

Virginia Department of  
Medical Assistance Services

Compiled Public Comment  
Submission  
Managed Long-Term  
Services and Supports

Comment Period  
05/18/15 – 06/16/15

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## Advocate

I am an advocate for people with disabilities, i go out and talk to local legislators about trying to improve things for people with disabilities. I would like to see the MLTSS program help in having more slots for the waivers, they need to have more funding so that clients are able to participate in day support programs as appropriate. I also encourage DMAS, when they discuss all of the waivers, to think about how much they can better someones life, also needing to get the waivers to provide better transportation. Individuals in the MLTSS program need to be entitled to all services. They should be able to make decisions for themselves rather than having someone like case managers make decisions for them. The program needs to make sure every individual has a good team working together. The case managers need to provide the clients with all of the sources and leave it up to the client to choose after they make sure everyone understands what the choices do and their rights and responsibilities. Most importantly, the MLTSS program should make sure the case managers have a good relationship with clients. When someone is trying to develop a plan for an individual they need to look at the persons diagnosis, all medications, any required medical equipment, what the client wants and the services they can provide the client. I believe the MLTSS program would be more attractive to individuals if they offered lots more services, had more waiver slots, and had more opportunities for people to do things. Providers may be more attracted to the program if the authorizations were easier to get, the paperwork was simpler, and and the billing and payment process was easy. The simpler the process the quicker clients get services. DMAS should handle the F/EA by providing more options for the clients. Everything should be flexible because each individual is different and has a different situation. My recommendations for health plan requirements are making sure that most prescription drugs are covered by insurance. Medicare need to have a special needs plan because right now, as far as I know, people with special needs mainly rely on Medicaid. I believe Medicaid needs to completely change in making sure people get the medical equipment that they require to function in a decent amount of time instead of making everyone wait for months to get something fixed. Medicaid needs to start being open to more people, their plans also need to cover Dental because after a person becomes an adult they do not have dental insurance and usually can not afford to see the dentist. Medicaid also needs to change their requirements so that people can at least choose between Medicare and Medicaid. Quality of accountability and transparency should focus on the peoples needs, If people aren't getting what they need someone has to be held accountable. They should require someone to be in charge so that if something "falls through the cracks" you know who to hold accountable for things not being accomplished as should be. Making sure everyone knows what opportunities are available and making sure the funding is available for services to individuals is the most effective strategy for engaging providers and individuals in outreach and education efforts. Lastly, the most important message that individuals and providers need to hear is this program starts providing services faster than others and will be more sufficient for people and their one on one needs.

Sincerely,

██████████ Graduate of Partners In Policymaking 2013

**Advocate  
Organization**

Virginia Poverty Law Center  
Managed Long Term Services and Supports (MLTSS)  
Public Comment  
June 2015

**General:**

***Top Three Significant Features of an MLTSS program:***

- **Increased supports and services** for individuals to include services currently available to those in the EDCD waiver. It is important that individuals receive the supports and services they need early on rather than having to experience physical deterioration before they “qualify” for additional services. Additional services such as environmental modifications, assistive technology, vision and hearing exams and devices, dental care can help people remain independent in their homes and can ultimately save costs.
- **Care coordination** has been a significant added value in Commonwealth Coordinated Care and should be a part of any expansion of managed care. Care coordinators must be adequately trained and aware of the full range of services available in the community and through the plans. They must have a person-centered approach to care coordination and should see their role as not merely coordinating medical care, but also as helping the individual with any non-medical issues which impact the individual’s quality of life.
- **A clear and independent appeals and complaint process** must be available to ensure that beneficiaries receive the care they need in a timely and person-centered manner. The appeal process should include benefits continued pending the appeal, clearly drafted notices and appeal rights, and the availability of a neutral party such as the CCC ombudsmen to assist with appeals.

**Beneficiary Experience:**

*Essential protections for individuals in an MLTSS program and most significant features in assisting individuals to transition between providers and treatment settings:*

- **Continuity of care provisions.** Ensure strong networks so that most beneficiaries are able to continue with their current providers. Where that

is not possible, the program must ensure that the individual's services are not interrupted by allowing the current provider to continue to provide care for 6 months or longer while the beneficiary can evaluate and change providers if necessary. Education of the providers and beneficiaries is also critical so that providers know that their services will be covered during the transition period even if they are not in the plan's network.

- **A clear and independent appeals process (see above).**
- A well-publicized and adequately funded **ombudsman** program is key to assist beneficiaries who have difficulty accessing appropriate care, who are having difficulty moving from one treatment setting to another, or who otherwise need assistance in navigating the managed care system and in advocating for their rights.

***Considerations in developing person-centered needs assessments, service planning and care coordination:***

The phase in of this program needs to be gradual and carefully done. The CCC experience has taught us that there are a number of problems with any rollout, no matter how well-intentioned. It is critical that beneficiaries understand the program and that they have ample time to select the best plan for them, and to make the decisions that are necessary and there need to be neutral parties available to assist with that process. Providers need to be thoroughly educated about the plans, the processes, and continuity of care provisions so that they can assist beneficiaries, not confuse and distress them with misinformation. There must be an adequate network of providers available to ensure adequacy of choice. Care coordinators must be hired, trained, and ready to provide services. A thoughtful gradual phase-in will reduce problems initially and reduce bad publicity.

***What would make MLTSS program attractive to individuals:***

- Expanded choices and services, particularly additional LTSS--including environmental modifications, dental, vision and hearing services—which can enhance independence and postpone or prevent placement in an assisted living or nursing home.
- Care coordination which seeks out of the box solutions which go beyond traditional medical services in order to support independent living and person-centered care. The care coordinators should be well-trained and

available to the beneficiaries early in the transition process to enable a smooth transition and positive feelings about the mandated managed care.

- Clear information about the program and ease of use.

### **Provider experience:**

The health plans must be prepared and have established procedures in place before the program goes live. Providers must be educated in advance so they are aware of procedures and payment mechanisms. Where possible, plans' use of the same forms and procedures for assessment, billing, reporting will make things easier for the providers and ultimately for beneficiaries as well.

### **Service package:**

- A comprehensive and integrated package which includes LTSS which are currently available in the EDCD waiver and Money Follows the Person demonstration, including assistive technology, environmental modifications, as well as dental, vision, hearing services.

### **Quality Measures:**

- The individual's satisfaction with the program is the most important indicator of the success of the program. There should be regular evaluations to assess whether the individual is receiving the services needed, the ease of accessing supports and services, the clarity and ease of the process, the helpfulness of the care coordinator, the avoidance of hospitalization or institutional care. Use of these measures to improve the program will be critical.

### **Financing:**

- Community support provider rates need to be better aligned with institutional placement rates. Currently they are too low to attract an adequate number of quality providers and to ensure choice.

### **Outreach and Communication:**

- There need to be multiple approaches to reach out to beneficiaries, families and also to providers who can have a major impact on the beneficiaries' first impression about managed care.
- There should be written materials which are clear and in language that is easy to understand.

- Written materials need to be supplemented with opportunities—in person and by phone—to ask questions and to receive assistance from a neutral impartial and well-informed party about what options are available and which options are best suited to the individual’s needs and preferences.

**Advocate  
Ombudsman**

Date: June 16, 2015

To: Cindi Jones, Director, Department of Medical Assistance Services

From: Joani Latimer, Office of the State Long-Term Care Ombudsman Dual Eligibles Demonstration Ombudsman Program

RE: VAMLTSS Public Comments

We appreciate DMAS's interest in soliciting stakeholder input with regard to transition the majority of the remaining fee-for-service populations into integrated managed care models. We believe DMAS deserves significant credit for its earnest engagement with stakeholders throughout the process of planning and implementing the demonstration initiative, Commonwealth Coordinated Care, to maximize the potential success of this critical demonstration. With reference to the current plans to expand this effort to include the majority of those eligible beneficiaries who are not presently under managed care, we have some concerns about the timing/pace of this extensive expansion.

While we understand the external pressures that may be driving the rapid expansion, we feel that this schedule undercuts some key potential benefits of the demonstration – i.e., opportunities to identify and remedy problems in care delivery/coordination/oversight before significantly expanding the scope of operations and simultaneously eliminating beneficiary choice regarding participation. There really has not been ample time to allow for full and scientifically valid analysis of the demonstration's impacts on quality of care/life for enrollees or even to evaluate the relative costs - - since significant data on both of these aspects depends on adequate time to measure significant outcomes. It is concerning that significant expansion of the model is planned before meaningful results have had a chance to fully materialize and suggest modifications to the model. Since one of the main benefits of the integrated model of coordinated care is on the highly important 'preventive' end, the data is clearly not 'in' with regard to measuring impact and adjusting processes to improve results. Clearly no outcome is more important than that of ensuring that the coordinated managed care system that becomes the universal model for this vulnerable population results in overall gains in quality of care and quality of life. It is apparent that there has not been sufficient time under the demonstration and its measures to evaluate the relative benefits of the demonstration model and to ensure an appropriate balance between cost containment and health outcomes for enrollees.

We offer the following comments on specific aspects of DMAS' Proposed Managed Long-Term Services and Supports (MLTSS) Initiatives:

## General

We suggest that the top three significant features of the MLTSS program are the following:

1. Strong beneficiary protections that include the availability and accessibility of an independent ombudsman/advocate to assist to access care, understand and exercise their rights and responsibilities, navigate transitions in care, and understand and navigate the grievance and appeal processes. The ombudsman/advocate function should be independent of DMAS and the MMP's and adequately funded to ensure timely and effective assistance, accessible via telephone, electronic communication, or in-person visit as needed. Informational mailings to beneficiaries should prominently feature information about the advocate's role and how to contact that individual in order to ensure access and meaningful protection of beneficiary rights.
2. Truly person-directed care planning that supports maximum consumer direction (including choice of providers) and ensures timely assessment of needs/goals, truly multi-disciplinary care planning, and timely assignment of a care coordinator is essential. (For example it should not be the case that some beneficiaries have care coordination in place in a timely manner, while other beneficiaries have repeated difficulties in receiving timely, consistent coordination.)
3. Robustness of provider networks (including participating long-term care facilities) needs to be enhanced to ensure beneficiary choice and to minimize disruptions in care. To this end, targeted outreach (to provide clear information to potential providers/participants) needs to be increased going forward (starting immediately). Clear educational materials for providers should stress 3-4 primary benefits to providers and patients participating with the managed care system. MCO's should set specific quality criteria with regard to selection of participating long-term care facilities and should monitor the quality of participating facilities on a regular basis.

Other critical issues:

- As a part of the implementation process for MLTSS, a thorough review and analysis needs to be completed on the number of CCC plan "opt-outs." This data from the plans, the enrollment broker, etc. could be vital in understanding issues that would impact the implementation of the expanded MLTSS.
- In the area of auto-assignment, there must be truly 'intelligent' (more fully informed) initial plan assignment that is based on accurate information about existing primary physician utilization patterns of beneficiaries (taking into account

that physician specialists, rather than generalists/internists) may be the drivers in some instances. Long-term care facility assignments should take into account physicians/physician groups currently overseeing a LTC facility resident's care.

- In advance of the expansion, we recommend greater stakeholder input (from a broad range of enrollees, Ombudsman, beneficiary advocates and caregivers) on the education materials that are sent out by DMAS. We particularly recommend the inclusion of easy to understand ombudsman information and grievance and appeal information on all materials.
- The continuity of care provisions tested through CCC are essential to protecting the health and well-being of beneficiaries and to supporting increased provider participation. The CCC experience to date underscored the importance of clear early education for providers regarding these provisions of the model, so that beneficiaries are not denied needed care due to provider misunderstanding/confusion.
- Overall, the MMPs need to shorten response times in reaching out to new plan member to avoid confusion and frustration/dissatisfaction with a new health plan. Measures should be taken by plans to ensure that a Care Coordinator is assigned and makes contact with the beneficiary/member in a timely manner.

#### Beneficiary Experience:

We believe that the following protections are essential for individuals in an MLTSS program:

- It is critical that MCOs and DMAS notify individuals of the availability of the ombudsman in enrollment letters, enrollee notices, and marketing materials including annual notices summarizing grievance and appeal procedures, and all notices of denial, reduction or termination of a service, whether sent in writing or in another format. The lack of understanding about the availability and role of the ombudsman prevents early resolution of problems that can significantly impact beneficiary health and well-being and negatively impact the success of the care model. This information should be prominently featured in materials going to beneficiaries, families, partners, and providers. Entities providing choice counseling and consumer direction also need to be fully educated about the ombudsman/ role in the model. Inclusion of such information on, for example, on page 57 of a member handbook will not ensure beneficiary awareness/access.
- The most critical factor in assisting individuals to transition between providers is ensuring they clearly understand what will be changing with their health plan and

what the steps are during the transition period and after, especially concerning their physician and local hospital. Beneficiaries need to understand early what will take place during the transition period to alleviate fears and anxiety that they will automatically lose their relationships with current health care providers.

- Stakeholders and advocates should make recommendations related to the clarity of content in the beneficiary enrollment letters and other plan outreach materials/mechanisms to ensure they are ‘beneficiary-friendly’ and contain key elements. (Need a 3-4 key point message to inform beneficiaries and providers about value of program).
- Robust participating provider networks need to be in place well in advance of new member assimilation to ensure smooth transitions and enable meaningful beneficiary choice. Consideration should be given to development of materials/dissemination strategies specific to providers – clear and simple explanation of advantages to patients/providers, including continuity of care provisions, simplified explanation of authorization and billing procedures, etc. ( Provider misinformation about CCC has had significant negative impact on enrollment.)
- Beneficiaries receiving care in long-term care facilities should receive the same level of inter-disciplinary support and monitoring to ensure quality outcomes. Plans enrolling LTC facility residents with mental health needs should ensure that participating facilities are practicing person-centered mental health care/dementia care.

#### Quality Measures:

- Given that one goal of MLTSS is to improve “quality of life, satisfaction, and health outcomes” for enrollees, a comprehensive data collection system is needed. For example, data recorded should allow for the collection, analysis and dissemination of meaningful information in areas such as enrollees’ access to needed medical and behavioral health providers, experiences with care coordination, understanding of benefits available, and opportunity to remain in their home due to enhanced supports/services, etc.

#### Person-Centered Planning and Self Direction:

- Counselors, ombudsmen, and others that are independent from DMAS and the MCO should be available to enable and assist beneficiaries to identify and access services.
- Mechanisms must be in place to minimize conflict of interests in the facilitation and development of the plan.

- The beneficiary plan should include strategies for resolving conflicts or disagreement within the process and clear guidelines on how to request a revision of their plan, or appeal a denial, termination or reduction of a service.
- MCOs should continue to offer self-directed HCBS options that were in place prior to the implementation of managed care. MCOs should provide objective information and training about the decision-making tools to assist individuals who use HCBS services to understand self-direction and implement it to the extent they choose.

#### Provider Experience

- Of primary importance to providers is ease of authorization and billing. Greater uniformity of process overall would significantly reduce provider dissatisfaction. Early provider education is critical.
- Adequate, timely, and accurate information to providers as to how they will be paid during beneficiaries' transitions between plans/models is critical.
- 'Intelligent assignment' based on accurate information to preserve existing physician-patient relationships (whenever possible) is critical to success of the model and essential to continuity of care- particularly critical to this population.

#### Outreach and Communication

- In advance of implementing upcoming phases, DMAS should develop a key point message to serve as the basis for strengthened outreach efforts to advocacy agencies such as Area Agencies on Aging, Aging Disability Resource Centers, Independent Living Centers and Councils, etc. about the program. Hold community forums for advocates and providers alike.
- DMAS should engage individuals, enrollees and stakeholders in the development of the strategies for outreach and education and utilize consumer group and stakeholders in reviewing education pieces or enrollee letters.
- Consideration should be given to the fact that differing outreach and education strategies apply in rural versus urban areas. For example, residents in rural areas may have benefits which entitle them to see a Podiatrist, but they would have to travel many miles to a city in order to find a provider who accepts their plan. More intensive, focused efforts are needed to find providers who offer health care in rural settings.
- There must be adequate investment in educating beneficiaries and providers well in advance of roll-out to ensure network adequacy and consumer choice. Lessons learned from evaluating the effectiveness of CCC outreach should help shape the development of strategies for any program expansion outreach strategies.

**Advocate  
Parent**

Public Commentary by  
[REDACTED] Parent Advocate  
June 16, 2015

Cynthia B. Jones  
Agency Director  
Virginia Department of Medical Assistance Services  
600 east Broad Street  
Richmond, VA 23219

Dear Director Jones:

Since 1997, I served on a variety of local and state civic boards and commissions, including

[REDACTED]

Each panel has provided me with an up close look at Virginia educational, public mental health and intellectual disability services systems. From this vantage point, I have worked to move systems forward on behalf of the children and adults who have or who are at risk of mental illness, serious emotional illness, intellectual and developmental disabilities.

**Access to Health Care**

All Virginians should, regardless of age, ability to pay or disability, have access to comprehensive health care.

I **strongly urge** the Department of Medical Assistance Services to consider and incorporate as part of the waiver design three specific themes: (1) accessible healthcare for everyone, (2) comprehensive behavioral and mental health services and supports provided by culturally and linguistically appropriate staff; and (3) affordable out of pocket expenses are affordable for people with disabilities and their families.

**Support for those with Autism**

I **strongly urge** the Department of Medical Assistance Services to develop a comprehensive waiver that is based on functional criteria rather than diagnosis. For example, it is difficult for someone with autism to get mental health services, as requirements keep the local Community Service Boards “boxed in” as to who they can serve, since in order to access any necessary services through the Community Service Boards, autism cannot be a primary diagnosis, which is disappointing.

Waivers need to provide some type of basic level of supports in order for those with autism to be successful in the community living on their own. The waiver needs to provide some behavioral support and access to BCBA professionals to provide training, support and supervision services to adults with autism which would help them with their functional daily living skill development, community integration skill development, work

environment skill development, social and interpersonal skill development, and travel training development.

### **Occupational Therapy Services**

I **strongly urge** the Department of Medical Services to include occupational therapy services as part of any waiver redesign. Occupational therapy services focus on the performance of activities of daily living, like such as bathing, showering, dressing, personal hygiene and grooming and can also include more complicated activities such as meal preparation, fiscal management, and shopping. Additionally, the waiver should allow the services to be provided to the client, at an individual or organizational level. This means could include direct service, consultation, education, support to the individual, family members, education to staff and community agencies.

### **Medicaid Waivers Redesign**

Any system redesigns needs to incorporate flexibility to support each individual over the lifespan of the individual. There always need to be a way for the system to be able to responsive for those who need intense supports and or have multiple disabilities and should incorporate the ability to leverage local resources. Additionally, the waiver should allow for services to be provided that allow for independent living, consumer direction and employment which often require assessments and behavioral health services.

### **Service Coordination**

This should be incorporated in the waivers design as access to service coordination should be available as necessary and upon request to all persons with disabilities who have functional needs for an array of services and supports. Service coordination is a level of advocacy that must be provided to the client, at an individual or organizational level. This could include direct service, consultation, education, support to the individual, family members, education to staff and community agencies to participate fully and be fully included in their communities. Those who perform this role should support an individual's right to access or refuse services or supports, develop their own service plans, request alternate services or supports and appeal decisions made about the services or supports that they receive.

### **Conclusion**

The newly designed Waiver must support the vision of community inclusion, citizenship, opportunity, and full participation. It should allow people with disabilities to live the life that they want to live and not just what can be accommodated. Finally, I **strongly urge** the Department of Medical Assistance Services to consider is commissioning an administrative census of the number of individuals with autism receiving services in Virginia. This data will be especially helpful to the Department of Medical Assistance Services in terms of program planning and better coordination of services among various state agency partners including education, law enforcement, and children and families.

Thank you for the opportunity to provide comments. If you have any questions you can contact me by at the following e-mail: [REDACTED]

## Advocate

[REDACTED]

We are the parents of a [REDACTED] who is still living at home, works in supported employment and has been dual eligible for Medicare and Medicaid for many years. [REDACTED]

We are very concerned right now about a suitable alternative living situation for [REDACTED] as our own medical issues continue to grow and be of major concern.

As we read the plans for medical insurance changes, now we have yet another major concern. Be advised, the first and biggest concern is **where** providers of care will be – i.e., in the local, easily accessed community or miles away. When managed care was being planned some years back for Medicaid recipients, we were initially assigned to a provider in *Manassas* – we live in [REDACTED]. Fortunately, someone saw the difficulty of such arrangements and we were able to go back to the providers our [REDACTED] has had for many years. The second issue is that [REDACTED] has had the same care providers, chosen specifically for their knowledge and expertise in handling [REDACTED] health issues, for a number of years. There have been easy transitions as providers have moved/ retired, etc. Please know that swift and very different means of accessing care for [REDACTED] [REDACTED] will be very difficult to put it mildly (not to mention the trauma for parents who are dealing with their own health issues!). Hopefully there will be a well thought-out plan in place that the affected clients can ease into before changes must be made.

Please consider that you are dealing with real people who need the best of care, and not necessarily the cheapest care obtainable.

Thank you for considering our thoughts in this matter.

[REDACTED]

## Advocate

My only comment and suggestion is that the nurses that take care of the disabled be able to make more then \$8.86 and hour, and possibly getting overtime like regular jobs! It's not fair for them to do the amount of work that they have to do, and only make \$8.86 and hour!! Also, patients

There aren't enough hours for [REDACTED] to have the care that [REDACTED], and [REDACTED] to pay out-of-pocket for the rest of [REDACTED] hours, and only get a check for \$[REDACTED] each month! [REDACTED] have to use that money for rent and groceries and any other items! It's very very hard to live, especially when [REDACTED] to take care of! If there be any way to possibly work on that, those are my only problems that I have! I hope my comments were helpful, and thank you for the opportunity to give my feedback!

Thank you!

**Advocate**  
Virginia Ability Alliance

May 20, 2015

To Whom It May Concern,

The Virginia Ability Alliance is a coalition of Northern Virginia non-profits focused on ensuring all people with disabilities are living a full life in their home community. We have a vested interest in ensuring managed care for both acute care and long terms support services (LTSS) is implemented in a way that affords maximum benefit to individuals with intellectual and developmental disabilities (I/DD) and their families.

In terms of acute care services, there are three priorities for the I/DD population.

1. Providers of primary and specialty healthcare should be provided with financial incentives to serve people with I/DD. This population often requires more time for diagnosis and assessment and is at a greater risk for chronic and overlapping health conditions than the typical population. Providers often need to allow extra time to work with paid staff or authorized representatives to ensure all relevant parties are apprised of what is going on and have opportunities to participate in care/treatment plans as appropriate.
2. The managed care organizations should be encouraged to enroll providers with existing experience serving people with I/DD as well as those who have experience serving people with both I/DD and mental health needs. Any necessary transition to new providers should be done over a 120 day transition period to allow the smoothest possible transition. When providers with this experience are not available in-network, individuals with I/DD should be eligible to receive services from out-of-network providers with appropriate qualifications.
3. Access to preventative care and dental care is necessary to ensure positive health outcomes.

Managed care for long term supports and services (LTSS) must be done with extreme caution. Any changes must be in keeping with the terms of the Department of Justice settlement agreement, the CMS final rule, and proposed Waiver Redesign. To proceed before Waiver Redesign has been implemented fully would undoubtedly be catastrophic. Even taken separately, the redesign process and moving to managed care are two massive changes in life sustaining services for a vulnerable population. Any steps forward must be taken with a great deal of forethought and consideration.

There are a number of critical steps to take and concerns to address as we consider moving to MLTSS. They include:

1. Ensuring that any cost savings obtained from this move will be maintained in the I/DD system and used to address critical needs, especially the waiting list for Waiver services.
2. A clear planned vision of what the program aims to do and how (e.g. How will the existing role of case managers be affected?, Who will provide oversight and appeal rights?, What functions other than cost savings are we hoping to see?)
3. Affirmation that the system will remain person-centered, consumer driven, and community-based.
4. Multiple opportunities for stakeholder involvement. The opportunity to make these comments is appreciated, but other opportunities (e.g. small group forums all over the state) on an ongoing basis to educate and engage the I/DD community will be needed to get valuable feedback opportunities.
5. Transparency in intentions, timelines, and the process must occur to prevent misinformation or fear from adversely affecting people with I/DD and their families.
6. Ongoing outreach to individuals, families, and service providers to offer clear information and assistance on the upcoming changes is vital. Information should be made available in a variety of formats (e.g. in person, in print, online, in video format) and accessible to non-English speakers.
7. Training by any MLTSS agency for service providers on billing formats and troubleshooting, licensing, technical assistance, RFPs, etc. must be mandated. Any selected MLTSS agencies should have common or identical processes for enrollment, billing, and assistance to providers to ease the large burden of having to navigate multiple systems with different rules simultaneously.
8. A premium should be placed on allowing all possible opportunities for members to maintain existing service providers.
9. Performance-based incentives and penalties should exist for any managed care organization. MCOs should be rewarded for successfully meeting objectives and demonstrating improved service and quality of life outcomes for participants. MCOs should also be rewarded for recruiting and retaining a network of qualified, quality I/DD providers and reviewing/approving requests in a timely fashion. DMAS should review these rates on an ongoing basis to ensure they keep pace with private service rates.
10. The RFP for this program should stipulate that MCOs offer “in lieu of benefits” that would enable them to offer services or supports not typically available through Medicaid or Waiver in lieu of more expensive but less effective Medicaid or Medicaid Waiver services.
11. The focus of MLTSS must be on community-based services. Training centers, nursing homes, and other facilities serving people with I/DD should also be managed by the agencies managing community-based care.

12. Services should be focused on the highest possible degree of self-direction and independence for each individual.
13. There should be robust protections for participants in this system. Safeguards and appeal right should be readily available. Any proposed decreases in services or supports should receive a heightened level of scrutiny and consent from the individual. Appeals should be managed by an independent party.
14. MTLSS should focus on quality improvement in the areas of independence, safety, quality of life, and community integration. Clear qualitative and quantitative data on service usage and individual satisfaction should be reported quarterly and made publicly available.

We urge DMAS to proceed with great caution in turning over management of support services for people with I/DD to a for-profit agency with expertise in acute health care. There is almost no room for error during this process.

Sincerely,

The Virginia Ability Alliance

**Advocate**  
Arc of Northern Virginia

May 27, 2015

Department of Behavioral Health and Developmental Services,

The Arc of Northern Virginia is a local chapter of the largest non-profit organization supporting people with intellectual and developmental disabilities and their families. We provide services and education locally and on the state level, as well as information and referral, special needs trust programs, and self-advocacy empowerment opportunities.

The Arc of Northern Virginia has been studying managed care for long term support services (LTSS) and acute care for years. Though it is clear Virginia and most of the nation is moving in this direction, there is still very little long-term data regarding the consequences of these moves for individuals with intellectual and developmental disabilities (I/DD) and their families. The implementation on managed care for acute and long term care must be done with a great deal of forethought and preparation.

Acute Care

A premium must be placed on the availability and usage of preventative care to prevent unnecessary medical complications and hospitalizations. This includes the need for routine dental care.

Successfully providing medical care to people with I/DD requires experience with the I/DD population, more time than it takes to serve typical patients, additional paperwork for people in licensed programs, and efforts to communicate with an entire support team. Consequently, managed care organizations (MCOs) should be required to have providers in their networks with a background in serving the I/DD population as well as those with dual diagnoses (e.g. ID and mental health). They should also be afforded additional financial compensation for the extra time and care it takes to serve patients with I/DD.

If people with I/DD must transition to new providers because their existing doctors are not enrolled in their MCO network plan, a 180 day transition period should be provided.

If in-network providers who possess the appropriate background in serving people with I/DD, knowledge of appropriate specialties and adequate time to serve the I/DD population are not available, people should be able to receive services from out-of-network providers.

Managed Long Term Support Services

MLTSS is a drastic change from the service system people with I/DD have used for decades. Any changes must be implemented slowly and with a great deal of planning.

First and foremost, any contracted MCO should have multiple and ongoing mandates to engage people with I/DD and their loved ones in learning about any proposed changes. Information should be available in multiple languages, online, in print, and at in person large and small group sessions. Feedback should be gathered by the MCOs and DBHDS and then used to adjust the system as needed. Transparency should be a central goal in this process.

Any contracted MCOs should be familiar with the ongoing Department of Justice Settlement Agreement, the CMS final rule, and Virginia's proposed Waiver Redesign. The MLTSS program must be person-centered and put a premium upon maintaining consumer-directed service options for all services.

The domain of any MCO must include nursing homes (public and private), rehab facilities, training centers, ICFs, and other institutional-style settings. The system should be focused on community-based services and transitioning individuals to the least restrictive environments with the appropriate supports.

Any cost savings gleaned from this transition must be reinvested in the I/DD service system. Ongoing outreach to individuals, families, and service providers to offer clear information and assistance on the upcoming changes is vital. Information should be made available in a variety of formats (e.g. in person, in print, online, in video format) and accessible to non-English speakers.

Individuals should be able to continue working with existing service providers as much as possible. MLTSS agencies should provide outreach and assistance to I/DD service providers to support them in making the changes needed to become in-network providers. RFPs, billing processes, and training should be common across all MCOs to limit the administrative burden on providers.

