ALTCS E/PD RFP YH18-0001 PUBLIC COMMENTS COMMON THEMES

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PUBLIC COMMENTS: COMMON THEMES

Public Comment Period: January 13th, 2016 through February 15th, 2016
Comments received via public comment e-mail box and Stakeholder Forums: Phoenix – January 14th, 2016 Tucson – January 19th, 2016

TOPIC: END OF LIFE CARE

- **How to help members plan?**
- **What services and supports should be available for members, caregivers, and families?**
  - **How can Hospice Care help?**
  - **How can Palliative Care help?**
- **What information and training should be available for providers?**

Number of Public Commenters: 7
Common Themes

No.	Common Theme
1.	Supportive of new/additional resources and initiatives in this area.
2.	Providers need improved coordination between Medicaid (AHCCCS) and Medicare (CMS) to provide hospice care to members.
3.	Palliative care and quality care are tied and are often staff intensive – recognize the cost associated with this support.
4.	Member’s and families/Provider/physician need education/training (for providers) on how to receive, direct and provide end of life care.
5.	Early End of life care planning is needed to provide member easier access to palliative care and hospice and reduce medical/ED costs.
6.	End of life care services should include support services for those who are deaf or hard of hearing or deaf-blind by providing the proper communication support services. The services include but are not limited to American Sign Language interpreters, assistive listening devices, and support service providers for individuals who are deaf-blind. Support Service providers inform citizens about their surroundings that the citizen is unable to see or hear. Access to communication even at the end of life is critical.
7.	AHCCCS should allow reimbursement and encountering for end of life discussions. This will allow providers to be properly compensated for this service. Additionally, this change should be included in AHCCCS’ capitation rates.
8.	Allow stakeholders to work with AHCCCS and the MCOs on improving end of life care.

TOPIC: ELECTRONIC VISIT VERIFICATION

- **Options for EVV**
  - **AHCCCS selects and mandates the use of a single statewide vendor**
  - **MCOs jointly select a single statewide vendor**
  - **MCOs individually select a vendor for their contracted providers**
  - **MCOs allow providers to individually select a vendor to use**

Number of Public Commenters: 16
Common Themes

No.	Common Theme
1.	Recommend AHCCCS confer with other states regarding EVV options and roll-out and that AHCCCS review system demos prior to mandating a vendor.

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TOPIC: ELECTRONIC VISIT VERIFICATION Continued

2. Concern expressed that it might extend to services provided outside of a member's own home, e.g. Day Treatment and Training and Residential programs.

3. Lack of education and adequate funding will make EVV difficult for small providers, providers in remote areas and providers in general.
- Members and providers need support in the 'electronic-age'

4. Access: Various significant accessibility issues in rural areas. Consider rural area when deliberating on implementation of a successful EVV system.
- Often members in rural areas do not have telephone land lines.
- Often there is no cell tower service in rural areas or service is intermittent.
- Due to connectivity issues in rural areas, an exception process or a back-up process should be implemented.
- A possible solution for the rural areas is to only mandate EVV in Maricopa and Pima counties and make it optional in other counties.

5. AHCCCS selects and mandates the use of a single statewide vendor
- PRO: Would create a single, consistent system for all users.
- CON: Would eliminate any current vendor relationships established with each MCO.
- CON: MCOs would have to develop systems to ensure appropriate connectivity between systems which would take considerable financial and workforce resources.
- CON: Implementation of a single statewide EVV system that is required for all providers eliminates competition, thus reducing the incentive for the EVV provider to maintain customer service that is responsive and effective for members.

6. Allowing MCOs to jointly select a single statewide vendor
- Consider having the Arizona Association of Health Plans (AzAHP) collaborate on the selection of a single vendor.
- PRO: Would create a single, consistent system for all users.
- PRO: MCOs have more flexibility with future enhancements.
- CON: Would eliminate any current vendor relationships established with each MCO.
- CON: MCOs may have to develop systems to ensure appropriate connectivity between systems which would take considerable financial and workforce resources, depending upon vendor choice.

