

Integrated Care for Medicare-Medicaid Enrollees

MARCH 21, 2012

PUBLIC COMMENTS

Jane Woods, Area Agencies on Aging

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Craig Connors, Riverside Health System

Comments Submitted For Public Record

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Hobart Harvey, Virginia Health Care Association

STATEMENT OF V4A FOR MARCH 21 HEARING #032101

The Virginia Association of Area Agencies on Aging, whose membership includes all AAAs in the Commonwealth and who serve the entire state, supports developing and implementing a care coordination model for individuals dually eligible for services under both Medicare and Medicaid. We are already serving many of these persons with care coordination and other services such as home delivered meals, personal care, transportation and caregiver support. AAAs serve as local VICAP, Virginia Insurance Counseling Assistance Program; and the SMP, Senior Medicare Patrol, providers funded through the Centers for Medicare and Medicaid Services. The Senior Medicare Patrol works with recipients and their caregivers to ensure the integrity of billings and the program.

Let me tell you about Mrs. A and her VICAP experience. VICAP provides one-on-one consultation regarding long-term care and health insurance to include Medicare, Medicaid, and private insurance. Recently, Mrs. A, age 87, contacted a VICAP counselor because her Medicare benefits had been cancelled resulting in her having to pay her Part B premium which is \$99.90 per month, which she could ill afford because of her low-income status. The VICAP counselor helped Mrs. A reapply for the benefits without penalty and they were reinstated; now she can once again pay her rent and have medical insurance coverage too.

We are uniquely positioned with expertise in Medicare, Medicaid and Care Coordination. Area Agencies on Aging are also the Commonwealth's lead agency for No Wrong Door. For these reasons, we request that we have a place in the advisory committee. We look forward to working together, learning from each other and developing a system that works for our shared constituents. Thank you.

Jane Woods for V4A and president, Courtney Tierney
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Integration of Care for Dual Eligibles Comments on DMAS Demonstration Project* March 21, 2012

As DMAS revisits integration of care for dual eligibles, I urge you to incorporate strong consumer protections throughout your model. As you know, dual eligibles are the most high-need individuals in the health system. Due, in part, to their very low incomes, they are extremely vulnerable and medically fragile. If the project is implemented with the beneficiaries in mind, you can improve care, decrease unnecessary institutionalization and slow the health care cost curve. But if cost savings and administrative efficiencies are the primary goals – especially with the capitated rate model planned by DMAS - there could be new barriers to care and new financial incentives for limiting necessary care. Even though CMS requires “upfront savings to both CMS and the State” to allow the demonstration to go forward, this must be structured very carefully.

The most essential consumer protections include the following ten items:

Dual eligibles must have a right to choose how, where, and from whom they receive care. Choice begins with a truly voluntary, “opt in” enrollment model. This is key to preserving continued access to specialists and other providers that may not participate in the integrated model – especially for people with complex medical conditions. Our successful PACE program is an opt-in model. You want participants to be engaged, committed and willing to use the care coordination services proposed. An enrollment broker and Area Agencies on Aging (VICAP programs) should be enlisted to assist individuals make choices about participating in the project and/or choosing the right plan.

An integrated model must include all Medicaid and Medicare services as well as enhanced benefits, especially those designed to keep individuals living at home and in the community. Coverage should include the highest and least restrictive level of services offered by either Medicaid or Medicare. (e.g. Medicare so-called “improvement standards” do not work in this model). Enhanced benefits offered should be clearly defined and standardized, but still allow for creative approaches to supportive services. New cost-sharing rules will need to be established and should never exceed the amount that is currently allowed. All Medicaid-eligible QMBs must be enrolled in that program and protected from most out-of-pocket costs.

There must be continuity of care, allowing access to current providers, services, treatments and drug regimens during the transition process. Beneficiaries must be allowed to continue successful drug and treatment regimens and continue with even non-network providers with whom they have an existing relationship during a transition period to the new plan. Time will also be needed to ensure development of adequate provider and specialist networks.

