

Virginia Department of
Medical Assistance Services

Compiled Public Comment
Submission
Virginia's §1115 Waiver
Application

Comment Period
12/04/15 – 01/06/16

Acknowledgements

The Department of Medical Assistance Services would like to thank our community stakeholders and partners who submitted comments on the §1115 Innovation Waiver Application. We appreciate your input and find the collective responses valuable as we continue to work towards a comprehensive waiver application. All comments will be taken into consideration as we move forward.

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Advocate Comments

Advocate: AARP Virginia

Dear Director Jones:

As a nonprofit, nonpartisan social welfare organization with a membership and offices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands, AARP's mission is to help people 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. We seek to help older Americans live long and healthy lives. AARP Virginia, representing over one million members, is Virginia's largest organization representing the needs, views, desires, and hopes of Virginia's 50+ population.

We greatly appreciate this opportunity to provide feedback on the Section 1115 Waiver Application that describes two strategic initiatives being pursued by the state: Medicaid Managed Long Term Services and Supports (MLTSS) and the Delivery System Reform Incentive Payment (DSRIP) program. This comment letter is limited to the MLTSS initiative. AARP Virginia has been heavily engaged over the years to advocate for a health care and LTSS system that adequately serves the needs of older Virginians and their families, and we believe that such a major change to Virginia's Medicaid system as is proposed in the Waiver deserves considerable thought, attention, and planning.

Medicaid managed LTSS provides many opportunities and challenges in care delivery and financing. AARP does not support or oppose a transition to managed care, but rather seeks to ensure that any changes to the state's LTSS system are person and family-centered and allow individuals to live as independently as possible and to exercise control over their own care arrangements. It is clear from the goals set forth in the Waiver that the state is also focused on many of these principles, and we hope that this focus will manifest itself more concretely as the Waiver progresses through the approval process and implementation.

We also note that earlier this year the federal Centers for Medicare & Medicaid Services (CMS) proposed the first major update to Medicaid managed care regulations in more than a decade. While these rules are not yet final, we urge Virginia to proactively incorporate elements of these proposed rules into the Initiative, especially those provisions that seek to protect individuals enrolled in managed care.

We urge Virginia to clarify, modify and expand the Waiver in the following key areas before final applications are submitted to CMS:

Community Integration

AARP supports the ability of people of all ages and incomes to participate as fully as possible in all aspects of community living. In particular, we appreciate the Waiver’s stated goal to “maximize opportunities for community living” and the plans to streamline home and community-based services authorities and require health plans to collaborate with community-based organizations and other community partners. Virginia has made strides to address the historical LTSS institutional bias, but there is still room for improvement. In fiscal year 2013, Virginia spent 52.9 percent of its total Medicaid LTSS dollars on home and community-based services – a significant improvement from past years, but still around the median of states nationwide.¹ Equally noteworthy is the fact that the spending imbalance is worse for older adults. Data from the same year shows that the state spent only 45.6 percent of its Medicaid LTSS dollars on home and community-based services for adults over age 65 and people with physical disabilities.² We are encouraged by the state’s goal to increase the percentage of individuals receiving LTSS through home and community based services to 69.9 percent by 2022. We know that an overwhelming majority of Virginians would prefer to receive services in their homes and communities, and correcting this imbalance should continue to be a top priority for the Initiative.

Involvement of Family Caregivers

Family caregivers provide the vast majority of LTSS in the home and community, and should be seen as a key component and partner in any effective Medicaid system when they are willing and able to help. We are pleased that the Waiver sets forth the broad goal to include "individuals and family members in decision making using a person-centered model" and that the previously-issued Model of Care recognizes the important role family caregivers play. We are also pleased that the Waiver mentions expanded investment in caregivers and “peers (individual and family)” as part of the DSRIP program. AARP strongly supports a person- and family-centered approach to LTSS. Such an approach should include family caregivers as part of the care team, when the beneficiary welcomes the involvement of family caregivers. In a person- and family-centered care system, family caregivers are no longer viewed as just a “resource” for the beneficiary; rather, they are viewed as “partners” on the care team, and also recognized as individuals who

¹ Eiken, Steve, Kate Sredl, Brian Burwell, and Paul Saucier. "Medicaid expenditures for long-term services and supports in FY 2013." Center for Medicare & Medicaid Services, June 2015. Available at: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf>

² *Id.* at Table AP. Note: FY2009 is the last year for which HCBS expenditures for 65+ (separately and not grouped with people with physical disabilities) is available. HCBS expenditures represented 22 percent of LTSS spending in Virginia for that group in FY2009. See Kaiser Family Foundation. “Medicaid’s Role in Meeting the Long-Term Care Needs of America’s Seniors.” January 2013. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8403.pdf>.

may themselves need training and support (such as respite care). We recommend that the Waiver specifically mention the involvement of family caregivers as part of the Interdisciplinary Care Team and in developing an individualized care plan, and that “family caregivers” be broadly defined to encompass the many types of relationships between individuals and caregivers.

In addition to these provisions, we recommend that the MLTSS Initiative include other ways for managed care organizations (MCOs) to involve and partner with family caregivers. As the Initiative moves forward, we urge the state to include in the Waiver and in its contracts with MCOs provisions to ensure that:

- Family caregivers of **all** Initiative participants have the opportunity to participate in assessment of need of their family member;
- Family caregivers receive an independent assessment to determine how the MCO can work with the caregiver and support their needs;
- MCOs train their case managers on how to communicate and work with family caregivers;
- MCOs have regular communication with the family caregiver and require paid home care/health provider to communicate/consult with the family caregiver on service delivery;
- MCOs offer caregiver training to family caregivers that covers both effective caregiving techniques and stress reduction practices; and
- MCOs provide paid respite support for family caregivers on a regular basis.

Enrollment and Choice

AARP believes that informed consumer choice should be a key principle guiding all aspects of design and implementation of the Initiative. Because the Waiver requires managed care enrollment for certain populations, the state must ensure that a choice of plans and providers is offered during all phases of implementation and in all regions. We urge the state to include more detail on any beneficiary protections that will be included in the enrollment process and include a period of time before automatic enrollment in which enrollees are given a choice of MCO. Any automatic assignment of an individual to an MCO should take into account continuity of care by the individual’s current providers. This is especially important in the context of LTSS, which often involves an individual’s living arrangements and provision of personal care services.

The Waiver should also address the need for conflict-free choice counseling, assistance with enrollment, and participant advocacy. No person should be enrolled in an MLTSS plan without

first receiving a conflict-free assessment of their needs and preferences and conflict-free counseling about the range of options available to meet their needs and preferences.

Virginia should guard against any MCO that might attempt to encourage disenrollment by individuals who are medically challenging and expensive to care for. We would also strongly urge the state to conduct exit interviews of those who disenroll and order corrective action in response to any enrollment manipulation. Plan retention rates will be a key indicator of quality and consumer services and should be made public and provided to consumers during the enrollment and renewal processes. The responsibility of the MCOs and their networks should not end with disenrollment. They should be required to develop and implement a seamless transition plan with no gaps in care for those transitioning to managed care, changing plans or opting out of the managed care system.

Network Adequacy, Quality, and Reporting

AARP believes that states must ensure that all network-based health and LTSS plans offer adequate and appropriate access to providers who can meet the needs of the enrolled population. We applaud the state for its goal of “system-wide quality improvement and monitoring” and its focus on MCO network adequacy and on ways to incentivize high-quality care. In order to better ensure a sufficient, quality network, we urge the state to expand upon the requirement that health plans “develop and maintain a provider network that is adequate to meet the needs of the individuals covered within the scope of MLTSS” to include specific provider quality and accreditation standards, language accessibility and accessibility for beneficiaries with disabilities, and the specific provider number, mix, and geographic distribution of the MCO’s network in both rural and urban areas. These measures are especially important in the LTSS context, in which providers play such an integral part in the lives of beneficiaries. The state should first make clear the standards for network adequacy supported by evidence-based research and data, and provide a clear plan for network adequacy review that does not simply require the submission of data to the state on an annual basis. Specifically, we encourage the state to use “secret shopper” and other practices, like surveys of beneficiaries and family caregivers, designed to evaluate provider networks. The state should ensure that MCOs will meet explicit network standards for providers and provider facilities, including primary, specialty, and other critical professional, allied and supportive services and equipment providers, in both rural and urban areas, with a right to an out-of-network authorization if the standard is unmet. We encourage the state to set a “good standing” requirement for MCO-contracted nursing facilities and home care providers. No Medicaid beneficiary should be forced to choose between a few poor performing nursing facilities or home care providers, simply because they

are enrolled in managed care. The state could use the Nursing Home Compare Five-Star Quality Rating system for this purpose or set similar minimum performance standards and accreditation for participating facilities and other providers.

We appreciate the state's plan for a phased geographical rollout to better ensure MCO readiness during implementation. As part of its transition to MLTSS, the state should develop a robust MCO-readiness review process to determine whether managed care plans are prepared to provide all contracted services in a safe, efficient, and effective manner. Plan readiness includes, at a minimum, network adequacy (including the ability to pay contracted providers within a reasonable amount of time); a proven track record of high performance; the ability to offer participant-directed LTSS including, but not limited to, counseling and financial management services; the ability to monitor and improve services; demonstrated financial stability in the plan and adequate protections against insolvency; the ability to generate required data and reports for governmental entities and public reporting; and adequate capacity to respond to enrollee grievances and appeals.

State Oversight

In shifting to a managed care program, robust MCO contract oversight and monitoring is critical to ensure that capitated payments do not create incentives for MCOs to stint on needed care and services for this very vulnerable population. Robust oversight is also imperative to ensure that all reporting requirements and performance standards are being complied with and that they are leading to improved quality and access. A recent AARP Public Policy Institute report points out that "although contracts between states and MCOs establish standards and requirements, such contracts are empty promises if states are unable to monitor and enforce plan compliance and performance."³ As Virginia transitions to MLTSS, the state should pay special attention to how it would conduct oversight and what resources it must dedicate to this effort.

Based on the experience of states that have successfully implemented Medicaid managed care and MLTSS, we are convinced that state governments must take a hands-on management approach to effectively oversee managed care contracts. The state must be committed and take steps (both from a staffing and knowledge perspective) to actively monitor and use all enforcement tools available to ensure that Virginia consumers receive the right care, in the right

³ Lipson, D., J. Libersky, R. Machta, L. Flowers, and W. Fox-Grage. "Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports." Report no. 2012-06. Washington, DC: AARP Public Policy Institute, July 2012. Available at <http://www.aarp.org/health/medicare-insurance/info-07-2012/keeping-watch-building-statecapacity-to-oversee-medicare-managed-long-term-services-and-supportsAARP-ppi-health.html>.

place, at the right time. The movement to managed care should not be seen by a state as a way to reduce its Medicaid role and responsibilities by simply paying MCOs and relinquishing these functions to them. Final accountability for the performance of its contractors, including managed care plans, must remain with the state. The state's monitoring of MCO quality and performance should include person and family-centered measures of beneficiary and family caregiver experience, including MCO retention rates, rebalancing and community integration activities for beneficiaries receiving LTSS. In addition, meaningful, readily accessible, and understandable plan information is critical to support consumer education, quality of care, and meaningful choice for enrollees and potential enrollees.

AARP also urges the state to create an independent oversight committee or task force independent of DMAS and the Department of Health to monitor and report on implementation of the Initiative with the ability to ensure that needed modifications and adjustments can be made. Legislative oversight committees were established in Indiana, and were a valuable vehicle for advancing Tennessee's long-term care transition to managed care plans.

Reinvestment of Savings

If Virginia is able to use the MLTSS program to achieve improved quality of life, satisfaction, and health outcomes for enrolled individuals, and its other stated goals, as well as generate cost savings for the state, AARP strongly believes that the state should commit to using these savings to improve access to and quality of home and community-based care on a larger scale. Transition to managed care must not be a way to gradually decrease the state's investment in, and thus, the availability of, LTSS or other services available to these populations. This commitment should be demonstrated by including specific language in the Waiver that directs that any savings achieved through the success of the program be reinvested to improve the network and quality of services and supports available to those in need of HCBS. Specifically, savings should be allocated to increase eligibility for services so that more individuals can receive home and community-based services. While we understand that savings may not accrue the first few years, we strongly believe that the commitment to reinvest savings should be made upfront.

We appreciate the opportunity to provide these comments and look forward to continued involvement as the Waiver process moves forward. As always, we are ready to assist in any way to help ensure that Virginia has the most appropriate, accessible and quality Medicaid LTSS program for Virginians. If you have any questions, please contact me at ddebiasi@aarp.org or 804-344-3059.

Sincerely,

DM DeBiasi

David M. DeBiasi, RN
Associate State Director – Advocacy
707 E. Main Street, Suite 910
Richmond, VA 23219

Advocate: [REDACTED]

[REDACTED] Oral health is important to overall health. I am saddened to see the so much money has been funneled to prisoners and our most vulnerable populations have been ignored. It is sad to me that unless a family can pay for sedation anesthesia, their family member cannot have a simple exam and oral health care treatment.

There is overwhelming research and evidence that oral health prevents diseases such as cardiovascular diseases, diabetes, and pneumonia. This lack of funding effectively sentences this population to a lifetime of even more vulnerability.

[REDACTED]

[REDACTED]

[REDACTED]

Advocate: Dental Aid Partners of the New River Valley

I am writing on behalf of the Dental Aid Partners of the NRV which is a 501(c)3 non-profit whose mission is to: a) create a culture of good dental and oral health in the New River Valley and, b) to facilitate care for our neighbors least able to afford this critical health service. My encouragement for you to include oral health in your DRIP application stems from my background as a businessman. My experience says that almost everything at its core is about money. Money is about priorities! Is money the reason that oral health has not been perceived related to overall health? My goodness, probably 45 to 45% of New River Valley households might be considered low-income and are forced financially to place a low priority on dental care and this leads to all sorts of medical complications. As I said, I am a businessman and from where I sit, it makes no sense to me why oral health is so artificially separated from the benefits accorded in health care benefits. Money and priorities.

Joe Thompson

Advocate: Glen “Skip” Skinner

Glen 'Skip' Skinner,
Executive Director, LENOWISCO Planning District Commission,
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Healthcare is a critical element of our regional economic development plan. We must have a healthy workforce if we are going to successfully grow and recruit businesses to this culturally rich region of the Commonwealth. We will not be unsuccessful as we transition our economy away from one dominated by resource extraction to one founded on sustainable economic development principals unless we recognize the importance of health and health improvement as an economic driver for a healthy workforce. The Commonwealth of Virginia must assist our efforts with effective public policy.

A healthy workforce also must include oral health as part of comprehensive health services. I wholeheartedly recommend that DMAS incorporate oral health as a component of each transformation step outlined in the DSRIP application in a complementary way to ensure the following: providers are knowledgeable about the importance of oral health; individuals enrolled in Medicaid have access to oral health education and referrals; and, the care delivery infrastructure supports full oral health integration of adult Medicaid dental benefits when they are realized.

Thank you for the opportunity to comment.

Advocate: Healthy Roanoke Valley

Dear Ms. Rockwell,

Healthy Roanoke Valley is respectfully providing comment regarding the DMAS application for Virginia's 1115 Waiver. Founded in October 2012, Healthy Roanoke Valley (HRV) is an initiative of the United Way of Roanoke Valley and derived from the 2012 Roanoke Valley Community Health Needs Assessment (CHNA) conducted by Carilion Clinic, the largest health system in our region. The community-driven CHNA identified three main priorities for improving health outcomes in the Roanoke Valley for underserved populations, including (1) access to services (primary care, behavioral health, and oral health); (2) coordination of care; and (3) wellness. A partnership of more than 50 organizations, HRV strives to enhance health equality related to these priorities as a means to create a "culture of wellness" across the Valley (e.g., Botetourt, Craig, and Roanoke counties and the cities of Roanoke and Salem, Virginia). Our target population includes the low-income, uninsured, underinsured and those suffering from chronic disease.

In 2015, we conducted a Community Health Survey with our target population who reported that:

- **36% of adults** do not use dental care services
- **24% of children** do not use dental care services
- **47% of respondents** have not used dental services in the past 2 years
- **19.7%** have not used dental services in 5 or more years

Focus groups with this population revealed that the top barriers to oral health services are lack of insurance (35%) and cost of services (22%).

As a health care stakeholder, I recommend that DMAS include oral health and dental providers as part of the Delivery System Reform Incentive Payment (DSRIP) initiative in a manner mindful of the existing dental benefits offered in Virginia's Medicaid program, the integral relationship between oral health and overall health, and the critical role dental providers play in supporting health and wellness.

We commend DMAS for its vision to address the health needs of Virginia's most vulnerable, through both the Medicaid Managed Long Term Care Services and Supports (MLTSS) and the Delivery System Reform Incentive Payment (DSRIP) initiatives; ***however, we are concerned that the absence of oral health is counter to the efforts across the commonwealth to create a comprehensive model of care and is not reflective of the entire array of services Medicaid-eligible adults are able to receive.***

To that end, we support the Virginia Oral Health Coalition’s recommendations as follows, which are organized by DSRIP proposed projects:

System Transformation Projects

Oral health is linked to outcomes for birth, diabetes and other chronic conditions, and medical and dental providers must be able to communicate to improve overall health. To that end, oral health providers are an important part of the care team, and thus we recommend they are included in the Virginia Integration Partner or “VIP” community. We recommend that VIPs provide oral health referrals, services and education to patients, as appropriate. Community health centers across the commonwealth are demonstrating the effectiveness of this approach and can provide a replicable model as VIPS emerge throughout the state. Additionally, as part of the commonwealth’s State Innovation Model (SIM) work, a diverse stakeholder group created five integrated care models that are reflective of current Medicaid benefits and include oral health services, education and referrals in primary care and ED settings. These models are shovel-ready and provide a framework for care delivery and coordination, data and electronic medical record (EMR) integration, provider education and communication. Each model can be augmented by VIPs to ensure oral health is included in efforts to provide comprehensive care.

