



Northwest Justice Project



Northwest Health Law Advocates

To: Duals Project Team via email Duals@dshs.wa.gov

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Subject: Comments regarding the draft proposal for "Pathways to Health: Medicare and Medicaid Integration in Washington State"

INTRODUCTION

Thank you for this opportunity to comment on the state's draft proposal for Medicare and Medicaid Integration Project. These are the combined comments of three legal advocacy programs with a wealth of experience and expertise advocating for individuals in the Medicare and Medicaid systems, as described in more detail below.

- **Disability Rights of Washington (DRW)** is the federally funded private non-profit protection and advocacy organization that protects the rights of people with disabilities statewide in accord with our federal mandates under 42 U.S.C. Sections 15001 - 15045 (2003) Protection & Advocacy for Individuals with Developmental Disabilities (PADD), 42 U.S.C. Sections 10801 - 10827 (2003) Protection & Advocacy for Individuals with Mental Illness (PAIMI), 29 U.S.C. Section 794e (2003) Protection & Advocacy for Individual Rights (PAIR), 29 U.S.C. Sections 3001 - 3058 (2003) Protection & Advocacy for Assistive Technology (PAAT), 42 U.S.C. 300d - 300d-53 (2003) Protection & Advocacy for Individuals with Traumatic Brain Injuries (PATBI), and 42 U.S.C. 1320b-20-1320-21 (2003) Protection & Advocacy for Beneficiaries of Social Security (PABSS).
- **Northwest Health Law Advocates (NoHLA)** is a non-profit organization based in Seattle, Washington, that promotes increased access to health care and basic health care rights and protections for all individuals. NoHLA seeks to achieve these aims through legal and policy advocacy, education, and support to community organizations in the Pacific Northwest. NoHLA provides educational materials, trainings and briefings to Washington state attorneys and social service providers on the operation of and changes to public medical programs.

- **Northwest Justice Project (NJP)** is a nonprofit law firm providing free civil legal assistance and representation to low-income people and communities throughout Washington. As a publicly funded legal aid program, NJP each year handles approximately 18,000 cases benefiting more than 40,000 people in cases affecting basic human needs, including access to health care services. NJP's comments on behalf of our clients are provided as part of our mission to secure justice through high quality legal advocacy promoting the long-term well-being of low-income individuals, families, and communities.

OVERARCHING ISSUES

We support the underlying goal for this project of improving coordination of care, independence in health care choice, and health outcomes for individuals who are dually eligible for Medicare and Medicaid in Washington State. We view the proposal for Strategy 1 as having much promise in working toward that goal. However, we believe the proposal, especially with respect to Strategies 2 and 3, which involve an "opt out" enrollment system and capitation, is not sufficiently developed. Our comments highlight areas we believe the state should address before submitting the proposal to the Centers for Medicare & Medicaid Services.

We recognize the state's efforts thus far to address the complex issues required for this demonstration and to engage stakeholders in the planning. However, making enormous changes in service delivery for a vulnerable population always poses the risk of creating harm as well as improvements. The changes proposed create tasks and challenges for state government, county governments, RSNs, health plans, local advocacy organizations, provider systems, and most significantly, beneficiaries. The state's ambitious plan to enroll SSI clients into managed care beginning in July 2012 will strain all these resources at the same time this demonstration requires major effort of all affected for initiation January 2013. The overlapping of these two huge initiatives also means there will be no opportunity for assessing the successes and failures in the SSI project and using that to adjust and inform the process for this demonstration.

As a result, we concur with comments from other stakeholders that *the timeline for implementation is unrealistic*. We are concerned that the capitated systems proposed in Strategies 2 and 3 cannot be implemented in a way congruent with the goal for the demonstration by the deadlines set. We request that the timeline be revised to delay implementation of Strategies 2 and 3 to a date no earlier than 2014.

The comments we make below about specific aspects of the proposal fall into these general categories:

- Strategy 1 Comments

- Enrollment-related Issues
- Capacity and Quality
- Consumer Protections
- Stakeholders
- “Best of Both Worlds” Assurance

Note: These comments are not intended to be comprehensive. Thus absence of commentary on any given aspect of the duals program should not be taken as an endorsement of that element of the proposal. Our comments are rather intended to focus reviewers toward particular areas we view as raising serious concerns or offering important opportunities for improvement.

STRATEGY 1 COMMENTS

Transparency regarding “high risk” criteria and the PRISM algorithm

The Proposal contemplates offering home health services under all three strategies to individuals who are identified as being “high-risk” in virtue of their scoring 1.5 on PRISM and possibly having a chronic condition on the State’s designated list of such conditions. It is not facially obvious why an individual with one of the listed conditions is necessarily more “high-risk” than an individual who has another serious, but unlisted, ongoing medical condition. Additionally, the clinical or functional differences between individuals possessing PRISM scores that differ by 0.1 is even more opaque.

The justification for restricting home health benefits to this subpopulation of the dually eligible is difficult to understand without knowledge of the actual criteria used to identify them. To this end, the State should promptly make public the PRISM algorithm and any basis used to determine the list of chronic conditions used for eligibility.

