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Virginia Board for People with Disabilities

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December 15, 2022

TO: Cheryl Roberts, Director
Submitted by email to MCOProcurement@dmas.virginia.gov

FROM: Teri Morgan *TM*

SUBJECT: Medicaid Managed Care Pre-Procurement Stakeholder Engagement

On behalf of the Virginia Board for People with Disabilities (the Board), I would like to offer comment regarding the upcoming procurement of Medicaid managed care services and supports. The Board deeply appreciates DMAS' efforts to engage and obtain input from stakeholders. The Board recognizes the many efforts underway to improve Virginia's Medicaid services for people with disabilities and offers the following comments in response to two questions asked by DMAS during the November 29, 2022, Medicaid Managed Care Advisory Committee Meeting.

I. What are the strengths of the current delivery system that should be maintained?

- 1) The opportunity to choose among different managed care organizations is a strength.
- 2) While each Managed Care Organization (MCO) provides the core benefits that all managed care members have access to within CCC Plus or Medallion 4.0, an MCO can offer enhanced services to its members. These enhanced services are another way to offer choice to the managed care members to find the MCO that meets their needs.
- 3) The DMAS Care Management Unit, in collaboration with MCOs, used several webinars to provide current information pertaining to COVID-19. These COVID-19 webinars had high

attendance and members and their families appreciated receiving the information. Opportunities for direct communication and information sharing with members should be sustained.

II. What opportunities are there to enhance member and provider experiences, better collaborate with key partners, and enhance outcomes?

- 1) Medicaid managed care procurement goals should be driven by data and outcomes. DMAS and the Secretary of HHR should critically analyze managed care outcomes, both in terms of fiscal outcomes and individual health outcomes, with a special focus on the benefits and gaps in addressing social determinants of health for people with disabilities and opportunities for improvement.
- 2) In the 2020 External Quality Review Technical Report: Medallion 2.0, Health Services Advisory Group (HSAG) recommends that the MCOs conduct “a focused review or other methods to receive direct information from members on their experience with access to care during their interactions with the healthcare system.” HSAG recommends that the MCOs use this information “to implement targeted interventions to improve the members’ experience interacting with the health plan or during visits with their personal doctor.” Relatedly, the Board’s 2022 assessment of Access to Information for Individuals with Disabilities and their Family Members found that people with disabilities and their families often do not experience customer focused and/or person-centered interactions when accessing services. Embedding the expectation for continuous quality improvement as it relates to understanding and addressing member experience is recommended. Data and findings regarding member experience and quality improvement initiatives should be transparent to the public.
- 3) For Consumer-Directed services, MCOs should be required to identify and analyze individual-level data and other indicators that may point to a need for enhanced care management as part of DMAS’ comprehensive care management solution. For example, frequent turnover in attendant care staff, consistent underutilization of approved hours and services, or an increase in primary or acute care services and/or hospitalization may indicate a need for enhanced care management.
- 4) Studies have found that many health care providers are not willing or able to serve people with disabilities. For example, see [this October 2022 study in the Health Affairs journal](#). During re-procurement, MCOs should be required to describe how they will ensure that their provider network is accessible to people with disabilities, how often they will monitor the accessibility of a provider after an initial determination is made, and what steps they will take to increase provider accessibility and when. Steps to increase provider accessibility could include the provision of provider training or funding to purchase accessible equipment like Centene’s Barrier Removal Fund in Illinois, Texas, and Ohio.
- 5) At least some, if not all, MCOs for Virginia’s CCC Plus Program have relied on voluntary provider self-reports for information on accessibility in their provider directories. This

approach increases the risk of inaccurate information and missing information. To ensure complete and accurate information on provider accessibility, DMAS should consider requiring MCOs to do the following, which appeared to be recommended but not required in Section 9.16 of the current CCC+ Contract: “Demonstrating compliance with the ADA by conducting an independent survey or site review of facilities for both physical, communication and programmatic accessibility, documenting any deficiencies in compliance and monitoring correction of deficiencies.” DMAS should develop a standardized survey or site review template for MCOs to use, like California has done, that assess physical, communications, and programmatic access. The independent survey or site review could be conducted on a random sample of providers, or on a rotating basis, to confirm the accuracy of provider self-reports over time.

