Survival Coalition

of Wisconsin Disability Organizations

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March 7, 2016

Department of Health Services
Secretary Kitty Rhoades
Family Care and IRIS 2.0
P.O. Box 7851, Room 550
Madison, WI 53707-7851

Dear Secretary Rhoades:

Thank you for the opportunity to comment on the Department's draft Concept Plan for Long-Term Care redesign. Survival Coalition was pleased to see that there were elements of the Concept Plan that addressed some of the concerns advocates have raised. However, questions remain on aspects of the plan, and Survival Coalition welcomes the opportunity to discuss specific questions, concerns, and solutions with the Department. Family Care and IRIS are programs where the details are critical. It is understandable that this plan lacks some details as a concept plan—however, there are areas where more detail is needed even at the Concept Plan level. These decisions on the specifics will fundamentally influence the entire direction of Family Care as DHS writes a waiver, Family Care contract, Request for Proposal, and implements the redesign. Survival Coalition requests robust and continuing involvement of advocates in each step of the redesign process. Our public testimony focuses on identifying positive aspects of the plan, questions that the draft plan raises for advocates, and recommendations for revisions that we feel will add clarity to the final Concept Plan. Survival Coalition cannot respond to details that are not contained in the Concept Plan, and there are a number of advocate questions and concerns that are not raised specifically in these comments. We respectfully request an ongoing dialogue with the Department to continue to problem-solve and find solutions to persistent and emerging issues. We have organized our comments in correspondence to the headings outlined in the Concept Plan.

Sincerely,

Survival Co-Chairs:

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Executive Summary

Survival Coalition appreciates the clarity this section offers on the populations that will continue to be served by Family Care (older adults, people with physical disabilities, people with developmental disabilities; commitment to full self-direction, partial self-direction, and managed care options; defining a number of regions and competition among IHAs in each region; intent to conduct a RFP process; continued use of ADRCs; and continuing the open enrollment policy.

However, it is important to maintain clarity about terms and principles that distinguish Family Care and IRIS as long-term care programs. Current language in the Executive Summary Section does not accurately describe Self-Direction as advocates know the current program—the concept of an individual budget, choices on using that budget, and direction on how services and supports are used. In addition, the concept plan should reflect the Legislature's clear intent to develop a self-directed option that is essentially identical to the current IRIS program.

Similarly the terms self-determination and self-direction seem to be used interchangeably at times, and the description of Family Care member centered approach and interdisciplinary team differs from how advocate understand the current program to operate.

Recommendations

- Revise the description of Family Care (page 3, paragraph 1) to read: *"Family Care is based upon the principles of member-centered planning with an interdisciplinary term of professionals to assist in coordinating services and supports to meet the member's needs. The member is a partner in planning with this team and exercises choice related to needed health and long-term support services that are cost-effective."*

- Revise the description of IRIS (page 3, paragraph 1) to read: *"IRIS is based upon the principles of Self-Direction and determining the needed supports and services that remain within an Individual Budget. These decisions are made within the guidelines of Medicaid allowable supports and services to meet his or her long term care needs. The participant has the flexibility to design a cost-effective and personal plan."*

- Include clarification of the concept of an "Individual Budget," an idea for language is as follows: *"The budget is used to pay qualified providers and is not funding directly available to participant."*

- Include language that emphasizes Family Care a strategy to reduce high institutional costs, Language might include: *Family Care is a mechanism that has resulted in a statewide trend transitioning away from use of Medicaid funded institutional settings in exchange for keeping people in their homes and community. This shift away from institutional settings has resulted in cost savings, and this trend must continue.* Consider using language from the December 2013 report to the Joint Finance Committee on Family Care, Section B (page 9) and Section D (page 26).

- Include language that highlights the cost effectiveness of the current IRIS program. The ability for participants to continue to self-direct without interference from an IHA is critical to continue the cost savings achieved by the current IRIS program. In a May 27, 2015 budget paper to the

Legislature the Legislative Fiscal Bureau cited figures indicating IRIS participants were underspending their budget allocations by nearly 20%. (Page 16 - https://docs.legis.wisconsin.gov/misc/lfb/budget/2015_17_biennial_budget/300_budget_papers/356_health_services_long_term_care_changes.pdf)

Public and Stakeholder engagement

Survival Coalition and its members have provided public comments and have had discussions with DHS on topics related to Long-Term Care redesign. The Concept Plan reflects many recommendations advocates have made; advocates, families, and participants still have many questions and concerns.

