



Care Coordination for Better Outcomes: Revisited

Written remarks by AARP Oregon State Director Jerry Cohen, J.D., M.P.A. to the Oregon Health Policy Board

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AARP is a membership organization for persons age 50+ dedicated to helping all enjoy the best life as we age while shaping societal attitudes to value all as we age. In Oregon, we have over ½ million members and half are under age 65. We accomplish this mission through education and information, advocacy, community service and providing value and best practices through the marketplace.

Care Coordination for Better Outcomes: It was a year ago that I had the privilege of presenting AARP's thoughts regarding better care coordination between our home & community-based care system and the array of preventive, public, primary and acute care now under our Health Authority. AARP remains an active supporter of initiatives to make health and health care more coordinated, integrated, and consumer- and outcome-oriented. We also support efforts to control health care costs through greater efficiency of systems that foster better care (e.g., reducing medical error and hospital readmissions, duplication of tests, and less use of institutional care when community care would be more appropriate).

The latest LTC-CCO Concept paper shared with us looks reasonable. And the elements relating to CCO responsibility to coordinate acute and LTC care and care assessments are fine. So is the general Olmstead "most appropriate setting" approach on placements. Thus, my comments on behalf of AARP will focus on a few key issues.

Provider Networks

- The new draft states that providers "are permitted to participate in networks of multiple CCOs." This is advantageous in increasing the likelihood that consumers can find a CCO that includes all their current providers.
- It states that CCOs will use "credentialing procedures, objective quality information" in building their networks and remove substandard providers, but doesn't indicate whether the State or the CCOs will set those standards. **We'd want to see reasonably high standards in either case, and ideally the standards should be uniform for all the CCOs.**
- **It would be appropriate to require NCQA accreditation for CCOs and the health care providers within their networks.**
- **The continuity of care and care providers who have direct contact with consumers/families needs to be addressed.**

Consumer Safeguards

- While mentioning “protections against underutilizations ... inappropriate denials; [and] access to qualified advocates, there are no details for how this will be accomplished.
- Given the high rate of behavioral health conditions and mental impairments with this population and the inherent incentive to limit per enrollee expenditures of a capitated payment system, strong consumer protections would be appropriate and would help ensure that the state and HHS receive good value for their dollars.
- The basic concept is to critically examine CCO-proposed changes in care that will result in reduced benefits or quality or lower CCO expenditures, and, when appropriate, to reject changes that are not in the best interests of the consumer.
 - Most Medicaid programs currently have an extensive prior approval system to limit access to medical care that may be inappropriate. **A modified prior approval system could be incorporated with CCOs required to obtain prior approval for:**
 - Significant decreases in the quantity of ongoing services (number of hours of aide service, number or duration of therapy services, etc.)
 - Transferring consumer to a provider with lower a lower quality rating than the current provider
 - Changes in LTC setting or provider
 - Significant changes in a plan of care that will decrease CCO-to-provider payments
 - Prior approval would not be needed where the CCO increases expenditures or services and might not be needed where an enrollee has the capacity to provide informed consent and affirmatively agrees to the proposed change.
 - **This could be coupled with a requirement for advance notice to the enrollee whenever a CCO proposes to:**
 - Decrease the quantity of ongoing services (e.g. reductions in the hours per day of aide service or the number or duration of physical therapy services).
 - Require consumer to change providers or treatment
 - Reject a request for a modification of the plan of care made by the enrollee or the primary care provider. This would allow the consumer to challenge the proposed change through the grievance and appeal system with the status quo being maintained pending a final decision.
 - Oregon should establish pre-CCO “baseline” measures of the quantity of services by the enrollee population, individually and cumulative, before implementation.
 - This would allow identification of instances in which significant decreases in the quantity of care have occurred that would warrant further review.
 - From this review, changes in care that maintain or improve patient care and outcomes and quality of life could be distinguished from those that have adverse impacts.
- **The new system should adequately fund an independent system that provides no-cost ombudsman-like services available to enrollees.** We appreciate the complexity of matching both Medicare and Medicaid beneficiary rights and thus supported HB 3650 explicit recognition of Medicare beneficiary rights.
 - Integration of benefits for dual eligibles should ensure that Medicare and Medicaid are aligned to meet the needs of the dual eligible population while affording access to the full range of benefits and rights afforded by both programs.

- **Consideration should be given to the creation of a dual-purpose independent review entity (IRE). In addition to handling appeals, an IRE could proactively monitor significant changes in individual care plans and care and support delivery, require corrective action when appropriate, and serve as independent means of assessing consumer satisfaction.**
 - An IRE could replace of the CCOs' internal grievance and appeal process.
 - This would provide a uniform process and review standards across all the CCOs and relieve the CCOs of the costs of establishing individual systems and training internal staff on the complexities of Medicaid and Medicare. In addition to handling coverage decision-related grievances and disputes initiated by beneficiaries, their families or primary care coordinators,
 - IRE could review significant proposed changes in the quantity of care or proposed changes in providers of long-term care service and support. Since many duals will be unable to identify or appeal inappropriate action by a CCO, this could also include automatic review of instances where a CCO does not promptly provide the care, treatment and support recommended by the care coordinator.
 - An effective IRE system for early reviews should drastically decrease the number of formal Medicaid and Medicare appeals, resulting in significant staff and cost savings for the states and HHS. It would also facilitate quick resolution of disputes, making it less likely that beneficiaries would experience harmful delays or gaps in service. Where disputes are not fully resolved, the IRE could provide guidance and assistance for those who wish to pursue formal Medicaid or Medicare appeals through their respective administrative and judicial procedures and forums. To ensure its integrity, the IRE should be independently funded with an appropriate and adequate portion of Medicaid and Medicare funds available under integrated programs.
 - In addition to ensuring that beneficiaries' benefits and rights are protected, an IRE could serve a valuable monitoring function for the states and CMS — identifying best practices as well as inappropriate patterns of denials. To allow Medicare and Medicaid to proactively monitor the CCOs, base lines could be established for those transitioned into the program — in terms of pre-transition costs for various types of care and the quantity of each type of care and supportive services provided. This would help identify promising practices that achieve savings through improved care and coordination. It would be used as a trigger to allow both programs, through the IRE, to critically examine cases where costs may have been reduced inappropriately such as reducing the number of hours of home health aide care or by transferring a consumer to a less costly, but poorer quality nursing home. For those receiving long-term services and supports who are required to change direct care providers or nursing facilities, this could include a comparison of the objective quality data on the pre- and post-transition providers.
- Safeguards in this program should also include a robust consumer evaluation process and their input should be a major factor in decisions regarding ongoing CCO participation and incentive payments. Consumer assessments should be solicited frequently during the early years of the duals program, when there are significant changes in an individual's plan or treatment, and when there is a change in providers of long-term services and supports. An IRE could be tasked with this function as well.

The bottom line is this: The latest LTC-CCO Concept paper is a positive step forward. And we hope that our comments will be addressed to both strengthen and clarify the work moving forward.