MCOs should receive financial incentives for successfully showing quality outcomes for participants, retaining a network of high-quality providers, and processing requests quickly. Alternatively, penalties should be imposed for not meeting expectations.

MCOs should be given authority to research and propose appropriate annual cost increases to keep pace with inflation.

As with managed care for acute care services, transparency is key. Performance measures should be publicly reported on a regular basis.

Appeals should be easy to file and adjudicated by an independent, neutral party.

Lastly, MCOs should have authority to offer "in lieu of benefits" that meet the needs of individuals in cost effective ways that don't fit within typical Medicaid or Medicaid Waiver service limits.

We urge DMAS to proceed with care in moving towards a managed care system for acute and LTSS services for anyone with an intellectual or developmental disability.

Sincerely,

A handwritten signature in black ink that reads "Rikki Epstein". The signature is written in a cursive style with a long, sweeping horizontal line extending to the right from the end of the name.

Rikki Epstein  
Executive Director

(703) 208-1119 x106

[REpstein@TheArcofNOVA.org](mailto:REpstein@TheArcofNOVA.org)

## Advocate

We have [REDACTED] in their [REDACTED] sometimes.

Taking them to a Dr., hospital, dentist, etc can be quite challenging

dental anesthesia would bankrupt most families

we do not go anymore than we have to!!!!

We already pay the [REDACTED] cause Medicaid does not pay enough.....

We could use a Dr that would come into our home locally, when needed for sickness.refill meds etc.

Do you pay for such a Dr.??? That would be a plus+

Can you recommend Dr., dentist , in harrisonburg, rockingham area, that are understanding, have safe place

All programs for Dev. Disabled adults cater to mild, moderate or those without behaviours

Would someone, somewhere start making those with behaviours or aggressions a priority for 10 yrs. &

build them a future where they are even considered, wanted. or there are programs built to help them, not

get rid of them cause they need too much attention & that cost agencies too much money

or they can't do what the mild or moderate can do-so throw them out

person centered programs are a hoot

For [REDACTED] yrs now, the more severe & their families are always left out.....

[REDACTED]

[REDACTED]

[REDACTED]

## Advocate

# Comments on Transitioning I/DD Services to Managed/Coordinated Health Care Plans

The following comments are submitted by The Arc of Virginia in response to a request for public input on fulfilling the Virginia General Assembly's directive "to include all remaining Medicaid populations and services into cost-effective managed and coordinated delivery systems" during the third phase of a Medicaid reform initiative being pursued by the state Department of Medical Assistance Services (DMAS). As a statewide advocacy organization representing tens of thousands of Medicaid-eligible individuals with intellectual and developmental disabilities (I/DD) and their families, The Arc has a major stake in the outcome of DMAS's deliberations on this matter.

## Timetable for Transitioning to a Managed/Coordinated Care Model

The Arc of Virginia supports DMAS's decision to postpone the enrollment of I/DD waiver participants in a managed/coordinated care delivery system until existing Medicaid home and community-based (HCB) waiver programs are revamped. Work on redesigning the current Intellectual Disability, Developmental Disability and Day Support waiver programs is ongoing. Assuming the current timetable holds, the redesigned waiver programs will not be fully in place until mid-way through the FY 2017-18 biennium. Then several years of operating experience will be required to pinpoint and correct flaws in service delivery and financing practices. Simultaneously, the Department of Behavioral Health and Developmental Services (DBHDS), in collaboration with DMAS, will have to expand opportunities for HCB waiver participants to live, work and recreate in fully integrated community settings in accordance with the provisions of the federal HCBS "settings" rule. The deadline for full compliance with the settings rule is March 2019. Realistically, therefore, the Commonwealth will not be in a position to fold ICF/ID and I/DD waiver services into a managed/coordinated care system until the FY 2020-21 biennium. The Arc of Virginia believes that the adoption of an accelerated schedule could result in major systemic disruptions that would jeopardize the well being of thousands of vulnerable individuals with lifelong disabilities.

## Unique Characteristics of the I/DD Population

The needs of individuals with I/DD differ substantially from those of other segments of the LTC population, including frail elders and individuals with physical, sensory and behavioral disabilities. In particular, for individuals with I/DD:

- The root cause of the disability often is unrelated to a treatable medical condition. Indeed, scientists only partially understand the complex mix of genetic, metabolic and environmental factors contributing to developmental disabilities. More importantly, the resulting functional limitations associated with a developmental disability typically cannot be rectified or even alleviated through the application of established medical interventions. Like every other human being, people with developmental disabilities need access to high quality medical services. But service delivery efficiencies (and related cost savings) are far more likely to occur as the result of reforms in the organization, delivery and financing of long-term services and supports than through medical interventions.
- The functional limitations of the disability exist throughout the person's life, rather than only during the latter stages life. As a result, individuals with I/DD require different interventions during each life stage, from birth to death, and the focus is on helping the individual acquire and retain functional life skills, rather than compensate for physical and mental capabilities that have been lost or significantly impaired. The success of age-appropriate efforts to support individuals with I/DD, therefore, rests extensively on effective collaboration between the long-term service providers and other human service systems, such as public elementary and secondary schools, vocational rehabilitation, mental health and public housing agencies.
- Enrollment in long-term I/DD services typically occurs only after a prolonged waiting period, a result that is at odds with the "reasonable promptness" standard embedded in federal Medicaid law. With nearly 10,000 individuals currently on waiting lists for I/DD waiver services, the Commonwealth is likely to have difficulty convincing officials of the federal Center for Medicare and Medicaid Services (CMS) that it will be able to enroll all qualifying individuals with I/DD in MLTSS plans without undue delay.
- The public-private system through which I/DD services are currently furnished to Virginians with I/DD has existed for over forty-five years. While the current service network can be improved, extreme care needs to be exercised to avoid disrupting longstanding relationships and undermining the knowledge base and expertise that exists within the current system. Any system redesign, therefore, should build upon, rather than replace, capabilities that already exist.

These differences have far-reaching implications that have to be taken into account in designing a cost-effective system for delivering Medicaid services to persons with I/DD. Simply grafting I/DD services onto a MLTSS system designed for frail elders and persons with physical disabilities is unacceptable. Even if you believe, as The Arc does, that improvements in the current delivery system are needed, it doesn't follow that shifting responsibilities to MCOs is best pathway toward a better functioning system.

## Essential Components of a MMLTSS Plan

Any plan to transition long-term services and supports to a managed/coordinated care framework must be consistent with federal policies. In May 2013, CMS released a guide to developing state Medicaid Managed Long-Term Service and Support (MMLTSS) plans.<sup>1</sup> This guide identified ten critical plan components including:

- Adequate advanced planning and transition strategies;
- Full stakeholder engagement;
- Enhanced provision of home and community-based services;
- Proper alignment of payment structures and programmatic goals;
- Support for beneficiaries throughout their MMLTSS experience;
- Person-centered planning and service delivery processes;
- An adequate network of qualified providers to meet the needs of plan enrollees;
- A robust set of participant protections; and
- A quality management system based on desired participant outcomes.

Requirements to ensure that the above features are built into all state MMLTSS plans are contained in proposed managed care regulations promulgated by CMS on June 1, 2015.<sup>2</sup> The MLTSS checklist issued by Community Catalyst, Inc. in 2013 also offers useful guidance on ensuring that the interests of participants remain paramount in designing a state's MMLTSS strategy. The CC tool kit includes links to best practice illustrations drawn from the experiences of states with existing state MMLTSS programs.

### Arc Recommendations

Given the unique challenges involved in improving the quality, cost-effectiveness and accessibility of I/DD services and the lack of solid information to support the efficacy of managed care as the preferred approach to achieving these goals, Commonwealth officials should approach the task of reforming existing I/DD service delivery systems with care. More specifically:

Recommendation #1: DMAS should establish an advisory body, comprised of representatives from a cross section of I/DD stakeholders, to assist the department in developing strategies to improve the cost-effectiveness, quality and accessibility of long-term services for children and

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<sup>1</sup> Centers for Medicare and Medicaid Services, "Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs," May 20, 2013 (<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>).

<sup>2</sup> *Federal Register*, Vol. 80, No. 104, June 1, 2015, pp. 31098-31297.

adults with I/DD. This advisory body should be tasked with examining the experiences of individuals with I/DD who have enrolled voluntarily in the Commonwealth Coordinated Care program as well as the experiences of other states that operate MMLTSS programs in which individuals with I/DD are enrolled. The study should encompass both specialty MMLTSS carve outs as well as fully integrated health and LTSS plans. The pros and cons of incorporating various components and participant safeguards in the plan should be scrutinized carefully by the advisory group and departmental officials before recommending a course of action.

**Recommendation #2:** DBHDS, in collaboration with DMAS, should strengthen the existing infrastructure for managing I/DD waiver services with an eye toward enhancing the state's capacity to monitor and enforce the quality, appropriateness and cost-effectiveness of services to individuals with I/DD. Particular attention should be directed toward: (a) strengthening the department's management information systems and ensuring that those systems are fully compatible with the state's Medicaid Management Information System (MMIS); (b) creating more robust quality monitoring and enforcement mechanisms; (c) analyzing the results of the revamped I/DD waiver rate setting system and assembling the cost data necessary to build an actuarially sound capitated payment system; (d) adopting case management performance standards and policies to ensure the provision of conflict-free case management; and (e) support and monitor efforts by community provider agencies to expand opportunities for individuals with I/DD to receive services in fully integrated community settings, consistent with the goals of the state's HCBS transition plan.<sup>3</sup> MMLTSS systems are premised on the delegation of broad, day-to-day operational authority to a managerial entity, operating under contract with the state. It is vitally important, therefore, that the state have the capability to effectively overseeing the performance of its managed care contractors. Fewer problems are likely to be encountered during the transition from fee-for-services to a capitated managed care system if DMAS and DBHDS officials use the I/DD waiver redesign process to create and field test these new capabilities over the next four to five years.

**Recommendation #3:** DMAS, in collaboration with DBHDS, should initiate a series of regional or area-wide pilot programs to test the effectiveness of alternative approaches to improving the coordination of acute health and preventive services and long-term services and support for the I/DD population. These pilot programs should be designed to examine the advantages and disadvantages of alternative service delivery models, including a fully integrated managed care model versus an approach where individuals

with I/DD are enrolled in managed health care plans but continue to receive LTSS on a fee-for-service basis. A representative sample (functionally and demographically) of

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<sup>3</sup> See The Arc of Virginia's comments on the latter subject in "Comments on a Statewide Transition Plan to Achieve Compliance with Federal Home and Community-Based Rule Governing Setting Requirements," submitted to the Virginia Department of Medical Assistance Services, March 2, 2015.

Medicaid beneficiaries with I/DD should be enrolled in these pilot programs so the results can be generalized to the broader I/DD Medicaid population. In addition, the pilot programs should: (a) employ a health home model to facilitate regular interaction between an individual's health care team and his/her long-term support team; and (b) be subject to a rigorous independent evaluation designed to inform follow-up policy decisions. I/DD stakeholders should participate in designing and monitoring the implementation of the pilot programs.

**Recommendation #4:** DMAS and DBHDS officials should keep interested stakeholder abreast of plans to restructure the financing and delivery of Medicaid-funded services to citizens with developmental disabilities and their families through regular news bulletins, fact sheets, periodic webinars and public meetings. It is especially important, The Arc believes, that such communiqués use consumer and family friendly language and clearly expand the goals of reform initiatives as well as the ways in which individuals with disabilities and their families are likely to be impacted.

\*\*\*\*\*

The Arc of Virginia appreciates the opportunity to share its views regarding the Commonwealth's plans to complete Phase 3 of reforming the delivery of Medicaid services and supports, as it impacts on individuals with I/DD. We stand ready to clarify any aspect of these comments. Questions should be directed to Rebecca King at [rking@thearcofva.org](mailto:rking@thearcofva.org) or by phone at 804-649-8481, ext. 105.

**Advocate  
Prince William Commission on Aging**

**Observations and Comments by the Prince William Commission on Aging on the Virginia Department of Medical Assistance Services (DMAS) proposed Managed Long-Term Services and Supports (MLTSS) proposed program design and implementation; May 13, 2015**

Submitted via e-mail to [VAMLTSS@dmas.virginia.gov](mailto:VAMLTSS@dmas.virginia.gov) on June 15, 2015

**Contact Information:**

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Chair, Prince William Commission on Aging  
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The following observations and comments are submitted on behalf of the Prince William Commission on Aging. Our comments do not address one particular question as the submitted items cross over many of the 17 questions.

1. Inclusion of the National Quality Standards: There already exists same for Care Transitions (which includes beyond just Hospital Readmission); HCBS Provider Conditions of Participation; Person- and Family-Centered Care & Service Planning; and the evolving standards for HCBS to include the common definition.
2. Integration with Virginia *No Wrong Door*, the Commonwealth's system of Aging & Disability Resources Connection (NWD/ADRC) for which "Aging has the lead" by Virginia Code § 51.5-135(A)(6) with DARS being the primary State Agency.
  - a. The US Administration for Community Living (ACL) has published "Key Elements of a NWD System of Access to LTSS for All Populations and Payers". <http://www.nasuad.org/sites/nasuad/files/NWD%20system%20national%20key%20elements.pdf> This document covers all the various initiatives/programs to include ADRCs, Veteran-Directed HCBS, Money Follows the Person, and others.
  - b. DMAS, at a minimum, should consider incorporating the key elements into the proposed MLTSS design. Additionally, this document should be used in working with DARS/Virginia Division for Aging and define the roles for these State Agencies and also the Area Agencies on Aging (AAA) and Centers for Independent Living (CIL) as the local Community-based Organizations.
3. Program of All-Inclusive Care for the Elderly (PACE): resolve the appearance that PACE will be in competition with the Commonwealth Coordinated Care initiative. PACE should also be expanded in the Commonwealth and DMAS

should follow the results of a local study for establishment of same, and not just assign zip codes to one entity if the study reflects only a portion of the studied area (i.e. Northern Virginia) is served by said entity.

4. Continue the initiative for Veterans to be moved off the State Medicaid enrollment to the US Veterans Administration for providing of care. The proposed design should include Veteran- Directed HCBS.

5. Inclusion of the Long-Term Care Ombudsman: This would not only be within HCBS, but also for those times a participant in Managed Care would need a short-term (episodic) stay in a Rehabilitation Facility. Requirement should be included in any Managed Care contract.

6. Integration of the Electronic Health Record (EHR) programs used by the Health Systems in Virginia with DMAS Case Management System, and other State systems such as those used by the AAAs and CILs.

a. This should also include a module for the Virginia Uniform Assessment Instrument allowing for completion by Health Systems for exchange with the State; and also enable the local entity to have the most up-to-date medical information on the person served.

b. This would also ensure compliance with the CMS Standards for EHR Meaningful Use enabling providers to focus on the objectives which support both evidence-based best practices for care and allow for Health Information Exchange, Consumer Engagement, and Public Health Reporting.

7. Inclusion of Disability Competent Care (DCC) as a standard. This was developed in 2014 by the Lewin Group under contract to the ACL. Training this year has focused on both Health Care Providers and the Insurance Companies. Standards and additional information can be found at:

<https://www.resourcesforintegratedcare.com/>

8. The Kaiser Family Foundation on June 1, 2015, released an Issue Brief "*Early Insights from Commonwealth Coordinated Care: Virginia's Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries*". We highly recommend this document be reviewed and the relevant recommendations be included in the development of the MLTSS design. Document available at: <http://kff.org/medicaid/issue-brief/early-insights-from-commonwealth-coordinatedcare-virginias-demonstration-to-integrate-care-and-align-financing-for-dualeligible-beneficiaries/>

In conclusion, we recommend the proposed design include each of these components:

- Person-centered Program Design and Service Plan Development
- Services and Supports Coordination (enabled by integrated EHR)
- Access to Qualified Providers
- Emphasis on Home & Community-Based Services (with participation by the

local Community-based Organizations such as AAAs and CILs)

- Participation education and enrollment supports (particularly at the local level)
- Preventive Services
- Participant protections (to include the LTC Ombudsman Program)
- Quality and Outcomes-based focus by incorporation of the National Quality Standards

\* \* \* End of Notations\* \* \*

**Provider**  
The Orchard

May 26, 2015

To Whom it May Concern:

I would like to take this opportunity to comment on the expansion of the dual eligible program to make it mandatory. As a provider of care/services, we are very concerned about this expansion.

During the time that we have been working within the system of the dual-eligible world, we have run into various obstacles. One is that the time required to get an authorization can be very cumbersome on our staff as they have to wait on the phone sometimes for over an hour. This is not a good use of their time. In addition, the care coordination is very difficult as we have not had good response from the Care Coordinators. For quite some time, we did not even know who our coordinator was, and still not sure for the providers with whom we do not have a contract.

Payment is very, very slow, at best. This creates a hardship on us as we are carrying this large outstanding receivable unnecessarily. Clearly, this needs to be resolved prior to adding even more consumers to the program.

Our concern is that with the increased number of consumers, we will get even less responsiveness from the providers and our payments will be even slower. In my mind, it is imperative to get the system straightened out before any expansion, especially mandatory, is implemented.

Sincerely,

Pamela E. Doshier, NHA, MBA, CDP  
Administrator  
The Orchard  
20 Delfae Drive  
Warsaw, VA 22572

## Provider

We have had ongoing issues related to the CCC Program Pilot. We are fortunate that we have only had three individuals enrolled in these programs:

- We are still not contracted with Humana. I had to continually follow up with Humana to obtain the contracting material. Our information is still under review.
- Conference calls and face-to-face meetings were held with Anthem regarding our account not being set up correctly. We have only been paid due to direct intervention by our contracting representative.
- We completed the contracting material sent to us by Virginia Premiere for Outpatient Psychiatric Services and Mental Health Skill Building. We have been in contact with our contracting representative to include a face-to-face meeting due to one of our NPI numbers not being available in the drop down menu used for billing. We were recently told we were not contracted for MHSS. The welcome letter we received did not list the services we were contracted for so we assumed we were contracted for the services and NPI's included in our contracting application. We are hopeful this will be rectified by Virginia Premiere so that we will be paid for services rendered.

St. Joseph's Villa has successfully contracted with multiple insurance companies and have not encountered the challenges described above. We provide services and are paid. Many of the staff involved with the CCC program are either new to the company or indicate they are still learning the process. Additionally, training on navigating eligibility, pre-authorization, and billing for each insurance company has not been adequately provided. We do not recommend expansion of this program under the current structure.

Please contact me with questions.

Thank you,

Bridget

**Bridget Baldwin, CMQ/OE, CQA**

Insurance Contract Manager

St. Joseph's Villa 8000 Brook Road Richmond, VA 23227

Phone: (804) 553-3279; Fax: (804) 553-3259; [bbaldwin@sjvmail.net](mailto:bbaldwin@sjvmail.net)

**Provider**  
Senior – Sherpa

**MLTSS Opportunity for Public Comment**  
**June 1, 2015**

Thank you for the opportunity to comment on the proposed design and implementation of DMAS' program initiative to transition remaining fee-for-service populations into a mandatory managed care program (MLTSS).

The design of this program represents an exciting and important opportunity to ensure a “wheel of security” around individuals and their family caregivers, particularly in the older adult population. This “wheel of security” is especially important in the population of those with cognitive impairment who may not be able to self-direct care without assistance.

**Background:**

1. According to the Alzheimer's Association, one in three seniors dies with Alzheimer's Disease or another dementia. Alzheimer's Disease is the United States' sixth leading cause of death. It also is the only disease in the top 10 in the US that cannot be prevented, cured, or slowed. Alzheimer's and other dementias result in cognitive impairment.
2. In 2015, Alzheimer's and other dementias will cost the US \$226 Billion.
3. Alzheimer's and other dementias have an enormous and negative impact on caregivers. According to the Alzheimer's Association's 2015 Facts and Figures, in 2014, friends and family of people with Alzheimer's and other dementias provided an estimated 17.9 billion hours of unpaid care, a contribution to the nation valued at \$217.7 billion. This is approximately 46 percent of the net value of Walmart sales in 2013 and nearly eight times the total revenue of McDonald's in 2013.
  - a. Approximately two-thirds of caregivers are women and 34 percent are age 65 or older.
  - b. Forty-one percent of caregivers have a household income of \$50,000 or less.
  - c. Over half of primary caregivers of people with dementia take care of parents.
  - d. It is estimated that 250,000 children and young adults between ages 8 and 18 provide help to someone with Alzheimer's disease or another dementia.
  - e. Alzheimer's takes a devastating toll on caregivers. Nearly 60 percent of Alzheimer's and dementia caregivers rate the emotional stress of caregiving as high or very high; about 40 percent suffer from depression. Due to the physical and emotional toll of caregiving, Alzheimer's and dementia caregivers had \$9.7 billion in additional health care costs of their own in 2014.
4. Cognitive and mood issues such as those caused by dementia create challenges in patient adherence.
  - a. Cognitive issues effect working memory, cognitive-communication skills, executive functions, contextual memory and functional abilities, not just short-term memory.
  - b. Cognitive issues raise the question of the individual's cognitive ability to comply with medical or care management advice. For example, there is a difference in and individual's remembering THAT he/she needs to take medicine versus

- remembering HOW to take the medicine. If the individual is not, is the caregiver cognitively able to compensate for the individual's lack of ability? Or, are there systems in place to ensure adherence?
- c. Cognitive issues raise practical questions, too. Does the individual have the ability to get his/her medicine? Buy food? Prepare food? Maintain a clean house?
5. Cognitive issues make care planning more difficult:
    - a. Cognitive challenges exacerbate physical challenges.
    - b. People get "in trouble" caring for themselves and others due to issues with cognitive functioning.
    - c. Cognitive issues cause problems in performing IADLs and ADLs. This is important because it often creates an unsustainable situation for people to remain safely at home.
    - d. People with cognitive issues often have increased morbidity (get sick more often).
    - e. People with cognitive issues have increased unnecessary hospitalization.
    - f. Caring for people with cognitive issues results in reduced productivity of adult children.
    - g. People with cognitive issues have an increased overuse of health care resources.
  6. People with cognitive issues have an increased likelihood of mortality.
  7. Addressing cognitive issues is of particular importance in Home Care and Home Health Care:
    - a. Studies show that there is an 80% base rate of cognitive impairment in clients over 70 years of age when one includes MCI.
    - b. Studies show that there is a 50-60% base rate of dementia in the home care population.
    - c. Unidentified cognitive impairment limits client compliance and adherence to care plans.
    - d. Failure to identify means failure to intervene.
    - e. Cognitive problems can lead to unnecessary residential transitions.
  8. There often are logistical and practical challenges in bringing the individual to the care provider:
    - a. Difficulties with transportation, mobility, and caregiver availability often make it impossible for the patient to get to the provider necessitating bringing the provider to the patient.

**Definitions:**

1. ADL: activities of daily living including bathing, dressing, toileting, transferring, and eating – self-care
2. IADL: instrumental activities of daily living including tasks such as shopping, cooking, transportation, etc.
3. DME: durable medical equipment
4. MCI: Mild cognitive impairment
5. Direct causes of cognitive issues include among others:
  - a. Alzheimer's disease
  - b. Vascular insults
  - c. Fronto-temporal dementia
  - d. Lewy Bodies dementia
  - e. Mixed and other dementias

6. Telemedicine: by our definition should be used only in cases where the medical professional has an already-established relationship with the patient. Technology can include interactive audio, video-conference, secure web-based communications, devices, etc.
7. House Calls: home visits by a doctor or other trained medical professionals including lab technicians, DME providers, etc.
8. Screening tools: must be scientifically validated and be able to identify weaknesses in particular areas of functioning. Short term memory loss is only one factor. Other important factors include: working memory, cognitive-communication skills, executive functions, contextual memory and functional abilities and are vital to the person's ability to remain safely in the community.
9. "Wheel of security:" a team approach including medical professionals, care coordinators, family caregivers, DME providers, legal and financial professionals, and others who ensure the safety and well-being of the person for whom they are caring. It requires a flexible team approach to ensure a safe living situation including both community-based and facility-based care options.

**Recommendations/comments:**

First and foremost, it is vital to clearly identify the medical and practical needs of the individual and to have a clear and realistic understanding of likely future outcomes. People with dementia are not going to get better - dementia is a disease that only gets worse. It is important to get a clear diagnosis and to understand what that diagnosis means. For example, some of the dementias result in behaviors that are dangerous to the individual and others. Other dementias quickly manifest as a loss of executive functioning or in a reduced ability to make new memories/learn a new task. Any coordinated care program must take this into account and have team members available to take over when the individual or his caregiver no longer can be "in-charge."

The wheel of security also must include: IADL and ADL assistance as needed, financial assistance and management of those funds, and legal protection to ensure that the patient is not scammed or harmed. This approach also recognizes that the person and/or his/her family caregiver must have the cognitive ability and practical knowledge to adhere to the comprehensive plan. If not, the professionals involved must supplement or take over the consumer-directed choice in order to protect the person and the family caregivers. One must balance consumer choice and consumer-directed care with the individual's ability to safely and effectively make those choices.

There also is a great need for caregiver and workforce training to ensure that caregivers, both paid and unpaid, can safely and effectively work with a vulnerable population that has a high incidence of cognitive and mood impairments. This includes early identification/diagnosis and implementation of clear, scientifically validated, practical methods of caregiving.

**Below are our comments to specific questions as outlined in the MLTSS Opportunity for Public Comment issued on May 13, 2015.**

**General:**

1. ***What would you like to see as the top three significant features of an MLTSS program:***
  - a. identification and recognition of cognitive decline in persons with dementia (whether already formally diagnosed or not) and the establishment of a proactive program to compensate for that decline.
  - b. streamlined operations to ensure people’s access to care and services in a clear, efficient and effective manner – similar to a “no-wrong-entry” model.
  - c. a holistic approach that includes medical, non-medical, financial, legal, and social supports in a tightly coordinated team approach.

**Beneficiary Experience:**

4. ***What considerations should be kept in mind when developing person-centered needs assessments, service planning, and care coordination requirements to meet the individual’s medical and non-medical needs?***
  - a. cognition is a vital sign and needs to be treated in the same way as blood pressure, temperature, and weight – monitored on a regular basis with a clear plan for intervention if the results so dictate.
  - b. there are scientifically validated tools that can be administered in 15 minutes or less by staff other than the doctor to monitor changes in cognition and mood. These can be done in a doctor’s office, at the patient’s home.
  - c. an individual’s ability to adhere to medical and care management plans is highly dependent on his/her cognitive ability to do so.
  - d. a comprehensive needs assessment, service plan, and/or care plan must:
    - Assess cognition, mood, and other medical needs
    - Assess ADL/IADL needs, family support + resources
    - Address cultural preferences
    - Protect both the individual and the family caregiver(s)
5. ***What would you consider to be the most significant features in assisting individuals to transition between providers and service/treatment settings?***
  - a. development of a clear path to obtain services and treatment
  - b. development of a simple method for team members to coordinate care
  - c. development of a simple method for family caregivers to communicate with the professional care team
  - d. reliable transportation or methods to mitigate the unavailability of transportation (such as telemedicine, housecalls, etc.).

**Service Package**

10. ***What are your recommendations for the design of a comprehensive and integrated supports and service package?***
  - a. accurately assess the full suite of an individual’s care needs including cognition, mood, social, financial and medical.
  - b. develop a care plan that is specific to the individual’s cognition and mood in addition to their other physical needs.
  - c. Include creative approaches to service delivery that are shown to result in the reduction of unnecessary hospitalizations. Components of a comprehensive package include:

- i. housecalls by primary care physicians, physician assistants, nurse practitioners and others who have been educated in working in the home environment and are part of a care team that covers both medical and non-medical expertise
- ii. telemedicine for those patients who already have an established relationship with the medical practitioner
- iii. establishment of a care planning team with expertise in medical, legal, financial, and social support.
- iv. inclusion of cognitive and mood screening using scientifically validated tools to identify and mitigate challenges to adherence
- v. caregiver support through consumer education, care management, and clear communication.

**Conclusion:**

We highly recommend that any plan

1. provide an easy way into the “system” and a clear path to follow once inside
2. begin with a clear, accurate, and comprehensive needs assessment as defined above
3. develop a team of experts to meet the needs of the individual
4. develop a care plan to realistically meet the individual’s needs and mitigate the challenges
5. provide caregiver support
6. provide caregiver and workforce training
7. recognize the special needs of those with or caring for people with cognitive issues.

Thank you for the opportunity to comment on the proposed design and implementation of the MLTSS program. We stand ready to be a resource as you continue the design and implementation of this plan.

Respectfully submitted,

Jodi Lyons  
On behalf of SeniorSherpa  
[www.senior-sherpa.com](http://www.senior-sherpa.com)

**Provider**

**Managed Long Term Services and Supports (MLTSS)**

I would like to strongly endorse the inclusion of ABA (Applied Behavior Analysis) services in any benefit package providing care for eligible individuals who are disabled as the result of an intellectual disability or autism. As a clinical psychologist with over thirty years experience in managed behavioral health, I have observed the clinical and financial efficiency of these services with these affected populations. Regardless of the eventual model or vendor selected, ABA services delivered by appropriately educated, trained and licensed ABA providers can contribute enormously to improving the quality of life for those disabled individuals as well as their families.