Recommendations

- Include language to reference DHS 'specific plans for conducting ongoing engagement and dialogue with advocates, families, and participants in all steps of the Long Term Care redesign process (development of waiver, Family Care Contract, RFP).
- Include language to reference DHS ongoing engagement and dialogue with advocates, families, and participants at both the regional and state level throughout initial implementation and continuing as a part of ongoing program operations. We recommend a model that would at a minimum include 3 regional oversight boards correlated with IHA regions, and with majority membership of program participants and relevant advocacy organizations.

Guiding Principles Section

Survival Coalition appreciates the Department's emphasis on the right for people to live independently, the focus on community living, self-determination, and participant choice, and commitment to develop strong contractual obligations for vendors and rigorous oversight by DHS to assure contract compliance and program quality.

Questions:

- The Concept paper references building on key features and strengths of current Family Care/IRIS. What does DHS consider the key strengths for the current Family Care/IRIS programs (what are the features does DHS to preserve and build on)?
- The Concept paper references transparency and access to contracts, policies, and procedures. Will that transparency be extended to outcome measures, data reporting, and results?
- The Concept paper references an Ombudsman, but not an independent external Ombudsman. Does this mean the Ombudsman role is housed within the IHA or the Ombudsman would continue to function as externally contracted?

Recommendations

- Include language to underscore the value of family care providers.

    - The focus on natural supports is important, but this must be balanced with the recognition that most participants will have needs that will exceed what natural supports can address.

    - Without family care providers as part of the care workforce, participants care needs go unmet and this may result in higher costs.

    - Participants are eligible for LTC because they have a higher level of need that can be provided by natural supports; if the system is does not provide support and family care providers are no longer willing or able to provide supports, the public system will end up covering all costs for the participant.

- Include a bullet identifying the direct care workforce is an essential component of sustainability of redesigned Family Care. Family care providers are a significant part of the direct care workforce.

- Revise Ombudsman bullets (page 7 and 13) to clarify that the Ombudsman is independent and external often, the Ombudsman include all services, and is available for all participant populations for all ages. Wisconsin's existing Ombudsmen program is a model for the nation, Survival Coalition wishes to work with DHS to develop a model for external independent Ombudsman for different services).

- More specifically, we recommend the Concept Plan indicate the structure for an independent, external ombudsman will remain the same as outlined in current Wisconsin statute, and will include:

    - A prohibition on contracting with any entity that has a contract to provide long-term care services

    - Services to all actual or potential recipients of the family care benefit and the self-directed services option or to their families or guardians.

    - Provision of all services outlined in 16.009 (2) (p) 1. to 5.

- Strengthen the existing bullet on transparency and access extended to outcome measures, data reporting, and results. The current system has restricted access, considering some policies proprietary; DHS, advocates, and participants must have access to real time information.

Program Design Section

Survival Coalition appreciates DHS specifically identifying supported employment, transportation, and supportive home care in the list of services IHAs must provide.

Questions:

- For participants who are not dually eligible, is this population at risk of losing doctors, specific specialists if those folks are not included in a given IHA's network? In areas of care where the number of specialists is limited, will participants be able to access certain services/specialists regardless of whether they are in the IHA network? How will continuity of care be maintained?

- How does the “care team” referenced in this section interface with self-direction? What criteria does the care team have to meet to limit or override participant choices?

- Wisconsin counties have statutorily defined responsibilities for providing crisis care. How will IHAs and counties work together to develop crisis plans, and community based crisis response and diversion?

Recommendations

- Include language that clarifies whether participants will be able to access specialists out of network, especially for services where there is a limited number of qualified providers in the state.

- DHS’s press release portrayed self-direction as distinct; the Concept Plan seems to use self-determination in lieu of self-direction. Recommend adding a bullet specific to self-direction, and include the IRIS language suggested in the Executive Summary section

- Add a bullet specific to self-direction, recommended language “*IHAs are required to support both full and partial self direction and not interfere with allowable choices made by self-directing participants.*”

- Add a 3rd bullet specific to behavioral health services as part of program design. Recommended language “*IHAs should be required to contract with counties to provide access to community based mental health and substance abuse services, including CSP, CCS, and CRS.”*

- Add self-direction to the list in the 4th bullet.

- Include language that Certified Peer Specialists (CPS) are included as a long-term care benefit.

- We recommend that IHAs be required to establish protocols with counties on development of member involved/centered Crisis Plans for members with mental health and/or substance use disorder needs. We further recommend that DHS work with counties and IHAs to develop capacity for access to 24/7 Crisis Response Teams, and community based crisis placements.