Availability of home health services to less “high-risk” individuals

We recognize the promise that home health homes hold out for better care coordination for the entire spectrum of a beneficiary’s health needs through local providers and agencies. Indeed, it seems likely that home health services would be valuable to many dually eligible individuals who do not have one of the chronic conditions in the Proposal’s designated list or have a 1.5 score on the PRISM. We recommend that the State considering offering home health services to such less “high risk” individuals as well. If necessary, a lower provider rate could be considered for such individuals, given the possibility that they will be lower utilizers of this service than “high risk” individuals.

Confusion born of simultaneous rollout with Strategy 2

The Proposal’s explanation of the difference between components of a home health provider and the Strategy 2 health plan are complex and can be difficult to understand. For

example, the difference between a home health provider's network and an MCO's network may not be facially obvious. Nor may it be immediately clear to some what role an MCO's care coordinator plays that is different from many of the responsibilities of a home health providers. Add to that various considerations beneficiaries will have to take into account when deciding whether to choose to receive home health services, at same time as they are deciding whether to enroll in an MCO, and one has a recipe for confusion. This further supports the previously discussed reasons for extending the rollout date of offering capitated medical coverage to dually eligible individuals.

ENROLLMENT-RELATED ISSUES

A Voluntary Opt-In Process Should Be Provided for Beneficiaries to Enroll in MCO's Under Strategies 2 and 3

Dual eligible beneficiaries must retain their freedom to choose how, where and from whom they receive care, and have access to the full range of providers they already see. To be truly voluntary, the state must provide the beneficiary an *informed* and *affirmative* choice whether to participate in a dual eligible integration demonstration – that is, whether to “opt-in” to the demonstration or choose not to do so. An opt-in system offers the highest level of consumer protection and honors the autonomy and independence of individual beneficiaries by preserving for low-income dual eligibles the same right to provider and delivery system choice that exists for middle and higher income Medicare beneficiaries. As a practical matter, preserving that choice is often necessary to maintaining beneficiaries' continued access to specialists and other providers who may not participate in the integrated plan networks. This is particularly important for dually eligible individuals with complex medical conditions, such as residents of skilled nursing facilities.

Voluntary “opt in” enrollment processes have been used by integration models that are regarded by many as positive, beneficiary-centered programs. For example, the Program for All-Inclusive Care for the Elderly (PACE) is an “opt in” model. Massachusetts' Senior Care Options, Minnesota's Senior Health Options and Wisconsin's Family Care Partnerships all use an “opt in” enrollment model. Advocates in those states report that the enrollment mechanism helps participating plans attract and retain enrollees. The “opt in” model also helps ensure that program participants are committed to using the care coordination services that the model is designed to provide, and that beneficiaries are prepared to accept any changes in coverage limits or procedures attendant to managed care participation.

The passive enrollment procedure proposed for assigning beneficiaries to MCO's operating in Strategy 2 or 3 with a 90 day lock-in period raises serious questions that go unanswered in the Proposal. It also creates a significant risk that some beneficiaries will receive inadequate services as a result of their enrollment in a plan that they do not understand and that will be unable to meet their care needs. Beneficiaries who accept the default

passive enrollment into one of the selected health plans may not have sufficient information about the plan, and they may not realize that the plan chosen for them is not a good fit. For example, a beneficiary may not find out that a chosen provider is not in the plan's network or does not provide a desired level of services until after the passive enrollment has taken effect. By that time, the individual may have experienced a disruption in care that opting out after ninety days comes too late to remedy.

Required Components of An Opt-Out Process that Preserves Freedom of Choice

If the State chooses to continue to base Strategies 2 and 3 upon passive enrollment with opt-out provisions, it must adopt and express in the Proposal a commitment to implementing a number of protections for beneficiaries to bolster the notice provided to enrollees with the information they will require to make decisions regarding plan enrollment (or rejection) and allow greater continuity of care for new enrollees. The goal of these protections, and a pre-requisite to maintaining enrollees' freedom of informed choice in making enrollment decisions, is to ensure that they will suffer no significant harm as a result of their decision to enroll in an integrated care MCO. These protections must at a minimum include:

1. Advance Notice of Enrollment Options Must Be Detailed

- a) **Two Pre-Enrollment Notices** - Because of the particular vulnerability of and frequent communications and cognitive challenges faced by this population, advance notice should occur in at least two separate written notices before the opt-out deadline. Initial notice should be sent 90 days before the deadline. If a notice recipient does not respond to the initial notice, an attempt should be made to contact the recipient by phone. In addition, beneficiaries should receive a notice after enrollment occurs that includes information about the right to opt out.
- b) **Required Notice Contents** - The notices must include at least the following information:
 - A clear description of the integration demonstration proposal and each strategy open to the individual;
 - A listing of which of the beneficiary's providers are, and are not, participating providers in the demonstration program/network to which they will have access;
 - A description of the consequences of staying in the demonstration, including restricted provider networks and impact on current treatment plans particular to the beneficiary;
 - A description of how a beneficiary can disenroll;
 - Contact information and descriptions for enrollment brokers, ombudsman and other consumer assistance programs.