As the parent of a [REDACTED], I can personally testify to the dramatic and sustained improvement that ABA services have enabled our family to achieve. I encourage DMAS to include input from the Virginia Association for Behavior Analysis as progress continues in work on the MLTSS Project.

Sincerely,

[REDACTED]

## Provider

### Virginia Beach Department of Human Services

#### MLTSS Survey Comments

June 2015

#### General:

1. What would you like to see as the top three significant features of an MLTSS program?  
Enhanced network of providers  
  
Uniform and streamlined authorization methodology  
  
Extensive medication formulary with practitioner friendly authorization requirements
2. What suggestions do you have as DMAS continues to explore the feasibility of including acute and primary care in the MLTSS program for individuals enrolled in the ID, DD, and DS Waivers? This has the potential to limit consumer choice of providers and create a burden to an already complex billing system.

#### Beneficiary Experience:

1. What protections do you consider to be essential for individuals in an MLTSS program (e.g., enrollment/disenrollment services, including choice counseling; offering consumer direction; continuity of care provisions so individuals can maintain relationships with current providers; an advocate or ombudsman to help individuals understand their rights, responsibilities, and how to handle disputes with the managed care system or state; a critical incident management system)?  
Ensure that consumers are able to maintain their current providers and medications  
  
Provide 24 hour support and assistance for consumers to understand their benefits and access care  
  
Openly ask about “representatives” that should also engage in communication regarding care/benefits to assist consumers with accessing needed services.
2. What considerations should be kept in mind when developing person-centered needs assessments, service planning, and care coordination requirements to meet the individual’s medical and non-medical needs?  
  
Avoid situations where consumers must answer the same questions in multiple settings  
  
Ensure that a consumer’s stage of change is factored into treatment planning  
  
Maintain CSB Care Coordination role

CSB's consistently reach out to medical professionals for continuity of care; it would be beneficial for an MLTSS to promote the initiative of communication from the medical providers.

Continue to allow consumer choice of providers.

3. What would you consider to be the most significant features in assisting individuals to transition between providers and service/treatment settings?

Communication and planning prior to and as a part of the transition

Exchange of medical records

Ensure that the CSB Care Coordinator (Case Manager) is involved as a central member of the treatment team

Provide written instructions to consumers and problem-solve any potential barriers to follow through with the transition plan.

4. What would make an MLTSS program attractive to individuals?

Access to providers of their choice, minimal copays, no premiums, comprehensive service coverage (including behavioral health, dental, vision, etc.), coverage of medications, ease of use without complicated claims processing

#### Provider Experience:

5. What program features do you see as important to providers who are making the transition to an MLTSS program (e.g., a payment floor, ease of authorization, billing, and payment processes)?

Develop and communicate an implementation plan so that providers and consumers are able to prepare in advance.

6. What would make an MLTSS program attractive to providers?

Create an easy to use, streamlined, and single system for service authorizations.

Adhere to DMAS regulations in a more clear and consistent manner; avoid additional layers of regulations and requirements for providers

Make timely payments

Educate MLTSS staff so that they are prepared to answer provider questions

Establish a culture of customer responsiveness

#### Service Package:

7. What are your recommendations for the design of a comprehensive and integrated supports and service package? For example, would you recommend community-based behavioral health services be included in the benefit package or be managed by a behavioral health services administrator?

Based on other experiences, behavioral health services are most effectively managed by a behavioral health services administrator.

8. What thoughts do you have on how DMAS should handle Fiscal/Employer Agent (F/EA) services for Waiver individuals who choose consumer direction of eligible waiver services? Should DMAS require that the health plans contract with the Department's designated F/EA or should DMAS give the health plans flexibility in determining how they want to provide or which entity they want to subcontract with to provide the F/EA services? For uniformity, individuals should contract with the Department's designated F/EA.

#### Health Plans:

9. What are your recommendations for health plan requirements (e.g., accreditation, offer a Medicare Advantage Plan with Prescription Drug Plan or a Medicare Special Needs Plan, experience providing services to special needs populations, other core competences)?
10. What strategies would you recommend the health plans utilize to maximize coordination with Medicare for individuals who are dually eligible?
11. What value-based payment opportunities would you suggest the health plans implement to reward providers for implementing health care transformation that could result in better clinical outcomes, improved member satisfaction, and cost containment under an MLTSS program?

## Provider

### *Living made better.*

I would first like to start by saying thank you for taking the time to listen to the comments, opinions and suggestions of those that collectively maneuver through the healthcare delivery system. In a response to the request of for public comment on the proposed design and implementation of DMAS' program initiative to transition the remaining fee-for-service populations into a mandatory managed care program, I have 3 distinct areas I would like to ensure are discussed and considered prior to effecting change in the manner proposed. Each of these areas relate to the initial mission that was agreed upon under Commonwealth Coordinated Care.

The Commonwealth Coordinated Care (CCC) Mission statement is: "To provide Virginians high quality healthcare and supports by coordinating the benefits of Medicare and Medicaid into a single, person-centered program". This coordination should be done in a manner in which the foundation is on the delivery of primary, preventive, acute, behavioral, and long-term services and supports that is focused on their needs and preferences. Coordination in itself can mean a variety of things depending on the context it is used, but philosophically it's all about ensuring the a set of beliefs or items are operating in unison, whether it's a mathematical coordinate on a plane or a group of people planning a party. The steps in doing so are what cause the ultimate reaction that allows this to be. Based on the unified mission of CCC, the goal was to be able to improve quality by ensuring that benefits are being used efficiently across the healthcare delivery system. I do not feel that we have accomplished this as evidenced by the following:

#### Communication Across the Delivery Spectrum.

As mentioned above, the goal is to coordinate individual services a patient across a different portions of our delivery system. While the program conceptually makes sense to ensure efficient delivery as no one healthcare organization can effectively manage all of the necessary healthcare issues, we have yet to understand the different languages, challenges and protocol necessary to efficiently manage the patient and reduce further healthcare risk. Currently there are different healthcare accrediting and monitoring bodies associated with the different levels of care. Because of this, there is a lack of understanding of the requirements placed on each area of delivery. We have experienced this early on in the transition of CCC. There was and still is a lack of understanding of the authorization process to ensure the timeliness of patient care delivery. In some cases this has caused a delay in services which ultimately affects patient outcomes. While there has been some headway through discussion, the issues

still remains and still occurs. The communication of these issues happened however it was not until larger groups were involved, and very heated discussions occurred before any change took effect. This interrupted cash flow from several centers as there were payment disputes and discrepancies with levels of care that were authorized. There were clear issues of a lack of understanding of process and procedure for each area, Insurance Company, Hospital, Skilled Nursing Facility and Home Health companies alike. Again, while communication was effective in drawing out some of these challenges, they still exist and there are still centers and facilities that are lacking in understanding on what to do in certain circumstances. As a result of these challenges and/or inability to successfully implement the expectations, the patient suffers the consequence which further degrades the fabric of CCC's mission.

#### Degradation of Quality

Referencing the mission statement again, quality is the cornerstone of the initiatives development. Since inception there has been no documented demonstration of how the initiative has improved quality. Based on weekly CCC phone calls and personal provider references, we have seen several documented issues, to included negative outcomes due to lower level of care authorizations to discontinuation of services and subsequent re-hospitalizations. While this is expected with any change that may occur, the gravity of the changes should have been anticipated and communicated in advance. It can be inferred that the issues presented were not communicated because of the lack of forethought as a reasonable expectation due the program not being clearly thought out. While this may be a limitation, it does not mean that the program should come to a halt. It simply means that more time and thought needs to be put between the demonstration and its full implementation or expansion as a mandatory requirement.

#### Increased Operational Costs

With the aging of the population in the United States, more individuals will need long-term care services in the future meaning that the demand for long-term care services will be increasing as well. We also see the increase of comorbidities along with these longer living individuals which can also mean that community based living may not be appropriate.

The abrupt changes that came along with CCC have also introduced many new financial costs to the already constricted models. Most skilled nursing facility experience very small profit margins, likely in the neighborhood of 3% or less. With the inception of the newer models, many facilities had to increase the administrative cost due to the additional burdens placed on the system, further reducing the margins. In addition to the reduced margins and increased costs of operations, Centers are

expected to do so with reduced reimbursement. It seems that the project failed to review the domino effect that this would have on providers. Those that are able to stay in business will have to do so by cutting "somewhere" which for some will be done in payroll or other care areas, further degrading, as mentioned above, the fabric of what the mission is trying to accomplish with is improved quality. As a byproduct, those centers that may not be able to evolve with the change may have to close their doors, reducing the number of available beds which as alluded to above, is a growing need. Further discussion on how this restriction is affecting all areas of delivery is something that should be explored.

While the demonstration seems to be a great attempt at reducing the cost of healthcare, there seem to be gaps in its planning that have left providers and beneficiaries alike with much to be desired. In short, it is my opinion and the opinion of other healthcare constituents that transitioning the remaining fee-for-service populations into a mandatory managed care program is premature and significantly increases the risk of poor quality and increased financial burden. I ask that the thoughts outlined in this letter be taken into consideration and additional plans be made to ensure that the decisions have a reduced effect on an inclusive delivery model and not simply a part.

Thank You,

A handwritten signature in black ink, appearing to read 'Theric Brown', with a stylized flourish at the end.

Theric Brown, MBA, LNHA

Manassas Health and Rehabilitation Center

**Provider  
Association**



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June 16, 2015

Dear DMAS,

Thank you for the opportunity to provide initial comments regarding the Department's plans to transition the remaining fee-for-service (FFS) populations into a mandatory managed care program. As you know, the Virginia Health Care Association is a member-driven organization dedicated to advocating for and representing the interests of over 275 Virginia nursing and assisted living facilities and the thousands of residents/patients they serve. We recognize that DMAS has over twenty years of successful management of Virginians who require medical assistance. The Virginia managed care infrastructure developed by DMAS is among the longest tenured and most effective in the country. However, as you know, the services required by Virginians who require long term care services and supports are complex and very challenging to manage.

We understand from your announcement of this opportunity for public comment that there will be further opportunities to comment as more details emerge from the Department on the proposed plan. As always, we appreciate the Department's willingness to engage stakeholders in the planning process and in the case of Commonwealth Coordinated Care (CCC) specifically, in the process of working through the many issues that have emerged in this first foray into "managed" Medicaid long-term care services. The collaboration between the Department, the managed care plans, and the nursing facility providers has been integral in the identification and potential resolution of issues experienced in CCC. The many lessons learned in the past 12-18 months and going forward should prove useful in the Department's future efforts.

VHCA would like to learn more about how the Department intends its new "MLTSS" program to meet the goals articulated in the public comment solicitation when it is focused on a "Medicaid-only" program. As stated in the solicitation, the majority of the remaining LTSS populations covered under FFS are dually eligible, with Medicare representing the primary benefits for which "coordination" could be a benefit for the nursing facility population. Previous studies/programs have shown the vast majority of nursing facility residents do not have viable community care options, due to their high acuity and lack of community supports. Any Medicaid nursing facility resident that can transition back to the community should do so and our

members work very hard to ensure this happens. However, our experience has supported the research indicating that very few can residents can successfully do this with the current support services environment, particularly under the strict eligibility standards of Virginia's Medicaid program.

VHCA has discussed with DMAS that our members have not seen a meaningful impact of care coordination under the CCC for nursing facility patients and residents. DMAS and the plans are working to better define the role of the care coordinator specific to the multiple CCC population types served, and we appreciate the inclusion of nursing facility input into that process. However, it has yet to be determined what added value the "coordination" under the managed care delivery model can have to a nursing facility resident population with interdisciplinary care teams who are already assessing the residents' needs and developing a plan of care. Adding another layer to this process could serve as an additional resource, or create conflict due to the coordinator's relationship with the payer. To date, our members are not clear which way the care coordination role has developed under CCC because other than the initial assessments, the role has not been functioning as planned. The value of this coordination is further limited in a Medicaid-only program, given the high reliance on Medicare as the payer for the "service/treatment settings" transitions of nursing facility residents, for example.

VHCA is interested in learning how the Department intends to link a Medicaid-only managed care model to the Medicare program, where flexibility between conflicting Medicare and Medicaid program rules/policies has the most potential to improve both quality and efficiency in the care delivered to this extremely vulnerable population. As a profession, we are interested in pursuing any and all flexibility to serve as the bridge between the two programs for the populations we serve. Whether that be reflected through provider-sponsored operation of a Dual Eligible Special Needs Plan (D-SNP) also participating with DMAS in the MLTSS program as a risk-bearing partner; or, through contractual arrangement as the "care coordinator" for an external managed care plan, it is clear that for the population served in nursing facilities, those facilities are uniquely positioned to bridge the service gap between programs, as they are already well-aware of the service needs and have already developed interdisciplinary care plans, as required under federal regulations.

We are also concerned that the approach to first make CCC-eligibles mandatory participants in at least a Medicaid product managed by one of the three existing CCC plans likely making those individuals exclusive to CCC plans going forward will, among other concerns not related to this comment request, create a bifurcated delivery system for LTSS depending on the specific locality of residence. Given that the CCC model may not continue after the demonstration, nor will the evaluation of CCC be available, it appears premature to develop a program for the "rest of the state" and for the handful of Medicaid-only LTSS recipients in the CCC regions. Additionally, excluding the CCC population from the MLTSS procurement and model(s), particularly given the stated timing of MLTSS effective coverage beginning only six months before the scheduled end of the CCC demonstration, seems problematic, and it is not clear whether there will be interest for new MLTSS respondents to even consider the CCC regions in their proposals given the exclusivity granted the existing CCC plans in those localities.

We look forward to continued dialogue as the Department further develops its plans for a MLTSS program, and we encourage flexibility in the Department's approach to "managing" this frail and vulnerable population. As always, we appreciate the Department's willingness to engage stakeholders in the program development. VHCA's support of this new initiative is contingent upon the successful resolution of the many issues within the existing CCC program – this and other future iterations of managed LTSS should not progress until the CCC program is corrected. Below, you will find some bulleted responses to your listed questions in the public comment solicitation. We would be happy to discuss these and other concerns in more detail at your convenience as you develop the plan more fully. Thank you for your consideration.

Sincerely,

A handwritten signature in cursive script that reads "Keith Hare".

J. Keith Hare

- Q1: The program should not create additional obstacles to efficient and effective delivery of care – the implementation of CCC has had a significant negative impact on the administrative resources of providers as implementation issues have arisen. Anecdotally, the CCC program has had a negative impact on some beneficiaries as well, in terms of authorization delays, etc., although this impact has been mitigated by the optional participation nature of the program
- Q1: Flexibility in program design – allow for different models than under CCC, such as the provider sponsored D-SNP linkage or other innovative models that better represent a true patient centered medical home than the current external managed care organization model has achieved under CCC.
  - Provider Sponsored Organizations ("PSOs") should be given the opportunity to bid on the MLTSS RFP, which should include CCC regions and eligibles in terms of program choice. There should be a mechanism established for these organizations to apply to CMS as a D SNP in conjunction with the CMS MA/SNP application process.
    - We would note that the application process for a SNP would begin in November of 2015 with a letter of intent and on or about 2/18/16 the applicant would require a letter from DMAS indicating that the PSO is applying to be a MLTSS plan and would qualify as a D SNP
    - The nursing facility population should be delayed at least until 1/1/2017 from the mandatory enrollment process for their Medicaid benefit under Phase I (CCC Program).
    - Approved PSOs for the nursing facility population should be able to enroll interested members on a voluntary basis effective 1/1/2017.
- Q1: Recognize that the individuals best positioned to coordinate the care of recipients, particularly those whose home is a nursing facility, are the direct caregivers of this very vulnerable and frail population; administrative layers do not represent true coordination, particularly when the layers are not resourced properly to have any meaningful impact.
- Q3: Consideration should be made for populations, such as the nursing facility population, to allow disenrollment due to network adequacy concerns. CCC implementation highlighted the problem with applying general network adequacy requirements to a “niche” population; continuity of care, if time-limited, only postponed the problem in many cases. Opt-out decisions based on network participation of established providers for this vulnerable group are reasonable and should be protected, particularly if preferred networks are allowed for institutional long term care providers
- Q3: “Any willing provider” should be maintained for the nursing facility population under any future managed care plan so that recipients are not forced to move, with Medicaid rate floors protected for those facilities who do not wish to participate
- Q4: Nursing facilities are already required under federal and state law to develop care plans through utilizing interdisciplinary care teams for residents of their facilities – this should be recognized in the plan design to avoid the addition of layers versus actually adding value to

the existing process; the CCC program has not yet achieved a “value-add” in this regard for nursing facility residents, thus, we are skeptical that expansion of the current CCC model is the proper direction for MLTSS

- Q5: Based on the population to be covered and from the point of view of nursing facility services, the typical transition from the recipient’s home (the facility) to another setting require interaction with the Medicare program, as the coverage is typically Medicare-primary for these individuals. It is not clear to us how a Medicaid-only program would improve the misalignment of program rules. To the extent the program design included flexibility between the two programs, more potential for improved quality and efficiency, as well as beneficiary experience, would exist. We are interested to better understand how DMAS expects MLTSS to achieve that flexibility with Medicare, and we reiterate our unique position in easing such transitions for our residents should such flexibility between programs be achievable.
- Q6: For the population we serve, no disruption in care provision and flexibility with program rules between Medicare and Medicaid would be the primary tenets making MLTSS attractive to residents
- Q7: Any willing provider for nursing facilities; Medicaid rate floors, particularly for non-par providers; enforced payment within specified timelines (14 days); Authorization timeliness requirements specific to the vulnerable nature of the population served; Covered service, billing/payment processing and authorization procedure consistency between payers, preferably consistent with existing fee-for-service
- Q8: See responses to questions 1, 3, 4, 5, 6 ,7
- Q9: For the nursing facility population, supports are mostly integrated already given the scope of the facility services. However, access to other benefits, such as behavioral health, have been inconsistent and likely underutilized thus far under CCC, likely due to the lack of care coordinator presence in the facilities. Notwithstanding that it does not appear that the CCC program has handled this issue optimally, we reserve judgement on the future program until we fully understand the flexibility in design the Department may pursue (see question 1, above)
- Q11: The lack of plan experience with the long term care population, particularly on the Medicaid side, has been a tremendous impediment to the program’s success to date. To the extent “plans” have experience in *effectively* providing services to these vulnerable populations, it would be a benefit. Thus, considering provider-sponsored D-SNPs or reliance on nursing facilities for the actual care coordination of their resident population would improve the potential for success of MLTSS
- Q11: Further, it is also clear to VHCA that the real potential benefit of a “managed” program is the possibility of flexibility between the Medicare and Medicaid program rules. It remains unclear how the Medicaid-only nature of this program will facilitate that flexibility. Even with

co-management of a Medicare managed care plan, it is not entirely clear how the incentive structure within the conflicting program rules will be overcome, particularly since Medicare has primary coverage of the services most likely to achieve efficiencies with such flexibility

- Q12: Co-management of a provider sponsored D-SNP appears the most likely approach to maximizing coordination of this population. A D-SNP offers several advantages for providers seeking ways to support sustainable reform efforts that result in cost and quality benefits for patients, states, and providers. A provider sponsored D-SNP would allow providers to focus on the specific patient population that they are most equipped to manage – the Medicaid recipients to whom they currently deliver care. The D-SNP model allows long term care providers to do more of what they already do very well—provide high quality care and services for nursing home patients and those patients living in the community with long term care needs. The development of a risk-bearing D-SNP with an associated network of providers, facilities, and community-based services will ensure DMAS to hold the provider-sponsored organization accountable for care coordination, appropriate utilization, and overall accountability for nursing home residents. Providers are empowered to make the investments and changes needed in the existing system in order to achieve the goals important at the individual level for patients and at the macro level for the overall sustainability of the Medicare and Medicaid healthcare systems.
- Q12: Even without bearing risk, nursing facilities acting as care coordinators within a third party plan for the residents they serve would also increase the probability of a real impact of “managing” the care of this population.
- Q13: There are several value-based payment initiatives under experiment, and whatever program is designed should allow for incentive-based rewards, payment or otherwise, to providers. Again, it is difficult to contemplate this in a Medicaid-only program for a nursing facility resident, as the improvements related to shortened length of rehabilitation, re-hospitalization reductions, etc. relate to services for which Medicare is typically the primary payer. It is important for us to understand how MLTSS will interact with Medicare prior to fully contemplating this question. Again, to the extent the provider is the intermediary between the two programs (as a D-SNP or as a care coordinator, for example), the potential for transformation is greater.
- Q14: We look forward to providing input as the plan progresses. For now, we would recommend that there is no reason to reinvent the wheel. Depending on the models utilized under MLTSS, there are already a cadre of measures developed and utilized for nursing facility and other care. Consistency in reporting across programs is paramount.
- Q15: See response to Question 13
- Q16: We look forward to working with DMAS on outreach and education going forward. It is clear from CCC implementation that despite significant efforts by DMAS on outreach, the unique needs/situation of nursing facility residents warrants specialized approaches.

- Q17: “DMAS will take its time to correct the deficiencies of the CCC program and incorporate these lessons learned into any future MLTSS development, including both the mandatory Medicaid participation within CCC (Phase 1) and the program developed for statewide application (Phase 2). We will not proceed until such time that the issues with CCC can be fully resolved to the satisfaction of recipients and providers, the evaluation of CCC can be completed and understood, and a statewide approach to MLTSS can be considered more fully, possibly incorporating the CCC model, but allowing all approved models to apply across the State, including the current CCC regions/populations, based on beneficiary choice. We look forward to working with all stakeholders on the program design, including flexible approaches beyond current CCC design to better achieve true and effective reform on Medicaid delivered LTSS.”

## **Provider**

Efforts to coordinate care are applauded, however, providers credentialed with Medicare and Medicaid should not have to go through a separate and lengthy credentialing process with Coordinated Care contractors.

Audiology Associates of Harrisonburg

590 Neff Avenue, Suite 5000

Harrisonburg, VA 22801

540-574-4327

## Provider



MLTSS Public Comments – Medicaid Managed Care Comments

June 3, 2015

- The CCC program has not been successfully implemented so far and any expansion of managed care before it is operating as planned is premature.
- The CCC program has not demonstrated that case management of the nursing home long term care population is beneficial in terms of cost reduction or quality of services.
- The CCC payers have failed to provide effective case management services to the nursing home population so it is impossible to conclude if this can be effective or not.
- Adding greater administrative burden and costs to providers runs counter to trying to reduce the cost of health care, and any managed care expansion has to deal with regulatory relief to allow providers to reduce costs and survive with lower payments.

The Medicaid Program has been working for years to help folks who do not have the resources nor family to take care of them in their old age. A benefit many worked all their life to help in their older time of life.

The medical necessity should be determined by medical folks and not dictated by insurance and other non-medical professionals.

While assets should be considered, a person should be able to maintain their home and their vehicle.

As an individual turning 68, I personally hope that due consideration is given to the patient, nursing facility and home health that needs to be able to be paid enough after the hospital stay, so the patient can get the services they deserve and need, not only medical but therapy services as well.

Thank you for your consideration as you work through this process.

Sincerely,

A handwritten signature in black ink that reads "Robert K. Ham, LNHA, RN".

Robert K. Ham, LNHA, RN

Administrator

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## Provider

Parisa Farhi, MD  
1901 S. Main Street, Suite 1  
Blacksburg, VA 24060  
Phone: 540-552-1120

Dear Madam/Sir,

Thank you for allowing for public comment on proposed expansion of MLTSS. It is serendipitous that this email arrived today since I just had to deal with the negative consequences of MLTSS. I think this example will explain the problems with MLTSS and its proposed expansion.

I am an ophthalmologist in SW Virginia. About 40 minutes ago, at 3:00 am, I received a call from our ER. They had a [REDACTED] on now Medicaid [REDACTED] who had [REDACTED]. They had seen [REDACTED] a few days earlier in ER and had asked [REDACTED] to follow up with an ophthalmologist after prescribing [REDACTED]. [REDACTED] was told that it is important that [REDACTED] follows up with an ophthalmologist. The [REDACTED] could not find an ophthalmologist who takes the [REDACTED] version of Medicaid. So [REDACTED] returned with [REDACTED] to the ER. The ER doctor called me at 3 am asking for help for follow up. Our office accepts regular Medicaid as a public service despite it being 20% below Medicare and despite a loss for us. However we refused to accept the new expanded Medicaid involving [REDACTED] since they wanted to cut us another 20 percent below it, a total of 40% below Medicare. Worst of all when the agent from one of these companies wanted to recruit us they tried to conceal the fact the overall impact of participating with them as a 40% cut over the already shrinking Medicare costs. The difference and the profits presumably goes to the middleman ([REDACTED]). These two companies in the past have been difficult for us to get referrals from or to work with. So, we refused to participate with the new Medicaid involving them. The introduction of a profit-seeking middle agent complicates the billing process, increases the administrative staff costs and the extremely low reimbursements makes participation in this program as a provider a huge disincentive.

As a result, this [REDACTED] costs the system more by going to the ER twice, has prolonged pain, has possibly [REDACTED], my office staff is spending time to help [REDACTED] find an ophthalmologist and care, and I am writing this letter at by now 3:45 am. Currently, some practices, without recognizing the severe cuts, are enrolled with [REDACTED] Medicaid. But I suspect that will change after they recognize the reduced payments and the increased staff time these plans require, making healthcare less accessible to many in-need Virginians and increasing the cost to the system by landing them in Emergency rooms and hospitals. These patients after running to such problems will probably switch to regular Medicaid, shifting their now increased healthcare costs to the state. This is a negative step encouraged by health insurance industry in order to increase their revenue at the expense of providers and the patients and it will create more problems as demonstrated. Thank you for the opportunity for public comment.

Cordially Yours,

Parisa Farhi, MD

## Provider

To Whomever it may concern in the eye care business:

While I have no problem with your working to change everyone over to an HMO, I would like to express my concern with allowing these HMO's to be more selective than the State has been in who they will accept as a provider. Is not your sole purpose to care for those less fortunate or in a financial bind? I hope you realize this is not the sole concern of most HMO's. Allow me to give you this example:

I own a small optical shop in the little town of Brookneal. I am an independent optician serving this town which is thirty miles from the nearest optical shop. For around 95% of my Medicaid patients they get to leave with their new prescription glasses the same day. But because I am an independent, Virginia Premier will not allow me to sign up with them. What this means to some of the local people here is that they will now have to travel 60 to 80 miles (round trip) at least twice. They will need to order their glasses and then return to pick them up days or even weeks later. For whatever reason Virginia Premier decided this was best for their own bottom-line, they certainly were not considering the welfare of these people. Instead, they, in this case, have added to their financial burdens. But surely this is not what the Medicaid program is all about.

So my comment is to ask you to consider who are you approving to be qualified HMO's and require them to not refuse any current Medicaid providers from signing up with them as a provider. I personally do not care for Virginia Premier but, after serving here for 18 years, I really do care for the people of my area. Isn't that why Medicaid came about in the first place, concerned or people in need?

Sincerely,

Mark A. Kramer RO

Brookneal Optical

## Provider

6/4/15

Re: MLTSS Opportunity for Public Comment

DMAS,

As an Administrator of a dual eligible skilled nursing facility The Managed Long Term Services and Supports program is of major contributor in how we are able to care for our patients. My specific concerns and comments are the following:

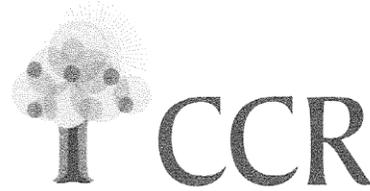
- 1) As my center was a part of the central Virginia implementation of CCC I have particular concern regarding the premature nature of extending this program prior to working through the challenges that have presented themselves during the current implementation. The MCO's were unable to keep up with the demands of being actively involved in the care of our residents, unable to attend care plan meetings and unable to make on-site visits as promised. Some instances occurred where patients faced delays in care due to the timeliness of the approval process. For this reason many of our patients and families who had enrolled, later un-enrolled in CCC. I believe better organization and coordination in this process is needed before expansion can occur successfully.
- 2) The managed long term services process has put greater burden on staff members who assist in the managed care process. Thus taking away from direct care to the patients and the care planning process. For our social worker, therapy staff, nursing management and business office staff the time spent on facilitating the items needed by the MCO's on an ongoing basis consumes much needed time that should be dedicated to the needs of our patients. This is counterproductive in both patient care as well as cost savings. The additional administrative burden alone prohibits us from reducing costs of providing healthcare.

Lastly, I would like to thank DMAS for allowing us the opportunity to provide comments regarding the MLTSS program moving forward. It is through coordinated efforts such as these that I believe we will be able to move forward in providing better care and coordination to the patients we serve within the Commonwealth of Virginia.