Self-Direction

The Concept Plan still leaves unanswered questions that long-term care participants continue to ask, including whether participants will continue to experience self-direction in the same way they do now. , The Legislature directed the department to replicate IRIS in the new system, the proposal in the Concept Plan does not do that.

Full and partial self-direction must be a distinct experience from managed care, and we understand the legislature’s intent to maintain the ability to self-direct long-term care services the way members are able to do today through the IRIS Program. The Legislative Fiscal Bureau outlined in a May 2015 Budget paper significant differences between IRIS self-direction and partial self-direction under managed care. These distinction should remain throughout all aspects of the newly designed program (see pages 16-17:

https://docs.legis.wisconsin.gov/misc/lfb/budget/2015_17_biennial_budget/300_budget_papers/356_health_services_long_term_care_changes.pdf)

Questions & Concerns:

- Full employment authority is not discussed in the plan, although it was itemized in a previous DHS press release. Will self-directed participants be able to hire whomever they choose to provide services (regardless if they are with a provider agency or within and IHA's network)?

- Can family care providers still be hired and paid for doing Medicaid allowable services that are itemized in an individual IRIS budget?

- Can DHS clarify what budget authority means as it is referenced in the Concept Plan?

    - Does this mean full budget authority, where participants can choose which qualified providers they pay for Medicaid reimbursable services and how to allocate their allotted budget across services they receive as part of their care plan?

    - It is unclear how the self-direction budget will be calculated. Currently it is based on needs identified in the long term care functional screen and claims experience in IRIS. While that is not a perfect means of developing a budget, it is a tried and reasonably accurate system. We believe that system should be carried forward into Family Care/IRIS 2.0 and should be used by all IHAs. It is certainly preferable to allowing IHAs, which have had absolutely no experience with IRIS-type self-direction, inventing their own methodologies.

    - Will the self-directed budget reflect the total amount budgeted for self-directed services across the care plan? The Concept Plan says the budget will be based on "the services the member elects to self-direct." It is unclear if participants will be allocated budget for each specific service they self-direct. Survival Coalition maintains that allotting mini-budgets by service will jeopardize full self-direction.

        - The participant will not have one inclusive budget to direct at the services they prioritize. The current model of inclusive budget authority results in a more flexible, cost-effective decision-making on behalf of the participant as comparted to self-direction under managed care – to allow for choices of allowable, and less formal services that still meet the intended person-centered member goal (i.e. Weight Watchers with added social benefits instead of a clinical nutritionist).

    - The Concept Plan indicates the IHA will complete the assessment and work on a care plan before it sets the self-directed budget. Survival Coalition is concerned that an IHA is incentivized to develop an individual's plan based on billable spending categories rather than on the needs/goals of the person. There is great risk that an IHA will develop a budget to implement rather than a service plan that determines the budget. In addition, the ability for each IHA to establish their own process will create great inconsistency in the provision and quality of self-direction statewide.

- How does the proposal to have both an internal IHA IRIS Consulting Agency and an externally contracted IRIS Consulting agency comply with the CMS conflict-free case management rule (the IHA that sets the self-directed budget would also administers an internal ICA service that participants must use and for which the IHA would bill Medicaid). Currently an independent entity sets a participant's IRIS budget, and the ICA is independent of the MCOs.

- Why are all Behavioral Health services prohibited from being self-directed? Mental health advocates believe self-direction should be an option for behavioral health services

Recommendations

- Include assurances and a clearer definition for full employer authority, including the ability to pay caregivers not associated with provider agencies and family members, within the Concept Plan

- Include a bullet stating participants have full budget authority for LTC services that are included in the current benefit package and can be self-directed.

- Clarify that the self-direction budget will be calculated based on the needs identified in the person's long term care functional screen.

- Clarify that all IHAs will use the same long term care functional screen based budget calculation methodology.

- Clarify that people who choose self-direction will know what their total budget is before they begin deciding which services they want in their plan.

- Clarify that participants will be able to request budget adjustments and make exceptional expense requests when their initial budget is insufficient to meet all their long term care outcomes.

- Include a bullet allowing for self-direction of behavioral health services.

- Include a bullet assuring participants of due process and appeal rights as well as the ability to consult with an Independent external Ombudsman with questions, complaints, or cases.

- Include a bullet clarifying that participants have the right and the ability to consult with an ADRC at any time regarding choice of IHA, choice between managed care and self-direction, choices of services to self-direct, and choice between internal and external ICAs.