- 6) The current CCC Plus contract lists a variety of factors to be considered with respect to network adequacy, beyond the existing time, distance, and choice standards, but it is not clear how DMAS’ official determination of network adequacy accounts for these factors. For example, no quantitative benchmarks appear to have been established for assessing whether a sufficient portion of providers accept new patients, can accommodate people with various disabilities, or have sufficient hours of operations. DMAS should clearly define how additional indicators of accessibility will be considered in official network adequacy determinations and establish related benchmarks. Indicators should include
 - whether a provider is accepting new patients, which should be supplemented by an analysis of how many Medicaid patients the provider served in recent months, like what was done in [this 2022 study from Yale and Cornell universities](#);
 - whether a provider is accessible to people with disabilities, which should be based on a clear, consistent, and enforceable definition of accessibility that includes physical, communications, and programmatic access; and
 - whether a provider is willing and able to serve people with disabilities.
- 7) The existing time, distance, and choice standards for network adequacy in the CCC Plus contract don’t account for provider capacity or expertise. DMAS should consider incorporating service fulfillment standards into its network adequacy requirements for MLTSS services, versus continuing to rely on a combination of choice standards and time and distance standards. Service fulfillment standards are based on the gap between service authorization and utilization. Service fulfillment standards are considered a promising practice according to the Community Living Policy Center at Brandeis University (see [this webinar](#) for more information).
- 8) Many Virginians with intellectual or other developmental disabilities (ID/DD) are best served by service providers with the capacity, knowledge, and skill to meet their needs. Many people with disabilities need providers who have adaptive/accessible examination equipment and tables, as well as trained support staff, in order to take advantage of the

providers' services. Individuals with ID/DD have health and support needs which are typically ongoing throughout their lives. In communities with insufficient provider networks to meet the needs of people with significant developmental and other disabilities, MLTSS plans should allow for penalty-free out-of-network care or, if needed, out-of-state care.

- 9) To ensure that the Managed Care Organization (MCO) and providers communicate with individuals and their families in a meaningful way, MCOs should describe how they will ensure that their written or electronic materials to members are "user-friendly," fully accessible, and culturally competent.
- 10) Build into the rate model for MCOs expectations for identifying and mitigating social determinants of health (SDOH). With appropriate funding, community-based organizations and MCOs can implement SDOH screening measures and interventions that help capture critical data around gaps in care and develop a clear picture of the cost for these services.
- 11) The Board recommends addition of language on the Use of Self-Directed services (see New York State MLTSS model)
 - *Describe how your organization will educate individuals and informal caregivers on Consumer-Directed service options as well as managed care services and operations*
 - *Describe how your organization will monitor the quality of education efforts*
 - *Describe how your organization will monitor and evaluate Consumer-Directed services used by individuals*
- 12) The current compliance process appears to be primarily focused on compliance with technical requirements (based on a VBPD staff review of the list of violations in Section 18.1.2 of the CCC Plus contract) and has not been consistently implemented (based on [this December 2016 report by the Joint Legislative Audit and Review Commission](#)). During the re-procurement process, DMAS should design and consistently implement a robust compliance process that provides sufficient incentives for MCOs to proactively comply with key technical and qualitative requirements. Areas of focus should include qualitative concerns identified in past years by consumers, providers, and DMAS. For example, network adequacy and the grievances and appeals process were identified as key weaknesses of the CCC Plus program in [the 2021 Operational System Review](#).

Finally, the Board agrees with the following comments and recommendations provided by other stakeholders and organizations during the November 29 Medicaid Managed Care Advisory Committee meeting:

- The speed and consistency of credentialing needs to be addressed.
- DMAS should raise awareness among both members and state agencies of what is available to help address social determinants of health and share related data.
- Data on the number of referrals for a service and the number of people who

actually access a service should be regularly reviewed and transparent to the public.

- Factors beyond health that are leading to institutionalization should be identified and proactive strategies to keep people in the community should be developed and implemented.
- Ensure that value-based purchasing does not hurt providers who are helping people with complex needs or who have difficulty accessing ancillary providers/supports e.g., many providers are already hesitant to serve people with disabilities.
- More consistency and ease arranging non-emergency Medicaid transportation, along with more consistent rates.
- Network adequacy should consider driving distance and geography, as well as the provision of culturally and linguistically competent care.
- Require more meaningful value-based purchasing metrics, which will necessitate more incentives and coordination between providers.
- Require data transparency regarding prior authorization, denials, and adjudicated claims.

Again, thank you for this opportunity to provide comments on the procurement of Virginia's Medicaid managed care contracts. Please feel free to contact me if you have any questions or want additional clarification either by phone at (804) 786-9369 or by e-mail, teri.morgan@vbpd.virginia.gov.