Date: November 22, 2011

To: Pris Boroniec
Brett Davis

From: Survival Coalition of Wisconsin Disability Organizations and the Wisconsin Aging Network

Subject: **Recommendations and Concerns regarding the Virtual PACE Program**

We appreciate the recent briefings that various advocates have attended, at which time DHS staff have presented the state's initial plans for the Virtual PACE (VP) Program. We are also glad to hear that you are not "locked in" to a particular program design yet, and that you are actively seeking our input.

Advocates and consumers have reviewed the DHS proposal to CMS and have begun reading various papers regarding integrated case models for dual eligible individuals. As a result, we have an initial set of recommendations and concerns which we have included in this memo. It is likely that we will have more issues to raise in the future.

1. Subcommittee of the LTC Council. The DHS proposal to CMS includes a statement that:

   > *"The Department proposes to create a subcommittee of the LTC Council that is composed of a broad range of stakeholders, including consumers, advocates, Partnership and Family Care MCOs, ADRCs, and long-term care service providers along with additional representatives with expertise that is relevant to the demonstration project, including representatives of the acute/primary health care industry… (This) subcommittee would be charged with providing advice on the development of the proposed demonstration project".*

   Now that DHS has hired VP program staff, we strongly encourage DHS to form and convene this Subcommittee in December. Our experience has been that when consumers and advocates are involved early in the planning and implementation stages, there is less likelihood of backlash later and less need to go back and fix problems that originated from the initial design. A strong Subcommittee could be a valuable partner for DHS in developing an effective Virtual PACE program.

Specifically, we recommend that a majority of the Subcommittee be composed of a combination of advocates and consumers, and that at least a third of the committee consist of consumers (ie. people with disabilities and elderly people, including some dual eligible individuals.)

2. Auto-enrollment (or "passive enrollment") with a 6 month opt out (or "lock in"). We are very concerned about the possibility that people who have received options counseling from ADRCs and made an informed choice to enroll in Family Care, Partnership, or IRIS could now be told that their choice has been pre-empted by state government and that they will be involuntarily enrolled in a program they know nothing about.

   This would be antithetical to the original "consumer choice" promise of Family Care, and it appears to contradict CMS' strong urging to DHS to create IRIS or some other non-managed care choice for people entering the LTC system. Why create a choice, allow people to choose it, and then take it away? It also violates the longstanding concept of "free choice" in Medicare. We believe that enrollment should be 100% voluntary.

   There are 3 levels to this:

   a) For people currently in an integrated managed care model, ie. Partnership, this may not be a big disruption in their lives or their service plans, especially if they stay with the same MCO and the same provider network.

   b) For people in Family Care, it will be a big change. They are currently obtaining their primary & acute health care on a fee-for-service basis, and some of them have longstanding relationships with primary physicians, specialty providers, etc.

   c) For people in IRIS, it would be a dramatic reversal of the informed choice of consumers and families to participate in a non-managed care approach based solidly on self-determination values, with none of the restrictions of a provider network.

   If in fact the Virtual PACE model has merit, and will result in improved coordination of care (especially for people with multiple intersects between their long term care and acute/primary health care needs), why not assume some people will affirmatively choose it? Why not consider a pilot with voluntary enrollment, accompanied by intensive education and consumer-friendly information on this new option?

3. Consumer Education. It is hard to overstate the importance of developing a comprehensive consumer education plan and carefully implementing it over an extended period before the first person enrolls in VP. When IRIS was rolled out with inadequate ADRC training, inadequate consumer materials, and very little lead time, there was mass confusion and many inaccurate first impressions of the program. Wisconsin should be able to do better than that this time. This is another area in which a Subcommittee with strong consumer representation could play an invaluable role.

4. Avoiding Undermining our current LTC System. An MCO needs a minimum number of "covered lives" in order to manage its risk. If a significant portion of current Family Care and Partnership members enroll in VP (voluntarily or involuntarily), this could result in some MCOs becoming "non-viable" and losing their MCO certification from OCI. This would cause major disruption to all the remaining members of these MCOs. We encourage DHS to implement VP in such a way that you ensure against the unintended demise of any existing MCOs.

5. The Future Role of existing Family Care and Partnership MCOs. Presumably the risk reserve requirements for a Virtual PACE MCO will be fairly high, given that such an MCO will have to withstand the potential of incurring high costs from a variety of long term care and acute/primary care causes. Do any of the existing Family Care or Partnership MCOs have the fiscal wherewithal to meet those reserve requirements on their own, or would they be forced to enter into an MCO-HMO partnership in order to participate?

6. Consumer Protections. There are a variety of consumer protections that we believe must be incorporated into the design of Virtual PACE. These include (but are not limited to):

    - access to all Medicaid and Medicare services,

    - continuity of care both in LTC and primary/acute care,

    - due process, and rights to appeal MCO decisions and file complaints (and receive assistance from an outside entity to do this, as needed), using the appeals process that offers the most protection, and

    - payment structures which promote delivery of optimum care (not reward the denial of needed care or services).

Conclusion

We look forward to an ongoing in-depth dialogue with DHS as the plans for Virtual PACE evolve. We consider this memo to be an initial step in that dialogue. We

believe that an active, engaged Subcommittee with strong consumer and advocate participation is the most promising mechanism to continue the dialogue.

We look forward to an early start for the Subcommittee, and your response to the other issues we have raised in this memo.

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