- Add "customized goods and services" to the Addendum 1 Benefit Chart. This is a service currently included in IRIS and should be included in the new system. "Customized goods and services" is a much broader service than counseling/therapeutic resources, and should not be considered a subservice of "counseling and therapeutic resources". "Customized goods and services" includes anything that is not already specifically covered by IRIS and is necessary to meet an individual's outcomes. By definition it isn't a subservice of any other category, and needs to be a stand-alone service just like it is in the current IRIS program.

Family Care Partnership

Questions

- Will participants in the 14 partnership counties have a choice between an IHA and Family Care Partnership?
- Does this impact actuarial soundness of regions?

Integrated Health Agencies

Survival Coalition appreciates and supports the use of an RFP process to solicit and evaluate potential IHAs.

Questions:

- The Concept Plan addresses IHA failure to meet contract obligations or an IHA withdrawing from a region. Some clarifying questions.
  - Does DHS have a continuity plan for the participants when an IHA has failed (are other IHAs required to take participants and expand their networks to accommodate?)
  - When/how/who determines when contract obligations have not been met, how long does that process take (will participants have lower quality care in some or all areas before an IHA is determined to have failed, or will DHS actively relocate participants into other IHAs)
  - Does DHS intend to always have three IHAs operating in a region, is there a plan to recruit or an RFP process that happens if an IHA leaves?
- How will readiness be measured? Will DHS/other entity do continued monitoring of network adequacy/provider capacity? Will there be and what will be the specific metrics used to determine readiness? Why does the IHA readiness review "seek to ensure that each IHA has appropriate systems capacity for member… enrollment and functional screen?
- What does "adequate" provider network and "adequate" staffing levels mean?

Recommendations

- Include language to ensure readiness assessments are conducted by an independent external assessor, not DHS
- Include a bullet that specifies a routine and ongoing assessment process for network adequacy and staffing levels; this is not a one-time function conducted only to assess initial readiness. Network adequacy and staffing level needs may change depending on the number of people enrolled in the program, whether providers are accepting new Medicaid participants, and lack of provider capacity in certain service categories or geographical areas.

- Include a bullet to assess provider capacity and workforce shortages, and require development/implementation of plans to increase provider capacity and improve provider quality.

- Include a bullet specific to assessing the readiness of IHAs to implement full and partial self-direction.

- Clarify the IHA's role in member enrollment and functional screen as it pertains to IHA readiness.

- Include a bullet specific to ensuring IHAs have adequate cultural competence to serve a diverse pool of participants.

- Specify that IHA readiness must include specifics on the IHA's ability to address the unique needs of each of the three target populations.

Family Care 2.0 Regions

Questions

- Will IHAs and regions be equally ready and prepared to serve all target populations?

- Which existing Family Care regions will be merged together? What are the borders of the new regions?

- Will regional boundaries respect the boundaries of the emerging CCS regions?

Recommendations

- Include specific language on IHAs being required to work with all counties providing behavioral health services in the regions they serve, to ensure members have access to county administered behavioral health services, if desired and eligible.

Continuous Open Enrollment

Survival Coalition appreciates the content of this section.

ADRCs

Survival Coalition is pleased to see the ADRC's continuing role in the functional screen, enrollment counseling, that ADRC's will be using provider network information and quality outcomes data when presenting options to participants, and all other functions enumerated in the section. The key to the success of ADRCs is their "local" presence and knowledge of and relationship with the community.

Questions

- Will ADRCs continue to do all other functions that are enumerated in their current contract (including disenrollment counseling)?

- Can DHS clarify how ADRCs will serve enrolled members?
- Clarify Benefit Specialists that covers people with disabilities of all ages continue as an ADRC function, and that they will be available statewide?
- Will ADRCs maintain their local presence and operation?

Recommendations

- Clarify that ADRCs should assist participants in whether they are interested in self directing (full or partial) services first; self-direction may make a difference on IHA choice.
- Recommend that, in addition to long term care options counselling, ADRCs will continue to provide a wide range of information and assistance including Disability Benefits Counselling, consultation and assistance with Resident Relocations, counseling to caregivers, and services to people with dementia and their families.

Payments to IHAs

Survival Coalition appreciates reference to actuarially sound rates, connection of rate setting to incentivizing high-quality cost-effective care, reference to pay for performance requirements and alignment with outcomes for members, and the statement that the payment model is intended to encourage IHAs to invest in HCBS services and prevent or avoid use of more costly services.