c) Accessibility

- *LEP and ADA compliance* - This notice should be accessible to people with Limited English Proficiency, available in alternate formats and accessible to people with disabilities, satisfying standards of Title VI of the Civil Rights (See 68 CFR 47311), the ADA, as well as section 1557 of the ACA. Readers must be readily available for clients with literacy challenges.
- *Translation* -All notices must be translated as required by limited English recipients, in compliance with federal law and operative court decisions, and industry best practices. We request that all English language notices also include taglines with at least 15 languages that explain how LEP persons can access language services. The American Translators Association has published guidelines for written translation (https://www.atanet.org/docs/Getting_it_right.pdf) that could provide additional guidance in this area.
- *Readability/Plain language* - Notices must be tested for readability and appropriate grade level; all notices should be at a 6th grade reading level or lower. Notices should comply with relevant plain language requirements, such as the Plain Talk Executive Order 05-03 issued by Governor Christine Gregoire.

d) Stakeholder involvement - The state must consult with beneficiaries and their advocates in designing notices (see below for broader discussion of this issue). Notices should never be designed solely by an interested party, such as a managed care organization. Notices must be designed or approved by independent or government reviewers, in coordination with consumer stakeholders.

e) Format/Compliance with §1392(a) - In implementing the above, when relevant, the State must specifically comply with section 1932(a) of the Medicaid Act, including section 1932(a)(5) requiring information in chart-like format allowing beneficiaries to compare their options.

2. Enrollment Consumer Assistance

The state should conduct independent enrollment and consumer assistance that includes the following components, commitments to which should be included in the Proposal.

- a) **Independent enrollment broker** - For enrollment, the state should use an independent enrollment broker (IEB) or assume that role itself. The enrolling entity should not be an interested party, such as a managed care plan. The IEB can also help meet the consumer assistance requirement.

- b) **Consumer assistance independent from the plans must be funded and available** - The state must not rely on the health plans as the only or even primary source of consumer assistance. This consumer assistance requirement should be satisfied by state contracting with community-based organizations like Area Agencies on Aging, Aging and Disability Resource Centers, local ARC affiliates, Independent Living Centers, SHIBA and other appropriate agencies. Although the proposal contemplates SHIBA meeting this need, there is no provision for funding for this consumer assistance. This would place a major burden on SHIBA and commitment of agency resources. Without substantial funding, SHIBA or other agencies will not be able to offer adequate consumer assistance

- c) **Consumer assistance access to necessary information and other capacities** - The enrollment and consumer assistance entities, whether independent enrollment brokers, state offices, or other contractors, must have access to real-time network provider lists including PCPs, specialists, hospitals, home supports agencies, and also drug formularies, and pharmacy networks, as well as the capacity to provide personalized counseling to beneficiaries. In addition to the capacity to answer specific questions, consumer assistance entities must have a general introduction option where consumers do not have to ask all of the relevant questions, and are instead guided through the important content.

In order for beneficiaries to make good choices, they and their helpers need access to accurate lists showing which providers are available in which networks/plans. The network information is needed for beneficiaries to determine which current providers are in the networks, and whether any network will cover all the beneficiary's current providers. The information must include which plans and providers are accepting new enrollees or patients. This information must be accessible before the first notice goes out. To ensure accuracy, the State must commit to in the Proposal and ensure that this information is updated regularly.

The state also must provide adequate access to customer service staff. Currently Medicaid clients frequently complain to advocates about difficulty reaching live assistance through the existing customer service lines. The existing resources cannot begin to address the needs that will arise during enrollment of the SSI and the dual eligible clients into new managed care systems. Adequate funding for sufficient staffing and for training of that staff is essential.

The state should also place meaningful restrictions on marketing practices and materials that provide inaccurate or misleading information. The state should require advance approval of all marketing materials, call scripts, and practices, and should include stakeholder notice and participation in the approval process.

3. Enrollment Assignment System

If the state is permitted to passively enroll individuals and auto-assign them to a managed care plan, there should be minimum standards and use of “smart” auto-assign methods and commitments which should be articulated in the Proposal.

- a) **If there is only one integrated care MCO health plan offered in any particular geographic area**, the dual eligibles in that service area should never be auto-assigned or passively enrolled into that single network, *if it does not include their PCP*. For these individuals the state must use an opt-in system.
- b) **If there are multiple managed care organizations available in a particular county or area**, the auto-assignment should only allow *assignment to networks that include the individual's PCP*. If multiple plans include the PCP, then assignment should be based on factors that serve the patient's interests, such as maximum participation of providers and coverage of services.
- c) **If individuals have no record of health history**, assignment should be based on some other set of criteria that are intended to serve recipients' best interests, such as geographic proximity to providers, diagnosis driven provider capacity, and language preference.
- d) **Change the Strategy 2 and 3 Rollout System and Timetable** – The Proposal contemplates that integrated care MCO's will have a phased enrollment based on geographic area. However, phasing by geography simply divides the burden, rather than assisting the state and plans in testing and strengthening the system by beginning with enrolling beneficiaries with less complex presentations. Given the enormous complexity of this process, all parties may benefit from having enrollees with fewer identified and chronic medical needs enrolled first, with populations with more complex needs enrolled over time in phases. To this end, the state should establish a maximum threshold for passive enrollment at any given time, with more vulnerable populations with complex health needs phased-in after less complex populations.

