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Commonwealth of Virginia

*Virginia Board for People with Disabilities*

| **Mary McAdam** | *Washington Building, Capitol Square* | 804-786-0016 (TTY/Voice) |
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| *Chair* | *1100 Bank Street, 7th Floor* | 1-800-846-4464 (TTY/ Voice) |
| **Rachel Loughlin** | *Richmond, Virginia 23219* | 804-786-1118 (Fax) |
| *Vice Chair* |  | info@vbpd.virginia.gov |
| **Jamie Snead** |  | www.vaboard.org |
| *Secretary* |  |  |
| **Heidi L. Lawyer** |  |  |
| *Executive Director* |  |  |

September 19, 2018

TO: Tammy Whitlock

Deputy Director for Complex Care and Services

Virginia Department of Medical Assistance Services

FROM: Heidi L. Lawyer Signature

RE: Round 1 Contract Changes for January 2019 CCC Plus Contract

The Virginia Board for People with Disabilities, Virginia’s Developmental Disabilities Council greatly appreciates the opportunity to provide input on the round one contract changes for the January 2019 CCC Plus Contract. The contract is an important accountability mechanism for a program that provides vital services to thousands of Virginians with disabilities.

The Board believes that several contract provisions, including many related to transportation, should be further strengthened per the recommendations on the following pages. We believe there are opportunities to better ensure that (1) members are informed of, and given the opportunity to exercise, their rights including choice of setting, choice of care model, and ability to request accommodations; (2) members can access and receive high-quality services; (3) program requirements are clear and up-to-date; (4) program requirements are effectively enforced through adequate data collection, data analysis, and sanctions; and (5) references to individuals with disabilities are culturally competent. These changes would greatly improve the provision of health care services for people with disabilities, and thus better enable them to participate in community life.

Please feel free to contact me should you have any questions at 786-9369 or [Heidi.Lawyer@vbpd.virginia.gov](mailto:Heidi.Lawyer@vbpd.virginia.gov). Thank you again for the opportunity to provide comment.

| **Contract Reference**  **(Include**  **Sub-Section and Page Number)** | **Specific Contract Language at Issue**  **(Highlight or Underline Areas at Issue if an editorial change)** | **Reason for Amendment/Change**  **(Ex – Regulation change, inconsistent with stated policy, updating antiquated language, duplication, etc.)** | **IC Comment and**  **Final Decision** |
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| 4.3, pg 43 | “Coverage is required for children under the age of 5, persons ~~who are severely disabled~~ with severe disabilities, and…” | This suggested revision is to use people-first language. |  |
| 4.7.2.8, pg 54 | “In accordance with 12VAC30-120-924.B, the Contractor shall develop policies and procedures for Department approval prior to implementation, and at revision, and upon request that include the ability to determine the capacity of Members to self-direct services, the criteria for determining when a person receiving services is no longer able to self-direct services received, and regularly verifying that appropriate services are provided. The policies and procedures should also address intermediate steps the Contractor will use to address emerging issues prior to resorting to involuntary disenrollment from consumer-directed services. Intermediate steps could include assessing whether the provision of additional training and assistance to the member or representative could be beneficial and, if so, ensure training is provided through the service facilitator. It could also include collaborating with the member or representative, the member’s service facilitator, the member’s care coordinator, and the Department on how to address issues. The Contractor shall report instances of involuntary disenrollment from consumer-directed services to the Department per the CCC Plus Technical Manual.” | VBPD is pleased that the Department added the requirement that the Contractor obtain Department approval of these policies and procedures, in response to our feedback last year.  This provision could be further strengthened by better ensuring that the Contractor is acting in the best interest of the member and supporting the member’s informed choices to the greatest extent. MCOs may have a conflict of interest given the additional education and oversight components needed for consumer-directed services, and MCOs may not have the expertise to sufficiently determine when a member does or does not have the capacity to self-direct services. At a minimum, additional safeguards should be implemented, including requiring the Contractor to implement intermediate steps as suggested in the Joint Legislative Audit and Review Commission’s December 2016 report, *Managing Spending in Virginia’s Medicaid Program* (see pages 74-5) – such as facilitating the appointment of a representative, providing additional training and assistance as needed, and collaborating with the member or representative, service facilitator, and the Department - prior to resorting to the denial of consumer-directed options. The Contractor should also be required to report instances of involuntary disenrollment from consumer-directed services to the Department, which VBPD did not see in the current CCC Plus Technical Manual. |  |
