INDEPENDENT CARE HEALTH PLAN

April 5th, 2013

Deborah Rathermel
Virtual PACE Project Director
Division of Long Term Care, Department of Health Services
1 West Wilson Street, Room 550
Madison, WI 53703-3445

Dear Ms. Rathermel:

The purpose of this letter is to express our appreciation for the opportunity to comment and provide input into the proposed Wisconsin MOU draft. We applaud both DHS and CMS for their efforts to alleviate fragmentation, improve care coordination, enhance care quality and reduce costs. Independent Care Health Plan (*i*Care) supports these outcomes, along with the regulatory streamlining that underscores this demonstration program.

Following are comments on the draft MOU:

1. Medicare Part D (page 4 Section II.): The MOU notes that submission of a successful Medicare Part D application to CMS is a prerequisite for plan participation in a three-way contract. While *i*Care has operated a Part D program since 2007, it is unclear how CMS will structure the application, bid and contracting requirements for a Virtual PACE Part D plan.

2. Enrollment and Disenrollment (page 8 Section 2): There is some concern that the rate setting process will rely on encounter claims only rather than also including assessment information that documents condition intensities. Equally, such consideration of condition intensities will be needed to adjust rates to avoid adverse selection, compounded problematically by what promises to be a relatively small enrollment susceptible to catastrophic cost swings.

3. Continuity of Care (page 10 Section III. E. 2.): This section specifies that plans must contact non-network providers on an ongoing basis with information on becoming credentialed in-network providers. While *i*Care values the principles underlying this requirement (offering consumers their provider of choice), additional clarity on the extent, scope and frequency of this ongoing effort is needed to ensure adequate staffing.

4. Participating Plan Risk Arrangements (page 10 section III. D. 2.): Does the statement that "any payment...that serves to withhold, limit, or reduce...services" imply that plans will not be able to capitate providers? Does it limit an ICO's ability to share savings with nursing homes? Clarification will be useful to *i*Care.

INDEPENDENT CARE HEALTH PLAN
1555 N. RiverCenter Dr. Suite 206
Milwaukee, WI 53212
Tel 414-223-4847 Fax 414-231-1092
www.icare-wi.org

5. Beneficiary Participation on Governing and Advisory Boards (page 13 Section E. 7.) The last sentence implies not only an advisory committee role for consumers, but also demonstration of additional consumer participation within the governance structure. Clarification is needed regarding the scope and nature of the additional participation required.

6. Consolidated Reporting Requirements (page 17 Section G. 3.): While the goal of consolidating Medicare and Medicaid reporting requirements bodes well for administrative efficiency, it would be helpful to understand if there are reporting requirements above and beyond those outlined in Appendix 7.

7. Quality Management and Monitoring (page 17 Section H.1.): Will measurement criteria be entirely new, or will existing measurements be adapted for Virtual PACE? If the latter, will DHS or CMS provide measurement data for the demonstration population prior to the introduction of Virtual Pace?

8. Financing and Payment (page 18 Section I): Accepting that encounter data and rate coordination are still under discussion, adequate funding of the ICO contribution continues to be a concern. Current allocation is 3%. This rate seems insufficient in light of the enhancements expected from the program. This allocation does not seem to take into consideration the quality withhold (1% Yr1, 2% Yr2, 3% Yr3). The allocation does not seem to take into consideration the excise tax which may be as high as 1.5% of premium. The ICO could be faced with the prospect in Yr3 of operating with a negative allowance. Is it presumed that the entire allowance will be withheld during Yr3 with the ICO paying, additionally, an excise tax of 1.5% of premium as a condition to participate?

9. Monitoring and Evaluation (page 18 Section J. 2.): What methodology will be used to define the sub-populations measured under this section?

10. Enrollment and Disenrollment Processes (page 43 Section III. b.): While the detailed description of the interChange and MARx submission process is helpful, further clarity regarding Part D enrollment transactions is needed. Will DHS or its vendor utilize MARx to submit Part D enrollment transactions? If so, page 71 lists a Part D Enrollment Timeliness measure that will not apply to ICOs. If ICOs are to submit Part D enrollment transactions utilizing MARx, DHS must supply enrollment files to ICOs with sufficient lead time to meet this standard.

11. Uniform Enrollment and Disenrollment Letter and Forms (page 43 Section III. c.): As an existing contractor to CMS, DLTC and DHCAA, *i*Care is familiar with the range of enrollment correspondence issued under Medicare, Medicaid and integrated programs. Efforts to create a single set of uniform notices are applauded. It appears from the MOU language that DHS will issue this correspondence to consumers; not the ICO. Clarification is appreciated.

