MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Proposed DSHP+ Initiative

Date: September 2, 2011

I am providing a critique of the proposed Diamond State Health Plan Plus through this memo. Given time constraints, the commentary should be deemed preliminary and non-exhaustive.

REGULATORY HISTORY

In July, the Division of Medicaid & Medical Assistance published notice of an initiative to dissolve the E&D waiver and incorporate its participant base and services into a Diamond State Health Plan Plus program. The July SCPD P&L memo contained the following information on the initiative:

11. DMMA Prop. Diamond State Health Plan Plus Waiver Amend. [15 DE Reg. 45 (July 1, 2011)]

The Division of Medicaid & Medical Assistance proposes to revamp the Diamond State Health Plan to integrate the current E&D Medicaid waiver into the existing managed care delivery system. A Powerpoint presentation and timeline are attached. DMMA plans to achieve implementation by April, 2012. The notice in the July Register of Regulations recites that the waiver amendment application will be available on its Website on July 15, 2011 with comments due by July 31. When I questioned the short timeframe, the Department responded with the attached June 30 email extending the deadline for comments to August 15, 2011. The waiver amendment had not appeared on the Website as of July 11 so review will have to be deferred until August.

There were some delays in acquiring specific background information. I have now reviewed the Powerpoint presentation; Concept Paper submitted to CMS in May, 2011; July, 2011 Waiver Amendment Request; DMMA MCO Contract, Exhibit W (Case Management); and Chapter II, Program Description. Some of these document are voluminous (e.g. the latter document is 123 pages). I also received but did not have time to review a Quality Management Strategy document which is 88 pages in length.

I have the following observations.

BACKGROUND

The Waiver Amendment document is similar to the Concept Paper. DHSS notes that Delaware ranks near the bottom of the states in percentage of Medicaid funds devoted to community-based alternatives. It also notes that Delaware's population is aging and 72% of Delaware residents age 35 or older believe it is extremely important to remain in their current residence for as long as possible. DHSS proposes to expand its current DSHP Section 1115 demonstration waiver by establishing a DSHP+ program which would include dual eligibles; individuals receiving institutional LTC (excluding the DD waiver population); and individuals enrolled in the E&D and AIDS Section 1915(c) waivers. DHSS plans to address mental health services planning on a parallel track but not directly through the DSHP+ at this time. Both adults and children would be affected by the initiative, including the medically fragile children in Voorhees. Since the TBI waiver was consolidated with the E&D waiver in December, 2010, the DSHP+ would also cover E&D waiver enrollees with TBI.

The Powerpoint provides the following statistics on expected DSHP+ enrollees: dual eligibles, 5000 (65%); nursing home residents, 3,000 (19%); and community HCBS, 1,800 (16%). Thus, the E&D and AIDS waiver populations are actually a small percentage of the overall DSHP+ program. The Powerpoint also contains the attached comparative list of benefits under the existing DSHP and proposed DSHP+ programs.

A community-based model will be promoted. For example, a LTC level of care currently requires a need for assistance with only one ADL ("activity of daily living"). This will be converted to a need for assistance with two ADLs for new institutional admissions effective April 1, 2012. Existing LTC residents will be "grandfathered", i.e., they will continue to be eligible for institutional LTC by meeting the single ADL limitation standard. Individuals will be able to qualify for community-based services by demonstrating a need for assistance for only one ADL.

There will be a transition period for E&D and AIDS waiver participants. Their services will be maintained for at least 90 days from conversion date (April, 2012). The following services would continue to be excluded from DSHP+: pharmacy, child dental, and non-emergency medical transportation.

DHSS will implement DSHP+ using only the two current, private MCOs.

DMMA MCO Contract: Exhibit W, Case Management (8/5/11 Draft)

This document covers case management standards for DSHP Plus members meeting the institutional level of care and who either reside in a nursing home or in the community. Since this document and the Chapter II Program Description (critiqued below) overlap in some key contexts, I have sometimes included commentary related to both documents in this section. Section I.A.1 and 2 : The case manager qualification standards could be improved. Consider the following:

a. An individual with 3 years of unspecified case management experience is not required to have a college degree or even a high school diploma.