| 4.7.3.6, pg 61 | “The Contractor shall ~~be prepared to~~ offer services in the home ~~if discharge to home is appropriate and consistent with the Member’s choice~~. The Contractor shall support the Member’s right to choose the setting in which he/she receives care and shall work to ensure that the care received is in the least restrictive setting to ensure the Member’s health, safety and welfare.” | This provision implies that the Contractor does not have to offer home-based services if the Contractor decides they are inappropriate. However, as the draft language goes on to state, the member has the right to make their own informed choices about the setting in which he or she lives and receives services. Therefore, the Contractor should be required to offer home-based services regardless of the Contractor’s opinion.  This provision also implies that the Contractor does not have to offer home-based services if they are not consistent with the member’s choice. However, this poses a catch-22 because the member has to first be informed of the option prior to being able to make an informed decision about what setting they would like. Members may also change their decisions over time, so Contractors should be required to offer the option of home-based services regardless of the member’s previous decisions. |  |
| 4.7.3.6, pg 61 | “The Contractor shall review with the Nursing Facility, and the member or the member’s representative, on at least a quarterly basis (or at such time as the interest is expressed by the Member) and whenever the Member expresses an interest in being discharged, any and all options for discharge from the Nursing Facility.” | VBPD is pleased that the Department added the requirement that the Contractor review discharge options whenever the member expresses an interest, in response to our feedback last year.  This provision should be further strengthened by requiring that the Contractor also review discharge options with the member or the member’s representative, not just the provider. This change would ensure that the member is made aware of, and reminded of, their right to choose a different setting. This is especially important given that one of the triggers for reviewing discharge options is “at such time as the interest is expressed by the member.” This change would also ensure that the Contractor considers the member’s desires during the review, rather than just those of the provider who has a conflict-of-interest. |  |
| 4.7.6, pg 64 | “~~Eligible~~ CCC Plus Waiver Members who are eligible per 12 VAC30-120-924.B may choose the Consumer-Directed model of service delivery for their personal care and respite services in which the Member, or someone designated by the Member, employs attendants and directs their care.” | This provision does not specify what makes a member eligible for consumer-directed services, leaving open the possibility for a Contractor to interpret eligibility differently than intended. The revision clarifies that eligibility is based on 12VAC30-120-924.B, for which the Contractor is required to develop related policies and procedures per section 4.7.2.8 of the contract. |  |
| 4.10, pg 86-7  4.10.28, pg 101  4.10.28.1, pg 102  Att. 5, pg 3645 | These sections repeatedly refer to the CL, BI, and FIS waivers as “ID/DD” waivers or “ID/DD/DS” waivers. | The Department should use the state’s current terminology of “DD waivers.” Reference to the old terminology throughout the contract may unnecessarily confuse individuals, particularly since the current terminology of “DD waivers” is used in other contract sections including 4.7 (pg 48-9), 4.7.4 (pg 62), 4.7.9.5 (pg 77), 4.11 (pg 102), 5.8. (pg 118), 8.2.1. (pg 153), 12.5.1 (pg 220), and Attachment 5 (pg 416-20). Reference to the old terminology also regresses to the practice of identifying and serving individuals based on diagnosis rather than need, which the Commonwealth intentionally moved away from in its waiver redesign. If the Department is concerned that MCOs or members may not understand the connection between the DD waivers and the previous ID/DD/DS waivers, the best location to provide that context is the glossary. |  |
| 4.10, pg 86 | “The Contractor shall not be responsible for transportation to DD waiver services for Members enrolled in the Community Living (CL), Building Independence (BI), and Family and Individual Supports (FIS) Intellectual and Developmental Disabilities (ID/DD) Waivers. Transportation to CL, BI, FIS (ID/DD) waiver services for these Members will be paid through Medicaid Fee-For-Service as “carved out” services.” | The first sentence, as written, implies that the contractor does not have to provide any transportation services for these members. The revision clarifies that the contractor is not responsible for providing transportation to DD waiver services, implying that transportation to non-DD waiver services is required.  The revision to the second sentence is to correct what appears to be a typo. |  |