Thank you,

Amy Oakley, LNHA

## Provider



*Committed. Caring. Responsive.*

June 8, 2015

Dear Sir / Madam,

We are writing, as requested, to provide comments about the expansion of Medicaid managed care services to recipients of Medicaid long-term support and services (LTSS) in the Commonwealth of Virginia. We hope that the comment period is not merely a formality to meet regulatory requirements, but a sincere effort to gain feedback from stakeholders regarding a proposal that has the potential to negatively impact the most frail and vulnerable population in Virginia. We offer these comments with the anticipation that these remarks will be considered in a serious manner and from a perspective that comes from providers of services to the vulnerable elderly Medicaid recipients the Commonwealth has a duty to protect. We also provide these comments as a commitment to continue working with DMAS and the Department of Health to achieve the desired outcome. These comments are meant to work towards a system that works and is free of fundamental cracks in the foundation of the current Commonwealth Coordinated Care program before we add more citizens to a managed care system.

Starting July 1, 2014 the Commonwealth Coordinated Care (CCC) program began providing managed care services to individuals residing in nursing facilities. The CCC program has not been successful in meeting the needs of individuals who are residents of long term care facilities and has been extremely disruptive to providers. Nearly one year into implementation this program continues to have numerous shortcomings:

- The touted differentiating feature of the program is to provide case management services to a population that has never received these services. For the long term care population these services have either been very limited or not been delivered at all.
- The case managers from the insurance carriers have provided minimal if any assistance with the discharge process into a community setting. This transitional service is the one point where they could actually contribute to benefit the nursing home population and produce savings in the program but it has not materialized.
- One year into the program the three insurance payers cannot consistently pay claims in accordance with the contract (a 14 day payment window for a clean claim) and continue to make incorrect payments which is only one of the many issues with the program.
- There has been a lack of engagement from the federal level at CMS to help with the program and resolve serious issues related to coverage eligibility. While this may be seen as a side issue to a mandatory Medicaid program, any plan that involves interaction between the Medicare and Medicaid program

must deal with this very fundamental issue. MMP/Managed Care denials of eligibility for skilled care services that would have been clearly provided under traditional Medicare Part A SNF coverage shifts the payment burden directly to the Medicaid portion of the program.

- These issues point to the fact that the Commonwealth has not yet demonstrated the ability to successfully manage the contracted insurance companies providing managed care services to the long term care population in nursing facilities.

To those of us who have worked for well over a year to make the CCC program work, and continue to do so, it is important to truly recognize the shortcomings of this program, learn from the experience and take a deliberate path to any new program. In retrospect the timetable for rolling out the CCC program did not allow for the infrastructure to be built to run the program effectively. Too many things were left to be resolved after the program launched and almost one year into the program remain a problem with no clear resolution in sight.

To expand managed care across the entire Medicaid population is not logical based on the lack of demonstrated success with the dual demonstration program as it applies to the long term care population. As of early April 2015 the CCC program serves approximately 26,000 individuals with less than 4,000 of those being in nursing homes. Increasing the number of people under Medicaid managed care by adding the projected 37,000 in the summer of 2016 and another 50,000 starting in 2017 using an ineffective program as the foundation for expansion invites failure in the long run.

Given the ability to opt out, a large number of individuals who were automatically enrolled in the CCC program have chosen to move back to the fee for service Medicaid program. This is a clear indication of the shortcomings of the program. Making participation in managed care mandatory for the LTSS population as a solution to increase enrollment ignores the flaws in the program and fails to fix the problems. This approach to achieve whatever perceived savings there are to the Commonwealth from a managed care program shows little regard to improving services to the patients.

One consideration in any expansion is that long term care facilities effectively and efficiently provide case management services to the frail and elderly nursing home population, and have done so for many years. Licensed nursing homes prepare interdisciplinary care plans for all patients and coordinate care needs with other providers when necessary to meet the patients' needs for outside services. Having a third party involved adds no meaningful benefit to this process and has in fact proven to increase costs and the administrative burden of the nursing facility Social Work Case Managers by introducing yet another party into the process. The concept that managed care services will decrease the number of individuals in facility settings is not reasonable. Previous studies conducted by the Commonwealth have shown that the primary factor limiting safe discharges of nursing home residents who could be in a community setting is the individuals' personal living circumstances and the absence

of an informal caregiver. Adding managed care services will not create informal caregivers to reduce utilization of inpatient long term care services.

Managed care services through a network of case managers can achieve some of Medicaid's objectives for community based beneficiaries who are dealing with episodic illnesses or managing chronic health conditions. However, once a person reaches a skilled nursing facility as a long term care resident they are in a setting where their needs are managed by the provider making the case management services of a third party redundant while adding costs to the system not reducing costs.

The stated objectives of a Medicaid managed care program are not applicable for the population residing in skilled nursing facilities. For example:

- "Increased access due to larger and more comprehensive provider networks" – Virtually every nursing facility in Virginia is part of the Medicaid network of providers by virtue of their participation in the program. It is doubtful that adding a managed care program will improve access to long term care services. In fact, under the CCC demonstration access to primary care physicians has been problematic by steering patients away from the physicians who have cared for the individuals for years to "in network" physicians who do not know the patients nor have the expertise or desire to serve the nursing facility population.
- "Focused quality improvement programs" – The nursing home regulations currently require quality assessment programs. Nothing has occurred in the CCC program to show that the introduction of managed care services has contributed to improved quality and in some cases has hindered the ability to provide quality services in a timely manner by adding bureaucratic processes to the referral process.
- "Improved quality of life, satisfaction, and health outcomes for individuals enrolled" – Skilled nursing facilities are already regulated to meet all of these objectives and are extensively surveyed to measure compliance. A managed care program provides no added value to meet this objective.
- "Service coordination that provides assistance in navigating the service environment" – The CCC program has not demonstrated any improved services and has not shown that these objectives can be met.
- "System-wide improvement and monitoring" – The services in nursing homes are already extensively monitored by the current survey process and publicly report quality measures. Adding case management only adds a burden to providers to deal with another layer of administrative overhead while not improving care at the patient level.

Given the shortcomings of the concept of case management for the nursing home residents the only stated objective of moving to mandatory Medicaid managed care that remains is the budget predictability of a capitated payment system. In other words, a managed care program allows the state to set a total amount to be spent to meet the needs of the frail and vulnerable population residing in nursing homes while transferring administration of the program to contractors. These contractors must pay

for the case managers and earn some profit for their services. This means the only way to balance the equation is to reduce the amounts paid to providers to meet the health care needs of the patients. If there are no community based services allowing for safe discharges and a lack of engagement by case managers to find appropriate settings for discharges, the only option is to simply reduce payments to providers. This is what we have experienced in the CCC program in terms of delayed payments, redefining coverage criteria, and in some cases retroactive denial of benefits. The Medicaid program currently does not pay for the full cost of care requiring indirect subsidy from the Medicare program and other payers. Further restricting the payments for the Medicaid population only makes this problem worse.

If the CCC is the model to be followed, the concept that managed care is a solution to the fiscal challenges of funding long term care services by simply outsourcing the administration of the claims and fixing the states spending via a capitated premium is not sound health planning. The current pilot of this concept in the CCC program shows that calling something managed care with case management services does not change the simple economics that currently do not appear to add up. Under the CCC program providers have seen their uncollected receivable balances mushroom even though the individuals covered by the program are a subset of the total population served. Statewide expansion without first understanding the reason for and finding solutions to the current program's shortcomings is setting providers up for financial burdens that some providers likely will not be able to endure.

In developing a managed care program to cover the long term care population served in nursing facilities, fundamental issues regarding overly burdensome and outdated long term care regulations must be addressed. It is doubtful that this can be accomplished in the timeframe currently being considered.

Introducing managed care network concepts to build financial incentives to improve care runs counter to the highly regulated nature of nursing facilities. Providers are severely restricted by federal and state laws from creating new and innovative approaches due to the need to meet the stringent regulations that form the basis for the survey process. These regulations are based on a time when nursing facilities provided primarily custodial care services, not the current environment. Market incentives inherent in managed care networks are inconsistent with a micro-managed regulatory environment. As payments to providers are squeezed in a managed care environment it is essential that flexibility be restored by removing burdensome regulations to allow providers to find cost savings while maintaining quality services.

The CCC program has proven to be administratively burdensome and expensive for providers while not improving care or delivering on the promise of case management services. Moving forward before that program can be fixed to serve as a basis for expansion is an invitation for problems that may prove to be insurmountable. A rapid rollout as proposed could easily lead to a situation where the program does not work. If the current Medicaid infrastructure is dismantled in the process (which it has to be to

get the savings for the state) then there will be no turning back to fix the problems and nothing in place as a safety net for our frail population.

In closing let us thank you for reading our comments and carefully considering these points. We are hopeful that this will foster serious debate about:

- How we should move forward to meet the needs of the long term care population
- How a program can be structured to address the serious shortcomings of the CCC program and avoid the same mistakes going forward
- How the Commonwealth structures a program that truly brings the concepts of case management and market forces into the long term care setting given the legacy issues of federal and state regulations that are outdated
- What implementation timeline is reasonable, because too aggressive a rollout with inadequate planning will likely lead to failure

Embarking on extensive change to fundamentally change the system for funding long term care is not a risk that can or should be taken lightly with the lives of many frail and vulnerable Virginians at risk. Many of these individuals were those who powered our economy, dug our coal and educated all of us. These individuals will in the end bear the brunt and be hurt by hasty timetable. Taking a measured and deliberate path down the right road may not be the most expedient but it will be the most likely to succeed in balancing the needs of the program beneficiaries and the fiscal constraints of the Commonwealth.

Kind Regards,



David Tucker, President & COO

Kind Regards,



Stan Huffman, CFO

## Provider

06/09/15

Re: MLTSS Public Comment

Dear DMAS,

I would like to express my concerns regarding the expansion of the CCC program and managed care services to the nursing home population. As administrator of a dual eligible skilled nursing center, my concerns are the following:

- 1) The CCC program has not been successfully implemented. There are numerous patients, vendors, families, and potential residents who are unaware that they are even enrolled in the program. We have seen potential admissions to our center be denied and recommend home health care which has resulted in the referral not receiving appropriate and necessary care due to the home health agencies not participating in the program. This program has limited the availability of services in a community that already has a lack of available service providers due to being small and rural. This has caused several people from our community to disenroll from the CCC program.
- 2) This program has added a greater burden and costs for providers to manage this process. Any managed care expansion has to involve with regulatory relief to allow providers to reduce costs and survive with lower payments. These issues will result in a reduction of time in providing direct care to the patients. This CCC program has not demonstrated that it is beneficial to the quality of services that is provided.

Thank you for allowing me the opportunity to express my concerns regarding this process. Together we will be able serve the Commonwealth of Virginia to the best of our ability and provide the most services possible to our residents.

Sincerely,

Angela Baldwin, LNHA

**Provider  
Association**



Email: [VAMLTSS@dmas.virginia.gov](mailto:VAMLTSS@dmas.virginia.gov)

June 11, 2015

Cindi Jones, Director  
Department of Medical Assistance Services  
600 East Broad Street  
Richmond, VA 23219

RE: Managed Long Term Services and Supports (MLTSS)

Dear Ms. Jones:

The Virginia Association for Home Care and Hospice (VAHC) Board of Directors is responding to Virginia's Upcoming Proposed Plans for MLTSS. VAHC is aware of the national trend for Medicaid programs to move toward MLTSS systems. VAHC supports the opportunity to create a seamless, integrated health services delivery program that improves care and compensates providers adequately.

Given the fact that we are one-year into a significant demonstration program with the Commonwealth Coordinated Care (CCC) program, VAHC believes it unwise to implement any additional system changes at this time. The managed care plans (MMPs) along with the long-term care provider community continue to have implementation challenges. Specifically, in the home care arena, MMPs routinely fail to pay providers for episodic skilled services, credentialing has been slow, payments have passed the 14 day prompt pay window for a variety of reasons, and care coordination has been delayed.

Virginia's long-term care system (LTCS) is composed of a broad range of business entities, including large multi-state entities to small family operated organizations. Our experience with CCC to date has demonstrated that providers continue to experience issues with inflexible and rigid contract terms that result in under or nonpayment for care that would be traditionally paid by either Medicaid or Medicare. We believe that the MMPs participating in CCC continue to have an inadequate understanding of Virginia's LTCS.

Historically poor reimbursement rates to waiver providers has significantly limited the ability to invest in information technology systems. This void has been further complicated as providers are now interfacing with multiple MMPs each with their own unique systems and definitions of "clean claims." As VAHC conveyed to DMAS during early discussions prompt payment is critical for small LTCS providers with limited or small reserves. This has put some LTCS at risk of financial collapse.

Tracking enrollment and disenrollment has been a significant challenge for the provider community. This has been compounded by the ability of a beneficiary to change plans or to seek disenrollment every 30 days. Beneficiary health status may remain relatively stable and they may even use the same provider, yet the enrollment status changes continuously. This has added another level of verification and complexity to the coordination of care and put LTCS providers at an addition financial risk once the hold harmless period has ended.

Despite DMAS and MMP efforts to provide technical assistance to LTCS providers the transition has been challenging. Many LTCS providers have felt market pressures created by CCC that are forcing major changes to their business practices and in some cases, their business models. The MMPs have little experience with community based providers which has been compounded by ridged inflexible systems designed to accommodate acute care.

Many of these problems with CCC are a result of the expedited transition time resulting in the MMPs not having systems in place at the outset. We have learned from CCC that many LTCS providers do not have the internal resources to negotiate contractual agreements with MMPs. The contracts are more formal and complex than traditional DMAS provider agreements. This expansion will only add additional layers, contracts, processes, billing rules, pre-authorizations, and new sets of requirements for each contract. The industry continues to adjust its business model to these new changes for CCC. Additional changes at this time would further stress this sector and will result in significant compression of the industry.

MMPs should be held accountable for person-centered needs assessments, service planning, and care coordination that are timely and meet the individual's needs. This must be done face-to-face and in a timely fashion. DMAS must devise a robust public reporting of MMP performance. There must be a demonstrated benefit to the Commonwealth resulting in significant savings and improved patient outcomes. A robust public reporting system will allow beneficiaries to make better decisions regarding their health care.

MLTSS must be fully automated with timely accurate information. This would include an electronic Uniform Assessment Instrument system with automated authorization processes. Provider reimbursement rates must compensate providers accurately and quickly. A payment process must be developed to include detailed reasons for rejected or “unclean” claims. DMAS must provide detailed publicly accessible reports regarding MMP performance in these areas. This level of information will provide the industry with the necessary information in determining which MMPs they wish to contract.

VAHC is currently developing a model of value-based payment opportunities for MMPs to consider implementing. Our intent is to reward providers for better clinical outcomes, improved member satisfaction, and cost containment. These quality measures will help maintain accountability and transparency among both providers and MMPs. They will also assist beneficiaries in making better health care decisions.

VAHC's is extremely concerned with the expedited timeline to transition the LTSS population to managed care by 2017. VAHC strongly believes completion of the CCC demonstration project should first be accomplished prior to transitioning the LTSS population to managed care. VAHC members, DMAS and the MMPs continue to learn lessons from the implementation of CCC. Until the three year CCC demonstration is complete and fully evaluated, it is premature to move the remaining LTSS population into managed care.

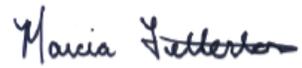
The signal DMAS is unintentionally sending the MMPs is that they will have the opportunity to compete for additional covered lives and expand their business in the Commonwealth regardless of their success implementing CCC. This message further risks the successful implementation of CCC.

Historically, waiver rates across the board have been suppressed. Provisions must be made to include increased waiver rates annually based on the appropriate health care index in the base budget for Medicaid inflation indexes.

VAHC is also concerned with the current organizational structure of DMAS. DMAS is transitioning to a fully managed care environment and internal organizational staffing must be modified to meet the changing model of the agency. To improve transparency, we believe that DMAS should provide its reorganization plan to its partners.

VAHC will continue to work with DMAS on the expansion of managed care in Virginia, but requests that the timetable for implementation be revisited to allow time to fully evaluate CCC.

Sincerely,

A handwritten signature in cursive script that reads "Marcia Tetterton".

Marcia A. Tetterton, MSG, CAE  
Executive Director

## Provider

June 11, 2015  
Commonwealth Health & Rehab  
4315 Chain Bridge Road  
Fairfax, VA 22033  
To Whom It May Concern:

As a provider I am tasked daily with providing good care to the residents and patients that reside in my center. I am also tasked with being a good steward of the money provided through various programs such as Medicare and Medicaid. The CCC demonstration has not successfully done either. The impact of this legislation is detrimental to the patients, and providers that are involved.

In regards to the Commonwealth Coordinated Care Demonstration, as a provider this program has been very difficult to navigate. Our center is in an area where only Humana has managed to get enough providers to enroll patients. This limits our residents to only getting one choice of the CCC providers. Because the CCC has not been successfully implemented, the utilization of the program has been done prematurely. The CCC case management component has not benefited the patients that they serve. While a case manager has seen these patients they have not offered any additional services or support to those patients or in terms of cost reduction or quality services. Therefore, not doing what they said they would do.

The case managers that were assigned to these patients have not worked as an advocate for the patient ensuring that they get all services they are entitled to through the program. At best they have limited the amount of services that these patients receive. Their authorization process for services can be drawn out requesting same documentation time and time again only to decline the service. They were to be the advocate for the patient when in fact they are another hurdle for them. The pre authorizations alone are requiring more administrative staff to initiate, update and continually track to make sure patients are able to receive services that they qualify for. Due to this ineffective case management it is impossible to judge if this demonstration has been effective.

The additional administrative burden the CCC has required by the facilities that have signed up with is far greater than one could imagine. This contradicts the idea of reducing the cost of health care, which was the concept behind the introduction of the CCC. As any managed care expansion occurs there is a need for regulatory relief to allow providers to reduce costs and survive with lower payments.

Ultimately any additional expansion of the CCC demonstration at this point would be reckless at best. The patrons of the CCC demonstration are the true victims at this point. They are getting delayed care the minimum requirements set forth by the individuals plan. I have the opportunity daily to see how this program has been poorly planned and prematurely been operated. Thank you for allowing my concerns to be heard on this very delicate but very important subject.

Sincerely, Leslie J. Ruffner BA, LNHA

## Provider

6/10/15

Re: MLTSS Opportunity for Public Comment

DMAS,

I am the Administrator of River View on the Appomattox Health and Rehab Center, a SNF participating in The Managed Long Term Services and Supports program. I am writing to express our concerns regarding the MLTSS program on behalf of our facility staff.

We share the following concerns:

- Our center was included in the Central Virginia implementation of CCC and we have found that the program has not added any value to the participating patients. At this point, the MLTSS program is not a seamless system as it was intended, information is not timely and effectively transferred, and has not improved the quality and cost effectiveness of care. For example, Medicaid renewal statuses are often not accurate between Medicaid and MMPs. When it is time to renew a resident's Medicaid status, the MMP does not have the most accurate Medicaid status. Also, some medications that have been covered by traditional Medicare/Medicaid are not covered by the MMP and the facility is not made aware timely. The cost then becomes the facility's expense.
- It takes time away from resident care to pursue an MMP to provide authorization for equipment, Part B therapy or anything requiring authorization. Facilities have to take on the risk of providing therapy or purchasing equipment while waiting for the MMP to communicate authorization. Authorizations are not timely when we initiate needed care for a patient. For example, a Part B beneficiary is provided therapy while the facility waits several weeks before authorization is given. Waiting for such approvals does not benefit the resident or facility and wastes valuable time pursuing the authorization with MMPs. Business office staff, social work, admissions, therapy and nursing are often left chasing information required for an authorization update. This additional burden on these departments takes time away from direct patient care and care planning. The extra time managing MMPs does not allow for additional costs savings, rather increases it.

Thank you for allowing us the opportunity to provide comments regarding the MLTSS program expansion. We hope by providing current feedback on the program we can improve it before it becomes mandatory for all of Virginia.

Thank you,

Lauren Noonkester, MBA, LNHA

**Provider**

June 4, 2015

To: [VAMLTSS@dmas.virginia.gov](mailto:VAMLTSS@dmas.virginia.gov)

Re: Managed Long Term Services and Supports Opportunity for Public Comment

As a licensed nursing home administrator for many years I have worked diligently to keep abreast of changes and directives involved in the provisions of Medicare and Medicaid. I would like to take this opportunity to comment on my concerns regarding the MLTSS.

First of all, my comment would be that any expansion of managed care before it is operating well is premature. It is my opinion that the CCC program has not been implemented as well as necessary to move forward.

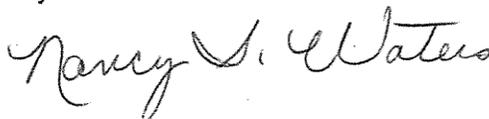
I have not been able to see that the CCC program has shown that case management in long term care has positively affected cost reduction or most importantly quality of services.

At this point in time it seems the CCC payers have failed to provide effective case management and services to our frail and elderly to the point that it is difficult to determine if this will work going forward.

In conclusion, I would respectfully request that DMAS consider how difficult it is for seniors in parts of our state to access information and obtain education. I fear that early implementation without first determining a plan will create dangerous situations for our frail and elderly both at home and in our long term care centers.

Thank you for the opportunity to comment.

Nancy S. Waters  
2273 Viewland Circle  
Christiansburg, VA 24073



## **Provider Association**

VIRGINIA ASSOCIATION FOR HOSPICES AND PALLIATIVE CARE (VAHPC)

### Comments Regarding the Design of a Managed Long Term Services and Supports Program (MLTSS)

VAHPC is very appreciative that DMAS is requesting public comments on the proposed design and implementation of the proposed MLTSS program. VAHPC represents hospices throughout the Commonwealth of Virginia and is committed to assuring access to quality hospice services for all who need this special type of care.

Hospices in Virginia have been providing care coordination services through a managed care concept under Medicare since 1983 and under Medicaid since 1991. For a set per diem fee, hospices manage all components of the patient's care related to the terminal illness, including staff visits, medications, medical equipment and supplies, inpatient and respite care, and bereavement services for the family after the patient's death.

We believe that the current system of carving out hospice from the Medallion and Commonwealth Coordinated Care Programs remains the best way to insure that patients who are terminally ill receive quality hospice care in a timely manner according to Medicare and State hospice regulations, and we strongly urge that hospice be carved out from the proposed MLTSS Program.

Our basis for this belief rests on the following:

1. Hospice is "managed care". Once someone is admitted to hospice, all care and services related to the terminal illness become the responsibility of hospice to coordinate, manage, and administer. Medicare and Medicaid hospice rates are closely monitored to assure that hospices provide necessary services and that hospice care is cost effective.
2. Both Medicare and State hospice regulations mandate that certain services be provided by hospice. Allowing hospices to continue to manage the patient's care as a carve out, and not risking the unbundling of any of these hospice services by a managed care provider will assure that required services are not compromised, thus putting the patient at risk for reduced services and the hospice at risk for regulatory non-compliance.
3. Providing hospice care under the direction of hospice programs aligns with several goals of the MLTSS program:
  - a. Improved quality of life and satisfaction. The hallmark of hospice is promoting quality of life through excellent symptom management and care of the family. Hospice family satisfaction surveys typically rank higher than all other healthcare providers and provide evidence of the ability of hospices to manage complex conditions so that patients live out their last days in comfort and with dignity.
  - b. Care coordination for individuals with complex needs that integrates the medical and social models of care, ensures individual choice and rights, and includes individuals and family members in decision making using a person-centered model. Hospice regulations require that we include the family as the focus of our care. The hospice interdisciplinary team of physicians, nurses, social workers, chaplains, aides, volunteers, and dietitians helps patients and families with a range of complex needs focus on "what matters most" to them.

- c. Facilitation of communication between providers to improve the quality and cost effectiveness of care. The per diem system of reimbursement for hospice assures that hospice will manage all aspects of the patient's care related to the terminal illness through excellent communication with providers and attention to quality and cost of care. Once someone comes into hospice, the hospice program coordinates virtually everything that patient needs. "Call hospice first" is one of the first things hospices stress with patients and families. Hospices are their safety net. Hospices help them achieve "what matters most".
- d. System-wide quality improvement and monitoring. Hospices are required through regulations to "develop, implement and maintain an effective, ongoing, hospice-wide, data-driven quality assurance and performance improvement program." In addition, hospices are required to participate in ongoing assessment of services through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey process.

The current system of carving out hospice from managed care to allow hospices to continue to provide care to patients on an individualized basis that consistently improves quality of life and also meets regulatory requirements is working. We recognize that efforts are still in progress to improve coordination with the CCC providers to ensure timely and appropriate referrals to hospice. We will continue to advocate that the "Serious Illness Care Transitions Algorithm" developed by VAHPC be the standard tool with which CCC providers determine someone's appropriateness for hospice. We look forward to advocating for the same screening process with providers under the MLTSS program to insure that all enrollees who need and want hospice care can access that care in a timely manner.

In addition, we believe that one quality indicator for every managed care provider should be the number of patients who have hospice care for at least 30 days prior to death.

*June 12, 2015*

## Provider

As a Licensed Behavior Analyst, I strongly urge that Applied Behavior Analysis (ABA) be included as a service option in all offerings for people who access DMAS services. As an evidenced-based, data-driven science, ABA addresses many of the principles of the proposed initiatives including the goals of improved quality of life, satisfaction, and health outcomes for individuals who are enrolled and arranging services and supports to maximize opportunities for community living. There is a large and robust body of evidence not only of the effectiveness of ABA but also the efficiency and cost effectiveness of this service. ABA has been used to great effect with many diverse populations, including elderly adults, people with mental illness, people with substance abuse issues, people with physical disabilities, students, people with intellectual and developmental disabilities, and most notably the recent applications for people with Autism. ABA is recommended by the National Standards Project for both children and adults with autism spectrum disorders. There is a large body of research regarding ABA and its beneficial outcomes for persons with developmental delays or intellectual disabilities, as well as other persons who have challenging behaviors.

In the Commonwealth, ABA must be provided by a Licensed Behavior Analyst or Licensed Assistant Behavior Analyst, and as of April, there are almost 700 licensed persons. These providers are held to strict ethical guidelines and receive extensive training. ABA needs to be an available option among the array of services, not replacing other services, but in addition to them as requested by individuals. Please strongly consider including ABA as an option for all of DMAS' offerings. Please involve Licensed Behavior Analysts and Licensed Assistant Behavior Analysts from the Virginia Association for Behavior (VABA) in future planning endeavors.

Lastly, to the extent that care will be provided through MCOs I am concerned that, based on observations and data collected from other states, this will not be a good direction for Virginia. I hope that if this is an option, the Commonwealth will look closely at the ramifications and benchmark other states prior to taking this step.

Christy Evanko, BCBA, LBA

Snowflakes ABA, LLC

804-310-1128

[christy@snowflakesaba.com](mailto:christy@snowflakesaba.com)

## Provider

Brittney Bright  
Radford Health & Rehab Center  
700 Randolph St  
Radford, VA 24141

June 10, 2015

Department of Medical Assistance Services  
600 East Broad Street  
Richmond, VA 23219

To Whom It May Concern:

I am writing this letter in response to DMAS's Opportunity for Public Comment notice regarding the proposed expansion of the managed care across the entire Medicaid system over the next two years. I currently serve as the Administrator of Radford Health & Rehab Center in Radford, VA. As the administrator of this center I have seen the current managed care program for Medicaid up close and personal for the last year. It is due to the experiences that our patients enrolled in the program, my staff, and I have had over the last year that have compelled me to write this letter.

I have grave concerns regarding the proposed expansion as the current program has not been successfully implemented so far and any expansion of managed care before the current one is operating as originally planned seems premature. From the day this program went live in our area, providers were told that traditional Medicare guidelines would be followed for skilled services and that services would be authorized for seven days to begin with followed by updates to continue the skilled stay. During [REDACTED] our center admitted a managed Medicaid patient and on the day of the scheduled admission the center alerted the patient's managing insurance company that [REDACTED] would be coming and needed a skilled authorization. The center was told that patients need a pre-auth before entering the building and acted surprised when the seven day authorization was brought up. An authorization form was filled out by the center and sent for authorization and the center was then told that more information was needed. During this time the patient was in the center being cared for. After seven days an authorization was finally obtained, only to be told that discharge was going to be in two days. On the same day the center received a notice from the insurance company stating that our request to authorize and pay for services had been reviewed and they were "unable to authorize the request due to coverage for skilled nursing facility care is being denied and is not medically necessary." The insurance company proceeded to tell the center that they felt services were not necessary, and when questioned about the seven day authorization the insurance company stated that authorization is only if the services are deemed medically necessary. Aside from being told seven days into the patient's stay that they had deemed services not medically necessary, the center was also told that even though this patient was hard to place for discharge she did not qualify for a case manager as she was not in the community well program, and that the center was going to have to figure out a discharge plan. The patient did eventually discharge home, but with little to no

assistance from [REDACTED] insurance company with placement. The center spent numerous hours working on appeals and fighting with insurance for skilled level payment for a patient who under a traditional Medicare stay would have received skilled services with no issues, and would have been able to stay under skilled services past the date that [REDACTED] insurance company said [REDACTED] had to leave.

