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TO: Va-MedicareMedicaidCoordination@cms.hhs.gov

FROM: Jill A. Hanken, Health Attorney

Kathy Pryor, Elder Law Attorney

RE: Virginia's Proposal to "Integrate Care for Medicare-Medicaid Enrollees"

Thank you for the opportunity to comment on Virginia's proposal. We recognize that the proposal has the potential to be very helpful to dual-eligibles in Virginia by improving their care, decreasing unnecessary nursing home admissions and simplifying procedures and paperwork. However, we have deep concerns that the capitated model chosen by Virginia to implement the project, as well as the expected/required savings to the federal and state governments, will result in barriers and denials of necessary care. We also have many concerns about the lack of specifics and the absence of consumer protections in several areas. [Please note: The Virginia Poverty Law Center has also joined many other national and state organizations in a June 27, 2012 letter to Secretary Sebelius that expresses concerns about the evaluation and impact of expected cost savings on duals in these demonstration projects.]

Concerns about a Capitated Model. If CMS approves Virginia's capitated model, we urge you to require the state to adopt several measures that we believe are needed to protect consumers. [We raised these issues with DMAS in earlier comments, but they were not incorporated into the final proposal.]

1. Select only non-profit health plans to carry out the project

2. Use a strong and enforceable Medical-Loss-Ratio of not less than 85% to ensure that premiums paid by DMAS and CMS are used for actual health care services and quality improvements.

3. Require pay-for-performance incentives for MCOs. Virginia's proposal states that such incentives are just being "considered" (p.28). We believe financial incentives and disincentives are particularly important in a capitated model.

4. Require MCOs to include pay-for-performance incentives for participating providers. Again, the proposal says DMAS would "encourage" those incentives. (p. 22, 27) We believe financial

incentives and disincentives are particularly important in a capitated model to encourage provider participation and high quality care coordination.

5. Require a firmer commitment to oversight and quality measures. While the proposal lists a variety of work that "might" be done (pp 28-30), consumers need assurances that this experimental "demonstration project" will carefully collect and actually evaluate data. Moreover, all such evaluations and reports must be made public.

Concerns about Passive Enrollment. While we have encouraged DMAS to adopt an "Opt-in" model to ensure that individuals truly want to participate (as Virginia does for PACE), the Proposal calls for passive enrollment. As directed by CMS, DMAS dropped its idea of a 6-month lock-in and now permits people to opt-out "at any time". The opportunity to opt-out at any time is helpful, but the proposal still lacks specificity about the process for doing so. Details will be in contracts and regulations (p. 12), but this gives little assurance to consumers at this time.

We also believe the form and content of notices and information that will be sent to dual-eligibles need to be very carefully constructed. Obviously, the material will have to be clear, understandable and written at appropriate grade level. It must be LEP and ADA compliant. CMS should insist on such compliance. The state should also have clear restrictions on MCO marketing practices.

We ask CMS to require DMAS to formally (1) involve stakeholders in developing materials and (2) utilize community based organizations (e.g. AAAs, SHIPs) to educate consumers about the project and their options.

Concerns about Transitions to Managed Care. Virginia's proposal appears to provide only one specific protection for consumers during the transition to managed care. That is to honor any already-preauthorized service for a period of 6 months. (p.11) This is clearly not enough. There are no protections for successful drug regimes, meaning that people could have to restart "step-therapy" before regaining access to medications that have worked well for them. There is no guarantee that people can remain with their established providers with whom they have a successful relationship. An algorithm for auto-enrollment is insufficient, because there will be providers who choose not to be on an MCO network, but who are willing to continue treating an individual. We ask CMS to require a 6 month transition period which would allow individuals to maintain providers and prescriptions.

Concerns about Provider Networks. This is a critical aspect of the demonstration, and we believe Virginia's proposal outlines appropriate provisions for MCO network requirements. However, certain mandatory language and details (e.g. the actual time and distance standards for accessing providers and specialists) were revised or removed from the final proposal. We believe the mandatory nature of these requirements – with details – should be incorporated into the plan approved by CMS, so that subsequent regulations or policies cannot water them down.