7. Allowing MCOs to individually select a vendor for their contracted providers
- PRO: Provides increased flexibility for MCOs.
- CON: Providers would need to report in a format prescribed by each MCO.
- This may require provider agencies to adjust their systems based on varying MCO reporting requirements and therefore create a large burden on provider agencies, particularly small, locally based agencies.
- NEUTRAL: Each MCO would need to report in a uniform format to the state; recommend AHCCCS develop this reporting template.

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TOPIC: ELECTRONIC VISIT VERIFICATION Continued

8. Costs issues and implications

- Concerns expressed over using a system with soft/hardware with a cost to members and caregivers (e.g. cell data plans).
- Who will pay for the EVV service? Please note that there are additional overhead costs associated with developing, implementing, and maintaining a technological time capture system such as EVV. Recent and prolonged rate cuts for Medicaid providers across the State over the last several years markedly decrease providers' ability to comply with such a systems change without an increase in reimbursement of some kind to accommodate.
- Reduction in costs and occurrences of fraud, waste and abuse.

9. System features and flexibility

- Choose a system that is not administratively intensive and will ensure reduction in paperwork as intended.
  a. What mechanisms will be used in place of member signature? Consider formally allowing electronic signature.
  b. EVV may not eliminate this practice altogether due to the lack of technological capability in the Member's home. However, experience tells us that some reduction in the administrative burden of timesheets can be expected.
- Produce reports similar to the Non-Provision of Services (NPS) log process to replace the current NPS report.
- Address language barriers.
- Need a system that allows for care providers with split shifts.
- Consider requiring use of an EVV 1-800 number for dial-in, ensure it is an efficient/speedy process for call-in (e.g. taking minutes to get through a call-in system will vary the actual clock-in time).
- Consider an EVV system which allows for multiple methods of time entry (e.g. telephonic, online, fax, paper mail) to address all populations served.
- Consider each caregiver having a unique code/identifier.
- The system should incorporate authorizations (PA) for services:
  a. Allow updates of authorizations as they are often not entered timely or are not entered with an adequate # of units on payer end.
- Clock-in considerations:
  a. Consider a back-up plan for when clock-in times are missed.
  b. Ensure an individual clocking-in/out is actually at the correct location.
  c. Delayed clock-in due to member care emergencies/issue requiring immediate attention upon arrival. This requires administrative work-around to enter/validate work hours which can be time consuming and costly.

10. Providers and MCOs must be informed of their specific responsibilities and obligations pertaining to the relationship, contractual requirements, oversight, and reporting requirements with the EVV vendor. Provide clear description of required EVV features which enables each provider to choose how to integrate those requirements into EVV operations and service delivery.

11. Will it be required for EVV and Remote Health Monitoring be provided in a single system?

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TOPIC: ELECTRONIC VISIT VERIFICATION Continued

12. Consider how EVV will impact live-in caregivers.

13. Will EVV be used to track supervisor/customer service visits.

TOPIC: REMOTE HEALTH MONITORING

- **What opportunities exist for implementing Remote Health Monitoring?**
- **What challenges exist for implementing Remote Health Monitoring?**
- **How can Remote Health Monitoring be utilized to improve member outcomes?**

Number of Public Commenters: 5
Common Themes

1. Concern expressed that it might extend to services provided outside of a member's own home, e.g. Day Treatment and Training and Residential programs.

2. Cost issues and implications:
- Lack of adequate funding will make these services difficult for small providers and providers in remote areas.
- Remote Health Monitoring involves additional overhead cost.
- Consider provision of additional reimbursement to cover the cost of the new system.
- Consider, in the event additional reimbursement is passed along via payments to MCOs that specified amounts are passed through the MCO directly to individual providers who will be responsible for implementing the system for the populations they serve directly.
- May be costly to providers. Use of such a system requires that the provider engage in actively scheduling and tracking in-home visits with members to prevent any missed monitoring of the Member's health needs.
- RHM systems are often integrated with EVV, which adds additional administrative cost.

