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July 8, 2013

Cindi Jones, Director
Virginia Department of Medical Assistance Services
600 E. Broad Street Suite 1300
Richmond, VA 23219

RE: Memorandum of Understanding (MOU) – Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (Dual Eligible Project)

Dear Mrs. Jones:

Congratulations to you and your team on all the hard work needed to secure the MOU between Virginia and CMS for the Dual Eligible Project. The project has potential to improve the availability and delivery of health and supportive services to a very vulnerable population of low income Virginians.

We have reviewed the MOU and have the following questions, comments and concerns:

Section III(C)(1)- Eligible Populations

The MOU excludes "individuals who are required to "spend down" income in order to meet Medicaid eligibility requirements." Does this exclusion apply to nursing home residents and EDCD participants who must spend down to eligibility? If not, this provision should be clarified to apply only to "non-institutionalized" individuals required to spend-down.

Section III(D)(1) – Participating Plan Service Capacity

The MOU states that "…CMS and DMAS may choose to allow for greater flexibility in offering additional benefits that exceed those currently covered by either Medicare or Medicaid . . . " .

This is very disappointing and undermines the goals of the project. We have always considered the availability of supplemental benefits/services (which could include a wide array of services such as personal care, vision, dental, home modifications, air conditioners, etc.) as one of the most important aspects of this demonstration. We believe that plans should be required to provide supplemental services whenever such services are needed to protect a dual eligible's health and safety in the community. Yet nowhere in the MOU are supplemental services described or required. (Reference to "non-covered services" as part of the Plan of Care on page 62 has no meaning without further definition and standards. Likewise, on p. 72, flexible benefits

are described as completely discretionary.) On page 11, the MOU suggests that CMS and DMAS can decide not to allow supplemental benefits at all.

We believe a specific, but not exclusive, list of supplemental benefits/services must be developed by DMAS/CMS and required of participating plans. The plans will need to publish the list of covered, supplemental services so that individuals will know what they are eligible to receive. Standards for coverage must also be developed to ensure that plans will actually provide those services whenever necessary to maintain the health and safety of participants and to ensure rights to appeal and objective reviews if such services are denied.

Section III(E)(4) - Ombudsman

We strongly support the use of independent Ombudsman services as part of the demonstration. However, the MOU is very vague about the capacity (i.e. adequate staffing) of the Ombudsman office and how it will be funded. Additional detail is needed in the MOU, especially because Ombudsman services, presumably, will not be addressed in the 3-way contract.

Section III(F)(1) – Participating Plan Grievances and Internal Appeals Processes; Appendix 1 Definitions – "External Appeal", "Provider Appeal"; Appendix 7

We strongly oppose the requirement that participants complete an internal plan appeal before being able to request an external appeal from DMAS or Medicare. This is not a requirement for current enrollees in Medicaid MCOs. See 12 VAC 30-120-420. For any grievance or appeal related to an action taken by a Medicaid MCO, state law allows enrollees to appeal directly to DMAS first.

Participants in the Dual Eligible Project should not have fewer rights or lose rights by choosing to enroll in the dual eligible project. Moreover, the 90-day time frame for concluding Medicaid appeals is rendered meaningless, if an internal MCO appeal is first required.

Appendix 1 Definitions

Expedited Appeal – The standard should apply both to appeals filed by an enrollee or a provider.

External Appeal – As noted above, we strongly oppose the requirement that participants complete an internal plan appeal before being able to request an external appeal from DMAS or Medicare.

Provider Appeal – If services have already been provided and the issue is about payments or an audit, it is appropriate for the provider to complete an internal appeal with the plan first. However, if the provider is appealing a denial of service that has not yet been provided, an internal appeal should not be a prerequisite.

State Fair Hearing - As noted above, we strongly oppose the requirement that participants complete an internal plan appeal before being able to request an external appeal from DMAS or Medicare.

