



## SEIU Healthcare 775NW

President: David Rolf • Secretary-Treasurer: Suzanne Wall  
Vice Presidents: Adam Glickman-Flora and Sterling Harders

Member Resource Center (toll-free): 1 (866) 371-3200  
33615 First Way South • Ste. A • Federal Way, WA 98003  
(253) 815-3700 • Fax: (253) 815-3701 • [www.seiu775.org](http://www.seiu775.org) • [mrc@seiu775.org](mailto:mrc@seiu775.org)



**To:** Robin Arnold-Williams, Department of Social and Health Services (DSHS) and Doug Porter, Health Care Authority

**From:** David Rolf, President, SEIU Healthcare 775NW

**Subject:** Feedback on “Pathways to Health: Medicare and Medicaid Integration in Washington State” Proposal

**Date:** April 13, 2012

**CC:** Jonathan Seib, Jason McGill, MaryAnne Lindeblad, Dan Murphy, Bea Rector, Kathy Pickens-Rucker

SEIU Healthcare 775NW represents 43,000 workers in Washington state who provide services primarily to dually eligible seniors and people with disabilities in home care, nursing home, and adult day health settings.

Thank you for the opportunity to provide written feedback on the proposal “Pathways to Health: Medicare and Medicaid Integration in Washington State.” SEIU Healthcare 775NW staff and member leaders have participated throughout the planning process for Washington’s dual eligibles integration planning process, including:

- Participating in stakeholder engagement forums in Lacey, Everett, and Spokane,
- Convening a focus group with individual providers and agency home care workers focused on the role of paid personal care workers,
- Participating in key informant group follow up meeting,
- Participating in webinar announcing release of design plan, and
- Attending various meetings and discussions with DSHS/HCA staff and advocacy groups to refine proposal.

We appreciate the effort that has gone into preparing this proposal and recognize the challenge you face in balancing the opportunity for shared Medicaid savings and improved health outcomes while ensuring that beneficiaries are protected and that we maintain our commitment to a home and community based long-term services and supports system. We share the goal of better coordination of Medicaid and Medicare services and support the need for meaningful systems change. Home care aides are well aware of the impact of fragmentation and lack of coordination on dually eligible individuals, including lack of access to needed care in

the fee for service system, inadequate coordination between medical providers, and underinvestment in home and community based services.

In addition, direct support workers supporting dually eligible individuals are frustrated by the barriers that prevent them from playing a meaningful role in the care team and in improving health outcomes for the individuals they support. Home care aides are extremely well-positioned to play a role in improving care as part of a multidisciplinary care team because they serve a small number of clients, have regular contact with dually eligible individuals in their own homes, develop trusting relationships with clients and their families, and are uniquely positioned to notice subtle changes in condition. Given the significant percentage of dually eligible individuals with long-term services and supports needs,<sup>1</sup> it is frequently the case that a home care aide knows the consumer better and has significantly more contact with them than any other member of the health care team. Yet in our current system and in existing health home models, these workers are not treated as a valued part of the care team and are simply given a list of tasks to complete without being held responsible for improving health outcomes.

In informal focus groups held in October 2011, home care aides identified the positive role they could play as coordinators, advocates, and coaches to facilitate care and communication between the health care team, motivate and encourage consumers to follow a care plan, and act as an advocate for the consumer with other health care providers. Successful approaches at care integration must include strategies for appropriately utilizing the direct care workers in the long-term care system and creating a team approach that crosses the silos between medical care, behavioral health, and long-term services and supports.

Before providing feedback on the details of the proposal, we want to provide feedback on the process up to this point and specifically to the challenge of having two separate state agencies share responsibility for developing a vision of improving care for people with long-term services and supports needs. The three-strategy approach in this proposal is convoluted and difficult to understand and seems to reflect the lack of consensus between state officials about what is the right approach to care integration. It is difficult to imagine how our state will be able to simultaneously implement all three strategies successfully, especially given that some of the approaches included in the proposal are not well developed and many of the basic questions – such as what consumer protections and quality measures will exist in Strategy #2 and 3 – are left unanswered. As we embark on a systems change, we need to have a clear vision of where we are going and commitment from agency leadership and stakeholders to make that vision a reality.

In terms of content of the proposal, we have consistently encouraged the state to be ambitious and put forward ideas that will be transformative for dually eligible beneficiaries and for providers such as home care aides. We have focused throughout this process on two key

---

<sup>1</sup> Dually eligible individuals use Medicaid-paid long-term services and supports at a high rate - 60.5% of duals 65 and older and 20.3 percent of those under 65 use long-term services and supports. High-risk duals have especially high utilization of long-term services and supports - 79 percent of high risk dual eligibles use long-term services and supports.

recommendations and continue to believe that these areas need to be improved before this proposal is submitted to the Centers for Medicare and Medicaid Services (CMS).