3. Allowing freedom for providers to choose their own systems
- Allows providers who have already implemented a system to remain with their existing vendor.
- Consider provider mandate of outcome measures rather than a focus on use of a particular EVV system.
- Consider integration requirements that would allow providers to integrate current systems with a new vendor system (e.g. "interface").

4. Will it be required for EVV and Remote Health Monitoring be provided in a single system?

5. Opportunities in Remote Health Monitoring
- A mechanism for capturing health data in real time.
- Can increase the Member's ability to manage their own care, and that increased monitoring of service utilization can help reduce cost for MCOs and state agencies.
- Allows for real-time data capture through GPS (Global Positioning Systems) technology.

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TOPIC: REMOTE HEALTH MONITORING Continued

6. Members may feel that their care is being monitored too closely.

7. Our experience has shown that remote health monitoring can be very helpful in reducing serious complications when combined with other interventions performed collaboratively with a cooperative, adherent patient. While the results were successful, the process was highly labor intensive and not scalable.

There are now more sophisticated sensors available but most require a landline or internet connection in addition to the cost of the equipment. The real cost and operational hurdle, however, is establishing who will receive the information and what steps they are able to take to intervene rapidly. Having access to multiple clinical measures is only useful if there is a clear, timely process to act on the information received. Providers will have to actively participate in the process and be reimbursed for their time.

8. AHCCCS should stress the philosophy that Attendants are a significant part of the Member's care management team, and can at times play a significant role in improving health outcomes for Members, which can be accomplished with in-home provider or agency involvement.

- Attendants working in the homes of Members can help to improve health outcomes, either via the use of quality reporting measures or via engaging in RHM in the member's home.
- Attendants can encourage the member to participate in health screenings, surveys on care quality, and education on their own care needs resulting in positive health outcomes.
- As caregivers, Attendants know better than most about the member's lifestyle, wants, and needs related to their health condition. Attendants have the ability to work closely with the member to affect alterations (small and large) in the member's lifestyle, which can also impact health outcomes over time.
- MCOs should develop systems that train and employ attendant care workers working with members who have chronic conditions on the collection of real-time health care data. This will help the MCO track and monitor ongoing healthcare needs of the member, enabling the MCO to prevent unnecessary hospitalizations, emergency rooms visits, or other avoidable heath crises.

TOPIC: VALUE-BASED PURCHASING

- **How can we incorporate VBP in an LTSS environment specific to long term care services (HCBS and NFs)?**
  - **What do these VBP initiatives look like?**
  - **What are the measurable outcomes to determine valued providers?**

Number of Public Commenters: 4
Common Themes

1. Incentives should not come from base rate but funded as increases or incentives.

2. Delivery should be based on predictive outcome analysis, data driven, and a mixture of technology and focused care services.

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TOPIC: VALUE-BASED PURCHASING Continued

3. Geographical considerations: Identify how many providers each geography is able to support. When you fragment the market too much providers are generally weak, do not innovate because there is no rewards for doing so and can not achieve the economies of scale.

4. Consider the proposed CMS Conditions of Participation in Medicare and Medicaid proposed rules (COP) and the cost implications for SNF's should these be adopted as proposed in 2016/2017. CMS projects the cost for COP implementation to be at least $45,000 per SNF- our own estimates more than double that. Much of the cost is centered on new credentialed staffing requirements, quality improvement assurances and more stringent rules around clinical outcomes. The Plans and the state will have to support these changes – both monetarily and in program initiatives – or both quality outcomes and financial viability may be seriously compromised.

5. How will value-based purchasing work across the disciplines when multiple providers are involved?

6. Use current reporting and measurement data, to ensure that new administrative burdens are kept to a minimum.

7. Problematic areas with the current policy include the percent of spend requirement that will ultimately reach 50 percent. Currently, there is very little penetration among providers, *especially in rural areas*.

