Catherine K. Anderson, MPA
Vice President
Medicare-Medicaid Enrollees
37 West 2000 South
Driggs, ID 83422

April 9, 2012

Washington Health Care Authority and the Department of Social and Health Services
Duals Project Team
P.O. Box 45600
Olympia, Washington 98504-5600

Regarding: Draft Design Proposal- *Pathways to Health: Medicare and Medicaid Integration in Washington State*

To Duals Project Team:

UnitedHealthcare Community & State appreciates the opportunity to provide the Washington Department of Health Care Services, Aging and Disability Services Administration (DSHS/ADSA) and the Health Care Authority (HCA) comments on the Centers for Medicare and Medicaid Services (CMS) draft proposal to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid. As one of the nation's leading providers of Medicare and Medicaid services, our response to Washington's request for comments is based on our direct Washington state experience operating an integrated program for dual eligible beneficiaries in King and Pierce counties and best practices from several capitated integrated Medicare and Medicaid programs that we operate across the country.

We recognize that Medicare Medicaid Enrollees (MMEs) are some of the most complex individuals served by the two programs however; we believe the three proposed strategies/ demonstration models holds great promise to improve quality, increase access to preventive and proactive care, enhance the use of community-based supports and services and decrease the reliance on costly services.

Care Model Overview

Proposed delivery system/programmatic elements including geographic service areas, enrollment methods and provider networks

<u>Strategy 1: Implement health homes for all high cost/high risk dual beneficiaries under Managed Fee for Service where financial integrated capitation does not exist (beginning January 1, 2013)</u>

We agree that a comprehensive, person-centered care coordination program that manages care across service domains and the continuum of care is important to ensure effective integration and coordination of services across funding streams and a seamless experience for beneficiaries. We also believe effective primary care is a foundational element to an effective integrated model of care for populations with complex needs. Our understanding from the draft proposal is care coordination is a priority and health homes are included in all three models of care. Further, for high-cost/high risk MMEs, certified health home providers will be responsible for the provision of care coordination services under all three proposed strategies/models.

We agree that every member should have a primary care provider who should support regular, preventive care and proactive treatment of chronic conditions. However, establishing a model that encourages effective primary care and coordination of care is quite different from establishing certified health homes for all high-risk/high cost Medicare-Medicaid enrollee. Our experience has shown that many practices lack the resources and/or desire to develop a more progressive model that would result in their recognition as a person-centered health home. Particularly for complex populations such as MMEs, practices are not universally inclined to manage the full range of services and supports across the continuum of care and settings.

As such, for Strategy 2 we recommend the State consider adopting the standard that every high-cost/high-risk MME be assigned a primary care provider rather than a certified health home. The additional flexibility to assign high-risk/high cost MMEs to certified health home providers to the extent possible allows health plans the opportunity to identify, work with, and foster the development of more progressive primary care models for practices and clinics that are interested in expanding their capabilities. This coupled with a comprehensive approach to integrate physical and behavioral benefits as outlined in the proposal, would result in a more effective approach to primary care and would ensure that expanded primary care is supported for those practices that are best prepared to embrace a more expansive role in managing MMEs. We think this is particularly important given the short timeline for implementation of strategy 2 (the fully capitated managed care model) by January 1, 2013.

Last, the proposal is silent on how the State under the health home fee-for-service model option will attribute eligible beneficiaries to a health home provider. This attribution/member assignment process needs to be carefully thought out to ensure continuity of care assuming that not all primary care providers will be qualified as health home providers at the start of the demonstration.

