible. CMS maintains similar quality data on hospitals and home health agencies that could be used to build high quality networks and some objective quality data is available on medical professionals.

AARP strongly encourages the inclusion of a requirement that Strategy 2 and 3 plans obtain National Committee for Quality Assurance (NCQA) accreditation. Currently, nine states and the District of Columbia require NCQA accreditation for managed Medicaid plans. We believe that establishing this baseline will emphasize the value and importance of strong quality measures with the Proposal. Health plans and their network of providers should also be required meet the State Medicaid access standards for LTSS and Medicare Advantage access standards for medical services and prescription drugs.

Current and prospective enrollees should be provided with information on the objective quality measures considered and minimum standard selection criteria applied by plans in constructing provider networks along with data on comparative quality ratings of each network's providers when such ratings are available.

In coordinating and managing LTSS services and providers, health homes should be required to provide consumers with objective quality data on LTSS providers and to encourage consumers to use highly rated LTSS providers. If placement with a low rated LTSS provider is necessary, health homes should be required to notify consumers when placement with a higher rated provider becomes available. Part of the coordination process should include periodic review of consumers already in the LTSS system to determine if higher quality placement options are available.

Standards should also be established for plans and health care providers as to the reduction of disparities in access or outcomes based on race or ethnicity and cultural competency.

### **Effective Oversight**

The Proposal provides a good system of retrospective monitoring for quality indicators, but does not include a system of targeted, proactive monitoring during the critical initial years of this program. For this population and their often complex medical needs in the largely uncharted waters of a merged Medicare and Medicaid managed care system that includes long-term care, the interests of consumers, HHS and Washington warrant a prompt, proactive system of oversight. It is generally acknowledged that a fee-for-service system rewards over utilization and a capitated payment system rewards underutilization. While better coordination and high quality care may make reductions in total care, services and costs possible, a capitated system's inherent financial incentive to simply spend less remains. To ensure that Washington and HHS receive good value for their dollars and that this population receives the coverage they are entitled to, it will be advantageous to rapidly identify and address problem areas as well as to reveal promising, replicable practices that result in improved quality and cost containment.

### ***Proposed Modifications***

Most state Medicaid fee-for-service programs incorporate effective prior authorization systems to prevent inappropriate utilization of medical services. Under these systems, proposed use of specific prescription medications and treatments must be justified and subjected to independent medical review. A similar system should be developed to prevent inappropriate underutilization of care under this Proposal. It would be appropriate for the Department and the Authority or an independent contractor to prospectively examine any proposed changes in a plan of care that would result in significantly reduced benefits or lower plan expenditures, and, when appropriate, to reject such changes if they are not in the best interests of the consumer. From this review,

changes in care that maintain or improve patient care and outcomes and quality of life could be distinguished from those that may have adverse impact on the individual. .

The dual eligibles will also need ready access to assistance in advocacy. Accordingly, the proposal should include an adequately funded, independent system that provides no-cost advocacy and ombudsman services to ensure that enrollees receive access to the full range of benefits and rights afforded by both Medicare and Medicaid. Advocacy in both programs will be complicated by the significant differences, as well overlaps, in benefits and by disparate appeals processes, with differing coverage standards set by federal and state law, regulation and policy; different administrative and judicial forums, procedures and timetables, and different governing state and federal case law. Ensuring that benefits and rights are maintained and protected under both programs will require professional staff with sophisticated knowledge, legal expertise and experience.

### **C. High Quality, Person Centered Care**

One of the biggest challenges in this proposal is the linkage to long term services and supports. AARP makes the following suggestions to ensure that whenever possible, we build on existing systems and successes in our long term services and supports system.

#### **Benefits and Shared Savings**

The Proposal calls for capitated managed care to provide “enhanced” benefits — for care and services not covered by either Medicaid or Medicare — and for the sharing of any savings realized by Medicare and Medicaid, but provides few details.

#### ***Proposed Modifications***

A portion of any savings achieved by Medicaid and Medicare should be allocated for expanded coverage and benefits for the duals and other residents of Washington who will soon become dual eligibles. This could include savings achieved by the capitated portions of the Proposal as well as retrospective performance payments received from HHS under Strategy 1 that exceed the costs for care coordination. These funds could be used, for example, to provide chronic care management services for those not yet dually eligible and ancillary supportive services for those seeking to remain in the community, e.g. home modification, respite care, personal emergency response system, and transportation services.

#### **Quality Management/Expected Outcomes**

The Proposal’s quality performance metrics address several key domains including beneficiary engagement, appropriate service utilization and access to care. Health homes are appropriately required to provide performance measure reports. The evaluation section of the Proposal plan identifies quality monitoring reports (i.e., HEDIS quality measures) that will be made available beginning year two of the demonstration.