- First, a situation in which an MCO contracts with primary care providers, the MCO is required to have signed agreements with providers who treat less than 50 members in order to hit the 50 percent target.
- Second, contracting with home and community based service (HCBS) providers where the members are placed becomes problematic, particularly if 40 percent or more of MCO spend is generated by home-based members. Contracting with HCBS providers, such as personal care attendants, is equally ineffective as these providers may not sustain enough contact with members to influence behavior.

Due to the low volume of membership in any one geographic area, as well as the high variability of costs from year to year among ALTCS EPD members, any rewards structured into the contract would more likely be earned as a result of normal fluctuation rather than improved oversight and management. While there are many providers who are very strong in the areas of data analytics and utilization management, when contracting with small providers with limited membership, it becomes difficult to provide sufficient financial benefit to incent providers to take on the additional administrative functions that would be required for the desired results.

Providing MCOs flexibility in contracting will result in positive outcomes for both members and AHCCCS, we also believe that the current value based purchasing medical spend requirements will force MCOs to enter into agreements that will not result in the desired outcomes. We recommend that AHCCCS create an ALTCS EPD MCO and provider workgroup tasked with examining the issues surrounding value based purchasing in the long term care industry and producing policy recommendations for AHCCCS consideration.

Other topics for consideration include combining Medicare and ALTCS EPD spend (a medical spend target sufficiently high to incentivize provider contracting while avoiding contracts that have very little chance of success and will result in administrative costs to AHCCCS, its MCOs and providers) and determining the necessary scale among providers to implement management functions that will result in improved outcomes.

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TOPIC: GEOGRAPHIC SERVICE AREA COMPOSITION

- **Should the GSA composition change?**
- **Considerations**
  - **Access to care**
  - **Network sufficiency**
  - **Rural and Urban areas**
  - **Cultural factors**
  - **Member placement**
  - **MCO financial viability**
  - **Capitation rate credibility**

Number of Public Commenters: 1
Common Themes

1. Consider a three GSA structure – Northern Arizona, Southern Arizona (excluding Maricopa County), and Maricopa County.
  - Allows for continuity throughout the care continuum and enables contractors to have the critical mass necessary to deploy infrastructure and programs that will improve the health outcomes and overall well-being of the ALTCS population.
  - In order to ensure that the experience meets the needs of our member expectations, an understanding of unique cultural and linguistic attributes is necessary. This regional structure is designed considering the cultural competencies and tendencies of Arizona's populations, and will permit ALTCS issuers in single contract regions to streamline and integrate medical health treatment throughout the care continuum.
  - Structure permits ALTCS issuers to establish the integrated network necessary to meet the needs of the complex membership, ensuring that members are obtaining services closer to home while continuously monitoring referral patterns to identify gaps in care and ensure care is delivered at the right acuity level, at the right time.

2. Within a three GSA structure, consider awarding a single plan for each of the Northern and Southern Regions.
  - This structure will also decrease the administrative burden for ALTCS providers, having only one set of contracts and processes, best promoting seamless experiences between the contractors and the sub-contractors (providers) in order to facilitate optimal overall health outcomes for this complex population.
  - In rural counties allow for leverage scale to develop efficient transportation management systems as well as a telehealth vendor to ensure care, especially specialist care is more accessible to members and affordable to contractors and the state.

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AHCCCS received Public Comment regarding other important areas of focus. Those topics are summarized below. For comments received outside the scope of the RFP, the comments are not listed below; however, AHCCCS will take follow-up action as appropriate.