| 4.10.17, pg 94 | “Members with a physical, sensory, intellectual, developmental, or cognitive disability. Members with disabilities~~, especially those residing in nursing facilities, dialysis or attending Day Support programs or Adult Day Health Care programs,~~ may require door-to-door or hand-to-hand transportation assistance.” | Other members with disabilities who are not addressed in the second sentence may also need additional levels of assistance, and are no less of a priority e.g., an individual with an intellectual disability who does not attend a day support or adult day health care program and who is traveling to a medical appointment. |  |
| 4.10.17, pg 94 | “Consideration must be made regarding: 1. Level of Assistance - Member assistance requested or when necessitated by the Member’s mobility status or personal condition. This includes door-to-door and hand-to-hand assistance. Curb to Curb is the default level of assistance. At the time of scheduling, the Contractor or their transportation broker shall inform the members or the member’s representative of their right to request assistance and shall solicit information from the member or the member’s representative to help determine whether assistance is needed.” | This provision should be strengthened by requiring the Contractor to inform members of their right to request assistance given that one trigger for the provision of assistance of “Member assistance requested.” Otherwise, members may not be aware of the need to request such assistance ahead of time.  This provision could also be strengthened by clarifying that the Contractor is responsible for soliciting information from the member or the member’s representative regarding whether assistance is needed. The Contractor would likely need information from the member, such as information regarding their health status and whether they think they need assistance, in order to make an accurate determination of whether assistance is needed. |  |
| 4.10.18, pg 95 | “The Contractor shall ensure that covered transportation services are available twenty-four (24) hours a day, three hundred and sixty-five (365) days a year.” | Availability and reliability of Medicaid transportation services has historically been a huge barrier for people with disabilities obtaining needed services. VBPD feels strongly that additional quality assurances related to transportation are needed to address this issue, beyond the broad and vague requirement that services be available 24/7. VBPD was pleased to see consideration of standards for scheduling, assigning, dispatching, pick-up, and delivery in last year’s contract revision process, and urges the Department to re-consider those same standards, or similar standards, this year. VBPD was also pleased to see consideration of requiring contingency plans, adverse weather plans, and a quality assurance program in last year’s contract revision process, and urges the Department to re-consider those same standards, or similar standards, this year. |  |
| 4.10.21, pg 97-8 | “At the time of scheduling, the Contractor or their transportation broker shall  Inform the member or the member’s representative of their right to request an attendant and shall solicit information from the member or the member’s representative to help determine whether an attendant is needed. The use of an attendant must be prior approved by the Contractor, broker, or internal transportation services…. The attendant, when required, must be identified and provided for the Member’s transportation needs within five (5) business days of approval. ” | This provision indicates that the use of attendants must be arranged for ahead of time, but does not clarify how the need for an attendant is determined and who is responsible for the determination. This provision should be strengthened by clarifying that the Contractor is responsible for informing members or member representatives of their right to use an attendant and soliciting information from the member regarding whether an attendant is needed. The Contractor would likely need information from the member, such as information regarding their health status and whether they think they need an attendant, in order to make an accurate determination of whether assistance is needed. |  |
| 4.10.23, pg 98 | “An escort or personal assistant is a parent, caretaker, relative or friend who is authorized by the Contractor to accompany a Member or group of Members who have special needs or who are minor children (defined as under age 18). No charge shall be made for escorts or personal assistants. At the time of scheduling, the Contractor or their transportation broker shall inform the member or the member’s representative of their right to request an escort or personal assistant. The Contractor or their transportation broker shall also solicit information from the member or the member’s representative to help determine whether an escort or personal assistant is needed. “ | This provision does not clarify how the need for an escort or personal assistant is determined and who is responsible for the determination. This provision should be strengthened by clarifying that the Contractor is responsible for informing members of their right to use an escort or personal assistant and soliciting information from the member regarding whether an escort or personal assistant is needed. |  |
