April 13, 2012

Dual Project Team
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Thank you for the opportunity to provide public comment on the Pathways to Health: Medicare and Medicaid Integration in Washington State draft proposal dated March 12, 2012.

We appreciate the opportunity to have met with Bea Rector and Kathy Pickens-Rucker, on April 12, 2012, at which time we discussed many of the comments on the draft proposal you will find recited below.

It is evident the two state departments, the stakeholders, and the involved beneficiaries, have been very diligent in their efforts over the past year designing the proposal and preparing for this grant application.

We are in support of the State of Washington efforts to seek additional federal dollars to fund the demonstration to fully integrate care for dual eligible individuals. Our comments below should be read in support of addressing the dual eligible population but also must be read as cautionary to any replication or expansion of these demonstration practices to non-dual populations.

We support the concept of "one stop shopping" for all Medicare and Medicaid acute and LTSS for duals as the basic premise. We applaud the state in its openness to consider and develop new strategies to improve health care, services and supports and their associated costs. This proposal covers all of healthcare services and supports for the dually eligible population. Our lens, in reviewing this draft proposal, although trying to be open to the totality, is heavily focused on the long term services and supports elements of the healthcare system.

The benefits/service plan, as described on pages 24 thru 26, is quite robust. We agree it needs to be to serve and support the whole person who often presents with multiple health issues; physical, behavioral, long-term and chronic. We ask if you might, under the LTSS component, include the opportunity for new and innovative services, the title of any such service yet coined, that promotes appropriate navigation and transitions through the spectrum of service needs. Many LTSS providers today, when trying to meet the needs of the consumer and remain as a viable business, are developing new services consistent with the goals of the health care law, and we should not, unintentionally, preclude these new services from coverage by omitting them from the list in this draft application.

The draft speaks to how Washington State is a leader in certain areas including re-hospitalization rates, appropriateness of LTSS, appropriate utilization of skilled nursing facilities, increased utilization of community options, and in the innovation of services that support improved access to quality long term

services to those who need them and in their preferred location. This creates a high bar from which to measure any improvements or successes, however they may be defined, when and if the state is compared to others participating in this federal grant. The fact that Washington is already a leader should be acknowledged; at the least any CMS measurements used in determining success of this grant may need to be weighted for Washington's entry point.

There is considerable reference to aligning payment, cost containment, integrated financing, fiscal accountability, financial incentives, savings, and return on investment. However, throughout the year of meetings and in this draft proposal, there has been and is an absence of detail regarding payment, capitated, fee for service, managed care, modernized or simplified funding. Therefore, we remain concerned with the adequacy of funding, the appropriateness of distribution of funds and the financial alignments necessary for this proposal to succeed. Not addressing the funding detail, does not allow potential contractors the opportunity to weigh their support and involvement and thus calls into question any of the actuarial work regarding viability of networks, enrollment expectations, etc.

Further, and specific to the duals, acknowledge that it is largely savings from federal expenditures (Medicare) that will be gained by reducing avoidable hospitalizations, rather than a reduction in spending and potential savings from Medicaid. Without the suggested overall program "savings" from decreased Medicare utilization, only applicable with duals, we question whether this proposal can move forward. To sustain this project, these savings must be redirected to the other Medicaid service lines, SNF, HCBS, etc., rather than appropriated to fund other federal programs or cover administrative costs of health plans or health homes. Beyond Medicare savings, any savings accrued through managed care due to utilization of less costly service lines, is more a redirection of those funds than it is a savings.

We caution anyone against believing that this type of a proposal truly saves money. At best, it might spend our health care dollars more appropriately, it may promote better utilization of health care services, but it has not been proven that programs such as this will actually result in lower spending. The LTSS system is significantly underfunded at this time and, in the minds of many, this underfunding will only increase in future periods. Any Medicare savings must be invested back into the system to improve care and financial stability in SNF and HCBS; valuable and necessary partners in reducing avoidable hospitalizations and reoccurring Medicare covered stays in skilled nursing facilities. In so doing, you may increase availability of HCBS and reduce unnecessary use of Medicaid SNF services if Medicaid capitated rates provided appropriate incentives for community care. Any return on investment for the state is surely long term and difficult to measure.

Health plans using health homes is an intriguing concept and difficult to envision. However this concept unfolds, one of our concerns is with the contracting for these health plans and those health plans contracting with health homes. The departments must look for plans that have experience or strong interest in managing Medicaid LTSS, not just the typical medical and related services of the past. Health plan contracting terms need to specifically address and emphasize timely payment processing with providers. Negotiated funding, or funding set at already too low of level, is only exacerbated by cash flow problems brought on by unnecessarily delayed provider network payments. The departments must

also identify and promote staff and other resources needed to negotiate contracts, measure deliverables, and enforce those contracts.

The draft proposal and the federal guidance for these integration proposals speak to improved use of electronic health care records and information. It calls for advancing portability and suggests improvements in this arena are necessary. We could not agree more. Today in Washington State, the governmental funding for this purpose has only been awarded to certain qualified professionals and or hospitals, not inclusive of providers of LTSS. To best meet the goal of expanding and improving the use of EHR, we ask that the departments, within this grant proposal, expand the incentive funding to providers of EMS and LTSS. This can only improve the chances of Washington meeting that goal element as it is part of the federal duals innovation grant program.

We appreciate the departments acknowledging that there are significant obstacles to implementation of this proposal for the duals population. Although understood, we need to reiterate, that much of the service provision, the licensure criteria and the payment mechanisms in Washington Medicaid LTSS programs are in statute and are in accord with filed state plans and waivers. The processes, political and regulatory, in changing these codes may be slow at best. This may affect planned effective dates. This also needs to be acknowledged.

It is understood that the departments will be revising the draft and pulling together a complete and final version by month's end. Above, we have offered our comments on the departments' draft proposal at a fairly high level. However, we did review the draft proposal in depth, and as for format, location of certain data tables, charts and text, we could offer suggestions. If you would like that level of detailed comment, we could offer it under separate cover.

Thank you again for the opportunity to review the state's draft proposal for integrating health care services for the dually eligible population.

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