



Washington Health Care Association

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Advocates for the Long-Term Care of Washington's Elderly and Frail

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Duals Project Team
Post Office Box 45600
Olympia, Washington 98504-5600

Dear Sirs/Madame:

On behalf of the more than 400 skilled nursing and assisted living provider members of the Washington Health Care Association ("WHCA"), I am writing to provide public comment on the Department of Social and Health Services ("DSHS") and the Health Care Authority's ("HCA") proposal for participation in the CMS demonstration project establishing innovative service delivery models integrating care for dually-eligible ("Duals") Medicare and Medicaid beneficiaries.

WHCA commends the leadership of DSHS/HCA for their participation in this project and is encouraged that Washington has taken a leadership position in proposing new strategies designed to overcome barriers to beneficiary's access to care, extract additional efficiencies from current systems, and ensure the provision of quality care. WHCA is pleased to have the opportunity to partner with the state to help ensure that these goals are realized as this initiative unfolds.

Because WHCA is a professional trade association representing providers of facility-based, post-acute health care services and the vast majority of our clientele is made up of Medicaid and Medicare beneficiaries, our members have a significant, vested interest in the outcome of this initiative. Subsequently, we have three objectives that we believe must be achieved and sustained as this program unfolds:

- Ensure beneficiary's access to quality care/services;
- Provide a stable and predictable financing system; and,
- Maintain an adequate compliance program for system integrity.

It is important to note that throughout this initiative, the proposal(s) attempt to reconcile two inherently competing yet inextricably linked features of any health care delivery system – sound health policies and reasonable health care financing. This dichotomy is not new to regulators or providers, yet it remains to be seen if such a reconciliation can be achieved through the program design under consideration.

WHCA offers the following comments and thoughts, focusing on two principle features of the proposal: the development of the necessary infrastructure to effectuate the management and delivery of program services and its financing and related patient/provider safeguards. In addition, we have offered

comments on our on-going work to address a key component of this initiative as it relates specifically to skilled nursing facilities – the prevention of avoidable rehospitalizations.

Infrastructure: Health Homes and Care Coordination

WHCA is encouraged that the state's program design begins with efforts to better organize and consolidate beneficiaries' experience with their health care delivery systems through the more effective allocation and access to necessary services, both medical and social. Beneficiaries' current navigation of the complex and fragmented delivery system often times results in gross inefficiencies. These add not only to unnecessary costs, but to an inappropriate and oftentimes ineffective utilization of scarce health care resources. This is further compounded by the lack of both access to and coordination of critical social service support systems.

At the heart of this initiative is the development of a standardized entity that can identify and allocate necessary resources – Health Homes. This will necessitate the development of an infrastructure that combines the talents and resources of individuals with familiarity of both medical and social models of service coordination. While the proposal details several specific criteria that must be met in order to qualify as a Health Home, questions arise over the ability to have them effectuated over the entire geographical service area (and future services areas) and across the entire spectrum of patients' needs.

Of concern is the fact that because of the vast array of client needs, many such needs may lie outside the scope of traditionally covered services and therefore be unfamiliar to existing providers of care management services. As this program develops and is moved under the control of private managed care organizations (MCO), the differences between “case management” and “care coordination” will become evident and must be reconciled in order to produce an effective service allocation program.

Much of the success of Health Homes will be determined by their ability to educate program beneficiaries (and their guardians, family members, etc.) as to not only available services, but the rationale for changing earlier patterns of behavior in accessing the various components of the health and social care delivery system. This will likely prove challenging – not only for beneficiaries, but for providers as well. DSHS/HCA would be well served to initiate and maintain both consumer and provider “re-orientation” programs that complement the changes in service delivery envisioned by this initiative. Ultimately, this will be an evolutionary process for everyone concerned and DSHS/HCA should anticipate a prolonged and protracted experience.

Once operational, we presume that performance evaluation metrics will be applied to evaluate the effectiveness of the Health Homes in general and that a systematic application process for these metrics to individual Health Homes will be applied on a regular basis. WHCA would be interested in seeing these metrics as they are developed and to lend the expertise of our provider constituencies in order to ensure their effectiveness.

