



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

## **Idaho Division of Medicaid**

***Stakeholder Comments  
for Idaho's Draft Proposal  
to Integrate Care for Dual  
Eligibles***

**May 2012**

**Developing a managed care program for dual eligible participants is a statewide effort of Medicaid staff, providers, community partners and agencies, participants and families.**

**Idaho Medicaid held a statewide meeting of these stakeholders to gather specific recommendations and priorities on October 26th, 2011. Over 50 people participated in the meeting, which was held at the Boise Medicaid state office and video-conferenced to six other sites throughout the state.**

**Following this, Idaho Medicaid hosted a second videoconference on April 17, 2012 to review Idaho's draft proposal and collect feedback from stakeholders. From the feedback of the first two meetings, Idaho Medicaid developed refined the draft proposal and encouraged stakeholders to submit their comments by mid-May, 2012. Ten stakeholders submitted written comments, which are contained in this document.**

**Idaho's Draft Proposal to Integrate Care for Dual Eligibles**  
**Stakeholder Comments**

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May 10, 2012

On behalf of Idaho Health Care Association, I submit the following comments and questions on the Managed Care Draft Proposal.

Thank you for consideration of these concerns.

Kris Ellis

### **Questions, Comments and Concerns with the Managed Care Draft Plan**

1. If a patient who meets nursing home level of care chooses a particular care setting, but the plan chooses a lower cost care setting... can the plan withhold payment to the setting the patient chose? Or require discharge?
  - a. We recommend that patients have the right to choose their care setting within reason. This should be a negotiation between the plan and the participant.
2. Will the current Medicaid provider payment be the minimum payment required by the plan?
  - a. We recommend that the current rate be required by the plan and that savings are generated by case management...not rate management.
3. Require that cost reports be maintained, to ensure that the assessments can continue, and structure the UPL to be paid as a rate adjustment, not as a lump sum. This will require a statute change that will need to be finalized in the 2013 legislative session.
  - a. We recommend the department work with IHCA and others to rewrite the statute to comply with these objectives.
4. Will the federal access requirements (and the rules being developed by Idaho) still apply to a managed care plan?
5. How can balance be assured between family/patient choice and case management decision making?
6. Ensure that perception between independence in non-institutional settings and services provided by SNFs are put on an even playing field.
7. Will expense for home health travel mitigate perceived savings from non-admission to SNFs?
8. How will the cost savings be measured? Is there expected to be cost savings?



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9. Is there an expectation for assessments and care planning for the home setting?
10. What is the difference between person-centered care and those services provided by a SNF?
11. Will there be any beneficiary satisfaction surveys?
12. The report fails to address that those placed in a nursing home setting are generally more medically complex than those in a non-institutional setting, resulting in a higher number of hospital admissions.
13. Is there a process for the state to immediately intervene on behalf of the beneficiary if required?
14. In section ii 'Payments to Providers' (lines 721 thru 740), include a bullet point for 'Prompt Payment' language and define it to mirror the language currently in effect with Medicaid.
  - a. Currently, the state of Idaho can process claims on a Thursday and payment is in the provider's bank account the following Thursday (1 week turnaround from billing to payment).
15. Include/clarify language on section D. of lines 611 thru 613 and consider changing the sentence 'Contractor shall maintain a network of appropriate providers supported by written agreements.' to 'Contractor shall establish written agreements with any willing provider.'
  - a. We would want to be able to provide service to any resident or client that may wish to receive services from us. The current language may allow the contractor to dictate and/or limit the providers that the resident/client can use.
16. In K. Workplan/Timeline, there is no Key Activity/Milestone of when the contractors will issue agreements to providers to execute. The three-way contract between the Health Plans, CMS, and the State is set to be completed in September 2013; however, there appears to be no timeline of when the providers will be expected to review and execute the agreements with the respective contractors.



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May 11, 2012

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Deputy Director Clement,

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 Idaho, representing 177,000 members, is the state's largest organization representing the needs, views, desires, and hopes of Idaho's 50+ population.

We are writing to comment on the state's demonstration proposal to integrate care for dual eligible individuals. The proposed plan will be responsible for coordinating the care of those people eligible for both Medicaid and Medicare. Because this population is among the frailest and most vulnerable of Idahoans, AARP is committed to ensuring that any transition to a new system is seamless and improves their quality of care and their quality of life.

The Idaho proposal is an outline of the plans to establish a statewide capitated financing model that would require mandatory enrollment into health plans for Medicaid benefits and passive enrollment with an opt-out provision for Medicare benefits. Idaho's experience with Medicaid Managed Long Term Supports and Services (MMLTSS) is limited. AARP finds the transition to a statewide managed care system requires time to build the infrastructure, protections and quality measures needed to provide a seamless transition for this vulnerable population. As the state undertakes this transformation it must take the time to build in these elements. Our comments are therefore intended to offer a foundation for creating a system that will assure that those in the demonstration program experience improved coordination of care. Such a system must be built on assuring quality care both now and in the future.

### **Critical Recommendations**

In particular, we urge Idaho to include the following four critical recommendations in the demonstration proposal submitted to CMS:

1. A plan to implement specific **quality control measures** for participating plans and **specific triggers** to signal the need for corrective action when quality thresholds are unmet.
2. A plan to create an **oversight committee or task force independent of the Medical Care Advisory Council** to monitor the demonstration with the ability to ensure that needed modifications and adjustments can be made during the demonstration timeframe.
3. A plan to **reinvest financial savings** realized through the demonstration program to improve access to and quality of home and community based-care services on a larger scale.
4. Start with a **regional pilot program** in 2014 or implement the plan in stages.

We discuss these critical recommendations in greater depth below, and provide additional suggestions for necessary improvements to the proposal.

### **Quality**

The state's recognition of the need to monitor quality and establish incentives for attaining quality goals and improvements is a welcomed step. Unfortunately, there are currently no nationally-recognized quality measures for long-term care. Therefore, the proposal should establish that quality improvement is a cornerstone of the demonstration and speak to how data collection can provide insights into whether quality is being improved. This should be a clearly articulated goal in the proposal. Serious consideration should also be given to including language that specific quality of care measures will be developed and implemented in order to provide consumers with objective data. Ensuring that care plans provide measures for determining whether the consumer's health and well being is improving, sustained, or declining should also be a focus of the proposal.

With respect to quality, setting and assessing quality measures are only the first steps. These measures must be shared with the public at-large so that the performance of plans can be understood and the process is transparent. A number of states have identified in their proposals a variety of ways to build quality awareness and improvement. These include:

Creating public report cards;

Using quality outcomes to guide assignment into integrated care entities;

Establishing special enrollment periods to reward high functioning plans; and

Requiring contractor adherence to person-centered planning that is evaluated, publicly reported, and rewarded from the first year forward.

AARP believes the proposal should set forth specific measures to ensure quality, including contract performance language to protect enrollees. While the state recognizes the value of certification by the National Committee for Quality Assurance, it should require that certification is a requirement for contractors. The state should also spell out the contractual provisions to promote quality performance, as well as protections in the event plans fail to deliver on their contracts with the state. Plans should also be required to meet quality targets or face the risk of suspension or denial of new enrollment. There should be a protocol for a full range of corrective actions and established quality triggers that signal the need for corrective action to be taken. Additionally, the state should set forth an explicit back-up option in the event a plan is no longer operating in a region, whether voluntarily or involuntarily.

### **Oversight**

AARP believes that states have an obligation to provide effective oversight of the programs with which they contract to provide services to their frailest and most vulnerable citizens. Idaho should not be permitted to reduce its Medicaid role and responsibilities to dual eligibles by simply paying a capitated rate and relinquishing these functions to health plans. Final accountability for the performance of its contractors, including managed care plans, must remain with the state. Therefore, Idaho should include in its proposal measures to assure CMS and the public that its proposed demonstration program will be adequately monitored and enforced.

AARP urges that the state's proposal include creation of an independent oversight committee or task force independent of the Medical Care Advisory Council to monitor the demonstration with the ability to ensure that needed modifications and adjustments can be made during the demonstration

timeframe. Legislative oversight committees are active in Indiana, and were a valuable vehicle for advancing Tennessee's long-term care transition to managed care plans.

### **Reinvestment of Financial Savings**

Once the demonstration achieves its goal of improved quality and care coordination for dual eligibles, as well as cost savings for the state, AARP strongly believes that the state should commit to using this success as an opportunity to improve access to and quality of home and community-based care on a larger scale. This commitment should be demonstrated by including in the proposal submitted to CMS specific language that directs that any savings achieved through the success of the demonstration be reinvested to improve the network and quality of services and supports available to vulnerable Idahoans. While this reinvestment would likely require legislative action, we strongly urge that it be included as a part of the proposal submitted by the administration.

### **Care Coordination**

In establishing a new system, there is the risk of disrupting care for the vulnerable dual eligible population. AARP has identified a provision that has been included in other states' proposals that establish necessary protections during the transition period. We believe that ensuring that a care coordinator for each enrollee who has primary responsibility for the management and coordination of all services is extremely important.

The state's proposal says the health plans will coordinate services through a care management team that will implement the principles associated with a health home model of care. While this recognition of the value of the health home model and a care management team reflect the state's interest in assuring coordination of care, there are no specific details on how the plans will contract with these teams or the time frame for building a broader team. This care coordination piece should be built out before the state implements the demonstration.

### **Network Capacity**

As the state transitions dual eligible individuals into the demonstration program, it is critical to ensure prior to enrollment that the plans have the capacity to meet the needs of the enrollees. The state should first make clear the standards for network adequacy supported by evidence based research and data, and provide a clear plan for network adequacy review that does not simply require the submission of data to the state on an annual basis. The proposal should ensure that plans will meet explicit network standards for providers and provider facilities, including primary, specialty, and other critical professional, allied and supportive services and equipment providers, with a right to an out-of-network authorization if the standard is unmet. We urge Idaho to adopt these or similar provisions in the demonstration proposal and consider other measures to ensure continuity of care and network adequacy for participants.

In order to assure the network is able to serve this population, there should be metrics to measure the performance of the plans. The timeframes for beneficiary appointments should be monitored and enforced with penalties for poor performance. Timeframes for NEW Medicaid beneficiaries to become established patients should be collected and analyzed geographically. Timeframes should be specified for access to physician specialists. This information should be collected and reported by the plans and released publicly.