b. The standards treat case managers as “fungible”, i.e., someone with general experience in case management is determined qualified to perform as an expert in TBI, AIDS/HIV, etc. regardless of lack of experience or background in these subpopulations. This is particularly troubling for individuals with TBI. DSAAPD attempted to obtain specific training and certification for in-house TBI case managers in recognition of the special needs of this subpopulation. Case managers have the authority to unilaterally deny services: “Determination to deny or limit non-skilled long term care services for DHSP Plus members may be rendered by a qualified long term care case manager.” [Chapter II Program Description, §13.2.3.1] Granting such power to marginally qualified individuals is a “recipe for disaster”. Moreover, case managers are expected to make quick decisions which would logically require a solid background in the client’s disability: “Case managers must be able to quickly assess/identify a problem or situation as urgent or as a potential emergency and take appropriate action.” [§II.E.4]

c. By analogy, MCOs are required to have an adequate network of providers, including specialists and “sub-specialists”. [Chapter II Program Description, §§7.2.2g; 9.3c;9.3eiii; and 10b.] <u>See also</u> Chapter II, Program Description, §II.10, which recites as follows: “The Contractor must use specialists with pediatric expertise for children where the need for pediatric specialty care is significantly different from the need for adult specialists (e.g. a pediatric cardiologist for children with congenital health defects).” This requirement is based on the notion that the DSHP Plus population is varied and may have complex needs. It is anomalous to recognize the need for specialists for services while treating case managers as fungible. Under the current standards, someone whose case management experience is limited to the elderly is considered qualified to be a case manager for children with obviously different needs and a different service delivery system. Case managers for nursing home patients are deemed experts in community services and vice versa.

d. The role of the DSHP Plus case managers transcends that of a typical case manager given the breadth of medical and non-medical services being coordinated, including home modifications, specialized DME not included in the Medicaid State Plan, home-delivered meals, and MFP issues such as security deposits, landlord-tenant issues, telephone connection fees, and groceries. [Chapter II Program Description, §7.5].

e. DHSS should consider strengthening the case management standards. For example, there could be separate pediatric and adult case managers. There could be a “carve out” for case managers for individuals with TBI to maintain DSAAPD case managers or to contract with the Brain Injury Association. Chapter II, Program Description, §9.5.2, encourages MCOs to contract with some providers, including DSAAPD. This could be changed to a requirement in some contexts such as using DSAAPD case managers for individuals with TBI. There is already a limited “carve out” for AIDs/HIV case managers: “Under DSHP Plus , the Contractor is required to offer a contract to all previous AIDS Waiver Case Management providers for a period of at least one (1) year from the date of implementation of the DSHP Plus.” [Chapter II Program

Description, §8.2.1.1c] Finally, Section I.A.2. could be amended to include a Par. "g" to read as follows: "g. the needs and service delivery system for the subpopulation(s) in the case manager's caseload".

Section IA.3: The case manager-client ratios are "thin". Overall, there will be 1 case manager for every 120 nursing facility clients and 1 case manager for every 60 clients in the community. This capacity is diluted further by the authorization to assign unrelated duties to case managers for up to 15% of their time. [§I.F] Thus, the ratios are actually 0.85 case managers per 120 and 60 clients respectively. This is roughly equivalent to a "true" case manager-client ratio of 1 case manager to 138 nursing home clients and 69 community-based clients. Even these ratios can be exceeded with DMMA approval. [§I.D.2] There is obviously some "tension" between these sparse ratios and the requirement that case management be "intensive" and comprehensive:

> The case manager provides intensive case management for DSHP Plus members in need of long term care service planning and coordination to identify services; brokering of services to obtain and integrate services; facilitation and advocacy to resolve issues that impede access to needed services; monitoring and reassessment of services based on changes in a member's condition; and gate keeping to assess and determine the need for and cost effectiveness of services to members.

[emphasis supplied] Chapter II Program Description, §7.5.1.

For purposes of comparison, the 12/07 DHSS ABI waiver envisioned 50 waiver clients receiving case management services costing $200/month for an annual cost of $120,000 and an individual annual cost of $2,400 apiece. This was based on national norms ("rate data canvassed from other states"). See attached waiver excerpts. If DHSS paid $2,400 per client for a case manager with 69 community-based clients, as contemplated by DSHP Plus, the case manager would cost $165,600! Obviously, the case manager-client ratios will be much "thinner" than the ratio under the former waiver to the detriment of individuals with TBI. Finally, the ratios could be "thinner" if the case manager qualifications were robust. However, as discussed above, individuals can serve as case managers without even a high school diploma.