Preliminary DSRIP Transformation Project List

While we recommend that oral health be included in all models of patient centered care, oral health is a pivotal component in two of the transformation projects identified in the DSRIP application. They are described below:

Emergency Department Diversion

Dental issues are often the number one reason Medicaid-enrolled adults visit the ED, despite the fact that no treatment is provided. Often, individuals present at the ED with severe infection due to a tooth abscess that needs to be extracted. Virginia Medicaid covers extractions; however, in the ED, a patient typically receives a prescription for an antibiotic and a pain pill (often an opioid). Stopping this cycle by integrating oral health referrals and education into all ED diversion programs is an important step in reducing inappropriate use of the ED. Several hospitals in Virginia partner with area safety net sites and dental clinics to curb use of the ED for dental issues with great success, such as Halifax Regional Medical Center and VCU Medical Center. As the VIPs address issues related to ED use, we recommend oral health be included in care models and data-sharing.

Condition-focused Initiative

As mentioned above, the SIM planning process resulted in five integrated models inclusive of oral health; safety net sites and other health systems throughout the commonwealth are also implementing excellent oral health integration initiatives. Thus, myriad integration models that include oral health and are sensitive to existing Medicaid dental coverage are available and can be scaled and replicated by VIPs to ensure that oral health is incorporated in appropriate condition-focused initiatives.

For example, research demonstrates the importance of good oral health as part of a healthy pregnancy. Partly due to research such as this, Virginia recently began to offer a comprehensive dental benefit to pregnant women enrolled in Medicaid. As the VIPs implement high touch care models designed to improve pregnancy outcomes, oral health education and referrals for care are important components. Additionally, diabetics have improved health outcomes and reduced hospitalizations when they receive successful oral health treatment, and thus could benefit from coordinated care and education.

Thank you for the opportunity to provide comment; we look forward to an ongoing effort to ensure that person-centered health care is the norm for all Medicaid beneficiaries. We are happy to provide any additional information or resources, or answer any questions.

Sincerely,

A handwritten signature in cursive script that reads "Patricia E. Young".

Patricia E. Young, Director
325 Campbell Avenue, SW Roanoke, VA 24018 HealthyRV@uwrva.org

Advocate: Institute for Public Health Innovation

Hi,

Thanks for taking the time to talk about the potential roles for CHWs in the DSRIP. I have reviewed the draft 1115 Waiver. I did have a general question regarding the role of a state plan amendment in this entire process. Several states are using state plan amendments to include non-licensed professionals as providers whose delivery of preventive services can be paid for when ordered by a licensed provider. This would allow CHW services to be paid for using Medicaid funds. Is there potential for utilizing a state plan amendment to achieve this result in Virginia? In terms of the DSRIP, the potential roles for CHWs are identified in several relevant areas. CHWs could also be utilized in the following areas:

- The care navigation and support aspect of VIPs is perfectly aligned with the roles of CHWs in outreach, education, and navigation to care and services.
- Emergency Department diversion. Several studies have found CHWs to be effective. We (IPHI) are currently completing a pilot project with VCU Health System to evaluate the impact of CHWs on unnecessary ED utilization. Results will be ready by February 2016.
- CHWs can also play an important role in connecting beneficiaries to housing and employment resources and services.
- Workforce training
 - While IPHI and other organizations have developed core CHW training curricula, there will likely be a need to develop additional modules to prepare CHWs to assure duties specific to the DSRIP. In particular, there will be a need for training to be created on issues such as behavioral health, complex patients, and disabilities. IPHI would be available to work with VIPs to develop appropriate training content as we have with other partners.
 - The statewide CHW Advisory Group will develop a statewide training and credentialing process over the next several months. The entity that will oversee the training and credentialing process is yet to be defined, but there will be a need for funding to support its efforts. If DSRIP funding can be used to support such an entity (in addition, to funding the actual training of CHWs), this would support a functional process to assure that CHWs are adequately prepared to carry out their roles.

I hope these comments are helpful. Please let me know if you have any questions. I look forward to further conversations as the application process continues.

Thanks,

Michael O. Royster, MD, MPH, FACPM

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Advocate: Laura Doyle

As a Virginian with a strong interest in the health care of fellow Virginians, I recommend that DMAS include oral health and dental providers as part of the Delivery System Reform Incentive Payment (DSRIP) initiative in a manner mindful of the existing dental benefits offered in Virginia's Medicaid program, the integral relationship between oral health and overall health, and the critical role dental providers play in supporting health and wellness.

Poor overall health has a direct impact on overall health with the greatest impact on those with diabetes, cerebral vascular disease and coronary artery disease. Oral health does impact overall health. Include oral health and dental providers as part of the Delivery System Reform Incentive Payment initiative.

Laura Doyle

1510 Judd Ct

Herndon, VA

703-597-8847

Advocate: Northern Virginia Health Foundation

Dear Ms. Rockwell:

The Northern Virginia Health Foundation's mission is to improve the health and healthcare of low-income residents of Northern Virginia through traditional grant-making and involvement in health-related initiatives. We regularly convene the oral health safety net providers in this region to share information about best practices.

We support DMAS's efforts to transform the Medicaid delivery system by applying for a Section 1115 application, as we noted in our October 14, 2015 letter to Cindi Jones. However, we were disappointed that oral health care is not included in the most recent version of the application.

Oral health is health. While Virginia's Medicaid benefit is limited, coordinating care could eliminate costly visits to the emergency room for adults seeking treatment for oral health issues. In addition, coordination of primary and oral health care can lead to better health outcomes for persons with diabetes and heart conditions, and pregnant women. There are several safety net providers in Northern Virginia that are successfully integrating primary and oral health, to the benefit of their patients.

We urge DMAS to add oral health to models of patient centered care, consistent with the Virginia Department of Health's "Virginia's Plan for Well-Being," and include oral health providers in all integrated partnerships, education for patients and providers, electronic health records improvements, and as part of the network in the VIP community.

Sincerely,

A handwritten signature in blue ink that reads "Patricia N. Mathews". The signature is written in a cursive style and is positioned above the typed name and title.

Patricia N. Mathews
President and CEO
Northern Virginia Health Foundation

Advocate: Robert Klink, MD, MMM, FACOG

Dear Ms. Rockwell,

Thank you for the opportunity to submit comment regarding the Department of Medical Assistance Services' (DMAS) application for the Virginia Section 1115 Waiver Application and the Delivery System Reform Incentive Payment (DSRIP) design. I commend DMAS for its vision to address the health needs of Virginia's most vulnerable through both the Medicaid Managed Long Term Care Services and Supports (MLTSS) and the Delivery System Reform Incentive Payment (DSRIP) initiatives; however, I believe oral health should be included in these initiatives to mirror comprehensive care models across the Commonwealth, and reflect the entire array of services Medicaid-eligible adults are able to receive.

I am a retired obstetrician, having practiced for over 35 years in Gloucester, Virginia, and a current board member for the Virginia Oral Health Coalition (VaOHC) – an alliance of partners committed to ensuring oral health is part of comprehensive health care for Virginians. I wholeheartedly support VaOHC's recommendations regarding the DSRIP application to include oral health providers in the Virginia Integrated Partner or "VIP" community, including safety net and charity dental providers, and to integrate oral health into patient and provider education, community supports and improvements in electronic health records. Dental issues are often the number one reason Medicaid-enrolled adults visit the emergency department, despite the fact no treatment is provided. Additionally, myriad integration models exist that include oral health, are sensitive to existing Medicaid dental coverage, and can be used in condition-focused initiatives. Following this, I support VaOHC's recommendation that the VIPs include oral health in integrated care models and data-sharing to fully address emergency department diversion and condition-focused initiatives, which are two of the transformational projects identified in DSRIP application.

As a health care provider and advocate, I encourage DMAS to strengthen the DSRIP application – and take advantage of a critical opportunity to improve health of Virginia's costliest and most medically complex patients – by including oral health in its integrated care design. The marked association between oral disease and systemic illness is well known, but doesn't receive the recognition it deserves.

Sincerely,

RWK

Robert W. Klink, MD, MMM, FACOG

Advocate: Sarah Raskin, PhD, MPH

Dear Ms. Rockwell,

I am a medical anthropologist whose research centers on oral health disparities in far southwest Virginia, and a member of the Virginia Oral Health Coalition Board of Directors. I am writing to urge DMAS to strengthen its commitment to overall health by including in the Delivery System Reform Incentive Payment (DSRIP) the dental benefits that DMAS *already provides*.

Oral health is a crucial component of overall health, whose effects on pregnancy outcomes, quality of life and participation in daily activities, and inflammatory disease such as cardiovascular disease and diabetes are increasingly documented in the scientific literature, clinical practice, and the stories of everyday people who suffer from advanced dental disease. Evidence demonstrates that underlying such emotionally and physically burdensome and systematically costly complex medical problems are low income people's exclusion from dental care. Indeed, there is also a strong business case to be made for DMAS's inclusion in the DSRIP of *existing dental benefits*: the encapsulation of risk of increased emergency department visits in lieu of the payment incentives that can drive dentists to treat publicly insured patients. Here, we need only to look to other states' rescinding of dental benefits from publicly insured plans to see the effects of such regressive policies on both underserved populations and on public and private budgets. In California, for example, the elimination of adult dental Medicaid benefits caused a ["significant and immediate"](#) increase in dental visits to Emergency Departments statewide and a 68% increase in dental-associated ED costs.

While the case of excluding DMAS's *existing dental benefits* from the DSRIP is not the same as eliminating an entire program, the lesson of California and other states bears extrapolating: Policies which "leave behind" crucial programs, for example by not incentivizing dental care alongside other specialty care that is crucial to overall health, place tremendous risk on health care systems, state spending, and individual patients.

I urge DMAS to include its existing dental benefits as part of DSRIP.

My very best,

Sarah Raskin, PhD, MPH

Advocate: Vicki Brett

As a health care stakeholder, I recommend that DMAS include oral health and dental providers as part of the Delivery System Reform Incentive Payment (DSRIP) initiative in a manner mindful of the existing dental benefits offered in Virginia's Medicaid program, the integral relationship between oral health and overall health, and the critical role dental providers play in supporting health and wellness.

Vicki Brett
Dental Assisting Program Director

ECPI University | 1001 Omni Blvd., Suite 200 | Newport News, VA 23606
(Phone) 757-873-2423 x73929 | VBrett@ecpi.edu | www.ecpi.edu

Advocate: Virginia Oral Health Coalition

Dear Ms. Rockwell,

The Virginia Oral Health Coalition (VaOHC) is pleased to provide comment regarding the Department of Medical Assistance Services' (DMAS) application for Virginia's Section 1115 Waiver. VaOHC is an alliance of over 150 organizational and individual partners striving to improve the health of Virginians by ensuring that oral health is part of comprehensive health care. It is well-documented that poor oral health is linked to chronic disease, frequent emergency department visits and adverse pregnancy outcomes. To that end, the Virginia Department of Health (VDH) included oral health as part of a foundational goal within "Virginia's Plan for Well-Being," stating that Virginia's system of health care should aim for a **"strong primary care system linked to behavioral health care, oral health care and community support systems."**

Virginia's Medicaid program covers emergency extractions for adult enrollees, including an exam and x-ray. While far from a comprehensive benefit, an extraction can mean the difference between a fatal infection and a mouth free from pain. It also contributes to a reduction in use of the emergency department (ED) for dental issues and can help reduce inflammation that contributes to increased A1C levels in diabetics. Pregnant women enrolled in Medicaid and FAMIS MOMS have access to a comprehensive dental benefit.

A 2014 statewide survey conducted by the VDH found that over 11 percent of adults reported they had a tooth that needed to be pulled (extracted), and almost five percent of adults reported they had visited the ED for dental issues.⁴

We commend DMAS for its vision to address the health needs of Virginia's most vulnerable, through both the Medicaid Managed Long Term Care Services and Supports (MLTSS) and the Delivery System Reform Incentive Payment (DSRIP) initiatives; however, we are concerned that the absence of oral health is counter to the efforts across the commonwealth to create a comprehensive model of care and is not reflective of the entire array of services Medicaid-eligible adults are able to receive.

To that end, we provide the following recommendations, which are organized by DSRIP proposed projects:

System Transformation Projects

Oral health is linked to outcomes for birth, diabetes and other chronic conditions, and medical and dental providers must be able to communicate to improve overall health. To that end, oral health providers are an important part of the care team, and thus we recommend they are

⁴ 2014 Adult Dental Survey, Virginia Department of Health

included in the Virginia Integration Partner or “VIP” community. We recommend that VIPs provide oral health referrals, services and education to patients, as appropriate. Community health centers across the commonwealth are demonstrating the effectiveness of this approach and can provide a replicable model as VIPS emerge throughout the state. Additionally, as part of the commonwealth’s State Innovation Model (SIM) work, a diverse stakeholder group created five integrated care models that are reflective of current Medicaid benefits and include oral health services, education and referrals in primary care and ED settings. These models are shovel-ready and provide a framework for care delivery and coordination, data and electronic medical record (EMR) integration, provider education and communication. Each model can be augmented by VIPs to ensure oral health is included in efforts to provide comprehensive care.

Preliminary DSRIP Transformation Project List

While we recommend that oral health be included in all models of patient centered care, oral health is a pivotal component in two of the transformation projects identified in the DSRIP application. They are described below:

Emergency Department Diversion

Dental issues are often the number one reason Medicaid-enrolled adults visit the ED, despite the fact that no treatment is provided. Often, individuals present at the ED with severe infection due to a tooth abscess that needs to be extracted. Virginia Medicaid covers extractions; however, in the ED, a patient typically receives a prescription for an antibiotic and a pain pill (often an opioid). Stopping this cycle by integrating oral health referrals and education into all ED diversion programs is an important step in reducing inappropriate use of the ED. Several hospitals in Virginia partner with area safety net sites and dental clinics to curb use of the ED for dental issues with great success, such as Halifax Regional Medical Center and VCU Medical Center. As the VIPs address issues related to ED use, we recommend oral health be included in care models and data-sharing.

Condition-focused Initiative

As mentioned above, the SIM planning process resulted in five integrated models inclusive of oral health; safety net sites and other health systems throughout the commonwealth are also implementing excellent oral health integration initiatives. Thus, myriad integration models that include oral health and are sensitive to existing Medicaid dental coverage are available and can be scaled and replicated by VIPs to ensure that oral health is incorporated in appropriate condition-focused initiatives.

For example, research demonstrates the importance of good oral health as part of a healthy pregnancy. Partly due to research such as this, Virginia recently began to offer a comprehensive dental benefit to pregnant women enrolled in Medicaid. As the VIPs implement high touch care models designed to improve pregnancy outcomes, oral health education and referrals for care are important components. Additionally, diabetics have improved health outcomes and reduced

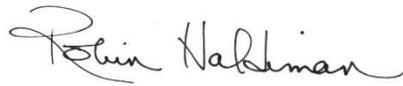
hospitalizations when they receive successful oral health treatment, and thus could benefit from coordinated care and education.⁵

Thank you for the opportunity to provide comment; we look forward to an ongoing effort to ensure that person-centered health care is the norm for all Medicaid beneficiaries. We are happy to provide any additional information or resources, or answer any questions.

Sincerely,



Sarah Bedard Holland
Executive Director



Robin Haldiman
Chair, Board of Directors



Tegwyn Brickhouse. DDS. PhD
Chair, Legislative Committee

⁵ Periodontal Therapy Reduces Hospitalizations and Medical Care Costs in Diabetics. March 2012. M. Jeffcoat, J. Blum, and F. Merkel, School of Dental Medicine, University of Pennsylvania, Philadelphia, PA, United Concordia Companies, Inc. (UCCI), Harrisburg, PA. Based on three years of data.

Advocate: Virginia Poverty Law Center

TO: Seon Rockwell

FROM: Jill Hanken

RE: Section 1115 Waiver

I support DMAS efforts to pursue delivery systems reform to improve services to Medicaid beneficiaries and bend the cost curve.

The waiver application contains a robust plan, but many important details are not yet provided. My particular interest is to ensure that:

- Beneficiaries receive quality health care in a timely manner
- Beneficiaries' due process rights are protected
- DMAS conduct very stringent oversight and comprehensive analysis to ensure that providers and health plans are meeting all requirements and expectations
- Beneficiaries and their families/advocates must be formally involved throughout to provide comments and feedback

Regarding MLTSS:

- I urge DMAS to incorporate some managed care that is not built on the risk-based capitation model. There is room in this demonstration (as well as the DSRIP demonstration) to utilize a primary care case management system as an alternative approach – whose results can be measured and compared to the other model. Thus, I do not support the waiver of Freedom of Choice protections for participants (p. 29)
- There must be avenues for people to change MCOs or opt out of managed care entirely. It is especially important for individuals to be able to demonstrate good cause for such changes.
- A more robust Ombudsman program is needed to assist individuals who have questions, complaints, and those who need appeals.
- The waiver of amount, scope and duration of services (p. 29) is worrisome without more details. In the CCC waiver, my understanding is that there are enhanced services, but no existing services are reduced. Is that also proposed for MLTSS?

Regarding DSRIP:

- The plan requires the VIP providers to contract with MCOs. I don't understand this design element and the relationship between the "coordinating health system" and the MCOs. I urge DMAS to allow VIPs, Affiliate Providers, and the health systems to operate independent of MCOs (especially capitated, risk-based MCOs). This could also result in greater cost savings for the state. Thus, I do not support the waiver of Freedom of Choice protections for participants (p. 29)
- VIPs will select for a "menu of projects" to achieve goals. What are those projects?
- I support the innovative proposals to work closely with community partners, school nurses, supportive housing, mobile clinics, employment supports, etc.
- "Patient engagement strategies" (p. 26) are not defined. Depending on actual design, this could be problematic for certain beneficiaries.
- It appears that the non-federal share of DSRIP costs has not yet been identified. (p. 28) It is difficult to fully endorse the plan without know how Virginia will pay for its share.
- Waiver of amount, duration and scope is worrisome without more details. (p. 29) The existing package of services must continue to be the "floor", with enhanced services available.

Thank you for the opportunity to comment.

Health Plan Comments

Health Plan: AmeriHealth Caritas

AmeriHealth Caritas is pleased to provide comments related to the Virginia Department of Medical Assistance Services' (DMAS) Section 1115 waiver application. Please see below for our specific comments and recommendations.

1) *“DSRIP includes support for the establishment of groups of high-performing providers known as Virginia Integration Partners (VIPs).” (Program Description, page 3)*

AmeriHealth Caritas would like DMAS to consider allowing Managed Care Organizations (MCOs) to also serve in the role as a coordinating entity for a VIP partnership in coordination with a health system. MCOs can add value by bringing management expertise, infrastructure, and capital into the process.