Concerns about Grievances and Appeals. We are very concerned that the proposal leaves many questions about the appeal process unanswered. (pp. 14, 25) It is impossible to endorse the proposal when so many critical consumer protections are lacking – or "to be determined". For example, we

believe that many aspects of the current Medicaid appeal system are needed in this demonstration, such as: Keeping MCO internal appeals optional, providing advanced and adequate notice of proposed actions; allowing services to continue pending appeal; establishing clear timeframes for decisions and expedited reviews. In addition, appeals should be available for disputes involving issues others than only denials of services. For example, there could be disputes about timeliness of decisions, availability of providers, and accessibility of providers.

Concerns about Health Screenings and Risk Assessments and Service Coordination. We support the DMAS decision to require MCOs to conduct face-to-face assessments within specified time frames (60 days for waiver participants and individuals with chronic conditions; 90 days for others). However, the proposal is not clear about when the Uniform Assessment Instrument (UAI) would be used. (p. 16). We believe the UAI is a comprehensive tool that should be used in every case to document health status and needs. It may uncover areas of need that the patient herself is not aware of. We support the concepts of "basic" and "enhanced" service coordination, but believe DMAS must impose clearer demands on MCOs to provide enhanced service coordination when necessary. (See p. 18 - MCOs will be "expected" to provide enhanced service coordination in certain circumstances. We believe mandatory language – "shall" – is needed to ensure this will happen.)

Comments about Benefits. We strongly support the inclusion of nursing home/institutional services and LTSS as part of the capitated risk. This is absolutely essential for the demonstration to be worthwhile.

We also support the flexibility given MCOs to offer non-traditional services such as personal care, dental & vision services, home equipment, etc.

Concerns about Benefits.

Behavioral health – We understand that the Community Services Boards (CSBs) have a role to play in providing case management/health homes to dual eligibles needing mental health services. However, more detail is necessary to explain exactly what services will be provided by CSBs and which will be provided by MCOs. Who pays whom? What happens to individuals with some degree of mental illness who aren't served by CSBs? Who bears ultimate responsibility for care coordination and case management? How will MCOs and CSBs work together?

Personal Care Services – Currently, Virginia does not offer personal care services to adults who are not enrolled in community based care waivers. Yet on p.6, the proposal says that personal care is provided dual eligibles in the "Medicaid works" buy-in program. This provision requires further explanation. There are other duals who could clearly benefit from personal care services.

Preauthorization/Medical Necessity (p.14) - The proposal allows different MCOs to use different criteria for medical necessity determinations and preauthorizations. This lack of uniformity could lead to confusion, inequities and shifts between plans. We believe the state should establish common criteria/standards to be applied by all the MCOs.

Case Management – The services chart indicates that some case management is carved out of the services which MCOs must provide. (p.49-50) This is confusing and seems to undermine the project's goal of coordination and case management.

Transplants – (p.58) – The proposal allows plans to use different criteria for transplant services. As noted above, this lack of uniformity could lead to confusion, inequities and shifts between plans. We believe the state should establish common criteria/standards to be applied by all the MCOs.

Interpretation Services - The proposal does not mention the availability of reimbursement for necessary interpretation services. This should be included.

Comments on Customer Service (p.26) – We support the operation of MCO call centers that will operate 24/7. We also support the required language and ADA access for those services.

In addition to customer service provided by MCOs, we recommend that the state be required to establish or support an ombudsman program/service to trouble-shoot specific, individual problems that may arise – especially during the first years of the demonstration.

Comments on Stakeholder Involvement (p.24-25) – We support DMAS' stated intention to establish workgroups for various stakeholders. We recommend that specific appointments are made to the workgroups, rather than open invitations (although the public should always be invited to attend and present comments). This achieves a stronger commitment to the work. In addition, while different stakeholder workgroups should have the opportunity to meet separately, we believe jointly held meetings of all stakeholder interests are also extremely important and valuable.

In conclusion, we have raised a variety of concerns about DMAS' proposal. We acknowledge and appreciate DMAS' openness in developing their proposal and inviting/receiving public comments. However, if this demonstration is to move forward, we urge CMS to insist upon more specificity and revisions as we have outlined.

Thank you for your attention.