Section I.B: This section includes the following recital:

> Guidelines to be used in developing and implementing an assessment tool or process for personal care/attendant care (including participant-directed services) will be developed as part of the Implementation Team Meeting process.

By law [Title 16 Del.C. §9406], the SCPD is the advisory council for the DHSS attendant services program. This section could be improved by incorporating a reference to development of tools and processes related to attendant services in consultation with the SCPD. Parenthetically, since DHSS is required to prepare an annual report on attendant services [Title 16 Del.C. §9404(7)], it may wish to ensure that adequate data is generated to facilitate completion of the report.

Section I.C:

a. This section requires "uniform training" to all case managers. As discussed under Section I.A. 1-2, this is consistent with the general approach that all case managers are fungible. The weakness with this approach is that it does not contemplate any specialization.

b. Under Par. I, it would be preferable to also list "free or low cost legal assistance". CLASI maintains both an Elder Law Program and Disabilities Law Program.

Section I.E: This section includes an expectation of prompt return calls but no analogous expectation for responding to emails.

Section I.H: There are no qualifications provided for case manager supervisors. It would be preferable to include some qualifications. Moreover, there is an ostensible "disconnect" between this section entitled "Supervision" and Chapter II Program Description, §6.10. The latter section refers to a "Case Management Administrator" which is not mentioned in Exhibit W. Conversely, §6.10 does not mention case manager supervisors.

Section II.B: It would be preferable to include a reference to educating members on the availability of "free or low cost legal assistance". CLASI maintains both an Elder Law Program and Disabilities Law Program.

Section II.C: The DSHP Plus program is ostensibly based on an aggregate cost neutrality system rather than an individual cost basis. However, this section includes some implicit disincentives to provide services to an individual to maintain community residency. A case manager has additional "hoops to jump through" for clients approaching institutional care costs. For example, a supervisor's approval is necessary to qualify for services which exceed 80% of institutional costs of care. If an individual in the community receives services valued at 100% of the costs of institutional care, the individual is reported to DHSS with a statement of "if and when costs are expected to drop below the cost of institutionalization." The "message" conveyed by adoption of these standards is that providing services to individuals with more severe disabilities in the community is discouraged. In contrast, CMS has issued long-standing guidance that the Medicaid program should be designed to foster community-based services and policies should be adopted to implement this preference. See attached July 29, 1998 and January 14, 2000 HCFA Letters to State Medicaid Directors.

Section II.D, preface and Pars. 9 and 15: The "member choice", "home preference", "back-up plan" and LRE references merit endorsement.
Section II.D.4: The implication of this section is that the current attendant services agencies (Easter Seals and JEVS) are being supplanted. These agencies have excellent "track records". There is already a limited "carve out" for AIDs/HIV case managers: "Under DSHP Plus , the Contractor is required to offer a contract to all previous AIDS Waiver Case Management providers for a period of at least one (1) year from the date of implementation of the DSHP

Plus." [Chapter II Program Description, §8.2.1.1c]. At a minimum, a similar provision could be established for attendant services.

Section II.D.7: E&D Waiver participants have typically not contributed financially to their services. The Councils may wish to solicit clarification of the scope and parameters of patient pay amounts under DSHP Plus. This comment also applies to Chapter II, Program Description, §II.3.1.1.

Section II.D.23: In their commentary on the E&D waiver consolidation last year, the Councils recommended consideration of adding supported employment as an available service. Otherwise, including only "adult day services or day habilitation" in the services menu is inconsistent with the ADA. Such services are typically segregated, austere, and disfavored by many individuals with disabilities. It would be preferable to offer a supported employment option for DSHP Plus participants.

Section II.E.2: This section and Section II.I.1 contemplate visits to facilities to review services, the member's condition, and progress at 6 month intervals. This does not comport with the expectation of "intensive" case management. [Chapter II Program Description, §7.5.1]

Section II.E.8: CMS previously expressed misgivings about the lack of guardianship and lack of capacity in the Public Guardian's Office. See attached July 30, 2010 Letter from Rosanne Mahaney to CMS, pp. 4-5. This section, which is limited to a referral system, will predictably not result in the availability of decision-makers on behalf of individuals lacking competency. DHSS should consider a more affirmative approach (e.g. contract with Public Guardian to accept DSHP participants who may not qualify as priority by Public Guardian).

