Department of Medical Assistance Services

Virtual Medicaid Managed Care Advisory Committee

July 20, 2021

10:00AM- 12:00PM

Conference Room 102 A and B

Meeting Minutes

Agenda Item	**Presenter**
Welcome and Introductions	Tammy Whitlock, Deputy of Complex Care
Overview of Managed Care Delivery System	Cheryl Roberts, Deputy of Programs and Operations
Cardinal Care Design Approach	Liz Osius, Director - Manatt Health Strategies, Manatt, Phelps & Phillips
Managed Care Advisory Committee Input on Cardinal Care	Discussion facilitated by Kinda Serafi, Partner, Manatt, Phelps & Phillips, Liz Osius and Cheryl Roberts
Managed Care Programs Update	Cheryl Roberts and Tammy Whitlock
Public Comment	Tammy Whitlock

Public Comment

Please sign up for public comment at the beginning of the meeting. Please send additional written public comment to katie.hill@dmas.virginia.gov by the end of the day to be included in the official meeting record.

Virtual Meeting Notice

This meeting is occurring in person at DMAS 600 E. Broad St, Richmond VA and virtually via WebEx.

Accommodations

Reasonable accommodations for this presentation will be provided upon request for persons with disabilities, and limited English proficiency. Please notify the DMAS Civil Rights Coordinator at (804) 482-7269 at least five (5) business days prior to the meeting to make arrangements.

The link to view live captions is:
https://www.streamtext.net/text.aspx?event=HamiltonRelayRCC-0720-VA2876

Agenda Item	**Presenter**

Welcome and Introductions - Tammy Whitlock, Deputy of Complex Care
Tammy welcomed members and did verbal introductions
Jennifer Fidura, VNPP
Sara Cariano, VPLC
Craig Connors, VHHA
Doug Gray, VAHP
Gayl Brunk, VA Association of Centers for Independent Living
Gwen Hinzman, LCAAA
Kathy Harkey, NAMI
Raziuddin Ali, BMAS
Rufus Philips, VAFCC
Scott Castro, MSV
Teri Morgan, VA Board for People with Disabilities
Keith Hare, VHCA-VCAL
Attendance reported from the Webex participation list
George Graham, VA PACE Alliance
Holly Puritz, ACOG
Shannon Wilson, DBHDS
Kathy Miller, DARS
Beth Ludeman-Hopkins, VACSB
Debra Blom, VA Association for Home Care and Hospice
Emily Roller, VHCF
Presenters: Kinda Serafi, Manatt
Liz Osius, Manatt

Overview of Managed Care Delivery System - Cheryl Roberts, Deputy of Programs and Operations
Comments from members to have more interaction in meeting so decided to get members involved in Cardinal discussion – Manatt will engage the conversation of strengths and weakness of the contract – Cardinal is a process and not an end game.

Cheryl provided history of the managed care programs in VA – idea of Cardinal not new but looking at where we can bring synergy between the 2 programs – adds value for members, providers, DMAS, MCOs and the Commonwealth – some of this alignment began under the Medicaid Expansion implementation – developed plan with goal date of July 2022 – did RFP for national consulting firm and Manatt was awarded contract.

Craig Connors – VHHA – are you planning on putting DD waiver services in Cardinal or will it remain carved out – for now will remain carved out.

Cardinal Care Design Approach - Liz Osius, Director - Manatt Health Strategies, Manatt, Phelps & Phillips
Manatt provided overview on process for consolidating the two contracts
Focus areas: model of care, and reporting/monitoring/oversight
DMAS eager to hear from members of the committee re: strengths to maintain, opportunities to improve on current requirements, what should be considered for inclusion re: model of care and reporting/monitoring/oversight

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Managed Care Advisory Committee Input on Cardinal Care - Discussion facilitated by Kinda Serafi, Partner, Manatt, Phelps & Phillips, Liz Osius and Cheryl Roberts

Strengths:

Consumer Advocates

Teri Morgan – ensure MCOs don't assess solely on medical necessity but quality of life services to remain in the community – Cheryl asked for an example – Teri: opportunities to receive services in integrated settings, work, employment, access to recreational activities, access to transportation – look at most flexible options to be included in community

