



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES

MARGARET M. O'NEILL BUILDING
410 FEDERAL STREET, SUITE 1
DOVER, DE 19901

VOICE: (302) 739-3620
TTY/TDD: (302) 739-3699
FAX: (302) 739-6704

MEMORANDUM

DATE: October 24, 2016

TO: Ms. Kimberly Xavier, DMMA
Planning & Policy Development Unit

FROM: Ms. Jamie Wolfe, Chairperson
State Council for Persons with Disabilities

RE: 20 DE Reg. 247 [(DMMA Proposed Targeted Case Management Regulation (10/1/16)]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMAs) proposal to adopt a State Medicaid Plan amendment affecting DDDS clients. The proposed regulation was published as 20 DE Reg. 247 in the October 1, 2016 issue of the Register of Regulations.

In a nutshell, "targeted case management" (TCM) would be added as a State Medicaid Plan service with 2 target groups: 1) DDDS clients who are receiving residential services through the DDDS Medicaid waiver; and 2) DDDS clients who are receiving DDDS services and living in their own homes or with their families. The State plans to later file an amendment to the DDDS waiver effective January 1, 2017 to allow the second group to enroll in the waiver. The expanded waiver will be called "the Lifespan Waiver". DDDS will "phase out" the existing "Family Support Specialists" (FSS) who currently provide some case management services to the second group. Instead, DDDS will issue an RFP to obtain some contract agencies who would hire targeted case managers ("Community Navigators") to serve the second group under the waiver. See Supplement 3 to Attachment 3.1-A, p. 1. This approach should result in no additional cost. DDDS clients in the first group (residential clients) would continue to receive case management services from DDDS employees who would be designated "Qualified Support Coordinators".

SCPD has the following observations.

First, the minimum credentials of both the "Community Navigators" (serving non-residential clients) and "Qualified Support Coordinators" (serving residential clients) are weak. Apart from some DDDS training, the standard is as follows:

1. Have an associate's degree or higher in behavioral, social sciences or a related field OR

experience in health or human services support, which includes interviewing individuals and assessing personal, health, employment, social, or financial needs in accordance with program requirements.

See Supplement 3 to Attachment 3.1-A, Page 6; Supplement 4 to Attachment 3.1-A, Page 6

These individuals are responsible for a host of high-level activities requiring expertise and skills, including monitoring health and welfare; ensuring implementation of service plans; responding and assessing emergency situations; participating in investigations of reportable incidents; assistance with linkages to obtaining services available through Medicaid, Medicare, private insurance, and other community resources; and coordination with MCO representatives, DVR, and educational coordinators. See Supplement 3 to Attachment 3.1-A, Pages 3-6. See also 42 C.F.R. 440.169. It is patent that more robust credentials will be necessary to perform the above functions in a meaningful way. These individuals must be expert in identifying and facilitating access to support services in complex federal, state, and private systems. Under the proposed standard, someone without even a high school diploma and minimal experience in human services will qualify to be hired as a case manager. Contrast the DMMA standards for a Medicaid MCO case manager:

- 1) nurse with 2 years of qualifying experience;
- 2) individual with 4 year degree in human services field plus 1 year experience; or
- 3) high school diploma plus 3 years of qualifying experience.

See 2016 DHSS MCO Contract, §3.7.1.2 [attached]

Second, the level of involvement with the DDSS clients is minimal. A unit of service is “1 month” so compensation is paid based on fulfilling the following de minimis activity once per month: “one (1) service contact that can include face-to-face or telephone contacts with the recipient or on behalf of the recipient”. See Attachment 4.19-B, Page 27; Attachment 4.19-B, Page 28. Thus, a case manager meets minimum standards for monthly compensation under the Medicaid program for making a single phone call per month. The combination of case managers with minimal credentials and minimal client contact is inconsistent with the recital that “every jurisdiction in the State will be able to receive high-quality, comprehensive case management services”. See Supplement 3 to Attachment 3.1-A, Page 6.

Third, there is no “caseload” benchmark in the Medicaid State Plan Amendment. It would be preferable to include a benchmark such as an upper cap on case manager caseload. Contrast DMMA MCO case management “caseload management” standards, §3.7.1.5.3 of the 2016 DHSS-MCO contract [attached].