1. First, we encouraged the state and other partners to think creatively and intentionally about the role that home care aides and other direct care workers can play as part of a care team in coordinating care and in improving health outcomes for dually eligible individuals.

***We request that this proposal incorporate a clear and intentional role for home care aides and other direct care workers in the health homes proposal (Strategy 1).***

2. Second, we recommended that the state focus on developing a fully integrated, capitated approach that aligns incentives across medical, behavioral health, and long-term services and supports so that providers have an incentive to invest in lower-cost services such as home care that reduce costs in other areas such as emergency rooms.

***We request that this proposal incorporate a more ambitious and well-developed approach to testing the fully integrated capitated model (Strategy 2).***

In this document, we will provide feedback on each strategy included in the “Pathways to Health: Medicare and Medicaid Integration in Washington State” Proposal.

### **Feedback on Strategy 1: Health Homes**

As the State implements health homes, our core recommendation is to explore a new health home model that includes a clear role for home care aides and other direct support workers to serve as high-touch extenders to care managers for individuals with long-term services and support needs. We believe that for the population of Medicaid beneficiaries with long-term services and supports needs, and especially the dual eligibles, the success of the health home intervention will depend on a clear plan for engagement and involvement of paid home care aides in the care team.

#### **Health Home Must Be Appropriately Designed for Populations with Functional Limitations**

As the state moves forward to implement health homes we encourage variation in the approach to serve the distinct needs of different groups of Medicaid beneficiaries. In general, we believe that those who are dually eligible and receive long-term services and supports will require a more intensive, higher-touch approach to care coordination than other Medicaid beneficiary groups.

As drafted, the health home intervention will be based largely on chronic care self-management approaches that aim to engage the consumer through health goal-setting leading to improved health outcomes. This approach may work well for those who are younger, with good cognitive

reserves, and family and social supports. But, for the segment of the population with functional limitations (as measured by ADL and IADL capacity) the chronic care model is lacking. The two most frequently referenced chronic care health home models are not designed for the dually eligible population or individuals with long-term services and supports needs: the New York Medicaid Health Home program excludes individuals with long-term services and supports needs<sup>2</sup> and Washington's Chronic Care Management (CCM) program excludes dually eligible individuals.<sup>3</sup> It is worth noting that 91 percent of aged Medicaid beneficiaries are dually eligible; therefore this significant population was excluded from the CCM models.<sup>4</sup>

In this proposal, the state plans to use PRISM to identify clients who might benefit from health homes but, it is not clear whether PRISM is sensitive to functional losses or whether it measures cognitive loss. Therefore, it is important that consumers with these characteristics not be lost in the algorithm that will be used to select people to participate in the health homes model. It is also concerning that if this targeting excludes important factors such as cognitive or functional losses, that individuals who could benefit from this intervention will be excluded.

The most recent caseload report indicates that about 47,500 elderly Medicaid consumers are receiving home and community based care; another 10,150 are being cared for in nursing homes.<sup>5</sup> While we have not seen analysis of this cohort with respect to age, functional abilities, and cognitive reserves, we can assume that:

- More than half of the 47,500 are over 64 years of age with the largest percentage of that cohort being over 75;<sup>6</sup>
- About 91 percent of aged Medicaid beneficiaries over 64 and 37 percent of disabled Medicaid beneficiaries between 18 and 65 are dually eligible<sup>7</sup>;
- About 25 percent of people receiving in-home and community residential care are nursing home comparable in ADL/IADL status;<sup>8</sup>
- A very high percentage of the over 64 consumers have dementia and the older the cohort the more prevalent the disease (perhaps as high as 33 percent of those older than 80).<sup>9</sup>

---

<sup>2</sup> The New York Health Home Program only includes long-term care on a short term basis. If individuals require long-term care services for more than 120 days they are excluded from being enrolled in health homes. See Question 3 at

[http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/questions\\_and\\_answers.htm](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/questions_and_answers.htm)

<sup>3</sup> Evaluation of Washington State Medicaid Chronic Care Management Projects Qualitative Report: Qualis Health December 31, 2008

<sup>4</sup> Kaiser Family Foundation: State Health Facts (2007 data)

<sup>5</sup> Most recent caseload forecast council report. Home and community based care is the universe of people who receive in-home (35,260) and residential (12,150) care.

