May 30, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

Re: Washington State Demonstration to Integrate Care for Medicare-Medicaid Enrollees

Dear Ms. Bella:

Thank you for the opportunity to submit comments on Washington's proposal for a demonstration to Integrate Care for Medicare-Medicaid Enrollees. As detailed below, while AARP supports integration efforts generally and the HealthPathWashington, we believe that specific modifications in the proposal or requirements in the terms and conditions are warranted to enhance consumer protections and to ensure that they receive high quality care and support.

As a nonprofit, nonpartisan social welfare organization with a membership and offices in all 50 states, AARP's mission is to help people 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. We seek to help older Americans live long and healthy lives. AARP Washington, representing nearly one million members, is the state's largest organization representing the needs, views, desires, and hopes of Washington's 50+ population.

AARP supports Washington's ongoing efforts to craft new health care systems for the dual eligibles. This project holds great promise in eliminating the current fragmentation and improving the quality of care and health while adequately protecting the rights and benefits of this highly vulnerable population. We are particularly pleased that consumer input has been sought throughout this proposal development process and that Washington has significantly clarified and modified the initial proposal based on stakeholder concerns.

The three-strategy proposal Washington has submitted is ambitious, but it is very well and thoughtfully designed and has been extensively vetted with all stakeholders. Strategy 1 — Health Homes for High Cost/High Risk Duals — will provide critically needed improvements in care coordination as quickly as feasible. As revised, the proposal appropriately ensures "high touch" care coordination coupled with the authority needed to achieve meaningful change and care quality and delivery.

Washington addressed major concerns as to Strategy 2 — Fully Financially Integrated Model through Health Plans — by delaying the starting date until 2014 and with clarifications as to the plan and provider selection standards. Strategy 3 — Modernized Delivery System with Partial Capitation — should be an effective means of providing highly coordinated care with a simplified, consolidated delivery system in those parts of Washington where inclusion of behavioral health and long-term services and supports in a fully capitated system is not presently viable. Limited capitation will integrate health care services without moving control or authority for long-term services and supports to entities with limited experience in managing these services. While complex, we support the concept of knitting these services together through the health home concept and through the use of performance measures and incentive pools. Taken together, the three strategies should provide improved care and support for all covered individuals. Where appropriate, we urge CMS to allow Washington to implement more than one strategy in the same geographic region.

While pleased with the response to our previous comments, there remain a few issues that should be resolved before the proposal is allowed to proceed.

While Strategy 1 has been refined to require "high touch" care coordination and initial and continued enrollment is completely voluntary, it would be appropriate to specifically prohibit conflicts of interest. Since the proposal allows health homes to be networks of providers including clinics, hospitals, and other direct providers of medical care and long-term services and supports that may also be receiving fee-for-services payments for the same client, conflict protections should be required. The proposal should require health homes to use objective quality data in their care coordination and referrals. For example, if a client requires hospitalization, the health home should provide objective quality data on the array hospitals available so that clients can select one with a low rate of preventable infections and other "never events," even if it is a hospital outside of the health home's network.

The passive enrollment system within Strategy 2 allows individuals to decline initial enrollment. For this population, independent enrollment counseling services are critical. As the proposal documents, over 60% of the 65+ population qualifies for Medicaid long-term services and supports because of their medical condition and need for assistance with activities of daily living. High portions are being treated for mental health issues (psychosis, dementia, mania/bipolar disorders, etc.). A portion of the duals who are unable to make informed medical and support services decisions on their own do not have family or others actively involved in medical and service decisions. The proposal conditions the availability of counseling services on the availability of CMS funding. Unless high quality, independent and adequately funded counseling services are provided, enrollment should be completely voluntary. While the proposal does provide for continuity of care throughout the 90-day lock-in period, at a minimum consumers should have the right to disenroll at any time for cause, *e.g.*, if the plan fails to provide timely access to appropriate medical care.