Fourth, it would be preferable to have case management provided by State employees rather contracting with private firms with a profit incentive. There may be minimal or no financial benefit to paying a broker agency which charges overhead and then pays case managers

undefined compensation. The fee schedules for government and private providers for case management are the same. See Attachment 4.19-B, Page 27. For example, in practice, MCO case managers have proven much less responsive to client needs than State case managers. Their primary “loyalty” is to their employer, not the State. If CMS prefers a “firewall” between case management and direct service provision, the case managers could be placed under the Office of the Secretary. This was the approach adopted to separate the Long-term Care Ombudsman from DSAAPD since DSAAPD provides direct services in public nursing homes (e.g. DHCI; GBHC).

Fifth, DMMA should consider amending the following reference: “(i)nforms and assists an individual or his or her family to obtain guardianship or other surrogate decision making capability”. See Supplement 4 to Attachment 3.1-A, Page 4. Federal HHS is actively promoting alternatives to guardianship such as supported decision-making. See attachments. Delaware supported decision-making legislation (S.B. 230), co-authored by DHSS, was signed by the Governor on September 15, 2016. Consider the following substitute for the above reference: “(i)nforms and assists an individual or his or her family with surrogate decision making and assistance options, including supported decision-making agreements, powers of attorney, and guardianship.”

Sixth, DMMA should reconsider the following reference: “(f)acilitates referral to a nursing facility when appropriate.” See Supplement 4 to Attachment 3.1-A, Page 4. Placement of DDDS clients in nursing homes is highly disfavored. For that reason, DMMA implements the federal PASRR process. Cf. 16 DE Admin Code 5304.1. Moreover, DHSS has been actively prioritizing diversion of individuals from nursing homes through programs such as MFP and the DSHP+. Therefore, it is somewhat “odd” to specifically highlight and prioritize facilitation of referrals to nursing homes in the Medicaid State Plan Amendment.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations and recommendations on the proposed regulation.

cc: Ms. Rita Landgraf
Mr. Stephen Groff
Ms. Jill Rogers
Mr. Brian Hartman, Esq.
Governor’s Advisory Council for Exceptional Citizens
Developmental Disabilities Council

20reg247 dmma-targeted case management 10-24-16

EXCERPTS: DHS - MEDICAID
MCO CONTRACTS (2016)

to assisting the member in reaching his/her goals as stated in the plan of care.

3.6.4 Clinical Practice Guidelines

3.6.4.1 The Contractor's care coordination program shall utilize evidence-based practice guidelines.

3.6.4.2 The Clinical care coordination program shall be described and included in the contractor's utilization management program description.

3.6.5 Informing and Educating Members

3.6.5.1 The Contractor shall inform all members of the availability of care coordination program activities at all levels and how to access and use care coordination program services.

3.6.6 Informing and Educating Providers

3.6.6.1 The Contractor shall inform providers regarding the operation and goals of the care coordination programs at all levels. Providers shall be given instructions on how to access appropriate services as well as the benefits to the provider.

3.6.7 Care Coordination System Capabilities

3.6.7.1 The Contractor shall maintain and operate a centralized information system necessary to conduct risk stratification. Systems recording program documentation shall include the capability of collecting and reporting short term and intermediate outcomes such as member behavior change. The system shall be able to collect and query information on individual members as needed for follow-up confirmations and to determine intervention outcomes.

3.6.7.2 The Contractor shall work with DMMA to develop Contractor system capacity around promoting provider level care coordination services.

3.6.8 Evaluation

3.6.8.1 The Contractor shall submit the care coordination reports specified in Section 3.21 of this Contract.

3.7 CASE MANAGEMENT FOR DSHP PLUS LTSS MEMBERS

3.7.1 Administrative Standards

3.7.1.1 General

3.7.1.1.1 The Contractor shall provide case management to DSHP Plus LTSS members. This Section of the Contract does not apply to DSHP members nor to DSHP Plus members who are not DSHP Plus LTSS members.



3.7.1.2 Case Management Staff Qualifications

3.7.1.2.1 The Contractor shall ensure that individuals hired as case managers are either:

3.7.1.2.1.1 Individuals with a Bachelor's degree in health, human, social work or education services with one or more years of qualifying experience; or a high school degree or equivalent and three years of qualifying experience with case management of the aged, including management of behavioral health conditions, or persons with physical or developmental disabilities, or HIV/AIDS population; or

3.7.1.2.1.2 Licensed as an RN; or LPN with two years of qualifying experience with appropriate supervision in accordance with Delaware law (see 24 DE Admin Code 1900).