### **Pilot Program**

AARP finds that states adopting Medicaid managed care often require time to put in place the infrastructure to establish and test the system in order to provide a seamless transition. This is

especially crucial when it comes to moving to Managed Care Long Term Supports and Services. The states that have been successful at making this transformation have had many years of experience with statewide managed care before expanding the program to LTSS. Given Idaho's lack of experience in managed care and the lack of detail included in the proposal, we believe the state should start with a pilot program in 2014 or implement the program in stages. This would allow the state to gain valuable experience and use the lessons learned to build an effective care coordination program that would provide quality care for this vulnerable population.

In conclusion, AARP Idaho believes that the state has an opportunity to improve this demonstration proposal, and thereby the lives of those who would be impacted by it, by incorporating the elements we have set forth above. Most importantly, AARP will look to see that the four specific critical recommendations we have delineated above are incorporated into the final proposal submitted to CMS. We appreciate the opportunity to provide these comments and look forward to discussing them with you.

Sincerely,

A handwritten signature in black ink that reads "Cathy McDougall". The signature is written in a cursive style with a large, sweeping flourish at the end.

Cathy McDougall  
Associate State Director

Board of Directors

May 11, 2012

Division of Medicaid  
Idaho Department of Health & Welfare  
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Boise, ID 83720-0036

Dear Sir/Madam:

Thank you for this opportunity to submit comments regarding the “Demonstration Proposal to Integrate Care for Dual Eligibles” on behalf of NAMI Idaho who represents individuals living with mental illness and their family members. The proposal, if implemented properly, should have great benefits for both the dual eligible individual and the taxpayer.

Our comments focus on the impact implementation will have on those individuals living with mental illness who make up a minority of those affected by this proposal but whose current successful treatment could be significantly disrupted. Our major concerns are as follows:

1. The capitation rate should be based upon the actuarial rate and not the desired rate. The rate must be reflective of cost trends and must encourage service excellence and attract an adequate number of competent and professional service providers.
2. Outcome data is critical and every effort should be made to collect the data in a timely fashion and to promptly make such data available to the legislature and the public in an easily-comprehended format. The performance data to be utilized is not described in the proposal. It must include:
  - a. System Performance – availability of services, utilization levels, rate of critical incidents, time between inpatient discharge and first outpatient appointment, consumer involvement in the program planning, and use of evidence-based and promising practices
  - b. Clinical Performance – symptom improvement, hospital diversion rates, identification of medication gaps, quality of life improvement (housing, employment, relationships), re-hospitalization level, emergency room use, homelessness, incarceration, and involvement with the criminal or juvenile justice systems
  - c. Administrative Performance – consumer and provider satisfaction surveys, service appeals, service denials, complaints/grievances, call pick-up, claims payment rate, network turnover, timeliness of data reporting.

3. There must be a mandatory process for reporting by a health care team to the managed care provider when a person living with mental illness drops out of treatment in unstable condition and direct follow-up by a mental health professional representing the managed care provider with the person living with mental illness to make sure that that individual is receiving services from another mental health provider. A person living with mental illness who is unstable may not have the capacity to reconnect with new services without the assistance of this follow-up service. This service is essential to prevent individuals living with mental illness from ‘falling through the cracks’ with severe behavioral, social and irreversible health consequences.
4. A change of mental health providers for a person living with mental illness can be a traumatic and dangerous event. It often takes a long time to create a trusted relationship with a mental health provider. It can take years for a mental health service provider to properly understand a particular individual’s illness and determine the right mix of medications and therapy. Every effort should be made to minimize changes of mental health providers, such as during the transitions into and between managed care plans. Consideration should be given to continuity of care. A “grandfather” provision should be required so that individuals living with mental illness can continue with their current mental health provider, if they choose, and such provider will be reimbursed under the plan.
5. There should be a formal requirement for the managed care provider to develop and implement an assertive outreach program to maximize the number of mental health providers included under the plan. Plans should be required to deliver and document education to providers regarding plan rules and communication requirements among the members of the care team.
6. To minimize confusion surrounding the change to integrated care teams and managed care plans, independent enrollment brokers should not be used. Plans should be required to inform and recruit all individuals who are eligible for coverage under the plan using internal marketing staff. To avoid confusion and conflicting messages, the State and managed care plans must coordinate their communications to clearly assist beneficiaries in evaluating plan options. The State should work with the plans and beneficiary focus groups, including people who live with mental illness, to develop models for member materials so that information is clear and consistent. Passive enrollment information should be in plain English and all options for changing enrollment should be explained to the beneficiary at the time of passive enrollment notification. The plan should provide objective enrollment, benefit, and appeals assistance.

Thank you for your consideration of our comments.

Sincerely yours,



Douglas McKnight, President  
NAMI Idaho



## **DisAbility Rights Idaho's Comments on Idaho Proposal to Contract with a Managed Care Organization (MCO) for Medicaid Services for People Who are Eligible for Both Medicaid and Medicare.**

### **Introduction:**

The Idaho Department of Health and Welfare (IDHW) has requested public comment on their proposal to contract with a Managed Care Organization (MCO) to provide Medicaid services to people who are eligible for both Medicaid and Medicare (Dual Eligible). This contract is intended to cover not only the types of medical services typically handled by health insurance companies, but also mental health services including psychiatric rehabilitation services, home and community based, long term care services and developmental disability related community supports. There are important differences between traditional medical treatment services and these community based support services which require careful and cautious planning and implementation. Although there are examples of MCO contracts covering some of these services in other states, we have not found any examples of states with a significant history of using a single MCO contract to provide all of these services statewide. This proposal appears to be without precedent.

The degree of uncertainty and the potential for large scale unpredictable changes in Idaho Medicaid in the next three years is enormous.

1. Idaho is currently preparing a Request for Proposals (RFP) for an MCO contract for Medicaid mental health services.
2. That contract is expected to be expanded to include substance abuse services after about a year of implementation.
3. Sometime this summer, the U.S. Supreme Court is expected to rule on the constitutionality of the Affordable Care Act.
4. In 2014, if the Act is upheld or partially upheld, a large number of people with severe and persistent mental illness (SPMI) will become eligible for Medicaid. Most of them will also be eligible for Medicare.
5. Implementation of the Children's Developmental Disability Redesign and changes in the Adult Developmental Disability including changing authority to §1915(i) are in process.

If the Mental Health MCO is different from the Dual Eligible MCO, there will be overlap or conflict between the populations served. Since the Mental Health MCO will already be in place by the time the Dual Eligible MCO is initiated we should expect to see large shifts of participants and costs into and between these two contracts as each of the

events described above occurs. These shifts will cause confusion, and disruptions which are generally not beneficial to the participants or anyone else involved in the process. Even if the same MCO wins both contracts, the differences in terms and “per member per month” (PMPM) rates between the two contracts will cause problems. It may be unreasonable to expect any system to absorb all of these separate but interconnected changes in such a short period of time. Coordination of all of these change processes may simply overwhelm a newly created system which has no history or precedent.

### **Incentives to Provide Effective Preventive and Supportive Mental Health Services**

It is imperative that the financial incentives built into the system reward high quality care and effective preventative practices. It has been demonstrated that it is possible to save money by employing effective preventive and support services for several chronic conditions such as asthma and diabetes. There is evidence that bundling traditional physical health with mental health treatment can reduce the cost of traditional medical care and reduce psychiatric hospitalization. However, these demonstrations placed the burden for the cost of psychiatric hospitalization on the MCO.

1. If the cost of hospitalization is borne by the state, the MCO has an incentive to place people in state hospitals and to delay their return to the community as long as possible. Unless the full cost of hospitalization in state hospitals is somehow charged to the MCO, there is no incentive to prevent hospitalization or to have robust mental health supports to prevent recidivism.
2. The system should also provide incentives for preventing people with SMI from entering the criminal justice system or jails, or committing suicide. All of these events can actually lead to cost shifting or cost savings for the MCO unless the payment system provides disincentives for these events.

### **DD Services and Supports**

The PMPM method does not by itself provide incentives for effective DD supports services or treatment. The goal of these supports is to increase the capacity of the person for self determination, independence and community integration. The success of such services is not measured by their physical health status or need for more expensive medical treatment. Short of institutional placement, there is no consequence to the MCO for providing inadequate or ineffective services and supports. Placement in a state facility like SWITC would even be a net savings to the MCO and for certain individuals ICF/ID placement could be a savings over a robust and effective community supports plan. To be effective, there must be a strong incentive to provide effective developmental services and supports. This can only be accomplished with a robust and accurate quality assurance system and well designed incentives to meet the expectations of that system. We are not aware of any examples of such a system. Traditional health insurance plans do not have expertise or experience with these services.

1. The MCO should be required to contract with a highly qualified, independent entity to evaluate the quality and effectiveness of DD supports and services.

2. IDHW should consider carving out DD supports and services from the plan or preserving them as a fee for service system. With a robust system of quality assurance and care management practices.

**Enrollment:**

1. Require that consumers have at least 90 days to make a choice among plan providers.
2. Require plans to contract with community-based organizations such as Independent Living Centers, and others.
3. Include programs for people with mental illness, to educate potential enrollees about their options and to assist them in selecting delivery systems that best serve their individual needs.
4. Allow enrollees to change plans at any time, without imposing a lock-in period.

**Provider Networks:**

Many dual eligibles have longstanding, beneficial relationships with providers that might not be in the existing network of a health plan or delivery system that participates in the program. To maintain continuity of care and respect these relationships, participating plans should:

1. Maintain an open network provider system in order to contract with providers that are not currently in the network.
2. Offer single case agreements that allow participants to continue seeing their current provider without arbitrary limits on the duration of the relationship.
3. Require that all providers are trained on independent living and mental health recovery approaches.

**Long Term Services and Supports (LTSS):**

The goal of LTSS for dual eligibles should be to promote their independence, choice, dignity, autonomy and privacy. LTSS must emphasize community and home-based services over institutional care in compliance with the *Olmstead v. L.C. and E. W.* decision.

1. LTSS services and should be based on conflict of interest free comprehensive evaluations which include an evaluation of functional status, social and vocational needs, socioeconomic factors, personal preferences, and the ability to obtain accessible services.
2. Require plans to maintain current levels of LTSS until a comprehensive assessment is conducted.
3. Contract with LTSS providers who have the capacity and expertise to meet member needs.
4. Have the beneficiary play the central role in the LTSS assessment and in the development of an LTSS plan.
5. Support family care giving through designation of family members as paid aides when consumers request this, as well as through respite services.
6. Provide personal care assistant services, including an option for self-directed services.