2) *“Health Systems focused on addressing enrollees’ complex needs will coordinate the VIPs. Funds to support the establishment of VIPs and initial processes will be obtained through achievement of outcome measures.” (Program Description, page 3)*

AmeriHealth Caritas requests clarity as to which providers will become VIPs and how will they be selected. Additionally, we would like to know how affiliate health systems will be held accountable for supporting outcome measures.

3) *“Additionally, DMAS will require that selected plans have or achieve status as a Dual Eligible Special Needs Plans (D-SNP) in the localities in which the plan is selected to provide services.” (Virginia’s Plan to Test the Demonstration Hypotheses, page 6)*

AmeriHealth Caritas recognizes the importance of aligning enrollment for dual eligible members in the same MLTSS MCO and Medicare D-SNP. If a beneficiary chooses to receive their care in a D-SNP that is not aligned with his or her Medicaid MLTSS MCO, DMAS should encourage and facilitate coordination between the non-aligned MLTSS MCO and D-SNP. To enable this coordination, we suggest that DMAS supports a roster/data sharing dashboard that will help facilitate successful alignment while still being mindful of federal guidelines. AmeriHealth Caritas also suggests that DMAS aligns the use of any auto-assignment algorithm preference based on D-SNP affiliation with the full operationalization of the D-SNP provision.

4) *“Virginia had a SIM grant that they used to evaluate the appropriateness and applicability of a DSRIP demonstration.” (Rationale for the 1115 Demonstration Waiver, page 5)*

AmeriHealth Caritas requests the related SIM grant analysis and findings be made available to MCOs if possible.

5) *“Through the DSRIP, DMAS will focus on supporting the transition to alternative payment models.” (Virginia’s Plan to Test the Demonstration Hypotheses, page 8)*

AmeriHealth Caritas supports the use of alternate payment models and value-based purchasing to shift payments toward quality and outcomes-based measures. To support these initiatives, we request that DMAS collaborates with MCOs and allows flexibility for the development of proposed alternate payment models and value-based purchasing.

6) *“DMAS will use the VIPs to enhance the care delivery to the most complex MLTSS and Medallion 3.0 Medicaid enrollees.” (DSRIP Program Description, page 15)*

AmeriHealth Caritas supports leveraging strengths of MCOs and VIPs; however attribution methodology between an MCO and VIP should consider the impact to the MCO’s provider network negotiations. AmeriHealth Caritas recommends using methodology that avoids the possibility of health systems using member attribution relationship as a rate negotiation tool. AmeriHealth Caritas also would like to ensure that MCOs owned by health systems do not receive preferential treatment in rates or membership by contracting with their own health plan. DMAS should create a level playing field that promotes competition and innovation and supports entry of new health plans into the Commonwealth.

7) *“Establish data pathways between providers in the VIP partnership and data pathways between VIP partnership, contracted health plans and statewide system.” (DSRIP Program Description, page 15)*

AmeriHealth Caritas supports the Commonwealth’s approach to investing in and integrating data for purposes of better care coordination and management, as well as the use of the proposed integrated central system that will allow for reduction in duplicate services. However, such integration should not curtail innovation or competition for the proposed statewide care management system.

AmeriHealth Caritas supports the Commonwealth’s approach of leveraging existing technology assets of providers and plans to develop a solution. Providers and plans have already made significant investments in their Electronic Health Records (EHR) and data repositories that allow them to securely exchange information with other entities and health plans. We suggest MCOs should be allowed to retain their technology platforms and proprietary processes while still facilitating simple low cost data exchange through the proposed central system. Furthermore, we suggest that DMAS use existing standards as appropriate, as custom fields within a standardized document result in a fully customized transaction that may not be practical or cost effective in terms of a timeline and implementation.

In addition, it’s been our experience that technology and process are equally important. Process integration for these new programs requires new process flows that are compatible with the MLTSS program. The Commonwealth’s plans must account for considerable training, monitoring, and follow-up for development of this system. The Commonwealth will need to provide plans with

the difference between how participating entities codify their data. For example, provider EHRs typically classify drugs as RXNorm while health plans classify drugs towards NDC. Similar differences are found in the long-term services and supports and behavioral health areas. AmeriHealth Caritas would like the Commonwealth to provide existing transaction data for analytics. This secondary use of transaction data will allow for more timely and accurate data analytics.

8) *“DMAS would like to expand their REACH program that is for their ID/DD population that is currently in five regions.” (DSRIP Program Description, page 20)*

AmeriHealth Caritas request clarification on whether enrollees of the REACH program will be included as a mandatory population since the ID/DD program will still be administered separately at this time.

9) *“MLTSS program will be statewide and with a regional rollout while the DSRIP will be in a number of geographic areas around the state. Most likely in the more population dense areas. The Affiliated Provider portion will be in the same regions as the VIPs.” (Required application elements by CMS, page 23)*

AmeriHealth Caritas requests clarification on whether interested MCOs will be required to bid on all regions in the RFP or if MCOs may select specific regions on which to bid.

Health Plan: CareSource

Dear Ms. Rockwell,

CareSource appreciates the opportunity to offer comments on Virginia's Section 1115 Waiver proposal. CareSource is a leading non-profit managed care company based in Dayton, Ohio which has been meeting the health coverage needs of under-served individuals for over 25 years. Serving nearly 1.4 million Medicaid beneficiaries in Ohio and other states, CareSource has grown to become one of the largest non-profit HMOs in the nation. Through ongoing Medicare-Medicaid Plan (MMP) and Home and Community Based Services (1915c) Waiver contracts, CareSource has gained extensive experience with managing the full continuum of benefits for our most vulnerable members. We excel at providing community based, person-centered care coordination for a comprehensive array of acute, long-term care, and behavioral health services which support a broad spectrum of beneficiary needs.

CareSource believes that movement toward fully integrated, outcome-driven models of care is in the best interest of all beneficiaries (from the lowest acuity members to intensive/high risk). CareSource applauds the Virginia Department of Medical Assistance Services (DMAS) for exploring new integration concepts within their 1115 Waiver which will better align the Virginia healthcare system to deliver improved access, continuity, and quality for all Virginians. Additionally, the incorporation of innovative payment, value-based reimbursement models, which address both quality and long term cost-effectiveness, are key strategic elements which will establish a framework of sustainability for future Virginia DMAS models of care.

CareSource's experience as one of the largest MMPs in the U.S. confirms that achieving optimal outcomes in the complex environment of dual eligible/managed long-term support services programs requires a willingness to work collaboratively with our members, providers, partners, and stakeholders to address long standing fee-for-service processes which perpetuate a fragmented experience of care for our beneficiaries. CareSource feels that Virginia's 1115 Waiver design represents a shift in the right direction toward improved communication, accountability, and value, and we would welcome the opportunity to participate in such an innovative model.

CareSource stands in full support of the Virginia 1115 Waiver application as it is currently proposed.

Sincerely,

Anthony Evans
Vice President Integrated Care
937.531.3472

Health Plan: Delta Dental of Virginia

Dear Ms. Rockwell:

Delta Dental of Virginia (DDVA) is the largest dental benefits carrier in Virginia, covering more than 1.9 million people. DDVA is committed to protecting the oral health of Virginians, and through our foundation we have donated millions of dollars to support charity dental clinics throughout the commonwealth.

Although limited, the adult dental benefits that the Virginia Medicaid program currently provides are an important part of protecting oral and overall health for those who qualify. Having access to even a limited benefit may prevent those in pain from seeking costly care from an emergency room. These limited Medicaid benefits coupled with the safety net programs that we support offer access to care that could actually help save the Medicaid program money down the road. More importantly, as oral health care needs are met, other health complications may be prevented.

DDVA applauds the goal of the Department of Medical Assistance Services (DMAS) in applying for Delivery System Reform Incentive Programs (DSRIP) funding. Strengthening integration, coordination and communication among health care providers promises to improve outcomes for patients. However, by not including oral health providers in the DSRIP, the plan does not approach the health of individuals in a comprehensive fashion.

Since Medicaid does include an adult dental benefit, and enrolled pregnant women have comprehensive dental benefits, it follows that all efforts to strengthen and integrate coordinated patient-centered care in the Medicaid program should involve dental providers and oral health care.

On behalf of DDVA, I recommend that the DSRIP application include oral health and dental providers in all integrated partnerships, patient and provider education, community supports and improvements made to electronic health records communication. Furthermore, I recommend the DRSIP application acknowledge the network of safety net and charity dental care providers and include this network in the VIP community. I encourage DMAS to strengthen the DSRIP application – and take advantage of a critical opportunity to improve health for Virginia’s costliest and most medically complex patients – by including oral health in its integrated care design.

Sincerely,

A handwritten signature in black ink, appearing to read "Chris Pyle". The signature is fluid and cursive, with the first name "Chris" written in a larger, more prominent script than the last name "Pyle".

Chris Pyle

Vice President, Marketing & Government Relations

Health Plan: Humana

Humana offers the following comments in response to the Virginia Department of Medical Assistance Services (DMAS) request for comments regarding its Section 1115 Waiver Application.

Humana is committed to serving Virginians eligible for managed long-term service and supports (MLTSS) through our current partnership with DMAS as a contractor for the Commonwealth Coordinated Care (CCC) program. Through this program, we provide services to more than 9,700 Medicare-Medicaid Dual Eligible individuals (duals) and coordinate Managed Long-Term Service and Supports (MLTSS) benefits for more than 1,200 individuals. Humana currently covers more than 118,000 Medicare Advantage (MA) members and 120,000 Medicare Prescription Drug Plan (PDP) members across the Commonwealth, including approximately 3,600 duals enrolled in our plans in addition to the duals in our CCC program. Our commitment to Virginia's MA plan also includes our current rating of 4.0 Stars, which demonstrates our leadership in quality improvement.

Humana has been a provider of Medicaid MLTSS services since 2007, and currently serves more than 36,000 members nationally in both stand-alone Medicaid MLTSS programs and fully integrated models. Nationally, we provide coverage to more than 172,000 duals in our MA plans, many through our Dual Eligible Special Needs Plans (D-SNP) offered in 20 states across the country, including nearly 1,500 D-SNP members in Virginia. Through our experience with Dual-Eligible Demonstrations, MLTSS, and D-SNPs, Humana has developed strong capabilities for managing complex care. Given our extensive experience in long-term care programs, we are focusing our comments regarding the 1115 Waiver Application on the MLTSS program design and components.

Humana is also a member of the Virginia Association of Health Plans (VAHP), the principal state-wide trade association representing organizations providing services to more than 730,000 Medicaid covered lives. We have provided input into VAHP's comments regarding this waiver application. We endorse and concur with the comments and recommendations submitted by VAHP under separate cover. The following comments are intended to supplement those provided by VAHP.

We appreciate this opportunity to provide comments and are pleased to answer any questions you may have.

Based on our experience, Humana recommends the MLTSS program include the following features:

Program Design

- Humana supports the provision of fully integrated benefits through the MLTSS program. This enables plans to coordinate physical and behavioral health, pharmacy, LTSS, and transportation among community based providers to offer members the most person-centered and individualized care plans possible, and improve the identification and treatment of conditions resulting in better outcomes.
- Humana supports a Model of Care similar to the CCC program, as it encourages highly engaged relationships with providers and administrative efficiency for the overall program. This also promotes continuity of care for members transitioning from the CCC.
- Humana supports requirements for MCO plan licensure, certification and accreditation, as well as the requirement health plans offer D-SNP plans in the same localities as their MLTSS programs.
- Humana supports an enrollment process which auto-assigns dual eligible members with Medicaid MCOs already providing members with medical benefits through an MA program in instances where that MA Plan also participates in the MLTSS program. This includes D-SNPs as well as stand-alone MA and PDP Plans. Alignment under the same plan across Medicare and Medicaid enables optimized coordination of clinical and social supports across the enrollee's full continuum of care, resulting in improved health outcomes
- Humana recommends consideration of statewide contracting, which include advantages such as increased program stability and greater MCO accountability for ensuring access to critical provider types in underserved communities. Statewide contracts improve continuity of care by allowing members to move between regions without changing health plans. If the program was to be bid regionally, Humana suggests limiting awards in regions with fewer Medicaid enrollees to no more than two plans to ensure adequate membership to support plan viability while offering beneficiary choice.

Beneficiary Protections

- Humana suggests DMAS work with the selected MCOs to outreach to consumers, caregivers, providers, advocacy organizations and community based organizations to provide information and education about this new program as early as possible, but especially during open enrollment and before the auto-assignment process begins. It will

be important to develop key messaging for stakeholders, including information about timing, Medicaid and Medicare enrollment, available benefits and services, providers, PCP selection, key contact numbers and other relevant details.

- Humana recommends members should be allowed to change plans under a “special disenrollment for cause” in the event an established PCP or key LTSS provider no longer participates with a member’s current MCO.
- Humana recommends a continuity of care period of 60-90 days as members transition from fee-for-service (FFS) and the CCC to the MLTSS program. At the time of enrollment, if a member is receiving current services through out-of-network providers, the MCO’s clinical staff will work with the member to either contract with the providers or transition to in-network services.
- Humana suggests DMAS convene stakeholder, provider, and community advisory committees to ensure members, caregivers, providers, and advocacy organizations have appropriate forums to share concerns, and for the MCOs and DMAS to report progress on initiatives to address these concerns.

Quality Improvement and Outcomes

- Humana recommends the use of standardized quality metrics applicable to the LTSS population. Understanding many LTSS quality metrics have yet to be standardized, we recommend collaboration between DMAS and MCOs. Key measures to consider include: CAHPS member satisfaction surveys, referrals to HCBS programs and facility-to-community repatriation rates. Quality measures need to be within the scope of plans’ benefit coverage and ability to improve outcomes; medical HEDIS measures may not be relevant when dual eligible members covered under Medicaid MLTSS are receiving their medical benefits through Medicare.
- Humana supports actuarially sound capitated rates which include the opportunity for MCOs to earn incentive payments for meeting quality goals. DMAS can use value-based strategies to improve access to HCBS services. For example, when an MCO successfully transitions a member from a nursing facility to the community, DMAS would continue paying the higher facility-based capitated rate (rather than the lower community-based rate) for a pre-determined period of time. This incentivizes MCOs to identify and transition members who are able and willing to live in their homes and receive services in their communities.
- To support quality improvement, Humana recommends DMAS share comprehensive demographic information with MCOs, including members’ medical history and existing

provider relationships to aid in the development of person-centered needs assessments, service planning, and care coordination requirements.

Provider Outreach and Engagement

- Important factors for providers transitioning to MLTSS include timely payment, education, and reduced administrative burden. Humana recommends collaboration between DMAS and MCOs to address these concerns and deliver consistent educational communication to reduce providers' administrative burden by developing simplified, standardized processes.
- Humana supports including the following messages in provider and member outreach efforts, to ensure stakeholders understand the goal of the program is not to reduce services:
 - Program design will ensure the transition to MLTSS will happen with the least amount of disruption to members and providers possible;
 - MCOs will have supports in place to help each member with the transition and will be available to address any issues which arise during transition; and,
 - Individuals will be able to maintain their current providers and the MCO's will strive to ensure their care is not disrupted.

Humana appreciates the opportunity to submit comments as DMAS prepares its 1115 Waiver Application, and we look forward to continued engagement in support of Virginia's MLTSS program.

Health Plan: Inova Health System/INTotal Health

Inova Health System and INTotal Health appreciate the opportunity to comment on DMAS' proposed 1115 waiver application to the Centers for Medicare and Medicaid Services. The Commonwealth's proactive approach to stakeholder engagement is essential in producing the best care models to help the recipients of these important health programs. This response is from a perspective of Inova Health System as both a provider and a managed care organization. Inova Health System is a not-for-profit healthcare system based in Northern Virginia that serves more than 2 million people each year. Inova is a comprehensive network of hospitals, outpatient services and facilities, primary and specialty care practices, health and wellness initiatives, and a commercial and a Medicaid health plan.

The Medicaid health plan, INTotal Health, is a Managed Care Organization (MCO) that specializes in Medicaid services and helps more than 58,000 members throughout Northern Virginia, Alleghany/Roanoke, Culpeper, Winchester and the southwestern regions of Virginia. Our job is to improve access to high-quality care for our members while reducing costs for taxpayers. INTotal Health is accredited by the National Committee for Quality Assurance (NCQA) and has met rigorous requirements for consumer protection and quality improvement for its well-established service programs and clinical quality.

Managed Long Term Services and Supports (MLTSS)

Inova Health System/INTotal Health fully endorse the movement of the LTSS population into managed care. The managed care model has proven time and time again its ability to improve recipient access to services, improve coordination of care and help control costs. The competition between participating MCOs is the driver of this improved quality and efficiencies. Besides driving program innovation, Managed Care Organizations bring additional predictability to the State budget.

Inova currently participates as a provider, a partner with local municipalities and as a managed care organization (e.g. Inova Cares for Seniors PACE, Medicare Shared Savings Program, Elderlink, INTotal, and Inova's participation in Commonwealth Coordinated Care as a provider). This multitude of perspectives, we believe, gives us a broad understanding of the challenges of implementation and makes us uniquely qualified to comment.

- MLTSS must overcome the challenges seen during the CCC demonstration

- Contractually require claim processing requirements for the MCOs to the LTSS providers.
- During the initial implementation phase, allow any willing provider to participate in networks while the MCO supports their integration into a more comprehensive delivery system.
- Value Based Purchasing, which aligns financial incentives, should be required but allowed to develop as the LTSS network migrates to managed care.
- Continue standing meetings between DMAS, LTSS providers and the MCOs.
- The initial implementation years should be focused on the transition to managed care with balancing and other quality improvement expectations being required in year three forward of the contract. This will ensure a better partnership between the MCOs and the LTSS provider community. This long term partnership is what eventually drives improved benefit coordination.
- Given the newness of managed care to many of the LTSS providers we do not encourage their initial participation in DSRIP. This will put another complication on this migration reducing the chance for success.
- It is important to be sensitive to the fact that for LTSS providers geographically outside of the CCC, they will be starting from “square one” in the process.
- While requiring MCO applicants to participate in a DSNP program is a prudent first step, we highly recommend, once the eligible population understands the merits of managed care, the eventual migration to a Fully Integrated Dual Eligible (FIDE SNP). This program will serve as the vehicle to complete integration of all benefits, both Medicare and Medicaid, all under a single financial umbrella.