3.7.1.2.2 The Contractor shall ensure that case managers have:

3.7.1.2.2.1 Experience interviewing and assessing member needs;

3.7.1.2.2.2 Knowledge and experience regarding caseload management and casework practices;

3.7.1.2.2.3 Knowledge regarding determining eligibility for DHSS programs;

3.7.1.2.2.4 Knowledge regarding Federal and State law as it applies to DHSS programs;

3.7.1.2.2.5 The ability to effectively solve problems and locate community resources;

3.7.1.2.2.6 The ability to collaborate with Caregivers, involved State agency representatives and providers;

3.7.1.2.2.7 Good interpersonal skills;

3.7.1.2.2.8 Fundamental background in cultural and socio-economic diversity; and

3.7.1.2.2.9 Knowledge of the needs and service delivery system for all populations in the case manager's caseload.

3.7.1.4.4.5 Cultural Competency;

3.7.1.4.4.6 Medical/behavioral health issues; and/or

3.7.1.4.4.7 Medications – side effects, contraindications and poly-pharmacy issues.

3.7.1.4.5 Training may be provided by external sources, for example by:

3.7.1.4.5.1 Consumer advocacy groups;

3.7.1.4.5.2 Providers (for example, medical or behavioral health); or

3.7.1.4.5.3 Accredited training agencies.

3.7.1.4.6 The Contractor shall ensure that a staff person(s) is designated as the expert(s) on housing, education and employment issues and resources. This expert must assist case managers with up-to-date information designed to aid members in making informed decisions about their independent living options.

3.7.1.5 Caseload Management

3.7.1.5.1 The Contractor shall have an adequate number of qualified and trained case managers to meet the needs of DSHP Plus LTSS members.

3.7.1.5.2 The Contractor must ensure that newly Enrolled DSHP Plus LTSS members are assigned to a case manager immediately upon Enrollment. The case manager assigned to a special subpopulation (e.g., members with HIV/AIDS or ABI or PROMISE participants) must have experience or training in case management techniques for such population.



3.7.1.5.3 The Contractor must maintain case manager staffing ratios of:

3.7.1.5.3.1 1:120 for members living in nursing facilities;

3.7.1.5.3.2 1:60 for members receiving HCBS (living in their own home or assisted living facility); and

3.7.1.5.3.3 1:30 for members receiving services under the Money Follows the Person (MFP) program.

3.7.1.5.4 If the Contractor utilize the services of agencies to provide case management services for DSHP Plus LTSS members with HIV/AIDS who meet acute hospital LOC:

- 3.7.1.5.4.1 The agency's case manager staffing ratio must be 1:60 members; and
- 3.7.1.5.4.2 The Contractor's case manager staffing ratios must be 1:100 members.
- 3.7.1.5.5 The Contractor shall ensure that case management is provided at a level dictated by the complexity and required needs of the member, including coordination needed to implement a comprehensive plan of care that addresses all of the member's needs.
- 3.7.1.5.6 The Contractor shall ensure that each case manager's caseload does not exceed a weighted value of 120. The following formula represents the maximum number of members allowable per case manager:
 - 3.7.1.5.6.1 For nursing facility members, a weighted value of 1 is assigned. Case managers may have up to 120 institutionalized members ($120 \times 1 = 120$).
 - 3.7.1.5.6.2 For HCBS members (living in their own home or assisted living facility), a weighted value of 2 is assigned. Case managers may have up to 60 HCBS members ($60 \times 2 = 120$).
 - 3.7.1.5.6.3 For MFP members, a weighted value of 4 is assigned. Case managers may have up to 30 MFP members ($30 \times 4 = 120$).
 - 3.7.1.5.6.4 If a mixed caseload is assigned, there can be no more than a weighted value of 120. The following formula is to be used in determining a case manager's mixed caseload:
 - 3.7.1.5.6.4.1 $(\# \text{ of NF members} \times 1) + (\# \text{ of HCBS members} \times 2) + (\# \text{ of MFP members} \times 4) = 120 \text{ or less}$
 - 3.7.1.5.6.5 The Contractor must receive authorization from the State prior to implementing caseloads whose values exceed those specified above. The Contractor may establish lower caseload sizes at its discretion without prior authorization from the State.
- 3.7.1.6 Accessibility
 - 3.7.1.6.1 The Contractor shall provide members and/or member representatives with adequate information in order to be able to contact their case manager or the Contractor's member services information line for assistance, including what to do in cases of emergencies and/or after hours.