Section II.E.13:

a. This section recites that "(t)he case manager is responsible for coordinating physician's orders for those medical services requiring a physician's order." DHSS may wish to consider whether this would be considered the practice of nursing. As discussed under Section I.A, minimum case manager qualifications are somewhat weak. Moreover, as discussed under Section I.A.3, the case manager - participant ratios are so high that it may be dangerous to entrust case managers with the responsibility to coordinate physician orders. Finally, for institutional DSHP Plus members, it may be more appropriate for the facility's nursing staff to coordinate physician's orders.
b. This section would ostensibly authorize a case manager who disagrees with a PCP to simply substitute judgment. Referral to the MCO's Medical Director is discretionary. This is unacceptable. The case manager should either defer to the PCP or refer the matter to another physician for resolution. See Chapter II, Program Description, §II.9.1.b.iv.

Section II.E.15: It would be preferable to include a provision notifying the member or

representative of the availability of sources of free or low cost legal services to assist with hearings and appeals. Otherwise, the member or representative will be dissuaded from exercising appeal rights.

Section II.E.18: This section would benefit from inclusion of a reference to State law, i.e., Title 16 Del.C. §1121(18), which includes supplemental limitations on discharge.

Section II.H: DHSS should consider clarifying the role of the ICT in this section. See Title 14 Del.C. §3124. In practice, Medicaid funds are used to support out-of-state placements such as Devereux. Within the State, AdvoServ is also accepting Medicaid funds and accepts ICT referrals. Other sections that could be affected by the ICT are Chapter II, Program Description, §§ II.2.3; II.3.3.2.b. In a similar context, it is unclear how the DSHP Plus interacts with the school district Medicaid cost recovery system. DHSS could consider inserting some clarifying language in Chapter II, Program Description, §II.7.2.2; §II.7.6.3; and II.9.5.2.

Section II.K.1.e: DHSS may wish to insert "on a non-temporary basis". Temporary absence from the State does not disqualify an individual from remaining a DSHP Plus participant. The same comment applies to Chapter II, Program Description, §II.5.1.f.

Section II.L:

a. This section omits reporting of child abuse to DFS and the DSCY&F Office of Child Care licensing (which licenses 1500+ facilities). The DSCY&F Website contains information on reporting child abuse. Abuse/neglect of pediatric nursing home residents would be reported to the DLTCRP. See 16 DE Admin Code 3210 and 16 DE Admin Code 3201, §9.8.

b. This section is inconsistent with Chapter II, Program Description, §14.10. The latter section erroneously contemplates reporting all incidents involving adults to APS to the exclusion of the DLTCRP and Ombudsman. The latter section does refer to "Child Protective Services" for children. However, it omits any reference to reporting abuse/neglect of pediatric nursing home patients to the DLTCRP.

CHAPTER II: PROGRAM DESCRIPTION

Section II.1: This section recites that "(t)he State wishes to have a maximum of two Contractors to provide a statewide managed care service delivery system...". This is apart from the State-run MCO, Diamond State Partners (DSP) which DHSS notes is closed to new members. See also §II.3.3. There are multiple "concerns" with this approach.

a. The Division of Prevention and Behavioral Health Services (DPBHS) is an MCO under the DSHP. This is not clarified in this section or elsewhere in the document. Section II.7.6.2.1, which uses outdated references to the Division of Child Mental Health Services, does not identify DPBHS as an MCO under the DSHP. Parenthetically, an outdated reference to DCMHS also appears in §9.5.2.

b. Allowing only the 2 current private MCOs to implement the DSHP Plus severely limits participant freedom of choice. The original DSHP had four (4) MCOs - Amerihealth, Blue Cross, First State, and Delaware Care. This provided real competition and an incentive to offer supplemental services (e.g. eyeglasses) to attract participants. Although the current plan authorizes MCOs to offer supplemental services (§§II.7.3.1.a; 7.3.3; and 7.5, final bullet), the prospects for MCOs offering such services are marginal given the non-competitive system adopted by DHSS. The prospects for "conscious parallelism", "price fixing", and collusion are enhanced with only 2 MCOs. No RFP was issued to invite competitive bids to serve as an MCO. Moreover, DHSS eschews any negotiating leverage with the 2 approved MCOs which are quite aware of the burden faced by DHSS if 1 of the MCOs withdraws. The Concept Paper contains the following recitation:

> (I)n the unlikely event that one MCO should discontinue participation in DSHP Plus, DMMA requests authority to continue mandatory managed care for up to 15 months under a single MCO while DMMA seeks participation from a second qualified MCO.