4. No lock-in period

Beneficiaries must be provided with the right to opt-out of their MCO's at any time, including the first 90 days of enrollment in the plan. CMS has broad waiver authority under §1115A(d)(1) of the Social Security Act to require mandatory enrollment of Medicare beneficiaries *who are not dual eligibles* in managed care plans under specified circumstances (e.g., if necessary to test and evaluate a model or proposal for service, and

where quality of care is preserved or enhanced and program costs do not increase). However, CMS authority under 1115A(d)(1) to waive the rights of Medicare beneficiaries *who are dual eligibles* is very constrained. Dual eligibles have rights under both Medicare and Medicaid law, and §1115A(d)(1) does not allow CMS to waive the *Medicaid* rights of dual eligibles that forbid the involuntary assignment of a Medicaid recipient to a managed care plan. CMS cannot waive sections 1902(a)(23) and 1932(a)(2)(B) to allow a state to require enrollment in a Medicaid MCO, in order to receive Medicare and Medicaid benefits under the demonstration proposal, even if the purpose of the proposal is to test and evaluate innovative models of payment and service delivery.

5. Continuity of Providers and Treatment

The passive enrollment process in Strategies 2 and 3 must include protections to ensure continuity of access to providers and treatment plans. Passive enrollment created serious health problems in the 2006 Medicare Part D passive enrollment process. We can expect similar health problems to occur if a beneficiary is auto-enrolled into a new managed care plan in Strategies 2 or 3 and is immediately unable to access her medical providers or medical treatments. The following protections related to beneficiaries' continuity of care must be provided by the State and contracting integrated care health plans, commitments to which must be included in the Proposal:

- a) **Six (6) month enrollee transition period** -Enrollees in Strategy2 and 3 MCO's should have *at least a 6-month (rather than 90 day) transition period that begins on the date of the beneficiary's first provider visit after enrollment occurs.* For example, if a beneficiary is passively enrolled on January 1st, and next goes to the doctor on March 14th, the transition period should last until at least September 13th. Enrollees may not begin to recognize disjunctures between their new plans' networks and the set of providers from whom they previously received services until they seek such services again after enrollment.
- b) **No change in terms of care and provider availability during transition** - During this six month transition period, individuals should not be subject to any of the network limitations of the managed care entity or treatment controls, such as new prior authorization criteria, quantity limits, step therapies, drug formularies, with respect to the individuals' on-going treatment. A beneficiary's providers should receive reimbursement under their previous rates for the span of the continuity period.
- c) **Continuity remains unbroken when authorization period for ongoing treatment expires:** Continuity of treatment must apply to all individuals' current treatment plans, and the continuity protection should not be broken because of the end of an authorization period for an on-going service. For example if a beneficiary has a home attendant service that is re-authorized every

- 3 months, the authorization in place at the beginning of a 6-month transition period would clearly expire in mid-transition period. That expiration should not end the continuity requirement if, in the medical provider's opinion, a re-authorization is part of the same treatment.
- d) **Continuity must be maintained even with a change of provider** - There must also be specific provisions for maintaining the approved level of services for the continuity period, if the beneficiary changes provider in the middle of an approval period.
 - e) **Application of continuity to foreseeable care** - These treatment continuity protections must apply to any service addition or change that is a reasonable, foreseeable or necessary part of a current treatment plan.
 - f) **Continuity of care at the end of the continuity period** - Strategy 2 and 3 MCO's must be required to develop a plan for how they will handle the end of the continuity period. If a beneficiary's PCP has not joined their network, the state must develop a system to outreach the beneficiary in the 30 days prior to the end of the continuity period to inform the beneficiary their provider has still not joined the network, that the continuity period is ending, and that they have the option of opting out or changing providers.

The Proposal lacks other details about the continuity provisions required of the plans that are needed to assess their adequacy. Which entity, the plan, or the state, will pay for out of plan providers during this period? Will the providers be required to enter into a contract with the plan in order to serve the client? How will the plans have the information needed to comply with these continuity requirements? These issues are important to address to ensure that announced continuity protections are truly meaningful.

CAPACITY/QUALITY CONCERNS

Network Adequacy

We are gratified to hear that "[t]he state is committed to a thorough readiness review and will not enroll participants unless and until the managed care organization demonstrates an adequate provider network." Proposal at 49. Provider networks must be robust enough to meet the unique service needs of the new populations being enrolled, especially beneficiaries with physical, mental, and/or intellectual disabilities, older adults, and individuals needing LTSS. In order to ensure that this takes place, the Proposal should: a) include positive commitments for areas in which the State will require plans to meet network adequacy standards; and b) a general descriptions of the types and minimum schedules of monitoring and reporting activities that the State will require of the plans and in which the State will engage to enforce its network adequacy requirements. Specifically, plans should be required to:

General Standards

- 1) Geographic standards for available providers: adhere to specified standards for maximum distance and average travel time each enrollee will have to travel to reach providers. and average. The relevant standards in HCA's current Managed Care Template Contract (MCTC)¹ should serve as a floor. However, the State must review these standards with stakeholder input to determine whether and to what extent they should be made more protective of enrollees than those in the current MCTC, due to the specific requirements of the duals population being served in the localities in question. Additionally, due to the increased rate of specialty care required by the duals population, the State should establish specified standards for distance and average travel time to reach the following types of specialists, for whom standards are not listed in §5.10 of the MCTC: Cardiologists, Neurologists, Oncologists, Ophthalmologists, Orthopedic Surgeons, General Surgery, Gastroenterologists, Psychologists, Psychiatrists, Pulmonologists, Otolaryngologist, Specialists in Physical Medicine and Rehabilitation, including Physical and Occupational Therapy, and Speech Language Pathologists.
- 2) Choice of providers within a specialty: require a choice of at least two eligible providers for each service identified in the plan benefit package.
- 3) Waiting times: require that in-network providers furnish office appointments to enrollees within specified waiting times assessed as reasonable for this population.
- 4) Maximum time required to receive care: establish maximum times within which different types of medical care/appointments must be made available to enrollees. The relevant standards of §§5.5 and 5.7 of HCA's current MCTC should serve as a floor for these standards, with the following exceptions. Stakeholders have particular concerns with the standard articulated in: §§5.7.1, 5.7.2, and 5.7.5. Given both the institutional service needs of this population, and the reasonable goal of this integration proposal to reduce the need for long-term facility-based care, there are concerns as to whether providing transitional health care services within the seven (7) calendar days specified in §§5.7.1 and 5.7.2, from when enrollees are discharged from inpatient and institutional care, will adequately address this population's needs. Additionally, the medical fragility of many members of this population counsels that urgent symptomatic care must be provided in fewer than the 48 hours specified in §5.7.5 (New York's duals proposal, for example, requires

¹ The contract is available online at http://www.hca.wa.gov/documents/managed_care/2012BH-HOFinalContract.pdf.

that such visits be provided within 24 hours²). In any event, the State must review these standards with stakeholder input to determine whether and to what extent they should be made more protective of enrollees than those in the current MCTC, due to the specific requirements of the duals population being served in the localities in question.

- 5) Access to out-of-network providers: provide clients access to out-of-network coverage at no extra charge any time that emergent care is not reasonably available at an in-network provider, any time that an enrollee cannot schedule an in-network provider visit for urgent care, and when other required care, including care required by subspecialists who are not network providers, cannot be furnished by a network provider. Plans shall be responsible for directly or through home health services providing assistance to enrollees with scheduling medical appointments.
- 6) Maximum provider to enrollee ratios: adhere to maximum ratios between the number of enrollees in a given geographic area and the number of primary care providers³ and various types of specialty providers in the plan's network. The State will establish these ratios initially and review them and make appropriate corrections on at least an annual basis.
- 7) Provider training in specific areas: mandate that all network providers are trained on independent living and mental health recovery approaches.
- 8) Enable enrollees to maintain provider relationships: Many dual eligibles have longstanding, beneficial relationships with providers that might not be in the existing network of a health plan or delivery system that participates in a duals demonstration program. To maintain continuity of care and respect these relationships, integrated systems should:
 - a) Maintain an open network provider system in order to contract with providers that are not currently in the network.
 - b) Offer "single-case agreements" that allow members to continue seeing their existing provider while being reimbursed by the health delivery system, without arbitrary limits on their duration.

Readiness Review

² New York State Department of Health's Demonstration to Integrate Care for Dual Eligible Individuals, Appendix D, available at <http://dualsdemoadvocacy.org/wp-content/uploads/2012/02/NY-proposal-3.22.12.pdf>.

³ The Illinois duals plan proposes a maximum limit on the number of enrollees per PCP of 1:600. Illinois Medicare-Medicaid Alignment Initiative at 10, available at <http://dualsdemoadvocacy.org/wp-content/uploads/2012/02/IL-proposal-2.17.12.pdf>.

We appreciate that the state has indicated it “will work with stakeholders over the next several months to develop readiness review criteria for the new services that would be provided by health plans under this full financially capitated model.” Stakeholders have a unique and critical role to play in informing the State what factors are required of provider networks to insure that proper care is furnished to this vulnerable population that has not received care through such an integrated model in Washington state in anything approaching this scale before. The state must better articulate in the Proposal how it conceives the readiness review process will be conducted, what are its timelines to design, conduct, and make decisions based on this review, how stakeholders will be involved in the process at each step, and how the state will work with CMS in designing and conducting this process.

Monitoring

A robust readiness review process is a critical first step in ensuring that health plans can provide the full range of timely and necessary care required by dual eligible. But a program of ongoing monitoring of network adequacy is required to insure that the initial promise of the integration plan is kept to its participants and their families over the full duration of the plan. To this end, we request that the Proposal specify that:

- 1) Quarterly monitoring: plans and the State must monitor and report on provide adequacy on at least a quarterly basis. Plans must receive confirmation from participating providers that they are accepting new patients as part of monitoring.
- 2) Form of monitoring: the State will engage in testing of Plans’ and their providers’ compliance with network adequacy metrics amenable to measurement by such methods (e.g., provider acceptance of new Medicaid patients, maximum provider office visit wait times, etc.), as well as patient surveys, as part of their ongoing monitoring of Plans’ compliance with network adequacy standards.
- 3) Redress for problems: Network adequacy problems can be addressed by their care coordinator and/or the ombudsman with maximum specified response and correction times.