7. Ensure that people with developmental disabilities (DD) have the opportunity to participate in the My Voice, My Choice HCBS Waiver option.
8. Ensure that people with both a developmental disability and a mental illness have coordinated LTSS from providers with expertise in supporting both conditions.

### **Care Coordination:**

Most health insurance companies have no experience with community based services for people with SMI or DD. Typical health plan care coordination generally consists of having a nurse call the member occasionally on the phone. Case Management and Service Coordination services for people with SMI or DD must be much more “hands on”. It must include regular face to face meetings and intervention or advocacy on behalf of the member with other providers and community contacts such as landlords or the courts. Traditional health plan care coordination must not replace these vital support services. Plans must be required to contract with qualified and experienced DD service coordinators and SMI case managers, and whenever possible to continue with the member’s current services.

The care coordination team must include a LTSS provider or coordinator (could be the case manager or the TSC) who is responsible for maintaining the LTSS. Few PCPs are able or willing to perform this function.

LTSS care coordinators will often be needed for people receiving home care LTSS as well.

### **Crisis Services:**

People who require LTSS for physical disability, DD, or SMI are at risk for crises in their lives and in their care needs. Plans will need to be able to quickly approve and provide additional services to deal with a crisis caused by a change in the person’s physical or mental health status, the imminent loss of living arrangements, unpaid supports, or other catastrophic events. The ability of the system to respond to unexpected crises in the community without resorting to institutional placement should be a key requirement of the plan. The plan should also be well coordinated with non-Medicaid crisis services and be able to access them when needed.

### **Compliance with *Olmstead v. L.C. and E.W.* and Best Practices for community based services.**

The MCO must be in full compliance with the community integration mandate of the Americans with Disabilities Act (ADA) and the Supreme Court decision in *Olmstead v. L.C. and E.W.* Although the ADA has lesser implications for private health insurers, the Medicaid program must comply with Title II of the Act and the community integration mandate. This will require the contractor to make community services available in cases where institutional placement would be less expensive. It also requires services to help prevent hospitalization for people with mental illness.

1. There must be incentives and requirements in the plan to provide for recovery oriented, person centered plans of service.
2. The plan must allow for self directed services in all areas of long term services and supports including mental health.
3. DD services should emphasize self determination, community integration, employment opportunities and training for eligible individuals.

The proposal for a single MCO contract for all Medicaid services for all people with dual eligibility is unprecedented and moves Idaho into uncharted territory in LTSS models. IDHW should be extremely cautious and move slowly and deliberately toward this project. Planning to implement it in the current time frame with such an array of both known and unknown variables (e.g. the Mental Health MCO contract, the implementation of the ACA, the pending decision in the Supreme Court on the constitutionality of the ACA, the efforts to redesign DD services, several pending federal lawsuits) may be too ambitious and ill advised.

If Idaho does proceed at the proposed pace, there are serious issues to be addressed in the areas of DD services, mental health services and other LTSS.

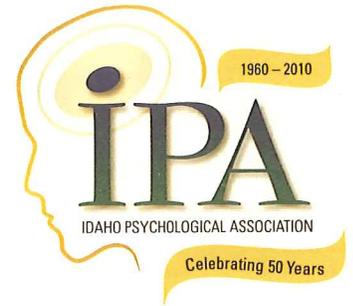
Submitted by

James R. Baugh  
Executive Director, DisAbility Rights Idaho.

May 8, 2012

Leslie Clement, Deputy Director  
Idaho Department of Medicaid  
450 W. State Street  
Boise, ID 83720

RECEIVED  
MAY 09 2012  
DIV. OF MEDICAID



Dear Deputy Director Clement:

I am a Licensed Psychologist in private practice in Payette and am writing this letter as the co-chair of the state advocacy committee for the Idaho Psychological Association (IPA). The IPA Board has asked me to respond on behalf of the association to the Call for Comments regarding Medicaid's plan for managed care of mental health and the plan for Medicaid and Medicare to share in the coordination of care for "Dual Eligible" enrollees.

In the Demonstration Proposal to Integrate Care for Dual Eligibles, it was noted that the goal of the initiative is to make services available for enrollees, "anywhere in the state, in order to improve their health and quality of life...improve quality and cost-effectiveness of care..." The IPA has a number of suggestions and concerns that should be taken into account toward accomplishing that goal for the Dual Eligibles and for improving the managed care of mental health. There are also some issues for which we request further clarification.

There are weaknesses in the current Medicaid Mental Health Clinic Model, which utilizes the Healthy Connections referral system for all mental health. Barriers prevent enrollees from accessing quality, cost-effective care in a timely manner. The barriers severely limit many psychologists from participating in Medicaid. If replicated in the model for Dual Eligibles and continued under the managed care for mental health, the same limitations would continue. We recommend the following:

- Eliminate the requirement for all licensed clinical providers to be employed by an agency designated as a Mental Health Clinic. This reduces a Medicaid client's access to quality care by limiting the number of licensed clinical providers willing to participate in Medicaid because the already low reimbursement rates are further reduced by the employing agency's percentage. Given their advanced education and training, doctoral-level clinical providers, in particular, should not be mandated to be employed by a clinic. Consequently, most determine it is not cost effective to do this work. Also, it prevents many clinical providers, who are willing to dedicate a small percentage of their practice time to Medicaid clients, from being able to because they are not employed by a clinic.
- Reduce the steps to providing clients with appropriate and timely referrals. Just to get a referral to a psychologist for an evaluation under the current system, a client must: 1) get a referral to Healthy Connections from their primary care provider; 2) see their Healthy Connections medical provider; 3) see the medical director of the mental health clinic; and 4) participate in a Comprehensive Diagnostic Assessment. The psychological evaluation determines an accurate diagnosis to qualify the client for needed services. There are too many hoops for clients to jump through to get to a psychologist for appropriate services; many aren't willing and some just aren't "able" to make it through all these steps. For Medicaid, there are unnecessary expenses accrued by these issues, as people who could have been helped before a crisis, fall through the cracks and ultimately end up costing the system or the State even more. This process also results in more post-service work for the psychologist, which again cuts into the already limited pay; another reason many find it lacking cost-effectiveness for their practices.
- Eliminate the requirement that MDs must sign off on treatment plans prepared by psychologists. In the current Medicaid system, psychologists, who are all doctoral-level providers already licensed by the State of Idaho to diagnose and treat "independently," must have the medical director of the clinic approve their treatment plans. This is an unnecessary form of supervision that further slows treatment. In addition, the psychologist has to pay the M.D. for this unwarranted oversight, which further reduces the already low reimbursement for the psychologist's work. If the goal is to integrate care, there are other ways to accomplish that.

The Health Home Model discussed in the Demonstration Proposal sounds like a good concept but, realistically, the likelihood of finding a medical home with all needed services in a rural area is slim. This limitation may very well result in the need for significant travel by enrollees to obtain necessary services. For many, that is not a viable option. The model also indicated

Leslie Clement  
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May 8, 2012

enrollees need to be able to self-direct care, something that is not available to much degree in the current Mental Health Clinic Model of Medicaid. We suggest building flexibility into the system by allowing for telehealth services, when necessary and appropriate. Also, if all medical home providers are required to be located in the same facility, it would be important to provide other options for rural communities, as mental health clients may be reluctant to come for treatment if they are likely to run into their friends and neighbors who are seeking medical treatment in the same building.

Other suggestions and concerns for one or both plans are:

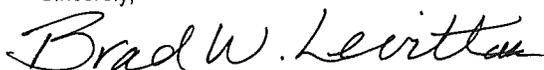
- Make certain psychologists are considered primary care providers as they are under Medicare. Including psychologists serves to increase the size of the network, decrease wait lists, decrease the number of psychiatric and other hospitalizations, decrease medical costs in general, and streamline mental health treatment.
- Include psychologists as leaders for "care management teams" for enrollees needing mental/behavioral health services. Since psychologists are the most highly-trained specialists in the mental health field, their knowledge and leadership in making recommendations and direct referrals to the appropriate mental health providers would be beneficial.
- Don't restrict the size of the network. In addition, psychologists often specialize in certain areas of treatment. A client's access to the "right" provider can be more effective and less costly in the long run. Also, this will help "Dual Eligibles," who already may be receiving psychotherapy and/or evaluation services from psychologists, continue in their current treatment.
- Keep the paperwork simple. Make it easy for a provider to sign up to accept Medicaid and to bill for reimbursement.

There are some issues that remain unclear. How exactly would the Health Home provide links to the outside services that it is unable to provide? Would psychologists qualify for the Physician Incentive Payments? Would there be other incentives for psychologists to participate in; for example, reimbursement rates that recognize their doctoral level of training? What, specifically, are considered "National Accreditation Standards"?

Finally, there were some references made to the Oregon model. I personally worked, in the past, as a psychologist in Oregon and am aware of the limitations in the OMAP plan for mental health treatment, particularly in a rural area. You should be aware of those limitations as you proceed. For example, there is only one mental health agency, for all of Ontario and parts of Eastern Oregon, awarded all of the monies for services through OMAP. That clinic rarely seems to make referrals to providers they do not regularly employ, in my opinion. Many clients decide not to obtain services there, as there is a general mistrust of such a large agency and feelings of embarrassment related to attending counseling/therapy sessions in that setting. This is an important concern for mental health clients. My office in Payette, quite regularly, receives calls from Oregon residents on OMAP looking for an alternative to receiving services at that clinic.

Thank you for the opportunity to provide input into both programs. We would welcome further discussion and would appreciate more information as it becomes available. To reach me, please call 208.649.7221 or email me at belnrad@gmail.com. To reach the IPA Office, email IPAoffice@idahopsych.org or call 208.454.5594.

Sincerely,



Brad W. Levitt, Psy.D., Licensed Psychologist  
Co-Chair, State Advocacy Committee

**Did you know?** 24 percent of patients who present themselves to primary care physicians suffer from a well-defined mental disorder. The majority of these patients (69 percent) usually present to physicians with physical symptoms and there is ample evidence that many of these cases remain undetected.

**Psychologists receive a median of seven years of education and training beyond their undergraduate degree**, including practica and internship training in hospitals and other health care settings. Psychologists are licensed in all 50 states, the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands. Licensure is generally uniform, authorizing a psychologist to independently diagnose and treat mental and nervous disorders upon completion of both a doctoral degree in psychology (PhD, PsyD or EdD) and a minimum of two years of supervised direct clinical service.