Delivery System Reform Incentive Payment (DSRIP)

Moving healthcare financing from a Fee For Service (FFS) model, where providers are rewarded for volume of services performed, to a Value Based Purchasing model, where providers are rewarded for health outcomes of the populations they serve, is one of the highest public policy needs to help address ballooning healthcare costs. The Delivery System Reform Incentive Payment (DSRIP) program can be a key accelerant in achieving this transformation and the Inova Health System lauds the Commonwealth’s decision to take advantage of this Federal program.

The Inova Health System has made significant investment in creating a clinical integrated partnership through its Signature Partner Network and as such is very familiar with the Virginia

Integration Partners (VIPs) concept. This experience can help inform the Commonwealth's efforts as it creates the details of the VIPs. Key Inova learnings include:

- Partnerships should be among providers that have a shared vision and therefore State mandated partnerships will undermine provider participation. Any willing provider undermines the trust and accountability of an organized CIN.
- VIPs should be seen as an extension and partner with the MCOs, that together improve the current. VIPs should not be thought of as a replacement for the MCO.
- As described in the Public Comment Document, data sharing, coordination and quality informatics between the providers of the VIP and the MCOs are key for successful, transformative medical management.
- VIP projects should not be restrained to the list provided in the Comment document.
- Value based arrangements should be negotiated between the VIP and the MCO. Mandated arrangements stifle creativity and flexibility for the program to evolve and improve over time.
- Identifying attribution to a VIP should align with the current existing Federal program, Medicare Shared Savings Program (MSSP). The creation of new attribution models as defined in the program description seems overly burdensome for the provider to understand. Also, with small numbers, it is difficult to measure success or improved outcomes driven by performance vs. randomness. Any model using claims and reported health conditions on an assessment form will likely miss future high cost recipients that are identified through provider – patient interactions. The VIP should be accountable for all the attributable population not just those patients identified as “high utilizers.”
- The MLTSS program should be excluded from the DSRIP until the program matures. The providers most ready to implement the DSRIP are those that provide traditional medical services. Given the high rate of dual eligibles, these services will mostly be covered by Medicare. This is described more below in the section titled Linkage of DSRIP and MLTSS Procurement.
- Homelessness is something that requires a more focused approach. Successful programs must accommodate the complexity of this often chronic condition in all of its variations.
- It is important to recognize and include other non-traditional clinical support for this population such as Congregational Health or Grand-aids.

Linkage of DSRIP and MLTSS Procurement

The Inova Health System/INTotal Health recognizes the importance of fully integrated care delivery and payment systems to produce the highest quality and most efficient outcomes. Inova has concern about linking DSRIP to the new MLTSS program. The Medallion 3.0 program is a

mature managed population with providers, eligible members and Managed Care Organizations having well established relationships, communication paths and processes. Applying DSRIP to help accelerate Value Based Purchasing for this population is possible because of the environment that exists today.

Trying to apply DSRIP to the MLTSS program, while well meaning, is premature. There is not sufficient infrastructure in place to support DSRIP in the current environment. While the acute medical providers are the same ones that participate in the Medallion program, for most of the LTSS waiver providers as well as the LTSS waiver recipients, managed care is something completely foreign. It is important to first let the Managed Care Organization, LTSS provider community, and LTSS recipients create a foundation before complicating the relationship by overlaying DSRIP. Just like it took time for the Medallion program to mature and develop, it will also take time for MLTSS. It is better to apply the lessons of DSRIP in future years to MLTSS and not simultaneously with its inception. We recognize the time constraint on accessing Federal support for DSRIP activities, but think the application of DSRIP to MLTSS puts the larger endeavor at risk.

Health Plan: Molina Healthcare

Dear Ms. Rockwell:

Thank you for the opportunity to comment on behalf of Molina Healthcare regarding the draft Section 1115 research and demonstration waiver. As the nation's largest Medicare-Medicaid (MMP) health plan, and as a national leading provider of managed care and care management services for publicly funded health care programs, Molina is particularly pleased to offer our thoughts on building blocks that can help make the Managed Long-term Care Services and Supports (MLTSS) demonstration as successful as possible.

Our first suggestion is that we encourage CMS to view this waiver request in the context of Virginia's proactive work over time to improve the quality of care for Medicaid recipients through managing care and to control cost growth in long-term support services through effective management. Virginia was the first state to implement nursing home preadmission screening, which was developed in the early '80s. Over time, Virginia developed a uniform assessment instrument to make this screening process more consistent among agencies and local partners. Virginia was also one of the first states to deliver Medicaid managed care for children and pregnant women in pilot regions and eventually expand the program statewide. This waiver request encompasses the vast majority of Medicaid recipients and for the first time, the lion's share of Medicaid costs.

Our second suggestion comes from reviewing the stakeholder feedback you have received on your ongoing demonstration program for dual eligibles: the Commonwealth Coordinated Care program. There are clearly notable successes and important lessons learned from the program. However, a threshold issue that we have experienced and overcome in other markets is engaging providers (acute and LTSS), consumer advocates, regulators and other key stakeholders early in the process. It is essential that we work together to design a beneficiary centered care system that rewards improving quality, balances Home and Community Based Services (HCBS) to keep the beneficiary in their setting of choice and develops a value based reimbursement model for the provider community that incentivizes the right care at the right time and in the right setting.

At Molina, we have found that a targeted approach on managing care of all of the consumers we serve, combined with an around-the-clock focus on even more intensive care management for the subset of the consumers with the highest utilization, is the path to sustainable cost control without simply adjusting provider rates downward from the current fee for service levels. We were pleased to see that a focus on consumers with very high utilization was one of the objectives of your proposed DSRIP program and is also embedded in the approach that you are taking for the MLTSS program.

Similarly, our third suggestion is that as you assess your implementation timeframes, please consider doing all that you can within the administrative and resource constraints that you are facing to offer the MLTSS health plans that you select as wide a range of services as possible to manage. The more comprehensive the approach is to managed care, the better the plan is able to manage both the quality of care and the cost of care, closely linked metrics. It is axiomatic at Molina that quality care is cost effective care. Accordingly, the more opportunity there is to align the full range of services for an individual, the more successful the program will be in the long-term. We were very pleased to see in your 1115 hypothesis for the MLTSS that you identified reducing service gaps and providing coordination between physical health, behavioral health, and LTSS as key opportunities. We were also pleased to see the emphasis placed on social and community providers, whom we view as vital partners in a success program of managing long-term supports and services.

In fact, the goals that you have identified for the MLTSS are well-aligned with the federal government's core goal for DSRIP waivers: improving the quality of care for existing Medicaid recipients and building the necessary infrastructure to sustain this improvement. DSRIP and MLTSS have the opportunity to be leveraged together to both improve care in the short-term and to make systematic improvements in the longer term, thereby helping lock in the gains in both quality of care and cost effectiveness.

Thank you for the opportunity to comment on this comprehensive and timely waiver proposal. Please know that we wholeheartedly support this proposal and stand ready to assist in any way that you find helpful.

Sincerely,

Lisa Rubino
Senior Vice President, Strategic Products
Molina Healthcare, Inc.

Health Plan: Virginia Association of Health Plans

The Association is proud to represent our Managed Care Organizations that serve approximately 750,000 Medicaid covered lives. We appreciate the opportunity to provide public comment regarding the state's Delivery System Reform Incentive Program effort. As your trusted partners, we feel strongly about our role to support the Department in achieving its goals by providing the highest level of institutional knowledge and industry expertise. Our Members are truly vested entities in helping to bring the Department's concepts to fruition. It is for this reason, that we have crafted an industry response to the Department's DSRIP 1115 Waiver.

The relationship between Managed Care and the designated coordinating entities of DSRIP dollars has been noted as an ambiguous one in the seven states where the DSRIP 1115 Waivers have been approved. This has presented challenges for MCOs as they attempt to identify their roles during the implementation stage, while simultaneously planning ahead for a future that does not include additional DSRIP dollars. To date, there has not been a state that has executed this perfectly, however, we feel strongly in Virginia's capability to develop and implement a pragmatic and effective proposal that leverages the symbiotic strengths between the Department, Managed Care Organizations and their provider partners. Garnering both experiential and practical consult from our membership in Virginia and our colleagues around the nation, we have consolidated a response and questions for consideration on the Department's DSRIP concept in its current form.

There are some general principles in the existing 1115 Waiver proposal that are of concern to our Managed Care Plans. Managed Care Plans assume full risk for their members and employ strategies to most effectively manage their member's quality and cost of care. In doing so, Managed Care Organizations provide budget predictability for the Commonwealth's Medicaid program. As an industry, we invest a great deal of our own financial and intellectual capital, developing innovative strategies for managing our high-risk members. We do not feel that the Department's experience with the CCC program justifies the need to create an additional administrative layer for managing 'high-risk' members. If the goal is to bring greater budget predictability and highest-quality care to our most complex and vulnerable members by including them into Managed Care arrangements, we do not believe the current 1115 draft waiver has laid out the most effective way of meeting these goals. We do not support the formation of Virginia Integrated Partnerships as it is structured in the current draft as this seems to promote fragmentation and duplication, as opposed to reducing it.

We are most successful at managing our populations when we have; 1) full responsibility for managing the care of high-cost enrollees from a care coordination and utilization review perspective, 2) the ability to maintain autonomy in our contractual arrangements with providers, to include authority over who we participate with in our networks and autonomy from prescriptive the alternative payment models.

We have underscored our concerns and questions to consider, in more detail below:

1) Attribution of High-Risk or Super-Utilizer population to VIPs

Concerns/Questions to Consider:

- In the current structure, who is bearing the risk? If the health plan is bearing the risk, but not managing the benefit, how will this truly reduce costs, bring budget predictability and improve quality outcomes and care coordination?
- Our Managed Care Organizations are held to standards, set by both nationally accredited organizations (e.g. HEDIS and NCQA) and solidified in our contracts with state Medicaid agencies. We are measured on our performance on important dimensions of care and service that are incentivized by quality withhold arrangements-arrangements that place our internal assets at stake. Will VIPs to the same level of compliance accountability?
- What population is being considered here? Does this include Medallion 3 and future MLTSS populations?
- Currently, MCOs employ sophisticated risk-stratification tools to identify their ‘high-risk’ populations, for which they subsequently allocate internal resources to better manage these individuals. How will ‘super-utilizer’ populations be defined and identified in this proposal?
- What are the contracting parameters around VIPs/coordinating entities?
- How would a VIP network coincide with a health plan’s current network and the existing contractual relationship between the two?
- For commercial/MCO plans, what would the impact be for commercial line of business?
- In this structure, do MCOs have the autonomy to choose who they contract with in the VIP?
- Will members be required to change their providers during the attribution process? If so, how will continuity of care be mitigated?

2) Value-Based Purchasing Component

Concerns/Questions to Consider

- It is mentioned that alternative payment models will be implemented through the VIP networks in tandem with the MCOs. If this is to be done with a specific population, such as MLTSS, we do not recommend prescribing specific VBP models in the first seven years of implementations, particularly those that involve the provider's capability to share risk. There may be some pockets of PCPs/other providers that are capable of and have the critical mass necessary to engage in these models, but we feel strongly against the Department dictating any one model in its contract with MCOs, as this may ultimately present unintentional consequences for the member.

3) Data Component

Concerns/Questions to Consider:

- How would this system integrate with the HIE/APCD and other tools/HIT systems that are currently in use with the health plans and hospital systems?
- An enterprise system with this level of sophistication and interoperability would come with a sizable price tag (Epic's eHRs systems ranged between \$100 million-1.2 billion in 2015 and none of those include state-wide implementation). Would the state be able to leverage enough funds to build such a product? If full funding was not capable, who would be the responsible party/parties left to incur the additional costs?

We look forward to meeting with you over the next nine months and continuing to work through these issues with you.

Sincerely,



Doug Gray
Executive Director
Virginia Association of Health Plans

Provider Comments

Provider: AmeriCare Plus

I am writing to you to voice concerns from a Personal Care Providers perspective.

- 1) Additional work for provider office staff with no additional reimbursement as happened with the CCC program. For example, items such as tracking which provider the member is enrolled on a monthly basis. Managing and seeking authorizations for service from multiple MCO's on a monthly basis. Under the MLTSS program I understand the number of MCO's will increase which will require more time for providers to track where a member is enrolled. Increased office time to bill under the CCC program because of billing to FFS and three MCO's. This time will only increase with more MCO's in the MLTSS program. Flow of reimbursement slowed from 7 days FFS to 14 to 30 days with MCO's due to difference in processing requirements.
- 2) Providers are now subject to audits from DMAS, Anthem, Humana and Virginia Premier as a result of the CCC program. This requires more office time to maintain separate records for each MCO and FFS at no additional reimbursement rate. Also, providers are spending more time with auditors as a result of more audits from more sources. With the MLTSS the time spent with auditors could only be expected to increase due to more MCO's in the program. Again, will this be at no additional reimbursement rate to personal care providers.
- 3) Members being able to switch from MCO to MCO monthly. This has placed an undue burden on all providers to track the member status on a monthly basis. The members should only be able to switch from MCO to MCO on a quarterly or semiannual basis.
- 4) Loss of Members freedom of choice. The CCC program has had more eligible people opt out of the program than has been passively enrolled. The number one reason for opt out, as I understand it, is that the member's primary physician is not a participating provider or that a specialist physician is not a participating provider. I do not see how the MLTSS will be able to resolve this issue differently than the CCC program thus requiring many members to switch to a different primary physician which could not be good for continuity of care. If we want to achieve person centered care at a reasonable cost, the MLTSS program will need to find a way to incorporate many more primary physicians.

Suggestions for MLTSS program:

Have a standardized form for all MLTSS MCO's for authorizations for service such as the KePro form or have a system such as Atrezzo for authorizations that all MCO's have access to.

Have a standardized requirement for billing electronically such as we currently use with FFS for all MCO's. On the slim margins we currently have we cannot afford a clearing house.

Do not allow members to switch from MCO to MCO monthly. The member cannot possibly have any benefit of services when switching on a monthly basis. I suggest quarterly or semi-annual as a minimum enrollment time as most insurance plans are annual enrollment.

DMAS to coordinate Audits with all MCO's so that providers do not have multiple audits at the same time or in a short time frame.

Plan an abundance of provider training early in 2016 with the MCO's and DMAS as was done with the CCC rollout. The biggest fear of a new program is the unknown.

Establish provider advisory groups early in 2016 to get input on how to have a successful MLTSS roll out in 2017.

Thank you for considering my comments,

William E. Hurt, Jr.

AmeriCare Plus

V.P. Growth and Development

Provider: Bay Aging

FROM: Kathy Vesley-Massey, President & CEO, Bay Aging and EVCTP
on behalf of V4A

SUBJECT: Public Comment on the DSRIP Initiative

3.1 Transformation Step #1: Integrate Service Delivery

- AAAs, already in client homes, have the expertise and skill sets to deliver quality, effective home and community based services.
- AAA coaches visit 1,000 new homes per month and successfully incorporate home and community based services and resources into the client's transitional care.
- Monitoring system must be developed to ensure that all parties understand and adhere to protocol that will lead to sustainability. Provide incentives for comprehensive inclusion of public and private providers.
- All formation of Virginia Integration Partners will at minimum include community based organizations – AAAs, Community Services Boards and Federally Qualified Health Centers.

3.1.1 Team-based, Integrated Behavioral Health and Primary Care

- AAAs already play an important role in working with behavioral health and primary care health interventions by delivering low-cost, high-quality, impactful evidence-based programs.

3.1.2 Mobile Care Teams

- AAAs are already in client homes and connect people, either directly or through referrals, to other home and community based services – including rescue squads and other partners – to access the services they need.

3.1.3 Care Transitions and Diversions from Institutional Care

- A statewide provider network of Coleman Care Transitions Intervention practices already established with Virginia AAAs is very effective at addressing the social determinants of population health – proven to be far more impactful than primary care alone.

3.1.4 Addressing Super-Utilizers

- Incentivize primary care health systems, physicians groups and community based organizations to develop a system where emergency departments will be less utilized as a source of primary care.

3.2 Transformation Step #2: Build a Data Platform for Integration and Usability

3.2.1 Data System Development within VIPs

- Having worked with CTI, EVCTP has numerous measurable goals to be incorporated.
- AAAs have numerous goals and outcome recommendations to incorporate.
- Strongly recommend a single system to provide continuity of care among providers and other organizations.

3.2.3 Statewide Set of Minimum Data Standards

- Recommend AAAs and other community based organizations form workgroups to establish effective and relevant minimum data standards.

3.3 Transformation Step #3: Build Community Capacity

3.3.1 Training

- Establish a train the trainer protocol.

3.3.3 Telehealth

- AAAs, already in the homes, are a natural extension of this initiative. Many AAAs already working with telehealth groups throughout Virginia.

3.3.4 Housing and Employment Support

- Recommend partnering AAAs with other community based organizations to develop an effective database system containing up-to-date information on available housing and supports, and employment supports.

3.4 Transformation Step #4: Redesign How DMAS Pays for Services

3.4.2 Partner with Medicare

- Opportunity to partner with CMS Medicare-Medicaid with Care Transitions.

Provider: Caren Cajares, DNP, CRNA

I am a nurse anesthetist who currently provides sedation to the vulnerable population of special care dental patients (intellectually disabled, Alzheimer's, anxiety, chronic pain). I am overwhelmed with the decision not to include funding for this population in the latest budget. This population is in dire need of dental care, and for a variety of issues cannot comply with a simple dental exam and basic oral health cleaning and screening.

This lack of funding for primary prevention in turn costs the state of Virginia and the federal government millions of dollars in emergency room visits, extractions, missed work, and chronic health conditions that develop due to poor oral health.

Please reconsider this lack of funding.

Dr. Caren Cajares, DNP, CRNA

ccrna@icloud.com

Provider: Carilion Clinic Dental Care

Carilion Clinic Dental Care has a long history of providing dental care to underserved populations including those who are medically-compromised, developmentally or intellectually disabled, and HIV infected, along with children who have cleft lip and palate, and disadvantaged and disabled children. We also are strongly involved in education and training of healthcare professionals by way of a Dental General Practice Residency program and leading oral health education for medical students of the Virginia Tech Carilion School of Medicine and Physician Assistant and Nurse Practitioner students of the Jefferson College of Health Sciences.