Appendix 7 – III.D – Enrollment Effective Dates

The MOU sets out a very ambitious timeline for launching the project. Plan assessments and selection by DMAS/CMS, along with the required readiness reviews, are critically important to the success of the project and should not be abbreviated in any way. We encourage you to take whatever time is necessary to do this right.

Appendix 7 – IV.A.2 – Health Risk Assessments

The MOU calls for face-to-face risk assessments only for EDCD enrollees and nursing home residents. We believe the other "vulnerable subpopulations" (listed on p 59) should also have face-to-face assessments. The vulnerable subpopulations all have very serious and complicated health conditions and other limitations. It would be impossible to fully assess their circumstances and design an appropriate person-centered plan of care without a face-to-face interaction.

Appendix 7 – V.C – Flexible Benefits

The MOU gives plans total discretion about providing flexible benefits. This is inappropriate and, in our opinion, undermines the entire purpose of the demonstration project. Please see comments above (III.D.1). To reiterate, we believe a specific, but not exclusive, list of supplemental benefits/services must be developed by DMAS/CMS and published so that individuals will know what they are eligible to receive. Standards for coverage must also be developed to ensure that plans will provide those services whenever necessary to maintain the health and safety of participants and to allow for substantive appeals.

Appendix 7 – V.F – Excluded Services

The MOU fails to describe the kinds of dental services that are currently available to adults under fee-for-service. For example, adults are entitled to medically necessary extractions, and this coverage should be explained in the MOU, even if it is covered under fee-for-service.

It appears that the description of excluded services is incomplete. (the third and final bullet ends with ";and,". Are there other excluded services?

Since plans of care and care coordination are such important aspects of this project, the full range of available services needs to be clear. MCO care coordinators should also be required to incorporate fee-for-service items into their care planning.

Appendix 7 – V.G – Continuity of Care

In addition to protecting "prior authorized" services, this section should protect "prescheduled" services (some of which did not require pre-authorization.)

In addition, in Paragraph 1 the MOU says the nursing home resident "or their families" can choose to move to a different nursing facility or return to the community. It should be made clear that such a decision is the resident's alone, unless the resident has a guardian or has appointed someone else with that decision-making authority.

Finally, we note the critical importance and necessity of clear communications with beneficiaries so that they understand their care continuity rights and how to exercise those rights.

Appendix 7 - IX – Appeals

Again, we strongly oppose the internal appeal exhaustion requirement contained in the MOU.

We also point out that, while an effort has been made to "integrate" Medicaid and Medicare appeals, the system explained in the MOU remains very complicated. (pp.77-79) Different procedures and different timelines apply, depending on whether the service is "traditional Medicare", Medicaid-only, or "overlapping". We urge CMS and DMAS to reconsider ways to truly streamline and integrate the appeal process.

We are concerned that the MOU is silent about appeal rights that apply if supplemental or flexible benefits are denied by a plan. While we have urged you to require plans to offer such services, even if they are provided by plans as an option, appeal rights must attach to denials.

In addition, we believe a great deal of input and focus groups will be necessary to design notices and written information about appeals that will be understood by participants. The MOU calls for a "simple integrated notice" (IX-D). This will be extremely difficult to craft, given the continued bifurcation that the MOU contemplates.

Moving forward

The MOU defers many critical details about consumer protections to the three-way contract. We ask you to make a draft of the contract available to us and other members of the Stakeholder Advisory Committee for review and comment before committing to those terms. Publishing a draft of the three-way contract will not compromise the negotiating process with plans. Rather, it will allow stakeholders to provide feedback on the elements of the contract before problems unfold during implementation.

Thank you for considering our comments. We look forward to discussing these issues with you.

Sincerely,

Jill Hanken
Health Attorney

Kathy Pryor
Elder Law Attorney

Cc: Karen Kimsey, Deputy Director, Complex Care and Services, DMAS
Melanie Bella, Director, Federal Coordinated Health Care Office, CMS