The proposal includes no details on disenrollment after the 90-day lock-in period. Washington and CMS will want to guard against plans that might attempt to encourage disenrollment by

consumers who are medically or behaviorally challenging or expensive to care for. Washington should be required to carefully monitor disenrollment to deter inappropriate action through systems such as exit interviews. Also, the responsibility of the managed care entities and their networks should not end with disenrollment. They should be required to develop and implement a seamless transition plan with no gaps in care.

The proposal (page 19) indicates that supplemental benefits may be required or will be "encouraged" and notes that beneficiaries repeatedly identified their inability to meet critical needs on their limited incomes. It also estimates combined Medicare and Medicaid savings in excess of $50 million over the course of the demonstration. A portion of these savings should be allocated for expanded coverage and benefits. These funds could be used, for example, to provide chronic care management services for those not yet dually eligible and ancillary supportive services for those seeking to remain in the community, *e.g.*, home modification, respite care, personal emergency response system, and transportation services. Provision of additional services would provide a strong incentive for individuals to remain in the program.

While the proposal provides a good system of retrospective monitoring for quality indicators, it does not include any system of targeted, proactive real-time monitoring as to Strategies 2 and 3. For this population and their often complex medical needs, the interests of consumers, HHS and Washington warrant prompt, proactive oversight. It is generally acknowledged that a fee-for-service system rewards over utilization and a capitated payment system rewards underutilization. While better coordination and high quality care may make reductions in total care, services and costs possible, a capitated system's inherent financial incentive to simply spend less remains. To ensure that Washington, HHS and taxpayers receive good value for their dollars and that this population receives the coverage they are entitled to, it will be advantageous to rapidly identify and address problem areas as well as to reveal promising, replicable practices that result in improved quality and cost containment. To counterbalance the intrinsic pressure within a capitated system to limit expenditures, additional systems are needed to deter inappropriate reductions or denial of care. If the plans and their provider networks act in the best interests of enrollees, these protections would rarely be invoked and the related costs would be low.

Washington's current Medicaid program includes an effective prior authorization system to prevent inappropriate utilization of medical services and prescription medications. The proposal should be expanded to require a system to prospectively examine any proposed changes in a plan of care that would result in significantly reduced quantity of care or lower plan expenditures, and, when appropriate, to reject such changes if they are not in the best interests of the consumer. From this review, the cost cutting practices that maintain or improve patient care, outcomes and quality of life could be distinguished from those that may have an adverse impact.

The dual eligibles will also need ready access to advocacy assistance. Washington should be required to include an adequately funded, independent system that provides no-cost advocacy and Ombudsman services to ensure that enrollees receive access to the full range of benefits and rights afforded by both Medicare and Medicaid initially and on an ongoing basis. Advocacy

will be complicated by the significant differences, as well overlaps, in Medicare and Medicaid benefits and by disparate appeals processes, with differing coverage standards set by federal and state law, regulation and policy; different administrative and judicial forums, procedures and timetables; and different governing state and federal case law. Ensuring that benefits and rights are maintained and protected under both programs will require highly skilled, professional staff with sophisticated knowledge, medical and legal expertise, and experience.

Many grievances and appeals will be decided based on medical opinion and evidence. In contest between the plans, their attorneys and their health care professionals, enrollees will be at a distinct disadvantage. To counterbalance the plans' monopoly on medical records and expertise, enrollees should have access to an independent medical assessment for the purposes of rebutting plan proposals to deny or reduce services.

AARP remains committed to working collaboratively with Washington and CMS on creating and implementing a high quality dual eligible financial alignment demonstration that will improve the delivery of care, health, functional outcomes and quality of life for the dual eligible population. Thank you for the opportunity to comment on this proposal. If you have questions, please feel free to contact Doug Shadel, AARP Washington State Director, at (206) 517-2316.

Sincerely,

Doug Shadel
AARP Washington State Director

Elaine M. Ryan
AARP Vice President
State Advocacy and Strategy Integration