## Dana Gover

### **1. Idaho's Managed Care plan must include requirements for Managed Care entities to have previous experience in providing long-term services including Home & Community Based Services.**

Idaho's demonstration project must include requirements for Managed Care entities to have previous experience in providing long-term services including Home & Community Based Services. The plan should target specific sub-populations across differing disabilities and age groups to test and ensure program functionality and make needed adjustments that best align plan and program components before the entire dual eligible population is included.

Experience is limited in managed care for higher risk disability populations, so Idaho should not rush to implement a full managed care program which could result in widespread disruption in services and negative health outcomes. Testing the plan is key and will require at a minimum of 2-3 years of experience to ensure that appropriate quality and performance features are in place and adequate payment rates set for both the service providers.

### **2. Idaho's plan must change to a voluntary opt in, opt-out model of enrollment ensuring that program participants have personal choice in their services and are committed and willing participants in utilizing the coordinated services that the model is designed to provide.**

*Lines 105-111 "...Idaho will replace the current MMCP with the new coordinated program. The new program will utilize mandatory enrollment into health plans under concurrent §1915(b)/ §1915(c) Social Security Act authority for Medicaid plan benefits, and passive enrollment with an opt-out provision for Medicare benefits."*

Idaho's draft managed care plan does NOT encourage or provide incentives for managed care entities to actively recruit participants. Idaho is utilizing a mandatory enrollment model requiring duals to enroll into a managed care plan. Duals will have no choice to opt-in on a voluntary basis or opt- out if the providers don't meet our unique medical needs. If the managed care providers offer quality services and meet people's unique medical care needs a mandatory model is unnecessary. People choose services that they are aware of and services that will improve quality of life.

An "opt-in" enrollment mechanism ensures that participating plans attract and retain enrollees by offering each enrollee a high quality, more coordinated experience than the one they have in the fee-for-service system. The "opt in" model also ensures that program participants are committed and willing to use the care coordination services that the model is designed to provide.

The right to "opt out" of Medicare alone is not adequate to protect dual eligibles from harm. Out of network providers must be available for those with specialized needs. A dual eligible who is mandatorily enrolled into a managed care model may experience a disruption in care and opting out into another managed care plan may not meet the person's medical needs.

Voluntary, “opt in” enrollment processes have been used in the United States that are regarded as positive, person-centered programs. For example, the Program for All- Inclusive Care for the Elderly (PACE) is an “opt in” model. Massachusetts’ Senior Care Options, Minnesota’s Senior Health Options and Wisconsin’s Family Care Partnerships all use an “opt in” enrollment model.

Idaho’s draft plan states that the reason people didn't enroll in the existing Managed Care program is because people were not mandated to do so. The reason many of us didn't enroll in the plan was the lack of publicity and informational material explaining how our services could be improved if we enrolled in the managed care system. Why switch plans requiring us to change primary health care doctors who don't have a long-term relationship with us. Many of us have built long-term relationship with our primary health care practitioner who understands our health care needs.

### **3. Institute a Sound and Accountable Consumer – Driven Quality Management and Improvement System**

The draft plan does not include an unbiased third party that will provide oversight unrelated to the Managed Care organization and the State of Idaho to ensure duals will receive timely and quality services that meet our complex medical needs.

Idaho must oversee and ensure that managed care programs provide a quality management process that includes independent third-party monitoring, written evaluation of the managed care entities performance and assessment of various quality care indicators. These parameters need to be measured specific to the needs of persons with disabilities and should be based on principles outlined in the managed care plan.

### **4. Clearly describe and emphasize requirements of program and physical access for individuals with disabilities.**

The plan requires managed care entities to comply with Federal and State Laws by citing the laws on page 19. However the draft plan doesn’t clearly describe or emphasize requirements of program and physical access for individuals with disabilities.

Additionally, managed care organizations serving Medicaid beneficiaries via government programs should be expected to be model employers in practicing affirmative action in the hiring of qualified workers with disabilities. Section 503 of the Rehabilitation Act requires affirmative action among federal contractors in the hiring of qualified candidates with disabilities. Contractors to Medicaid, a federal-state partnership program that provides significant services to those with disabilities, should take similar responsibility for achieving fairness in the employment of individuals with disabilities.

### **5. Self-direction must be clearly outlined and defined in the draft plan.**

Self-direction is far more complex that what Idaho’s Draft managed care plan outlines. Line 608

on page 17 states, “Beneficiaries must have an option to self-direct their care; they must be permitted to choose and change their direct care staff”.

Idaho’s draft plan doesn't spell out clearly a dual’s personal rights and choice as guiding principles in the self-direction or person centered planning discussion. Self-direction is discussed in the plan but only states that duals can choose and change staff. The managed care plan should clearly follow Idaho Statute Title 39, Chapter 56 outlining the self-direction model that provides individuals the right to choose who they interview, direct, schedule, train, hire and fire. This includes the hiring of family and friends to assist with personal assistance needs.

Medicaid's self-directed care programs have demonstrated the capacity of beneficiaries to plan, direct and make appropriate and cost-effective choices about their care that improve their health, functionality and general well-being. This important element of quality care for those with disabilities should not be sacrificed in a managed care plan and clearly described in Idaho's operational plan.

The plan does not address the budgeting authority that participants have under the DD Waiver. The plan states that there will be changes to the Waivers but the specifications of these changes are not described.

**5. a) Person-centered planning is discussed in Idaho's draft plan, but it does not provide clear and specific language incorporating personal choice in all areas of managed care including the recommendations and voices of stakeholders, especially beneficiaries and their caregivers, to make sure that the integrated programs truly embrace the aspiration of integrated care.**

The managed care plan must define service and program delivery based on individual choice, person-centered planning and self-directed care and services. Beneficiaries in managed care must have choice in selecting service and support options, providers and care settings, especially in relation to the very personal nature of long-term care needs in both home and community based settings and institutional care settings.

Person-centered planning is designed to increase beneficiaries’ self-determination, independence and inclusion in their communities. Self-direction emphasizes personal budgeting and oversight of one’s direct services and supports related to life’s instrumental functions, including activities of daily living, health maintenance, community participation and employment.

Medicaid enrollees living with disabilities should be given the opportunity to actively opt into or out of these programs depending on the specific program approaches offered.

## **6. Establish Fair and Adequate Payment Rates and Reinvest Savings in Medicaid Services**

Idaho's Draft Managed Care plan does not outline requirements for the Managed Care entity to provide adequate reimbursement rates. No matter how much effort and good intention Idaho and CMS incorporates into Managed Care programs, if reimbursement rates are not adequate, then

neither providers nor managed care organizations will be interested in participating. Or, even if they are interested at first, these programs will not be sustainable. Getting the rates right for integrated care is imperative. Proper rates ensure that neither the federal government nor the states are paying too much for services, but they also ensure that Managed Care Providers and network providers are in the position to provide the right services, at the right time, to the right person.

Idaho must ensure transparency in their rate setting and demonstrate that these rates are actuarially sound. In any managed care payment process intent on meeting the needs of those with significant disabilities, such payment rates must account for severity of condition and be adjusted for varying levels of risk.

To accommodate this need, a “risk pool” or “risk corridors” approach can be taken. The former would provide a pool of funds that would be drawn from and added to the capitation payment to meet outstanding unpaid claims. The latter would create specially designed pools that would adjust payment based on estimated services and supports used by enrollees based on their disability functional needs and related demographics.

Payment rates should initially be based on at least 2-3 years of the most recent Medicaid (and, as appropriate Medicare) claims data so payments account adequately for marketplace realities and are not artificially decreased to achieve savings. Therefore, Idaho Medicaid budgets should not be cut prematurely on the basis of “anticipated” savings. Experience applied to higher risk populations under such programs is first needed before savings can be determined as definitive. Moreover, savings that are achieved should remain at the disposal of the state’s Medicaid program and reinvested in needed services and supports and improved care access, quality, coordination and efficiency.

**7. Managed care systems addressing the needs of individuals with significant disabilities must ensure adequate access to appropriate durable medical equipment, prosthetics, orthotics, supplies and assistive technologies that allow daily function and the capacity for independence and employment where feasible.**

Covered services should include professional assessments of beneficiaries’ needs for technology, as well as set-up, maintenance and user training. Managed care should also remain open to innovations in technologies that have the capacity to improve care quality and achieve short- and long-term cost savings.

**8. The plan must include the provision of transportation and how the managed care entity will address the concern for those with limited transportation options.**

Idaho is a rural state, what happens if network providers in close proximity to the person are not available? Is there allowance for transportation costs?

Thank you

Dana Gover, person who is dual eligible

[danagoforit@gmail.com](mailto:danagoforit@gmail.com)

**From:** Rick Holloway [Rick.Holloway@westernhealthcare.com]  
**Sent:** Thursday, May 10, 2012 3:01 PM  
**To:** LTC Managed Care  
**Subject:** Comments on Managed Care proposal

Thank you for the opportunity to discuss the proposed managed care program for Idaho's dual eligible population. Below are my comments:

First, the bulk of this document contains mostly high level theoretical concepts that have limited practical application at this point. There are some principles that need to be considered while the managed care for dual eligible program is developed.

1. This program relies heavily on input and direction regarding the stated preference by a patient or responsible party on that patient's preferred care setting (lines 113-116, line 304-305). In many cases in the skilled nursing facility (SNF) setting, the patient and/or family member is unable or unwilling to make that decision. The decision will then defer to a case management worker who may be financially incentivized to send that patient to a setting where the case worker may be paid more to manage that patient's care rather than a setting that is best suited to the patient's needs.
2. The pervasive perception among state and federal policy makers is that most of the 6,000 or so Idahoans in SNFs do not want to be there and could be easily cared for in a home setting (lines 219-224). In fact, patient satisfaction surveys done in Idaho's skilled facilities prove this perception to be false. While many would prefer to be back in their homes, they also recognize they cannot survive in a home setting without 24-hour care and oversight. Policymakers who automatically assume greater independence equals greater quality of life fail to recognize the significant medical and other needs of the residents in skilled nursing facilities.
3. The proposed program strongly emphasizes home care as a primary care setting for beneficiaries to receive as much health care as possible (line 300). Once again, this stated focus ignores the significant medical needs and assistance with Activities of Daily Living (ADLs) required by residents of Idaho's SNFs. With much of Idaho being rural, provision of care, especially intensive therapy, restorative care, and general nursing and assistance with ADLs becomes extremely expensive as providers end up spending a large amount of their time traveling instead of providing patient care.
4. There is also a pervasive, and largely incorrect, perception that the care in an institutional setting is always more expensive than a home setting (lines 225-227). This perception assumes a patient who can be managed in a home setting under the Personal Care Services (PCS) or HCBS program with 3 hours of assistance per day for 4 days per week is the same type of person as in Idaho's SNFs. If the average cost of a SNF in Idaho is \$180 per patient day, and the payment rate for PCS or HCBS providers is \$12 per hour, this translates to 15 hours of care per day to equal \$180 per day. If a SNF had all PCS or HCBS patients in their facility, and the SNF staff arrived at 7 am and served breakfast, lunch, and dinner to their residents, then all of the staff left at 10 pm and required the residents to fend for themselves the other 9 hours totally unsupervised, the Idaho Department of Health and Welfare would fine the building hundreds of thousands of dollars because of the "Immediate Jeopardy" situation created by not having any staff available to care for the residents. But that is the exact situation that would happen if that same patient was transferred to a home setting under the managed care program under the assumption the cost is

lower. Even so, the amount paid to a SNF for a day of patient care includes ALL supplies and services needed by that patient with the sole exception of pharmacy services.