Questions:

- We are interested in more detail on which services will have pay for performance outcome requirements, and what pay for performance payment incentive program will look like?
- Will there be caps on administrative costs and profits as there are in the current system?
- What happens if IHAs do not pay providers well, or on time? Will there be penalties to the IHA?
- What specific pay for performance metrics and outcomes is DHS considering and on which services? We welcome the opportunity to work with DHS to develop specific pay for performance metrics and outcomes.
- How will the “county share” for behavioral health services be incorporated into the capitation rate, and how will IHAs and county’s deal with authorization for CCS, CSP, and CRS services?

Recommendations

- Insert a bullet to clearly articulate that the payment system will include disincentives to institutionalization, incentives to return institutionalized persons to the community, and pay for performance measures to ensure high cost people are served in the community.
- Insert a bullet detailing how DHS plans to limit IHA administrative costs and ensure that profits are modest and are not an incentivized above quality and participant needs.

- Profits above a certain amount should be returned or required to be invested in quality improvement initiatives.

- Insert a bullet addressing the need for IHAS to work with counties to ensure access to county administered behavioral health services, including how the "county share" will be incorporated in the capitation rate.

Quality Measures

Survival Coalition appreciates DHS's use of HEDIS and NCI, reporting of institutional admissions and relocations, and DHS-conducted audits of direct service providers, reference to DHS oversight of IHAs, and quality reviews conducted by an external quality review organization.

Survival Coalition believes there are many additional data elements that are necessary to collect for a robust evaluation of the system's performance. Survival Coalition requests discussion of specific and additional metrics for IHAs to report that contribute to the assessment of outcomes and performance. Survival Coalition also wishes to discuss the development of an IHA scorecard that will provide accessible quality information to help participants make choices between IHAs.

Questions:

- Will the Ombudsman referenced be for all or certain service types, and is this Ombudsman independent from the IHA?

- Clarification requested on what an accreditation incentive program that may include substitution of accreditation for certain contract requirements means, and what such a program would look like. What specifically would credentialing look like for different types of long-term care services?

- The Concept Plan does not reference benchmarking. Will benchmarks be established to evaluate outcomes and progress over time, and to be able to better compare between IHAs?

- Will financial incentives and disincentives associated with quality measures be tied to not only individual outcomes, but a continuous improvement process that meets and exceeds benchmarks?

- How will quality data be used? What happens if the quality measures are not indicative of progress or acceptable outcomes? Is there a remediation or quality improvement process that DHS initiates? How low must quality for a given service or overall quality be before a remediation process is triggered? Is there a threshold where DHS may withhold payment or terminate a contract?

- Are the mechanisms for members to file appeals or grievances internal or external to the IHA?

- Will consumer outcomes be limited to the HEDIS?

Recommendations

- Require IHAs to have capacity building initiatives to address identified shortages of providers for certain services or workforce shortages, and to improve provider quality.
- Require IHAs to identify at least two process and quality improvement projects per year, that are aligned with DHS goals.
- Insert language on establishing benchmarks, continuous quality improvement, and a remediation process to address low performing IHAs or providers.
- Require IHAs to monitor adverse events (falls, UTIs) and monitor trends in things that could become serious if not addressed early. Some events may require immediate reports to DHS, others in a quarterly summary.
- Insert a bullet to include advocates in the development of additional quality measures, outcomes, benchmarks, and development of a scorecard.

Contracting with Any Willing Provider

Consistent with Act 55, Survival Coalition appreciates DHS ensuring the "any willing provider" clause will remain in effect for at least three years. We hope the Department will evaluate provider capacity and quality of providers before making a decision that could reduce the diversity of a provider network

Question:

- To clarify, does the language requiring providers meet all guidelines established by the IHA related to the quality of care mean that the IHA is responsible for ensuring that its subcontracting providers are producing the quality metrics and outcomes that are required for IHAs under a Family Care contract?

Tribal waiver

Recommendations

- Include assurance that DHS will continue to work on the separate Tribally-operated waiver.

Next Steps:

Questions:

- Where in the timeline is the development of the Family Care Contract? Can advocates be involved in the Development of the Family Care contract?
- The Concept Plan does not address what role advocates will play in the RFP process.
- How do you move this forward without losing existing expertise of MCOs, ICAs, and quality providers

- Can the Concept Plan provide further details on the timeline for this process?
- How do stakeholders continue to be involved in each step of the process?

Recommendations

- Identify a role for advocates, participants, and families in each of these next steps (waiver development, contract development, RFP development, etc.).
- Add a bullet specifying external advocates will be involved in reviewing RFPs