Rate Structure

The methods for setting rates for capitated systems serving this vulnerable and diverse population, such as in Strategies 2 and 3, must assure that the delivery systems have the necessary resources to provide care to its enrollees. This is especially a concern for individuals with the most complex conditions. If the state’s proposal does not get this issue right, health systems are likely to receive either windfall profits or devastating losses, either of which would undermine the success of the program.

A huge challenge in rate setting for capitated plans for this dually eligible population is the large disparity in costs for different members. The draft proposal illustrates this in the description of the enrollee population starting at page 12. The per member per month costs are strikingly different for these two groups, and for clients within these groups who use or need Long Term Care Services and Supports, chemical dependency treatment, mental health services. The information provided indicates that the range of costs attributable to individuals within these subgroups is highly diverse.

The State and plans should provide to stakeholders the information required the considerations factored into the rate structure. We further request that the State address the following principles in the design of any Strategy 2 or 3 capitation system that places financial risk on plans (or “shared savings” with the Medicaid agency):

- Financing and payment structures must be transparent to allow for oversight and appropriate stakeholder input.
- Payments must not give providers an incentive for denying or minimizing services and care needed by beneficiaries.
- Payment structure should incentivize care provided in community-based settings rather than institutional settings.
- Consider both aggregate and individual information in determining risk for payments to any delivery system in the program. Consider whether to include validated measures of functional status as well as other relevant factors.
- Mechanisms should be designed to avoid delivery systems receiving either windfall profits or devastating losses, particularly in the early years of a demonstration project.
- Establish a minimum medical loss ratio limiting administrative expenses to a maximum of 15 % (consistent with limits applicable in other contexts under the ACA).

CONSUMER PROTECTIONS

Overview of Consumer Protections

We recommend the inclusion of additional protections and increased specificity in the description of consumer protections for beneficiaries who are subject to enrollment in managed care through the implementation of the proposed Washington State Duals Eligibles Integration Design Plan.

There are several factors that create this enhanced need for consumer protection. The individuals who are affected are especially vulnerable to harm from the changes the plan will bring. The prospective enrollees include individuals with complex medical needs.

Many cannot read or have limited English proficiency (LEP), and have minimal or no support in navigating the service and medical systems.

In addition, there is a strong financial incentive to limit or deny access to services inherent in the managed care system. Managed care organizations are businesses that pay careful attention to the bottom line, so advocacy will be needed in many cases to obtain expensive services or treatments. There will be additional challenges to beneficiaries who need this advocacy. The implementation of managed care requires beneficiaries and advocates to re-learn how to access services, with new concepts, service models, and vocabulary. These are all daunting challenges – the more so, given that the timetable for implementing this project is so aggressive that most of the beneficiaries are not likely to be prepared to respond to the enrollment and network selection choices.

We have specific recommendations for changes to the draft plan to address these concerns. We include these suggestions below, in the context of the section of the draft plan that identifies the protections for beneficiaries at pp. 32-33, “Description of protections (e.g. continuity of care, grievances and appeals processes, etc.) that are being established, modified, or maintained to ensure improved beneficiary experience and access to high quality health and supportive services necessary to meet the beneficiary’s needs.”

We recommend the following changes to the consumer protection section:

1. Include additional elements in the list of “core elements of an effective delivery system”.

The Proposal identifies several “core elements” at pages 32-33. Our suggestions for additions to these elements are:

Core elements of an effective delivery system:

- Beneficiary control of the dissemination of confidential information.
- Beneficiary voice, choice and participation and an active role in their service delivery, including service design and quality assessment and improvement..
- Accommodation for disability and identification and removal of barriers interfering with access to services by consumers with disabilities.
- Respect for consumer rights by all professionals in the health care system
- Skilled, independent advice and advocacy is available to beneficiaries at all stages from evaluating whether to enroll through transition to standard FFF service provision after disenrolling in a Strategy 2 or 3 MCO.

2. Consumer protections should include specific requirements for support of beneficiaries in understanding service choices and rights, obtaining services.

appealing service denials, and independent monitoring of service quality, and an independent ombudsman in order to assure these requirements are followed.

The integration of the Medicaid and Medicare “dual eligibles” carries both risks and potential benefits. In order to secure the benefits of enhanced quality, and avoid the harm that can result from unsupported transition to managed care, *we strongly recommend that the State include in its plan a funded, independent source of individual advocacy and systemic-monitoring in their proposal – an ombudsman.* The State of Wisconsin has had such a system for their managed care beneficiaries for several years. We are in agreement with the National Senior Citizens Legal Center, that in order to protect the rights of vulnerable beneficiaries served through a dual eligible integration model, “A Dedicated, Funded Ombudsman Program is Essential”. (March 27, 2012) <http://dualsdemoadvocacy.org/a-dedicated-funded-ombudsman-program-is-essential>

We strongly support the creation of an independent ombudsman program. Based on review of ombudsman programs, including the Wisconsin program, we identify the following as some key characteristics and duties of an ombudsman program.

a) Ombudsman

1] Characteristics

Independence. The ombudsman should be an independent contractor with the State, and not subject to the control of the managed care organizations. Provisions guaranteeing ombudsman independence should be made in contract and regulation (or statute).