<sup>6</sup> Washington State Office of Financial Management: Research Brief No. 40 December 2006

<sup>7</sup> Kaiser Family Foundation: State Health Facts (2007 data).

<sup>8</sup> DSHS RDA Report August 2011: Estimating Nursing Home Comparable Home and Community Based Long-Term Care Capacity

We also know that functional limitations are more predictive of high spending for health care than chronic conditions alone.<sup>10</sup> Consequently, we can assume that high spending for health care is very closely correlated with the presence of Medicaid long-term services and supports needs. It is also safe to assume that existing chronic care models will not be effective with this group of consumers. Because of the very high prevalence of dementia their ability to engage in patient activation or to set health goals is limited. In fact, a recent issue brief (Lessons from Medicare’s Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment, January 2012) from the Congressional Budget Office reviewed the results of 10 major Medicare fee for service demonstrations (six disease management/care coordination pilots and four value based payment demonstrations) and found that most pilots failed to reduce Medicare spending. Specifically, evaluation of the disease management/care coordination projects found:

*“In nearly every program involving disease management and care coordination, spending was either unchanged or increased relative to the spending that would have occurred in the absence of the program, when the fees paid to the participating organizations were considered. Programs in which care managers had substantial direct interaction with physicians and significant in-person interaction with patients were more likely to reduce Medicare spending than other programs, but on average even those programs did not achieve enough savings to offset their fees.”*

This population of older individuals with significant functional limitations deserves care that will honor their dignity, minimize the avoidable trauma of transfers, provide a safe environment, and alleviate suffering. The health home model must be adapted to meet the different needs of this population.

Our recommendations to ensure that health homes are appropriately designed for populations with functional limitations include:

- Add language to page 4 that clarifies that distinct health home models will be needed to serve the diverse needs of Medicaid beneficiaries and the particular needs of those who are dually eligible and receive long-term services and supports.

---

<sup>9</sup> Alzheimer’s Association Report: 2012 Facts and Figures.

<sup>10</sup> For example, a recent report by Harriett Komisar and Judy Feder of Georgetown University “Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs” notes that “many of the most expensive Medicare beneficiaries—and the people for whom better care, more efficiently provided, will generate perhaps the most significant savings—are people whose illness creates the need for long-term services and supports (that is, help with routine activities of life, like bathing and preparing meals) as well as medical care.” The report finds that the 15% of Medicare beneficiaries who have both chronic illness and long-term care needs (as indicated by functional limitations in routine activities) experience disproportionately high Medicare spending and account for about one-third of Medicare’s total spending. Medicare’s spending for beneficiaries with both chronic conditions and functional limitations averaged about \$15,800 per person in 2006, twice the average amount for Medicare beneficiaries with 3 or more chronic conditions but without functional limitations (\$7,900).

- Clarify that health homes for dually eligible individuals, for a defined transition period, must be existing community based organizations or Medicare special needs plans with expertise in serving the dually eligible population.
- Specify clearly the expectation of care coordination across the spectrum – including ancillary services such as housing, nutrition transportation, and OAA funded services.
- Require a minimum number of in-person touches or require health homes to utilize other members of the health care team such as direct care workers to provide high touch extension to care coordinator.

### Need for Formal Role for Home Care Aides and Direct Support Workers in Health Homes

In order to make the health home intervention truly value-add for individuals with long-term services and supports needs, there must be a formal role for home care aides in the new health homes and a clear plan for enhanced direct care worker training and responsibilities with measurable health outcome metrics. Home care aides generally spent 20-30 hours per week providing paid personal care supports to a Medicaid client and are well-positioned to play a central role in the coordinated care team because they serve a small number of clients, have regular contact with dually eligible individuals in their own homes, develop trusting relationships with clients and their families, and are uniquely positioned to notice subtle changes in condition and behavior. However, in our current system and in existing health home models, home care aides are an underutilized asset because they are not treated as a valued part of the care team and are simply given a list of tasks to complete without being held responsible for improving health outcomes or being listened to by other care providers.

For those individuals receiving long-term services and supports, the goals set out on page 6 of the proposal simply cannot be achieved without the formal, active engagement of the direct support worker. For example, one of the goals is to “establish person-centered health action goals designed to improve health and health related-outcomes.” The health provider with the most contact with an individual who is best positioned to support them to achieve their health action goal is in many cases a Medicaid-paid home care aide or other direct support worker. If this worker is not appropriately-trained, given clear responsibilities, and held accountable, this goal will simply not be attainable.