5. Will the requirement that SNFs complete frequent Minimum Data Set (MDS) assessments on Medicare and Medicaid patients be removed once the transition to this system is completed? If MDS's would still be required to be completed in the SNF setting, would the same assessments, with the same frequency, also be required of any patient who would have been admitted to a SNF but was diverted to a home setting? What assessments and care planning would be required to be completed once that person is diverted from a SNF to a home setting? In other words, it is not equitable to require massive assessments and care planning, as well as provision of care on a 24-hour basis, in a SNF setting but remove all of those requirements if that person is in a home setting.
6. There are several references to "person-centered" care (line 312, line 320, for example). How is "person-centered" care as stated in this program different than the individually developed care plans and treatment programs written and implemented in Idaho's SNFs, and verified by state surveyors on annual visits?
7. Listed as a "Potential improvement target for quality measures" is the number of hospital and skilled nursing facility admissions (line 764 and 766). How will either of these be an indicator of quality? If there are increased hospital and nursing home admissions, it could be that the population is aging (which is expected) and the incidence of admissions to a health care facility increases as a person ages. It could also be that the case workers identify patient conditions that require inpatient care even though the beneficiary would have delayed the care for a variety of reasons. But more problematic is a significantly decreasing number of inpatient admissions. If health plans deny admission to beneficiaries even though inpatient admission is warranted, the state may not know needed care was denied until after the patient dies. Why are there not quality measures that include beneficiary satisfaction surveys, tracking complaints from other providers (such as a hospital or SNF who was refused payment by the health plan despite following all of the health plan's requirements), improvements in a beneficiary's ability to perform ADLs and be self-sufficient, increasing practices of healthy lifestyle choices by beneficiaries, and so on? We have had many situations where Medicaid beneficiaries who were being cared for in a home setting came to a SNF after a hospitalization due to infected decubitus ulcers acquired while in the home setting, unmanaged diabetes or coronary/respiratory issues, significant decline in function, and so on. What will be put in place to make sure the quality of care in the non-institutional setting is maintained?
8. At least part of the rationale for embarking on this project is because of the emphasis of CMS to reduce rehospitalization among nursing home residents (lines 912-917). This section states, "CMS research has indicated that 45% of hospital admissions for those receiving Medicaid nursing facility services are preventable." However, the report which is referenced here says nothing about "45% of hospital admissions" for dual eligible are from nursing facilities. It says that "26% of rehospitalizations may have been avoidable" but it fails to mention what constitutes an "avoidable" and "unavoidable" rehospitalization. What is striking in the original CMS report is that Idaho is the second lowest State in the nation regarding hospital readmission rates from a SNF. The state may be placing a considerable amount of resources and emphasis implementing a solution which is in desperate need of a problem if it is trying to reduce rehospitalizations among nursing facility patients. The glaring problem with the entire report is that it lists nursing homes as the primary care setting in which patients are readmitted to a hospital, but ignores the fact that

patients in a SNF are considerably more medically compromised than patients in a home care setting.

9. Will the health plans dictate to beneficiaries where they can go to receive inpatient hospital or SNF care? Will they be allowed to direct patients to and away from certain facilities? Will there be oversight regarding which hospital/SNF/health care provider is used by the health plan and which are excluded? What quality measures will be in place to be sure beneficiaries receive the level of care deemed appropriate by their attending physician? My biggest concern about this program is it places total control over the health care services provided to beneficiaries without any oversight or monitoring. If bad patient outcomes occur, there does not appear to be any process for the state to immediately intervene and require the plan to provide medically necessary care.
10. Will the payment rates to hospitals and SNFs be negotiated directly between the health plans and the providers or will the state have any input or influence? If the health plan sets payment rates too low and a provider in a given area refuses to accept the low rates, the plan enrollees may be forced to travel 50 miles or more to another provider to receive health care services.
11. Will the payment rates established between the health plans and health care providers be made public? Typically, these negotiated rates are a tightly guarded trade secret between the health plans and providers. Additionally, health plans or providers could engage in collusion or price fixing if the payment rates between different health plans and providers were made public.
12. Will there be a limitation on the amount of times a health plan could require an enrollee to move if the health plan finds another provider who will accept a lower rate for that patient? For example, a patient could be in SNF "A" at a negotiated rate of \$180 per day, and the health plan decides to move the patient to SNF "B" because that facility will accept \$178 per day. Two months later, the health plan moves the patient to SNF "C" because that facility will accept \$175 per day. Each move is extremely disruptive to the life of the enrollee, but there appears to be no limit on the number of times a health plan could transfer a patient if it finds another facility which will accept a lower rate. Just as critical is the ability of a health plan to move a patient potentially 100 miles or more away from their family and community only because the health plan finds a provider in another community in Idaho which will accept patients at a lower rate. Is there any restriction on how far a health plan can direct a patient away from his/her home or family, or will the health plan be required to place an enrollee needing SNF care in the community from which he/she resided prior to hospitalization or the acute/chronic episode which subsequently required SNF care?
13. Will the payment rates established between health plans and SNFs be a factor when determining the Lower of Cost or Charges (LOCC) limitation on SNF Medicaid rates for non-dual eligible? If so, this would by default reveal the payment rate negotiated between the health care plans and the SNF providers, which could again lead to possible collusion or price fixing problems.
14. How will patient days and acuity scores for the health plan enrollees be considered in the derivation of facility-specific Medicaid rates for non-dual eligibles?
15. What happens to the current 2.7% across the board rate reduction for all Medicaid patient days when the dual eligible population enters a health plan? I assume that will go away for all dual eligibles in a health plan, but I just need to be sure.

16. As we still have a SNF provider tax program in Idaho, and likely will have the program in the foreseeable future, how will non-Medicare days and Medicaid days be counted to calculate the provider tax and UPL payments? Will the UPL payments be made only based on non-dual eligible Medicaid patient days? Will the provider tax be calculated based on total days less Medicare only days?

I look forward to continuing to work with the Idaho Department of Health and Welfare as this project moves forward.

Sincerely,  
Rick Holloway, CEO  
Western Health Care Corporation

**Sharon Brigner**  
Deputy Vice President  
State Advocacy



May 11, 2012

**Leslie Clement**  
**Deputy Director for Medicaid, Behavioral Health & Managed Care Services**  
**Idaho Department of Health & Welfare**  
**Idaho Division of Medicaid**  
**450 West State Street**  
**Boise, ID 83720**

**VIA ELECTRONIC SUBMISSION**

**Re: State Demonstration to Integrate Care for Medicare-Medicaid Enrollees: Proposal to the Center for Medicare and Medicaid Innovation**

Dear Ms. Clement:

The Pharmaceutical Research and Manufacturers of America (“PhRMA”) appreciates the opportunity to submit comments regarding the Idaho Demonstration Proposal to Integrate Care for Medicare-Medicaid Enrollees.<sup>1</sup> PhRMA is a voluntary nonprofit organization representing the country’s leading research-based pharmaceutical and biotechnology companies, which are devoted to inventing medicines that allow patients to lead longer, healthier, and more productive lives. PhRMA companies are leading the way in the search for cures.

PhRMA supports efforts “to ensure that all necessary Medicaid and Medicare Services (including primary and acute care, pharmacy, behavioral health and long-term supports and services) are provided coordinated and managed” for Medicare-Medicaid enrollees (“dual eligibles”).<sup>2</sup> We applaud Idaho for its ongoing efforts to deliver better coordinated and more cost-effective care to dual eligible individuals through its Medicare-Medicaid Coordinated Plan (MMCP), in which approximately 1000 dual eligible individuals participate in a Medicare Advantage plan offered by Blue Cross of Idaho and have voluntarily enrolled in a health plan that receives a capitated payment to deliver both Medicaid and Medicare services. We appreciate that this experience gives the State a clear understanding of the wide-ranging and complex health care needs of this population and the challenges and benefits to integrating their care. Idaho now proposes to use the demonstration to replace the MMCP and to significantly expand its efforts to coordinate care for dual eligibles by requiring all full-benefit dual eligible individuals statewide to participate in the demonstration through new and existing coordinated health plans.<sup>3</sup> We are concerned, however, that such a massive expansion may inadvertently, but significantly disrupt beneficiaries’ access to care, and in particular, that the expansion may interfere with beneficiaries’ prescription drug coverage, which for many dual eligible individuals is vital to managing their complex and chronic medical conditions.

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<sup>1</sup> Idaho Dep’t of Health & Welf., Idaho Division of Medicaid, Demonstration Proposal to Integrate Care for Dual Eligible Individuals Draft for Public Comment (Apr. 2012), (hereinafter “Idaho Proposal”), *available at* <http://www.healthandwelfare.idaho.gov/Portals/0/Medical/Managed%20Care/Idaho%20Demonstration%20Proposal%20Draft%20for%20Public%20Comment%20April%202012.pdf>.

<sup>2</sup> *Id.* at 3.

<sup>3</sup> *Id.* at 9–10.