Consumer-orientation. The ombudsman must listen to what the beneficiary wants, and assist the beneficiary in obtaining a favorable result subject to the beneficiary’s approval. To the extent possible, the ombudsman should promote involvement of the beneficiary in his or her own decision-making and advocacy.

Full range of advocacy. The ombudsman should advocate at the lowest possible effective level – preferably without the need to resort to formal adjudication. However, this office must also be empowered to pursue advocacy at higher levels and assist enrollees with service and eligibility appeals as needed.

Skilled and knowledgeable. The ombudsman must understand managed care in a Medicaid and Medicare setting, what services/treatments are available, and consumer rights required by the Plans, as well as state and federal law. The ombudsman should be able to present a case in the appeal process, and in general should have the skills of an advocate.

Funded. Sufficient funding must be provided to ensure that the ombudsman service is reasonably available to beneficiaries who seek assistance. The funding should be secure and consistent.

2) Ombudsman duties

Assist beneficiaries in obtaining needed services and treatments, including appealing adverse decisions. Ombudsman can be involved at any decision-making point, including enrollment/disenrollment, development of a care plan, appeal from a service denial, etc.

Provide information about rights and services to beneficiaries. This can be through response to individual inquiries, publications, or through outreach activities.

Identify systemic problems, report, and advocate for solutions. The ombudsman will encounter many individual issues in performing his/her duties. Where the same problem appears over and over, the ombudsman will identify a systemic issue. The ombudsman should provide information to the managed care organizations and the State regarding these systemic issues, and advocate for solutions. For information on the Wisconsin managed care ombudsman program, see:

<http://www.disabilityrightswi.org/programs/fcop>

b) Explicit consumer protections

The ombudsman service can play a critical role in ensuring that consumer protections are effective. These protections should be explicit, and their implementation should be guaranteed by the contracts with the managed care organizations, and by regulation and statute. We recommend substantial additional specificity in the consumer protections section (Proposal at 33), indicated below in the underlined text:

Consumer protections:

- Information that is clear, up to date, understandable, and available and addresses choice, rights and available resources, and offers individualized support for consumers in understanding choices.
 - Enrollment notice fully informs the beneficiary of consequences and benefits of enrollment, and any limitations on disenrollment
 - All notices and informational materials are provided to individuals who assist in decision-making, including guardians, Necessary Supplemental Accommodations (NSAs), and others identified by the beneficiary
 - Enrollment brokers shall be independent of the managed care organization.

- All notices and informational materials are tested to ensure readability, translated and available in primary languages, and available in alternate formats
- Consultation with stakeholders and ombudsman in design of all notices
- Beneficiary choice and voice with an opportunity to say what they do or don't want, participate in care choices and transitions, and assess their services and their optimizing their situation.
 - Individualized, in person assistance in developing care plan is available to all beneficiaries upon request
 - Beneficiaries are included in design and implementation of managed care organization's quality assessment and improvement
- Access and service equity regardless of geographical location and accommodation if needed to travel for services.
- Clear and understandable appeal and grievance processes stating what can and cannot be appealed or grieved, and the steps and timelines for each process.
 - Appeals process provides full Medicaid due process/appeals rights, including core protections (e.g., timeliness, continued benefits pending resolution)
 - Explicitly incorporates fair hearing requirements of 42 CFR part 431.200
 - All Medicaid fair hearing rights apply, including right to present witnesses and evidence, right to examine records and cross-examine, right to present new evidence at all appeal stages
 - Medicaid notice and advance notice requirements apply, including effective date of action, explicit reason for action, cite to governing authority, instructions on right to appeal
 - Medicare amount in controversy requirements do not apply
 - Between Medicare and Medicaid time frames on hearings and appeals, the more favorable to the beneficiary shall be applied.
 - Beneficiaries need not exhaust managed care grievance process in appeal
- Support for beneficiaries in obtaining desired services, including support with individual advocacy in the appeal and grievance process, by a funded entity independent of managed care organizations and the State.
- Quality of care measurement and oversight and access to outcomes and results, including monitoring of quality by a funded entity independent of managed care organizations and the State.
- Confidentiality and privacy protections for beneficiaries shall be included in managed care contracts and state regulations
- Continuity of care and information with minimal disruptions with more integrated services

- Open-network transition availability for at least six months after enrollment
- Managed care entity will continue current treatment plans for at least six months following enrollment where beneficiary makes request

STAKEHOLDERS

We appreciate the strong role that the Proposal acknowledges stakeholders have played in its initial formulation as well as the even more vigorous role they must play in many critical phases of the Proposal's design and implementation (*see, e.g.*, Proposal at 22, 23, 34, 48). To this end, we recommend that the State adopts a formal Stakeholder Engagement Plan that lists the areas in which stakeholder input is necessary, the timelines for the receipt and consideration of such input, and the mechanisms for receiving that input and providing timely feedback. The Proposal should include a commitment to creating such a Stakeholder Engagement Plan that includes at least the following elements.