Further, there is broad consensus among aging stakeholders that there needs to be a high touch approach to serve this population. It would be both cost prohibitive and unrealistic to assume that a very high touch approach can be achieved by relying only on nurses and social workers as care coordinators. Washington faces a serious health care workforce crisis resulting from the aging of the current workforce and challenges with recruitment and retention, and these challenges are expected to get significantly worse as demand for health care services increases from the baby boom generation and 300,000 Washingtonians becoming newly insured in 2014 by the Affordable Care Act. Designing a proposal that does not take these very real workforce challenges into account is not a strategy for success.

We believe that a model that engages the consumer’s home care aide (and thereby family and other informal caregivers) offers real promise to meet the goals of this intervention in a cost-effective way. There are several versions of how such a model could work. For example:

1. The health home services might be provided by an Area Aging on Aging (AAA). This is the point in the system today where the client is monitored and that has considerable interaction with the home care aide. The AAA could dedicate resources from the per member per month allotment to upskilling home care aides, creating a way for members of the care team to communicate with one another, and having the direct care worker perform high touch support to care coordinator.
2. The health home could be an adult day health program in which home care aides would be incorporated into the care team. In some situations the home care aides would be employed by a home care agency; in others individual providers would provide in-home care and would serve the high-touch extension to the care coordinator housed in the adult day health care.
3. This model could also be effective in a fully capitated model where the state would hold the plan accountable for including home care aides in patient’s care. Savings from the Medicare program from reducing emergency room utilization, for example, could be used to fund the health home intervention.

There are undoubtedly other variations that one could design. No matter the model, what is important is a clear, intentional strategy to include the home care aide in the care team. This goes beyond a simple assertion on paper that the home care aide is part of the care team to having a performance measure in the contracts. Simply put, what is funded and what is measured matters. The home care aide role must be expanded beyond the informal role currently in the CCMP pilot so that home care aides are treated as full members of multi-disciplinary care teams.

Incorporating a formal role for home care aides will not only improve the health homes’ quality and likelihood of success, but it also will align this proposal with the legislative direction provided in Substitute Senate Bill 5394. In 2011, the legislature explicitly included home care and long-term care workers as part of the “multidisciplinary health care team”<sup>11</sup> and this approach should be included in this proposal.

Our recommendations to create a formalized role for direct support workers include:

- On page 4, add assumption that “Health homes for individuals with long-term services and supports needs will include a formal role for home care aides and other direct support workers.”

---

<sup>11</sup> See intent section and definition of “multidisciplinary health care team” in SSB 5394.

- Instead of just having a 1:50 care manager ratio, add requirements/standards for number of touches to ensure a high touch, in-person approach to care coordination and encourage health homes to utilize other members of team such as direct support workers to provide high-touch extension.
- On page 7, include requirement that health home networks serving individuals who need long-term services and supports must “demonstrate a plan to communicate with and formally incorporate direct support workers into the health home network.”
- In definitions section, add “home care aide” to list of allied health staff that can facilitate the work of the care manager (in Care Manager definition).
- Add “home care aide” to definition of “multidisciplinary health team” on page 20.
- Recognize that enhancing the role of the home care aide will also likely require additional training to teach *observe and report* skills and perhaps additional nurse delegation tasks. Consider dedicating a portion of the increased health home funding to this purpose.

Home care aides frequently know the consumer better than any other member of the health care team, yet their views are rarely sought and they are frequently left outside of the care team. Continuing that approach wastes resources that are already being spent and does nothing to enhance the quality of care and life for some of our most vulnerable citizens.

### **Feedback on Strategy 2: Full Integration Capitation**

We believe that Strategy 2 offers the best possibility for improving health outcomes and reducing Medicare costs through a fully integrated model that includes long-term services and supports, behavioral health, and medical care in a single capitated payment. This approach eliminates the silos that have led to fragmented and uncoordinated care, overuse of emergency room and nursing home services, and underinvestment in home and community based long-term services and supports. This model permits the State to set the requirements that plans must meet, establish quality metrics, and design consumer protections.

We encourage the state to move forward with Strategy 2 in as many counties as possible and with as few carve outs as possible. In addition, we suggest that health homes be integrated into this financial model and not set up as a separate intervention outside of the managed care contract. We would suggest a few small, but important changes to improve this strategy.