| 4.10.26, pg 99-100 | This section requires NEMT providers to maintain trip logs that contain information regarding the driver, the member, the vehicle, and actual pick-up and drop-off times. | This section should be strengthened by adding requirements that the log also include the originally scheduled pick-up time for each member, originally scheduled drop-off time for each member, the member’s appointment time, level of service requested, level of service provided, and reasons for any issues that arose such as delayed pick-up or delayed drop-off. This information would better enable the Contractor, the Department, and other stakeholders to assess the adequacy of service provision. |  |
| 4.10.27, pg 100 | This section requires the Contractor to report missed trips on a weekly basis. | This section title should be changed from “Reporting Missed Trips” to “Reporting Transportation Issues,” and a new paragraph should be added requiring the Contractor to report information on a monthly basis regarding transportation concerns beyond missed trips. Missed trips are one indicator of inadequate transportation service provision, but there are several other indicators such as late trips (which may result in the individual missing their appointment) and individuals being dropped off at the wrong location (which has been reported before and poses grave safety concerns for individuals with disabilities). Complaint data may be the best way to get this information on a regular basis, since the provider trip log requirements are relatively limited at this point, but any additional data available should be reported as well. |  |
| 4.10.28, pg 101 | “4. Provide an analysis of the activities that the Contractor has in place that support the goal of ensuring that CL, BI, FIS (ID/DD) Waiver members have access to transportation services that are of ‘good quality, appropriate, available and accessible to the CL, BI, FIS (ID/DD) population. The analysis should include suggestions for improvement.’” | This provision could be further strengthened by specifying that the Contractor includes suggestions for improvement in its analysis. This encourages the Contractor to identify areas that can be improved, not just areas that are satisfactory. |  |
| 5.2.1.1, pg 107 | “At a minimum, the Contractor’s HRA shall effectively identify the Member’s unmet needs, and shall encompass social factors (such as housing, informal supports, and employment), functional, medical, behavioral, cognitive, LTSS, wellness and preventive domains, the Member’s strengths and goals, the need for any specialists, community resources used or available for the Member, the Member’s desires related to their health care needs ~~(as~~ ~~appropriate)~~, and the person-centered ICP maintenance.” | This provision implies that the Contractor can decide when the Member’s health-related desires should be considered, but the Member’s desires should always be considered in a person-centered approach. |  |
| 5.2.3, pg 108-9 | “The Contractor’s Care Coordinators shall make accommodations available at no charge to the Member that address the needs of Members with communication impairments (e.g., hearing, speech, cognitive, and vision limitations) and Members with limited English proficiency, in a culturally and developmentally appropriate manner ~~and shall consider a Member’s physical and cognitive abilities and level of literacy in the assessment process~~ that ensures accessible communication.” | This provision should be strengthened by including a more comprehensive list of the types of communication impairments.  This provision could also be strengthened by replacing the reference to consider abilities and literacy levels in the assessment process, which is vague, with the assurance that communication be accessible. |  |
| 5.3.2, pg 112 | **“**Plans for transition coordination and services for Members who wish to move to a less restrictive setting, including members in nursing facilities who wish to move to the community.” | This provision should be strengthened by broadening the item to ensure that members in settings other than nursing facilities are also served in the least restrictive setting, if they desire. |  |
| 5.3.2, pg 112 | “Member’s choice of services (including model of service delivery for personal care and respite –consumer-directed vs. agency-directed ~~when~~ ~~appropriate~~ for CCC Plus Waiver Members who are eligible per 12VAC30-120-924.B).” | This provision should be strengthened by removing the phrase, “when appropriate,” which is vague and could be interpreted differently than intended, and adding a reference to the consumer direction eligibility requirements. |  |
| 5.14.3, pg 130 | “In the event of a NF closure, or as necessary to protect the health and safety of residents, the Contractor shall arrange for the safe and orderly transfer of all Members and their personal effects to the setting of their choice, which could include another facility or a home- and community-based setting.” | The need to move presents a good opportunity for the member to re-consider all of their options, including home- and community-based settings. Some members may no longer prefer a nursing facility if they cannot remain in their previous facility. |  |