Gayl Brunk – increased services when moved to managed care – would like to keep – somethings individuals may not know how to access – transition out of nursing homes, housing assistance – would like to see ensure that those are able to be accessed timely

Sara Cariano – time and distance standards and appointments for pregnant women and would like to see this expanded – our language re: EPSDT is more clear than other states and relatively strong

Providers

Craig Connors – network adequacy requirements – urge with final contracts to evaluate needs and limitations of some groups and ability to travel based on individual populations – contracts here good compared to other states

Keith Hare – specificity of contract – prescriptive nature good for members in LTSS – appreciate fact that plans have handle on LTSS and medical – maintain distinction

Gwen Hinzman – transportation huge – MCOs broker out and huge disparities in reimbursement rates especially in rural communities – when travel distance the reimbursement doesn't cover minimum wage – different rates – would like continuity across the board for all the MCOs – Kinda: Cheryl are you tracking the issue – will put on the consideration list for standardization in rates across contracts

Raziuddin Ali – integration of dental and behavioral health care in contracts

Craig Connors – value based arrangements – doesn't happen as much as it should – would like to see more creative and incent more of this

Rufus Philips – echo value based contracting – compliment DMAS and MCOs and free clinics under MedEx – was not easy process but once negotiated has been very smooth for clinics

State/Local Agency Partners
None

Opportunities to Improve:
Consumer Advocates

Sara Cariano – time to get an appointment could be strengthened especially high needs children – accessing service timely not just distance – access of Private Duty Nursing and Personal Care hours and monitoring of hours – more specificity around providers and providers who can handle special conditions – equity language re: language as a barrier or access to providers like child psychologists – access to services to prevent institutionalization – improve wait times for appointments – on paper network adequate but can be challenging to members

Teri Morgan – echo comments – beneficial re: language where MCOs provide additional support re: consumer directed and help with workforce issues – how and where to recruit resources and other educational resources – Tammy: understand issues and struggle to find and keep attendants – work with MCOs but need to be careful re: Employer of Record – can work to provide better resources

Raziuddin Ali – DMAS geared to vulnerable pops – justice involved or recently incarcerated – maybe better outreach to recently incarcerated re: what happens when leave

Teri Morgan – HB 169 – incarceration of people with disabilities – barriers is when someone goes in and getting access to their health information – can MCOs with consent of individual provide this info

Kathy Harkey – strengthen workforce – help develop workforce or cushion to fall back on - strengthen language and supports to assist in addressing the shortage in the behavioral health workforce.

Providers
Gayl Brunk – Personal Care hours and equity – one MCO allows to bill for interpreters – spend lot of money for interpreters – need language line or allowed to bill for interpreters – MCOs to be required to have portals to check auths and billing – not all have portals we can check so we have to call – service facilitation can bill some of the MCOs but not all for interpreters – appreciate DMAS clarification Personal Care hours not based solely on member score on bottom of DMAS 97 – may need ongoing clarification

(Cheryl asked that comments also be submitted in email)

Jennifer Fidura – interpreters – ADA issue re: sign language interpreters is a huge issue – would like to add to contracts – need at the professional level when someone arrives at ER is issue – strengthen consistency across MCOs – challenging to work with 6 MCOs – serv auths, billing, claims review – legitimate access not just listing of doctors especially for specialty pops is challenging – doesn't help if care coordinator in IN – need local tie in – Cheryl: is this actual care coordinators, call centers or happening just during COVID – Jennifer will research but thinks pre-COVID – acute care side for those on DD waiver is complicated to begin with and care coordinators are pretty useless – challenge with workforce post COVID – finding additional Consumer Directed services and workers

Scott Castro – echo Jennifer comments re: consistency re: approvals and billing – good opportunity re: prior auths – biggest complaints – physician reimbursement to get more providers to accept Medicaid and provide services

Keith Hare – specificity re: provider agreement and verbiage that not necessary for SNFs - claims processing and payment needs to be more specificity – care coordination is not significant value add and very complex pop with care plans in place – lots of turnover in those positions – more explicitly what SNF responsibility re: care planning or recognize SNFs are doing this already – contract enforcement – concern with encounter data and ability to set specialized rates and is data accurate -

