King County

Department of
Community and Human Services

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Public Health
Seattle & King County

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Duals Project Team
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Dear Duals Project Team:

Public Health-Seattle & King County and the King County Department of Community and Human Services welcome the opportunity to comment on the Department of Social and Health Services (DSHS) and the Health Care Authority's (HCA) paper titled "Pathways to Health: Medicare and Medicaid Integration in Washington State." Please note that we have prepared and submitted a separate letter with comments on the associated Draft Health Homes Proposal, released February 22, 2012. A copy of that letter is enclosed.

We appreciate that the DSHS and HCA heard and incorporated elements of the feedback provided by the community on the options for purchasing of behavioral health and long-term services and supports. In the models laid out in the Pathways to Health proposal, it is clear the State is working to move toward meaningful integration and taking steps to address the inherent risks associated with the full capitation model and with the coordinated model where some system carve-outs remain.

The range of proposals offered takes into consideration the unique differences of various communities across the state and allows for a more thoughtful design of integrated services. Overall, we support the direction the state is proposing by offering three distinct models to further integrate services and achieve the triple aim.

Below are some specific concerns and recommendations that we hope you will consider as you finalize the proposal for Medicare and Medicaid integration prior to its submission to the Centers for Medicare and Medicaid services.

Strategy 1: Implement health homes for all high cost/high risk dual beneficiaries under Managed Fee for Service where financial integrated capitation model does not exist

- Comments and concerns regarding the health homes proposal are addressed in a separate letter (enclosed).

Strategy 2: Implement full financially integrated model purchased through health plans

- **Support a single point of accountability for services and outcomes:** Overall, the proposed approach of combining Medicaid and Medicare funding into a single financing strategy for dual

eligibles is a good one – assuming certain safeguards are incorporated—in that it allows for a single point of accountability for services and outcomes. It also sets the stage for a less fragmented approach to care from the client perspective.

- **Ensure active role of counties in development of model:** We support the proposed strong role and approval of county legislative bodies for participation in Strategy 2 demonstration. Counties can and should play an active role in establishing the selection criteria to assure that managed care organizations have the appropriate provider and social service networks in place to succeed, and that the model builds on, rather than destroys, the effective community-based services and relationships that are already in place. We welcome more dialogue with the State to design the specific parameters of county involvement. Additionally, there needs to be a mechanism for counties to monitor the impact of the proposed model on other systems to prevent cost shifting. How will counties be able to access data and other information to ensure accountability?

- **Ensure continuity of care:** Our experience is that a number of dual eligibles fall on and off Medicaid due to spend down requirements. It is unclear what will happen if an individual is enrolled in the dual eligible full capitation program and is not dual eligible for a period of time. In order for this strategy to be effective in reaching desired outcomes we recommend that the benefit package remain consistent for individuals whether they have the full Medicaid status or are on spend down, and/or there needs to be modifications to spend down requirements that will allow individuals to continue to be served within the dual eligibles program and maintain continuity of care.

- **Increased flexibility in Medicare program:** Medicare rules give certain restrictions on mental health provider credentials and types of services that create barriers to appropriate mental health treatment. For example, Medicare restricts payment for master's level service to only those clinicians who have a master's degree in social work. However, many community mental health clinicians have master's degrees in areas other than social work, preventing their services from being reimbursed under Medicare. Additionally, Medicare does not currently provide reimbursement for case management, a service that is critical to recovery and resiliency for individuals with serious mental illness. We believe Strategy 2 will be most effective if Medicare broadens the provider credential to include those individuals who have a master's degree in social work and other related fields such as psychology and expand the covered treatment modalities to include case management.

- **Clarify Payment and Shared Savings:** The substance abuse system currently operates on a fee for service payment structure. It is unclear how capitation reimbursement will be calculated for those dual eligibles participating in the full capitation model will be determined and how that might impact the rest of the substance abuse system that remains fee for service. Transparency is critical in rate-setting and counties, Regional Support Networks (RSNs), and Area Agencies on Aging (AAA) should be provided access to information and assumptions regarding rates prior to making agreements with health plans. Additionally, if funding flows through a managed care organization how will savings be shared between Centers for Medicare and Medicaid Services (CMS), the state, health plans, and providers? We believe that savings

or other incentives should be directed, in part, back to the community to support services and supports not typically covered under Medicaid and Medicare (such as housing) but that contribute significantly to overall health outcomes.

- **Allow adequate time for design, capacity building and start up:** We appreciate the State's recognition that the implementation timeline for Strategy 2 is very aggressive. We have concerns about plans and systems ability to mobilize and prepare for implementation so quickly. It is important to recognize that this type of redesign is an evolutionary process that will require time for building trust, designing and ensuring adequate capacity and developing the infrastructure across providers.

Strategy 3: Modernize current service delivery system

- **Identify a single point of accountability:** The proposal does not adequately identify a clear point of leadership to ensure integration and accountability across systems. We recommend the State identify mechanisms beyond contract performance measures and outcomes reporting to ensure accountability across systems and to the overall community. Counties can and should play an active role in supporting cross-system integration and monitoring accountability. We welcome more dialogue with the State to design the specific parameters of county involvement. Additionally, there needs to be a mechanism for counties to access data and other information to ensure accountability.

- **Clarify Payment and Shared Savings:** the proposal does not describe how incentives will be paid or how savings will be shared between CMS, the state, health plans, and providers. We have concerns that using a payment withhold to achieve incentives would significantly decrease resources to the community, negatively impacting the ability to achieve outcomes. Furthermore, we believe that savings or other incentives should be directed, in part, back to the community to support services and supports not typically covered under Medicaid and Medicare (such as housing) but that contribute significantly to overall health outcomes.

Additional Comments

- **Ensure full range of services available:** Services mentioned under chemical dependency mention opiate substitution treatment. It does not, however, include other medication-assisted treatments such as depo-naltrexone for alcohol use. We recommend that the service package include a full range of treatments and interventions, including evidence-based medication-assisted treatments.

- **Maintain current processes that are working:** On page 23 of the proposal, the State specifies using the CAGE to screen for chemical dependency problems. The state has already invested significantly in the use of the GAIN-SS for system-wide screening. We recommend continued use of the GAIN-SS, unless there is a justification for changing to the CAGE for this population.

- **Clarify specific ages for stratification and maintain continuity:** The proposal sometimes uses over and under age 65 for data stratification and other times uses over and under age 55. It is unclear why the State is using two different metrics. We would appreciate clarification on why different age groupings are used and how the differences apply to implementation of each of the strategies.

In closing, thank you for the opportunity to comment on the Pathways to Health proposal. We look forward to working with the DSHS and HCA to improve the integration of services for dual eligible beneficiaries in King County.

Sincerely,

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Department of Community and Human Services

David Fleming, MD, Director & Health Officer
Public Health--Seattle & King County

Enclosure

cc: Anna Markee, Health and Human Potential Policy Advisor, Office of the King County Executive
Susan McLaughlin, Health Care Reform Project Manager, Department of Community and Human Services
Janna Wilson, Senior External Relations Officer, Public Health-Seattle & King County