

## **SE Washington Aging and Long Term Care 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)

**From:** Lori Brown, Director Southeast Washington Aging and Long Term Care

**Introduction:** Southeast Washington Aging and Long Term Care participated in multiple stakeholder meetings pertaining to the development of the multi-phased design and implementation plan for service delivery models that integrate care for individuals who receive both Medicare and Medicaid services. SE WA ALTC appreciates the stakeholder process and the due diligence in obtaining public comment throughout the process. We applaud the Department and Authority for looking at methods to better integrate service delivery systems for consumers that use multiple care delivery systems. With modifications, we support the “Managed fee for service financial model,” outlined in Strategy 1, and the “Design Plan Financial Model,” outlined in Strategy 3 of the plan.

There are areas that SE WA ALTC supports and areas that create some concern. SE WA ALTC requests the following modifications to the plan.

**Consumer Protections:** The plan appropriately calls for the State (and presumably its agents) to perform long term supports and service CARE assessments. ALTC believes this approach will ensure that there is uniformity in consumer benefits that will help provide the consumer with equal public access to a suite of service delivery options from a nonbiased entity. ALTC also supports the use of a standardized assessment across the State for long term supports and services.

**Recommendation:** SE WA ALTC believes consumer protection could be strengthened by ensuring that reassessment and conflict free care coordination also remains with the State and its agents within Long Term Supports and Services and is specifically cited as such in the plan. The Long Term Supports and Service delivery system in Washington State is highly visible and has been tremendously successful. They have sixteen years of proven history in Washington State performing this work with disabled adults age 18 and over. There is a service delivery infrastructure in every county with experienced staff Care Coordinators (aka Case Managers) who are familiar with the broad array of service availability and have rapport and expertise with this population. They have a strong tradition of advocacy and ensuring consumer choice and client directed service planning. This is a service delivery system that has had proven results in cost savings, high levels of client satisfaction, choice, family supports and consequently is rated 2<sup>nd</sup> in the nation by AARP in the AARP’s 2011 State Scorecard report for long term supports and services. This same study rated Washington State’s Long Term Supports and Services 30<sup>th</sup> in the Nation for cost.

It is important to ensure that consumers have one uniform and standardized assessment and standardized care coordination from a nonbiased entity. It is necessary to look at the history of the successful program delivery and its structure and build upon this success.

**Evidence Based Programs and Practices:** The Department and Authority reference evidence based practices and programs. This is vital to ensuring successful health outcomes and meeting the triple aim for some of the most challenging client populations that are high cost and high risk.

**Recommendations:** Although the plan references the Department on its Chronic Care Management program, it is important to note that the evidence based practices outlined in the draft plan evolved from the “mobility project,” that started in 2003 to what became known as the Area Agency on Aging Chronic Care Management Project that focused on the high cost/high risk clients receiving long term supports and services. The studies have played out that there was significant monthly cost savings in the Medicaid Medical, improved health and mortality rates that were significantly lower than the control group. There is also evidence of high levels of client satisfaction within these programs. (There is also a promising behavioral health program that has similar results.) As the State, working in partnership with the Area Agencies on Aging and Cowlitz County Behavioral Health, has a history of successful Chronic Care Management Programs with specific populations, the rapid time lines for health homes and the lack of reference protecting these particular program specifically, may have the unintended consequence of undermining evidence based programs that have proven effective with the population that the State hopes to impact. **Therefore, it is our recommendation that the behavioral health program and the Chronic Care Management program operated by the Area Agency on Aging, receive a grace period significantly longer than January 1, 2013 while they attempt to establish a partnership with a health home.** The deadlines do not provide adequate time to appropriately process and network with community providers in a meaningful way and as a result there is high potential to undermine the work that has proven successful. The time frames could also disrupt the continuity of care for clients benefiting from the Area Agency on Aging’s Chronic Care Management Program, as if a health home is slow in developing in a community where clients receive this program, they will be bereft of the services come January 2013.

**Time Lines:** Although ALTC appreciates that much has been done at the State level to develop innovative approaches to dual eligible populations, the timelines for roll out do not account for the kind of slow implementation and evaluation that should be taking place. It also doesn’t account for the local community development process that needs to happen so that community providers are working together in an integrated way for the benefit of the consumer.

Primary Medical Providers, hospitals and health and human service providers serving the dual eligible populations have had significant funding cuts and policy changes as a result of the State’s lack of revenues. This has slowed innovation down as organizations grapple with these significant changes and has also resulted in inundating providers with clients whose needs are

not met as well due to limited resources. This has taken time and attention away from innovative ideas and placed organizations in a crisis mode. Thus, staffing resources have been devoted to responding to these issues, and not tracking on current proposed innovations. Because of this, health home development will be a much longer process on the ground thus rendering the time lines in the plan unrealistic.

ALTC recommends greater flexibility and time lines that are pushed back further than those currently proposed.