CHAT (Public attendee): Leticia Rasnick to all panelists: 11:21 AM
It would be great to have the flexibility for parents and spouses to continue to provide attendant care after the PHE - Federal Emergency ends. To have this become permanent in policy would be a great help for members and families

CHAT: Gayl Brunk to everyone: 11:24 AM
I'll add to my email but to echo consistency: 1 year service authorizations for personal care attendant hours be required by all MCO's vs some doing 6 month authorizations. Also including timelines for when environmental mods and assistive technology requests need to be fulfilled. This leads into next question too in that a network to fulfill these requests is needed. Thanks

Model of Care:
<u>Consumer Advocates</u>
Sara Cariano – EPSDT for children in waiver and align with non-waiver children – based on need of child vs how child came into Medicaid

CHAT (Public attendee): Leticia Rasnick to all panelists: 11:29 AM
When the EPSDT children age out of this services it would be nice to have some type of transition services if they do not qualify for waiver services. The seems to be a gap with providing care threat the EPSDT child received to aging out at 21 and then not qualifying for any more services.

Providers
Craig Connors – more than just eligibility in care coordination – some don't have as M4 has flexibility – look outside eligibility category and look at utilization of care (eg frequent ER visits)

Jennifer – capture what is in practice re: guardianship re: decision making and ensure all MCOs on same page as where moving in VA re substitute decision making – through care coordination can be extremely helpful

Reporting/monitoring/oversight:
Consumer Advocates
Sara Cariano – more publically available data from MCOs – race, data, by geography – not in aggregate – more external review beyond EQRO – secret shoppers on network adequacy – appeals data to compare pre and post DeNovo – categories of appeals – change MCOs for good cause and data on why changing and if being granted

Teri Morgan – with performance measures – being able to translate data from measures for those making decision re: which MCO to choose – what is quality of MCO – Cheryl: how can we get our members to be more engaged in making an active decision – Teri: will give more thought – need more access to information to help educate on plans – not just services but quality and in additional languages

Gayl Brunk – SNFs following with MDS Section Q and tracking the data and transitioning out

Kathy Harkey – having quarterly discussion to address issues that may emerge

Providers
Craig Connors – policies like site of service to restrict members usage and network adequacy – access to care and continuity of care issues

Please feel free to send comments in writing – not the last of these conversations

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Managed Care Programs Update - Cheryl Roberts and Tammy Whitlock
Will see in packets the contract changes for July 1st – new services added to contract – aligning contracts where can

COVID flexibilities – state emergency over and moving things back and will see more Medicaid memos

Thank you for being so candid and appreciate relationship with stakeholders – ongoing process not an end

Thank you to Manatt

Public Comment - Tammy Whitlock
No [verbal] public comments

Written Public Comments received by email

LaVar A. Bowers - If I may add, I think it would be helpful if there were SWaM and or small business focused research to study the impact of the previous system and the projected system changes on SWaM and or small business providers. Scale of operation(s) and ability to scale up varies based on business size and infrastructure. This impacts businesses ability to operate effectively within the system.

Written Comments from Committee members

Steve Ford -

What are the strengths of the current Medicaid managed care contracts that DMAS should maintain?

From the VHCA-VCAL membership perspective, the current CCC Plus contract strength is the level of specificity on requirements for the MCOs in regards to LTSS providers. The prescriptive nature of the contract has been vital to holding the MCOs accountable to fix issues that have arisen over the life of the program. Under a consolidated "Cardinal Care" contract, continued specificity for LTSS and within LTSS, the certain provider types, will be absolutely vital. While the current plans have gotten a handle on the major differences between LTSS and acute care (Medallion), the single contract should maintain these distinctions to promote a continued understanding of the differences, but also to educate potential future new entrants that would enter without the multiple year history and learning curve.

Where are the opportunities for DMAS to strengthen and improve upon in its current Medicaid managed care contract requirements?

The primary areas of CCC Plus in which VHCA-VCAL members have experienced difficulty is in network provider agreement generic language, claims processing and payment, care coordination, and contract enforcement. From a more global perspective, the lack of reliable MCO data (not sure if this is a MCO, DMAS, or combination issue) has been a major concern.