1. Consider aligning behavioral health benefits and services provided by ALTCS E/PD system and the RBHA system, particularly for those members transitioning from the RBHA system to Long Term Care, including members determined to have a serious mental illness. Ensure adequate access to care in all areas, including rural areas.
2. Keep a program focus on the outcome of keeping members safe and healthy at home and set expectations accordingly.
3. Consider moving toward a different model of care where we focus all packages on clear and defined outcomes - short visits focusing on ADL's, medication compliance and safety.
4. Member Councils are important and so are Provider Councils and Stakeholder Groups. This expectation should be imbedded in the requirements.
5. Providers consistently encounter challenges on the payment front, often in the form of inaccurate or delayed payment. Please carefully consider capability and capacity when evaluating a bidder's ability to pay in a streamlined and timely fashion.
    - Systems conversions are typically a nightmare and should be monitored.
    - Customer service aptitude should be key.
    - We appreciate the provider claims survey that AHCCCS conducts annually and encourage you to continue this.
6. We value your intense scrutiny on the accuracy of the SNF Provider Assessment payments, and urge you to continue to make this a staff priority.
7. The SNF network is fragile. We just recently experienced a SNF closure in rural Wilcox. There are several rural locations where there is only one SNF available and more closures are possible.
    - MCO partnerships must be established with an understanding Medicaid rates do not currently meet cost, and expectations must be realistically set by both existing and new ALTCS Plans. We believe that a CPI or COLA should be annual, as the state budget allows.
    - Convene a stakeholder discussion about the effectiveness of the Uniform Assessment Tool (UAT). I believe that the consistency of application of the UAT and the validity of the tool is in question after decades of use without substantive revision. This tool has significant clinical and financial implications.
8. We have seen a great increase in acuity reported by our Medicaid assisted living providers and the rates are insufficient to meet the increased care needs. I urge you to make *identifying costs and member needs in assisted living* a priority. If you want to keep ALTCS members at a less restrictive level than SNF, then we need to know what that those costs truly are and what the market will bear. Quality of care is at risk, particularly on the behavioral front, if we do not move assisted living acuity and its accompanying ramifications front and center in our public policy dialogue. New MCO's will find Arizona assisted living very different from other states and that should be noted in the bidding process.
9. An increasing amount of specialty care is being provided both in the SNF and AL setting, much of it focused on behavioral care but also including ventilator, dialysis and bariatric care- just to name a few key areas. AHCCCS needs to better understand the scope of this care, and create greater uniformity in scope of service between the various MCO's and, of course, any new bidders. I recommend an examination of cost and rate differentials in specialty care, so that we can truly document the acuity in the ALTCS program.

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AHCCCS received Public Comment regarding other important areas of focus. Those topics are summarized below. For comments received outside the scope of the RFP, the comments are not listed below; however, AHCCCS will take follow-up action as appropriate. (Continued)
10. There is a disconnect with the ability of MCO's to seamlessly serve the duals- both clinically and financially. Often one side of the MCO/company does not communicate with the other and incentives are not aligned. Complex high dollar claims for Medicare Advantage and Medicaid can cripple a provider if they are not paid in an accurate and timely fashion. On the clinical side, it is concerning when a length of stay determination is made that benefits one payer but not the other. ALTCS individual member quality outcomes must be deemed front and center by all appointed contractors and new bidders. Medicaid cannot simply continue to be a loss leader for other programs.
11. There is an increase of acute AHCCCS members being cared for in the SNF setting and encourage you to educate any bidders about increase in utilization of SNF services for acute members. It would be helpful to make certain that these Plans understand the cost and regulatory framework of long term care.
12. We support the exchange of information inclusive of long term care providers in order to create an effective post acute care continuum. Skilled nursing and assisted living facilities have not been financially incentivized to participate in electronic information sharing. The long term care community will need education and financial resources to support our evolution.
13. Improve assistance for members regarding navigating the long term care system and available services.
14. Consider the best ways to provide service to rural populations. Consider how best to weight the evaluation of services for rural communities (i.e. the smallest portion of the population).
15. Telehealth is a valuable mechanism to service beneficiaries who live in less accessible areas and/or experience restricted mobility and increases the frequency of engagement with the member, and decreases costs associated with transportation. Utilizing telemedicine will assist with specialized services and increase member communication mediums. Additionally, telehealth practices will also improve the competency of providers to care for chronic pain and improve prescribing safety. This will support clinical integration and care coordination as it relates to the ALTCS population. Overall, telehealth capabilities should be a consideration for the upcoming ALTCS procurement in order to assist with managing the care of the ALTCS population.