Another example of how this program has not been successfully implemented has to do with a patient we admitted to our facility under a skilled managed Medicaid stay. After we had issues obtaining an authorization for skilled services the first time we felt it best to call for a prior-auth, even though this program has boasted that you may bring patients in for skilled services without an auth, and the first seven days will be covered. When we called we were told again that a prior-auth would be required. After this patient's information was reviewed it was determined that the patient would not meet skilled criteria and the center was given a custodial care auth with five day a week part B services. When the center questioned if [REDACTED] was eligible for five day a week part B services then [REDACTED] was qualified for skilled services we were told no [REDACTED] was not, and that [REDACTED] would be custodial care. The patient was a [REDACTED] who was [REDACTED] POA made the decision to opt out of the program. Due to the patient having a three night hospital stay prior to [REDACTED] admission, we were able to pick [REDACTED] up under traditional Medicare A days. The center was able to keep [REDACTED] on caseload through the exhaust of [REDACTED] Medicare A days and we then converted [REDACTED] to part B therapy and continued to work with [REDACTED]. I am happy to say that after several months of extensive therapy the staff here at Radford were able to have the patient return back to [REDACTED] home with [REDACTED]. This would have most likely never been accomplished had the patient remained under [REDACTED] managed Medicaid, as the center was told [REDACTED] was custodial care and would only receive minimal part B services. Had that occurred the patient would most likely still be in our care as [REDACTED] would not have received the amount of therapy [REDACTED] needed to be able to rehab and eventually return back home.

There are plenty of other examples of issues with patients in this program that I could share that would highlight the increased administrative burden and extra cost associated with the numerous hours that are spent by staff attempting to obtain authorizations, appeals, and attempting to get claims paid that have been denied. However, I go into detail on the two previously mentioned patient cases because they directly affected patients and the care they should receive. I chose to get into this profession because I am passionate about providing quality care for the geriatric population in our community. Since this program has been rolled out, it has become increasingly hard to provide that quality care as the insurance companies are attempting to cut cost, but in return that cost cutting is affecting the services patients should receive. One of the goals for this program that was listed in the MLTSS Opportunity for Public Comment letter is "improved quality of life, satisfaction, and health outcomes for individuals who are enrolled." I can't understand how that goal is being achieved when patients such as the ones listed above are being denied the exact services needed to help achieve that goal. For a [REDACTED] patient to be told that [REDACTED] does not qualify for skilled services and will have to be custodial care before ever even giving [REDACTED] the opportunity in our setting to try is not the way to achieve quality of life, health outcomes, or satisfaction. All that is achieved by doing that is cost savings, not what is best for the patient. While our long term care setting is a beautiful and a needed one for many individuals it is often

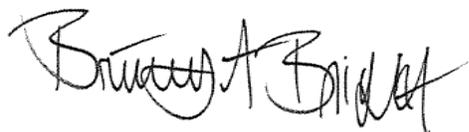
not the quality of life that younger people who have been at a lower level of care or at home want or desire. So why would this program want to automatically make someone a custodial care patient when they have the potential to eventually return to a lower and cheaper level of care? This current program is not working, and unfortunately this exact same issue is going to continue to occur if this program expands unless it is fixed beforehand.

Another goal that is listed on the MLTSS Opportunity for Public Comment is "care coordination for individuals with complex needs that integrates the medical and social models of care, ensures individual choice and rights, and included individuals and family members in decision making using a person-centered model." One of the patient examples I listed above was the perfect candidate for that goal. [REDACTED] had an extremely complex social history and was unable to return to [REDACTED] prior home, and due to extenuating circumstances was unable to go to live with [REDACTED] family. This patient was in need of assistance integrating [REDACTED] medical and social needs and when the center reached out to the insurance company managing [REDACTED] care we were told [REDACTED] did not qualify for a case manager because [REDACTED] was in our setting and that we would have to figure out the discharge on our own. How as providers are we to safely transition patients, especially ones with complex social issues, when the insurance managing the care and that will continue to manage the care after the patient returns to the community is refusing to even send a case manager to help with that transition? What good does integrating the medical and social models of care and insuring individual choice and rights are honored do if it doesn't start until after the patient has been discharged (possibly to somewhere he or she did not want to go, but had no choice due to the lack of involvement and help from the insurance company)? With the current focus on hospital readmissions this piece of the current program must be fixed before the program is expanded. Safe transitions are vital to ensure that patients remain out of the hospital after discharge, and with the issues with the current program there is no way enrollees will have safe transitions home and will have a higher risk of readmitting to the hospital after discharge from our setting.

There is no doubt that Virginia needs to find ways to reduce healthcare cost and find savings in the Medicare and Medicaid programs. However, reducing cost of healthcare at the expense of our patients and geriatric population is not the way to go about saving money. This program, if managed correctly has the potential to achieve goals such as improved quality of life and outcomes, and integration of medical and social models of care; however, the program is not at that place yet and needs to be reevaluated before being expanded. My fear is with the expansion of this program that more patients like the ones I discussed earlier in my letter will have similar experiences and be denied the services they need to return to the quality of life they once enjoyed. There has been no real evidence that this program has demonstrated that case management of the nursing home long term care population is beneficial in terms of cost reduction or quality of services. This is partly due to the issue I mentioned previously where case management services have not even been offered, so there is no real way to conclude if the program can be effective. The program is supposed to be a cost reduction, but instead it has added many more cost burdens to the nursing homes providing services to these patients. I fear that many great community providers will not be able to continue to service their community due to these cost burdens. My hope is that this letter will help you to see just a few of the many examples in the state of Virginia of what has not worked with this

program, and the importance of fixing the current issues before expanding the program and creating even more issues. I hope to be able to provide my community with quality care and services for years to come, but in order to do that my center must be allowed to provide those services and be properly reimbursed for the services rendered.

Sincerely,

A handwritten signature in black ink, appearing to read "Brittney A. Bright". The signature is written in a cursive, flowing style.

Brittney A Bright  
Administrator  
Radford Health & Rehab Center

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**Provider  
Association**



June 11, 2015

Contact: Dana Parsons  
Legislative Affairs Legal Counsel  
LeadingAge Virginia  
(Formerly VANHA)  
[dana@leadingagevirginia.org](mailto:dana@leadingagevirginia.org)  
804.965.5500

Thank you for the opportunity to comment on the proposed design and implementation of the Department of Medical Assistance Services' program initiative to transition remaining fee-for-service populations into a mandatory managed care program. LeadingAge Virginia believes the program is designed to reduce the escalation of Medicaid costs and if effectively administered with the provision of quality health care this goal can be accomplished.

Quality measurements of the healthcare provided under this managed care program should be made available in order to truly evaluate the program. If cost savings are to be realized, the coordination of the best possible health care resources for the patient should not negatively impact the outcomes of the care that the individual receives. These quality measurements need to be an integral part of the program, but without increasing the administrative burden on the providers.

True coordinated managed care for dual eligibles involves not only the long term care providers but also acute care, rehabilitation and home care services (e.g., the entire health care continuum of care). At some point in the development of this program, acute care providers will be further impacted. The current process is experiencing significant issues in the timeliness of payments for approved care at all levels of care, and this difficulty should be resolved before any further expansion of the program is considered.

## Provider



June 15, 2015

FAX [VAMLTSS@dmas.virginia.gov](mailto:VAMLTSS@dmas.virginia.gov)

Virginia Department of Medical Assistance Services  
600 East Broad Street  
Richmond, VA 23219

RE: Opportunity for Public Hearing, Managed Long Term Services and Supports

Dear Sir/Madam:

As an interested stakeholder caring for Virginia Residents receiving Skilled and Long Term Care Nursing Services, I wish to provide public comment. I support your goals of working to improve quality of life, satisfaction, and health outcomes for individuals being served or those who will require such services in the future. However, I am opposed to the future expansion of the managed care process, when in fact to extend this program could prove to be a failure affecting all those being served.

Clearly, it is premature to continue in the expansion when current findings continue to reveal noted problems and issues. There is insufficient evidence to contend said program is beneficial in terms of either cost containment or reduction, or that it provides improved services to the beneficiary or provider of services.

CCC is not providing effective case management of the nursing home population, in terms of quality services or appropriate levels of care. It is clear that increased administrative burdens are being placed on both LTC providers and present CCC management will only increase cost to the program and taxpayers, when the goal is to reduce both cost and the burden of regulatory affairs. Why would we move forward with this project when we have so many problems of the present not to mention the unresolved issues of the past?

Therefore, I ask you to please reconsider continued implementation of this program in order to make a sound decision about its future. The results from the implementation of CCC thus far support discontinuing advancing any further until all issues have been

thoroughly evaluated for their effectiveness of cost savings and enhancement of services offered.

Thank you for your consideration.

Respectfully,

  
Stephen Reynolds, MA, NHA  
Administrator

## Provider

June 16, 2015

To Whom It May Concern,

Thank you for the opportunity to provide comments as the future of the Commonwealth Coordinated Care (CCC) program in Virginia. I am alarmed at the thought of a program that affects so many citizens would be expanded so quickly. The CCC program has not been successfully implemented so far and any expansion of managed care before it is operating as planned is premature. The headaches for citizens is only just coming to the forefront; more time is needed before any expansion is even considered.

The CCC program has not demonstrated that case management of the nursing home long term care population is beneficial in terms of cost reduction or quality of services. The complications for nursing home providers is constant. While providers are struggling to advocate for needed health care services, the nursing home patients and residents are left with little support from the CCC program providers. Many of the much needed and promised services are not available or not convenient for nursing home patients and residents.

The CCC payers have failed to provide effective case management services to the nursing home population so it is impossible to conclude if this can be effective or not. The lack of case management results in additional burden for nursing home staff. While nursing home staff are struggling to address CCC program issues they are not able to perform other essential duties and support other non-CCC patients and residents in the same manner. Nursing home staff spend an unnecessary amount of time working with the CCC to address ongoing program issues.

Implementing the CCC program at my Center is adding greater administrative burden and costs to providers. This runs counter to trying to reduce the cost of health care, and any managed care expansion has to deal with regulatory relief to allow providers to reduce costs and survive with lower payments.

It is for the above reasons that we therefore urge you to stop the expansion of the CCC program in Virginia. Thank you for the opportunity to provide comments. If you should have any further questions, please feel free to contact me at 703-834-5800.

Sincerely,

Zoie B. Nikov, MSA, LNHA  
Administrator

**Provider  
Association**

Emily McClellan  
Regulatory Manager  
Division of Policy and Research  
600 E. Broad St, Suite 1300  
Richmond, VA 23219

Ms. McClellan,

I write on behalf of the Virginia Council of Nurse Practitioners (VCNP) to offer comment on the proposed design and implementation of DMAS' program initiative to transition remaining fee-for-service populations into a mandatory managed care program.

VCNP is the principal organization representing Nurse Practitioners across the Commonwealth. Our members provide a substantial percentage of all care delivery to the Medicaid population in Virginia. In fact, the contribution of NPs to the total volume of care delivered is most likely significantly underestimated due to difficulties in quantifying and isolating care delivered by NPs as opposed to other providers. NPs are a vital and essential part of the health care safety net in Virginia.

In any redesign of care delivery contemplated by DMAS, we would simply request that language utilized be provider-neutral and that the system allows for care delivered by NPs to be accurately measured, quantified and appropriately reimbursed.

Thank you for the opportunity to provide comment.

Sincerely,

Mark Coles RN BA MSN NP-C  
Chair  
Government Relations  
Virginia Council of Nurse Practitioners

## Provider

June 16, 2015

To whom it may concern:

Thank you for the opportunity to submit comments with regard to Managed Long Term Services and Supports (MLTSS) and the expansion of Commonwealth Coordinated Care (CCC). While Virginia is gaining experience in this type of program, the CCC program to date has not been implemented successfully and plans to expand the program are rather premature. There are several concerns that I have from the perspective of both a provider as well as a consumer of Medicaid services on behalf of [REDACTED]

One aspect that was a great selling point of CCC was the opportunity for case management of services to the nursing home long term care population and the benefits that this would provide in terms of both cost reduction and quality of services. To date these benefits have not been realized and the reasons for this are many. Specifically, there is not an infrastructure within the provider network to support the services often needed by our most vulnerable and frail population. In addition, the case management support services does not have the ability to respond to the demand for services in a timely manner often creating delays. These delays occur for patients needing access to emergency services and diagnostics, coming to the nursing home, physician services, etc. In order for case management services to be successful there must be a network expansive enough to support the beneficiaries and not deny them access. As a provider, we are often left holding the bag to assure that timely care and services are provided and in delivering quality care we cannot allow undue burden of the system to delay necessary care.

Another concern with case management is the denial of access to benefits in which this population would otherwise have access to (dual beneficiaries). For example, skilled nursing services. Much needed rehabilitation, necessary to maintain quality of life, is denied or scaled back due to denial of access to skilled services. As a consumer of services, these issues are the main reasons of why I would not consider CCC as an option for my loved one at this time. The program has not demonstrated the benefit to the consumer beyond the cost savings to the program(s). Our ability to fully evaluate the effectiveness of case management services cannot be done because of the failure of the CCC payers to provide these services as outlined.

Since the inception of the CCC program the administrative burden to providers has been great. Our teams have to often fight for approvals and access to services, medications, etc. This administrative burden has come at a cost to providers and is counter to one goal of the program of reducing the cost of health care. Further expansion of the program has to deal with regulatory relief to allow providers to effectively reduce cost and survive as a provider of services with lower payments.

When you consider health plan requirements, an understanding of the needs of the nursing home population is a core competency. While the motive of the payer is to contain/lower cost it has to be balanced with delivering quality care and services to the consumer and not shifting cost to the providers. While I don't have specific recommendations, due to the overwhelming nature of designing a program such as this, more time and consideration needs to be considered so this can effectively worked out. A logical first step seems to be a complete analysis of why the program has not been successfully implemented thus far and a work plan to address those issues prior to expansion. We cannot afford a build it as we go mentality that shifts the burden of design to the consumers and the providers.

I thank you for the opportunity to provide comments. If I can provide further contribution as you consider this program do not hesitate to contact me at [REDACTED]

Warm regards,

[REDACTED]

**Provider**

*LIVING MADE BETTER.*

June 16, 2015

FAX [VAMLTSS@dmas.virginia.gov](mailto:VAMLTSS@dmas.virginia.gov)

Virginia Department of Medical Assistance Services  
600 East Broad Street  
Richmond, VA 23219

RE: Opportunity for Public Hearing, Managed Long Term Services and Supports

Dear Sir/Madam:

As an interested stakeholder caring for Virginia Residents receiving Skilled and Long Term Care Nursing Services, I thank you for this opportunity to submit public comment for your review and consideration.

I am a forty year veteran in the long-term care/skilled nursing and rehab industry; during this time it has been my experience that the goal of healthcare service providers has been to meet the needs of the patient through the most effective and efficient delivery system possible. I don't believe that goal has ever changed, however unfortunately I do believe there has been some focus lost on the operative phrase "meet the needs."

To date, CCC has not produced a track record capable of demonstrating a commitment to meeting the needs of the patient. It would seem prudent that prior to expanding CCC services, current "bugs" in the system should be eradicated, only then, if the program is capable of effectively meeting the needs of the patients and the providers who serve them, should expansion could be re-considered.

The community I serve deserve the best the Commonwealth has to offer and at this point CCC does not appear to be the best solution. As their advocate I ask you to please reconsider continued implementation and/or expansion of this program until the program can operate as it is intended and is capable of sustaining a system capable of meeting the needs of the patient.

Sincerely,



Lori Jmler L.N.H.A.  
Administrator

**Provider  
Association**

Virginia Association of Centers for Independent Living  
Managed Long Term Services and Supports (MLTSS)  
Public Comment  
June 15, 2015

**General:**

*Top three significant features needed in an MLTSS program:*

To ensure that individuals are able to pursue problems with accessing and using MLTSS services, robust and user-friendly complaint and appeal processes must be established. The processes should be consistently applied, adhere to a timeline for resolution of issues, and be independent of DMAS and the managed care plans.

Expansion of supports and services that are now available to individuals who use the Elderly or Disabled with Consumer Direction (EDCD) Waiver would improve their quality of life. Environmental modifications including home and vehicle modifications will support people to become more independent or to maintain current independence. Dental care would prevent more extensive and costly periodontal procedures.

Support coordination is needed to assist individuals with securing and using Medicaid and other support services. Medical care coordination should be a component of planning for Medicaid services. However, individuals often need support coordination to assist with nonmedical issues such as transportation, housing, peer support and navigating services that are not medical components. Care coordination would focus on the medical needs of the individual. Support coordination would be more inclusive and include nonmedical needs of the individual.

*Suggestions to explore including acute and primary care in the MLTSS program for individuals enrolled in the ID, DD, and DS Waivers:*

It is vital to significantly involve advocates in all steps of this process. People with developmental disabilities and their families are accustomed to advocating for what is needed. Providing basic information about managed care and the parameters that need to be considered and ultimately decided should be communicated to people with developmental disabilities, their families and disability advocacy organizations as soon as possible. There is a lack of clear, concise information about managed care, why DMAS is pursuing expansion of managed care, and assurances that valued existing supports will not be in jeopardy.

**Beneficiary Experience:**

*Protections essential for individuals in an MLTSS program*

A seamless transition of services must occur when an individual transitions from fee for service to/from managed care or from one managed care plan to another. The transition

should ensure that the individual's services are not interrupted. Plan and provider readiness should be approached differently than what was done for Commonwealth Coordinated Care (CCC) to ensure that processes are developed and operational before managed care is expanded.

There will be a need to provide significant education and informative materials to people with disabilities who are accustomed to the current Medicaid fee for service and long term care service delivery system. New terminology and processes must be adequately explained before people with disabilities can be expected to select a managed care plan and before any service change begins on an individual basis. Prior to enrollment, the individual should receive written material explaining the following:

- General differences between fee for service and managed care;
- How each plan is organized;
- Services available, services that are no longer available, and any differences in the services that will remain available but that will be different;
- List of providers used in the past 24 months;
- List of providers that are available in each the plans;
- The plans' complaint and appeal process; and
- Descriptions of the role of the support coordinator and the role of the care coordinator.

This material should be available to the individual 60 days prior to their enrollment in a plan and should include an opportunity to meet with an impartial, neutral program representative to review the material and explore questions and concerns before the individual makes their final decision about which plan to select.

Assurances of compliance with the Americans with Disabilities Act and Rehabilitation Act should include required documentation regarding physical access to offices and medical equipment, effective communication and nondiscriminatory practices. The plans should be required to demonstrate how the plan assure access to x-ray equipment, mammography, and exam tables within all of the geographical areas served by the plan. The plans should be required to describe how they will provide effective communication including the sources they will provide to or suggest that their providers use for sign language interpreting, CART, braille production or other manner of communication. Modification of policies, practices and procedures is needed to ensure that individuals with disabilities are not subject to discrimination. Specific examples of how a plan will accommodate a person with behavioral needs or developmental disabilities should be required to be addressed in the plan's readiness documentation. Transportation providers must have appropriate transportation equipment, well trained staff, accessible vehicles and provide effective communication.

Consumer-directed supports continue to be important to individuals with disabilities. The choice and control offered by consumer-direction helps to ensure that adequate support staff are provided at a time of most usefulness. The plans will need to receive information about how they can support individuals to use consumer-directed supports. The transition between fee for service and managed care needs to be carefully managed to ensure that there is no gap or delay in consumer-directed payroll.

*Considerations when developing person-centered needs assessments, service planning, and care coordination requirements:*

Some plans were not ready for the influx of people enrolling into CCC. The plans should identify care coordinators and train them prior to individuals being enrolled into managed care. The CCC process of passively enrolling individuals should not be replicated. Individuals should be given information, including a timeline, about enrollment. Then after meeting with an impartial, neutral program representative the individual can decide which plan would best meet their needs.

A comprehensive enrollment process is needed to avoid delays and to ensure individuals understand what is happening and how to influence the process. Support coordination should be established and provided to individuals enrolled in managed care who are also using community-based long term care. Support coordination would be person-centered and comprehensive including medical and non-medical needs. A care coordinator, similar to the service available through CCC, should be available for individuals with medical needs.

Support coordination and care coordination providers that work with children should have experience with community supports and services typically needed by children with disabilities. This should include demonstrated successful experience providing services to children with significant disabilities through Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

The plans should complete a survey to identify information about their readiness to provide support coordination and care coordination and other services to people with disabilities. The results of this survey should be published by DMAS in a public forum. The survey should include items such as access to medical equipment (exam tables, diagnostic equipment and office locations), experience providing effective communication with people with disabilities, EPSDT experience, and verification that support coordination and care coordination have been developed and trained.

The plans should have procedures that demonstrate an acknowledgement of and incorporation of planning activities that recognize people with disabilities want to be independent, in control of their lives, active in their communities and to remain productive and healthy.

*Features in assisting individuals to transition between providers and settings:*

Individuals need information and someone who is impartial and neutral to assist them in exploring options and understanding the process. This would include features such as choice of plans, provider choice, timeliness of decision making, buy-in of the individual and effective complaint and appeal procedures.

*A MLTSS program attractive to individuals:*

Individuals must be assured the program includes the following:

- Flexibility so that as needs and life choices change, the services are effective;
- Expanded choices and services;
- Ease of which they can use the program; and

- Procedures that ensure program integrity has been established and maintained.

### **Provider Experience:**

#### *Program features:*

The health care plans must be prepared. All procedures should be established before the program becomes operational. For home and community-based waiver programs, each of the plans should use the same forms and similar procedures for assessment, planning, reporting and billing. Adequate and comprehensive planning must be completed before any further expansion of managed care.

### **Service Package:**

#### *Recommendations for the design of a comprehensive and integrated package:*

The package should include access to long term care supports that at a minimum include the long term care services currently available in the home and community-based waivers and the Money Follows the Person demonstration project. Assistive technology and environmental modifications should be available to everyone who needs these services who is enrolled in the EDCD Waiver.

EPSDT has become a complicated and contentious process for some children in managed care. Families are reporting that they are unable to obtain from some of the existing Virginia Medicaid managed care plans the services their children need to correct, treat or maintain the child's disability, health problem or medical condition.

#### *Fiscal/Employer Agent (F/EA) services for consumer-direction of waiver services:*

DMAS should require that all health plans contract with the same F/EA.

### **Health Plans:**

#### *Recommendations for health plan requirements:*

The plans' proposals should include the following:

- Description of the prevalence and complexity of disability related needs and how these specific needs will be met;
- Development of standards for services to people with low incident disabilities;
- Demonstrated successful experience providing services to people with disabilities who have traditionally been carved out of managed care;
- Development of a transparent process that is understandable to people with disabilities about the process to obtain carved out services, specialized services and services out of network when needed. The process should make clear how a determination is made by the plan if a service will be provided by the plan, carved out, provided by a specialist, provided by an out of network provider as an exception, and how an appeal is pursued;
- Staff training to increase their ability to work with people with disabilities who will be advocacy oriented, in control of their services and who are users of services needed to ensure they are able to live independently;
- Production of demographic information about people with disabilities in the geographical area to be served to ensure the plan has adequately developed their network of providers; and

- Housing strategies the plan will operationalize to enable more individuals to transition to community living.

*Value-based payment opportunities:*

The MLTSS program should expand consumer-directed options to include assistive technology and environmental modifications. This could assist with cost containment by reducing the overhead for providing items that are available from reliable sources that may not be Medicaid providers.

**Quality Measures:**

*Areas of the program important to measure quality:*

Individual's satisfaction with the program is paramount. There should be ongoing reviews and evaluations that capture information about the ease of use, the clarity of the process, ease of accessing supports and services, the avoidance of institutional care, and the frequency of use of community supports. The following should be available:

- Use of a monitoring tool to determine how the influx of people with disabilities into managed care has impacted access to care and the quality of care provided.
- Report of findings from an annual survey of recipients. The survey should include feedback on issues related to physical and communication access, access to specialists and responses from people who have moved into managed care in that specific year surveyed. The findings should be disaggregated by disability, age and geographical area.
- Report on the prevalence of use of specialists and out of network providers.

**Financing:**

*Strategies to demonstrate high-quality, person-centered and cost-effective supports:*

Community support provider rates need to be reviewed. Community provider rates are too low to attract the number of quality providers needed to have a robust cadre of community providers.

**Outreach and Communication:**

*Strategies for engaging individuals and providers in outreach and education efforts:*

- Incorporate informational sessions into already planned meetings of organizations;
- Distribute information that can be reprinted in organizations' newsletters; and
- Webinars.

*Important messages in planning for transitioning to an MLTSS program:*

Improved communication with individuals is vital. Communication must be in writing and followed up with an opportunity for the individual to speak directly with a neutral, impartial representative to explore options. We must do a better job of explaining what managed care is, how it is the same and different from traditional fee for service options, and specific information about what managed care would mean to the specific individual based on their history of services, needs and preferences.

## Provider

Re: Public Comments – Medicaid Managed Care

To Whom It May Concern:

I have addressed this letter as a healthcare provider responsible for the care and service delivered to many of those affected by the recent and pending changes to the fee-for-service population. As a Long Term Care Administrator, I have seen the transition of many dual eligible residents be made to the Commonwealth Coordinated Care program with inconsistent results. Since the initial implementation there remain common problems such as:

- An authorization process that at times results in delaying residents receiving services caused by inconsistencies from plan to plan and a lack of effective case management provided to the long term care population.
- A lack of participation in the provider network by physicians and hospitals in our market area potentially requiring residents to travel further to receive care outside of their community.
- A general lack of understanding of the CCC program by residents and families due to a lack of effective communication regarding the changes to their coverage.

These concerns with the Commonwealth Coordinated Care program have forced providers to use additional resources to seek answers for our residents and advocate that they be granted the services they need. In my opinion, using the resources of providers to sort through gray areas and unresolved issues is placing a greater administrative burden (and increasing costs) on providers without addressing the root causes of the issue. I have not seen any evidence that I would consider an improvement in the quality of service for these residents. It would seem that growing the number of dual eligible CCC recipients would only increase the burden to the providers. The benefits intended to be offered to the Medicaid Managed Care population have not been consistently available due to the lack of the “seamless care delivery” it was designed to provide. I am not opposed to a reform of our healthcare system; however, any expansion of the Commonwealth Coordinated Care program would be premature and we would be missing the opportunity to resolve problems while serving fewer recipients.

Respectfully,

John Sevier, LNHA

**Provider  
Association**

June 16, 2015  
Department Of Medical Assistance Services  
600 East Broad Street  
Richmond, Virginia 23219  
VAMLTSS@dmas.virginia.gov

RE: DMAS Managed Long Term Services and Supports program

The Virginia Pharmacists Association, representing pharmacists in all practice settings across the Commonwealth, is pleased to provide comments concerning the proposed design and implementation of the DMAS Managed Long Term Services and Supports (MLTSS) program. We look forward to providing additional thoughts and suggestions as the MLTSS program design moves forward.

We would like to take this opportunity to provide comments on a few of the questions posted for public comment.

1) What would you like to see as the top three significant features of an MLTSS program?

- The program must provide for a coordination of healthcare throughout the system. To ensure coordination, patients should have access to comprehensive healthcare services provided by qualified practitioners including pharmacists.
- Providers should have easy access to patient information to ensure treatment is not duplicated or overlooked.
- Provider and pharmacy networks are open to all practitioners that have an interest in participating in the program. Many Medicaid patients live in urban or rural areas that have limited healthcare options. Arbitrary restrictions on network providers can negatively impact the Medicaid population in areas with limited providers.

5) What would you consider to be the most significant features in assisting individuals to transition between providers and service/treatment settings?

- Comprehensive medication review by a pharmacist at every step of the transition process is important as medication adherence remains a major problem in our current healthcare system.
- Discharge education by the pharmacist as well as post-discharge follow-up by pharmacists in the community setting.

8) What would make an MLTSS program attractive to providers?

- Uniform billing systems.

- 24 hour provider support lines staffed by qualified individuals.
- Easy access to complete medical records and read/write capability for all qualified practitioners.

14) Quality measures will help maintain accountability and transparency. In what areas of the program will it be most important for you to measure quality?

- The Pharmacy Quality Alliance (PQA - [www.pqaalliance.com](http://www.pqaalliance.com)) has developed a number of medication-use measures that are key to improving healthcare delivery.
- Primary Medication Non-Adherence is an important measure identified by PQA that pharmacists can play a vital role.

Again, we appreciate the opportunity to provide preliminary comments as the Commonwealth considers implementation of the MLTSS program for the Medicaid population that many of our pharmacists serve. We look forward to participating further in the development of a program that we hope will provide access to pharmacist-provided care and services to Medicaid recipients across Virginia.

Sincerely,  
Timothy S. Musselman, Pharm.D.  
Executive Director

**Provider  
Association**

**VACSB Public Comments  
DMAS Medicaid Managed Care Initiatives  
16 JUNE 2015**

The Virginia Association of Community Services Boards provides the below preliminary comments regarding the transition of the remaining Medicaid Fee-for-service target populations into coordinated/integrated managed care programs beginning in the summer of 2016.

There are approximately 37,000 individuals who were eligible to participate in the Commonwealth Coordinated Care (CCC) project but who opted not to enroll. These individuals, according to the proposal, will be required to participate in a CCC-like program with one of the three managed care organizations (MCO) that is already managing care within the CCC project. The opt-out ratio specific to CSB participants appears to be somewhat smaller than the 56% who opted out of CCC writ large, the actual number is unknown. A conservative estimate is that CSBs will experience at least a 40% increase in the number of individuals who receive services from the CSB who will now also be enrolled with one of the three MCOs. We believe that there are some real benefits to this transition such as:

- More CSB consumers will experience the benefits of integrated/coordinated care;
- Health outcomes should improve; and
- CSBs will gain increased experience interfacing/collaborating with the MCOs to coordinate care.