Provider Agreements: The current CCC Plus contract requires that the MCOs create specific provider agreements for different provider types and that DMAS review and approve those agreements. However, our membership has indicated from day 1 of CCC Plus that the provider agreements are too generic and include verbiage that is both unnecessary and inappropriate for the services provided by NFs under the Medicaid program. With a combined Cardinal Care

contract, this concern has significant potential to be exacerbated by the inclusion of many non-LTSS acute care services in the MCO/DMAS contract.

Claims Processing & Payment: The current CCC Plus contract is good in that it specifies a uniform billing process and specified payment methodologies for NFs and a few other LTSS services, but more specificity is necessary based on continued MCO issues in this area. To be clear, the multiple years of experience and troubleshooting has vastly reduced the volume and severity of issues, but issues remain and language could be clearer, particularly around the crossover claim issues.

Care Coordination: The general feedback from members remains that there is often high inconsistency in the care coordination of NF residents (MCO turnover, lack of participation). To be fair, COVID has clearly impacted the last year and a half, but there were these types of issues pre-COVID so the NF expectation is that they will continue to be issue post-COVID. We remain of the opinion that more explicit instructions that integrate the NF responsibility for care planning be provided in the contract, or that the contract simply recognize the NF as the coordinating entity and provide a plan contact for additional services or intensive needs.

Contract Enforcement: Based on our members' years of dealing with claims processing/payment errors by the MCOs, our collective take is that contract enforcement provisions were not punitive enough (or enforced effectively) over the course of the CCC Plus program since inception. For example, fines did not appear to be substantial enough to force quick action. We have come a long way on the issues we are referring to here, but nonetheless, the contract should be bolstered in the regard to both avoid a repeat of the past difficulty, but also to set a higher standard for any future new entrants to the contract.

Data: The lack of reliable encounter data (again, we are not sure why this has been the case, but experience has indicated an issue) has already impacted DMAS' ability to set NF and Specialized Care rates, and the issue will only get exponentially worse for future rate setting which will rely entirely on the managed care claim data. Further, various reports that had been provided to NF and Specialized Care providers under the FFS system, such as the reports that support the NF's completion of the Medicaid cost report and the case mix reports that help the facilities in resource planning and validation of the data prior its usage in rate setting (like the inclusion of specialized care case mix in the regular NF rate setting last time), have now been unavailable for many years. Perhaps this has been corrected, but to date, we have not seen evidence that the data is now in good shape. As stated, it will only get worse if unaddressed, and therefore should be emphasized more in the consolidated contract.

What requirements should DMAS consider for inclusion in the following areas in the consolidated managed care contract: model of care and reporting, monitoring and oversight (including network adequacy)?

See above. Also, with the consolidated contract, DMAS may want to consider a change in the organizational structure of the contract. With the addition of more detail on acute care

services under a consolidated contract, it will be increasingly difficult for the providers (and the MCOs) to scrub through the boilerplate for the specifics with LTSS and within LTSS, the individual provider types. To the extent feasible, it may serve everyone's interests to organize the LTSS section apart from the acute care section, and to provide the major components (model of care, reporting, monitoring, payment policy) by provider type. There could be generic language that fully applies to all provide types which could be referenced, but to the extent an exception or modification is made for a specific provider, it should be clear and concise, allowing the MCO (and frankly the provider) to reference a section ("Nursing facility care", for example) of the contract instead of scouring the whole document.