[Go Back to Previous](#)



Administration for Community Living

ACL BLOG

Preserving the Right to Self-determination: Supported Decision-Making

[View Replies](#)

By Aaron Bishop, Commissioner, Administration for Intellectual and Developmental Disabilities, and Edwin Walker, Deputy Assistant Secretary for Aging

For many years, state courts have routinely assigned guardians to people with intellectual and developmental disabilities as they became adults. Older adults with dementia-related disorders also frequently have been assigned guardians.

The trouble with guardianship is that it is a legal process. A court deems a person incapacitated or legally incompetent and assigns a substitute decision-maker for that person. Guardianship laws vary by state, but in some states, guardians are given the authority to make all financial, legal, and personal decisions on behalf of another person. Essentially, the person can lose ALL of his or her rights to independence, autonomy, and decision-making.

This approach assumes that people with disabilities and older adults are incapable of making decisions. That is simply not the case.

The goal of the Administration for Community Living is to maximize the independence and well-being of older adults and people with disabilities. We are proud to be a leader in exploring alternatives to guardianship. We believe supported decision-making poses the most promising and flexible model.

Supported decision-making starts with the assumption that people with intellectual and developmental disabilities and older adults with cognitive impairment should retain choice and control over all the decisions in their lives. It is not a program. Rather, it is a process of working with the person to identify where help is needed and devising an approach for providing that help. Different people need help with different types of decisions. For some, it might be financial or health care decisions. Others may need help with decisions surrounding reproductive rights or voting. Some may need help with many types of decisions, while others need help with only one or two.

The solutions also are different for each person. Some people need one-on-one support and discussion about the issue at hand. For others, a team approach works best. Some people may benefit from situations being explained pictorially. With supported decision-making the possibilities are endless.

The key is that the process is centered on the person to whom the decisions apply, and it enables the person to make decisions based on his or her wants and preferences. Supported decision-making keeps control in the hands of the individual, while providing assistance in specific ways and in specific situations that are useful to the person.

We know on a case-by-case basis and anecdotally that supported decision-making works, and it appears to have the potential to provide a significant improvement to current guardianship arrangements. However, it has not been formally tested, which can make it difficult for states to adopt the practice.

To address that challenge, the Administration on Intellectual and Developmental Disabilities and the Administration on Aging, two program components of the Administration for Community Living, jointly awarded a cooperative agreement to **Quality Trust for Individuals with Disabilities** to build a national training, technical assistance, and resource center to explore and develop supported decision-making as an alternative to guardianship. The resource center will gather and disseminate data on the various ways in which supported decision-making is being implemented and generate research in the area. Our goal is that

the information collected during the period of this cooperative agreement will lead to a model that will help states as they consider alternatives to guardianship.

We are excited by the possibilities this work may generate. It is another step toward ensuring all people are treated with dignity and respect throughout their lives. It is another step toward a vision for the future that includes a collective recognition that the right to self-determination and independence are fundamental for everyone. And ultimately, it offers the promise of new opportunities for people with disabilities and older adults to live and thrive in the communities of their choice.

[Back to top](#)

Update: A Message from Commissioner Bishop

February 13, 2015

Thank you to all our readers who joined this discussion and shared their personal perspectives. The range and diversity of stories, experiences, and responses shows there is no one-size-fits-all solution to this important issue. Many of the concerns shared here highlight exactly the sort of questions that the **National Resource Center for Supported Decision Making** seeks to explore.

As Deputy Assistant Secretary Walker and I noted in our blog, when it comes to supported decision-making, no two situations are exactly alike. The Administration for Community Living (ACL) recognizes that people with disabilities and older Americans sometimes experience challenges in understanding and communicating their preferences and needs—and, as your stories illustrate, family members and caregivers often play a critical role in ensuring that those preferences are honored and needs are met. Your stories also demonstrate the dangers that can arise when guardianship is viewed as the default option for those who only need support with making a few decisions.

ACL promotes the concept of supported decision-making not because it is the only option, but because it offers flexibility to provide as much assistance as needed—including total assistance, when that is appropriate—while also ensuring that the right to self-determination is preserved for each individual.

We thank you again for your contributions to this important discussion and hope you will keep the comments coming. The feedback you provide will help us think about, and talk about, this issue more clearly going forward.