### **Modify Criteria to Allow Full Integration to Be Tested in Additional Counties**

In the current proposal, there are too many barriers to pursuing a fully integrated model and we are concerned that the state will not be able to test this model in a robust manner. This requirement for a minimum of 5,000 duals in a county or multi-county area, combined with the

legislative requirement for agreement by county legislative authorities, will result in very few, if any, counties being able to explore this option. 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.<sup>12</sup> In addition, we suggest removing or reducing the 5,000 dual minimum threshold since there may be mid-sized counties that would be interested in testing this option and beneficiaries in those counties could benefit from an option for integrated care. While the success of this approach will depend in part on managed care plans having a sufficiently large enrollment with a balanced risk pool, we believe that this can be handled through the contracting process with plans, not by placing an arbitrary 5,000 minimum in the proposal.

#### Expand Managed Care Providers to Include Medicare Special Needs Plans (SNPs)

A majority of the individuals served in this proposal are over age 65 yet the current proposal limits managed care contracts only to the five plans selected through the Medicaid Healthy Options procurement. We recommend allowing additional plans, including Medicare Special Needs Plans, who have specific experience serving Medicare beneficiaries, to bid on these contracts. Since many dually eligible individuals may be currently enrolled in a Medicare Special Needs Plan, if their plan were able to develop an integrated option, this could be a great fit.

#### Provide Detail on Consumer Protections, Quality Metrics, and Requirements for Network Adequacy

It is important that the state have a clear plan to hold health plans and providers accountable yet this proposal only includes conceptual consumer protections, quality metrics, and network adequacy standards. Important details – such as a unified appeals and grievance process, continuity of care requirements, and beneficiary notification requirements – should be made explicit in the proposal. We support the recommendation by AARP Washington to articulate clearly and prominently the guarantee that during the 90 day retention period enrollees will not experience any reduction in services or changes in access to providers (ie, a continuity of care requirement similar to Illinois, New York, and Massachusetts). We also support an adequately funded, independent ombudsman to ensure that enrollees rights are protected and to provide independent advocacy with the health plan and the state. Finally, we believe that beneficiaries deserve information that is clear, up to date, understandable, and addresses choice, rights, and available resources. All materials should be readable and available in multiple languages. In addition, we believe that there is a need for additional detail in this proposal on long-term services and supports specific quality metrics and requirements for network adequacy.

---

<sup>12</sup> While the requirement for county legislative approval was included in the 2012 supplemental budget, that proviso language will expire at the end of the biennium and the approach will need to be re-evaluated. Re-stating this requirement in the proposal unnecessarily locks us into an approach.

### **Feedback on Strategy 3: Modernized and consolidated service delivery with shared outcomes and aligned financial incentives**

Strategy 3 is largely undefined but it appears to be financial integration of medical services with a carve-out for long-term care, developmental disabilities, and behavioral health services. Overall, we believe that provider behavior is driven by financial incentives and we are very skeptical that a system with a carve out for long-term services and supports will be successful at integrating care. For example, the first bullet on page 23 states that Strategy 3 “provides medical care through a health plan with strong financial incentives to reduce inpatient medical admissions and avoidable ER/ED utilization” but it is unclear how this will take place in the absence of full integration (since the health plan would not be responsible for providing lower cost services that reduce inpatient medical admissions and avoidable ER/ED utilization). It is unclear how this approach differs in a meaningful way from the option that dually eligible individuals have today to enroll in a Medicare Special Needs Plan (SNP) to integrate their Medicare services. We understand that the goal is to develop a shared incentive pool to encourage integration, but there needs to be much more development of how this would work. We are not currently aware of any models that successfully use a financial incentive payment to create functional integration. We request clarification about whether Strategy 3 is a step toward full financial integration or whether this model is the desired delivery system.<sup>13</sup>

In addition, it also unclear what “modernizing” and “simplifying” the system consists of and without additional detail, we cannot speak to the benefit or value of Strategy 3.

In conclusion, we are concerned that the state is trying to go in too many directions with too many models and that this will result in Washington not being successful in any of the new approaches. With the proposal as outlined, it appears that some counties could simultaneously be engaged in all three approaches and that duals will have to choose between a fully integrated model (Strategy 2), a partially integrated model with a shared incentive pool (Strategy 3), a health home intervention layered over a fee for service model (Strategy 1), or to stay in a traditional fee for service option with no health home. We would encourage that the state instead focus on an ambitious plan to roll out and test Strategy 2 and to develop an innovative health home intervention designed for those with significant long-term services and supports needs.

We appreciate the opportunity to provide feedback and look forward to continuing to work with you to achieve a successful integration of medical, behavioral health, and long-term services and supports.

---

<sup>13</sup> For example, page 36 states “Strategy 3 creates an environment that increases the viability of further delivery system integration” but does not provide a vision of what further delivery system integration means.