We have reviewed the Massachusetts 3-way contract and have the following comments and concerns, primarily related to the concerns we raised in our letter of July 8, 2013.

Participating Plan Service Capacity:

We hope that Virginia, in developing its 3-way contract, will follow Massachusetts' lead in the detail and specificity regarding the covered services which plans must provide in addition to the services currently covered by Medicare or Medicaid. From the definitions section defining, e.g., 'Long-Term Services and Supports' (p. 10) and 'Personal Assistance Services' (p. 13) to Appendix B which sets out a robust set of new community-based services, the Massachusetts contract requires the plans to include a wide array of expanded community-based services based on the beneficiary's comprehensive assessment and care plan. We urge Virginia to require participating plans to provide comprehensive LTSS such as day services, home care services, personal care assistance, respite care, medication management, environmental modifications, durable medical equipment and others set out in the Massachusetts contract. It is essential to the success of the Demonstration that plans provide additional services, not currently covered by Medicare and Medicaid, which encourage and enable quality independent living in the community for as long as possible. Unless the plan can point to additional specific services which it provides, beneficiaries will have no reason to leave traditional Medicare and Medicaid. Requiring plans to provide specific listed community based services is critical to a beneficiary's ability to weigh the benefits of enrolling in the demonstration and it is essential to the accountability of the plans through appeals when required services are denied. Importantly, the Massachusetts contract clearly provides that appeal rights do attach to the denial, reduction or termination of LTSS (2.12.A.4.c , p. 108-9).

We also encourage Virginia to adopt the provision of the Massachusetts' contract which allows plans discretion to provide additional services beyond those listed when those services would contribute to the health and independent living of the enrollee in the least restrictive setting and reduce reliance on acute inpatient care and institutional long term care (2.9.H.4, p. 100). Giving the plans discretion to provide additional individualized community-based services is essential to the person-centered approach which DMAS has long promoted.

Enrollment Effective Dates:

The Massachusetts contract seems to allow for some flexibility in the start date by stating that enrollment would begin "no sooner than" October 1st. We encourage Virginia to build such flexibility into its timeline so that if readiness reviews show that the plans are not yet ready for enrollment and rollout of the program, Virginia will delay enrollment.

Health Risk Assessments:

In our previous letter we asked that all vulnerable subpopulations be provided face-to-face assessments due to their serious and complicated health conditions as well as other limitations they may have in communication, etc. The Massachusetts contract requires that comprehensive assessments for all new enrollees include at least one in-person meeting within the continuity of care period of 90 days (2.6.A.3,

p. 46). At a minimum, we urge Virginia to require an in-person assessment for all the vulnerable subpopulations.

Enrollee Rights:

We urge Virginia to adopt Massachusetts' inclusion of a list of enrollee rights (Appendix C, p. 233-35) to ensure that beneficiaries are guaranteed, e.g., the right to be treated with respect and dignity, afforded confidentiality, to participate in all aspects of care, etc. In addition to the rights set out in Appendix C, we also urge Virginia to include in its 3-way contract a provision similar to Massachusetts' 2.3.B (p. 25) which prohibits plans from disenrolling any enrollee because of an adverse change in his or her health status or utilization of the treatment plan or services, or because of diminished mental capacity or disruptive behavior resulting from the enrollee's special needs. In addition to setting out these rights, we urge Virginia to clarify that a beneficiary may enforce these rights through the grievance and appeals process. We also urge DMAS to obtain stakeholder input into what rights should be included in statement of enrollee rights.

Provider Network Accessibility and Cultural Competency:

We encourage Virginia's contract to include language which requires the plans and the network providers to be responsive to the linguistic, cultural and other unique needs of the populations served and to promote the delivery of services in a culturally competent and sensitive manner. See, e.g., Massachusetts contract at 2.7.A.16-21 (p. 63); 2.9.A.1.c,d (p. 85-87); 2.14.B (p. 130) and 2.14.D.5 (p. 135) regarding marketing materials.

Grievance and Appeal Rights:

We continue to urge Virginia to allow beneficiaries to appeal directly to DMAS or Medicare without first completing an internal plan appeal. As you know, Virginia state law allows current Medicaid MCO enrollees to appeal directly to DMAS. 12 VAC 30-120-420. We hope that Virginia will NOT follow the Massachusetts contract in requiring beneficiaries to exhaust an internal plan appeal before requesting an external appeal to Medicare or Medicaid. Such a requirement would render meaningless the 90 day time frame for concluding Medicaid appeals and would inappropriately restrict rights of duals if they opt to enroll in the demonstration.

It is essential that the contract clarify that appeal rights attach to denial, termination or reduction in LTSS and other services provided by the plan which are in addition to services currently provided by Medicare or Medicaid. See 2.12.A.4.c, p. 108-9.

In addition, we hope that DMAS and CMS will find a better way to truly integrate Medicare and Medicaid appeals. The appeals system described in Massachusetts' contract and the system set out in Virginia's MOU are extremely complicated and will be very confusing to beneficiaries. The only place the Massachusetts and Virginia appeal plans have truly integrated the two programs is through an integrated notice, which, frankly, will likely be very confusing considering the continued bifurcation of

the two appeal paths. As we noted before, stakeholder input will be critical to designing notices and appeal information which can be understood and followed by participants.

Thank you for the opportunity to comment upon the Massachusetts contract. We hope that DMAS will continue to consult with stakeholders as Virginia's contract is being drafted and will obtain stakeholder input into the 3-way contract while it is in the negotiation process. Not only is this important to the transparency of the demonstration project, but it is a critical way to identify problems before they arise during implementation. It is to everyone's advantage to identify and correct problems in the planning phases and not when the care of vulnerable beneficiaries is at stake. Thank you for your consideration of these comments and please do not hesitate to call upon us if we can be of any assistance as you move forward with the demonstration.

Sincerely,

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