This undermines the important "choice" feature of the Medicaid program and merits opposition. Moreover, given the history of MCO's dropping out of the DSHP, the representation that discontinuation of participation by 1 MCO is an "unlikely event" is not realistic. The only reason DHSS established a State-run MCO was because MCOs cited monetary losses, dropped out of the DSHP, and left only one private MCO.

It would be preferable to include DSP as an MCO implementing DSHP Plus or to issue an RFP to enroll more than 2 private MCOs.

c. Freedom of choice is likewise reduced through other features of the plan:

1) Participants transferred from 1 MCO to the second MCO are required to stay with the second MCO forever. [§5.2.2, last paragraph]

2) MCOs may deny the election of participants with chronic illnesses and disabling conditions to have a specialist serve as their PCP. [§II.6.3.d]

3) When an existing DSHP member is determined eligible for DSHP Plus, the member must pursue a good cause exemption or categorically remain with that MCO. [§II.3.2, third paragraph]

Section II.3.3.1.1: It would be preferable to include a reference to incorporation of the following information in enrollment materials: 1) supplemental services offered by each MCO (§§II.7.3.1.a; 7.3.3; and 7.5, final bullet); and 2) list of providers in MCO's network and their locations. See §II.3.3.5.g and II.9.3e.iii.

Sections II.3.3.4 and II.8.1: The availability of retroactive coverage merits endorsement. However, in the context of community-based members, it is unclear if members can receive 2 months of retroactive coverage. Chapter II, Program Description, §II.8.1a. recites as follows: "The State will retroactively enroll DSHP members no more than two (2) months if deemed eligible." Does this mean that a member can obtain retroactive payment of eligible medical bills?

Section II.4.1: It would be preferable to include the following sentence after "Transfers...DMMA.": "'Good cause' will not be restrictively construed."

Section II.5.2.1: This section is too limited in identifying potential bases for "good cause". For example, a member may have relocated to an area of the State in which the current MCO has minimal provider options; a member may have relied on incorrect information (e.g. provider list; availability of supplemental benefit such as chiropractic treatment) proffered by the existing MCO; the member's primary language is uncommon and another MCO has a case manager or in-network PCP who speaks that language. The bottom line is that there are numerous ways in which "good cause" can arise beyond the 4 listed in this section. At a minimum, DHSS should consider a "catch-all" provision, e.g., "e. Other circumstances reasonably justifying transfer."

Section II. 5.2.2d:

a. This section authorizes the involuntary transfer of a participant from an MCO based on the following:

> A member for whom the Contractor has determined that it cannot safely and effectively meet the member's needs at a cost less than the member's cost neutrality cap, and the member declines to transition to a nursing facility.

This is somewhat disturbing. It could have an in terrorem effect on the member to accept nursing home placement. Moreover, since the waiver is based on an aggregate cost benchmark, there should be no individual "member cost neutrality cap". Finally, it is inconsistent with §5.2.2, Par. c ("high cost medical or behavioral health bills" do not justify disenrollment from MCO).

b. This section also authorizes involuntary transfer of a participant from an MCO based on the following:

> A member refuses to receive critical home and community based services as identified through the Contractor's needs assessment and documented in the member's plan of care.

This is ostensibly "heavy handed". If a member declines services for religious reasons, that should not justify involuntary transfer. Alternatively, a member could reasonably decline services due to side effects or other health risks (e.g. chemotherapy).

Section II.5.2.2.g: This section allows disenrollment from an MCO if disability-based disruptive behavior seriously impairs the MCO's ability to furnish services to the member or other

members. This is problematic since it authorizes disenrollment regardless of fault. For example, an individual with Alzheimer's or a TBI survivor with brain damage may be disruptive based on medical condition. Justifying disenrollment based on difficulty in providing services is overbroad.