The proposals enumerated in the Commonwealth of Virginia’s concept paper “Accelerating Delivery System Transformation in Virginia’s Medicaid Program” are totally in line with the practice and objectives we have followed for years. As a healthcare stakeholder, I wholeheartedly recommend that DMAS incorporate oral health as a component of each transformation step outlined in the DSRIP application in a complementary way to ensure the following: providers are knowledgeable about the importance of oral health; individuals enrolled in Medicaid have access to oral health education and referrals; and, the care delivery infrastructure supports full oral health integration of adult Medicaid dental benefits when they are realized.

Thank you for the opportunity to provide comment and I look forward to an ongoing effort to ensure that person-centered health care is the norm for all Medicaid beneficiaries. We at Carilion Dental are happy to provide any additional information or resources, or answer any questions.



Lee R. Jones, DMD

Section Chief

Carilion Clinic Dental Care

Provider: Carl O. Atkins, Jr., DDS

Ms. Rockwell:

As a member of the Dental Advisory Committee and a health care stakeholder, I recommend that DMAS include oral health and dental providers as part of the Delivery System Reform Incentive Payment (DSRIP) initiative in a manner mindful of the existing dental benefits offered in Virginia's Medicaid program, the integral relationship between oral health and overall health, and the critical role dental providers play in supporting health and wellness.

Sincerely,

Carl O. Atkins, Jr., D.D.S.

Atkins, Maestrello, Miller & Associates

Pediatric Dentistry, P.C.

804-741-2226

carl.atkins@verizon.net

Provider: Casey R. Tupea, RDH

Please accept this public comment submission regarding DMAS 1115 document MLTSS and DSRIP

I would like to touch on 2 main points:

1) The absence of a dental benefit, more specifically a dental benefit that includes not only basic dental care but also comprehensive and preventative

There are many medical problems directly related to or exacerbated by dental bacteria and plaque levels. In recent studies aspiration pneumonia in geriatric patients, and patients in long term care facilities have been linked to medication use and bacteria levels in the mouth. In many situations the pneumonia has resulted in death that may have been prevented with dental preventative and hygiene maintenance care. Research and personal experiences have shown me that a dental plan must be considered when trying to improve overall medical health and in the long run it will decrease unnecessary expenses.

Hospitals locally are seeing an increase in patients with dental emergencies due to lack of dental coverage. Instead of seeing a dentist patients are using Emergency Rooms and Urgent Care facilities as their treatment venues. Some of these situations are serious enough that they are leading to emergency surgeries and extractions and even admission to the hospital with serious infections that need ICU care. This is very expensive, many patients cannot pay the bill, and this could have been avoided if they had a dental benefit to visit a dental office prior to the emergency that ultimately left them no choice but to go to a hospital.

I have some case study information to submit to help support my discussion of hospital use for dental care. I have included an x-ray and dental chart.

57 year old female, had not been to the dentist in 15 years due to lack of dental insurance and no money for routine exams and cleanings.

Presents with 8 existing missing teeth and 7 broken teeth that are non-restorable.

Pain in the maxillary right quadrant area #4.

Patient visited “urgent care facility” 2 times in the last 2 months for abscess in maxillary right quadrant and at both visits the patient was given an antibiotic regimen to eliminate abscess, and was given no follow up instructions or options.

When patient presented in our office it was discovered that not only did the previously abscessed tooth need to be extracted but 6 other non-restorable as well. Patient will now need to replace all of the missing teeth with costly partial dentures to maintain function.

It could be argued that in situations like this that:

- A) Some patients are unintentionally abusing antibiotics and could be furthering another problem which is the spread of resistant strains of bacteria. Increasing the amount of inflated medical costs.
- B) Emergency care facilities are not providing patients that present with acute dental emergencies, information on affordable dental clinics for follow up care such as free or reduced fee dental clinics, and college dental clinics. Both of which are accessible by short drives to most Virginians.
- C) Patients are avoiding dental care due to lack of coverage and no means to pay out of pocket and in the long run it is costing more money for:
 - the frequent treatment of extensive infections with temporary remedies
 - tooth replacement to maintain healthy function after numerous extractions of broken and or non-restorable teeth.

2) The exclusion of the IDD population

All of the information above is applicable to the IDD population and many medical and dental problems worsen with non-compliant patients. In addition to non-compliance, IDD patients are often non-verbal and cannot explain what is going on medically and dentally. A large problem in IDD facilities is that there is a large turnover rate with staff due to poor benefits and pay combined with the difficulty and physically taxing nature of their job. If the patients do not have consistent staff who know normal and abnormal behaviors it is quite impossible to determine whether the patient could be having a deviation in behavior due to medical or dental problems. It is very important for these silent patients to have access to dental care on a regular basis by trained clinicians so at the very least they can receive a yearly exam and homecare regimens can be reviewed with the staff that cares for them.

Provider: CHIP of Virginia

Dear Ms. Rockwell,

CHIP of Virginia appreciates the opportunity to respond to the Virginia Department of Medical Assistance Services' (DMAS) request for comments on "Virginia's Section 1115 Waiver Application". CHIP of Virginia is a non-profit organization responsible for the development, implementation and maintenance of a statewide network of community-based maternal / child health and family support programs across the Commonwealth. Local CHIP programs provide services through a home visiting model focusing on healthy birth outcomes, equipping parents to be their child's first and best teacher, and increasing family stability and self-sufficiency. A CHIP team of a registered nurse and a parent educator provide services to low income families who are pregnant or have a child younger than the age of six (6). Through this evidence-based model, CHIP teams work in partnership with each family and their respective service providers to optimize achievement of full potential across a broad array of measurable outcomes. CHIP teams also support Parents as Teachers services, a home visiting model similar to CHIP without the same level of nurse involvement. In total, there are ten (10) regional programs that provide CHIP and Parents as Teachers services in 34 localities within the Commonwealth. As part of the Virginia Home Visiting Consortium, CHIP works collaboratively with other validated models of home visiting (e.g., Healthy Families, Nurse Family Partnership) to help serve families in many other localities as well.

As a participant in DMAS' stakeholder meetings, CHIP was pleased to see the emphasis placed on the underlying values and strategies that are core to our model of service delivery. To that end, we encourage DMAS to promote the inclusion of maternal child health home visiting programs as affiliates / community partners in the DSRIP application. While pregnant women and young children are generally not considered to be Medicaid cost drivers, specific high risk and high utilizer subpopulations such as pregnant women with gestational diabetes, preterm / low birth weight infants and young children with special health care needs would certainly fall within this definition as expensive to serve populations.

I. DSRIP System Transformation Projects

CHIP and other established MCH home visiting programs in Virginia have been proven to provide effective high-touch, culturally competent services in medically underserved communities within the Commonwealth. These services can serve as a solid foundation and a proven model for DSRIP waiver program activities focused on identifying and addressing

workforce development needs – particularly for Affiliate providers. In fact, the Virginia Home Visiting Consortium has a professional development system already in place that is appropriate for implementation with multiple types of Affiliate providers.

II. Clinical Improvement Projects

CHIP and several Healthy Families programs have in place existing formal partnerships with Medicaid MCOs that effectively and efficiently provide support services to address the non-medical needs of high risk pregnant women, young children with asthma, and young children at high risk of serious mental illness. In support of these models, CHIP and several Healthy Families programs have also established protocols and limited data pathways for the work undertaken with these Medicaid MCOs. These programs have been evaluated and proven to measurably decrease emergency department usage, preventable hospitalizations and poor birth outcomes. Families referred for these services often cannot be found by the MCOs, are non-compliant or are frequent users of emergency departments for non-emergency care. However, notwithstanding the proven success of these programs, without alternative payment models, their combined ability to meet existing demand are extremely limited. If integrated into DMAS' proposed Clinical Improvement Projects, these services could be significantly and immediately expanded and thus, further DMAS goals to facilitate stronger, bidirectional care models.

III. Condition-focused initiatives

As DMAS begins to develop the discussed Condition-focused initiatives, we respectfully request that the services currently provided through CHIP and other validated MCH home visiting programs be considered and included. Although traditional Community Health Workers clearly play an important role in the continuum of services, CHIP registered nurses and parent educators have been proven to play a critical role when included as part of the system. In fact, CHIP recently entered into a partnership with a pediatric practice in central Virginia to embed CHIP home visitors within the practice, working with families identified as high risk or non-compliant. These home visitors effectively support the person-centered planning approach, thus facilitating appropriate usage of medical services and social supports.

In conclusion, CHIP and other validated MCH home visiting programs already provide the type of high-value care for Medicaid enrollees with complex medical and social needs that the DMAS Section 1115 Waiver Application seeks to support. In fact, these programs are exactly the type of proven innovations that DMAS proposes to expand. Accordingly, these programs should be

included as foundational elements of the Section 1115 Waiver Application and the resulting work.

Again, CHIP of Virginia very much appreciates the opportunity to have participated in DMAS stakeholder meetings and to now provide DMAS with our thoughts during this comment period. We refer DMAS to our website at <http://chipofvirginia.org> for access to the discussed supporting data on the proven value of the CHIP model. Please do not hesitate to contact us if you have any questions regarding the information and views supplied herein or if you would like to arrange a meeting to discuss.

Very truly yours,

A handwritten signature in cursive script that reads "Lisa Specter-Dunaway".

Lisa Specter-Dunaway

CEO

Provider: Commonwealth Care of Roanoke, Inc.

Dear Sirs / Madam:

Thank you for the opportunity to submit comments regarding the Commonwealth's development of the Managed Long-Term Services and Supports (MLTSS) program. The experience obtained from the Commonwealth Coordinated Care demonstration project has provided valuable experience to be drawn upon to develop a fully functional managed care program for Medicaid recipients served in long term care facilities.

Following are our comments that we suggest be considered in the development of this new program. It is our intent to offer constructive suggestions to help in the creation of a system that is cost effective and efficient to work for program beneficiaries, the Commonwealth and providers.

Sincerely,

Commonwealth Care of Roanoke, Inc.

Claims Processing

1 - One of the ongoing issues with the CCC program has been continual problems related to claims processing and payment. While the MMP's have worked with providers to try to make improvements, this has been a slow process and issues still exist. One way to avoid these issues under MLTSS is to require any contracting insurance carrier to successfully process a comprehensive set of test claims to be submitted by DMAS for processing. DMAS has the expertise to develop a comprehensive data set of test claims covering different scenarios. The lack of a uniform testing process with the CCC program resulted in numerous payment delays and created substantial financial stress for providers. Thorough claims systems testing can avoid the issues experienced in the CCC rollout where the MMP's continually changed their claims edits and claims processing systems while developing an understanding of how to process Medicaid long term care claims.

2 - In addition to claims testing, requiring the insurance carriers to produce written claims submission guidance would give providers clear direction for the submission of claims. This will protect providers from having to go through the same "trial and error" process they have experienced under the CCC program to gain an understanding of the claims processing requirements and edits in place for the insurance carriers.

3 - Claims testing by DMAS should also include any subcontracted claims processor used by the contracted insurance carriers. Under the CCC program the use of subcontractors has resulted in numerous claims payment problems for providers that are continuing. Before any subcontractor is permitted to be used they, like the insurance carriers, should be required to meet the claims processing requirements under the DMAS testing process.

4 - The program needs to include a continuation of coverage requirement for the insurance carriers to continue to provide benefits until a safe transition to the community can be arranged for a beneficiary receiving LTC services. This will insure services are being received by program covered beneficiaries and protect providers from being required to provide services for which they are not paid while attempting to find safe placements in a community or a lower level of service setting.

5 - The MLTSS contracts with the insurance carriers should require that all carriers be able to process electronic crossover claims for Medicaid coinsurance for Medicare claims (both Part A and Part B). This would eliminate a long standing problem under the fee for service Medicaid program requiring providers to submit claims for coinsurance claims that do not cross over electronically.

6 - The MLTSS program needs to contain contractual provisions between the state and the insurance carriers to provide adequate customer service resources for providers seeking claims assistance. One of the ongoing issues for providers under the CCC program has been the inadequate customer service capability of the MMP's. This appears to be the result of an over reliance on the part of the carriers on the existing customer service call centers for the carriers other insurance products. Unfortunately those individuals are not adequately trained relative to the CCC program.

Case Management

1 - The case management process under the CCC program was not effective in providing services to individuals in the long term care setting. The MLTSS program needs to clearly define the role of the case managers. While case management may benefit individuals in the community setting to identify and obtain services, case management is not needed during the time the person is in a long term care facility. Under the CCC the case management functions proved to be duplicative of our current regulatory required service and burdensome / time consuming for our centers to provide time and information to CCC case managers. The need for

case management is really only needed at the points of transition in or out of a facility or to address continuation of services (re-authorizations).

Upon admission of new residents LTC providers need to be given a clear definition of the services to be provided and the time frame approved for services. Obtaining a clear authorization from the insurance carrier before services are delivered is essential to a smooth transition into the LTC setting for the program beneficiary. The program should have specific requirements for carriers to provide this service. This should include clear clinical criteria for services.

Insurance carriers need to provide assistance with the process of transition of the beneficiary out of the LTC facility to a community based setting when needed. Under the CCC program the MMP's have generally been disengaged from this process. While that is not an issue for the majority of cases, there is a subset of the population to be served under MLTSS that are difficult to place when they can be transitioned to a lower level of service. The expectation that the insurance carrier's case management services be available to assist with these cases should be part of the program. Including a continuation of coverage provision requiring payment to continue until an individual can be safely discharged from the nursing center to the community will provide an incentive for the insurance carriers to work with providers to arrange for a safe transition to the community. This will protect providers while insuring the best possible placement for program beneficiaries.

Benefit Eligibility for Services

1 - The CCC program continued to have requirements for providers to follow the regulations regarding the UAI for qualification of services and for the submission of PIRS forms. This is understandable given the optional nature of the CCC program and due to the continued Medicaid fee for service program. However, under a mandatory MLTSS program, both of these become redundant since the insurance carriers will have case management functions to approve the need for services being provided and the level of care. Continuation of both of these increases the costs to providers (both discharging hospitals and LTC facilities) and to the state. Both the UAI and PIRS processes originated at a time when the Medicaid system was substantially different from what is contemplated under the MLTSS. Taking steps through regulation or legislation to eliminate these redundant processes should be part of the MLTSS implementation.

2 - Eligibility for Medicaid services through the Department of Social Services can often be a long process subject to many delays in approval. These delays can be the result of problems in DSS obtaining the needed information for approval from beneficiaries applying for services or

due to the delays in the over-taxed resources of DSS. In either case this can delay processing of claims and payments. The MLTSS program needs to mandate that the insurance carriers allow for a period of at least 12 months for the submission of claims to protect providers from not being paid due to processes over which they have no control and little influence. In addition, the MLTSS system needs to provide for the filing of retroactive claims back to the date of eligibility for services, whether the retroactive payment comes from the plan or directly from DMAS.

3 - Currently there are no provisions for the approval of a direct admission of a Medicaid covered individual into long term care if the stay is expected to be less than 30 days. To effectively have the MLTSS system work this needs to be changed. Part of the reform of the health care delivery system is based on moving individuals into the most cost effective setting to meet their health care needs. LTC facilities are far more cost effective than acute care settings for individuals when their clinical needs can be met in the LTC setting. Providing for approval for payment in LTC facilities for less than a 30 day stay would open this avenue up for shorter term services in a lower cost setting thereby reducing costs in the long run.

4 - The CCC program did not provide an effective means for providers to identify which MMP covered an individual beneficiary under the program. The electronic alternative under the CCC program (the 270 / 271 file) was not effective due to the technical hurdles providers faced in accessing the information. Developing an electronic means to verify which carrier covers an individual would improve the efficiency and effectiveness of the MLTSS program as compared to the CCC program.

General

1 - From the perspective of providers, the more the contracted insurance carriers have uniform procedures and rules to follow the more efficient providers can be in working with the program. While the more extensive the differences are between payers, the more expensive it is for providers to do business with the payers. Where opportunities exist to mandate uniformity of processes between insurance carriers this should be included in the contracts between the state and insurance carriers to maximize the success of the program.

2 - The current CCC program contract between the insurance carriers and the state (the “Three Way Contract”) has little in the way of provisions available to the state to enforce compliance with the program’s requirements. In order to insure that the program requirements are followed the state needs to have the ability to influence actions by the insurance carriers through either the timing or amount of premium paid to the carriers. Once the claims processing is effectively

outsourced to insurance carriers, the state needs to have a means to compel the carriers to comply with the program requirements.

3 - Any measurements of performance on the part of the insurance carriers built into the program need to be carefully constructed to insure they truly measure compliance with the contract between the state and the carriers. Under the CCC program the MMP's reported that claims were being paid timely while providers experienced substantial build up in accounts receivable. The reporting by the MMP's only included clean claims and obscured the issues that existed with inconsistent edits, the lack of consistent applications of claims processing, and constant changes to the MMP's systems creating the situation where providers had to constantly revise claims submission without adequate billing guidance from the MMP's.

It would also be beneficial to measure the outcome of all authorization requests submitted, not just the number approved. Our experience with the CCC was that many requests for authorizations for services were denied up front by the payer but the only measurement of denials was denied claim payments. This does not allow for identification of trends of denial of services for which no claim will ever be generated.

4 - It is our understanding that the state intends to include some basic provisions in the MLTSS program to help insure the financial viability and success of the program. The things communicated so far to providers that we agree are essential to be included in a successful MLTSS program are:

A – An indefinite payment floor on rates based on the current Medicaid rate setting process.

B – Elimination of the opt-in / opt-out feature of the CCC program which led to numerous eligibility and payment issues.

C – Inclusion of a continuation of care requirement for any individual currently in the fee for service program upon transition into MLTSS.

D – Changes in the physician assignment process to address the problems in the CCC program of assignment of residents currently in LTC facilities to physicians who do not practice in the LTC setting.

Provider: Community Care Network of Virginia, Inc.

Dear Mr. Rockwell:

Thank you for the opportunity to comment on Virginia's Section 1115 Waiver Application which seeks to authorize implementation of the Medicaid Managed Long Term Services and Supports (MLTSS), the Delivery System Reform Incentive Payment (DSRIP) and transition administrative authority of three existing section 1915(c) into Home and Community Based Services Waivers into the waiver. Community Care Network of Virginia, Inc. (CCNV) is the Commonwealth's only federally qualified health center controlled network. As you are likely aware, almost 60% of the patients served by community health centers in Virginia have incomes at 100% of the federal poverty level and below. While the precise percentage of patients served by centers who are also in the aforementioned programs is not known, CCNV is certain its providers serve a disproportionately greater percentage as compared to other providers.