<u>Strategy 2: Implement full financially integrated model purchased through health plans (beginning January 1, 2013)</u>

UnitedHealthcare is in strong support of the key tenets of the fully integrated model as described in the design proposal. Creating a benefit structure for strategy 2 that ensures flexibility and coordination is fundamental to integrated care delivery models for complex populations such as MMEs. As such, we support the State's proposal to include the broadest set of Medicare and Medicaid benefits (i.e., medical, mental health, chemical dependency and long term care supports and services) under a capitated arrangement with health plans. We believe the inclusion of the broadest set of benefits under the proposed model facilitates the holistic delivery of services while avoiding redundancies, fragmentation of services, duplicative administrative costs, cost shifting, and poor outcomes. To that end, we recommend that the Adults with Developmental Disabilities HCBS waiver services be carved-in to Strategy 2 or at minimum be phased-in in year two of the proposed demonstration project. In order to maintain the foundation of person-centeredness, benefits should be combined into a seamless

delivery system focused on ensuring alignment of benefits and services to an individual's needs and the flexibility to modify plans of care as individual needs change. Carving out any benefits leads to fragmentation which is one of the fundamental weaknesses of a non-integrated model.

Second, we are in support the State's proposed facilitated voluntary enrollment approach for Strategy 2 that includes a passive enrollment process for MMEs eligible to participate in the demonstration if no choice is made. UnitedHealthcare believes that a passive enrollment process with an opt-out option and appropriate beneficiary protections is an essential program design requirement to ensure sufficient enrollment of all enrollees that can benefit from this demonstration. Based on our direct experience operating a voluntary integrated program for duals in Washington, a passive enrollment process for the demonstration is needed to ensure viability. Second, UnitedHealthcare also supports the State's proposed 90 –day retention period, however in order to establish meaningful relationships with MMEs, we suggest the State consider adopting a lock- in period of at least six months for the demonstration, following an initial opt-out period. A six month lock-in provision for both Medicaid and Medicare would allow participating health plans to appropriately identify individuals in the greatest need of support; conduct a comprehensive assessment of their clinical, functional and social needs and apply effective chronic condition management with the goal of positively impacting quality and outcomes. Further, we believe a longer enrollment period with the option to disenroll from the health plan only after six months will also enable the State and CMS to more effectively evaluate the merits of the demonstration and avoid potential adverse risk selection issues that can arise under a monthly disenrollment option. To ensure appropriate beneficiary protections, specific requirements could be developed for changing health plans that may include provider participation or demonstrated quality concerns by the MME.

Additionally, for both Strategies 2 and 3, it is not clear from the proposal whether or not the State intends to work with CMS to develop and use of a single enrollment and disenrollment process and how enrollments (i.e., effective dates) will be operationalized under both demonstration models. We recommend that the State follow CMS recommendations to develop a unified enrollment and disenrollment process and documentation for the proposed models.

We also support the State's proposed health plan selection RFS and readiness review process that will be jointly conducted by CMS and the State to ensure all applicable Medicare and Medicaid requirements are met. However, we have concerns with regards to information contained in the proposal that the selection of counties for implementation of Strategy 2 is contingent on "agreement by the county legislative authority". We believe this proposed provision may impede the advancement and implementation of Strategy 2 and the viability and scalability of a capitated delivery model option. Rather, we maintain that the State's proposed county selection criteria requirement that garnering "local support for integrating medical care, LTSS and behavioral health funding and services including obtaining appropriate agreements by entities to work collaboratively together to achieve the goals of service integration, improved health outcomes, and decreased use of institutional care" is sufficient and a more effective strategy to foster collaborative relationships with various stakeholders that will be impacted by the implementation of the capitated demonstration model.

<u>Strategy 3: Modernize current delivery systems, implement three-way contracting and capitation of Medicare payments and Medicaid medical payments coupled with the use of performance measures and incentive pools to improve the integration and financial alignment across medical, behavioral health, and long term care supports systems (beginning January 1, 2014).</u>

As outlined in the draft proposal, Strategy 3 goes beyond the managed fee-for-service and capitated models proposed by CMS in the July 8, 2011 State Medicaid Directors letter for dual integration

demonstration models. The primary objective of Strategy 3 is to "demonstrate the extent to which CMS goals for duals can be achieved in a mixed managed care and fee-for-service environment through health home service delivery models supported by health information technology capability and the design of financial structures to align incentives across medical, behavioral health and LTSS."

