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TO: Karen E. Kimsey, MSW
Virginia Department of Medical Assistance Services (DMAS)
DSRIP@dmas.virginia.gov

FROM: Heidi L. Lawyer

RE: DSRIP Concept Paper Comments

I am writing on behalf of the Virginia Board for People with Disabilities (the Board) to comment on the Virginia Medicaid Delivery System Reform Incentive Program (DSRIP) Concept Paper titled *Accelerating Delivery System Transformation in Virginia's Medicaid Program*. The Board appreciates DMAS's efforts to transform Medicaid in Virginia into a system that encourages and rewards high value acute and long-term care, increases community capacity, improves provider expertise, and ensures person-centered, community-based care. We agree that provider reimbursement based on utilization is not effective and, in fact, can incentivize unnecessary care, as opposed to preventive care and supports. We would like to work with DMAS as the DSRIP plan is developed and ultimately implemented. We are interested in participating in any of the stakeholder workgroups going forward. In particular, we would welcome the opportunity to participate in those related to workforce development and training, housing, employment, and care transitions/diversions from institutional care.

While we provide comments on specific elements of the DSRIP Concept Paper below, the Board feels compelled to offer words of caution about the DSRIP plan in general at the outset: Medicaid is currently undergoing significant changes in Virginia, from Medicaid Waiver

redesign and transition to managed care to implementation of the DOJ Settlement agreement. While the DSRIP plan covers a broader population than most of these changes, there is significant potential for overlap between these initiatives. It has been noted elsewhere, for instance, that the goals and strategies of managed care and integrated care overlap. This could present significant problems for Virginia in determining value-based reimbursement schemes, because it could become very difficult to disentangle the various changes to determine which change an improved outcome ought to be ascribed. The Board encourages DMAS to consider very carefully how DSRIP fits into the broader picture of Medicaid reform in Virginia, and if it can reasonably be accomplished along with all of the other ongoing changes. The Board further encourages DMAS to consider a phase-in approach to DSRIP implementation, where DSRIP initiatives could be piloted in specific localities to ensure their workability prior to expanding to statewide implementation.

The Board believes that any change to Virginia's system of Medicaid services should ensure that people with disabilities have access to person-centered services and supports that are delivered in the most integrated setting appropriate to their needs and in a manner that allows for maximum consumer choice and control, and which are available to all people with disabilities regardless of where they live. In light of these goals, the Board offers the following comments on specific elements of the DSRIP Concept Paper. Per the instructions provided in the Concept Paper, comments are organized according to the numerical references within the Paper itself.

3.1.1 Team-based, Integrated Behavioral Health and Primary Care

The Board supports DMAS's goal of making holistic, person-centered, community-based care the standard practice for Virginia's Medicaid enrollees. However, the Board urges DMAS to ensure meaningful consumer choice can coexist with integrated care models. The Board strongly believes that individual choice and control should be guiding principles in the design of Virginia's Medicaid system. The Board encourages DMAS, therefore, to ensure that behavioral health and medical care integration is not achieved at the expense of meaningful consumer choice and meaningful consumer control over one's own medical and behavioral healthcare, and one's choice of providers.

The Board notes that the integration of behavioral health and primary care requires specialized knowledge of both of these systems, and must be driven by people who possess this unique expertise. The Board encourages DMAS, therefore, to identify entities that are already engaged in the delivery of integrated care, such as an effective Person-Centered Medical Home,

and tap into the expertise of these providers to drive the expansion of this model. This expansion will likely require a gradualist approach, because the amount of training and internal systems change necessary to carry it out will be extensive.

3.1.2 Mobile Care Teams

The Board supports the multiplication of mobile care teams, particularly in rural settings where a lack of providers and limited transportation options are barriers to accessing medical and behavioral healthcare. These teams should be provided specialized training in the unique needs of individuals with significant disabilities that prevent them from traveling to a medical facility. The Board encourages DMAS to focus its investments in mobile care teams to areas with known shortages of healthcare providers and limited transportation options for people with mobility-related disabilities.

3.1.3 Care Transitions and Diversions from Institutional Care

The Board strongly supports DMAS's efforts to increase successful transitions from institutional to community settings. The provision of care in the most integrated setting appropriate to an individual's needs should be a foundational principle underlying the delivery of services to people with disabilities. The Board strongly supports, therefore, use of evidence-based practices, such as the Coleman Model, to avoid unnecessary institutionalization of individuals with complex medical and behavioral health needs and to facilitate successful transitions from institutional to community settings.

3.1.4 Addressing Super-Utilizers

The Board supports the implementation of protocols that increase access to primary care and care coordination by those who frequently use emergency department services. The Board urges DMAS to encourage creative solutions by providers that address the root causes of super-utilization of emergency services. Such causes are varied and may include serious illness, lack of access to primary care, poverty, or unmet behavioral health needs. The Board encourages DMAS to ensure that efforts aimed at curbing super-utilization of emergency medical services align with the values of person-centered care and maximum consumer choice and control.