Section II.6.6:

a. DHSS may wish to search the document to eliminate outdated language such as "handicapped" and "handicap" [§9.6d].

b. The "Language" section addresses Title VI standards but does not address ADA-based ASL interpreter services. For example, Par. "a" refers to "spoken" languages. ASL is not a "spoken" language.

Section II.6.11.2: It would be preferable to include a reference to sources of free or low cost legal assistance, including CLASI's ELP and DLP.

Section II.7.1.1: The EPSDT reference merits endorsement. However, in §II.7.1.1.3, the reference to "Medicaid- covered services" could easily be misconstrued to include only those services covered in the Delaware Medicaid system. Under EPSDT, providers may be required to cover medically necessary services authorized in the Federal Medicaid system, including optional services, regardless of whether Delaware has incorporated the optional service in its Plan. See attached HHS EPSDT Overview at p. 3.

Section II.7.1.1.5: There is an overlooked DHSS note - "Is this still accurate?".

Section II. 7.2.1.2: It may be implicit in this section that no reduction of services should occur without a face-to-face meeting. However, it would be preferable to make this requirement explicit. The same comment applies to Chapter II, Program Description, §8.2.1. DHSS should also clarify that the requirement of a face-to-face review prior to proposing a reduction in services will apply not only to new members but across-the-board. Compare attached April 8, 1996 letter from Phil Soule, Medicaid Director, to EDS and January 27, 2000 letter from Phil Soule, Medicaid Director, to Brian Hartman.

Section II. 7.2.6: This section should include an explicit reference to Title 16 Del.C. §214.

Section II.7.4: DHSS should consider whether to include a reference to EPSDT services in this section since they are apart from the Basic Benefit Package. See §II.7.1.1.3. DHSS may also wish to substitute "actuarially" for "actually".

Section II.7.5:

a. The presumptive 14-day respite cap, 20 -session cognitive services cap, home modification caps, and transition services cap can be exceeded. However, there are no standards to guide exceptions.

b. The last paragraph authorizes MCOs to limit services by invoking "utilization control" apart from medical necessity. This is an open invitation to limit the scope or extent of services based on arbitrary considerations. A similar objectionable recital appears in §II.9.1a.

c. There is some "tension" between the definition of attendant services in this section and the State statutory attendant services criteria which include bill payment and money management. See Title 16 Del.C. §9403(1). DHSS should consider how to ensure the full availability of State statutory attendant services to individuals enrolled in the DSHP Plus.

Section II.7.5.3: The interaction between the planned DSAAPD assessment of public nursing home residents and the MCO assessment contemplated by this section is unclear. There could be overlapping and redundant screenings.

Section II.7.6.3: This section contains the following problematic recital: "School-based therapy services (e.g. occupational, physical and speech therapy) are excluded from the MMC and are expected to be provided by the School." This statement is a flagrant violation of federal law. See attached In re A.G., DCIS NO. 5000703852 (DSS June 22, 2000) which rejected an MCO's attempt to deny in-home speech therapy since the school district was providing speech therapy. Moreover, the standards for determining the extent of speech therapy in school are based on educational progress which differ from medical justification.

Sections II.8.2.1 and 8.2.1.1: DHSS is categorically continuing existing payment rates for nursing homes for 3 years. In contrast, no such "hold harmless" provision applies to community providers. The predictable result is that nursing homes will receive relatively higher payment for services than community providers who will be forced to negotiate rates with MCOs. Moreover, the negotiating leverage of current community providers is explicitly undermined by only allowing payment of 80% of the contractual provider rate if the providers decline the MCO's proposed contract rate. See §8.2.3. The Councils may wish to highlight this "dynamic" to DelARF. It may be preferable to consider "carve outs" for long-term community contractors (e.g. Easter Seals) similar to that being established for nursing homes. For example, DHSS has essentially established a "carve out" for Westside, La Red, and Henrietta Johnson which are entitled to at least the Medicaid fee-for-service rate. [§II.8.2.4] A less explicit exhortation to contract with Nemours is contained at §II.9.4.4.

Section II.9.1:DHSS has a regulation defining "medical necessity" [2 DE Reg. 748 (November 1, 1998)] which has traditionally applied to the DSHP. In contrast, §9.1 "muddies the waters" by allowing MCOs to adopt their own definitions of medical necessity. Whether an MCO definition of "medical necessity" is more or less restrictive than the DHSS regulation may result in considerable disagreement and litigation. DHSS should simply require MCOs to abide by the existing regulatory definition of medical necessity.