Enrollees must be able to appeal decisions made by the integrated model and to file complaints about problems encountered in dealing with the program. Since Medicaid and Medicare appeal systems are completely different, I believe you will need to develop a new appeal system for this project. You should include the best aspects offered by both programs, including due process protections, meaningful and clear notices (language and ADA access), coverage of services pending appeal, opportunities for expedited review, a quick path to review by an independent decision maker (i.e. make internal review optional as in Medicaid today), time limits on decisions and judicial review.

An integrated model must provide enrollees with meaningful notices and other communications about enrollment rights and options, plan benefits and rules. DMAS should use and require communications written at no higher than 7th grade level.

Services must be culturally and linguistically appropriate and physically accessible. This is a good opportunity to improve language access and services for the visually, hearing and physically impaired. Certain financial supports should be built into the reimbursement system.

An integrated model must provide adequate access to providers who are able to serve the unique needs of dual eligibles. While absolutely critical to the project's success, this could be a major challenge in Virginia because many providers continue to resist serving Medicaid recipients, and many continue to resist participation in managed care. However, the reduction in paperwork and single reimbursement should be a real incentive for providers to participate. In its contract with health plans, DMAS must establish very clear and strict standards on network adequacy that include: primary care providers with geriatric training; adequate numbers of specialists in the right specialties; providers willing to take new patients; geographic accessibility; travel time requirements; and appropriate exceptions for services from non-network providers. Rigorous standards for wait times, appointments and customer service should be set.

Oversight must be comprehensive and coordinated to ensure that integrated models are performing contracted duties and delivering high quality services. This 3-way contract (DMAS, CMS & health plans) must include clear systems and standards for oversight and enforcement of all requirements. Public disclosure of program assessments and evaluations should be a part of this oversight. I also strongly recommend that an ombudsman-type office be established for assisting consumers with questions, complaints and appeals and for documenting problem areas.

Payment structures must promote delivery of optimal care, and not reward the denial of needed services. Your risk-based capitated model must have payment structures that encourage the appropriate utilization of care and reward the provision of preventive care, intensive transition supports, and community-based care. Overall rates will need to be based on Medicare rates to encourage provider participation, and your payment structures should incorporate longer appointment times necessary for the dual population. Plans must assume the risk for nursing home admissions, and there should be no financial reward when patients are placed in an institution.

Integration efforts must be designed and implemented thoughtfully and deliberately, taking into consideration the structures and readiness of existing service delivery systems. DMAS is proposing to implement the model for 78,000 dual eligibles in Northern Virginia, Richmond/Charlottesville and Tidewater in December 2012. This timeframe seems extremely ambitious. I would encourage a longer and slower phase-in period to ensure this is done right, perhaps starting in one region instead of all three.

Other initial questions:

Will people in institutions be allowed to participate?

Will people who qualify for Medicaid via a spend-down be allowed to participate?

How will Medicaid estate recovery be handled in a fully integrated model with a single capitation rate?

Thank you for this opportunity to comment. I look forward to learning more details about the DMAS proposal and discussing it further.

Jill A. Hanken
Staff Attorney

* Many of my comments come from a series of four papers on dual eligibles prepared by the National Senior Citizens Law Center, <http://www.nsclc.org/index.php/health/dual-eligibles/> I strongly urge you to consider these reports and NSCLC's recommendations.



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March 19, 2012

Ms. Cynthia B. Jones
Director
Virginia Department of Medical Assistance Services
600 E. Broad Street, Suite 1000
Richmond, Virginia 23219-1857

Dear Cindi:

We appreciate the opportunity to participate in Wednesday's dual-eligible project meetings and look forward to working with the agency and other stakeholders in support of making this important initiative a success. Virginia's hospitals and health systems are extremely supportive of the dual-eligible initiative and believe that it offers great prospects for simultaneously improving services for recipients and helping address longer term cost trends.

Our members spent many months last year researching opportunities to improve care coordination for Medicaid's high cost patient populations and conducted detailed analyses of Medicaid claims information the agency was good enough to provide. We reached out to other stakeholders in Virginia in this exploration, especially colleagues leading Medicaid managed care and long term care organizations. CMS leadership, especially Melanie Bella with the Office of Medicare and Medicaid Integration provided very helpful guidance as did Steve Ford on your staff. Finally, we learned a lot from leaders of the Community Care of North Carolina (CCNC) program, especially Allen Dobson.

