Survival Coalition Virtual PACE Comments

Survival Coalition is writing to provide our comments to the Virtual PACE draft proposal for public comment dated March 16, 2012. We recognize that this draft is still fairly early and, as such, many important details remain to be defined. We will try to identify what we support and what we are concerned about in the proposal and, to the degree possible, identify specific ideas about future policy development.

There are a number of positive things in the proposal:

- Thank you for narrowing the scope of the proposal and moderating the ramp-up. We appreciate your responsiveness to the feedback you received about not compromising existing long-term care (LTC) programs. We think that beginning with a few pilots in January 2013 is a much more feasible approach less likely to result in harm to members.

- We appreciate your commitment to interdisciplinary care teams (IDTs) having disability-specific expertise appropriate to the needs of the member. We are also very pleased to see that paraprofessionals, such as peer specialists, are expected to be part of the IDT. It will be important to identify assessment and care planning requirements that will reinforce the use of such specialty providers.

- We support your commitment to person-centered planning. This will need to be operationalized, for instance by requiring consumers to sign a copy of their plan indicating they were the lead in the development of the plan and providing for periodic review; e.g. every 3-6 months.

- We applaud your recognition of the need to ensure appropriate prescribing practices within nursing facilities. More appropriate use of anti-psychotics and other psychotropic medications will not only improve member safety and wellness; it will reduce unnecessary hospitalizations.

We do have concerns the following areas:

Passive Enrollment: Survival Coalition does not support a passive enrollment model as described in your proposal. You state in the proposal that:

> Certain SSI managed care elements, including enrollment policies, informed the design of Virtual PACE. Information from DHCAA staff and from advocates on the implementation of that program was helpful in understanding people's experiences during implementation of a managed care program. That model has successfully navigated an all-in/opt-out enrollment model by carefully balancing the business need for minimum enrollment levels with peoples' preferences.
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> The enrollment method proposed here attempts to reasonably balance these competing inputs.

We disagree with these statements because the proposed method does not differ from what was originally proposed, does not reflect a recognition of the desire for consumer choice expressed by

consumers and advocates, nor does it incorporate the enrollment process used in mandatory SSI managed care.

Our understanding from individuals who were at the last stakeholder advisory meeting is that CMS does not support the type of passive enrollment process you are describing either. Survival Coalition supports a voluntary enrollment process which would require an independent entity without financial conflicts of interest to provide enrollment counseling and an affirmative decision by the consumer to opt-in.

Continuity of Care: The proposal references continuity of care but does not describe what this will mean in the context of Virtual PACE. Survival Coalition believes that continuity of care requirements must be structured to first "do no harm". People with complex care needs have often spent a long time finding the right providers to address their needs and disruptions in these relationships and treatments can have significant negative impacts on the individual. There should be no short or long term interruptions in service, no service reductions or lost services until a thorough assessment is completed and the consumer has signed off on a care plan. The principles of person-centered planning, which the DHS endorses, require this.

Capitated Financing: We believe there remains an inherent conflict between capitated full-risk models and consumer choice. The capitated model in Family Care has led to numerous issues around provider contracting, especially with residential service providers. As a result many members have had to make numerous changes to housing, as well as other service options, against their preferences. These moves are incredibly disruptive to the member's well-being especially if they involve relocating to a different community. There have also been instances in Family Care of individuals being moved out of nursing facilities or residential arrangements without adequate community supports in the interest of saving money.

If DHS pursues a capitated model, the issue of payments to providers will be critical. It will be important to exercise more oversight in this area as suggested in the proposal:

> …it is the Department's expectation that provider payment arrangements under Virtual PACE do not disadvantage providers as compared to current systems; as such, some parameters for provider payments may be established in the ICO contract. DRAFT

An advantage of the capitated model is the ability to use "in lieu of" services. If DHS pursues a capitated model we encourage broad latitude around use of "in lieu of" services, but also to ensure that these reflect the consumer's preferences and are not simply a way for ICOs to reduce their costs.

Serving Persons with Disabilities: Given that 85% of the population is elderly we are concerned that resources might be directed to this population to the exclusion of the non-elderly population who have physical and developmental disabilities. While the proposal reflects person-centered planning and IDTs that are tailored to each member's needs, the contracts must provide strong direction on adequately serving these populations.

Mental Health Concerns: Because of its experiences in Family Care, the consumer and advocacy community remain vigilant about how mental health services are built into Virtual PACE. We appreciate the number of references to mental health this in the proposal. The proposal correctly notes that "…counties in Wisconsin invest a significant amount of funding into the provision of many mental health services, including some which are provided in institutional settings." The fact that many critical mental

health services are county-matched has been a challenge to truly integrating care in other managed care programs. Therefore we strongly recommend that DHS meet with county representatives to review how public sector mental health services will be incorporated into the program, how they will be managed, and how counties and ICOs can best collaborate and coordinate care. Responsibility for acute psychiatric emergencies and subsequent return of members to nursing facilities (NFs) following such care is an important issue to address because counties have often found themselves bearing the cost of this care and being unable to place members back into the NFs.

The proposal notes that with regard to individuals with Alzheimers:

> Concentrated resourcing in the area of age-related dementia, broad interdisciplinary expertise, and diligent preventive medical and psychiatric care have the potential to significantly reduce the risk of discharge or emergency detention petitions for these individuals. Care coordination and MOUs between the ICO and specialty facilities are two concrete opportunities to further improve care and reduce unnecessary transitions.

We support this plus note that challenging behaviors have also been an issue among individuals who are dually diagnosed with mental illness and developmental disability. IDT expertise should be constructed so that interventions can be addressed for this population as well.

We also recommend that the DLTC work closely with the Bureau of Prevention, Treatment and Recovery (BPTR) in the Division of Mental Health and Substance Abuse Services. BPTR staff have, in the past, done a thorough analysis of people with mental illness residing in NFs. They could help identify potential for transition to the community, needs that must be addressed for transition and needs of those remaining in NFs. They also have expertise in the area of challenging behaviors. DRAFT

Willing Partners: As noted earlier we appreciate the piloting proposed for the program. The draft proposal talks about working with “willing partners”. It is important that the willing partners not be limited to ICOs and providers but that they also include consumers, family members, and advocates who are willing to work on the local level to ensure the success of the program. Broad stakeholder involvement must be incorporated into the contracts with the ICOs and this must include specific and accountable mechanisms for engaging appropriate stakeholders, soliciting their input and responding to it.

Ongoing Stakeholder Involvement: We know that DHS intends to continue to utilize the stakeholder advisory committee. We appreciate the fact that the proposal has reflected the input of this committee and others. It will be important for stakeholders to continue to be involved as you flesh out the many details of the program such as the development of the certification requirements for the ICOs, member protections and quality measures.