CCNV commends the Department of Medical Assistance Services (DMAS) first for its approach in strengthening the alignment of MLTSS and DSRIP. It is particularly appreciative of the DMAS commitment to "Think Big, Start Focused, and Scale Fast" in achieving alignment. The second area that deserves special recognition is that the waiver program is designed to, "enable providers, community support services, and Medicaid managed care plans (MCOs) the opportunity to better coordinate and integrate member care. Taken together, alignment of the programs and providing care coordination opportunities among providers, community support services and MCOs promotes a strong infrastructure likely to strengthen and integrate Virginia's Medicaid community delivery structure and accelerate value-based payment structures.

The expanse of the MLTSS program is welcomed as the waiver seeks to operate the MLTSS program statewide. CCNV's network of providers will certainly be integral to network adequacy for any MCO. CCNV invites DMAS to explore incentives it may provide MCOs to encourage them to strengthen the alignment of providers by contracting with safety net provider networks when possible. CCNV is convinced the approach of program alignment that DMAS is utilizing to achieve acceleration toward value based payments is certainly transferrable to provider alignment and that MCOs should achieve such alignment by contracting with provider networks where networks exist. CCNV's network providers have a long history reporting on quality measures as a condition of federal quality health center program participation by the Health Resources and Services Administration. In addition, CCNV network providers work together to improve the quality of services rendered by the network collectively by collaborating across

centers on quality initiatives. Finally, economies of scale can be achieved by provider network participation as opposed to contracting with each individual center.

CCNV invites you and other members of DMAS leadership to learn more about the CCNV network and why encouraging MCOs participating in the Section 1115 waiver application program to contract with network providers when possible will result in value-based payment reform acceleration as well as a decrease in the administrative costs often inherent to new programs. The inclusion of MCO program participation requirements to network contracting when available will enable DMAS to quickly capitalize on its commitment to, “Think Big, Start Focused, and Scale Fast.”

CCNV also welcomes an opportunity for its network participants to be considered Virginia Integration Partners. Again, please feel free to contact CCNV to explore participation.

CCNV extends to DMAS its sincere gratitude for the hard work its employees render on behalf of residents of the Commonwealth.

Sincerely,

Rene S. Cabral-Daniels, JD, MPH
CEO
Community Care Network of Virginia

Provider: Helen Ragazzi, MD, FAAP

To whom it may concern,

I am a pediatrician in Richmond Virginia and would like to comment on the Delivery System Reform Incentive Payment (DSRIP). I applaud the effort to support integrated, patient centered care but I recommend that the DSRIP application include oral health and dental providers as part of the initiative. As you know oral health is an important part of a coordinated, patient centered health system. Tooth decay is the number one chronic disease of childhood and preventive oral health services are a key part of making sure that children are healthy. Oral health is also linked to diabetes, heart health, and pregnancy outcomes. As such, dental health providers play a critical role in supporting not only oral health but overall health and wellness. They should be part of the integrated provider community.

Sincerely,

Helen Ragazzi MD, FAAP

hragazzi@comcast.net

804-350-8672

Provider: Jeff Leidy, DMD, FAGD

Dear Ms. Rockwell,

In my opinion, true cost savings with Virginia's Medicaid program will be realized only when basic comprehensive dental care is included. The increased cost of treating systemic disease caused or complicated by acute and chronic dental infection must be addressed. The significant and long-standing body of scientific evidence has been too long ignored. Now is the time for change.

Sincerely,

Jeff Leidy

Provider: Kenneth Stoner, DDS

As a dentist, I see firsthand, every day, the need to have oral health be a part of the overall health care of Virginia citizens. There is a tremendous need for them to receive dental care to stay healthy.

I have spent many days overseas, all day long, removing teeth that could easily have been saved, if only they had access to simple restorative care. Then I come home to Virginia and find a large group of people that are in the same boat. HERE. In the United States. Simple fillings could save thousands of teeth that are lost, much like in a third world country... And for the same or less cost.

Sincerely,

Kenneth E. Stoner, DDS

Provider: LeadingAge Virginia

Thank you for the opportunity to comment on the Department of Medical Assistance Services (DMAS) §1115 waiver demonstration application that is seeking authority to implement two strategic initiatives, including the Medicaid Managed Long Term Services and Supports (MLTSS) and the Delivery System Reform Incentive Payment (DSRIP) program.

LeadingAge Virginia believes the §1115 waiver is designed to align MLTSS and DSRIP as a means to reduce the escalation of Medicaid costs, and if effectively administered with the provision of quality health care this goal can be accomplished. We look forward to partnering with DMAS to assist our members in becoming engaged in this upcoming managed care initiative.

It is our understanding that beginning July 1, 2017, DMAS will implement the MLTSS program. Under the program, the majority of the remaining fee-for-service populations, including those eligible for the Commonwealth Coordinated Care (CCC) program, dual eligible members currently not eligible for the CCC program, and individuals receiving long term services and supports either through a waiver or who reside in a nursing facility, will be mandatorily enrolled in managed care. In December 2017, when the CCC program ends, DMAS will enroll these individuals into the MLTSS program on a phased-in basis. We encourage DMAS to take the necessary steps to ensure that this is not a burdensome process for providers and participants.

We also understand that DSRIP is a strategic opportunity for Virginia to partner with the federal government and invest in the transition of its payment and delivery system to ensure robust community capacity, integrated service delivery, and reimbursement based on achievement of high quality outcomes. In order to truly evaluate the effectiveness of the alignment of these strategic initiatives, we encourage DMAS to develop quality measurements of the healthcare provided at the beginning of the program. If cost savings are to be realized, the coordination of the best possible health care resources for the patient should not negatively impact the outcomes of the care that the individual receives. These quality measurements need to be an integral part of the two strategic initiatives, but without increasing the administrative burden on the providers. DMAS should ensure that the following criteria are included in the Request for Proposal that will be released in the spring:

- Require that health plans provide a care coordinator for every provider.

- Ensure that health plans that promote value-added services will actually provide the services, including, but not limited to, behavioral health, dental, pharmacy and podiatry. Require health plans to report by quantifying the value-added services provided.
- Ensure that health plans will be flexible with their benefits to meet the needs of the patient.
- Require a timely, standardized process for authorizations, including a process for weekends.
- Ensure that billing is a standardized across the plans similar to the traditional Virginia Medicaid process.
- Require health plans specify a quantity of claim audits and have parameters established for the impact of such audits and payment of audited claims.
- Require that all health plans provide a testing environment for claims prior to live claims submissions.
- Ensure that proposals have a complete alignment with nursing home regulations and requirements.

Additionally, LeadingAge Virginia strongly encourages DMAS to consider the following before moving forward with the program:

- Clarify the role of the Virginia Integration Partners (VIP) and ensure the inclusion and participation of small health service providers within VIP networks.
- Align the timeframes regarding transitions, authorizations, and patient care requirements.
- Clearly define “clean claims” across all health plans.
- Ensure participants have full access to service providers.
- Develop a process for ensuring that information is shared in a timely manner with post-acute providers.
- Ensure the 100 day spell of illness is not applicable and Medicare eligibility requirements apply.
- Ensure that there is not a lower of cost or charges – applicable RUG rates should be applied.
- Be flexible with DSNP and consider ISNP as well

In closing, the current process is experiencing significant issues in the timeliness of payments for authorized care at all levels of care. We hope that DMAS will resolve these reimbursement issues prior to moving forward with the alignment of MLTSS and DSRIP strategic initiatives.

Provider: M. Anjum Shah, BSDH, MS, RDH

As a health care stakeholder, I recommend that DMAS include oral health and dental providers as part of the Delivery System Reform Incentive Payment (DSRIP) initiative in a manner mindful of the existing dental benefits offered in Virginia's Medicaid program, the integral relationship between oral health and overall health, and the critical role dental providers play in supporting health and wellness.

Thank you!

Anjum Shah

BSDH, MS, RDH

Assistant Professor and Chair of Dental Hygiene Program Admissions

Department of Oral Health Promotion and Community Outreach

Virginia Commonwealth University School of Dentistry

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Mashah@vcu.edu

Provider: Marge Green, RDH, MS

Dear Ms. Rockwell,

As a licensed dental hygienist who has provided patient care in Virginia since 1979 as both a clinical practitioner and college educator, I strongly support that person-centered health care is ensured as the norm for all Medicaid beneficiaries. Long standing scientific evidence validates that poor oral health is linked to chronic disease and adverse pregnancy outcomes. Virginia data has shown that poor oral health leads to frequent emergency department visits. These significant costs to the individual, family unit, community, state health systems and society will continue to escalate should oral health not be included as a component of comprehensive care.

I commend DMAS in striving to address the health needs of Virginia's most vulnerable, through both the Medicaid Managed Long Term Care Services and Supports (MLTSS) and the Delivery System Reform Incentive Payment (DSRIP) initiatives; however, I recommend that oral health be included in the comprehensive model of care for all eligible recipients.

Integrated health care systems do recognize oral health providers as important members of the care team; therefore, I recommend they be included in the Virginia Integration Partner or "VIP" community.

I recommend that VIPs provide oral health referrals, services and education to patients, as appropriate.

As the VIPs address issues related to ED use, I recommend oral health be included in care models and data-sharing.

Thank you for the opportunity to comment and share my expertise in support of your endeavors to improve the quality of life for all Virginians.

Provider: Mark L. Radler, DMD

Dear Ms. Rockwell,

I am writing in response to DMAS's application to the Federal Government for the DSRIP waiver. As a Pediatric Dentist and Assistant Professor of Pediatrics at EVMS, I teach the Pediatric residents and medical students the importance of good oral health as part of the total wellbeing of all patients. It is essential that oral health and dental care be part of the Virginia's DSRIP initiative.

Key findings from the CDC

Data from the National Health and Nutrition Examination Survey, 2011–2012

- Among adults aged 20–64, 91% had dental caries and 27% had untreated tooth decay.
- Untreated tooth decay was higher for Hispanic (36%) and non-Hispanic black (42%) adults compared with non-Hispanic white (22%) and non-Hispanic Asian (17%) adults aged 20–64.
- Adults aged 20–39 were twice as likely to have all their teeth (67%) compared with those aged 40–64 (34%).
- 42% of children 2 to 11 have had dental caries in their primary teeth.
- 21% of children 6 to 11 have had dental caries in their permanent teeth

What is even more important is the oral health of people with disabilities, a population I know you are focused on serving. At the present time, in the Commonwealth of Virginia dental care for those people who are in the DMAS program has a cut off at age 21 years. Those of us in Pediatric Dentistry have prominently contributed to the dental health care of the children with disabilities. This care has not come easily in many cases and has provided these children with optimum dental care for their childhood and adolescence. Many of us have also continued providing care beyond the teen years as there are few providers willing to care for this population. In our Commonwealth, those patients (over age 21) who are in the DMAS program drop out of the system as the only coverage available for dental care are emergency extractions, exam and x-ray. This makes very little sense, in that all of the care provided through their childhood and teen years will receive no follow-up. From a preventive health viewpoint this makes no sense and is not good healthcare. Many adults and the disabled have the hospital emergency rooms for dental emergencies. There, they will only receive palliative care. To that

end, it is vital that the DSRIP program, if it is truly comprehensive, include oral health education, referrals and services as available.

We are talking about improving the health care of the population in the Commonwealth and comprehensive oral healthcare is essential to the well-being of any individual. It is well documented that oral infection from neglect has an adverse effect on the cardiovascular system as well as other systems and chronic diseases.

Virginia's DSRIP initiative must and should include oral health in a manner consistent with the current Medicaid benefit – understanding that comprehensive dental care for all who are eligible under DMAS is an important and vital long term goal. It should also be expanded to cover the most vulnerable members of our society, the disabled.

Sincerely,

Mark L. Radler, D.M.D.

Provider: Medical Society of Virginia

Dear Ms. Rockwell:

The Medical Society of Virginia appreciates the opportunity to comment on the proposed Delivery System Reform Incentive Payment (DSRIP) application on behalf of our almost 11,000 members. The Medical Society of Virginia represents physician, medical student and physician assistant members and aims to make Virginia the best place to practice and receive medical care. MSV is appreciative of the department's commitment to identifying new ways of delivering better integrated and more efficient care for Virginia's patients covered through the Medicaid program.

MSV agrees that it is critical that Virginia make needed investments to ensure high quality integrated care for patients served by Medicaid. We would encourage DMAS to convene a stakeholder advisory group to review the development of the Special Terms and Conditions that will be created for CMS, as this will build upon the proposed application and provide much needed specificity to make the DSRIP program successful.

MSV would like to comment on the following sections of the proposed application:

Program Design and Payment

MSV appreciates that the application will require contracted health plans to produce evidence of an adequate network of providers to ensure the Medicaid population will have robust access to health care providers. While MSV appreciates that contracted health plans will need to develop high quality outcome measures and models of care, we strongly encourage DMAS and plans to engage with providers early in the development process.

With such great emphasis on value based payments, risk sharing, and modification of financial incentives also included in the application, MSV encourages DMAS to engage the provider community to review these proposals. As many physicians are currently engaged in new care models and financial arrangements, we share the department's assessment that there is much to learn from the ongoing work in these areas. However, we know that many clinicians are challenged by the rapidly changing landscape. MSV believes the program's success will depend on the practical application of many of these arrangements and encourages DMAS to actively engage physicians on these topics as the DSRIP application and relevant components are finalized.

Administrative Simplification and Data Collection

MSV was pleased to see the application focused on transforming data collection so that it is easier to share among providers and settings. When physicians have access to high quality data, they are empowered to make the best care decisions with their patients. MSV strongly encourages DMAS to engage the physician community as they continue to develop data standards and administrative requirements.

Currently, each insurer has a different take on innovation, accountability, value based purchasing, and care communities. With this, each insurer creates an entirely new infrastructure necessary to support the insurer's individual definition of all of the aforementioned. For physicians, this means time is taken away from actually caring for their patients and instead is spent figuring out how to comply with the administrative components.

MSV strongly urges DMAS to reduce this separate and redundant system and engage with physicians to determine administrative practices that will result in capturing useful data for the Medicaid population. MSV is concerned that another expensive layer of administrative infrastructure will take funding away from the actual treatment of patients. Therefore, we caution that any planned Medicaid savings required by the waiver be conservative and have truly achievable projections. That way, if the savings do not materialize – as has been the experience in other states – the Medicaid program will not be burdened with re-directing patient dollars to pay back the federal funds. MSV continues to offer our assistance in identifying opportunities for streamlining the administrative requirements for participation in the Medicaid program so that you can receive the information you need to administer a strong program and participating physicians and providers can care for their patients in an effective, timely and efficient manner.

Expanded Access to Primary Care and Behavioral Health

MSV remains encouraged by the department's goals of expanding access to primary care and behavioral health for the Medicaid population. We are encouraged to see a stronger focus on coverage for mental and behavioral health and expansion of telemedicine services. We were also pleased to see the application mention the structural issues, such as overhead costs and staff burnout or turnover, that prevent expanded access. Given Medicaid's traditionally low reimbursements, MSV appreciates the department suggesting changing financial incentives to address these issues and stands ready to partner with DMAS to find workable solutions for our patients.

Care Transitions and ER Diversion

MSV was pleased to see the DSRIP application focus on care transitions and reducing non-emergent care in the emergency department, as well as the intersection between the two issues. We ask DMAS consider cautious cost-saving projections in both of these areas. To implement successful programs in these areas will require not only an initial upfront investment, but as beneficiaries access needed services and supports to achieve these goals, program costs may rise without a comparable decrease in other areas.

VIPS and Affiliate Providers

We appreciate the department's interest in pursuing innovative opportunities for strengthening Medicaid's provider network to meet the needs of this unique patient population. MSV respectfully requests the department engages the provider community as they further develop the concepts of VIPs and affiliate providers. Many physicians have created both formal and informal integrated care delivery networks to accommodate the needs of their patients; their insight will be vital to making this component of the DSRIP application successful.

MSV appreciates the opportunity to provide comments on the DSRIP application. We believe that Virginia can be the healthiest state in the nation and look forward to partnering with DMAS to achieve that goal.

With best regards,



Michael Jurgensen

Senior Vice President, Health Policy & Planning

CC: Melina Davis-Martin, Executive Vice President, MSV

Lauren Bates-Rowe, Senior Director of Health Policy, MSV

Ralston King, Senior Director of Government Affairs, MSV

W. Scott Johnson, Esq., General Counsel, MSV

Provider: New Horizons Healthcare

Dear Ms. Rockwell,

Thank you for the opportunity to provide comments regarding the Department of Medical Assistance Services' (DMAS) application for Virginia's Section 1115 Waiver. We applaud the in-depth research and investment of many hours of labor conducted by DMAS to ensure the preparation of a comprehensive proposal for accelerating transformation of service delivery, coordination, and compensation.

New Horizons Healthcare is a Federally Qualified Health Center (FQHC), located in Roanoke, Virginia, with a mission to increase access to affordable, high quality, comprehensive and preventive health care that is culturally sensitive for the citizens of the Roanoke area. Our health center has made tremendous progress toward full integration of behavioral, medical, and oral health care services for an underserved and vulnerable population. We recognize the interconnectedness of the body and mind to overall health and wellness, and with this in mind, we offer our comments, specifically with regard to the absence of *oral health* in your proposal.

It is well-documented that poor oral health is linked to chronic disease, frequent emergency department visits and adverse pregnancy outcomes. In fact, the Virginia Department of Health (VDH) included oral health in its "Virginia's Plan for Well-Being," noting that Virginia's system of health care should aim for a "strong primary care system linked to behavioral health care, oral health care and community support systems."

Virginia's Medicaid program covers emergency extractions for adult enrollees, including an exam and x-ray. While far from a comprehensive benefit, an extraction can mean the difference between a fatal infection and a mouth free from pain. It also contributes to a reduction in use of the emergency department (ED) for dental issues and can help reduce inflammation that contributes to increased A1C levels in diabetics. Pregnant women enrolled in Medicaid and FAMIS now have access to a comprehensive dental benefit.

The 2015 Roanoke Valley Community Health Needs Assessment documented that access to general healthcare services including overall access to services, primary and preventive care was tied for the second greatest response along with access to dental care. Access to dental care included the need for affordable services for self-pay and Medicaid adults and seniors, the lack of pediatric dentists, and the unmet oral health issues present in the community. Nearly 20% of

the population surveyed indicated that they have not visited a dentist within the past 5 years, and more than 15% indicated they had last visited a dentist between 2 years and 5 years ago. The chief barriers to accessing care were cited as lack of insurance, and the cost of dental services.