Gayl Brunk –

- Strengthen and Opportunities to improve:
    - Require all MCO's to have portals for billing and checking authorizations-while I have a 8 page spreadsheet of portals that I need to check-or my staff-in order to provide all the services we do, it is certainly more efficient than needing to call and track down an answer on authorizations and is beneficial to also have the ability to print it off
    - Access to a language line or ability to bill the MCO's for interpretation-language (various languages as well as sign language) for providers. Some MCO's permit billing for interpreters but not all
    - Consistency
        - § do away with the need to have prior authorization for services that are required-ex: under CD services automatically have approval for CT/CV and a set amount of RA's and RV visits that permit for the 90 visit requirement-which is NOT quarterly. I of course would promote language change to quarterly visits vs 90 day visits as this seems to trip the MCO's up.
        - § 1 year authorization for personal care attendant hours vs 6 months authorizations by some MCO's
    - Timelines on environmental modifications and assistive technology requests being fulfilled. Ensuring that MCO's have adequate providers for these services-flexibility in being able to hire for these requests. People should not have to wait months for a ramp or bathroom modifications etc.
    - I appreciate that DMAS provided clarification that authorizations cannot be determined based on the score on the DMAS97 or that need doesn't justify request but the MCO provides no further explanation. I believe this needs further education as we continue to hear that the score does not warrant the hours being requested when the fact is I can be semi-comatose and still not "score" higher than 35 hours/week.
- Requirements that DMAS should consider for inclusion in consolidated managed care contract:

- Section Q MDS ensure the question is being asked if individuals wish to return home or to the community and then follow up on the transitions that occur

Craig Connors -

The network adequacy requirements in the MCO contracts are good elements. In the combined Cardinal Care contracts, we recommend varied network adequacy and time/distance requirements tailored to specific populations. Member endurance, transportation needs, comorbidities, caregiver availability, and other similar characteristics should be considered in setting the requirements.

The empowerment of value-based contracting is a positive provision in the current MCO contracts. Unfortunately, we don't think value-based agreements are as prevalent as they should be. We recommend strengthening the frameworks for VBC in the Cardinal Care contracts. Given the relatively low reimbursement in Medicaid, value-based incentives could encourage more providers – especially community based and outpatient service providers – to contract with the MCOs and engage in care management activities.

The care coordination requirements in the Cardinal Care contract should be reimagined and strengthened. MCO discretion is appropriate in some regards, but there should be more stringent requirements for care coordination based on utilization patterns (like high ED utilization), not just member eligibility category.

MCOs should be restricted in the Cardinal Care contract from implementing "policies" that impact in-network provider availability and access to care. For example, some MCOs nationwide have issued site of care policies that restrict access to contracted, in-network, providers for certain services. These policies circumvent network adequacy requirements and should not be allowed unless evaluated by DMAS first as network changes.

Sara Cariano-

12VAC30-120-370 (H) and (J), cited in the MCO contracts, states that the Department is responsible for accepting and responding to good cause requests. While this is allowed the be delegated, the Department cannot completely remove itself from the process or oversight of it. As far as I can tell, members interesting in changing MCOs are directed to the Managed Care Helplines but there is no way to submit a request to DMAS directly. There may be a mechanism for the Maximus to forward these requests to DMAS, but they cannot forward requests they refuse to take.

Additionally, enrollees are supposed to have access to the state fair hearing process if they are not satisfied with the good cause determination. When an enrollee calls one of the Managed Care Helplines to request to change their MCO, they are often told that they need to wait until

Open Enrollment. This is not a formal denial, there is nothing to appeal, and they are not provided any information on how to access the state fair hearing process. It is all done verbally, so no notice is provided.

Speaking more broadly about the MCO selection process, it is confusing to members that MCO selection must be done through a different website and phone number (not CoverVA, Commonhelp, or the local DSS) and the MCO selection information seems very siloed. One can't navigate to the managed care websites from CoverVA; the Medicaid Member Handbook page on CoverVA does not include the MCO member handbooks or link to them; and there isn't on option for MCO selection on the CoverVA phone menu.

It would be beneficial if the MCO selection process were more fully integrated into the eligibility and enrollment process. For example, an applicant could be prompted to select a preferred MCO after immediate after submitting an application on commonhelp, versus on the application. This way they could be provided additional information about the MCOs when being asked to select one, and they could indicate it on their online account. The process should also be aligned between FAMIS and FAMIS Plus. Families migrate between the two programs but don't fully understand that they are different programs. Having two different processes is confusing. It seems that having Maximus as the vendor for both CoverVA and the MCO enrollment process would allow for some more creative solutions.

Additionally, the application and enrollment process is already overwhelming for many, as are the many notices they get during this time. The MCO selection/assignment notice is sometimes even received prior to the NOA approving their application. This creates confusion regarding the start date of their coverage.