3.2 Transformation step #2: Build a Data Platform for Integration and Usability

The Board encouraged DMAS to focus significant efforts on developing effective data systems early in the DSRIP Waiver period. Data collection and data sharing will be central to the successful implementation of the DSRIP Concept. Value-based payment systems rely upon reliable data that allows benchmark and peer-to-peer comparisons. Additionally, efficient provider collaboration requires the capacity for providers to share necessary information in real time. Other states who have been awarded DSRIP grants have struggled with decentralized approaches to data collection. California, for instance, ultimately settled on using the national Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as a tool for comparing care systems. The Board recommends that DMAS consider whether an existing data platform, such as CAHPS, could be adopted to ensure uniformity and compatibility of data collected.

3.3 Transformation Step #3: Build Community Capacity

The Board supports DMAS's community capacity building strategies. We especially applaud DMAS's inclusion of housing and employment as critical elements of its capacity building plan. The Board encourages DMAS to go further than its capacity building plan by including integrated, competitive employment outcomes for individuals with significant disabilities within its value-based payment metrics for Long Term Services and Supports (LTSS) (discussed further below). Additionally, the Board strongly urges DMAS to add transportation as an additional element of its capacity building plan.

Transportation is vital to living a healthy and fulfilling life in the community. Reliable transportation is essential to maintain housing, access healthcare services, and shop for healthy groceries. Yet, people with disabilities too often lack reliable means of transportation. DMAS should, therefore, include transportation among its community capacity building objectives. Specifically, DMAS should incentivize and facilitate coordinated community development that links housing, transportation and services. Additionally, DMAS should facilitate local transportation planning that includes consideration of the transportation needs of people with disabilities.

3.3.3 Telehealth

The Board commends DMAS's efforts to expand access to healthcare, especially preventative and behavioral healthcare, for people with disabilities, including through expansion of the delivery of these services via telecommunication technologies (telehealth). While the advantages and disadvantages of telehealth have been explored in a number of contexts in recent years, it is worth noting that the use of telecommunication technologies for the delivery of behavioral healthcare is a fairly new phenomenon, the risks, benefits, and limitations of which are still being explored. The Board, therefore, encourages DMAS to ensure that as it promotes the use of telehealth to deliver behavioral health services to people with disabilities, it does so in a way that is supported by research and in accordance with best practices.

The Board also encourages DMAS to collaborate with relevant regulatory boards, such as the Virginia Board of Psychology, and the Virginia Board of Counseling as it plans its behavioral telehealth promotion activities. Current regulatory guidance on the appropriate use of telehealth by behavioral health providers is either nonexistent (Board of Psychology),[1] or very restrictive (Board of Counseling).[2] This current lack of regulatory clarity is a disincentive to provider participation in behavioral telehealth. Any telehealth capacity building strategy should, therefore, include clarification of and education about the regulatory and ethical issues involved in its use.

3.4.1 Initial Payment Strategies

The Board encourages DMAS to include quality-of-care outcomes among its value-based care metrics. Quality-of-care metrics would include, for example, competitive, integrated employment outcomes for people with significant disabilities, successful transitions from institutional settings to community settings, and consumer satisfaction/consumer experience metrics. The Board supports DMAS's efforts to move Virginia towards a system where providers are reimbursed for high *quality* care rather than for high *quantities* of care. The Board also supports DMAS's gradual approach to moving towards a value-based payment system. The Concept Paper indicates that DMAS will "include initial value-based payment standards in its upcoming MLTSS program," in its efforts to begin to work with providers to ensure that policies

[1] Some have contended however that the Virginia Board of Psychology would defer to Virginia Board of Counseling guidance on the issue (e.g. Baker 2010).
[2] Virginia Board of Counseling Guidance Document: 115-1.4, *Guidance on Technology-Assisted Counseling and Technology-Assisted Supervision*, 2008.

are developed for successful implementation of the value-based purchasing program. The Concept Paper does not indicate what these initial value-based payment standards will include, but it does identify cost-reduction goals of the DSRIP plan, such as reduction of emergency medical care utilization, and reduction of re-admissions. The Board encourages DMAS to ensure that quality-of-care is prioritized over simple cost reduction by establishing quality metrics.

Given the importance of metrics to a successful value-based payment scheme, the Board encourages DMAS to carefully plan this element of the DSRIP project. Specifically, the Board encourages DMAS to convene workgroups to develop proposed outcome metrics. As a starting point, however, the Board believes that value-based repayment metrics should be developed for multiple levels of healthcare outcomes, including individual outcomes, program level outcomes, provider outcomes, and systems level outcomes. Additionally, DSRIP metrics should reflect the ultimate goals of the services being provided. In the case of LTSS, these goals ought to include the provision of high quality services that promote independence, delivered in the most integrated setting appropriate to the individual's needs and in accordance with person-centered principles. The Board, therefore, strongly urges DMAS to include metrics that measure providers' success in achieving these goals in its initial value-based repayment standards. At a minimum, such standards should incentivize successful transitions from institutional to community settings, successful attainment of integrated, competitive employment, and delivery of services in a manner consistent with the individual's preferences and goals.

Thank you for this opportunity to comment on the DSRIP Concept Paper. The Board would very much appreciate additional opportunities to participate in future discussions about these initiatives, as well as to be included in any workgroups convened to plan and/or monitor the development and implementation of the DSRIP plan.