| 9.16, pg 174 | “Demonstrating compliance with the ADA by conducting an independent survey or site review of facilities for both physical, communication and programmatic accessibility, documenting any deficiencies in compliance and monitoring correction of deficiencies. Contractors should use the standardized form in the technical manual to conduct its assessments, and submit summary data to the Department as detailed in the technical manual.” | The research literature has consistently found that inaccessible health care is a major barrier to people with disabilities receiving high-quality care. Information on the accessibility of the CCC Plus provider networks is currently limited, and the information that is available indicates that there are few accessible providers:   * The CCC Plus Network Submission Requirements Manual on DMAS’ website, and 3 of 6 provider directories as of August 2018, only indicate a yes/no response to whether a provider is ADA compliant overall. However, ADA compliance has many different facets such as a physically accessible building/waiting room/exam room/bathrooms/equipment and the provision of reasonable accommodations such as shorter waiting times. A provider may meet one or more of these facets, but not necessarily all of them. * One Contractor’s provider directory identified only two providers who voluntarily reported having cultural competency training, and random provider searches of two other directories failed to find any providers who voluntarily reported having cultural competency training, as of August 2018 * Random provider searches of two Contractors’ provider directories failed to find any providers who voluntarily reported being near a public transportation route, as of August 2018 * Four Contractors’ provider directories identified very few providers who voluntarily reported having American Sign Language access. One of these directories only identified 50 providers statewide, another identified 0 within 100 miles of Richmond, and two others identified fewer than 15 in the Central region.   This information raises concerns about whether Contractors are meeting contract sections 8.4.2 and 9.16, which require the Contractor to assure accessibility to all services for people with disabilities, and raises concerns about whether the Department can verify whether Contractors are meeting those requirements.  In order to better ensure compliance with these provisions, VBPD urges the Department to provide additional guidance on how the Contractor should determine a provider’s ability to ensure physical accessibility, communication accessibility, and programmatic accessibility. For example, the Department could require Contractors to conduct site reviews and require them to use a standardized form for the site visits like some other states (see California’s form at https://www.ccah-alliance.org/PReview/PAR-tool-2011.pdf, or Massachusetts’ form at http://archives.lib.state.ma.us/bitstream/handle/ 2452/616835/ocn970347504.pdf?sequence=1&isAllowed=y). The use of a standardized form, and submittal of this data to the Department, would ensure the availability of standardized data to better oversee compliance with these provisions. |  |
| 9.2.1, pg 166 | “The Contractor shall provide Members with a choice of at least two (2) providers who are physically accessible to the member…” | The research literature has consistently found that inaccessible health care is a major barrier to people with disabilities receiving high-quality care. Accessibility includes more than just getting in the door. It includes accessible equipment (mammogram, MRI, X ray equipment), exam tables, etc. |  |
| 9.2.3, pg 167 | “When a Member with special health care needs has been identified through an assessment to need a course of treatment or regular care monitoring, and in compliance with 42 CFR § 438.208(c)(4), the Contractor shall have a mechanism in place to allow the Member to directly access a specialist, as appropriate for the Member’s condition and identified needs.” | This provision should be strengthened by clarifying what “mechanism” is. For example, is it referring to the member not needing a referral in order to see a specialist and/or not needing to choose an in-network provider if one is not readily available? |  |
| 10.4, pg 177 | “The Contractor shall have in place a written description of the QI Program that delineates the structure, goals, and objectives of the Contractor’s QI initiatives. Such description shall:  (1) Address all aspects of providing health care, including specific reference to behavioral health care and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral health and LTSS aspects of the QI program may be included in the QI description, or in a separate QI Plan referenced in the QI description. The QI program description should also address non-emergency medical transportation, the details of which may be included in a separate QI Plan referenced in the QI program description.” | While contract sections 10.2 and 10.3 state that continuous quality improvement should apply to all aspects of the Contractor’s service delivery system, the majority of contract section 10 appears to focus on direct medical services. VBPD was pleased to see consideration of requiring an NEMT quality assurance program in last year’s contract revision process (in a proposed new section 4.10.20), and urges the Department incorporate that requirement into section 10.4 this year. |  |