It is not clear from the Proposal how plans to work with CMS to develop a comprehensive quality management program that combines requirements for both Medicare and Medicaid for Strategies 1

and 2. It is also unclear how and when consumer experience and satisfaction will be measured and whether consumers will be involved in the evaluation process.

### ***Proposed Modifications***

The Proposal should include a more specific and robust evaluation component that includes uniform and independently collected and analyzed data on consumers' experience and satisfaction. For all three Strategies, the Department and Authority should establish advisory councils that include consumers and their representatives and advocates. Minimum quality improvement standards should be established and providers under each Strategy should be required to meet uniform targets for reducing disparities based on race or ethnicity as to access, health outcomes and consumer experience.

### **Long-term Services and Supports – Assessments and Coordination**

While the proposal requires a comprehensive long-term services and support assessment within 30 days of enrollment, it is not clear who will be responsible for this assessment and the standards employed to ensure that consumers are able to receive LTSS in the least restrictive setting.

### ***Proposed Modifications***

LTSS assessments should be reviewed periodically and whenever there is a significant change in the individual's medical condition. In Strategy 1, assessments should be completed by the health home provider and should form the basis for the LTSS plan of care. In Strategies 2 and 3, assessments that result in proposed changes in the plan of care that require a change in LTSS providers or a significant reduction in the scope, duration or amount of services and supports should be subject to independent medical review as well as appeal by the consumer.

It is particularly important that care coordinators under all Strategies be held responsible for coordination of medical care and non-medical supportive services. Many dual eligible individuals and their care takers will not be able to remain in the community without coordinated access to appropriate and affordable housing, transportation services, nutritional support, personal care and respite services.

## **D. Structure and Feasibility**

Washington's Proposal is far more complex and multi-faceted than those put forward by other states. This complexity, in combination with the aggressive time line for going live with Strategy 1 and Strategy 2 by January 2013 and the already over taxed capacity at state agencies raises concern. Delaying the time-line and simplifying the criteria for participation in Strategy 2 will improve feasibility and strengthen the Demonstration.

### **Delay Time Line for Full Capitation to January 2014**

To ensure successful implementation, AARP recommends pushing out the time line for Strategy 2 by one year to January 2014. It does not seem feasible to complete the complex steps involved in the selection and readiness review of plans and be ready to begin enrollment by November 2012 and go live by January 2013. Cramping this process into essentially a six month time frame (May –

October) is unrealistic and would force the state to begin implementation even before CMS takes action on the Proposal. The design and implementation of a new and complex system for such a large and vulnerable population should not be rushed. It is very difficult to see, for example, how the state would be ready to publish as soon as May 1<sup>st</sup> state specific requirements for plans such as provider network adequacy and the process for evaluating plans for services. Defining standards for long term services and supports is breaking new ground and must be done in a careful and thoughtful manner with stakeholder input. This is not feasible by May 1<sup>st</sup>, 2012.

The time line for completing the political process for getting county level approval is also unrealistic. To go live by January 2013, Washington would need to have decided which plans are approved and have final commitment from county authorities by the end of July. Given the unpredictability of political process generally and in the counties, this is unlikely to happen by then.

Instead of rushing forward and making mistakes, AARP recommends that the Proposal recommend a start date of January 2012 so that we can ensure high caliber, high quality demonstration.

### **Choose from A Broader Range of Plans**

The Proposal limited participation to the five plans chosen through the joint procurement of managed care plans to serve the Healthy Options program and its expansion to the SSI population of blind and disabled individuals. These plans were chosen for a different population and do not necessarily have a track record in serving the duals or managing long term services and supports. A later starting date will allow the state to solicit interest from a wider pool of potential plans that may have more experience and expertise serving the duals than the five plans.

### **Phase in Health Homes**

The implementation of health homes statewide beginning in January 2013 also seems unrealistic. AARP recommends phasing this implementation, with priority for establishing health homes in areas of the state likely to implement either Strategy 2 or 3. Limited agency staff capacity should be targeted to qualifying effective health homes in these targeted areas first, then moving on over a period of months or one year to focus on health homes in other parts of the state. Ensuring identification of strong health home partners will be essential to success of Strategies 2 and 3.

### **Broaden Criteria for Participating in Strategy 2**

If sufficient consumer protections are in place, AARP supports a robust test of Strategy 2. We are concerned that the county selection criteria outlined on page 22 of the Proposal are too narrowly defined and could result in only one of two counties actually testing Strategy 2. To increase the numbers of counties participating and duals served, , AARP recommends reducing the population requirement from 5,000 to 3,000 in the proposed country or multi-county service area or simply eliminating the requirement altogether. If the population is too small plans will not elect to participate. In addition, we suggest modifying the language on the role for counties to ensure that they have a role in decision making but not requiring affirmative action by counties to move forward.