12. Assessments for Nursing Home Residents (page 45 Section IV. a. iii. 1.): This section states that any assessments by the ICO can only supplement, but not duplicate or replace the MDS assessment. While this may prove to be the best workflow, it seems that this is too prescriptive for a demonstration that seeks to eliminate duplicate efforts and improve efficiency.

13. OCI Financial Review (page 48 Section IV. c. ii. 1. b.): To avoid duplication, please consider that existing filings made by insurers to the OCI should be sufficient to confirm solvency.

14. Culturally Competent Providers Including Indian Health Care Providers (page 48 Section IV. b.): This provision likely refers to inclusion of providers of the U.S. Department of Health and Human Services Indian Health Service agency. It could also be interpreted to require inclusion of providers of Native American descent employed by other health providers. Clarification will be appreciated.

15. Credentialing (Pg. 50 Section IV. d. 9. ii. f.): This section refers to use of indicators related to quality and clinical outcomes during credentialing processes. Greater specificity regarding the use of these indicators to credential providers is requested.

16. Prescription Drugs (Section VII., page 56): Does DHS anticipate that Medicaid-covered drugs will deviate from coverage currently offered under the Family Care Partnership program? Under Family Care Partnership, DHS requests Part B rebates; will this also be the process for Virtual Pace? Clarification of this item is requested.

17. Appeals (Pages 57 – 59): Efforts to integrate overlapping Medicare and Medicaid appeals processes are welcomed and will lead to greater efficiencies. Once integrated as described in the MOU, however, further efficiencies may be available.

    a. (Section IX. a. ii.) For example, the MOU describes four appeal levels: (1) the ICO; (2) the independent external entity; (3) the Fair Hearing; and (4) Medicare Advisory Council and/or Court. The MOU further allows consumers a choice to pursue the Fair Hearing either, instead of, or concurrently with internal or external appeals. Consumers may also choose to pursue a standard Medicaid or Medicare managed care appeal as an alternative. A separate and distinct Part D appeals process will also be available to consumers. While beneficiary protection is paramount, the multiple levels may be confuse consumers, and fall short of administrative streamlining goals.

    b. (Section IX. a. iii.) The ability to choose a Fair Hearing concurrently with an internal appeal creates additional complications. A streamlined, simplified process will appreciate the logic of exhausting appeal rights at the plan level before pursuing a Fair Hearing. It is possible that an ICO could reverse its initial decision at the

Grievance stage, eliminating member need to pursue a lengthier more complicated Fair Hearing process.

c. The appeal section does not permit an extension of the appeal decision timeframe as allowed under both Medicare and Medicaid.

d. (Section IX. a. iv.) The allowance to continue benefits pending an appeal implies that benefits must be continued during an appeal. If the language stated that the member may request continuation of benefits, as required in Medicaid, it empowers the member to make their own health care decisions. It would also reduce situations whereby costs are incurred for which the consumer may be liable. Section (a)(iv)(3) on page 59 states that the ICO may seek to recover costs incurred for services provided while an appeal is pending if the appeal is decided in favor of the ICO.

18. Data System Specifications (page 68 Section XI. g.): The value of electronic integration, interconnectivity and/or interoperability is clear and exciting. So far as this architecture may require ICO and/or participating nursing home adjustments and upgrades, does the MOU properly anticipate the need of upfront investments? It would be helpful if the need for this kind of support, along with other start-up costs, were recognized and included in the plan.

19. Core Quality Measures (pages 69 – 78 Figure 7.1): While the quality measures chosen are familiar from a Medicare and Medicaid perspective, *i*Care recommends that DHS also consider performance standards appropriate for end of life care. For example, the primary domains of care under the CMS Hospice Quality Reporting program may be more relevant for some Virtual PACE participants than those listed in Figure 7:1. Additionally, the list of quality measures for which a withhold will occur may be overly aggressive and not in line with the MOUs offered by other States. CMS approved MOUs for States already participating in the national demonstration appear to allow an abbreviated list of measures, reducing the performance risk. Is it presumed that the entire allowance will be withheld during Yr3?

20. Quality Measurement Refinement and Updates (last paragraph, page 78): Will ICO performance be measured against pre-determined benchmarks, or will benchmarks be established early in the demonstration, with improvement targets set in subsequent years? Will measures that are readily exceeded be eliminated and replaced with different and more challenging measures? Please clarify the degree of measurement domain stability.

While these items represent questions, concerns or recommendations from *i*Care's perspective, a number of MOU provisions represent substantial improvements to the status quo, and will further the systems change envisioned by the demonstration. Examples include:

1. Page 15 – creation of a single, joint CMS-State Contract Management team, which will create efficiencies for all parties involved.