All of this information helped inform some general principles and specific recommendations that we hope will be of use as Virginia moves ahead with the dual-eligible project. But let us begin with the conclusions we drew from our analysis of Medicaid claims.

VHHA Data Analysis

We received the final Medicaid claims information last September and commissioned Deloitte (with a team lead by Randy Gordon) to do a number of analyses. The Deloitte analysis did confirm many of our Task Force's hypotheses about the high rates of utilization for this population and the apparent opportunities for substantial savings from improved care management. The analysis also found significant variation within Virginia in terms of admission rates and ED utilization for the populations studied. We are considering undertaking additional analyses to zero-in still further on patient profiles and principal drivers of utilization (including mental health).



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The overall finding confirmed that there is substantial savings opportunity, for Medicare and Medicaid, of reducing non value-added care for Virginia's dual and Medicaid only-populations. We also found that current experience of Virginia Medicaid dual-eligibles shows:

- High preponderance of behavioral health diagnoses;
- High rates of admission for Ambulatory Care Sensitive Conditions;
- High readmission rates compared to similar populations;
- Three to four-fold variation across Virginia regions in admission/readmission rates; and
- Heavy reliance on the ED as "primary care" site based on frequency of visits for fever, sore throat and earache.

Principles and Recommendations

These findings, further informed by our dialogue with other stakeholders, led us to a number of general principles for the dual-eligible initiative that we believe will be integral to success:

- Approaches taken must recognize the diverse nature of patient needs among Medicaid aged, blind and disabled (ABD) and dual-eligible recipients;
- Some form of medical home must be part of any strategy; and
- There must be meaningful provider engagement at the point of care.

Additional recommendations informed by our research are:

- **Data** – as with any sustainable improvement project, timely and focused analytics and data are essential. The agency, in partnership with others, should establish a Medicare/Medicaid informatics center to focus care coordination, track outcomes and support improvement.
- **Provider Engagement** – we strongly recommend that the Virginia proposal directs participating plans in the regions where the capitated model is applied to:
 - engage in shared risk arrangements with participating local provider systems or coalitions who agree to be held accountable for quality outcomes; and/or
 - embed the practice management supports necessary to achieve the improved outcomes in local settings, including:
 - Case managers to help coordinate services;
 - PharmDs to assist with medication management;
 - Psychiatrists to assist in mental health integration; and
 - Palliative care coordinators.
- **Financial Structure Flexibility** – we encourage the Commonwealth to allow for a managed fee-for-service option, perhaps in the second phase, in regions where local provider coalitions or systems demonstrate a willingness and capacity to work collaboratively and be held accountable for desired outcomes. One model may not fit the needs and circumstances.

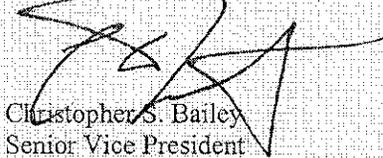


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- **Behavioral Health Integration and IMD Waiver** - it is becoming increasingly clear that our ability to improve the quality of care and lower the cost trajectory for Medicaid and Medicare is dependent on an integrated approach to caring for persons with mental health diagnoses. The Deloitte analysis of the dual eligible population found that mental health diagnoses were one of the top four reasons why inpatient admissions were higher for dual eligibles than a comparable Medicare only population. Other data suggests that inpatient admissions for behavioral health patients are often related to a high incidence of co-morbid conditions that include various surgical procedures, diabetes and orthopedics. It also important that the dual-eligible project incorporate, to the extent permissible, sufficient flexibility to waive the IMD rule that prohibits free-standing psychiatric facilities from accepting Medicaid patients. Although Virginia has only four IMD facilities, they are among the largest private inpatient providers in the state, accounting for twenty-three percent of all licensed beds. They also happen to be located in the same geographic regions targeted for the demonstration project. The ability to make full use of the existing behavioral health treatment capacity would be of benefit to the project.

Congratulations on pursuing this very important initiative. We look forward to working with DMAS and the other stakeholders to make the Virginia model successful.

Sincerely,



Christopher S. Bailey
Senior Vice President

Dual Eligible Demonstration Public Comments
March 21, 2012
Craig Connors, Vice President, Riverside Health System

First, I applaud the Department of Medical Assistance Services and the Commonwealth of Virginia for pursuing models of health care that provide better outcomes at lower cost. I agree that, if implemented thoughtfully, capitated partnerships between government and private payers and providers can yield excellent results for the citizens we serve.