A 2014 statewide survey conducted by the VDH found that over 11 percent of adults reported they had a tooth that needed to be pulled (extracted) and almost 5 percent of adults reported they had visited the ED for dental issues.

We concur with the *Virginia Oral Health Coalition* in its recommendations regarding the inclusion of oral health in the waiver proposal, as summarized below:

Oral health providers are an important part of the care team; therefore we recommend they be included in the Virginia Integration Partner or “VIP” community.

Virginia FQHCs with comprehensive, integrated services offer replicable models, as can the demonstration integrated care model developed under the State Innovation Model (SIM).

Oral health should be included in all models of patient centered care, and is a pivotal component in two of the transformation projects identified in the DSRIP application.

Integrating oral health referrals and education into all hospital emergency department (ED) diversion programs is an important step in reducing inappropriate use of the ED. Several hospitals in Virginia partner with area safety net sites and dental clinics to effectively curb use of the ED for dental issues. As the VIPs address issues related to ED use, we recommend oral health be included in care models and data-sharing.

The SIM planning process resulted in five integrated models inclusive of oral health; safety net sites and other health systems throughout the commonwealth are also implementing excellent oral health integration initiatives. Thus, myriad integration models that include oral health and are sensitive to existing Medicaid dental coverage are available and can be scaled and replicated by VIPs to ensure that oral health is incorporated in appropriate condition-focused initiatives

Thank you for inviting our comments on your proposal, and for your consideration of our recommendations. Please feel free to contact me directly, should you have further questions or need additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Eileen G. Lepro". The signature is fluid and cursive, with the first name "Eileen" being the most prominent part.

Eileen G. Lepro, MPH
Chief Executive Officer

Provider: Russell Libby, MD

As a health care stakeholder, I recommend that DMAS include oral health and dental providers as part of the Delivery System Reform Incentive Payment (DSRIP) initiative in a manner mindful of the existing dental benefits offered in Virginia's Medicaid program, the integral relationship between oral health and overall health, and the critical role dental providers play in supporting health and wellness.

Russell C. Libby, M.D.

Provider: Tammy Cahoon Ridout, BSDH, RDH

Ms. Seon Rockwell, DMAS

As a health care stakeholder, I recommend that DMAS include oral health and dental providers as part of the Delivery System Reform Incentive Payment (DSRIP) initiative in a manner mindful of the existing dental benefits offered in Virginia's Medicaid program, the integral relationship between oral health and overall health, and the critical role dental providers play in supporting health and wellness.

The Virginia Department of Health created “Virginia’s Plan for Well-Being” outlining a cost-effective, integrated plan aimed at making Virginia one of the healthiest states in the nation. At the center of this plan for a stronger primary care delivery system is a recommendation to ensure oral health, along with behavioral health and community support systems, be part of a coordinated, patient-centered health system. Furthermore, a key component of the State Innovation Model planning grant was to develop integrated care models. Of note, the oral health integration stakeholder group developed five integration models to provide a framework for health systems to integrate oral health while being mindful of current Medicaid dental benefits and costs.

It is common knowledge that oral health affects systemic diseases, therefore when oral health is part of the equation there is less inflammation in the total overall health of the body. Oral health is a natural and necessary component of whole health, and thus an important part of comprehensive health care, particularly for medically compromised patient populations. When I worked in a hospital dental clinic 30 years ago, Dentistry was part of the interdisciplinary team and still should be a part of the equation. It makes no sense if one’s goal is to make Virginian’s healthy for us to cut off the head at the neck and not include oral health care that AFFECTS THE ENTIRE BODY especially when cost-containment is important to all of us!

Virginia Medicaid also has a dental benefit that provides enrolled adults with an exam, x-ray and extraction which is important to the difference between life and death!! When these emergency services are provided in a dental home and not an emergency room the cost savings is well known not to mention the use of emergency room staff could be provided needed care by others in the health care system saving valuable resources and possibly taking care of other medical emergencies faster and therefore possibly costing less for medical care needs. Research shows that inflammatory factors from oral disease can negatively affect diabetes, low birth weight babies, heart disease and other expensive medical conditions that could be minimized by maximizing your financial resources through providing these dental services as part of the package. Pregnant women enrolled in Medicaid have access to a comprehensive dental benefit which can decrease low birth weight babies and more extensive medical needs for the mother and infant. As a pharmaceutical dental hygiene educator, I was able to see firsthand examples all

over Virginia where decreasing oral disease and infection had a correlation with other systemic disease states. To strengthen Medicaid delivery and payment reform and support integrated care among its programs and providers, all Medicaid programs, should include oral health benefits provided by dental providers who care for Medicaid-eligible populations. Leaving out the mouth is no different than leaving out optometry, When the eyes tell it all so can the mouth!

The Department of Medical Assistance Services (DMAS) is applying for Delivery System Reform Incentive Payment (DSRIP) funding with a goal to strengthen how care is delivered and paid for in Virginia Medicaid's community. The central tenet of DSRIP's design is an integrated provider community of Virginia Integration Partners or "VIPs" who will share responsibility for integrated care, data, processes and communication, with a focus on Medicaid's highest utilizers. The DSRIP application, in its current state, includes behavioral health and long-term care providers as part of the VIP community with medical professionals; however, absent from this community – and all mentions of integrated care in the DSRIP application – is oral health and dentistry. To truly reflect comprehensive, person-centered care, the DSRIP application (and subsequent design) should include oral health providers in the VIP community, including safety net and charity dental providers, and integrate oral health into patient and provider education, community supports and improvements to electronic health records communication. The existing dental safety net comprised of community- and charity-based care providers, some of which are co-located with primary care providers and are already practicing person-centered, integrated care. Virginia dental professionals have been volunteering for over 20 years in an attempt to provide oral health promotion and healthier Virginians!! The Mission of Mercy community outreach alone shows that dental professionals in Virginia want to make a difference and has been an example that others states' dental stakeholders have tried to emulate.

The DSRIP application, in its oversight of oral health, excludes a foundational goal of "Virginia's Plan for Well-Being" and does not reflect truly the DSRIP application – and take advantage of a critical opportunity to improve health for Virginia's costliest and most medically complex patients – by including oral health in its integrated care design. Now is the time to get it right!

Yours in Oral Health,
Tammy
Tammy Cahoon Ridout, BSDH, RDH
Past President – VDHA
Past Board Member – VOHC
Dental Consultant, Author, Business Owner
Consumer Advocate
8414 Copperpenny Terrace
Chesterfield, VA 23832

Cc: Senator Amanda Chase

Senator Glen Sturtevant
Delegate Roxann Robinson
Delegate Lee Ware
Delegate Riley Ingram
Sarah Holland, VOHC
Susan-Reid Carr, President, VDH
Barbara Rollins, VDAF

Provider: Robin Mitchell, BSHS, RDH

Dear Mrs. Rockwell,

As a health care stakeholder, I recommend that DMAS include oral health and dental providers as part of the Delivery System Reform Incentive Payment (DSRIP) initiative in a manner mindful of the existing dental benefits offered in Virginia's Medicaid program, the integral relationship between oral health and overall health, and the critical role dental providers play in supporting health and wellness.

Robin H. Mitchell RDH, BSHS

DANVILLE COMMUNITY COLLEGE

1008 South Main St.

Danville, VA. 24541

Phone: 434-797-8517

Fax: 434-797-6428

Provider: University of Virginia Health System

Dear Ms. Rockwell,

The University of Virginia Health System (UVA) welcomes this opportunity to provide comments concerning Virginia's §1115 Waiver Application, specifically with respect to the Delivery System Reform Incentive Payment (DSRIP) proposal. We are supportive of the Department of Medical Assistance Services (DMAS) undertaking this comprehensive project which should help transform the Medicaid program in Virginia and accelerate a shift toward value-based payment. However, after reviewing the Public Comment Document we have some questions and concerns about the DSRIP proposal, and we offer the following comments with respect to specific sections included in the document.

Pages 9-10, Virginia Integration Partners (VIPs): The bottom of page 9 states that “VIPs will be developed based on seven core components.” This is followed by a list of eight (not seven) components. The eighth component states that, “Each VIP will have a single coordinating entity, a health system that serves in this leadership role. The VIP, however, will be a separate legal entity from the coordinating health system....” This requirement will be a significant barrier for UVA to serve as a VIP as we will need to obtain approval from the Board of Visitors to create a separate legal entity. Perhaps this core component could be modified as follows: “The VIP, however, will be a separate legal entity from the coordinating health system, unless the coordinating health system is a state agency.”

Additionally, we suggest that the third core component which currently states, “All VIPs will participate in full data integration” be changed to say, for example, “All VIPs will participate in data integration to the fullest extent possible.” Full data integration is a goal worthy of achieving as soon as possible but, realistically, is not likely to happen within the next five years. Setting the bar this high may discourage some entities from serving as VIPs.

On pages 11-13, DMAS discusses how DSRIP will be implemented through a two-pronged approach which will initially focus on the high-risk, high-utilizer Medicaid population, then quickly scale the program to benefit a greater number of enrollees. UVA understands the desire to focus on the high-risk, high-utilizer population, but we are concerned that this will narrow potential opportunities, and we urge DMAS to expand the scope of the waiver population to include a broader range of Medicaid beneficiaries. By doing so the state may encourage greater VIP participation and will provide VIPs greater latitude to accomplish projects that may be

conceived of in the future but have not been conceived today which may help the state achieve its goals of improving health, improving beneficiary experience, and bending the cost curve. We understand that DMAS plans to subsequently develop alternative payment models for VIPs to improve care for Medicaid enrollees who are not in the high-risk, high-utilizer population (as discussed on page 18), but having a broader range of opportunities in the earlier years may yield more savings in the program.

Pages 13-14, Testing the Hypothesis for DSRIP:

The potential measures for the three goals identified by DMAS on pages 13-14 are all outcome measures, and there are no process measures. We think it would be prudent to add some process measures, especially during the first three years, so that it will be easier for the state to show some improvement over the short timeframe of the DSRIP waiver demonstration. When dealing with populations with worse than average social situations, it will be much more difficult to make headway on outcome measures even if you are following correct processes.

Potential process measures that could be added are in the areas of workforce development, VIP design, and Information Technology infrastructure. For example, with respect to workforce development, there are not enough mental health providers at any level of training to build out in the time frame of this DSRIP proposal. The faster the build out, the more providers will demand in compensation and the more expensive it will be to hire them. Also, the further one goes from a city, the harder it will be to hire providers in those areas. Therefore, an initial process metric in the area of workforce development could be to build or accelerate training programs through incentives such as student loan repayment plans, relocation incentives, housing incentives, etc.

Goal 3 (page 14) aspires to bend the cost curve through decreased inpatient and institutional spending. However, providing wrap-around services for high utilizers will mean increased use of primary care services and a large outlay of resources for home based care, social services, and behavioral health, so it may not be realistic to expect that there will be overall decreased utilization or spending of these resources for this patient population. Many of the potential measures anticipate decreased utilization of very expensive resources. Assuming that happens, one would expect to see higher utilization in the areas of primary care and behavioral health; therefore, it might be wise to include measures of utilization in those areas as well, with the expectation that the utilization and spending on these services would rise.

Other more specific comments concerning the measures are as follows:

Goal 2 (Page 13)

Hypothesis 1: This hypothesis states: “If DSRIP invests in integrated bi-directional medical and behavioral primary care, then access to care will improve.” A potential measure for determining if the stated hypothesis is effective is increased adherence to scheduled appointments. There are many reasons why patients—especially those with worse than average social situations—may not adhere to scheduled appointments. These reasons often have more to do with the patient’s transportation options or other social issues, or even the appointment scheduling process. While we agree that a patient’s access to care will improve if he or she adheres to appointment schedules, we do not think adhering to appointments is a natural outcome of providing better integrated medical and behavioral health care.

Hypotheses 2 & 3: Patient satisfaction is the proposed measure for these two hypotheses. Patient satisfaction is a very poor indicator of quality of care, particularly among high risk and high utilizer patients, and we do not recommend using this as the only measure. In addition to patient satisfaction, we would recommend using another tool such as the SF-12 Health Survey that has been used in other studies regarding chronic complex patients.

Goal 3 (Page 14)

Hypotheses 2 & 3: We suggest that the pertinent measures for hypotheses 2 & 3 should focus on whether ED visits, readmissions, and admissions have decreased, rather than on whether “potentially preventable” visits have decreased as it will be difficult to segregate potentially preventable visits from other visits.

Hypothesis 4: It is unclear what “If contracted MCOs optimize the strength of the VIP networks” means. It would be helpful to restate this hypothesis more clearly.

Pages 14–17, System Transformation Projects:

Page 14, A-3: We suggest modifying this section (and bullet A-3 in the “System Transformation Projects” chart) to make it clear that training and workforce development needs should take into account treating individuals with substance use disorders in addition to individuals with behavioral health needs and developmental disabilities.

We are concerned about the sentence beginning at the bottom of page 14 which states, “Training will be developed so that behavioral health can be integrated as an extension of primary care.” If this means that DMAS intends to train more primary care providers so they can provide more

mental health services, we are skeptical that this will be successful. We hope the intent is to train more mental health professionals so that primary care providers have more professionals to refer patients to, which we believe will be a more successful model. For example, UVA is using the “Impact Model” (created by the University of Washington) at its Primary Care Clinic in Orange, Virginia to create better access to mental health services, and the model is working well. We have co-located a Licensed Professional Counselor at the clinic to serve as a Behavioral Care Manager (BCM). The BCM sees patients with mental health issues who are referred to him by the patient’s primary care physician. The BCM is supported by a UVA psychiatrist via a telephone link who consults with the BCM and oversees his care of patients. This model creates access to mental health services for the patient but does not unduly burden the patient’s primary care provider.

On page 15, DMAS states that it “envisions expanded investment into disciplines such as: nurse practitioners (including psychiatric NPs), EMS workers, addiction specialist, caregivers, peers (individual and family), and community health workers.” We suggest adding behavioral care managers to this list as well. Furthermore, if Medicaid does not currently pay for the services of all of these workers, we encourage DMAS to ask CMS to waive existing rules to authorize reimbursement for their services.

Page 15, A-4: We encourage DMAS to implement a prospective attribution model rather than a retrospective model. Ideally, the VIPs should be allowed to make an assessment of population of patients’ needs rather than working from a list of patients that *could* be attributed but will not necessarily be attributed to the VIP at year end.

Page 15–16, A-6: We are concerned that the expectations for data sharing may be too ambitious for the short time frame of the DSRIP waiver demonstration.

Page 18, Preliminary DSRIP Transformation Project List

Page 18, C.1: The need for behavioral health access is paramount for the DSRIP waiver demonstration to be successful. We emphasize our earlier point that more mental health professionals should be trained so that primary care providers have more professionals to refer patients to, rather than training more primary care providers to provide mental health services.

Page 20, C.7: We suggest adding remote patient monitoring for appropriate patients to the list of best practices and principles that could be implemented when transitioning Medicaid patients between care settings.

Page 21, C.9: To accelerate the adoption of telemedicine services offered under DSRIP, we urge DMAS ask CMS to waive existing rules to authorize payment under the Medicaid program for store and forward telemedicine, for remote patient monitoring, and for a broad range of telehealth services originating in the home or school settings. Also, we urge DMAS to authorize reimbursement for all providers currently eligible to provide services in the Medicaid program when they provide such services via telehealth meeting the appropriate standard of care. Additionally, we ask DMAS to clarify whether in alternative payment models VIPs will be allowed to use whatever providers they believe are appropriate, especially since the VIPs will be bearing the risk of treating the patient population.

We appreciate your consideration of our comments and we thank you again for the opportunity to provide input. Should you have any questions, please feel free to contact me.

Sincerely,

Larry L. Fitzgerald
Health System Chief Financial and Business Development Officer
University of Virginia

cc: Pamela Sutton-Wallace

Provider: Virginia Association for Home Care and Hospice

Dear Ms. Rockwell,

On behalf of the Virginia Association for Home Care & Hospice (“VAHC”), I write to provide the following comments regarding the Department of Medical Assistance Services’ (“DMAS”) proposal for a Section 1115 waiver for the Managed Long Term Care Support Services (“MLTSS”) demonstration:

1. VAHC is particularly concerned about the potential increased administrative burdens on home care agencies that implementation of MLTSS will cause. This concern is particularly worrisome because of the Centers for Medicare and Medicaid Services (“CMS”) requirement that at least two managed care organizations (“MCO”) be contracted within each region and DMAS’ stated goal of contracting with at least three MCOs in each region. Accordingly, VAHC believes that DMAS and/or its MCO contractors’ data requests should be uniform and should utilize the same format for submission. This will reduce the administrative burden on home care agencies by permitting them to submit the same data in the same manner regardless of the MCOs they contract.
2. Clean claims submitted by home care agencies should be paid in full within 14 days of submission. Moreover, DMAS should require that MCOs participating in MLTSS to proactively work with providers to resolve issues with unclean claims and ensure payment of all claims within 30 days of submission.
3. DMAS should require MCOs utilize a single portal or clearinghouse for electronic submission of claims. This will reduce the burden on home care agencies by providing a single system for all electronic claims to be submitted.
4. DMAS should require the MCOs participating in MLTSS to ensure that the reasons for termination of the agreement are clearly spelled out, provide for 30 days’ notice before either party can terminate and provide appropriate due process for appeals of such action.
5. DMAS should require the MCOs participating in MLTSS utilize industry specific contracts that recognize the standard of care and scope of services of home care agencies rather than a generic contract applicable to hospitals, nursing homes and home care agencies.
6. DMAS should clarify to providers the manner in which rate increases will occur when MLTSS is fully implemented. Specifically, will rate increases appropriate by the General Assembly require contract changes to implement or will the DMAS contract with the

MCOs ensure that any rate increase will be passed on to the provider on the effective date?

7. DMAS should clarify the savings it estimates and how it intends to achieve the savings through implementation of the MLTSS program.
8. To the extent DMAS intends to utilize the Dual Eligible Special Needs Plans (D-SNPs) through the MLTSS waiver, which category of D-SNPs will DMAS utilize, All-Dual D-SNPs, Full-Benefit D-SNPs, Medicare Zero Cost Sharing D-SNPs, or Dual Eligible Subset D-SNPs?