*Pharmaceutical Research and Manufacturers of America*

Therefore, we urge Idaho to revise its proposal to:

- Require health plans participating in the demonstration either (1) to become a Medicare Part D plan subject to all of the Part D requirements or (2) to contract with the patients' Part D plan;
- Ensure that participating health plans offer the same level of access to medicines covered through Medicare Part B as is offered by Medicare Advantage plans and in Fee-For-Service Medicare;
- Significantly reduce planned enrollment in the demonstration to avoid destabilizing Part D for non-dual beneficiaries and risking significant disruptions of care for beneficiaries in Idaho, as well as to be consistent with the experimental nature of this initiative and allow for appropriate evaluation; and
- Protect beneficiary choice and avoid disruptions in care during this demonstration by exempting from passive enrollment in the demonstration all beneficiaries who have made an affirmative choice to enroll in Medicare Advantage or Special Needs Plans, or have affirmatively chosen a Part D plan; and
- Protect continuity of care by establishing a transition period of at least six months during which beneficiaries can access their current providers and maintain their current prescriptions.

#### **The Demonstration Must Incorporate Medicare Part D's Beneficiary Protections**

Since 2006, the Medicare Part D prescription drug program has effectively provided access to robust prescription drug coverage for Medicare beneficiaries, with high levels of beneficiary satisfaction, and at far lower costs than initially projected.<sup>4</sup> It has also resulted in substantial savings for other parts of the Medicare program. A recent study published by the Journal of the American Medical Association ("JAMA") found annual savings of \$1,200 on other, non-drug Medicare costs for seniors who previously had no drug coverage or limited drug coverage prior to the creation of Medicare Part D.<sup>5</sup>

The Idaho proposal does not clearly address how participating health plans will administer dual eligibles' Medicare Part D benefits. While we infer that Idaho might require participating health plans to qualify as Part D plans because the timeline attached to the proposal includes all of the relevant Medicare Part D submission deadlines for Part D,<sup>6</sup> the proposal does not expressly set out an approach for the health plans to administer Part D. CMS has indicated that all plans participating in the demonstration should meet Part D requirements in its *Letter to Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in Interested States* issued to plans on January 25, 2012 (the "CMS Duals Guidance"), and CMS reiterated that plans must meet these standards in *Additional Guidance on the Medicare Plan Selection Process for Organizations Interested in Offering Capitated Financial*

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<sup>4</sup> Congressional Budget Office, Updated Budget Projections: Fiscal Years 2012 to 2022 (Mar. 2012), at p.9, available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/March2012Baseline.pdf>; see also Centers for Medicare and Medicaid ("CMS"), Press Release, Medicare Prescription Drug Premiums Will Not Increase, More Seniors Receiving Free Preventive Care, Discounts in the Donut Hole (Aug. 4, 2011); CMS, Press Release, Premiums for Medicare Prescription Drug Plans to Remain Low in 2011 (Aug. 18, 2010); 2004 Medicare Trustees Report, p. 164.

<sup>5</sup> J.M. McWilliams, et al., Implementation of Medicare Part D and Nondrug Medical Spending for Elderly Adults with Limited Prior Drug Coverage, *Journal of the American Medical Association* (July 27, 2011).

<sup>6</sup> Idaho Proposal at 28–29.

*Alignment Demonstration Plans in 2013* issued to plans on March 29, 2012 (the “March CMS Duals Guidance”). We strongly support the principle laid out in the CMS Duals Guidance that all Part D protections and rules apply in the dual eligible care coordination demonstrations, including those for formularies, pharmacy networks, and benefits, among others. We therefore strongly urge Idaho to clarify its proposal before it is submitted to CMS to expressly address its approach to Part D benefits and specifically, to confirm that prescription drug coverage will be provided consistent with all of the Part D standards.<sup>7</sup> Indeed, Idaho already has experience using Medicare Advantage plans (MA-PD plans or Special Needs Plans) to administer the Part D benefit in its MMCP. Accordingly, we encourage Idaho to expressly address how it will meet the requirements in the CMS Guidance by either:

- Requiring health plans in the demonstration to qualify as Part D plans subject to all Part D standards, which would further Idaho’s objective of establishing “a single, cohesive set of benefits” handled by a single health plan,<sup>8</sup> or
- Requiring health plans to contract with the enrolling beneficiary’s Part D plan, which CMS will permit as acceptable subcontracting in the dual eligible demonstration.

Particularly given the short timeframe for implementation, the best way to capitalize on the successes of the Part D program without jeopardizing continuity of care is to structure the demonstration in a manner that is consistent with the CMS Duals Guidance and takes advantage of existing Part D coverage for participating dual eligibles. Doing so would maintain Part D protections in the demonstration, while taking advantage of cost savings and efficiencies that Part D has already created. Furthermore, these approaches are consistent with CMS’ expectation that states will work with entities “that have experience in coordinating and delivering care to Medicare-Medicaid enrollees.”<sup>9</sup>

An additional reason to adopt either of these approaches is that it is critical for Medicare beneficiaries in Idaho continue to receive pharmacy benefits through Part D plans in order for the rebates and discounts between drug manufacturers and Part D plans to be exempt from the best price provisions of the Medicaid drug rebate statute.<sup>10</sup> Under federal law, the rebates between manufacturers and Part D plans and MA-PD plans are exempted from the best price calculation and the policies behind that exemption should be continued.<sup>11</sup> Furthermore, clear rules are required to assure that participating plans maintain prescription drug claims data for the dual eligible beneficiaries separate from other drug claims. Outpatient prescription drugs are a Medicare-covered benefit for dual eligible beneficiaries and may not be paid for by Medicaid.<sup>12</sup> It is therefore important that health plans reflect that requirement in their operations and record-keeping, by maintaining Medicare Part D claims data and other records on dual eligible drugs utilization separately from data for other lines of business, such as Medicaid managed care.

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<sup>7</sup> History has already shown that Part D can be integrated in coordinated care programs serving this population; Medicare Special Needs Plans (“SNPs”) and the Program of All-Inclusive Care for the Elderly (“PACE”) have successfully administered part D benefits since 2006.

<sup>8</sup> Idaho Proposal at 10.

<sup>9</sup> CMS Duals Guidance at 5.

<sup>10</sup> Social Security Act § 1927 (c)(1)(C)(i)(VI), 42 U.S.C. § 1396r-8(c)(1)(C)(i)(VI).

<sup>11</sup> See, e.g., H. Rep. 107-539, at p. 110; H. Rep. 108-178 (11), at pp. 145–46; H.R. Rep. 108-178(ii), at pp. 154–55.

<sup>12</sup> Social Security Act § 1935(d), 42 U.S.C. § 1396u-5(d).

### **Idaho Should Preserve Equal Access to Medicines Covered Through Medicare Part B**

We note that the proposal indicates that Medicaid and Medicare will make capitation payments to the plans which are responsible for providing all Medicare and Medicaid services and coordinating care. Given the likelihood that managed care organizations that are unfamiliar with Medicare requirements related to coverage of medicines under Part B may participate in the demonstration, it is important that guidance to plans should include specific detail on the Medicare Part B requirements relating to coverage of drugs. The State should explicitly require that participating plans offer the same level of access to medicines covered through Medicare Part B as is offered by Medicare Advantage plans and in Fee-For Service Medicare.

### **Medicare Part D Costs and Plan Participation May be Adversely Affected**

As currently structured, we are concerned that the demonstration could fundamentally alter the Medicare Part D program for other, non-dual eligible Medicare beneficiaries in the State. As CMS has noted previously, the Part D bidding process is designed to incentivize plan sponsors to bid as low as possible in order to enroll as many beneficiaries as possible.<sup>13</sup> Idaho's proposal, which will remove as many as 17,219 duals from the Part D competitive bidding system, has the potential to change these incentives; this change raises a number of serious questions about the integrity of the bid process, the implications for costs and appropriate plan reimbursement, and the impact on the number of plans and beneficiary premiums for stand-alone coverage for Medicare beneficiaries that are not in the demonstration.

One reason for the success of the Part D competitive bidding model is that plans that bid low below the national average are eligible to maintain or receive new enrollment of beneficiaries that receive the low income subsidy, including the dual eligibles. This model produces savings for Medicare, duals, and all beneficiaries in a region who benefit from the effect of lower bids on overall premiums. In this initiative, however, these plans that have bid low and helped make the program such a success would be penalized for that behavior by removing a substantial volume of their enrollment when dual eligible beneficiaries are automatically disenrolled and placed into one of the demonstration plans in each region – demonstration plans that do not bid, but under CMS guidance would be reimbursed based on the bids of others. At a minimum, such a large market disruption would risk creating new market dynamics causing plans to redesign benefits and reassess their cost structure, leading to unpredictability for the Medicare beneficiaries who depend on Part D. Worse, if plans were to bid higher or withdraw from the State's market, the result would likely be higher costs for the State's other Medicare beneficiaries, as well as federal government. And because other states also are proposing to pull significant numbers of their dual eligibles out of Part D plans that bid, the net result will be a loss of the Part D savings to the demonstration programs as well, due to an increase in the national average bid that will be used to pay for the Part D benefit inside the demonstrations.

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<sup>13</sup> 73 Fed. Reg. 18,176, 18,179 (Apr. 3, 2008).

**Consistent with an Experimental Initiative, Idaho Should Limit Enrollment in the Demonstration to Avoid Significant Disruptions in Care**

In addition to helping with the unintended consequences of the Part D bidding problem discussed above, scaling back the initial phase of the demonstration would help to avoid significant disruptions in the care of these medically fragile beneficiaries. Given that most Medicaid benefits are delivered on a fee-for-service basis in Idaho, bidders to become participating health plans may be new to Idaho. Implementing changes that disrupt established patient expectations in ways that fall short may well undermine the program if patients and their families respond by simply opting out. A demonstration is not successful if it appears to undermine the quality of care or if demonstration enrollees lose the protections that are available to other Medicare beneficiaries who do not participate. Idaho proposes to include all full-benefit dual eligibles across the entire state, approximately 17,219 individuals, in the demonstration.<sup>14</sup> Focusing on a considerably smaller group would help ensure that the demonstration is successful in developing and refining approaches that could be more broadly deployed in a subsequent period. Particularly now that CMS is permitting 2014 start dates, a more phased in approach may help ensure that the lessons learned from early difficulties can help improve the program, rather than causing it to founder.

**Idaho Should Structure the Demonstration To Allow for Appropriate Evaluation**

We are concerned that enrollment of the entire dual eligible population in Idaho in the demonstration is inconsistent with the experimental nature of a demonstration. Instead, it appears that Idaho is proposing to make permanent programmatic changes to beneficiaries' coverage – on a massive scale – without prior evidence from a demonstration that could assure policymakers that the proposed changes will adequately protect beneficiaries or produce savings. As Idaho noted in its own proposal, while duals enrolled in the MMCP had lower monthly medical expenditures than duals not enrolled in the MMCP, only approximately 1000 dual eligible individuals are currently enrolled in the MMCP. Much greater information is needed to develop the best models to deliver integrated care before those approaches are expanded statewide.