I'm here representing Riverside PACE, Virginia's largest Program of All-Inclusive Care for the Elderly. PACE is an evidence-based, permanent Medicare and Medicaid provider model active in 30 states. It serves the frailest, highest risk, highest cost portion of our population. It has shown through published research that it delivers better outcomes than unmanaged, uncoordinated community-based long-term care programs and does so cost effectively. PACE has also demonstrated the ability to delay or prevent nursing home placement, saving money and letting people age with dignity in places of their choosing. This fact is especially important to consider when evaluating care model options for frail dual eligible beneficiaries.

PACE is financed through capitation and is authorized through a three-way agreement – similar to the model being proposed for the DualWay demonstration. PACE is also a Medicare Part D Plan because the prescription benefit is integral with the PACE model of care.

In many ways PACE is like a managed care organization. However, there are some significant differences that are pertinent to the DualWay program design. PACE is both a provider and payer. In PACE, primary medical, nursing, social, spiritual and rehabilitative services are delivered directly by employed PACE staff. PACE has physical facilities called PACE Centers where members visit to participate in a range of activities and receive services. These visits themselves are beneficial interventions.

PACE's ability to develop trusting relationships with the people it serves is an important differentiator. Trusting relationships and frequent in-person contact empower PACE to handle the very difficult social and medical situations that inevitably arise. They also establish partnerships between PACE and families that lead to better chronic disease management, health literacy education, and end of life planning.

While traditional managed care models are very effective and appropriate for a majority of our population, they organizationally and structurally cannot create the unique relationships and outcomes I just described. Therefore, in a very frail, sick and underserved population – like many of Virginia's nursing-home eligible Medicare and Medicaid beneficiaries – managed care organizations will have a very difficult time influencing utilization and delivering desired outcomes. "Health" in this population requires an evidence-based approach to treat both the social and medical determinants of care.

Virginia has supported the development and growth of its PACE organizations for the past several years because lawmakers and agency officials see the value of PACE. It would be a shame to implement a managed care demonstration for the duals that works well for the majority of people, but leaves the most chronically ill and needy underserved. In the same light, it would be foolhardy to potentially compromise the sustainability of our PACE programs by implementing a program that doesn't explicitly acknowledge PACE as one of the managed care options for those who qualify. Our citizens need access to the best models of care applied to the appropriate populations in the appropriate place at the appropriate time. Only with a thoughtful and target approach will we achieve the cost, quality and population health outcomes we strive for.

Therefore my explicit request is that PACE be considered as one of the options for enrollment in the DualWay project. This could be achieved using several different approaches which I and my PACE colleagues would be happy to discuss with DMAS and CMS. At the very least, beneficiaries should be made aware of PACE when being enrolled into the DualWay demonstration, and should be given the option to voluntarily choose PACE. It would be a disservice to beneficiaries and the State – and would compromise our progress – not to let people know PACE exists.

Thank you.

Kristin Parde
Senior Director
State Policy



March 19, 2012

VIA EMAIL

Dualintegration@dmas.virginia.gov

Cindi Jones
Director
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

Re: Letter of Intent to the Centers for Medicare and Medicaid Coordination Office and Dual Eligible Project

Dear Ms. Jones:

The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciates the opportunity to submit comments regarding the Medicare and Medicaid Financial Alignment Demonstration stakeholder meetings and the Dual Eligible Demonstration Project. PhRMA is a voluntary, non-profit organization representing the nation's leading research-based pharmaceutical and biotechnology companies, which are devoted to inventing medicines that allow patients to lead longer, healthier, and more productive lives.

PhRMA strongly supports efforts to improve the quality of care that individuals dually eligible for Medicare and Medicaid receive and believes it is important to test innovative mechanisms for improving care for the dual eligible population. Notwithstanding our strong support for improving coordination of care for dual eligible individuals and the important opportunity such improved coordination represents, we believe certain issues must be addressed for any program to be successful. Specifically, we urge Virginia to develop a demonstration that incorporates the full protections available to Medicare beneficiaries, specifically including coverage through Medicare Part D, to ensure that Virginia residents continue to have access to the full range of benefits and protections currently available to them, and to ensure that the state can take advantage of the cost-savings and efficiencies of the Part D program.

