COMMONWEALTH OF VIRGINIA
Virginia Board for People with Disabilities

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September 21, 2015

TO: Tammy Driscoll, Senior Programs Advisor
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FROM: Heidi Lawyer

SUBJECT: Expansion of Managed Care for Long-Term Services and Supports

On behalf of the Virginia Board for People with Disabilities (the Board), I would like to offer preliminary comment regarding the planned expansion of Managed Care for Long Term Services and Supports (MLTSS) and the proposed MLTSS Model of Care. The Board deeply appreciates DMAS' efforts to obtain input from disability advocates and other stakeholders on changes to the Commonwealth's Medicaid program. The Board recognizes the many efforts underway to improve Virginia's Medicaid services for people with disabilities, including the ongoing efforts to redesign Virginia's Medicaid Waivers. In light of the many changes and the available, albeit limited, information available about the successes and challenges associated with the transition to a managed care model in Virginia, the Board offers the following recommendations:

1. **Medicaid managed care expansion, including MLTSS, should be driven by data, rather than by prescribed timelines. Prior to expanding MLTSS, 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 potential impacts of managed care expansion for people with disabilities.**

The Board is concerned about the planned pace of managed care expansion. Based on the Stakeholder notice dated September 15, 2015, DMAS will be transferring 107,000 individuals into a managed care program effective December, 2017. A large proportion of those individuals are enrolled in a Medicaid Waiver. We believe this date is premature, given the lack of analysis that exists to date on managed care outcomes and in-network provider availability.

The transition to managed care is only one of many changes occurring in Virginia's system of services for people with developmental and other disabilities. Each of these changes requires significant time and resources in order to be successful. Compliance with the CMS Final Rule on Settings must be completed by 2019, and a major revision of the ID, DD and Day Support Medicaid Waivers must be completed in 2017. The redesigned Waivers are not likely to be implemented until the 2018-20 biennium. Waiver implementation problems are probable because the proposed redesign is a dramatic change from the current Waivers in both design and operation. Too many changes in the service delivery system at once will make finding both the sources of, and the solutions to, problems very difficult. This should be taken into account when considering the timeline for implementation of MLTSS.

Medicaid managed care should not be expanded without adequate examination of the fiscal and individual outcomes of the Commonwealth Coordinated Care program (CCC). Many questions about CCC efficacy need to be answered. What has gone well? What has not? Did CCC reduce Medicaid costs? If so, what was the level of savings and how were those savings achieved? What health outcomes were improved, if any, for CCC enrollees? It is doubtful, given the roll-out challenges, that CCC has operated long enough for sufficient data to be accumulated for a meaningful evaluation of its performance. The Commonwealth should make a decision on managed care expansion based on data analysis, not arbitrary timelines.

2. **Prior to expanding MLTSS, DMAS should: a) analyze provider participation in managed care networks and address the concerns of providers who do not join the managed care networks; and b) ensure that sufficient providers with the requisite knowledge and experience to serve people with significant developmental and other disabilities are included in managed care networks.**

Development of an adequate provider network must be addressed. According to the most recent CCC Monthly Enrollment Dashboard (8/8/15), only 44% of the currently eligible population has opted into CCC, while 43% opted out of CCC. A major factor identified among those who opted out was having an existing relationship with a provider who was not willing to contract with CCC. DMAS should identify the areas and Medicaid enrollees most affected by non-participating providers as well as identify the main reasons for which providers did not participate. Significant improvement in the provider network are not likely to be achieved in two years, especially for Medicaid enrollees who reside in rural areas, reside in other "provider desert" areas, or have a disability.

3. **Beneficiaries whose current providers are not members of a managed care network, and who cannot easily find comparable in-network providers, should be allowed to continue receiving care from their existing providers without penalty.**

4. **In communities with insufficient provider networks to meet the needs of people with significant developmental and other disabilities, any MLTSS plan should allow for penalty-free out-of-network care.**

Beneficiaries whose current providers are not in a managed care network, or who live in communities with limited provider access should have flexibility to obtain out-of-network care to meet their needs. Having trained, knowledgeable, and skilled providers is particularly important to individuals with disabilities and their family members or caregivers. Many Virginians with intellectual or other developmental disabilities (ID/DD) have worked very hard to find 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. Disruption in services and supports, including access to medications, due to changes in providers, as some stakeholders report experiencing in CCC, can have major negative consequences for the individuals with ID/DD and their families. Losing "what works" is a profound fear regarding managed care for many self-advocates and family members. A robust provider network additionally enables meaningful choice.

5. **Finally, the Board recommends the following additions to the MLTSS Model of Care:**

   Item #4: Interdisciplinary Care Team (ICT) – **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*

   Item # 9: Communication Network – **The Board recommends addition of the following language** to ensure that the Managed Care Organization (MCO) and providers communicate with individuals and their families in a meaningful way:

   - *Describe how MCO will ensure that its written or electronic materials to clients are "user-friendly," fully accessible, and culturally competent*.

Item # 11: Performance and Health Outcome Measurement – **The Board recommends the addition of the following language** to enable transparency and enable consumers to make informed decisions by comparing outcomes for MCOs and individual providers.

- *Each managed care organization will provide data on quality of services by provider and system wide by type of provider according to a template developed by DMAS. This template will require a standard set of data from each MCO (a "Report Card") which will be posted online for public comparison*.

In conclusion, the Board urges caution as DMAS expands managed care in Virginia. Managed care expansion should be based on data, rather than on any prescribed timeline, and should occur only after analysis demonstrates better outcomes for beneficiaries of managed care as well as sufficient provider choice among beneficiaries. Finally, managed care should not come at the expense of sufficient provider availability and/or provider choice among plan beneficiaries. Therefore, when DMAS does move forward with the MLTSS plan, it should ensure that MLTSS plans incorporate assurances that beneficiaries will not lose their existing providers; beneficiaries will have access to skilled and accessible providers; and beneficiaries will have meaningful choices among providers and access to the information needed to make informed choices among plans.

Again, thank you for this opportunity to provide comments on this important proposal. 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, Heidi.Lawyer@vbpd.virginia.gov.