Given the proposed carve out of Medicaid- funded LTSS and behavioral services, the development of appropriate financial and quality and outcome measures related to shared accountability with the LTC and behavioral health systems is critical to ensure the model as proposed meets the State's policy and program goals. We recognize that this model is still under development and look forward to working with HCA and DSHS and stakeholders in the coming months to develop appropriate contractual, performance and financial incentives that support the goals of the demonstration under a mixed risk-based managed care and managed fee-for-service model.

Stakeholder Engagement and Beneficiary Protections

Description of Consumer Protections

We are in agreement with the proposed core elements of an effective delivery system as outlined in the draft design proposal. We also firmly support the State's goal to ensure appropriate beneficiary protections are in place for the three demonstration models. We recommend for strategies 2 and 3 that the State adopt CMS' preferred requirement standards (outlined in the January 25, 2012 CMS Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans) for integrated appeals and grievances; network adequacy, and marketing/beneficiary information.

Financing and Payment

Strategy 2 Full Financial Capitation through Health Plans
UnitedHealthcare believes that one of the most important elements of Strategy 2 is the development of an actuarially sound integrated financing and payment model to ensure long-term program viability and sustainability. Appropriately structured rates will result in savings for Medicare and Medicaid as well as increased early detection of individual needs and appropriate alignment of benefits and services. We support the State's payment reform principles for Strategy 2 as outlined in the demonstration proposal.

We offer the following additional key principles that we believe should also be taken into consideration as you move forward with the further development of the financing model for Strategy 2:

- The blended capitation payment should be based on member-level historic experience with appropriate risk adjustments to ensure appropriate plan-level funding for the population served by the demonstration.
- When calculating Medicaid utilization and, therefore, savings targets, Washington should include increased costs associated with historic limited collection of cost share amounts.
- Savings assumptions should be based on aggregate Medicare and Medicaid utilization and should be phased in over the course of the three-year contract to allow for appropriate recognition of savings impacts over time.
- Medicare funding should be established in such a way as to ensure adequate funding and appropriate savings for program sustainability.
- Medicare funding should be structured in such a way as to minimize underfunding as compared to Medicare Advantage.

- Supplemental benefits that are appropriately aligned to the needs of Medicare-Medicaid Enrollees, such as dental and vision benefits should be allowed and funded to encourage appropriate competitive positioning against Medicare Advantage products.
- The use of risk mitigation strategies such as, risk-corridors and re-insurance, is important particularly in early years of the demonstration.

In addition, quality withholds should be based upon appropriate criteria to ensure alignment of incentives and should be sensitive to shifts in membership absent extended facilitated enrollment timelines. For year one of the demonstration proposal, we believe that the financial incentive structures (proposed quality incentive pool) and quality standards and performance targets should largely be focused on administrative processes and access to services to appropriately take into consideration the ramp up of membership/enrollment under the three-year demonstration.

Expected Outcomes

Key Performance Metrics

Establishing quality criteria that supports program success and alignment with the population to be served and covered benefits under all three strategies/demonstration models will positively position the program for broader adoption and success. For example, given the proposed carve out of Medicaid-funded LTSS and behavioral health services under Strategy 3, the development of appropriate quality and outcome measures related to shared accountability with the LTC and behavioral health system is critical to ensure the model as proposed meets the State's policy and program goals. In addition, we believe member quality criteria should use appropriate STAR criteria and include additional metrics to ensure measurements of quality such as person-centeredness, community placement and repatriation, and comprehensive alignment of care planning for clinical, behavioral, social, and functional needs.

In closing, UnitedHealthcare Community & State appreciates the opportunity to comment on this important demonstration proposal. We look forward to continued participation in the stakeholder process and partnering with HCA, DSHS/ADSA, local providers and consumers and other key stakeholders in the community to improve the experience for Medicare Medicaid Enrollees in Washington state while systematically improving costs associated with managing their care.

Sincerely,

Catherine K. Anderson, MPA
National Vice President
Medicare-Medicaid Enrollees
UnitedHealthcare Community & State