A Demonstration Must Incorporate Medicare Part D's Beneficiary Protections

As the state is likely aware, the Medicare Part D drug benefit effectively provides access to robust prescription drug coverage for all Medicare beneficiaries, including dual eligible beneficiaries—a population that accounts for a disproportionate share of both Medicare and Medicaid spending. We strongly believe that the Virginia demonstration should seek to clearly incorporate Part D's effective prescription drug delivery system for the state's duals population.

Pharmaceutical Research and Manufacturers of America

The Part D benefit has resulted in substantial savings for other parts of the Medicare program. Indeed, a recent study by the Journal of the American Medical Association (“JAMA”) found annual savings of \$1,200 on other, non-drug Medicare costs for seniors who previously had no drug coverage or limited drug coverage prior to the creation of Medicare Part D.¹ Furthermore, as described below, certain cost-savings are achieved with respect to the drug benefit itself through the Medicare Part D competitive bidding process. We believe these cost savings may be compromised to the extent that dual eligibles are moved out of Part D.

There should be no question that Virginia, like all other states, is required to incorporate Part D’s beneficiary protections into the demonstration. According to the Guidance to Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans issued January 25, 2012 by the Centers for Medicare and Medicaid Services (CMS), “Medicare Part D requirements – including with respect to specific benefits and cost-sharing, network adequacy, formularies, and submission of prescription drug event data – will be applicable to demonstration plans.”² We believe that a demonstration that directly incorporates Part D will be most successful at maintaining the program’s beneficiary protections, consistent with the CMS Duals Guidance.

Dual eligibles often have varied and complex healthcare needs, including the management of multiple prescription medications. Any disruption in care for this population has the potential to exacerbate their existing conditions. Thus, consistency and predictability in prescription drug delivery should be paramount in serving this population. Transferring accountability on a massive scale to new and untested Plans risks disrupting established patient-provider relationships and current treatment plans of dual eligibles. Continuity of care could be lost, and patients may accept ill-advised substitutions of medications, or cease medication compliance altogether, if coverage is changed at the time they are seeking refills of medication, or if robust drug coverage is no longer available.

Particularly given the short time period for implementation, we believe that the best and most efficient way for Virginia to capitalize on the successes of the Part D program without jeopardizing continuity of care is to structure the demonstration in a manner that is consistent with the CMS guidance and takes advantage of existing Part D protections for participating dual eligibles.

Chosen Plans Should Participate Fully in Part D Coverage

In light of the foregoing, PhRMA recommends that Virginia’s proposal require Plans to participate fully in Part D coverage. History has already shown that approaches to coordination of care can work with the Part D program; indeed, both Medicare Special Needs Plans (“SNPs”) and the Program of All-Inclusive Care for the Elderly (“PACE”) have successfully administered Part D benefits since 2006. Alternatively, participating plans could contract with current Part D plans in Virginia, as CMS will permit this type of subcontracting in the dual eligible demonstration context.

Providing care through existing Part D plans in this manner will enable Virginia to incorporate Part D protections into the demonstration, while taking advantage of the cost savings and efficiencies described above. Furthermore, this approach is consistent with CMS’ expectation that states will work with entities “that have experience in coordinating and delivering care to Medicare-Medicaid enrollees,”³ and will mitigate continuity of care concerns by allowing for a seamless continuation of prescription drug coverage. Additionally, Virginia

¹ J.M. McWilliams, Implementation of Medicare Part D and Nondrug Medical Spending for Elderly Adults with Limited Prior Drug Coverage, *Journal of the American Medical Association* (July 27, 2011).

² *Id.* at 4.

³ CMS Duals Guidance at 5.

could assist with the assignment of dual eligible beneficiaries to Part D plans that meet their medical needs (e.g., by enrolling a beneficiary in a plan with a formulary that includes his or her maintenance medications)—an approach that has been successful in assuring continuity of care in both Pennsylvania and Maine. Moreover, it is critical that Plans participating in the demonstration become Part D plans, rather than just meeting Part D standards, or contract with Part D plans so that rebates and discounts between drug manufacturers and Plans continue to be exempted from the Best Price provisions of the Medicaid drug rebate statute.