We are also aware; however, that there will be some challenges, both for CSB consumers such as:

- Most of the CSB consumers who originally opted-out of CCC reported that they did so because they had a pre-existing relationship with a provider who was unwilling to participate in the program. Those consumers will likely experience a disruption in care when they are mandated to participate with a CCC MCO and will be required to select or will be assigned to a new PCP.
- Individuals also decided to opt-out of the CCC when they discovered that some of the participating MCOs charge higher co-pays for prescriptions compared to the regular Medicaid fee-for-service co-pay charges. The majority of these consumers are on multiple medications and they reported that they simply could not afford to get their prescriptions filled if they had to cover the increased co-pay fees. Many of these same consumers will be assigned to MCOs with higher prescription co-pay charges when they are enrolled in the CCC. Consequently, these

individuals may decide to discontinue their medications AMA due to financial constraints, which will place them at serious risk for decompensation and hospitalization.

In order to mitigate these challenges, we recommended that enrollees into the new CCC-like managed care program be prohibited from switching from one participating MCO to another within the calendar year, unless the change is required due to extenuating circumstances. Another alternative is that there could switch MCOs during open enrollment periods whenever those occur.

The above represents what we believe are the short-term implications. In the long-term, we anticipate there being a need to answer several questions including:

- Will the managed care initiatives include all areas of the state?
- Will the Dual Eligible and the LTSS populations be rolled into one managed care approach when the CCC demonstration project ends, or will the Dual Eligible population remain under a separate managed care approach?
- How will the plan to expand managed care interface with DMAS' plan to create BH Homes?

The VACSB presents the following preliminary recommendations, understanding that we are still in the beginning phases of understanding how this might impact our system:

- Ensure that case management remains a registered service
- Continue the existing CCC program as a separate managed care approach and require that the participating MCOs develop/include BH homes as an essential service array component
- Replicate the current MCO/VACSB Steering Committee structure and concept when expanding managed care to the other target populations to ensure that coordination of care exists for one of the most vulnerable target populations (CSB consumers)
- Eliminate/restrict the ability of individuals to switch among participating MCOs
- Require that participating MCOs demonstrate an adequate full-continuum provider network before allowing them to enroll individuals, in order to avoid some of the challenges experienced with the CCCP implementation. For example, individuals in some parts of the state were enrolled with certain CCCP MCOs that lacked an adequate number of local providers, including inpatient facilities. As a result, some individuals were required to travel long distances to secure inpatient care instead of being able to access the closest hospital
- Encourage innovative MCO/Provider service design proposals that target special populations (i.e. SMI) and demonstrate the ability to improve the quality of care and reduce cost
- Require that all MCOs offer the same prescription co-pay scale

**Provider**

*Living made better.*

June 16, 2015

Department of Medical Assistance Services  
600 East Broad Street  
Richmond, VA 23219

Dear Sir or Madam:

I am writing today as a concerned stakeholder regarding the proposal to expand managed care across the entire Medicaid system over the next two years. Thus far, the CCC program has not been successfully implemented and I feel that any expansion of the program would be premature.

As a Licensed Nursing Home Administrator, I have seen first-hand examples of how the CCC payers have failed to provide effective case management services to the population we serve here at Gainesville Health & Rehab Center. It usually takes weeks or months for the initial assessment by the case manager and often multiple attempts at getting authorizations for services that our patients need.

As a result of the CCC program, our center has incurred additional administrative burden and costs which runs counter to trying to reduce costs and survive with lower payments. The failure to provide effective case management deems it impossible at this point to determine if CCC is beneficial in terms of cost reduction or quality of services. I feel strongly that Virginia should not move forward with expansion until some of the issues that individuals and providers are already facing are addressed.

Sincerely,



Robin Brockwell, LNHA  
Administrator

## Health Plan



June 15, 2015

Department Of Medical Assistance Services  
600 East Broad Street  
Richmond, Virginia 23219

Via Electronic Mail to: [VAMLTSS@dmas.virginia.gov](mailto:VAMLTSS@dmas.virginia.gov)

**RE: Managed Long Term Services and Supports (MLTSS) Opportunity for Public Comment**

HealthKeepers, Inc. (Anthem HealthKeepers) is pleased to submit our response to the Opportunity for Public Comment issued on May 18, 2015, regarding "*Managed Long Term Services and Supports (MLTSS)*". As a wholly-owned subsidiary of Anthem, Inc., Anthem HealthKeepers is part of an organization that is the nation's leading provider of healthcare solutions for state-sponsored programs. Together with our affiliate health plans, we serve more than 5.6 million people in state-sponsored health plans in Virginia and across 18 other states, providing MLTSS in eight of these markets. In Virginia, we serve approximately 276,000 Medicaid and FAMIS beneficiaries as well as approximately 11,000 Medicare-Medicaid beneficiaries participating in the Commonwealth Coordinated Care program. We bring deep organizational expertise and passion for serving individuals with complex needs through a variety of state-sponsored programs.

We commend the Department for seeking input across stakeholders as part of its strategic review of potential program opportunities. We greatly appreciate the opportunity to participate in this information-gathering process, and look forward to further collaboration with the Department on the future MLTSS programs designed to transition remaining fee-for-service populations into a mandatory managed care program.

Should you have any questions regarding this submission, please contact me by phone at 571.919.9619 or via email at [robert.hager@anthem.com](mailto:robert.hager@anthem.com).

Sincerely,

A handwritten signature in blue ink, appearing to read "Robert Hager".

Robert Hager  
General Manager  
Staff VP Duals Management  
VA Medicare Medicaid Plan

HealthKeepers, Inc. (Anthem)\* is pleased to provide its response to the Department's (DMAS's) request for comments on a Managed Long-Term Services and Supports (MLTSS) program.

*1. Top three significant features.*

**Covered Populations.** We recommend mandatory enrollment for all Medicaid enrollees meeting criteria for Nursing Home (NH) Level of Care, Intermediate Care Facility (ICF), or Home- and Community-Based Services (HCBS), including Elderly or Disabled with Consumer Direction (EDCD) waiver, nursing facility, Fee-For-Service (FFS) dual eligibles, Alzheimer's assisted living, technology assisted waiver beneficiaries, and individuals with intellectual or developmental disabilities.

**Comprehensive Scope of Services and Benefits.** LTSS Managed Care Organizations (MCOs) should be at risk for the full complement of acute and long-term services for MLTSS enrollees, including physical and behavioral health, LTSS (NH, ICF, and HCBS), prescription drugs, self-directed services, and routine non-medical transportation. MCOs should also be allowed to provide "in lieu of" services when appropriate.

**Geographic Area.** DMAS should implement the program statewide to maximize the potential for improvements and access to care and services, improve outcomes and program savings, and maximize the availability of MLTSS to all eligible Virginia Medicaid enrollees. DMAS may wish to use a phased geographic/regional implementation, but should award statewide MLTSS contracts to MCOs in a manner consistent with the Commonwealth Coordinated Care (CCC) contract awards.

*2. Feasibility of including acute and primary care for ID, DD, and DS waiver enrollees.*

Given sufficient time for implementation, we believe that some MCOs will be equipped to manage and coordinate ID, DD, and DS waiver services from the outset of the program. However, we recognize the importance of these services to waiver members and the relationships they develop with support systems and service providers. We believe a two-stage approach for these individuals will be viable. DMAS could include these waiver enrollees in the program from the beginning for primary and acute medical services, and implement HCBS and habilitation services later. This will help ID, DD, and DS enrollees, their families and caregivers, and advocates to gain experience and familiarity with managed care programs and develop relationships with MCO care managers, while preparing the way for an eventual move of all ID, DD, and DS waiver services into managed care.

*3. Essential protections for individuals.*

Anthem believes there is a role for all of these protections at the outset of the program, with possible refinement as the program matures. An independent enrollment facilitator that can provide accurate, detailed information and options counseling will be important to member choice and satisfaction. The opportunity to self-direct will be an important option for some beneficiaries. Continuity of care provisions for the first six months of the program will reassure members and providers and help smooth transitions. An ombudsman program will complement the existing fair hearing process. The program should leverage existing systems for reporting abuse and neglect. Another important consumer protection is clear and transparent *information*. All stakeholders will be best served by a process in which DMAS, the enrollment facilitator, and the MCOs provide clear, frequent, and accessible information that prepares enrollees and providers for the program and that gives them updates on progress and opportunities to ask questions and allay concerns. Outreach should use channels such as answer lines, provider orientation/education sessions, advisory groups, direct mail, town hall meetings, print and social media.

*4. Person-centered needs assessments, service planning, and care coordination requirements.*

The core activities of assessment and service planning should use a person-centered approach to evaluate members' needs for functional, medical, behavioral health, and social services and supports,

and support members in achieving the quality of life and level of independence they seek. In addition, individuals should have the option to self-direct their personal care and respite services and manage caregivers in ways that ensure choice, foster independence, and continue satisfaction.

**Comprehensive Assessments.** MCOs should perform comprehensive assessments of each member's physical, behavioral, cognitive, environmental, social, and functional needs, including comprehensive medication review, home safety evaluation, and the member's goals, preferences, and capabilities. Assessments should be strength-based and conducted as soon as possible after program launch, with high needs individuals prioritized first. MCOs should reassess members annually or when transitions of care or unexpected episodes of care occur. The assessment tool should be standardized across MCOs to assure consistent results regardless of a member's MCO.

**Service Plans.** Based on the member's assessment, the MCO should create a member-centered plan to address the members' goals, care, and service needs. Service plans should be developed with the member, family/caregivers/legal guardians s/he designates, and providers. Service plans should identify both natural supports and contracted providers. MCO staff should update and revise the plan as needed to reflect information from reassessments and changes in the member's goals, condition, or needs; and following significant changes in health or functional status.

**Case Management.** Case management involves executing a member's plan for physical and behavioral health care and non-medical functional, social, and supportive services. With a benefit package comprising the full range of acute physical and behavioral health, LTSS, and HCBS, MCO case managers are best positioned to manage the full range of service from contracted providers, natural supports, and community resources.

#### *5. Most significant features in assisting individuals with transitions.*

Advance planning and timely, clear communication among MCOs, providers, members, and caregivers are the most important elements in managing transitions. MCOs should work with members and providers to create transition plans that assure coordination and continuity of care when individuals transfer between treatment settings. Transition plans should account for members' goals, preferences, and functional and health status. They should emphasize member and caregiver education on post-transition issues, expected outcomes and possible complications, plans for in-home and support services (including contingency planning), medication administration, and how to communicate concerns. They should also address logistical issues, such as transportation and respite services, and next steps for follow-up care, including post-transition medical/therapy appointments, home care, medical equipment, and medication reconciliation. For members transitioning from nursing home to community settings, housing and the availability of natural supports can be significant challenges. Such concerns can be resolved by collaboration, thoughtful and comprehensive planning, identification of suitable housing pre-transition, face-to-face visits within the first 24 hours during transition, and a transitional benefit to pay for rent, utility deposits, and basic household items.

#### *6. What would make an MLTSS program attractive to individuals?*

MLTSS programs offer enrollees the prospect and reassurance of receiving all care and services through a case management system that provides seamless coordination and promotes access, driven by a designated case manager they can contact for any reason. The case manager serves as a "point person" to assist members with care and service systems, program information, and problem resolution. Together with a person-centered assessment, and care and service plan tailored to the individual's needs, these aspects of care management will promote better satisfaction for members as compared with the current FFS system. The person-centered process also identifies personal goals such as housing, employment, recreation, and social and community participation. "Value-added" benefits also play a key role in attracting enrollees to the program.

### *7. What MLTSS program features would be important to providers?*

MCOs should hold multiple, repeated provider training sessions throughout the service area in the months before program “go-live”. These in-person and web-based sessions will address provider concerns and questions regarding practical aspects of managed care (e.g., care coordination, claims submission, and issue resolution). DMAS should require contracted providers to attend at least one training session to increase engagement and assure program success. Led by MCO provider staff, training should cover processes for eligibility verification, prior authorization, case management/care coordination, transition management, and claims submission and billing. Staff should be available to address provider questions and concerns about the MLTSS program and MCO policies and processes. Additionally, MCOs should collaborate, where possible, on LTSS provider training, credentialing, and site visit processes.

Experienced MCOs know that many LTSS/HCBS providers are small businesses. Such MCOs provide individual administrative support, process provider payments frequently to support cash flow, offer electronic claims submission and funds transfer, and respond timely to requests for authorization or assistance. All eligible providers should be required to have a National Provider Identifier to support accuracy of payments and directory information. DMAS should set a clear definition of a “clean claim” for the MLTSS program, set payment floors for certain LTSS services, and establish reduced rates for providers who decline to participate in the program. Such features assure providers and MCOs that payment rates will not be a barrier to success of the MLTSS program. DMAS should encourage MCOs and LTSS providers to develop creative payment models that align the parties.

### *8. What would make an MLTSS program attractive to providers?*

MCOs with experience in the Virginia MLTSS program already recognize that there is a lack of sufficient providers to meet all the needs of MLTSS individuals. As a result, MCOs can present new business opportunities to providers, giving them a chance to create new services to close gaps in needed services. This encourages providers to diversify into either new services types or service areas, creating new economic opportunities for providers while simultaneously improving services to Virginians.

Providers will appreciate streamlined administrative processes that support the provision of care and services; for example, greater flexibility on “in lieu of” services and administrative practices as compared to FFS LTSS processes that may unintentionally create obstacles to addressing members’ needs. Providers will value timely and accurate payment, resources for provider questions and assistance, and having a designated provider service representative as a primary point of contact to resolve issues. Providers may also be interested in participating in value-based payment programs that reward quality and performance.

### *9. Design recommendations for comprehensive and integrated supports and service package.*

The MLTSS program should place MCOs at risk for a comprehensive, integrated package of acute care and LTSS, including physical health, behavioral health, social, nursing home, ICF, HCBS, prescription drugs, and non-emergency medical transportation. DMAS should include all EDCD waiver HCBS and the full actuarial value of Medicare cost sharing for dual eligible members. Anthem strongly believes that we can best serve members and improve outcomes when MCO case managers can coordinate the full range of program services and benefits needed to holistically address members’ needs.

### *10. How should DMAS handle Fiscal/Employer Agent (F/EA) services?*

Anthem supports a continued role for DMAS’ F/EA and a requirement that MCOs contract with the F/EA to manage fiscal and employment aspects of the Consumer Direction option. Designation of a single agent will also support compliance with federal Medicaid and labor regulations.

### *11. Recommendations for health plan requirements.*

To best serve Virginia's MLTSS population, DMAS should select MCOs that understand the diverse needs of the various populations receiving LTSS. Anthem suggests the following criteria:

- **Demonstrated Experience in Coordinating Services within LTSS.** MCOs should have previous organizational MLTSS experience across different states and keen knowledge of the Virginia LTSS program, including experience in Virginia's CCC program. MCOs with a range of experience can provide innovative solutions to support members who have a diverse array of conditions and abilities while giving DMAS the benefit of experience in other states. Criteria should include number of members served, years' of MLTSS experience, number of MLTSS contracts, scope of services managed, and experience with Medallion and EDCD waiver programs.
- **Experience Coordinating Services for Dual Eligibles.** MCOs should have broad organizational experience in dual eligible programs such as special needs plans and Medicare-Medicaid plan demonstrations. MCOs should be experienced in coordinating Medicare and Medicaid services over a range of acuties and care settings to meet members' needs. Existing MCOs in Virginia's Medicare-Medicaid Plan demonstration have experience serving current LTSS members and providers, so DMAS should consider those plans' unique experience. Adding MCOs in addition to the MMP MCOs could create considerable additional confusion and administrative burden for MLTSS providers.
- **Expertise in Assembling and Serving Integrated Provider Networks.** MCOs should have demonstrated organizational experience in building integrated provider networks with adequate capacity, breadth, and scope to provide and coordinate the full spectrum of person-centered physical, behavioral, social, and functional care and services, including employment supports. MCOs also should have familiarity and experience with provider engagement, education and collaboration, and the business needs of small and mid-size providers for eligibility verification; authorization access; billing and claims payment; and provider service, training, and technical assistance.
- **Quality Management.** MCOs should demonstrate organizational capabilities for improving member health outcomes and quality of life; delivering timely and effective care; reporting a range of quality and performance measures; and reducing fraud, waste, and abuse. The program should include meaningful quality and performance measures and reward MCOs for superior performance.

### *12. Strategies for health plans to maximize coordination with Medicare for dual eligible individuals.*

The key to maximizing coordination of Medicare and Medicaid for dual eligibles is through aligned enrollment in Medicare-Medicaid demonstration plans or Dual Eligible Special Needs Plans (D-SNPs). All MLTSS MCOs should have a Medicare contract and be able to operate D-SNPs in Virginia's most populous counties. Aligning enrollment so that members receive their Medicare and Medicaid benefits from the same MCO promotes coordination, and DMAS should make this a primary element of its MLTSS program design.

### *13. Value-based payment opportunities to reward providers for improved outcomes*

Value-based payment opportunities will depend on: 1) the scope of MLTSS services included in the program, and 2) the kinds of services and possible outcomes associated with a given provider type. For example, MCOs might use Value-Based Payments (VBPs) with nursing homes for members successfully transitioned to the community; reductions in rates of stasis ulcers, ER visits, and hospital admissions; and for providing skilled treatments "in place". HCBS providers could receive VBPs for reduction or elimination of incidents such as falls, unnecessary ER, nursing home or institutional placements and stasis ulcers, timeliness of home visits, and completion rates. Physicians could receive VBPs for relevant HEDIS measures, care coordination, and interdisciplinary care team participation.

#### *14. Most important program areas for quality measurement.*

DMAS should include a range of HEDIS measures for covered physical and behavioral health services and general measures of member satisfaction. DMAS also should include measures that *specifically evaluate LTSS performance*, such as member participation in service planning, rates of participation in consumer direction, prevalence of falls, quality of life satisfaction, timeliness of services, the degree to which LTSS are meeting members' needs, and successful nursing home transitions to the community.

#### *15. Recommendations for financing, incentives, and other value-based strategies.*

MLTSS rates for MCOS should be actuarially sound and account for differences in clinical acuity, care/residential setting, and dual eligible status. MCOs should be incentivized to support client independence by avoiding unnecessary nursing facility admissions and lengthy stays. LTSS risk adjustment models should be based on members' periodic LTSS assessments as opposed to traditional risk adjustment models that rely on medical diagnoses. Risk adjustment systems based only on clinical status and utilization are inappropriate for programs dominated by LTSS and HCBS. Incentivize MCOs with quality bonuses for achieving designated performance metrics, such as rates of diversions from nursing home and ICF to HCBS; appropriate use of skilled nursing facility days; member participation in service planning, reductions in nursing facility, ER, and hospital admission/readmission rates; and overall member satisfaction.

#### *16. Effective strategies for engaging individuals and providers in outreach and education.*

A strong engagement and education plan is critical to the success of a new MLTSS program. Engaging members, families, and stakeholders with program information should begin early and continue over a period of time through multiple channels, such as town hall meetings, print media, Internet, television, and direct mail. DMAS may wish to engage MCOs in helping to defray costs of outreach. DMAS should engage key provider groups early on through an Advisory Council. During implementation, DMAS and MCOs should hold periodic regional meetings with providers and advocates to inform them of the program, obtain input, and respond to concerns. At roll-out, DMAS, the enrollment facilitator, and MCOs should hold events to orient members and stakeholders to the program, MCO selection, the enrollment process; and respond to questions. MCOs should engage with providers by creating advisory groups. Stakeholder meetings should continue through the program's first year to assure effective, ongoing communications and feedback on program issues. Information from these meetings should be tracked and evaluated for action and follow-up. MCOs should conduct periodic stakeholder meetings to communicate program updates/changes and provide a forum for questions.

#### *17. Most important messages for individuals and providers in transitioning to an MLTSS program.*

Key messages from DMAS to enrollees, providers, and other stakeholders should include the following:

- The MLTSS program will be realized through a thoughtful process that provides all stakeholders with multiple, ongoing opportunities for information and input.
- MLTSS is a logical continuation of the work to improve the delivery of Medicaid LTSS begun through the Commonwealth Coordinated Care initiative.
- Enrollees will not be losing benefits and providers will not be losing patients; rather, they will gain additional support for access, coordination, and execution of services across members' medical and behavioral care, social and support needs, and in concert with their individual goals.
- The timeline for MCO selection, client/stakeholder engagement and input, program implementation, and "go-live" is reasonable and achievable.
- DMAS will provide frequent communication on the process, progress, and updates.
- Enrollees and stakeholders will have multiple opportunities to learn about and provide feedback on implementation progress, communications, and other program elements.

**Health Plan**



Response to

**MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS)**

**OPPORTUNITY FOR PUBLIC COMMENT**

Presented to

**DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)**

Submitted by

**Aetna Medicaid**

**Due: June 16, 2015 at 5:00 p.m.**

**Department of Medical Assistance Services (DMAS)**

600 E. Broad Street  
Richmond, Virginia 23219

June 15, 2015

**Pamela Sedmak**

Chief Executive Officer  
Phone: 602-659-1160  
E-mail: [SedmakP@aetna.com](mailto:SedmakP@aetna.com)

4500 E. Cotton Center Blvd.  
Phoenix, AZ 85040

**AETNA MEDICAID**

RE: Managed Long Term Services and Supports (MLTSS) Opportunity for Public Comment

To the Virginia Department of Medical Assistance Services:

Aetna Medicaid is pleased to provide the following response to the Managed Long Term Services and Supports (MLTSS) Opportunity for Public Comment.

Aetna Medicaid has 30 years of experience managing high acuity, medically complex populations as well as the full range of Medicaid and CHIP beneficiaries. We currently serve nearly 3 million members across 17 states, including ten LTSS/Duals programs across seven states. Recognized as a national leader in Medicaid managed care, our success is built upon our local, community-based health plans and our bio-psycho-social integrated care management model. For the past 20 years, we have proudly operated Coventry Cares of Virginia, currently serving 42,000 Medicaid members.

Virginians receiving Medicaid LTSS services are among the most vulnerable citizens in the state. The Department of Medical Assistance Services is to be applauded for soliciting the input and guidance of experienced companies like Aetna as it develops the key tenets of its MLTSS program. Our attached response includes the recommendations we believe will help DMAS achieve its goals of health system transformation.

We appreciate the opportunity to provide this input and look forward to partnering with DMAS to achieve a fully integrated delivery system in Virginia.

Should you have additional questions or need clarification on our responses, please contact me at

(602) 659-1160 or [SedmakP@aetna.com](mailto:SedmakP@aetna.com).

Sincerely,

Pamela Sedmak

Aetna Medicaid is pleased to respond to a request for public commentary from the Virginia Department of Medical Assistance Services (DMAS). The goal of a managed long-term services and supports (MLTSS) program is to help beneficiaries achieve their optimal functional status in the right setting and help states manage the cost of the Medicaid program. Aetna Medicaid has 30 years of experience serving LTSS members and our experience spans the following states: Arizona, Delaware, Florida, Illinois, Michigan, New Jersey, New York, and Ohio. In these states, we have honed our approach to serving highly complex and frail populations with diverse benefits. We are equipped to manage successfully the varying benefits, cost shares, and eligibility requirements of the Virginia LTSS and Home and Community-Based Services (HCBS) waiver populations. Our experience in implementing, administering, and caring for high acuity Medicaid members results in members receiving quality care in appropriate settings, while achieving the State's goals and objectives. In Arizona, we operate our longest and most integrated program, managing TANF/CHIP, ABD, LTSS and duals populations for nearly 400,000 members. In addition, we manage Arizona's first fully integrated physical and behavioral health program for members with serious mental illness.

**Q.1** Aetna Medicaid recommends DMAS require:

- 1) A fully integrated program based on a person-centered approach. In this model, recipients who qualify for MLTSS receive coordinated care that best meets their individualized needs, including living in the most integrated, least restrictive care setting that supports optimal functioning. This model improves quality of care and of life for the recipient while minimizing the financial risk to the State.
- 2) Conflict-free care management and coordination of services and supports delivered face-to-face by local, experienced LTSS case managers. This model provides the best quality of care for the recipient by decreasing fragmentation, confusion, and duplication of services.
- 3) Providing individualized care management, service placement, and service delivery based on a comprehensive assessment of each individual's needs and goals delivered by an extensive network of high-performing, qualified traditional and non-traditional providers.

**Q.2** Aetna Medicaid recommends the DMAS MLTSS enrollment include all appropriate LTSS populations regardless of age, disability, dual eligibility or place of residence (e.g., own home, institutional or residential facility). An all-inclusive integrated approach will increase the program's effectiveness and drive key programmatic and legislative directives. The MLTSS program should include a person-centered model, with mandatory enrollment offering individuals choice of managed care organizations, acute care services, and primary care providers experienced in managing medically complex populations in the setting that is most advantageous to the recipient.

We recommend a state procurement process that procures and awards contracts statewide that are then implemented in a phased-in approach by region that encompasses all populations, including dual-eligible beneficiaries receiving LTSS, over a 12-month implementation period. A phased-in approach to the mandatory enrollment may help ensure that supportive services, including integrated behavioral health homes, habilitation homes, meaningful employment, and educational collaborations, address the needs of those enrolled in the ID, DD, and DS Waivers.

**Q.3** Aetna Medicaid recommends the state ensure effective oversight of the program, including explicit contract language outlining plans' responsibilities and performance metrics. Virginia should also solicit ongoing feedback from consumers and providers to help monitor program operations. MCOs must partner with DMAS and stakeholders to develop metrics to be used among all LTSS programs.

Participant protections should include ombudsmen, conflict-free care management, options counseling provided by trained staff, and consumer-directed care in which the MCO, FE/A, and participant collaborate to enable caregiver screening and training. Further, we recommend an early, frequent, targeted communication strategy focused on advocacy groups, provider communities, and caregivers of this vulnerable population. In addition, all communications with members should be readily available in their spoken language with culturally sensitive content. Additionally, translation services should be available for individuals to assist with communication barriers. Communications should include at a minimum: member handbooks, member rights, information regarding grievance and appeals and service continuation, and plans of care. Network adequacy, availability and access standards, and a defined continuity of care period will allow participants and providers to maintain established relationships during the transition from fee-for-service (FFS) to MLTSS.

**Q.4** The foundation of a person-centered approach is respect for an individual's preferences, interests, needs, culture, language, health literacy, and belief systems. Specific considerations should be taken into account when developing person-centered needs assessments, conducting service planning and care coordination. These include:

- **Assessments:** Comprehensive valid and reliable instruments that assess the members' bio-psychosocial and functional needs are common among MCOs. Assessments must meet the needs of the MLTSS population and be conducted face to face in the participant's residential setting by trained assessors. The process includes gathering information from family, friends, and representatives of his/her choosing, and results in evidence-based interventions for consideration in care and service planning. This should be done in a culturally competent manner and include the member's full circle of support.
- **Care and Service Planning** requires working with the MLTSS individual, his/her family, support systems, peer specialist, primary care provider, MCO's medical director and other providers using an integrated team approach. Collaboration during service selection assists the individual to attain his/her goals and support the highest level of self-sufficiency. During the care and service planning process, the case manager facilitates the identification and resolution of root causes that drive poor health, through the authorization of appropriate services, which are augmented by the development of backup or contingency plans to avoid unplanned gaps in service.
- **Care Coordination:** Educating and maximizing individuals' care and service options such as: the Virginia consumer-directed care waiver, Money Follows the Person (MFP), community rebalancing, transition coordination, and chronic condition self-management drives quality-based outcomes. These would include improved /maintained functional status; enhanced quality of life; increased satisfaction and adherence to the care plan; improved safety; and to the extent possible, increased self-direction.

**Q.5** Individuals' wishes, strengths, identification of perceived barriers and mechanisms to overcome barriers will drive transitions. Fluidity between individuals, providers, and funding agencies is necessary for members to receive optimal, uninterrupted health care, regardless of whether or not they enroll as new members, transition out of the program, or transition between funding streams. Facilitating compassionate and efficient care transition, including continuity of care should be seamless for individual recipients. Transition between providers and service/treatment settings require an appropriate transition period and a well-defined transition plan, and monitoring of that plan. Aetna recommends a 90-day initial transition period to support

continuity of care. We would also recommend that the state require selected MLTSS plans to have a corresponding D-SNP, in addition to mandating the medicaid benefit for Dual LTSS beneficiaries with selected MTLSS plans, in order to optimize benefit alignment between the Medicaid and Medicare programs and further enable seamless transition of care.

**Q.6** The core of the MLTSS program is to enable individuals to safely remain in the community with their circle of supports. DMAS should undertake an education program that emphasizes the benefits of the MLTSS program and the array of community options and alternative residential settings. An attractive model for Virginians is a proven, locally based statewide MLTSS integrated program administered by an entity experienced in managing the highly complex, high risk and frail individuals. The local program will have a comprehensive network of providers skilled in caring for the LTSS population including those currently providing care to the individuals. In addition, well-trained case managers navigate the systems of care and engage each recipient in their care while recognizing their strengths and capacities when addressing his or her critical physical, behavioral, environmental, and psycho-social needs in a culturally competent manner. Additionally, individuals should receive face-to-face care coordination through a local, community-based plan (e.g., Virginians serving Virginians), with the most effective technology-enabled, evidence-based systems and appropriate services and supports to create optimal health outcomes and enhanced quality of life for the individual recipient. Individuals would be invited to participate in member advisory groups along with key stakeholders, to offer insight into the governance structures and offer a “voice” in decision-making processes.

