Washington State Association of Counties

April 13, 2012

Duals Project Team
PO Box 45600
Olympia, WA 98504-5600

RE: State Demonstrations to Fully Integrate Care for Dual Eligible Individuals

Thank you for the opportunity to provide input on the Design Proposal document, the "Pathways to Health: Medicare and Medicaid Integration in Washington State."

Counties have a unique role and responsibility as partners of the state in service delivery to the most vulnerable individuals in our communities. Due to the close contact counties have with populations who are the "high utilizers" of costly health and related services, counties have a particular interest in ensuring that provisions are made for these individuals who may otherwise fall through the cracks and end up in more expensive crisis and medical services or in the criminal justice system.

We appreciate the work that has been done by staff at DSHS and HCA in providing information and being available to counties for questions related to the proposal. We believe continuing recognition of the partnership and open sharing of information and data at all levels will be key in any success of this project.

Areas of Support:

We appreciate elements throughout the plan proposal that recognize the importance of the local delivery system in order to make any strategy successful.

We appreciate recognition that there are elements of the current delivery system that are high quality and are working for individuals.

We appreciate the thought put into the accountability standards.

Implementation Considerations:

The plan builds in a number of requirements and provisions that would result in a good accountability structure. It will be important for the state to ensure strong oversight of the requirements to ensure that the contract provisions and contract standards are adhered to in the implementation.

The state must continue engagement with the counties on implementation issues related to risk and liability. There must be further discussion about inpatient risk and responsibilities for the crisis system, including courts.

The state must consider and work with the delivery system on how case management and the funding for case management will be handled under the proposals. As an example, AAAs provide case management/transport/meals

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etc. It will be important to define if this function would stay with current delivery system or move to the plans. It will also be important to ensure that all services currently provided under case management continue to be available.

The state should consider an ombudsman function in order to respond to issues that occur with implementation.

The state must ensure that "coordination" is not implemented as simply a phone contact or co-location of services. True integration and coordination must include screening for multiple needs, and coordination across practitioners through shared treatment planning and shared records.

The state must work with the counties to determine the costs and ensure that additional care coordination functions are funded. In addition, we must ensure an adequate level of funding so that local infrastructure continues to be sufficient to continue to provide services for those who are not within the duals strategies.

Consideration of geographic provisions are important to counties in a number of areas:

- Will the different options available, depending on which strategy is implemented in each county, increase disparity in services between urban and rural areas of the state?

- Transportation for Medicaid eligible individuals to Medicaid-covered services is not an optional Medicaid service, and so must be provided for in any program design. Transportation is an especially important service for residents in rural areas and counties. Local State-contracted Medicaid transportation brokers, providing non-emergent Medicaid transportation, are expert in meeting the challenges of the areas they serve, and there should be a defined role for these providers as well as a detailed discussion related to payment.

- In some areas of current services delivery system, including the RSNs and AAAs, rates are set by region rather than by county. It will be important to incorporate this variation into the rate setting mechanism.

It will be important to address issues that arise from lack of consistency related to eligibility criteria across the various health services (medical, mental health, chemical dependency and long term care). For example, Medicaid eligibility does not automatically make one eligible for public mental health services. There are stringent access to care standards for mental health eligibility. Since most dual eligibles have multiple needs, if they are eligible for one service, and need other services, will they be eligible for those other services?

The state must recognize that any changes related to supports and services for individuals with developmental disabilities are different than those related to BH or the medical model.

We believe that local providers who are already providing quality and robust services to the duals group, especially those serving the specifically targeted high cost/high risk duals, should be afforded a more definitive role in all strategies. Area Agencies on Aging are a clear example of that class of providers, delivering comprehensive care management to high cost/high risk Medicaid clients, coaching for clients in transition from hospital settings, patient and family support for dual eligibles and other populations, and a host of the other required elements for health homes. Other states have required participation of AAAs in health homes/duals grant projects, and we believe that should be a required feature of Washington State's proposal as well, at the very least, in the initial years of implementation. (Input from AAAs)

Will the state require plans to comply with federal substance abuse and mental health parity laws if they receive integrated (Medicaid) contracts?

In implementation of Strategy 1:

- How will the service overlay be implemented and paid for? Our understanding is that there will be an additional service level for care coordination. It seems that multiple care coordination/management entities may further fragment the system.

- Substance abuse is called out in many areas of the health homes plan as an important need to be addressed. Substance abuse is not listed as eligibility criteria under the health home plan and we believe it should be added.

In implementation of strategy 2:

- How will the blended rates be set without knowing what segments of the duals eligible population may choose to "opt-out"? This is important for a number of areas, but especially important to RSNs due to the funding structure that is also actuarially based. Any individuals who do not opt-in will then remain in the RSN population and the risk adjustment must somehow be built into the rates.

- Will counties be required to work with all plans in the county who have submitted a letter of intent to CMS if they agree to move forward with strategy 2? Will there be a requirement for consistent guidelines amongst plan services or will counties need to separately negotiate with each plan?

- Do we need additional time to implement this Strategy? We appreciate recognition that we are on a tight timeline and with the many factors at play, partnerships to be forged and actuarial work that needs to be done, does it make sense to push implementation date of this strategy out six to twelve months?

In implementation of Strategy 3:

- We appreciate the longer timeline within which this strategy will be implemented.
- There are many details that counties would like to further discuss related to this option, including payments, incentives and accountability.
- We appreciate that this option offers an incremental step that allows the state to more closely look at the areas where full capitation may not be appropriate and where it may make more sense to build on the current foundation of local services and supports. It will allow continuation of services that are delivering health outcomes and cost savings while giving the state time to assess if health plans will integrate these types of core services into their expertise.

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Recommended Changes:

The public health system in our state plays a key role in a number of the services addressed in the plan. For example, work around tuberculosis for the Medicaid population and health promotion activities. Therefore, the state should specifically mention work done by Local Health Jurisdictions as part of the plan.

There will be substantial costs involved in the planning and implementation of the strategies. We believe there should be discussion related to the role of the state in funding of the start up and infrastructure needs of the strategies.

In some parts of the proposal there is reference to "evidence based practices" (EBP) and in others it is expanded to "evidence based or evidence informed promising practices." Due to cost considerations with EBP monitoring and fidelity and lack of EBPs for the diverse population from a cultural competency perspective, counties suggest that the expanded language be used throughout the report.

We continue to have questions about funding and rates. We understand from our conversations with you that many details are still to be determined, but if there is a way to provide some parameters/guidelines of how the funding streams will flow it would be helpful.

We understand that a number of individual counties have also provided input with comments specific to delivery system and local needs. We will be continuing conversations at the county level and would like to be included in the continuing conversations as this Design Proposal moves forward.

Thanks you for the opportunity to provide input.

Sincerely,

Rashi Gupta

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Policy Director

cc: WSAC LSC Health and Human Services Workgroup Members

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