| 11.5, pg 195 | “The Contractor shall participate in the Department’s efforts to promote the delivery of services in a culturally competent manner to all Members including those with limited English proficiency, differing abilities, and diverse cultural and ethnic backgrounds.” | This provision should be strengthened by ensuring that the Contractor promotes the delivery of culturally competent services to people with disabilities. |  |
| 11.9 | *“*In accordance with Section 63.2-1606 of the *Code of Virginia*, the Contractor shall report immediately upon learning of any suspected or known abuse, neglect, or exploitation of ~~aged or incapacitated~~ adults to the local adult protective services office or to the Virginia Department of Social Services' toll-free Adult Protective Services hotline…” | This provision should be broadened to align with language in the body of Section 63.2-1606 in the *Code of Virginia* and to better align with cultural competence standards including people-first language. |  |
| 11.11.6  Page 201 | “The Department will periodically monitor the Contractor’s provider directories, at least once annually, to ensure compliance with these content requirements.” | VBPD is pleased that the Department added this sentence to the contract, in response to our feedback last year.  Specificity of the frequency of the review would strengthen this provision given that directories are updated on an ongoing basis and directories are still not fully in compliance. A VBPD review of CCC Plus provider directories in late August 2018 indicates that at least some provider directories available online do not appear to fully meet the intent of Sections 2.1.4, 11.5, and 11.11.6.1:   * Three directories did not indicate which specific accommodations were available for people with physical disabilities, only noting whether the provider overall was physically accessible despite the fact that there are many facets of accessibility. Section 11.11.6.1 required Contractors to note whether the provider has “specific accommodations for people with physical disabilities, such as wide entry, wheelchair access, accessible exam room(s) and tables, lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment;” * One directory did not appear to include any information regarding cultural competency training, and another two directories had a category for special experience or training but it was unclear whether this category specifically asked about cultural competency training; * One directory did not appear to include any information on proximity to public transportation routes based on random provider searches; * Five directories used the phrase “handicap access,” “handicap accessibility,” “handicapped accessible,” or “handicapped accessibility” rather than the more culturally competent phrases such as “physical accommodations,” “physical accessibility,” or “accommodations for physical disabilities.” * Five directories list when a provider voluntarily reported having a given characteristic, but did not list when a provider chose not to voluntarily report the information. This omission may leave members unaware of the fact that providers had an opportunity to report the information, which members may wish to factor into their choice of provider. |  |
| 12.3, pg 211 | “Special needs of Members that may affect access to and delivery of services (e.g., transportation needs, physically accessible buildings and equipment, cultural competency, and other reasonable accommodations under the ADA such as sign language interpreter services, large print materials, or shorter waiting times);” | The research literature has consistently found that inaccessible health care is a major barrier to people with disabilities receiving high-quality care. Information on the accessibility of the CCC Plus provider networks is currently limited, with Contractors often relying on voluntary self-reporting by providers to get accessibility information for their provider directories. Available information indicates that there are few accessible providers:   * One Contractor’s provider directory identified only two providers who voluntarily reported having cultural competency training, and random provider searches of two other directories failed to find any providers who voluntarily reported having cultural competency training, as of August 2018 * Four Contractors’ provider directories identified very few providers who voluntarily reported having American Sign Language access. One of these directories only identified 50 providers statewide, another identified 0 within 100 miles of Richmond, and two others identified fewer than 15 in the Central region * Three of six Contractors’ provider directories as of August 2018, only indicate a yes/no response to whether a provider is ADA compliant overall. However, ADA compliance has many different facets such as a physically accessible building/waiting room/exam room/bathrooms/equipment and the provision of reasonable accommodations such as shorter waiting times. A provider may meet one or more of these facets, but not necessarily all of them.   The reliance on providers to self-report their accessibility, and the few number of providers who do report being accessible, indicates that additional provider training is needed. |  |