- **Timeliness of Payments**— MCOs should pay LTC providers in the same manner that Washington State currently pays Medicaid providers. Generally, the state pays providers within ten days after submission. This timeliness standard is critical as we evolve to any level of managed care in order to maintain cash flow. Electronic Fund Transfers are an integral component of helping to ensure prompt payment while also providing for reduction in plan administrative costs for manual check processing and mailing.
- **Share of Cost**—MCOs should be responsible for the collection of the share of cost from a beneficiary enrolled in the health plan. The health plan should also be responsible for paying for services in a long term care facility, even in the event that the health plan is unable to collect share of cost from the beneficiary in any month.
- **Case Management Fee**— LTC providers should be compensated for the cost of the provider component of care management and coordination. This would include additional costs related to assessment, administering care plans, and transition to other settings within the continuum.

Beneficiary Safeguards

WHCA believes that many of the lessons learned over the past several years as managed care delivery systems have matured can and should be utilized as Washington develops systems for this initiative. We believe that the following features of any managed care system should include the following elements:

- **Patient Choice of Provider** — Beneficiaries shall be able to choose any willing LTC provider. All providers within the relevant geographic area shall be able to contract with the health plan.
- **Quality Review** —Plans should be required to have an annual quality review process conducted by qualified independent organization. The quality review process shall include review of the adequacy of placement and utilization as measured against the standard in the community or other acceptable clinical measures.
- **Independent Appeal Process** — DSHS/HCA should implement an independent appeals process for the timely resolution of denial of authorization of services for short-term rehabilitative services that would otherwise be covered by Medicare Part A in a SNF.
- **Patient Satisfaction**— Plans should be required to conduct periodic resident/patient satisfaction surveys. Surveys should be included as a review component within the annual Independent Quality Assessment Process.

Preventing Avoidable Rehospitalizations

Reducing hospital readmissions from skilled nursing facilities has been the focus of much work in Washington State over the past two years. Working with local area hospitals, LTC providers from throughout the state are engaging in work groups charged with developing processes to ensure smooth transitions back to nursing home and/or other home and community-based care settings.

Launched in 2009, the *State Action on Avoidable Rehospitalizations initiative*, (“STAAR”), aims to reduce rates of avoidable Rehospitalization. The Washington State Hospital Association (“WSHA”) has received grant monies to manage the initiative. WSHA’s work has focused on convening representatives from providers from every LTC sector to work actively to align hospitals with SNF providers and other key stakeholders with the goal of improving patient “hand-offs.” While there has been some work on a “universal transfer form,” the work to create a cross-sector, common discharge form that clearly delineates expected follow-up has yet to be completed.

The Washington Health Care Association has been actively engaged in a year-long campaign with Qualis Health to engage providers from the acute and sub-acute sectors in developing strategies to reduce hospital readmissions. In developing those tactics, the focus is threefold:

- Protect residents from risks associated with inpatient settings to avert complications that could lead to readmission (i.e., infection control practices);
- Design transitions processes that ensure the receiver is provided timely and appropriate information regarding patient status, care needs and aftercare plans with the primary care physician;
- Use specialized disease-management software and protocols to identify and triage residents at risk of readmission.

Currently, 78 skilled nursing facilities in the state are engaged in field-testing the Institute for Health Improvement guide to reducing avoidable rehospitalizations. These “early adopters” are targeted for peer-to-peer training opportunities as part of the WHCA campaign.

One of the barriers to better care coordination is lack of access to health information technology. The combination of a large number of residents and their ever-changing medical conditions coupled with a rotating facility staff makes it nearly impossible for all parties to communicate with each other. While hospitals have been provided with both state and federal funds to invest in state-of-the-art health information technology, chronic and on-going reimbursement shortfalls in the skilled nursing facility world have inhibited providers’ ability to invest in the technology infrastructure that would make information-sharing more efficacious.

Ultimately, the success of this initiative will be largely dependent upon both beneficiaries and providers access to adequate resources. The failure of the state and federal governments’ assurance of these resources will result in lower levels of access, quality, and consumer satisfaction. Again, WHCA is appreciative of the opportunity to offer both its comments and support as this program continues to evolve.

Sincerely,



Rich Miller
President & CEO