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December 12, 2011

Susan Otter, Oregon Health Policy & Research
c/o Oregon Health Authority
Oregon Health Policy Board
Oregon Medicare-Medicaid Integration of Care and Services Workgroup
500 Summer Street, NE E-20
Salem, Oregon 97301

Re: Follow up from dialogue with you and both Health Authority & Department of Human Services staff with a focus upon 3 Options presented in draft form by staff

Dear Ms. Otter,

The exclusion of long-term care services from the Health Systems Transformation system poses challenges for Oregon, including the potential for inappropriate cost shifting between providers of long-term services and supports (LTSS) and the Coordinated Care Organizations (CCO) that provide care management and acute care services. In follow-up to our recent conversation of November 22nd, below is a summary of our concerns and suggestions relating to cost shifting. As a membership organization of over 500,000 age 50+ in Oregon, we are pleased to continue to work with you and the various staff and state and community organizations engaged in transforming Oregon's health systems to best meet the Triple AIM.

In developing cost shifting mitigation strategies, we urge consistency with the Transformation system's person-centered focus — holding both CCO and LTSS providers accountable for delivering coordinated care that best serves the need of the individual. We believe that this approach will yield better results than a formulaic approach that assigns financial incentives or sanctions based on projections and expectations of global utilization by all the dual-eligibles or on the duration of long-term care. Since the state can and does set rates and measures outcomes, it would seem that the issue is not necessarily one of “cost-shift” as it is “better care through better coordination” across systems. Moreover, just who are “LTSS providers” envisioned in the demonstration project? The draft paper seems to infer ALL providers (from SNFs, ALFs, AHFs and In-Home programs to State and some Area Agencies on Aging & Disabilities...and even family caregivers and those paid by client). Since State and some AAAs authorize services, perhaps they are the accountable entities you really wish to tie in to accountability.

While we strongly favor maximization of home and community-based services, a performance metric based on the percentage of LTC clients served in the community or hospital and emergency room utilization (Option 1) could create an incentive for the CCO to favor HCBS even if institutional care is more appropriate and could encourage LTC providers to retain patients who really need hospital or ER care.

A system that ties shared savings based on global bench marks for nursing home utilization and costs (Option 2) could also encourage inappropriate HCBS placements and would encourage use of the lowest cost nursing homes providers even when higher quality providers are available.

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The Minnesota-modeled Option 3, tying liability for the costs of LTC to the duration of a nursing home stay and the nature of the care provided (skilled vs. custodial) would create an incentive for a CCO to shorten stays or eliminate skilled medical care. This option would also engender disputes between CCOs and LTC providers on the level of care that would require adjudication.

We believe that inappropriate cost shifting can be better addressed by the adoption of a person-centered accountability system. For example, when a nursing home resident is transferred to the hospital, an evaluation could be conducted to determine the root cause of the hospitalization. This could result in a finding that re-hospitalization was the inevitable result of a premature discharge by the CCO following an initial hospitalization, the consequence of substandard care by the nursing home, or the development of a new medical condition which neither CCO or LTC provider could have prevented. But this must also be balanced by another factor that is a cornerstone to person-centered care: when the person's personal preference does NOT align and may conflict with the care and setting preferred by the coordinator(s) of care. Thus, managing exclusively to a bottom-line may conflict with the individual's preference. How these conflicts are identified and resolved in a manner that respects the value of person-centered care is crucial. This is an area where perhaps the longer-term relationship building historically shown by our home and community-based long term care system may be of added-value.

Inappropriate cost shifting could also be addressed by ensuring that the care coordination provided by the CCO covers care in all settings, including the LTC services paid for outside the CCO system, and by encourage or requiring CCOs to select LTC providers for their networks based on objective quality data and the LTC providers track records relating to cost shifting. As we discussed, our Long-term Care Scorecard indicates a relative low incidence of hospitalization of nursing home and HCBS clients, but a higher than national average incidence of pressure sores and the use of physical restraints. A system that prioritizes transfers following an initial hospitalization to those LTC providers that have high scores for prevention of pressure sores, falls and medication errors, and limited use of restraints should result in low CCO costs, in addition to significantly better health outcomes and quality of life for the clients.

CCO standards could also ensure that they have an active and accountable role in provision of LTC care — establishing, monitoring and adjusting the LTC plan of care. Active involvement of CCOs could also be required whenever a LTC provider proposes to transfer a client to the hospital. This would allow the CCO to assess whether hospitalization is necessary or could be avoided through treatment, by the CCO or the LTC provider, in the nursing home or client home, or by modification of the plan of care.

Whatever system is selected, there will be disputes between CCO and LTC providers to be adjudicated and instances of substandard care and care coordination. This will require ongoing monitoring and dispute resolution systems administered by the state or an independent review organization. As additional data becomes available, Oregon should be able to develop new systems, contract requirements and incentives/sanctions to address systemic problems, allocate liability, and, when appropriate, eliminate CCO and LTC providers who try to game the system for financial purposes at the expense of high quality consumer care.

During our discussions, we also raised the idea of a Medicaid modification to provide medical care for those who are on track to be the dual-eligibles in future years — uninsured, lower income 50-64 year olds. This could be limited to preventive, screening and chronic disease management services and would only be necessary until the Affordable Care Act makes health insurance available to this population in 2014. Such a system should delay the point at which this population qualifies for Medicaid and would leave them in better health when they do qualify. By tracking outcomes and long-term savings for Medicare, as well as Medicaid and uncompensated care, it might be possible to fund such a program on the resulting longer term savings.

Respectfully submitted,

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