



April 12, 2012

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

Re: Pathways to Health: Medicare and Medicaid Integration in Washington State

On behalf of the Washington State Hospital Association (WSHA), representing 97 hospitals, we appreciate the opportunity to comment on the proposal for the dual-eligible population: *Pathways to Health: Medicare and Medicaid Integration in Washington State*.

We were pleased Washington State was one of 15 states that received an 18-month planning grant from the Centers for Medicare & Medicaid Services to develop an implementation plan for innovative service delivery models for beneficiaries enrolled in both Medicare and Medicaid (commonly referred to as dual eligibles). It is important to improve care and decrease costs for these 115,000 beneficiaries, who are some of the sickest and most medically needy individuals in our state. WSHA hopes the state is successful in securing funding in the next stage of this process.

We have two overall comments. First, we are concerned that there needs to be protections included in this process for the beneficiaries enrolled in health plans. Given the potential lack of experience among the health plans in managing care for this complex population, we want to make sure there are appropriate processes in place so beneficiaries receive needed services. For example, has the state considered requiring each managed care enrollee have a care plan created and a visit scheduled with a primary care provider within three months of enrollment? Ensuring proper access to care is crucial to improving care and decreasing costs.

Second, we believe the state should take advantage of the opportunity to improve transitions in care for this population, many of whom have high rates of re-admission. WSHA has been working with a variety of stakeholders to improve transitions between hospitals and nursing homes, and hospitals and home health providers. Has the state considered the benefits of working with providers and plans on adoption of standard practices, such as a standard discharge form with information needed post-discharge?

Our more specific comments are attached. Thank you for the opportunity to review the proposal.

Sincerely,

Claudia Sanders

Claudia Sanders
Senior Vice President
Policy Development

Chelene Whiteaker

Chelene Whiteaker
Policy Director
Member Advocacy

Attachment

Attachment

Washington State Hospital Association Comments on Pathways to Health: Medicare and Medicaid Integration in Washington State

The Washington State Hospital Association has the following comments about the proposal:

Overall framework. Washington State has done significant work to move beneficiaries needing mental health and long-term services out of institutional settings. Yet the proposal does not discuss this background and framework. The proposal addresses the information about Washington State's historic development of community supports on page 35, but does not set up the discussion up front in the proposal. We believe not framing this for the Centers for Medicare & Medicaid Services (CMS) may diminish from the proposal.

Coordination. The proposal does not address decision making and implementation of the strategies between Department of Social and Health Services and the Health Care Authority if the state is awarded the grant. Additionally, the process for involving counties and other entities that are currently coordinating services and payment flow under the various strategies is unclear. If this is not contained in the proposal to the CMS, this information should be shared with stakeholders if the state is awarded the grant.

STRATEGY 1: IMPLEMENT HEALTH HOMES

- **Patient assignment.** It is unclear from the proposal how this program will assign patients to a care manager and how these care managers will interact with the current mental health and long-term care infrastructure that operates in silos. The care managers are responsible for quality
- **Level of risk.** The proposal does not explain how many beneficiaries in each county have a PRISM score of 1.5. Also, the PRISM score should be lowered to expand the numbers of beneficiaries receiving care management services to prevent beneficiaries from becoming the sickest population.
- **Care managers.** The proposal outlines many entities as being able to provide health homes and the training required, but does not describe the additional training for care managers to perform to the new expectations.
- **Definition of community.** The proposal states that a health home will assign a "dedicated care manager who is located in the community in which the beneficiary resides." What is the definition of community and how will the interactions of beneficiaries and care managers occur in very rural parts of the state?

STRATEGY 2: IMPLEMENT FULLY FINANCIALLY INTEGRATED HEALTH PLAN MODEL

- **Access to providers.** WSHA supports the use of the client survey as indicated in the proposal. Most Medicaid managed care plans do not have the experience to deal with this beneficiary risk level. This survey will help determine if beneficiaries have ongoing access to primary care and specialty services, as well as if care management meets the expectations within the initial contract. The sample should be large enough to determine if certain plans have trends in access overtime. If found to be insufficient, mechanisms to correct this deficiency should be put in place.
- **Number of potential enrollees.** The proposal does not adequately describe how many beneficiaries (and counties) will be potentially eligible for health plan enrollment in geographic areas where legislative authority already exists.

STRATEGY 3: MODERNIZE CURRENT DELIVERY SYSTEM, IMPLEMENT THREE WAY CONTRACTING

- **Needs Clarity.** This strategy is unclear regarding contracting and the flow of payment to providers. Given the complexity of current payment systems, WSHA strongly encourages that more detail be given to this strategy. The payment system and claims process for non-health plans may be difficult to duplicate, especially given these small economies of scale with the dual population.
- **Care Management.** Interactions between care managers and health plans in three-way contracting is unclear in the proposal. This piece should be addressed more explicitly moving forward.
- **Payment.** The proposal does not adequately describe how incentives will be paid or how savings will be shared between CMS, the state, and health plans.
- **Access to providers.** Similar to our comment for Strategy 2, mechanisms should be put in place to correct insufficient access of beneficiaries to providers.

If you have questions about any of our comments, please contact Chelene Whiteaker at chelenew@wsha.org or 206-216-2545.