Demonstrations can provide meaningful insight into the best ways to integrate care for dual eligibles, but only if they are appropriately structured. As currently proposed, the size and scale of the Idaho proposal, which proposes to enroll the state's entire dual eligible population, means that it does not qualify as a demonstration in any meaningful sense and will make it almost impossible to assess results in a rigorous way. The State's proposal should reflect the likelihood that the initiative will involve participating plans that are new to the Idaho market and new to managing Medicare benefits, and should include rigorous oversight and monitoring to assure that beneficiary quality of care is protected. Such ongoing monitoring should include routine analysis of claims and other relevant data, results on quality measures, and establishment of processes at the state and federal level for meaningful beneficiary feedback.

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<sup>14</sup> Idaho Proposal at 7.

We strongly recommend that Idaho revise its proposal to reflect the experimental nature of a demonstration by limiting enrollment to a smaller proportion of dual eligibles in the state.

**Passive Enrollment Should Not Undo Choices Previously Made by Beneficiary**

PhRMA is concerned that under the proposal beneficiaries may have a choice of only two plans in their region. All beneficiaries, and especially dual eligibles (who often have complex care needs), should continue to have a meaningful choice of plans, as they do today. Providing choice and an opportunity to select a plan that best meets the beneficiary's needs would reduce the likelihood of disruption as beneficiaries move into the demonstration and increase the likelihood that beneficiaries will maintain, rather than lose, access to their current providers, especially if one or more of the plans selected to participate should find itself unable to participate for whatever reason.

As an example, the State should consider that dual eligible beneficiaries sometimes enroll in Part D plans with premiums substantially above the benchmark plans where premiums for duals are fully subsidized. These plans offer enhanced coverage and very robust formularies, demonstrating that some dual beneficiaries actively choose plans to meet their specific needs. We are concerned that if only two plans are offered, even if the plans meet Part D requirements, the absence of rigorous competition to attract enrollment will result in plan benefit designs that provide only the minimum required level of benefits, rather than the level of benefits that dual eligible beneficiaries currently receive, and which the most frail and vulnerable of beneficiaries need.

Because the State is only guaranteeing beneficiaries a choice of at least two plans, we think it is critical that where beneficiaries (and their families or caregivers) already have made a choice of care arrangements, including opting into the MMCP, the dual demonstration program should respect that choice and should not use its passive enrollment process to disrupt arrangements for care that already have been made. As a demonstration program, it is important for the State to use the demonstration period to identify issues and correct them as it develops its approach, rather than pushing to enroll as many dual eligibles as possible. It would be very disruptive if the passive enrollment process reversed a decision in which a beneficiary and his or her family had already enrolled in a program of managed care. For example, it would not be reasonable to disenroll beneficiaries who already are enrolled in D-SNPs to put them into participating plans that do not have experience managing Medicare benefits.

We strongly recommend that those beneficiaries who have already made an affirmative choice in electing their plan, e.g., enrolled in a Medicare Advantage plan, a special needs plan or affirmatively chosen a Part D plan, be permitted to stay with their plan—at least for Medicare benefits. These beneficiaries have made a voluntary, deliberate choice to switch out of Medicare Fee for Service into a specific managed care plan, and in some cases are choosing to pay a monthly premium payment for their plan instead of a plan whose premium would have been fully subsidized. Particularly where low income beneficiaries have chosen to enroll in Part D plans for which they must pay a premium, it seems highly likely these beneficiaries would not be making such a choice unless they had determined that the coverage available to them in these plans is necessary to meet their medical needs and superior to plans available to them at no cost. To use a passive enrollment process to override a beneficiary's purposeful choice of a plan is a reduction in beneficiary choice and is not necessary to

test new models of care integration.

We are also concerned about the use of passive enrollment and ambiguity regarding the opt-out policy for dual eligible beneficiaries. We strongly support beneficiaries' freedom to opt-out of a plan for their Medicare benefits. However, we urge the state to confirm that there are neither time constraints on beneficiaries' ability to opt-out nor complicated opt-out processes. Requiring the most vulnerable and frail beneficiaries who have cognitive and other difficulties, who typically have established relationships with multiple providers, to go through a cumbersome opt-out process to keep current coverage or switch plans may be very difficult. For such beneficiaries, such an opt-out process could likely entail extensive transfers of medical histories and records; establishing new relationships with physicians, pharmacies and other providers; understanding benefits and medical management procedures for the new plan; determining whether currently prescribed medicines are covered on the formulary; and plan administrative requirements. To go through this switching process twice — once when auto-enrolled, and a second time to opt-out — may simply be too challenging or impractical for many beneficiaries to carry through.

**Continuity of Care is Critical: Enrollees Should Have Access to Existing Providers and Prior Authorized Drugs for at Least Six Months**

Transferring accountability for dual eligible individuals' care on a massive scale, no matter how carefully planned, always presents risks for disrupting established patient-provider relationships and current treatment plans. Continuity of care could be lost, and patients may receive medically inappropriate substitutions of medications, or cease medication compliance altogether, if coverage is changed at the time they are seeking refills of medication, or if robust drug coverage is no longer available. Idaho appears to propose to enroll dual eligible beneficiaries in the demonstration using some combination of mandatory enrollment (for the Medicaid component of the coordinated health plans) and passive enrollment with an option to opt-out (for the Medicare component of the coordinated health plans).<sup>15</sup> Idaho further proposes to permit a beneficiary to change health plans effective the first day of any month (as long as the change is requested 15 days in advance).<sup>16</sup> We encourage Idaho to clarify how these enrollment approaches will fit together and to provide additional details regarding the timing and procedure for individuals to opt out of their Medicare plans before submitting its proposal to CMS.

We are also concerned that such an approach may create health care access problems for dual eligibles, especially in light of the complex and ongoing medical needs of the duals population and the significant increase in the number of duals that Idaho plans to enroll in coordinated care. We therefore recommend that Idaho include the following beneficiary protections for dual eligibles to help ensure continuity of care:

- Provide a 180-day period during which enrollees may continue to receive care from out-of-network providers, regardless of whether they are undergoing active treatment for a specific condition; and

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<sup>15</sup> *Id.* at 9–10.

<sup>16</sup> *Id.* at 17.

- Provide the opportunity for out-of-network providers to sign Single Case Agreements to permit them to continue to treat enrolled dual eligibles, regardless of whether the patient is undergoing active treatment for a specific condition; and
- Provide similar transition protections regarding medications for 180 days to allow for time to make appropriate changes in medication or to apply for a new formulary exception during this period;
- Allow beneficiaries to fill prescriptions for currently prescribed medications regardless of whether the medicine is on the formulary—current medicines should be exempted from new utilization management controls, e.g., prior authorization and step therapy. This will allow time for their physician(s) to evaluate the medical appropriateness of the proposed alternative in light of the patient’s condition, other medications and health history.
- Reduce disruptions in care by facilitating the transfer of appropriate medical management and utilization history from a patient’s prior Medicare Advantage or Part D plan to avoid unwarranted repetition of utilization management protocols such as prior authorization or step therapy simply as a result of change in coverage.

\* \* \* \* \*

We thank you for your consideration of these comments on the Demonstration Proposal to Integrate Care for Dual Eligible Individuals. We urge Idaho to revise its proposal in a manner that enhances coordinated care without either unnecessarily disrupting care for Idaho’s most vulnerable beneficiaries, or compromising Medicare prescription drug benefits for all Medicare beneficiaries in the State. We look forward to the opportunity to continue working with Idaho in its development of this demonstration. Please contact me if you have any questions regarding these comments. Thank you again for your attention to these important issues.

Respectfully submitted,



Sharon Brigner, MS, RN  
Deputy Vice President, State Government Affairs  
PhRMA



## Fresenius Medical Care North America

May 10, 2012

Via E-mail: LTCManagedCare@dhw.idaho.gov

RE: Dual Eligible Demonstration

Fresenius Medical Care North America (“FMCNA”) is pleased to provide comment to the Idaho Department of Health & Welfare Integrated Care Demonstration Project for Dual Eligible individuals. We applaud DHW for its approach on how to best achieve a comprehensive health delivery system and payment reform in both Medicaid and the broader health care systems. In its draft demonstration application, the State appears to include individuals who are diagnosed with end stage renal disease (“ESRD”). The focus of this letter is to address the specific needs of individuals with ESRD and to request that Idaho Medicaid give thoughtful consideration to how this costly, complex and vulnerable patient group should be treated in the context of the dual eligible integrated care demonstration.

FMCNA is the largest provider of dialysis products and services in the U.S. and provides renal dialysis services to approximately 110 Idaho residents at our 5 dialysis facilities in the State. Over 1,100 people with kidney failure receive life-sustaining dialysis treatments at one of 26 Idaho dialysis facilities. Idaho ranks 3<sup>rd</sup> in the nation in the rate of new cases of ESRD diagnosed each year.

### **Overview of Renal Failure**

Individuals with renal disease are among the most complex, vulnerable and costly of all patient groups. Chronic kidney disease (“CKD”) is a progressive illness and is defined as CKD Stages I through V, with CKD Stage V equating to ESRD. Once an individual reaches ESRD, their options are limited to:

- 1) Organ transplant – primarily kidney but also kidney/pancreas for diabetics;
- 2) Renal Replacement Therapy – most frequently this is in the form of (A) in-center hemodialysis, which is done generally three to four times each week for four hours per session; (B) home hemodialysis or (C) home based peritoneal dialysis;
- 3) Death – If a patient with ESRD chooses not to be on dialysis or cannot obtain an organ transplant, death will likely occur within a few weeks.

In addition to suffering the complications that accompany loss of renal function, these patients typically have multiple chronic conditions such as hypertension, cardiovascular disease or diabetes (over 50 percent of individuals with ESRD are diabetic) that lead to renal failure.

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### **Fresenius Medical Care North America**

Corporate Headquarters:

920 Winter Street, Waltham MA 02451

(800) 662-1237

The incidence of CKD is increasing in the general population due to hypertension and diabetes, and goes largely undetected. These patients are typically socio-economically disadvantaged, with approximately 50 percent being dual-eligible, kidney disease has a disproportionately high impact in minority and underserved populations. Due to the medically complex and chronic nature of this disease, the late stage CKD and ESRD population accounts for nearly 10 percent of total Medicare spending. The Centers for Medicare and Medicaid (“CMS”) has long recognized the specialized needs of this costly patient group and has tested a variety of models to address the clinical needs of this population and has engaged the kidney care industry in multiple demonstration projects and renal-specific initiatives.