1. Specify a base list of decisions and issues in which stakeholder input will be required, including.
 - a) Creation of educational and marketing materials and website design for enrollees regarding the integration program.
 - b) Creation of notices to be sent to enrollees regarding MCO and home health service, including their rights and choices to select or refuse such services, and the options available to them in doing so.
 - c) Articulation of the elements to be included in readiness review of MCO contracts
 - d) Develop and assess performance measures and financial incentives or disincentives provided to system participants for meeting or failing to meet those standards.
 - e) Drafting necessary legislation and regulations required to implement the proposal
 - f) Drafting notices to be sent to beneficiaries who appeal service, plan, or eligibility actions.
 - g) Creating training materials for consumer assistance entities, such as enrollment brokers, plan customer service personnel, independent beneficiary advice entities, and the ombudsman.
 - h) Creation of website for dual eligibles and their families regarding the integration proposal.
 - i) Consideration of any changes to the services that might be rolled into the Strategy 2 and 3 capitation packages.
 - j) Ongoing review of plan performance on issues such as network adequacy, beneficiary retention, accessibility, health outcome metrics, and customer satisfaction.
 - k) Design and review of the assessment of the program's success in achieving its goals, as well as its other, possibly unintended, consequences.

2. Create and publicize a base list of stakeholder engagement mechanisms to address these issues associated with a timeline for stakeholder participation in these decisions.

Stakeholder engagement can best be utilized and channeled to positive purpose when it is clearly articulated from the beginning at least some areas the issues, mechanisms and timelines applicable to when such input will be solicited and considered. This list must be subject to change as additional issues arise regarding which stakeholder input is valuable.

3. Create a robust stakeholder Advisory Committee with ongoing duties and authority.

The Proposal appropriately contemplates “[t]he creation of a standing stakeholder advisory committee to help guide continued planning and implementation activities.” Proposal at 34. However, little detail is provided regarding its brief or how it will be involved in ongoing monitoring and evaluation of the plans’ performance and the Proposal’s success. The Stakeholder Engagement Plan should include the following elements concerning the advisory committee:

a) Creation and Membership of the Committee

The advisory council should include beneficiaries and advocates representing a wide variety of groups, including seniors, individuals and advocates for persons with developmental disabilities, TBI or dementia, and culturally diverse groups, including individuals who are LEP. There should be an open nomination and application process to insure that the membership will include a diverse spectrum of the stakeholder community.

b) Role and authority of the Committee

The plan should both articulate an overall role/mission for the council and specify some of its duties and areas of authority, including:

- Access to all information regarding service use and quality
- A central role in the development of an outreach plan to ensure beneficiaries and potential beneficiaries are apprised of options and their rights.
- Evaluation of the adequacy of the networks
- Assessment of the transition process for beneficiaries moving onto a network
- Assessment of the MCO grievance process and appeals
- A central role in the development of regulations and contracts
- The development of local groups that will assess issues with the MCOs serving their community and provide recommendations for improvement

- Clear statement of the coextensive role and authority the Committee will share with other stakeholder engagement mechanisms

ENSURING THE “BEST OF BOTH WORLDS” (MEDICARE AND MEDICAID) FOR SERVICES AND RIGHTS

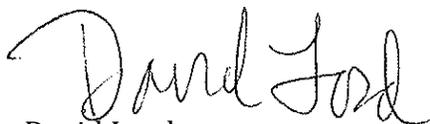
The proposal should demonstrate a firm commitment to providing beneficiaries with the full content of both their Medicare and Medicaid benefits. It should include an affirmative statement that all unified standards will be based on the more generous of the Medicaid and Medicare standards, such that a beneficiary in the demonstration will never have less than another beneficiary who was eligible for only Medicare or only Medicaid.

Oversight design for the demonstration and the managed care plans must include a mechanism to ensure that this occurs.

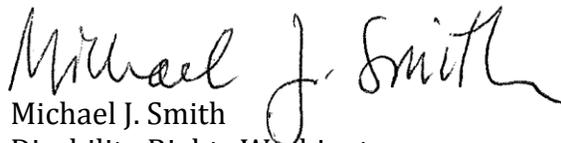
Examples include: Appeal processes must provide for the time frames most favorable to the beneficiary, including access to expedited decisions that may be provided for by Medicare and not by Medicaid regulations. Wheelchairs and home health should never be denied using the more restrictive Medicare standards when Medicaid standards would offer coverage. For more examples, see HHS Request for Information, “Medicare and Medicaid Programs: Opportunities for Alignment under Medicaid and Medicare,” at 76 Fed. Reg. 28196.

We look forward to continuing to work with you to achieve a successful integration project. Please know that you can contact us with any questions about the issues addressed in this comment.

Sincerely,



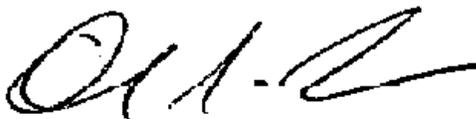
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Disability Rights Washington



Michael J. Smith
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Ann Vining
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