| 15.2, pg 237 | “In accordance with 42 CFR §438.408(c) the Contractor may extend the timeframe for processing a grievance by up to fourteen (14) calendar days if the Member requests the extension, or, with the Department’s permission, if the Contractor shows that there is a need for additional information and that the delay is in the Member’s interest. If the Contractor extends the timeframe from a grievance not at the request of the Member, the Contractor must give the Member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Member of their right to file a grievance if he/she disagrees with that decision. The Contractor shall respond to such grievances regarding extensions within 24 hours.” | This provision should be strengthened by specifying a timeframe for the Contractor to respond to member grievances regarding extensions. If the Contractor has the standard 30 days, then the grievance regarding the extension will not have to be considered before the decision on the original grievance is due in up to 14 days. Section 15.2 requires expedited responses within 24 hours for “each Member grievance whenever the Contractor extends the appeal timeframe” but this only references appeals, not original grievances. The provision should clarify that this expedited timeframe of 24 hours should also apply to original grievances regarding extended timelines. |  |
| 15.4, pg | “The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the Member requests the extension or if the Contractor provides evidence satisfactory to the Department that there is need for additional information and that a delay in rendering the decision is in the Member’s interest. Where the Contractor has extended the timeframe for an expedited appeal not at the request of the Member, the Contractor shall make reasonable efforts to give the enrollee ~~prompt~~ oral notice within 24 hours of the delay.” | This provision should be strengthened by defining “prompt.” Section 15.2 requires expedited responses within 24 hours for “each Member grievance whenever the Contractor extends the appeal timeframe.” This 24-hour response should also apply to Section 15.4. |  |
| 18.0, pg 271-83 | This section repeatedly says the Department “may” assess compliance points “at its discretion” if the Contractor violates certain requirements, unless the Contractor (i) “provided sufficient notification or education to providers of applicable program requirements,” or (ii) “took immediate and appropriate action to correct the problem and to ensure that it will not recur.” | VBPD urges the Department to replace each instance of “may” with “shall.” This change would substantially improve the Department’s ability to effectively oversee the Contractors and enforce compliance with program requirements. This change aligns with Recommendations 21 and 22 in the Joint Legislative Audit and Review Commission’s December 2016 report, *Managing Spending in Virginia’s Medicaid Program*. |  |
| 18.2.3.3, pg 274 | “Examples of ten (10) point violations include, but are not limited to, the following: …2. Failure to assist a Member in accessing needed services in a timely manner after receiving a request from the Member. This includes the failure to provide transportation to critical appointments, resulting in one or more individuals missing an appointment, and the failure to provide safe transportation to individuals such as dropping individuals off at the wrong location or the failure to provide an accessible vehicle to an individual with a disability.” | VBPD was pleased to see consideration of specific liquidated damages for NEMT non-compliance in last year’s contract revision process (in a proposed new section 4.10.22) and urges the Department this year to incorporate NEMT non-compliance into the already existing Compliance Monitoring Process. While the Compliance Monitoring Process does not appear to explicitly exclude transportation compliance issues, neither does it explicitly include transportation compliance issues. |  |
| 18.3.1, pg 274 | “The Department may assess sanctions (e.g. CAPs, points, freeze enrollment, impose fines) if: (1) the Contractor violates any provider network requirements…” | This provision should be strengthened by clarifying when sanctions for violating provider network requirements are determined via this provision versus Section 18.3.3.2. Section 18.3.3.2 identifies “failure to meet provider access to care & network standards” as a 5-point violation but this Section 18.4.1 implies that sanctions for violating provider network requirements may be determined through a different process. |  |
| 23.1, pg 324 | “A facility licensed by the Department of Behavioral Health and Developmental Services (DBHDS) in which care is provided to ~~intellectually disabled individuals~~ individuals with intellectual/developmental disabilities who are not in need of skilled nursing care~~, but who need more intensive training and supervision than would be available in a rooming, boarding home, or group home~~.” | The first revision is to use people-first language.  The second revision is to align with CMS’ definition, which now considers intermediate care facilities as an alternative to home- and community-based services, rather than settings that necessarily provide more intensive training and supervision as this definition implies. |  |