**Q.7** Based on our LTSS experience in other states, many LTSS providers are unfamiliar with the MCO requirements. Providers must be supported through the transition process, with education and training on the MLTSS program, the role of the case manager in authorization of services, the claims, billing and prompt payments services. MCOs must be able to accept claims submitted in both electronic and paper forms and offer a choice of payment options, (i.e. paper checks or direct deposit electronic funds transfers). MCOs should also have a Provider Advisory Committee to receive direct feedback from the provider community. MCOs in the LTSS program should be required to have locally based provider liaisons to assist LTSS providers. Providers should also have direct contact with the local case manager assigned to the member to ensure provider engagement in the member’s care, resolving member care concerns, identifying potential claims processing issues, and establishing a direct contact if they have questions regarding an authorized service.

**Q.8** Key features to a successful provider transition include promoting open, two-way communication and an interactive educational approach. This approach would include but not be limited to: in-person on-site support and education, provider forums held throughout Virginia and webinars customized by provider type. Additional communication mechanisms should be:

- Secure provider web portal for providers to communicate health care service information directly with the MCO. The portal would enable providers to verify eligibility, submit and check prior authorizations, and check claims status.
- Secure member care web portal allows providers to view care management and relevant member care and service plans and to communicate with LTSS case management staff.
- Written communication by LTSS case managers outlining the service, frequency, and unit(s) authorized for their client.
- Provider orientation using a comprehensive orientation kit, augmented by a provider manual and contract, participation requirements, program standards, and state and federal regulations.

- Provider office visits to reinforce previously presented information and communicate upcoming MCO initiatives, new regulatory requirements and any additional information.
- Ongoing provider communications via fax blasts or letters.
- Toll-free help line to respond to provider questions and provide assistance.

Aetna recommends the MCO offer educational assistance to help providers integrate behavioral and physical health and build customized training solutions related to: trauma-informed care, clinical supervision, and cultural competency to ensure providers can measure outcomes improving overall efficacy.

**Q.9** Aetna recommends a comprehensive, state-wide, fully integrated model of care for physical and behavioral health for all populations (including duals). This would include all services: acute care, behavioral health (inpatient, outpatient, peer counseling etc. as developed by the Department of Behavioral Health and Developmental Services and DMAS), skilled and custodial institutional/facility services, a full array of home and community based services (HCBS) to include consumer-directed care option along with fully integrated care management, social services and supports. This integrated design supports Virginia's rebalancing efforts to meet growing demands for LTSS services and provides a sustainable way to manage LTSS by transitioning members to their preferred community-based residential options.

**Q.10** Aetna Medicaid supports the MCO contracting with the Department's current F/EA, Public Partnership LLC (PPL). This approach enables the MCO's members' representative to retain their relationship with PPL, contributing to a seamless transition from FFS to MLTSS, and prevents disruption in care delivery. We would request the opportunity to negotiate rates and potentially add specific requirements into the contract language based on our experience in other states, as well as add another F/EA to our provider panel if PPL is unable to meet the needs of our participants. Aetna contracts with PPL in other states.

**Q.11** Our experience has shown that states are best served by partnering with accredited MCOs with comprehensive experience managing the LTSS population and use a capitated managed care approach through an integrated model of care. We encourage an open and fair competitive procurement of MLTSS that places significant value on experience specific to LTSS and dual eligibles. If awarded the contract, we would commit to implementing a D-SNP, aligned with the awarded Medicaid service areas and the D-SNP federal annual application timeline. To allow for fully integrated care, we recommend that the Medicaid benefit for Dual LTSS beneficiaries be mandated to MLTSS contract awardees who also commit to implement a D-SNP for optimal financial and clinical alignment and a more simplified member and provider experience. Ideally, the state should research and consider filing a waiver with CMS seeking to allow the state to also passively enroll the D-SNP dual LTSS enrollees with the same health plan the enrollees have for their Medicaid benefits, similar to what Arizona did in 2006. Choosing the right partner with experience in building provider networks and providing integrated care management specifically for LTSS recipients is critical to Virginia's success in meeting its program goals.

**Q.12** Aetna Medicaid recommends DMAS and MCOs fully integrate funding, benefits and coordination for dual eligibles receiving LTSS. Regardless of the underlying program, all dual eligibles receiving LTSS should be enrolled in an integrated and coordinated program of care. Inclusion of all appropriate LTSS populations regardless of age, disability, dual eligibility, or place of residence is necessary to increase the effectiveness of the program and to meet key objectives.

Dually eligible individuals typically have a more complex disease burden and utilize more services than their counterparts enrolled in traditional Medicare. While service utilization

increases, there are issues related to care coordination, fragmentation, and cost shifting, which increase the cost of service. Fully integrated service coordination increases beneficiary satisfaction, decreases costs, and increases positive health outcomes. Based on Aetna Medicaid's experience in four dual demonstrations, coordination strategies we recommend include:

- 1) Educating providers on the LTSS program, including care management process.
- 2) Using a value based solutions model that provides additional payments to providers who participate in the Interdisciplinary care team and rewards them for providing evidenced based care that closes gaps in care.
- 3) Employing robust interdisciplinary care teams to share information and create transparency regarding services and gaps in care across the care continuum among stakeholders.
- 4) Providing ready access to Medicare claims, this information would help to resolve issues related to access, transportation to services, etc.

The success of a fully integrated approach was confirmed by Avalere Health's 2012 study, "Analysis of Care Coordination Outcomes." The study examined the effectiveness of managed care for dual eligible members at the health plan we operate in Arizona, compared to a similar population receiving services through a fee-for-service delivery model. The Avalere study found that our integrated model effectively avoids utilization of unnecessary services and inefficient care, due to improved management of 1) inpatient (measured by hospital days, discharges, and length of stay); 2) ED utilization; and 3) all-cause readmissions.

**Q.13** We are committed to supporting innovative payment and delivery models tied to value based opportunities (VBO). Aetna recommends VBO provider initiatives, including financial arrangements and accountable care models designed to assist the entire provider continuum with achieving quality outcomes, population health management capabilities and improving the individual care experience. These would include pay for performance, pay for quality, patient-centered medical home/health homes, bundled payment, shared savings, and full risk accountable care.

**Q.14** Aetna Medicaid recommends a comprehensive quality strategy that is transparent and appropriately tailored to address the needs of the LTSS population. MCOs should implement robust quality metrics and continuous quality improvement initiatives. It will be important to monitor and measure performance such as network adequacy; timeliness of assessments, service plans and service plan revisions; nursing facility diversion, rebalancing and community integration, medication knowledge and adherence, disenrollment; utilization data; call monitoring; critical incident investigation and resolution; fraud and abuse reporting; outcomes data and complaint/appeal actions.

Continuous quality improvement and data driven decision-making will align the care and services of individuals, health plan operations, provider reimbursement, and the state's quality initiatives and program strategy. Subsequently, enhanced measures should be required, such as HEDIS and CAHPS access measures as well as those associated with gaps in care. We recommend a tiered quality structure to monitor closely the comprehensive quality program and would welcome the opportunity to serve in the development of LTSS specific metrics.

**Q.15** Building on the principles outlined in Q13, we would recommend specific pay-for-quality strategies involving MLTSS providers to meet the goals of community rebalancing. For those members residing in an institutional setting, indicators would include fall reduction, skin integrity, restraint use, preventable ER, and inpatient utilization.

**Q.16** Engaging individuals, providers, and key stakeholders need to be a priority in outreach and education efforts. We recommend that DMAS require multiple member outreach attempts

using different methodologies and at different times. Providers should be engaged in this outreach process for members who are not successfully reached initially. While standard outreach occurs more timely, for new programs, timely assessments should be conducted within 90 days of implementation. Continuity of care, person-centered, choice, and quality service provision from geographically convenient providers, with a single case management navigator, are important messages for MLTSS recipients.

**Q.17** A message to the individuals is that the plan will make every effort to invite their providers to participate in the network and, as discussed above, individuals will have opportunities to remain in the community through this program. Providers transitioning to a new MLTSS program need to hear that they will be invited to participate in the network, will be educated and supported on how to bill the MCO, and will receive timely and accurate payments. Training for non-traditional providers should be made available via webinar, telephonically, and in person to allow providers to receive the assistance necessary through the transition period. Moving forward, through our contracting process, providers will have opportunities to enhance payment opportunities based on shared savings, P4P and P4Q based on outcome measures.

## Health Plan



AmeriHealth Caritas

200 Stevens Drive  
Philadelphia, PA 19113-1570  
215-937-8000

June 16, 2015

**SUBMITTED VIA E-MAIL**

Commonwealth of Virginia  
Department of Medical Assistance Services  
600 East Broad Street  
Richmond, VA 23219

### **RE: Opportunity for Public Comment – Managed Long Term Services and Supports (MLTSS)**

Dear Madam/Sir,

AmeriHealth Caritas is pleased to provide this response to the above-referenced Opportunity for Public Comment issued on May 13, 2015. For over 30 years AmeriHealth Caritas has been a national leader as a Medicaid and Medicare Managed Care Organization (MCO) and currently serves over 6.6 million individuals in 16 states and Washington, DC. We deliver the highest-quality health care through a culture that prioritizes - above all else - member rights, cultural awareness and sensitivity, and an intractable commitment to serving members wherever they are and whatever their circumstances may be. Our partnerships and commitment to excellence ensure that our members have the best possible health outcomes through an integrated, cost-effective approach that coordinates physical health, behavioral health, pharmacy, community care, long-term care, and social services. We remain committed to leveraging our clinical and business expertise to provide seamless, quality health care experiences for our existing and future members.

The AmeriHealth Caritas Family of Companies offers a range of products targeting those most in need and at-risk populations including:

- **Full-risk Medicaid managed care** services with a variety of integrated programs and capabilities to meet the special medical and social needs of underserved populations (Temporary Assistance for Needy Families [TANF], Aged, Blind and Disabled [ABD], foster care, and Children's Health Insurance Program [CHIP]).
- **Dual eligible services** with prescription drug coverage through a Medicare Advantage special needs plan (D-SNP) and integrated Medicare Medicaid Plans (MMPs) designed for members enrolled in both Medicare and Medicaid.
- **Behavioral health services** leveraging our wholly-owned subsidiary PerformCare®, a full-service behavioral health managed care company that supports members through specialized behavioral health and human services programs in the public and private sectors.
- **Pharmacy services** through our wholly-owned subsidiaries PerformRx<sup>SM</sup> and PerformSpecialty<sup>SM</sup>. PerformRx provides innovative, cost-effective pharmacy benefits

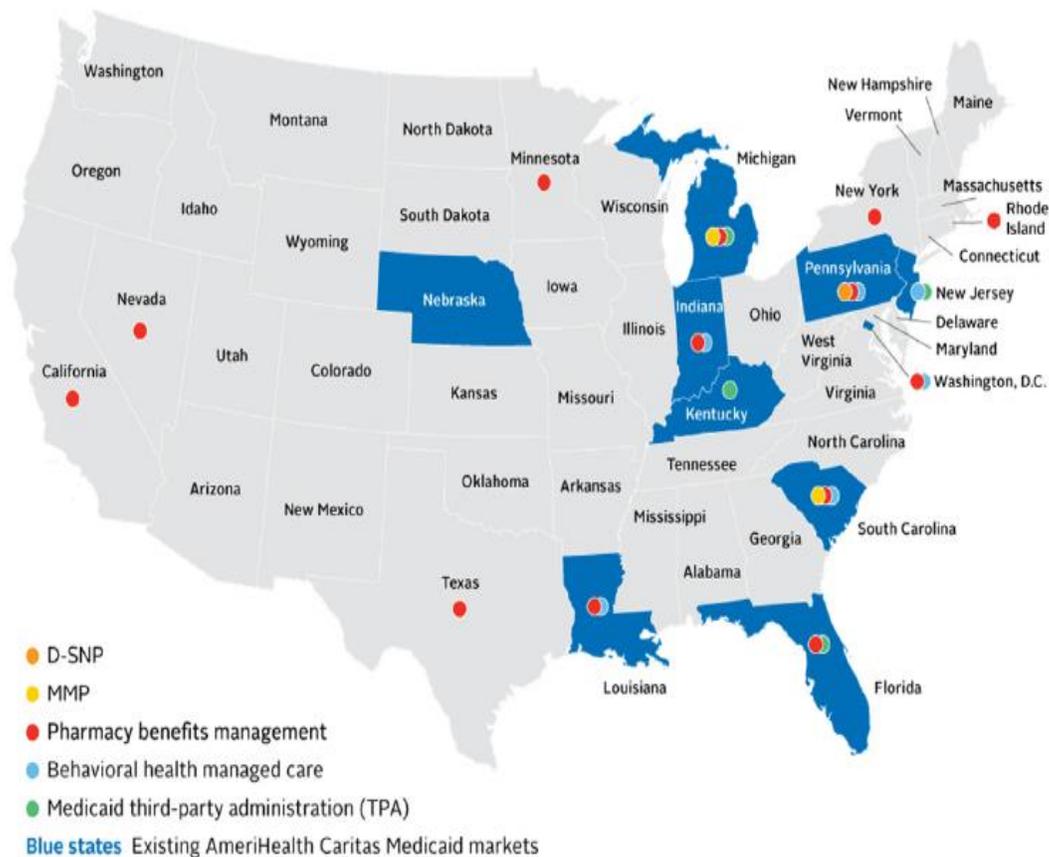
management services for Medicaid, Medicare, and commercial health plans, while PerformSpecialty provides specialty pharmacy solutions to members with complex pharmacy needs. Through a distinctive, high-touch approach, PerformRx and PerformSpecialty improve member outcomes and financial performance driven by cutting-edge, proprietary technology, and a strong Medication Therapy Management program integrated with health plans' care management models.

- **Inourced dental services** utilizing an internal team to create and manage clinical dental programs. This allows for the development of value-added integrated programs that add to improved quality outcomes for dental and physical health.
- **Third-party management and administrative services (TPA)** provided to managed care organization clients in four markets, including Indiana, Michigan, Kentucky, and New Jersey.
- **Program for members who need long-term services and supports (LTSS)** designed as an integrated solution across physical health, behavioral health, pharmacy, institutional care, home-based care, and social supports applied across all of our regions, including our MMPs in South Carolina and Michigan.



## AmeriHealth Caritas Coverage Area

Touching the lives of more than 6.6 million members nationwide



We believe that AmeriHealth Caritas is the right partner to help you achieve the objectives set out in this Opportunity for Public Comment and have included the following response to help you understand the capabilities and value we bring as a partner. Health care is not just a business to us; it is an *opportunity* to serve the least advantaged and make a difference in their lives. It is a commitment born from a mission started thirty-two years ago by a small, community health plan focused on serving the poor and today driven forward by a combination of proven expertise and a focus on designing person-centered innovations that deliver holistic care and service.

We look forward to the opportunity to present our capabilities and discuss the appropriate program design with the Department in further detail as we look to be a partner and resource to the State in this important program. Please feel free to contact Tom Lyman, Senior Vice President, Market Expansion, with any questions or comments regarding this submission; he may be reached via e-mail at TLYman@amerihealthcaritas.com or by phone at (215) 937-8564. Thank you for your attention.

Sincerely,

A handwritten signature in black ink that reads "Peter A. Jakuc". The signature is written in a cursive, flowing style.

Peter A. Jakuc  
Senior Vice President and Chief Development Officer

cc: Tom Lyman, Senior Vice President, Market Expansion

Attachment: AmeriHealth Caritas Response to Opportunity for Public Comment

## General

For over 30 years AmeriHealth Caritas has been a national leader as a Medicaid and Medicare Managed Care Organization (MCO). AmeriHealth Caritas currently serves over 6.6 million individuals in 16 states and Washington, DC across a variety of products and services that help the underserved get care, stay well, and live in healthy communities.

AmeriHealth Caritas supports an integrated approach similar to the Demonstration to Integrate Care for Dual Eligible Individuals program in which Virginia is participating, operating as Commonwealth Coordinated Care (CCC). Understanding that the state wants to move other populations into managed care that fall outside of the duals demonstration effort, AmeriHealth Caritas recommends that the Commonwealth of Virginia implement a statewide Managed Long Term Services and Supports (MLTSS) program as another pathway for the state to meet its objective of rebalancing the system to address the growing demand for services within existing LTSS expenditure levels. One of the key goals of a MLTSS program is to keep recipients in the community longer by providing support for daily living and access to quality health care services. Critical features of a successful MLTSS program include:

- a. ***Integrated model.*** The long-term care system should be based on an integrated physical, behavioral, and social health care model that incorporates person-centered comprehensive care planning. A broad range of medical and social services (wrap around services) - ranging from nursing home care to Home and Community Based Services (HCBS) for the elderly and disabled need to be included. Effective programs contain both medical and social components for a fuller complement of services and to more effectively coordinate services to drive better outcomes at lower cost.
- b. ***Inclusion of appropriate LTSS populations, including dual eligibles.*** States and MCOs should fully leverage existing pathways to integrate funding, benefits, and coordination for dual-eligible beneficiaries receiving LTSS. Regardless of the underlying program itself, all dual-eligible beneficiaries receiving LTSS should be enrolled in integrated and coordinated program of care. Inclusion of all appropriate LTSS populations is necessary to increase the effectiveness of the program and to meet key state objectives (both quality and fiscal).
- c. ***Enhanced community based alternatives.*** Focus on providing more robust community based living options, as an alternative to institutionalized care, with an emphasis on developing innovative care management models across the community care continuum. Collaboration with locally-based organizations and partnerships with provider and advocacy organizations with expertise in serving Medicaid LTSS populations is essential to effectively serving LTSS recipients.

## ID, DD, DS Waiver Enrollees

A comprehensive, integrated program would benefit the member and their family or support system and provide continuity for individuals enrolled in the Intellectually Disabled (ID), Developmentally Disabled (DD), and Day Supports (DS) waivers, while reducing waste and reliance on services that are not cost effective or involve the need for crisis intervention. The ID and DD providers need to be engaged in the solutions

and be invited to play a lead role in the assessment and care plan development. Likewise, family member and key stakeholder engagement is critical. Before beginning the program, the process for (1) how individuals would be assessed, (2) by whom, (3) under what timeframe, and (4) using which assessment tools needs to be well understood and articulated to providers, members, and the member's family and support system.

Coordinated, person-centered delivery is an important part of the MLTSS program for ID, DD, and DS waiver enrollees. The focus should be on LTSS consumers throughout the planning and implementation of MLTSS. States such as New York, Arizona, Delaware, and Illinois require MCOs to create member councils or advisory committees in which LTSS users can provide feedback to health plans. To ensure continuity of care, LTSS beneficiaries must understand how they will choose and access services - enrollees should be empowered to play an active role in their care through shared decision-making tools or self-managed programs. Effective programs contain both medical and social components for a fuller complement of services and to more effectively coordinate services.

Well-run managed care programs use information to measure quality and outcomes and insure a high level of continuity. This requires access to different sources of information and data such as pharmacy, emergency room, transportation providers, the enrolled individual, and his or her formal and informal support system. Whether this is metadata extracted from pharmacy claim files or the expressed goal of the individual enrollee, this is brought together to obtain a broader picture to begin the ongoing process of goal setting and member engagement.

### **Beneficiary Experience**

Strong beneficiary protections are critical to an effective MLTSS program and include:

- a. Diverse membership on a statewide and regional beneficiary advisory council to provide direct feedback to the state and health plans;
- b. Choice counseling to support the decision-making and enrollment process provided in ways that are sensitive to cultural and linguistic differences;
- c. Personal care connectors to support a "warm hand-off" from the current care system to the new integrated care model;
- d. Active participation by the beneficiary in the development of and on-going changes to his/her plan of care and in the selection and oversight of key service providers;
- e. An active beneficiary voice about the quality of services received;
- f. Continuity of coverage periods to assure no loss of critical services as the beneficiary transitions from FFS providers to those participating in a managed care delivery system;
- g. An independent ombudsman to provide information and advocacy to resolve beneficiary questions and concerns;

- h. An integrated system of data collection and data sharing that assures the availability of comprehensive information about care and services (regardless of the setting of care, quality and outcomes achieved within the integrated model) and information about the health and welfare of beneficiaries - all with appropriate privacy protections; and
- i. Effective protocols for managing transitions of care across settings, with special emphasis on transitions from institutional settings to home and community-based settings.

An effective person-centered needs assessment and service planning process includes the use of a multi-disciplinary team of professionals and non-professionals including the beneficiary and individuals chosen by the beneficiary. The professionals/ non-professionals involved in the process must have adequate knowledge, training, and expertise about disability, community living, and person-centered service delivery. The resulting plan must reflect the beneficiary's and caregiver's needs and preferences and address how these needs and preferences will be met by a combination of covered services and available community supports.

Person-centered service planning must be holistic in addressing the array of physical health, behavioral health, pharmacy health, and social needs to ensure the maximum degree of integration and the best possible health outcomes and beneficiary satisfaction. The person-centered process must also offer the beneficiary the opportunity and the supports for self-direction. Effective care coordination is guided by the resulting person-centered process and care plan, with changes to the care plan dictated by the feedback from members of the care coordination team as well as the beneficiary as to outcomes achieved.

The most significant features of assisting individuals transitioning between providers and service/treatment settings are:

- a. The availability of a transition coordinator who is knowledgeable about institutional and non-institutional settings and is motivated to help the beneficiary achieve his/her goals for improved health and social outcomes, including successful community living;
- b. The ability of MCO's to offer flexible services that meet individual health and social needs which are beyond the minimum benefits offered by the state; and
- c. An established protocol for transitions across care settings that is understood and embraced by all care providers participating in the integrated model, with a focus on ensuring the best health and social outcomes for the beneficiary.

The following features make an MLTSS program attractive to individuals:

- a. A comprehensive and flexible package of physical health, behavioral health, pharmacy health, social services and long term services and supports, from which the beneficiary can choose the services most important to meeting his/her desired goals/outcomes and which support the beneficiary's desire to function independently in his chosen home and community-based setting;

- b. A consistent “care coordinator” who facilitates access to those services and is available 24/7 to the beneficiary for assistance; and
- c. Appropriate services and supports for the caregivers of beneficiaries, to prevent caregiver stress and burn-out.

### **Provider Experience**

Managed care needs to be simple to use and seamless to providers. The health plan needs to engage providers as this is critical to managing care for enrolled members.

AmeriHealth Caritas recommends the following:

- a. Streamline and simplify administrative processes across MCO’s to minimize the burden on providers. Potential areas to streamline include benefit coordination, authorization, and adherence to “clean” claim standards;
- b. Regular and ongoing provider education and training via website, online provider manual, newsletters, workshops, dedicated account executives, and quarterly provider meetings;
- c. Peer-to-peer access to a locally-based Medical Director; and
- d. Provider access to dedicated call center support 24/7 and a nurse line for after-hours support.

### **Service Package**

AmeriHealth Caritas recommends that the Virginia DMAS consider the development and implementation of a fully integrated MLTSS care coordination model that encompasses all physical health, including acute care, behavioral health, pharmacy health, and LTSS services. MCO’s should use a set of comprehensive person-centered assessments to develop individual care plans which include solutions to address all these needs. The key to success with any integrated care model is the ability to ensure seamless transitions to and supportive maintenance of the appropriate level of care. For example, this program may implement initiatives to avoid nursing home placements through HCBS which include non-traditional health care services such as home delivered meals, home modifications, respite care, and personal care. Through this model, DMAS could move thousands of individuals currently residing in an institution with low level needs to a home or community based setting while preventing individuals from initially moving into an institution. This could save the state millions of dollars and individuals would reside in the least restrictive setting and the setting of their choice.

Consumer directed care should continue to be an option for members that are willing and able to direct their own care. If a member chooses to self-direct following a comprehensive assessment, the care manager will assist the member in developing a needs based budget and coordinate care with the contracted Fiscal/Employer Agent (F/EA). AmeriHealth Caritas recommends that DMAS allow MCOs the option to use the current designated F/EA or leverage existing F/EA relationships that each MCO currently has in place.

## Health Plans

States are best served by partnering with MCOs that have experience managing the Medicaid LTSS population under a fully aligned financial model or a capitated managed care approach for Medicaid populations receiving LTSS through an integrated model of care. Choosing the right partner with experience building provider networks and providing integrated care management specifically for LTSS recipients is critical to the program's success and the State achieving its quality and fiscal goals.

To maximize coordination of dually eligible individuals, AmeriHealth Caritas strongly encourages full integration of Medicaid and Medicare to allow care coordination across the entire continuum of services. In the absence of full integration like through an MMP, selected health plans should have successful experience with Duals-Special Needs Plans (D-SNP) and/or health plans participating in dual demonstrations. This will help ensure dual eligibles services are successfully coordinated with Medicare.

AmeriHealth Caritas recommends transitioning providers to value-based payment purchasing (VPP) models for MLTSS. Currently VPP models are not widely used. However, with a fully integrated model, there are quality outcomes measures that could be used for VPP. These include Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcome Surveys (HOS) data.

## Quality Measures

While nationally-recognized, standard measures are not fully developed, state Medicaid agencies have partnered with MCOs to develop measures that are responsive to the type of delivery system and payment approach the state employs. MCOs should implement robust quality metrics and continuous quality improvement initiatives that are responsive to the setting and type of delivery system and payment approach the state employs. Similarly, MCOs must reward high quality providers. At present, AmeriHealth Caritas produces reports for HEDIS and surveys members for CAHPS and HOS. In addition, each State has identified measures specific to their populations. AmeriHealth Caritas suggests that DMAS refer to state plans in Arizona, Delaware, Illinois, and New York for LTSS specific performance measures.

## Financing

Reimbursement strategies for MLTSS should include appropriate payment levels that take into account the acuity levels of the populations served. They should also allow for value-based purchasing and incentive arrangements for key providers that incentivize practice changes that promote quality health outcomes and quality social outcomes, including health recovery and community integration.

## Outreach and Communication

Community engagement, outreach, and education strategies tailored to the unique needs and culture of these populations are important. These strategies should focus on developing relationships and creating awareness of the benefits of managed health care on the population. Grassroots educational outreach strategies should be employed to promote wellness as a lifestyle and increase the target audience's knowledge of managed care. AmeriHealth Caritas also believes that it is crucial to engage and create true partnerships with providers. Strategies to engage providers

include conducting PCP orientations, distributing education materials, and co-sponsoring health fairs with PCPs.

### **Summary**

The primary goals of managed care are to improve the beneficiary experience, to promote the highest level of patient participation and independence, and increase communication and coordination between patients and their providers. The model of care AmeriHealth Caritas employs is designed to help achieve these goals and has been extremely effective in other markets. While each state and community in which AmeriHealth Caritas operates is unique, as is every enrolled member, the basic tenets of the model of care are the same and very transferable and can be appropriately customized to meet market-specific needs and circumstances.

## Health Plan

June 16, 2015

Ms. Tammy Driscoll

Senior Programs Advisor to the Deputy of Complex Care and Services

Virginia Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

Via email: VAMLTSS@dmas.virginia.gov

Dear Ms. Driscoll:

Sentara Healthcare appreciates the opportunity to provide initial comments on the Department of Medical Assistance Services' (DMAS) efforts to transition the majority of the remaining Medicaid fee-for-service populations into coordinated and integrated managed care models. We also acknowledge and appreciate that DMAS intends to continue meeting with stakeholders and will offer additional opportunities for input into the development of the Managed Long Term Services and Supports (MLTSS) program.

Sentara is an integrated delivery system that includes hospitals, nursing and assisted living centers, a variety of other providers, and Optima Health plan. Sentara supports the triple aim of improving care quality, increasing population health, and controlling costs. Transitioning more Medicaid beneficiaries to managed care will help to achieve these goals and with our integrated approach to healthcare I hope Sentara will be able to offer valuable insight as you move forward.

### General Comment

Health care is changing rapidly. As positive and impactful as government health care programs can be, they sometimes fail to keep up with the constantly changing healthcare environment. Sentara urges DMAS to **adopt as a principle allowing and encouraging provider and plan innovation** as part of this program. Program design should not be so prescriptive as to inhibit dexterous provider and plan evolution to new and better approaches to providing and coordinating care.

### Specific Issues

Quality is always paramount. You asked about areas of care that should be measured for quality. Sentara emphasizes that providers already report a wide variety of quality measures to a number of different entities. Sentara strongly encourages DMAS, to the extent possible, to **employ measures that have already been developed and are currently in use rather than developing yet more quality measures**.

It would make sense to adopt measures that have been vetted nationally.

Any health plan involved with the program should of course be appropriately credentialed. **Participating health plans also should be able to measure and report quality metrics** in order to assess their progress in coordinating care for this population.