### **Comments on Idaho’s Demonstration Proposal**

We support Idaho Medicaid’s goal for better health outcomes, greater cost-effectiveness, and care being provided in the most appropriate setting. We also support Idaho Medicaid’s interest in providing health homes for the following specific categories of individuals:

- 1) A serious, persistent mental illness, or
- 2) Diabetes and an additional condition, or
- 3) Asthma and an additional condition.

Because diabetes is the primary cause of ESRD, individuals with ESRD may be good candidates for health homes.

We also agree that dual eligible beneficiaries should be able to make plan changes based on changes in health status. Allowing a beneficiary to enroll in a new health plan, effective the first of any month, so long as Medicaid is notified and the change is requested fifteen (15) days in advance is something we support.

We have a suggestion regarding the proposal. The proposal states that the existing Idaho Medicare-Medicaid Coordinated Plan is a Medicare Advantage Special Needs Plan (SNP) and will cease in 2014. We support leaving duals already enrolled in MA or MA SNP plans outside of the demonstration project. Those individuals are already in a well-managed care environment and MA plans serve as another option for coordinated care plans.

Please contact me for more information regarding ESRD dual eligible beneficiaries or to discuss in greater detail how the dual eligible ESRD patient population can best be served in the context of the Colorado dual eligible integrated care demonstration. Thank you for your consideration of our comments,

Sincerely yours,



Robert Sepucha  
Senior Vice President, Government Affairs



**Submitted via E-mail**  
[LTCManagedCare@dhw.idaho.gov](mailto:LTCManagedCare@dhw.idaho.gov)

May 10, 2012

Idaho Department of Health and Welfare  
PO Box 83720  
Boise, ID 83720-0036

**RE: Idaho Division of Medicaid Demonstration Proposal to Integrate Care for Dual Eligibles**

To Whom It May Concern:

On behalf of the 177 chain pharmacies operating in the state of Idaho, the National Association of Chain Drug Stores (NACDS) appreciates the opportunity to submit comments to the Idaho Department of Health and Welfare (“Department”) on the proposal for the Idaho Division of Medicaid Demonstration Proposal to Integrate Care for Dual Eligibles. We appreciate the Department considering our input on this matter.

413 North Lee Street  
P.O. Box 1417-D49  
Alexandria, Virginia  
22313-1480

NACDS represents traditional drug stores, supermarkets, and mass merchants with pharmacies – from regional chains with four stores to national companies. Chains operate more than 40,000 pharmacies and employ more than 3.5 million employees, including 130,000 pharmacists. They fill over 2.6 billion prescriptions annually, which is more than 72 percent of annual prescriptions in the United States. Chain pharmacies fill the majority of Medicare Part D and Medicaid prescriptions, making them a critical access point for healthcare services for dual eligibles.

The goals of the Centers for Medicare & Medicaid Services’ (CMS) “State Demonstrations to Integrate Care for Dual Eligible Individuals” initiative are to improve performance of primary care and care coordination for individuals eligible for both Medicare and Medicaid and to eliminate duplication of services for these beneficiaries, expand access to needed care, and improve the lives of dual eligibles, while lowering costs. NACDS believes that the Department’s proposal incorporates various approaches to care that would enable the Department to meet this aim.

**Critical Role of Pharmacists in Coordinated Care Programs**

Successful outcomes for a coordinated care program are dependent upon coordinating care provided by multiple provider types, including the services provided by pharmacists as part of the healthcare team. NACDS applauds the Department for recognizing in their proposal the value of utilizing pharmacists, who regularly see their patients, as members of the broader care management team that will be utilized to more effectively coordinate and provide the full range of Medicare and Medicaid services. Pharmacists play a key role in helping patients take their medications as prescribed and offer a variety of pharmacist-delivered services, such as medication therapy management (MTM) to improve quality and outcomes. Including community pharmacists as a part of the coordinated care models for dual eligible beneficiaries is one of the many ways of using a

pharmacist's clinical skills to improve patient outcomes. Accessible in virtually every community, pharmacists are medication experts with the ability to identify patient specific medication-related issues and communicate those issues to the patient and their provider. In addition, pharmacists have the ability to educate the patient with the necessary information to improve patient compliance, outcomes and overall quality of care.

### **Medicare Data is Essential for Care Coordination for Dual Eligibles**

As the Department works to integrate care, we urge the agency to obtain Medicare Parts A, B and D data from CMS. It is important to note the role that Medicare data plays in the integration of care for dual eligibles. As noted in the proposal, dual eligible beneficiaries can have complex medical needs and are left to receive services from a system that is fragmented and has both overlapping and conflicting benefits and requirements. Access to Medicare data is critical to achieving the shared goals of the state and the federal government. With adequate access to Medicare Parts A, B and D data states can advance the integration of Medicare and Medicaid and facilitate care coordination, improve the quality of care dual eligible beneficiaries receive and utilize health care resources more efficiently.

### **Inclusion of Medication Therapy Management Services in Coordinated Care Model**

While the proposal does not go into great detail regarding the specific benefits that will be provided to beneficiaries, we note that the Workplan / Timeline indicates that the Department intends to pursue a Medication Therapy Management Program as part of its plans for the overall integration of care for dual eligibles. We commend the state including this in its plans. NACDS believes the appropriate utilization of pharmacist-provided MTM services can play an important role in helping states meet the goals of eliminating duplication of services, expanding access, and improving the lives of dual eligibles, while lowering costs and allowing the state to share in the savings achieved. Research has shown that only 50 percent of patients properly adhere to their prescription drug therapy regimens. Poor medication adherence costs the nation approximately \$290 billion annually – 13% of total health care expenditures – and results in avoidable and costly health complications, worsening of disease progression, emergency room visits and hospital stays. This inadequate medication adherence rate is associated with about \$47 billion annually for drug-related hospitalizations, an estimated 40 percent of nursing home admissions.<sup>1</sup>

Reasons for patient non-adherence to a medication regimen are multiple, including costs, regimen complexity and patient beliefs. This is especially true for the dual eligible population whose care is fragmented between the Medicare and Medicaid programs. The fragmentation of care can often lead to beneficiary confusion and increase the possibility that a beneficiary may not adhere to his or her medication regimen.

Pharmacists are the most highly trained professionals in medication management. They receive a minimum of six years and in many cases eight years of college where they study medication uses, dosing, side effects, interactions and patient care. As highly trained and accessible healthcare providers, pharmacists are uniquely positioned to play

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<sup>1</sup> New England Healthcare Institute, 2009.

an expanded role in ensuring patients take their medications as prescribed. MTM services provided by community pharmacists improve patient care, enhance communication between providers and patients, improve collaboration among providers, optimize medication use for improved patient outcomes, contribute to medication error prevention and enable patients to be more actively involved in medication self-management. Pharmacist-provided MTM services are one of the many ways of using a pharmacist's clinical skills to improve patient outcomes. Pharmacists already have the training and skills needed to provide MTM services and currently provide many of these services in their day-to-day activities.

In order to be effective in improving outcomes for the dual eligible population through increased medication adherence, MTM services should be provided in a setting that is convenient and comfortable for the beneficiary; this is especially true for beneficiaries transitioning from the inpatient hospital setting or long-term care setting. Because most patients obtain their prescription drugs and services from their local pharmacy, the convenience of pharmacist-provided MTM services is not only logical, but is a cost effective way to increase patient access to MTM services and coordinate the beneficiaries medication.

In the pharmacy setting, MTM includes services such as review of the patient's prescription and over-the counter medications, reconciliation with medications received in the hospital, development of a personal medication record for a beneficiary to share with his/her physicians(s) and a medication-related action plan to achieve specific health goals in cooperation with his/her pharmacist. To perform the most comprehensive assessment of a beneficiary, personal interaction with direct contact between a pharmacist and a beneficiary is optimal. A face-to-face interaction optimizes the pharmacist's ability to observe signs of and visual cues to the beneficiary's health problems. A recent study published in the January 2012 edition of *Health Affairs* demonstrated the key role retail pharmacies play in providing MTM services to beneficiaries with diabetes. The study found that a pharmacy-based intervention program increased beneficiary adherence and that the benefits were greater for those who received counseling in a retail, face-to-face setting as opposed to a phone call from a mail order pharmacist. The study also suggested that the interventions, including in-person, face-to-face interaction between the retail pharmacist and the beneficiary, contributed to improved behavior with a return on investment of 3 to 1.

For all of the reasons discussed above, we urge the Department to not only maximize its utilization of MTM services for beneficiaries currently eligible for the Part D MTM program, but *also* use this demonstration as an opportunity to expand the use of MTM to include dual eligibles entering Medicare for the first time and those beneficiaries in transitions of care. Doing so would target beneficiaries that often fall through the cracks and would improve their health outcomes and lower overall program costs by providing help early in the process, before lack of coordination and poor medication adherence can become an issue. For newly eligible beneficiaries who are new to the Part D program and Part D formulary requirements, MTM services would serve a vital role in coordinating care and understanding any prescriptions the beneficiary may have received through Medicaid as well as any over-the-counter drugs the beneficiary may be taking. MTM services would also ensure that any future prescriptions paid for through the

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program would be safe, effective and appropriate. Similarly, beneficiaries transitioning from a hospital or a long-term care setting are often released with new medications and are vulnerable to miscommunication between different provider types. Pharmacists are in the best position to minimize any chances for miscommunications by acting as the main source for monitoring and managing a beneficiary's prescription medications, both immediately during the transition and continuing on as the beneficiary continues to live in the community.

NACDS also asks the Department to maximize the promotion and utilization of MTM services provided by community pharmacists as a means for improving the health benefits in its initiative to integrate care for the dual eligible population. In doing so, we urge the Department to consider increasing access to those beneficiaries eligible for Medicare for the first time and beneficiaries transitioning from hospitals and other long-term care settings.

Thank you again for the opportunity to provide you with this information. We look forward to partnering with you in the future on issues impacting retail pharmacy.

Sincerely,

A handwritten signature in black ink that reads "Michelle Cope". The signature is written in a cursive, flowing style.

Michelle Cope  
Director, State Public Policy