Plan Selection

It is critical to the success of this initiative that beneficiaries have choices about where and how they receive care. Providing choice and an opportunity to select a plan that best meets the beneficiary's needs will reduce the likelihood of disruption as beneficiaries move into the demonstration and increase the likelihood that beneficiaries will maintain rather than lose access to their current providers. Placing limitations on the range of qualified plans could significantly diminish the benefits of plan competition over time, and should a participating plan drop out or be excluded for performance reasons, beneficiaries could be left with fewer choices.

We appreciate your consideration of our comments. Please feel free to contact us with any questions.

Respectfully submitted,



Kristin Parde
Senior Director, State Policy



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March 19, 2012

Ms. Cynthia B. Jones
Director
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Commonwealth of Virginia
Suite 1300
600 East Broad Street
Richmond, Virginia 23219

Dear Cindi:

On behalf of the Virginia Health Care Association and its nursing facility members, we appreciate the opportunity to participate in Wednesday's dual-eligible demonstration meetings and look forward to working with the Department and other stakeholders in support of this initiative.

Please see our attached comments related to the proposal.

Very truly yours,

Hobart M. Harvey
Vice President Financial Services

Comments of the Virginia Health Care Association Medicare and Medicaid Financial Alignment Demonstration

The Virginia Health Care Association (VHCA) is a non-profit professional association founded in 1953 to serve as a statewide organization for long-term care providers. VHCA's membership is comprised of more than 240 licensed non-profit and proprietary long term care facilities serving a wide spectrum of needs. Approximately 36,000 trained medical professional and support service staff care for over 28,000 Virginians in these facilities every day.

Virginia currently has approximately one million people over the age of 65. This number is expected to increase significantly by 2020. The greatest growth will be among the age cohort most reliant on nursing facility services – the elderly population aged 85 years and older. Our members play a leading role in the continuum of care that has evolved to meet the short and long term medical needs of this population. Medicaid and Medicare payments comprise 80 percent of the revenue for Virginia's nursing facilities.

While we support the Department's pursuit of a plan to integrate care and align payment for dual eligible beneficiaries, we believe that the intended implementation of the demonstration pilots encompassing the Commonwealth's three largest urban areas – Northern Virginia, Tidewater and Richmond/Charlottesville – is overly ambitious and will not serve the best interests of beneficiaries or providers. It is our understanding that pilot projects being pursued in states seeking to implement the capitation model for dual eligibles are considerably smaller in size. We strongly encourage DMAS to reconsider the size of the pilot projects and implement demonstrations on a scale that will allow for a comprehensive assessment and evaluation prior to consideration for statewide expansion.

We believe that comprehensive data capture and information analyses are vital components of the dual eligible integration pilots. We encourage the Department to fully study, define and obtain stakeholder consensus for the specific data that will be necessary to evaluate the demonstration's clinical and financial performance prior to their implementation.

We are concerned about the specific role of the federal survey and certification process as it applies to nursing facilities under the proposed dual eligible integration pilots. We encourage CMS, DMAS and health plans to work together to examine the survey process and consider modifications that will assist providers in working toward a common goal of better patient care – and not simply overlay the current subjective and often punitive survey process on top of the proposed coordinated care model.

Comments of the Virginia Health Care Association Medicare and Medicaid Financial Alignment Demonstration

Finally, we join with the Virginia Hospital and Healthcare Association and encourage the Commonwealth to allow for a managed fee-for-service option, perhaps in the second phase, in regions where local provider coalitions or systems demonstrate a willingness and capacity to work collaboratively and be held accountable for desired outcomes. A single model may not fit all care coordination needs and circumstances across the Commonwealth.

Long Term Care Environment in Virginia

Home and community-based services represent a desirable choice in long term care, and individuals able to benefit from this care setting should have access to a full range of options. Facility-based services are also a core element of the health care continuum, and those who require a level of care unavailable in the community should have access to facility-based services appropriate to meet their individual needs.