2. Pages 46 and 51 – viewing providers from a holistic standpoint, regardless of whether a service is considered a Medicare or Medicaid benefit. This streamlines program administration when benefits overlap between programs, and will improve consumer choice and satisfaction for dually-eligible beneficiaries.

3. Page 47 – accommodating the unique needs of nursing home residents in light of traditional regulatory standards pertaining to travel time from provider locations.

4. Page 63 – simplification of the ANOC in the event that benefits do not change.

As we have expressed previously, we are concerned with rate adequacy for a program that has the potential for significant contribution to continue Wisconsin's tradition of long term care reform. There is concern, of course, whether new definitions of "medical necessity" and other changing requirements will be correctly supported by reliance on historical encounters and trends. Evidence suggests that Medicaid nursing home rates are already below costs, suggesting that Medicaid is benefiting from a substantial savings policy already. Whether further Medicaid savings in such an environment is even possible seems to be a reasonable concern. These custodial levels of care may need to be increased to avoid acute episodes that are covered by Medicare. We do not doubt that further Medicare savings is possible through the reduction of transfers. These reductions can be achieved through a host of known strategies, including upgrading nursing home critical-care capability, strengthening network response available to both residents and nursing homes, and others. Nursing homes appear, at the same time, to rely on Medicare reimbursement to off-set shortfalls in Medicaid payments. Medicare savings could further deplete their resources. In the midst of these changes, there is some question about whether the ICO administrative allowance can provide sufficient value-add support to accomplish these changes. These parameters are the challenges caused by the principle: improve quality at lower cost.

Virtual PACE has the potential to support a transition to a new model of care for nursing homes. This new model would include the ability to provide home and community based services in addition to facility services. The new model might include the ability of nursing homes to function as medical homes for long term care. Even if Virtual PACE does not result in payment gains, it could result in re-setting a business model to better respond to a relentless growth in demand for all types of long term care over the next twenty-five years. It would be mistake to think of Virtual PACE as a pocket of reform within a segment of the nursing home. Changes resulting from Virtual PACE, should a nursing home chose to participate, should impact all residents to avoid the situation where the participating home is required to operate with still another set of new rules, new requirements, new practices. Virtual PACE should contribute to the need for simplification and not further contribute to complexities whether in the lives of members or in the operations of participating facilities.

From this more global standpoint, and beyond the specific wording and requirements of the MOU, *i*Care invites a shared vision of the Virtual PACE demonstration to incorporate a broader but related set of activities that include, among others, the following:

- Encourage nursing homes to become medical homes for frail-aged citizens.
- Encourage development of day activity centers for an integrated community.
- Encourage vent providers to also develop in-house dialysis capacity.
- Accelerate certification of nursing homes as home health agency providers.
- Allow nursing homes to be certified as hospice facilities at Medicare fee schedule.
- Add a nursing home consumer benefit to improve mobility, self-care or socialization.
- Develop an "acute-RUGs" rate for acute-episode care within the nursing home.
- Transfer pharmacy from Part A RUGs to Part D stabilizing nursing home pharmacy costs.
- Introduce multiple reimbursement levels to the current vent program for expansion.
- Eliminate bad debt from unpaid co-payments following day 20.
- Eliminate occupancy penalty on Medicaid rates resulting from relocations.
- Offer a P4P program based on new funds rather than redistribution of existing funds.
- Increase Internet-based patient connectivity with family members.
- Accept the Medicare cost report with supplemental schedules as Medicaid report.
- Survey high-performing homes every 3 years, more often for low-performing homes.
- Establish standards for 3rd party assessment of patient relocation candidacy.
- Configure ICO assessments and plans to current nursing home forms.
- Modify the standard and process for anomalous incident reporting.
- Integrate and simplify regulatory environment with the duals demo initiative.
- Develop a "0%-Interest" investment fund for expansion of nursing home infrastructure.
- Incentivize nursing homes to upgrade acute care and condition-stabilizing equipment.
- Incentivize nursing homes to provide home and community based waiver services.
- Restore a portion of the NH assessment to NHs to facilitate business model transitions.
- Introduce statutory zoning reform statewide allowing expanded community living.

We appreciate this opportunity to comment on the future of Wisconsin's Virtual PACE demonstration. We look forward to continuing collaboration to make this vision for integration successful.

Sincerely,

Thomas Lutzow, PhD, MBA
President and CEO
Independent Care Health Plan

Cc: iCare Board of Directors
iCare Officers