VAHC appreciates the tight timeframe DMAS is operating on for implementation of MLTSS and the many interests at play. VAHC looks forward to continuing to work collaboratively with DMAS towards a successful implementation of MLTSS.

Please do not hesitate to contact me if you should have any questions.

Respectfully yours,

Marcia Tetterton
Executive Director

Provider: Virginia Commonwealth University Health System

Dear Ms. Rockwell:

On behalf of the VCU Health System, I am writing to provide comments to Virginia's §1115 waiver application that will be submitted to the Centers for Medicare and Medicaid Services (CMS). A team of faculty and staff have reviewed the document and have offered the enclosed recommendations and edits for your consideration. The section headings and specific page numbers are bolded throughout the letter for reference.

DSRIP Program Description

Virginia Integration Partners (VIPs)

(p. 9) The Concept paper indicates that the “VIPs will share integrated care, data, processes, and communication and provide high-touch, person centered care for Medicaid’s highest utilizers and highest-risk enrollees”. There is a concern, however, that by exclusively focusing on those individuals who have moved into the high use/high cost category, an opportunity will be missed to achieve the defined goals (i.e., improved health, improved experience, and bending the cost curve) for the Medicaid population. DMAS has provided the criteria to determine “high utilizers” and “high risk” beneficiaries. Although DMAS’ data revealed that 72% of the enrollees were high cost in the preceding year, the opportunity to truly impact the population that will be drivers of cost and utilization over the course of the waiver may not be achieved if the identification of the population is too narrow. It is suggested that the population in the waiver be expanded to include the “emerging high utilization population” to mitigate the inappropriate utilization and engage with the population prior to the expenditure of significant costs. This suggestion is supported by a recent study published in Health Affairs regarding the experience at Denver Health. This organization did not experience short term positive results when focusing only on their high cost/high utilizer low income population, which actually showed a regression to the mean. Expanding the population to include those that have the proclivity to become high utilizers would allow the VIPs to work in collaboration with the Managed Care Plans to develop predictive models to identify factors for high utilization and introduce preventive strategies with community partners.

(p. 9) DMAS should clarify if it will allocate a percentage of the DSRIP funds to support the development of regional or statewide IT systems to assist VIPs in achieving waiver goals. Specifically, there is a reference to the utilization of a care management system. (“... The partnerships will also include care navigators, community health workers (CHWs), and be supported through a robust data driven care management system.”). Given the limited level of interoperability across health providers in the Commonwealth, the implementation of an integrated care management system may prove costly and require a designated allocation of dollars by DMAS to ensure this component of the waiver is implemented.

(p. 10) Item # 3 of the VIP Core Components states that “All VIPs will participate in full data integration”. DMAS should clarify the expectations for this component and specify if this includes sharing of clinical data across health care providers. This is a lofty goal to achieve at a regional level and may not be achievable given the timeline for the waiver.

Affiliate Providers

(p. 12) The Concept paper notes that “the goals of the VIPs align with the goals for MLTSS”. However, it is unclear if the expectation is to have a VIP work with multiple Managed Care Plans to support the complex populations in the MLTSS and Medallion 3.0 programs. If this is the case, it is proposed that the language in the following paragraph be modified to outline the intent to develop standardized metrics that will be utilized by participating health plans and VIP partners to minimize the data collection and monitoring activities required to support the initiative:

“DMAS and its partners will spend a significant amount of time in the first year of the demonstration, working with interested stakeholders to develop a governance structure and refine all necessary policies, protocols, contracts, metrics, and expectations to ensure successful implementation of VIPs throughout the Commonwealth.”

Testing the Hypothesis for DSRIP

Goal 3: Bend the Cost Curve (p. 14)

Hypothesis 2 and 3 outline several measures that will be challenging to monitor and report. It is suggested that metrics that examine overall utilization of the population such as ED visits, admissions, and readmissions replace those that propose reviewing data on “potentially preventable” volume. The latter may introduce a level of subjective review that will be difficult to standardize across providers and/or regions for evaluation purposes. It is also suggested that the “utilization of high cost settings” measure be deleted and replaced with a metric that is associated with rate of admissions to institutional settings for the population being managed.

System Transformation Projects

Project A.1 (p. 14) describes the intent to establish the VIPs, but does not provide any qualifiers to assist in providing the framework for the size or breadth of partners needed to achieve the desired outcomes. It is proposed that this project description be modified to read as follows: “Establish VIP delivery partnerships in select geographic regions across the Commonwealth *where there is an adequate volume of MLTSS and Medallion 3.0 enrollees who meet the criteria to support the transformation of the regional delivery system.*”

There is also an opportunity under **Project A.3 (p. 14)** to develop a comprehensive workforce training model to address both the clinical and social needs of the Medicaid beneficiaries. As a result, it is proposed that the following statement be modified to reflect the need to provide training for a broader group of individuals, including those who are medical professionals:

“DSRIP will support workforce training for health care and support services professionals, including school based providers where appropriate, to help meet this need.”

Finally, the level of data integration proposed under **Project A.6 (p.15)** may not be achievable within the timeframe of the proposed waiver. The goals outlined under this section are broad and encompass the need to address multiple systems and transform processes that impact a host of providers, agencies, and health plans across the Commonwealth. It is recommended that the language be modified to focus on the development of one to two critical IT projects (such as the suggested integrated care management systems or Emergency Department Information Systems under **Project A.7**) that can be uniformly implemented within the proposed scope and timeline of the project.

Financial Incentive Alignment Projects

The transition to alternative payment models as described under **Project B.1 (p.17)** will require full and transparent sharing of data between payers and providers to be successful. This will include timely sharing of historical information regarding the attributed population, timely access to payer claims history, and other central data sources for the enrolled/targeted populations. In addition, there is a need to ensure the eventual alignment of Medicare and Medicaid funding for the MLTSS population to ensure incentives are aligned with the delivery system transformation that will be required to achieve the desired goals. To the extent possible, it will be important to develop alternative payment models that 1) encourage the willing participation of all providers needed to support the population’s needs, 2) preserve existing, effective provider relationships to support patient-centered and coordinated care, 3) introduce reimbursement policies that support the integration of clinical services with community social supports, and 4) provide funding support for interdisciplinary teams that can address the needs of the targeted complex patient populations.

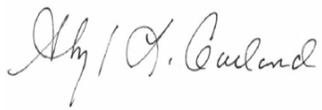
Preliminary DSRIP Transformation Project List

The State Innovation Model (SIM) behavioral health planning teams spent several months developing a framework that included research of models that effectively support the integration of behavioral health and primary care. It is proposed that these be referenced as models that VIPs could adopt to support the needs of the populations in their regions. In addition to these models, there are a host of proven models that can be implemented. It is proposed that a statement be inserted in **section C.1 (p. 18)** that references the adoption of evidence-based models to ensure that VIPs have an opportunity to be successful in addressing the behavioral

health needs of the populations served. Inclusion of this statement will assist in underscoring the importance of projects **C.1 and C.2**.

The VCU Health System team appreciates the opportunity to provide comments for this waiver. Please let me know if we can provide clarification regarding the items that are included in this document.

Sincerely,

A handwritten signature in cursive script, reading "Sheryl L. Garland", enclosed in a light gray rectangular box.

Sheryl L. Garland
Vice President
Health Policy and Community Relations

Provider: Virginia Dental Hygienists Association

Dear Ms. Rockwell:

On behalf of the Virginia Dental Hygienists Association (VDHA), I write to urge the Virginia Department of Medical Assistance Services (DMAS) to include oral health and dental providers as part of the Delivery System Reform Incentive Payment (DSRIP) initiative.

As part of the professional community, Registered Dental Hygienists are eager to advance improved oral health care access for Virginia's Medicaid beneficiaries. DMAS can make an impact by recognizing the integral relationship between oral health and overall health and the critical role dental providers play in supporting health and wellness. These efforts can maximize existing dental benefits offered in Virginia's Medicaid program.

Sincerely,

Susan Reid-Carr, BS, RDH

President, Virginia Dental Hygienists' Association

Provider: Virginia Health Care Association

Dear DMAS,

Thank you for the opportunity to provide input on the §1115 Demonstration Waiver application that would authorize both the Managed Long-Term Services and Supports (MLTSS) and the Delivery System Reform Incentive Payment (DSRIP) programs. As always, we appreciate the value DMAS continues to place on stakeholder input. These two programs will change how care is delivered for the 29,000 residents served in the over 250 nursing centers and assisted living facilities represented by the Virginia Health Care Association (VHCA). VHCA is proud of our role as the Commonwealth's largest association representing long term care. VHCA's strength, effectiveness, and integrity are significantly enhanced by the diversity of its membership which includes proprietary, non-profit, and government-operated facilities dedicated to providing the highest quality of care.

VHCA and its members understand that the §1115 Demonstration Waiver process can be an evolution as the Department and the Centers for Medicare and Medicaid Services (CMS) discuss the various aspects of the request for federal authority to implement these two substantial programs. We are appreciative of the effort made by the Department to educate stakeholders on the vision for MLTSS and DSRIP. In our previous comments on the MLTSS Model of Care (submitted September 28, 2015) and the DSRIP Concept Paper (submitted October 19, 2015), VHCA discussed that it was still unclear regarding the linkage of DSRIP and MLTSS for our members. We have attached these documents to this letter for reference. To the extent the issues identified in these previous submissions have not been fully addressed, we appreciate the Department's willingness to take those into consideration in terms of the §1115 Demonstration Waiver application.

As always, the Department has been responsive and willing to meet with VHCA staff and members to update us on the two programs as they have evolved, and we fully anticipate this continued collaboration as the §1115 Demonstration Waiver discussions commence with CMS.

In terms of specific comments on the waiver application, we would expand on two topics addressed in the previous public comments submitted by VHCA on DSRIP and MLTSS:

- 1) Virginia Integration Partners (VIPs); and,
- 2) value-based, alternative payment models.

Virginia Integration Partners (VIPs)

The interaction of the proposed VIPs with both the beneficiary's managed care entity and his/her service provider(s) remains somewhat ambiguous to nursing centers. The waiver application states that the purpose of the VIPs are to "provide high-touch, person centered care for Medicaid's highest utilizers and highest-risk enrollees." The application goes on to define "high utilizers" as "beneficiaries who have significant expenses due to high utilization of...inpatient care (hospital, *institutional*)...[emphasis added]." Nursing center residents would likely meet these criteria and therefore be a potential target population for the VIPs. Thus, the nursing facility resident may have yet another layer of care coordination and person centered planning in the form of the VIP.

Currently, federal and state law requires an interdisciplinary care planning team at the nursing facility to develop, implement and update a person-centered care plan for each resident. Under the Commonwealth Coordinated Care (CCC) program, an additional layer (or layers, based on our experience) was introduced in the form of care coordinators/case managers and the utilization review staff at the managed care entities. Our members generally have not seen significant added value from the managed care entity to the care planning component of a resident's care continuum. With the function of the VIP being a care planning/coordination function as well, we are concerned with yet another additional layer. To the extent the VIP serves to bridge the gap (as has been our general experience under CCC) between the managed care entity and the provider, the added resource would be a benefit. In summary, we are not clear how the VIP will interact with the beneficiary, the managed care entity and the providers, and therefore, we look forward to additional detail going forward.

Value-Based, Alternative Payment Models

The second topic we would like to expand on from previously submitted comments is the move toward value-based, alternative payment models. As indicated in prior comments, a value-based approach that provides additional payment (above normal reimbursement levels) would be workable, as the payment levels would account for the additional investments often necessary to promote even higher quality care. On the other hand, a "quality-withhold" approach would not work given that the Commonwealth's current Medicaid reimbursement methodology for nursing centers does not adequately address cost across the board as a starting point, and is losing ground relative to cost each year for at least the next four years.

Subsequent to our previous comments in this regard, the new biennial budget was introduced which continued an inflation deferral from 2016, affecting an additional four years (2017, 2018, 2019, and 2020). Additionally, the new budget proposed a second inflation deferral for 2018 which would further reduce payment relative to cost in 2018, 2019, and 2020. Combined, **these**

two inflation deferrals will reduce payment to nursing centers relative to cost by \$45.1 million in 2018 alone (with similar impacts in 2019 and 2020). A “quality withhold” approach to value-based reimbursement would be detrimental for a health care sector losing considerable ground on reimbursement of their cost of care for over 60 percent of their patient population. We strongly caution the Department against allowing such an approach under DSRIP and MLTSS.

Even a case rate or episode of care approach needs to be based on a more reasonable reimbursement of costs than is articulated in the most recent budget proposal for nursing centers. It is very difficult for nursing centers to improve care delivery without necessary funding of the cost of care. Nursing centers deliver quality rehabilitative care at a lower cost to individuals who previously relied on hospital stays for such care. When it comes to Medicaid long term care services, nursing centers are serving some of the most the frail Medicaid recipients as individuals remain in the community for a longer time and do not enter the center until their needs become even more acute. This trend in the nursing center population and services is a good thing for the health care system, but the ability for nursing facilities to continue in this role could be compromised by payment compression in Medicare, and in Medicaid under the recent budget proposal. We would urge correction to the reimbursement system in terms of recognizing costs of care before establishing unsustainable approaches under a value-based reimbursement system.

Again, on behalf of our membership, I would like to thank you for the opportunity to provide comments on the §1115 Demonstration Waiver application. We look forward to more details and continued conversation around these significant reforms.

Sincerely,



J. Keith Hare
President

Provider: Virginia Health Care Foundation

Dear Ms. Jones:

Thank you for taking the time and effort to so conscientiously research and create a Section 1115 Waiver application designed to strengthen and integrate the community delivery structure of Virginia's Medicaid program and accelerate payment reforms toward value-based payments. The combination of the Medicaid Managed Long Term Services and Supports initiative with the Delivery System Reform Incentive Payment (DSRIP) program is ingenious and creates exciting synergies to transform Virginia's Medicaid program.

Behavioral Health Integration

The Virginia Health Care Foundation (VHCF) has been engaged in promoting and funding the integration of behavioral health services with primary medical care for the past six years.

As such, I'm particularly interested in the DSRIP component of the waiver which ensures that Medicaid patients receive integrated behavioral health services within the community at low cost. (Goal 1) From 2000-2013, VHCF funded and administered an initiative, "A New Lease on Life". This underwrote nine 3 year grants that required collaboration between Virginia's local public mental health agencies and their local health safety net provider (FQHC or free clinic). We convened all nine of the grantees quarterly to in a learning collaborative to share experiences and lessons learned. The experience convinced us of the tremendous value of integrating delivery of behavioral health and medical care, and taught us about a number of significant challenges to achieving true integration.

Some things to keep in mind are the difference in approach and cultures of medical professionals and behavioral health professionals; the importance of using electronic health records that all involved health professionals can access and use easily; the tendency to have high "no-show" rates for behavioral health appointments, especially the first ones; the importance of continuously nurturing integration via organizational leadership and protocols; and the tremendous shortage of behavioral health professionals in most parts of Virginia.

At this point VHCF has funded 20 initiatives that integrate behavioral health with primary medical care. We will be happy to work with you to provide insights from past and current behavioral health integration grants, as the need for help or questions arise.

Behavioral Health Workforce Shortage

Nearly three quarters of the Commonwealth of Virginia is a federally designated mental health professional shortage area. This makes it extremely difficult to find and retain behavioral health professionals. We experienced this firsthand through the A New Lease on Life initiative. It was not unusual for a behavioral health provider to leave a position, and go to another one that appeared to be more attractive. It is definitely a "sellers' market" for behavioral health professionals in Virginia.

As a result of this experience, we explored how to address this very challenging workforce issue. All behavioral health professionals have a 4 - 6 year pipeline of post-graduate training and education before they can practice. The only exception is Psychiatric Nurse Practitioners (Psych NPs). They only require two years of training, and have prescriptive authority after they pass their boards and receive their credentials. They are the only behavioral health providers other than psychiatrists who have the ability to prescribe and manage psychotropic medicines in Virginia.

Unfortunately, there are only 155 Psych NPs currently licensed in Virginia. That is barely more than one per locality! We are delighted that the DSRIP component of the waiver addresses this issue of behavioral health workforce capacity and recognizes the value of investing in the training of more Psych NPs, in particular.

VHCF has taken a small step to increase the number of Psych NPs by providing full scholarships for existing nurse practitioners who work in Virginia's healthcare safety net and want to expand their scope of practice by returning to school for postgraduate education to become a Psych NP.

As we move more to behavioral health integration in Virginia, a nurse practitioner who has both medical and behavioral health training will be very valuable as a "translator" to both medical and behavioral health professionals in his/her practice.

In talking with the deans of some of Virginia's leading schools of nursing about the need for Psych NPs, they have indicated that they do not have sufficient faculty to expand or sufficient sites for clinical experiences and preceptorships. Much of this could be addressed as a result of your DSRIP proposal, and Virginia can increase the number of behavioral health providers as expeditiously and cost effectively as possible.

We hope your waiver proposal is successful. Thank you again for devoting so much energy and effort to move Virginia forward.

Sincerely,

Deborah D. Oswalt

Executive Director

Provider: Virginia Network of Private Providers

Thank you for the opportunity to offer comments on the 1115 Waiver that includes Managed Long-Term Services and Supports as well as Delivery System Reform Incentive Payment (DSRIP) strategies.

While the specific populations that we support in the Intellectual and Developmental Disabilities Waivers are scheduled to continue to receive their LTSS through the Medicaid Fee-for-Service for the foreseeable future, there are elements in this proposal which we will support and encourage for the following two reasons:

- Systemically, improvements in coordination of care, support for more seamless transitions between service/treatment settings, facilitating communication among service/treatment providers, increasing opportunities for community living, and maintaining quality are the right things to do in times of limited funding. And,
- Efforts to build partnerships among providers (public and private) to address the high utilization/high risk individuals who populate our programs.

Of the system transformation projects proposed, we were particularly pleased to see the references to workforce development especially for working with individuals with behavioral health needs and developmental and physical/sensory disabilities and the variety of clinical improvement projects (C1-10) many of which address critical needs in the ID/D community.

We would like to highlight the importance of integrated care, expanded access to primary care, emergency department diversion, expanded access to supportive housing, care transitions and diversions from institutional care, expanded REACH programs, and expanded employment supports.

It appears that you have favorably considered elements of the two proposals that we submitted and we appreciate your willingness to work to meet the critical needs of the individuals we support.

Jennifer G. Fidura
Executive Director