The following information is provided to help inform the discussion around Virginia's current situation relative to facility and community-based services:

- Virginia is among the leading states in "balancing" Medicaid funds between nursing facilities and home and community-based services. The Department of Medical Assistance Services forecast for 2012 indicates that expenditures for home and community-based services identified as an alternative to nursing facility placement will exceed expenditures for beneficiaries receiving care in nursing facilities.
- Nursing facilities are medical providers licensed by the Virginia Department of Health to provide comprehensive 24-hour health care to persons who require nursing, rehabilitation and specialty care services for complex medical or chronic conditions. The scope of services offered by community-based long term care providers is not equivalent to nursing facility care; their services are appropriately designed for a generally healthier population that requires intermittent care and often also relies on other medical and social services from public and private providers in the community.
- A high percentage of all nursing facility admissions come from an acute hospital and a majority of these patients are discharged from the facility within 90 days of admission.
- Virginia consistently ranks high among states in average resident acuity. Using December 2011 data published by CMS, Virginia's nursing facility residents ranked 8th highest in average acuity as measured by Activities of Daily Living (ADL) dependency. As this indicator

Comments of the Virginia Health Care Association Medicare and Medicaid Financial Alignment Demonstration

suggests, our residents require substantially more care and resources than those in most other states.

- In the four years since its inception, the Community Transitions Program (Money Follows the Person demonstration) has been able to divert only 1.4% of the residents in targeted Virginia facilities to the community. Most of the relocations were developmentally disabled, non-geriatric residents transferred to community facilities.
- Virginia has comparably fewer nursing-facility beds per 1,000 elderly than other states. In state-to-state program comparisons Virginia clearly outperforms most states in managing nursing-facility bed supply, creating/funding community-based alternatives and minimizing nursing-facility utilization.
- Estimates of “savings” from nursing-facility bed reduction or patient diversion efforts based on programs undertaken in other states are typically overstated because they do not factor in Virginia’s strict Medicaid utilization controls, emphasis on community-based services, significant loss of Medicaid patient share-of-cost revenue, additional medical care costs in the community (physician, therapist, transportation, pharmacy, etc.), and relatively higher use of personal care hours or frequent participation in multiple community programs by transitioned patients.

Dual Eligible Demonstrations – Long Term Care Considerations

VHCA recommends that the demonstrations reflect the following specific considerations:

- That both Medicare Part A post-acute care and long stay Medicaid nursing care are critical components of the long term care continuum. Pilots should demonstrate an in-depth understanding of Medicare skilled services and payment systems, not just Medicaid.

Nursing facility operations hinge on understanding and managing the delicate balance between Medicare and Medicaid. Significant modification to the clinical or financial components of either program will likely upset that balance and could risk the viability of providers.

- Health plans will continue to pay Medicare Part A payment rates and established Medicaid reimbursement rates to nursing facilities.

Comments of the Virginia Health Care Association Medicare and Medicaid Financial Alignment Demonstration

- That the payment structure established within the demonstration pilots should restore coverage for Medicare co-pay liabilities for skilled care provided to duals. In 1998, the Department implemented a policy that limited its responsibility to cover co-pay liabilities that arise from the delivery of skilled Medicare services to dual eligible beneficiaries.
- Participating health plans will utilize a common billing and claims processing system. Health plans will meet or exceed current Medicaid and Medicare claims processing and payment performance levels.
- That any willing provider should be able to participate in the demonstrations and provide long term care services.
- Health plans will remove the current three-day hospital stay requirement necessary to establish the need for skilled services.
- Health plans will be subject to the same medical loss ratio provisions applicable to Virginia's Medicaid managed care program for acute and primary care.
- Demonstrations should implement financial incentives and actively foster innovation as part of the effort to avoid unnecessary hospitalizations and emergency room utilization and to reduce hospital readmissions from both community and facility settings.

The demonstrations should require that participating health plans actively work with long term care providers to fund and implement telehealth capabilities as a resource to address the unnecessary hospital utilization and readmission issues.

- Health plans should recognize the critical role that therapy services play in the overall recovery and health of nursing facility patients and residents and strive to place a high priority on the expanded availability of such services.

We thank you for the opportunity to offer our comments related to the proposed Medicare and Medicaid Financial Alignment Demonstrations and look forward to working with the Department and other key stakeholders to develop a plan to integrate care and align payment for dual eligible beneficiaries.