Medicaid funding often represents a significant challenge. The **MLTSS program should be adequately funded to ensure access to high quality providers and adequate resources to plans so they may appropriately manage care**. This includes considering how the dual eligible population will receive services, accounting for how the program will interact with Medicare for this population, and ensuring overall funding is adequate. Patient education regarding the MLTSS program will be critical. **Patients must understand the impacts of moving into the new program, including the expectation that they will be active participants in their health**. Additionally, to the extent that patients may have the option of joining MLTSS or remaining with another program (the Program of All-Inclusive Care for the Elderly, or PACE, for example), easily-understood resources should be available to them explaining the

differences in programs. Likewise, providers should receive the resources necessary to ensure a safe and orderly patient transition.

Providing care and services to a population should mean **coordinating all services to ensure optimal outcomes and quality**. Participating managed care plans should either be able to offer or exhibit a willingness to contract for all services to be provided to the patient under this program.

Moving more Medicaid patients to managed care should help to reduce costs in part by realizing administrative efficiencies. This should include **streamlining service authorization while still allowing sufficient time for the payer to employ systems designed to ensure patient safety and care coordination**. The program also should employ a timeframe for transitioning in new patients that allows the patient sufficient access to medications and other care they received under their prior program while implementing new care coordination efforts as efficiently as possible.

**Regarding Value-Based Purchasing (VBP), health plans already are implementing a range of VBP strategies and contracts with their current provider partners. We anticipate that many such strategies will be used in the development of MLTSS networks.** However, it is important to note that some providers, particularly smaller, community-based agencies, may currently lack the experience, scope and technology to participate in VBP, at least initially at program launch. Targeting transition to VBP for these providers may be an appropriate longer term goal.

Thank you again for the opportunity to provide these initial comments and the promise of additional opportunities for input as program development progresses. Sentara looks forward to continuing to work with you to increase quality, improve population health, and drive efficiency in healthcare. If I may answer any questions, please contact me at 804-840-5087.

Respectfully,

/s/

Paul A. Speidell  
Director  
Government Relations and Health Policy

## Health Plan

Humana's Response to:

### Virginia Department of Medical Assistance Services

Opportunity for Public Comment on Managed Long-Term Services and Supports

## MLTSS PUBLIC COMMENT

Humana is pleased to respond to the Virginia Department of Medical Assistance Services' (DMAS) Opportunity for Public Comment on Managed Long-Term Services and Supports (MLTSS). We are committed to the Commonwealth of Virginia and its beneficiaries, and support the exploration of new models for these critical populations.

Our commitment to MLTSS eligible Virginians begins with our current partnership with DMAS as a contractor for the Commonwealth Coordinated Care (CCC) program in which we currently have nearly 11,000 dual eligible individuals (dual eligibles) enrolled, and provide MLTSS benefits to more than 1,200 individuals. We currently cover more than 138,000 Medicare Advantage (MA) members and 120,000 Medicare prescription drug plan (PDP) members across the Commonwealth, including approximately 3,600 members eligible for both Medicaid and Medicare. Our commitment to Virginia is also shown in our current MA quality rating of 4.0 Stars, which demonstrates our leadership in quality improvement.

Humana has been providing Medicaid MLTSS services since 2007 and currently serves more than 36,000 members nationally in both stand-alone Medicaid MLTSS programs and fully integrated models. Nationally, we provide coverage to more than 172,000 dual eligibles in our MA plans, many through our Dual Eligible Special Needs Plans (D-SNP) offered in 20 states across the country, including nearly 1,500 D-SNP members in Virginia. Through our experience with MLTSS and D-SNPs, Humana has developed strong capabilities for managing complex care.

### **General – Question 1: Top Three Significant Features**

Humana recommends that the MLTSS program include the following features:

1. Fully integrated benefits, including acute and primary care, behavioral health, pharmacy, long-term care (LTC), transportation, and community-based services
2. A model of care that is similar to the CCC to promote continuity of care for members, highly engaged relationships for MCOs and LTSS providers, administrative efficiency for DMAS, and consistency across quality measures
3. Enrollment of dual eligibles with the same Managed Care Organization (MCO) that covers their medical benefits through an MA program in instances where that MA MCO also participates in the MLTSS program

Further, we recommend interested plans be required to bid for the entire Commonwealth rather than in select regions. This adds greater stability and would create MCO accountability for ensuring access to critical provider types in underserved communities. If DMAS pursues a phased approach for enrollment, we recommend regional phases scheduled every 30 days from the start of implementation.

### **General – Question 2: ID, DD, and DS Waivers**

As DMAS explores the feasibility of including acute and primary care in the MLTSS program for individuals on ID, DD, and DS Waivers, Humana recommends extensive

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stakeholder engagement throughout program design, during implementation, and on an ongoing basis after the program is operational. Public forums such as advisory committees should be established to ensure all stakeholders (including members, caregivers, providers, advocacy associations, and MCOs) have input into program development.

### **Beneficiary Experience – Question 3: Beneficiary Protections**

We support an open enrollment process that utilizes an independent enrollment broker to coordinate between plans and is focused on education about the program and plan choices prior to auto-assignment. During this time, we recommend DMAS and MCOs work together to conduct outreach and education activities to inform members about their benefits, options, and key elements of the transition. It is important to communicate information across multiple channels in a way that is easy to understand. Members should also be allowed to change plans under a "special disenrollment for cause" in the event that an established primary care provider (PCP) or key MLTSS provider no longer participates with a member's current MCO.

Humana also recommends a continuity of care period of 60 to 90 days as members transition from fee-for-service (FFS) environments to managed care. At the time of enrollment, if a member is receiving current services through out-of-network providers, the MCO's clinical staff should work with the member to either contract with the providers or transition to in-network services. This policy also serves to enhance provider participation within the program and engagement with each MCO.

### **Beneficiary Experience – Question 4: Assessments and Care Coordination**

When developing person-centered needs assessments, service planning, and care coordination requirements, DMAS should share comprehensive demographic information with MCOs, including members' medical history and existing provider relationships. Further emphasis on maintaining updated contact and demographic information will create an environment more conducive to driving a positive member experience and effective coordination. MCOs play an important role in these processes, and we look forward to collaborating with DMAS in their development.

### **Beneficiary Experience – Question 5: Transitions**

An effective care coordination process is among the most significant features in assisting members with transitions between providers and between service/treatment settings. Improving the level of engagement and communication between the MCOs, providers, and members is important in facilitating a better experience for activities such as service authorizations, referrals, and claims payment. Another effective feature to assist members transitioning into the community is the repatriation benefit. This can assist beneficiaries who want to move from a facility into a community based setting with transition barriers such as unpaid utility bills, first month's rent, and necessary household items.

### **Beneficiary Experience – Question 6: Attractive Features**

Members will be attracted to a program that reduces complexity, simplifies their experience, and helps them remain in their setting of choice. MLTSS brings all of these features to

members. It reduces complexity by helping members find providers and access services, understand benefits, and manage conditions. Demonstrating that MLTSS will simplify their experience with provider billing and payment will make the program attractive. This is particularly true for dual eligibles and other members that currently have coverage across multiple payers. The coordination and planning services provided by MCOs enable members to remain in their setting of choice by helping them receive the services they need.

#### **Provider Experience – Questions 7 & 8: MLTSS Provider Features**

Important factors for providers transitioning to MLTSS include timely payment, education, and reduced administrative burden. Key features to enable this will stem from collaboration between DMAS and MCOs to deliver consistent educational communication and reduce providers' administrative burden by developing simplified, standardized processes. Humana was named "Easiest Health Care Company for Providers to Do Business With" by Athenahealth's PayerView rankings in both 2013 and 2014, including top rankings in both overall performance and speed of paying providers.

#### **Service Package – Question 9: Integrated Services**

We support and recommend a fully integrated benefit package, including all community-based behavioral health services. These services are essential to achieving outcomes across the entire continuum of care and support while enabling MCOs to provide the most person-centered and individualized care plans possible. This structure enables MCOs to impact all aspects of care planning and view all necessary data to best serve their members. In addition, management of these services will allow care managers to communicate key health and condition specific information (with permission) in a coordinated fashion to all service providers. This will lead to earlier recognition of impacts to care plans of co-occurring conditions or treatments and ultimately to better outcomes and experience.

#### **Service Package – Question 10: Fiscal/Employer Agent (F/EA)**

We recommend DMAS select a single F/EA provider for all plans to use. This will create administrative efficiency for DMAS, enable a better experience for providers, and support continuity for members (particularly if the program is set up to permit members to change MCOs throughout the year due to provider discontinuing participation).

#### **Health Plans – Question 11: Health Plan Requirements**

We recommend the following requirements for participating MCOs:

- Demonstrated MLTSS and dual eligibles experience in the Commonwealth of Virginia, including MA D-SNP or integrated CCC plan
- Demonstrated ability to assume and manage the financial risk associated with the provision of services for complex patients, including an insurance license with the Department of Insurance (DOI)
- Demonstrated provider network adequacy through an MCO's current CCC network or through letters of intent, with sufficient time to complete post-award contracting

### **Health Plans – Question 12: Coordination with Medicare**

Mandatory enrollment in MLTSS improves outcomes for dual eligibles by increasing stability and enabling aligned care planning activities with MA MCOs. The enrollment algorithm should consider MA and PDP enrollment status when assigning to an MCO.

### **Health Plans – Question 13: Value-Based Payment**

Humana has extensive experience in value-based contracting with providers to improve member outcomes, improve member satisfaction, and contain unnecessary costs. DMAS should use the MLTSS program payment structure to encourage MCOs to develop value-based payment models, including rewards for achieving quality goals and shared savings for containing costs. Value-based payment measures for MLTSS programs may include facility-to-community repatriation rates, reduced emergency department (ED) utilization, reduced readmissions, increased generic pharmacy utilization, preventative care measures, and member satisfaction measures, including measures of their experience with providers.

### **Quality Measures – Question 14: Measuring Quality**

Humana recommends the use of standardized metrics applicable to the MLTSS population that are consistent with the CCC program where appropriate. Understanding that many MLTSS quality metrics have yet to be standardized across the industry, we recommend collaboration between DMAS and MCOs to identify key quality metrics and specifications to ensure consistent and impactful measurement prior to implementation. Key measures for consideration should include: Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction surveys, referrals to home and community-based services (HCBS), and facility-to-community repatriation rates. To ensure quality measures are a meaningful reflection of health plan performance, they need to be within the scope of plans' benefit coverage and ability to improve outcomes. For example, medical Healthcare Effectiveness Data and Information Set (HEDIS) measures may not be relevant when dual eligibles covered under Medicaid MLTSS are receiving their medical benefits through Medicare.

### **Financing – Question 15: Financing and Incentive Recommendations**

Humana supports actuarially sound capitated rates that include the opportunity for MCOs to earn incentive payments for meeting the Commonwealth's goals for high-quality, person-centered, and cost effective supports and services. DMAS can use value-based strategies to improve access to HCBS, resulting in reduced dependence on nursing facilities for appropriate members who only require custodial care. For example, when an MCO successfully transitions a member from a nursing facility to the community, DMAS would continue paying the higher facility-based capitated rate (rather than the lower community-based rate) for a pre-determined period of time. Humana participates in Illinois' Integrated Care Program and Medicare-Medicaid Alignment Initiative, where this strategy has been successfully implemented to incent MCOs to identify and transition members who are able and willing to live in their homes and receive services in their communities.

**Outreach and Communication – Question 16: Outreach Strategies**

DMAS should work with the selected MCOs to reach out to consumers, caregivers, providers, advocacy organizations, and community-based organizations to provide information and education about this new program. It will be important to develop key messaging for stakeholders that includes information about timing, enrollment, available benefits and services, available providers, PCP selection, key contact numbers, and other relevant details. The MCO should also develop and provide training for community organizations about the program and work with them to refine the information presented during these sessions. Finally, stakeholder, provider, and community advisory committees should be created to ensure members, caregivers, providers, and advocacy organizations have appropriate forums to share concerns, and for the MCO to report progress on initiatives to address these concerns.

**Outreach and Communication – Question 17: Important Messages**

It is important that providers and members understand that the goal of the program is not to reduce services, but to ensure coordination of care and utilization at the right time and setting to help members get the care they need, while maintaining program and budget stability over the long-term. This message helps create goal alignment between the Commonwealth, the provider community, the MCOs, and the members. This can be accomplished by communicating consistently to individuals and providers, including the following key points:

- Program design will ensure the transition to MLTSS will maintain continuity of care
- MCOs will have supports in place to help each member with the transition and will be available to address any issues that arise during transition
- Individuals will be able to maintain their current providers and the MCOs will strive to avoid disrupting their care

Humana appreciates the opportunity to submit comments as DMAS explores managed care models, and we look forward to learning more about the MLTSS program.

## Health Plan

INTotal Health supports the Department of Medical Assistance Services goal to transition fee-for-service Long Term Services and Supports participants into the Commonwealth's managed care program. Virginia's Managed Care plans have demonstrated their ability to improve outcomes and access for beneficiaries while decreasing costs for the Commonwealth. Managed Care programs will increase beneficiary access to home and community-based services (HCBS) in lieu of institutional care, improve coordination between the different benefit segments, assist participants in the navigation of their benefit, ensure the care provided is appropriate and help reduce fraud, waste and abuse.

Successful MLTSS programs maximize member's participation in community, work and life activities. This goal is especially challenging given the diversity of the population. Three significant features of a successful MLTSS program are:

1. **Flexibility in program design** to meet the individualized needs of the member. Each member faces unique needs and challenges that must be addressed when creating a successful care plan. Whether they have a chronic disease, limited social support or are facing major life transitions, programmatic flexibility allows innovative ways to increase provider and community participation in care. Supporting care in the least restrictive environment and promoting evidenced based clinical outcomes will benefit participants. Access to a broad array of coordinated services and options will enable participants to make informed choices about optimal living circumstances and may reduce the need for institutional care.

2. **Coordination and integration of care.** Integration of benefits is crucial to producing the highest quality outcomes for the diverse needs of this population. Recognizing that Community-Based Services are the preferred service delivery method for much of this population, leveraging of and transitioning among the totality of benefits under the Medicaid/Medicare program produces the best outcomes.

3. **Accountability of the Managed Care Organization.** MCOs must be accountable to the member. This is achieved by allowing the member to decide which MCO, program design, providers and HCBS best meet their individual needs. The second form of accountability is regulatory oversight. Selected MCOs should be required to demonstrate the key competencies: strong privacy rights and protections, support of member's personal preference, sensitivity to cultural differences, programs that support integration with the greater community, independent advocacy when appropriate and member control over moving to, remaining in or leaving a care setting.

Extending the MLTSS to include ID, DD and DS waivers requires special sensitivity. Stakeholders should be active in the design, implementation and oversight of new programs. DMAS should abide by the sentiment so aptly described by this population's advocates as "nothing about us without us". Support can also be garnered by reinvesting savings to meet unmet needs (e.g. expand waiver slots) and by extending transition of care requirements.

## Beneficiary Experience

INTotal Health believes serving vulnerable populations demands attention to specific protections to guarantee quality and appropriate care for those we serve. MLTSS participants must be afforded the same rights and remedies guaranteed in the Medallion 3.0 contract along with protections that reflect the unique nature of the care they receive. The following represent elements of INTotal Health's view of essential participant protections:

- A written statement defining participant rights and responsibilities coupled with a clear plan to ensure participants understand these protections and how to obtain support
- Education for participating plans on how to identify, investigate, report and remediate potential member abuse, neglect and exploitation. Such education will necessitate continued training by the health plan on abuse, neglect, exploitation and reporting to program participants receiving services, their families and providers
- Apply current Medicaid beneficiary rights to appeal adverse decisions to the health plan and to the State, including access to a State Fair Hearing process.
- Independent Enrollment Counseling to provide beneficiaries with enrollment choice counseling that is independent of health plans, service providers, and entities making eligibility determinations.
- Adherence to CMS guidance that MLTSS contract include continuity and coordination of care for the transition of recipients to managed care.
- Enrollment with and access to participant's chosen MCO 60 days prior to active status. This allows for early outreach which is critical to ensuring a smooth transition between FFS and managed care. Lead time to develop a relationship with participant and their support systems will ensure client-specific concerns are addressed and give plans an opportunity to review their networks to align with the participants they will serve.

Offering experienced care providers and benefit management to MLTSS participants will be critical to a successful partnership among participants, family members, providers and health plans. INOVA/INTotal Health's experience in Virginia, coordinating and integrating service and supports for health and life needs of individuals underscores the national experience of dual demonstration projects which points to the necessity of a comprehensive patient-centered needs assessment as a pre-requisite for a successful MLTSS program. Our experience with the PACE program, and with INTotal Health participants engaged in the HAP, Behavioral Health Home, Foster Care, Special Health Care Needs and our Integrated social, medical and behavioral High-Risk Programs, informs the following considerations in developing an assessment:

- Be individualized, yet comprehensively assess the participant's spectrum of needs including but not limited to ongoing, social, life, wellness, mental & physical health, whether acute or chronic, with engaged involvement from the participant/family/caregiver
- Solicit input from and informed communication with all agencies currently engaged with the participant
- Be standardized in content, form and appearance across all MCOs

- Include current health status, advanced directives, treatment needs, palliative care needs, social employment, transportation needs and preferences, personal goals, participant and caregiver preferences for care, back-up plans for situations when caregivers are unavailable, and informal support networks.

Developing standards that require the MCO to assess and determine program specific plans for each participant will be essential to the clinical and financial outcomes. Care management standards for vulnerable populations call for comprehensive planning and implementation that includes coordination of all clinical and non-clinical services in conjunction with member and/or member's support system. These standards are considered best practice and should be included in the MCO Model of Care. Each transition in service provider, care level, services, or physical, mental or social supports, represents an important potential for previously well-managed participant experiences to destabilize or even fall apart. Our acute and chronic care management models have demonstrated that transitions in care represent the single greatest patient risk for unanticipated health costs and increased safety risk, due to often unpredictable yet avoidable factors. A major contributing factor is the timely sharing and transfers of information central to the participant's existing and newly reassessed needs. Significant features of a highly effective transition plan should include, at a minimum, individualized, comprehensive re-assessments of the participant's current and ongoing diverse social, life, mental and physical health, acute, chronic and wellness care needs with identification of new and future anticipated gaps in services and supports. Additionally, a culturally-sensitive, person-centered communication plan from the INTotal Health Integrated Team Coordinator that engages participants, family members, all transition-pertinent providers, and participant designees is necessary to effectively integrate recipients into a new care delivery system.

Providing high quality, high value care is the overarching goal of this program. But as the Department continues to respond to varied stakeholders it must recognize the fear such change may generate. It is the duty of the Department and interested MCOs to establish that the potential benefits outweigh the possible downsides of an MLTSS program, in order to attract the LTSS community to the merits of such a program. To make the program attractive, we must demonstrate transparent willingness to acknowledge and respond to both the real and the perceived fears and skepticism of participants and their engaged communities via DMAS organized and facilitated regional town hall meetings with MCOs. That dialogue will address fears without basis and allow a focus on actual barriers to program success. INTotal Health foresees the following for attracting LTSS recipients: expansion of the INTotal Health Member Advisory Committee to include non-member LTSS recipients and members of their advocate and support communities to continue the dialogue between parties; expanded hours for phone and live chat access to INTotal Health's "Answer your MLTSS questions" program to be offered 3 months prior to program start; access to a wide provider network; care coordination assistance and resources; programs including disease management, case management, transition planning and application of "Intelligent Assignment" based on existing networks broadening the match criteria to include specialists.

### **Provider Experience**

Providers' overwhelming mission and concern is the well-being of their patients. Improved care coordination for participants is dependent on the active participation of the full

spectrum of services providers. MCOs and DMAS must partner to address concerns in order to encourage provider engagement, facilitate care coordination and ease administrative burden. Methods to aid provider transition to MLTSS programs include:

- Proactive outreach by DMAS to existing FFS LTSS providers about the expected timing and process of the move to managed care
- MCO/LTSS Provider Education Forums to offer training and technical assistance and explain content and reasons contract provisions, processes and requirements benefit participants
- Extension of “Any Willing Provider” to all provider types during a defined transitional period

- Standing Single Case Agreement while completing an expedited initial credentialing process; creation of a unified core contract template
- Prior Authorization (PA) training; expedited authorization process
- Dedicated landing page on DMAS and MCO websites with LTSS provider tools and resources
- Practice Claims Billing Sessions on proper billing practices, edit checks, PAs, audit & FWA procedures; conducted in person, on line and recorded on web site
- Balancing the participants right to change MCOs with the Providers need for administrative continuity via more limited open enrollment periods
- Ease of checking client MCO enrollment information
- Access to MCO Case Management resources
- Single points of contact for LTSS Provider administrators and Provider clinicians
- Alternative payment arrangements to align payers' and providers' interests and reduce the provider administrative burden and need for MCO oversight

The aspiration of highly coordinated care in support of their patients, which is fundamental to this program change, will be very compelling to providers. The key to making the program attractive for providers is to ensure that MCOs are responsive to meeting providers' needs so that providers can focus on improved care and coordination for program participants.

### **Service Package**

INTotal Health values the incorporation of a whole-person focus as essential to service efficiency, enhanced health outcomes and quality of life. The foundational key to a successful comprehensive and integrated services and supports package rests on the incorporation of physical health, behavioral health, and LTSS services (including institutional and non-institutional LTSS) into the capitation payment. This lays the basis for optimal efficiency in formulating whole-person focused support and service plans. The following are requirements and suggestions for a comprehensive and well-integrated supports and services package designed to maximize opportunities for active community and workforce participation:

- A comprehensive and individualized assessment of current health status, advanced directives, treatment needs, palliative care needs, social employment, transportation needs and preferences, personal goals, participant and caregiver preferences for care, back-up plans for situations when caregivers are unavailable, and informal support networks to address all of the participant's health needs including those beyond the specific LTSS services.
- A collaboratively-developed participant needs-assessment specific to the participant's comprehensive health and wellness needs to facilitate easier transition across coverage entities.
- Creation of a person-centered plan, which articulates service and support goals to encourage participant engagement and preferences in their care.
- Utilization management decisions of ongoing services and supports based on periodically updated needs-assessments and with engagement of participant, provider and caregiver.

- Transition provisions to support participants as they traverse levels-of-care (home, community-based program, residential, physical and mental health institutional, acute care facility, acute & chronic rehab, etc.)
- A limited 3 month transition period requiring continuity of services and supports provided by any willing Virginia Medicaid/Medicare provider
- Flexibility to allow innovative care and wellness delivery methods including in-home clinical exams, mental health video /tele-health visits, MD-online visits, immunizations at home/ community setting, in-home wellness and chronic disease education, participant and caregiver engagement with INTotal Health via all available modalities including text, online, smartphone app, and live chat.
- Option to utilize Magellan as an INTotal Health behavioral health vendor where determined appropriate by INTotal Health.
- Inter-agency coordination via access to data and engagement with agencies and departments (e.g. schools, CSBs, etc.) which provide participant with ongoing services outside the Medicaid waiver

INTotal Health advocates for requiring plans to contract with the Departments designated F/EA.

### **Health Plans**

Establishing requirements for participating health plans reinforces our commitment to those we serve. Strict requirements may reduce outcome variation, improve efficiency, facilitate outcome comparison and reduce overall program costs. INTotal Health's suggestions for consideration of health plan requirements include:

- NCQA accreditation
- Virginia-based plan leadership with authority to make highest level plan decisions without veto by national-based parent corporate leadership
- Five year commitment to Virginia with financial penalty for health plan termination prior to year four
- Demonstrated expertise and experience in establishing relationships with Virginia-based providers of Long Term Supports and Services
- Established clear access standards for all services
- Demonstrated experience in managing services and supports to Virginia LTSS beneficiaries
- Effective and engaged network of LTSS providers local to Virginia regions
- Capability to perform a comprehensive and individualized needs assessment via modalities including home and or community-based visits.
- Timely DMAS / CMS recommendation regarding whether D-SNP and or MA plan options would be available and required of health plans.
- A commitment to producing the greatest opportunity for community and workplace participation

Opportunities exist to expand the coordination between Medicare and Medicaid with the MLTSS population. Because individuals dually eligible for Medicare and Medicaid services are the most complex and use extensive services from both programs, improved outcomes require coordination across the full spectrum of benefits. With changes in the DSNP approval process provided by the Medicare Improvements for Patients and Providers Act (MIPPA) and the creation of Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) through the ACA authorization, a FIDE SNP could be an effective means of generating coordination. But given the Commonwealths current limited participation in DSNPs and the only recent introduction of any LTSS to managed care via the CCC, a phased in approach towards coordination is more likely to produce success than the upheaval caused by moving more rapidly than the beneficiary and provider community can accept. Implementing the new MLTSS with limited initial DSNP requirements is a good initial step towards to complete integration. Over the contract term, DMAS can require increasing DSNP participation and offerings that conclude in the fully integrated FIDE SNP.

As the Medicaid program continues to encourage innovation in care delivery, payment reforms must be reviewed as well. Any value based payment opportunities must allow flexibility in design and reflect strategies currently employed by providers and payers. Too prescriptive a model may hamper innovation but too permissive a structure may generate wider variation between health plans resulting in diminished provider engagement.

### **Quality Measures**

Two areas of importance in maintaining accountability and transparency are first, the measurement of participant experience and quality of life indicators and second, the measurement of key process metrics in support of the INTotal Health MLTSS vision. The first area may allow measurement by an EQRO, providing plans data on the degree to which Participants and families report that they:

- have been given choices regarding their setting options;
- feel the guarantee of their rights of privacy, dignity, respect, and freedom from coercion and restraint;
- have been able to optimize their autonomy and independence in making life choices;
- were pleased with the facilitation of choice in services and service providers.

For the second area, INTotal Health's vision for the MLTSS program is to improve the quality of life and health experiences for participants and their diverse support community. In order to achieve this vision, INTotal Health identifies a highly-visible vision strategy to increase participant confidence and reduce unnecessary care costs. INTotal Health proposes a tactical focus on the following CMS National Quality Strategy (NQS) goals based on measures pertinent to a managed LTSS program:

1. "Making care safer by reducing harm caused in the delivery of care.". Measuring Quality of Care & Patient Safety (e.g. polypharmacy, medication issues, readmissions, delays in care, provision of services or supports, facility related quality) is an important way to account for the program's progress toward this goal.
2. "Ensuring that each person and family is engaged as partners in their care". Measuring the number of comprehensive participant needs assessments completed within 90 days of program entry is a foundational metric that supports this goal.

3. "Promoting effective communication and coordination of care". We will assess the percentage of participants a participant's community contact reference sheet. This reference sheet is a listing of the community of all identified service/ support / acute/chronic /family / facility /requested contacts identified by a participant and updated as needed and at least annually.

Additionally, assessment of the degree to which Participants perceive increased levels of self-confidence, changes in lifestyle and level of independence may be proxy measures in support of a vision that Participants find their experience in MLTSS consistent with a perceived increased quality of life. 7

## **Financing**

Per CMS in keeping with the intent of the ADA and Olmstead decision, payment structures must encourage the delivery of community-based care and not provide disincentives, intended or not, for the provision of services in home and community based settings. Inclusion of both institutional and non-institutional services in a managed care capitation rate, for example, provides plans with the flexibility to offer lower cost non-institutional services to beneficiaries and support system rebalancing towards greater use of non-institutional LTSS.

Strategies include:

- Enhanced rate for three months after a beneficiary transitions from a nursing facility (NF) to the community
- Incentives for expanded HCBS capacity
- Balancing Incentives
- Money Follows the Person participation incentive payments

## **Outreach and Communication**

Past program integrations demonstrated the need for early and frequent communications to participants, providers and auxiliary supports to minimize confusion and effectively transition to a new care model. Effective strategies for DMAS to consider include Community/Provider Forums (in person and web based meetings to accommodate participants with impairments for whom in person attendance is impractical) to review program design, timeframes and processes and dedicated, skilled, centralized enrollment assistance. Effective engagement strategies for MCOs include:

- Multi-layered, targeted outreach for potential beneficiaries, community based organizations, advocacy groups and providers including forums in various locations, printed and electronic newsletters, tailored web sites, webinars, and social media
- Culturally appropriate education materials in prevalent languages and diverse formats for individuals with visual, auditory or cognitive ability limitations
- Member, provider and community partners advisory committee of representative LTSS stakeholders to inform process and communication design
- Member and Provider Services staff training with designated LTSS specialists available for phone, in person or electronic (Live Chat) communication

INTotal Health is committed to serving our members through partnership with DMAS and we welcome the opportunity to expand our care delivery model to more individuals who will benefit from high value coordinated care. In order to be successful, providers and participants must become aware of the value managed care brings to the Medicaid Program and individual enrollees. Communicating to participants that MCOs have dedicated Case Specialists, Case Managers and Health Coaches who will partner with them to navigate the health care system and ensure coordination of care and to support them in the management of their health while maintaining their independence is key to demonstrating the added value of this care model. Providers also have the ability to benefit from dedicated, knowledgeable Provider Relations Specialists to assist in navigating administrative processes, including contracting, credentialing, authorization and claims payments so they can focus on patient care.

The most important message that participants and providers can hear is that managed care is a well-integrated, collaborative partnership, focusing on ensuring the member receives the highest quality care coordination every time every touch.