[Back to top](#)

[Back to ACL Blog posts](#) | [Leave a comment](#)

Replies

Name	Date	Comment
Silvia	January 29, 2015	This is a great and timely project—thank you! Just a couple of additional factors that would be great to consider as research is done. 1st, consider how the various options for partial decision-making authority impact on the person with a disability and those people in their lives who can/do provide assistance and decision support or actual transferred decision-making. That is, does a family member have to work through 2, 4 or 10 different forms and authorization processes for different agencies, government levels, and topical areas to avoid being an overall legal guardian? Does each agency or authority ignore other kinds of authorizations? 2nd, consider the impact or additional factors that arise in the context of the kind of passive enrollment processes that are commonly occurring in Medicare and Medicaid dual-eligible integration pilots, for example, where PWD are enrolled into managed care plans unless they hear otherwise from a beneficiary or "authorized representative." Thanks much
Cathy	January 29, 2015	My son self determines everything about his life. He is labeled ID. I could not imagine his life if someone else chose for him. He is well rounded and not pigeon holed.



U.S. Department of Health and Human Services
Administration for Community Living

Search:

[Help & Resources](#) [Newsroom](#) [Programs & Activities](#) [Data & Evaluations](#) [Funding Opportunities](#) [About ACL](#)

Home > [Newsroom](#) > [News & Information](#) > [2016 News & Information](#) > [A New Path: 2016 PCPID Report to the President Now Available](#)

Print Resize

News & Information

- [2016 News & Information](#)
- [2015 News & Information](#)
- [2014 News & Information](#)
- [2013 News & Information](#)

eNewsletter

Multimedia

- [ACL Photos](#)
- [ACL Logo Files](#)
- [Audio and Video Files](#)

New Media

- [ACL Blog](#)

Observances

- [Older Americans Month](#)
- [WEAAD](#)
- [OAA50](#)
- [Olmstead Anniversary](#)
- [2016 Observances](#)
- [2015 Observances](#)
- [2014 Observances](#)
- [2013 Observances](#)
- [2012 Observances](#)
- [2011 Observances](#)

Press Releases & Announcements

- [ACL Archived](#)
- [AoA Archived](#)
- [AIDD Archived](#)

Publications

Speeches and Testimony

- [Walker, August 29, 2016](#)
- [Greenlee, July 26, 2016](#)

A New Path: 2016 PCPID Report to the President Now Available

The President's Committee for People with Intellectual Disabilities (PCPID) 2016 Report is now available online.

The report, *Strengthening an Inclusive Pathway for People with Intellectual Disabilities and their Families*, recognizes the "great strides" made since President John F. Kennedy established a blue-ribbon panel to address the needs of people with intellectual disabilities and their families and PCPID Chairman Jack Brandt notes that, "despite these advances, the trajectory for a person with an intellectual disability remains limited."

The report examines four key areas to determine how a new path can be forged for people with intellectual disabilities to be included in all aspects of society:

- Early family engagement to support high expectations for students with disabilities;
- Federal education policies and enforcement strategies to end segregation in schools;
- Transition to adulthood as a critical timeframe for establishing paths to higher education and career development; and
- Self-determination and supported decision-making starting in early childhood and continuing throughout the individual's lifespan.

Brandt is the new chairman for PCPID and is appreciative of the efforts of the former chair, Julie Petty. Brandt says, "Julie's leadership of PCPID took the organization to a new and positive place. I appreciate her outstanding service to PCPID."

PCPID serves in an advisory capacity to the President of the United States and the Secretary of Health and Human Services (HHS) promoting policies and initiatives that support independence and lifelong inclusion of people with intellectual disabilities in their respective communities. The committee includes representatives from several federal agencies and 12 citizen members.

Last Modified: 10/6/2016

SITE SUPPORT

- [Home](#)
- [Contact Us](#)
- [Privacy Notice](#)
- [Accessibility](#)
- [Viewers & Players](#)
- [Disclaimers](#)

POINTS OF INTEREST

- [FOIA](#)
- [Plain Writing](#)
- [No Fear Act](#)

PARTNER SITES

- [The White House](#)
- [HHS](#)
- [Alzheimers.gov](#)
- [LongTermCare.gov](#)
- [Disability.gov](#)
- [USA.gov](#)
- [Grants.gov](#)

STAY CONNECTED

- [Facebook](#)
- [Twitter](#)
- [YouTube](#)
- [E-mail Updates](#)

Administration for Community Living • Washington, DC 20201