Section II.9.4: DHSS should ensure that the treatment plan criteria comport with Title 16 Del.C. §9404(6) for anyone receiving attendant services. This includes use of a standard DHSS form.

Sections II.12.1-12.4:

a. DHSS should reiterate its policy of tolling the time period for members to request a fair hearing while pursuing an internal MCO grievance. Under the proposed system, if a member pursues an MCO grievance and appeal, the time frame for resolution is at least 90 days which may be extended to 104 days [§12.4]. As a practical matter, the 90 days to request a fair hearing will often expire by the time the MCO issues its grievance decision. The approach adopted by DHSS under the DSHP was to characterize the MCO grievance decision as a "notice of action" permitting the member to request a fair hearing within 90 days of the new decision. <u>See</u> attached January 27, 2000 letter from Phil Soule, Medicaid Director, to Brian Hartman. Parenthetically, this provides the MCO with an incentive to process its internal grievances without "dragging out the process" so the member "conveniently" loses his/her time to request a fair hearing. An MCO attack on this interpretation was soundly rejected by a DSS hearing officer. <u>See</u> attached <u>In re A.B</u>, ID 001030240*01 (DSS September 12, 2001). In that case, the hearing officer specifically endorsed the above "Soule" guidance, commenting as follows:

> This language clearly indicates that it is the policy of the DMAP to allow requests for State fair hearings after conclusion of the MCO internal review process has been completed subject to the 90-day rule. The language is also consistent with both federal and state law, as indicated above, in that the plain meaning of the federal and state law both allow for requesting a hearing within 90 days of an action....
>
> To maintain that First State's internal process has absolutely nothing to do with the fair hearing process is ludicrous, at best. As written, but not as interpreted by First State, the current fair hearing procedures continue to provide procedural and substantive protection to those parties aggrieved by an adverse decision of the managed care organization. To interpret the regulations in any other manner would deprive members of these protections and provide absolutely no oversight of First State's ultimate determination.
>
> With respect to the mandates of 42 U.S.C. §431.221(d) and DSSM §5305(2), this hearing officer finds that the 90-day rule attaches to the Second denial notice dated March 9, 2001 and not the December 20, 2000 "Service Denial". Therefore, the Appellant's request for a State Fair Hearing dated Mach 20, 2001 is within the statutorily mandated 90-day period. As such, First State's Motion to Dismiss the request for a State Fair Hearing is denied.

At p. 5. On a practical level, it is also common for an MCO grievance decision to modify its original decision. However, limiting fair hearing requests to 90 days from the <u>original</u> decision renders the "modified" decision exempt from review in a fair hearing even though it is the final or superseding decision. The "Soule" guidance disallows such an absurd result.

b. Section II.12.2 violates standards imposed by <u>Ortiz v. Eichler</u>, 616 F. Supp. 1046, 1061 (D.Del. 1985), <u>aff'd</u>, 794 F.2d 889 (3dCir. 1986), <u>E. v. Department of Health & Social Services</u>, C.A. No. 02A-09-002 HDR (Del. Super. February 25, 2004) and partially reiterated in 16 DE Admin Code 5000, §5300.

First, it omits "the specific regulation supporting such action" contrary to the above precedents.

Second, it substitutes an anemic "(t)he reasons for the action" for the judicially-imposed standard of "detailed individualized explanation of the reason(s) for the action taken which includes, in terms comprehensible to the claimant, an explanation of why the action is being taken." See attached In re A.B., DCIS - (1999),enforcing Ortiz injunction; and 16 DE Admin Code 5000, 5300D.

Parenthetically, it would be preferable to include a requirement that the notice include information about the availability of free or low cost legal services, including the DLP and ELP.

Section II.12.4: The 90 day time period to issue a grievance decision, which can be extended to 104 days, is too long.

Section II.13.2.3.1 and II.13.2.4.g: These sections may literally allow non-medical staff to issue decisions denying medical benefits. They allow the case manager (who may lack a high school diploma) to "deny or limit non-skilled long term care services". This suggests that the case manager could deny DME not within a facility's per diem rate, cognitive services, attendant services, chiropractor services, etc. This authorization should be deleted.

Section II.13.5.2: A maximum penalty of $1,000 per month for failure to cure systemic deficiencies or submit a corrective action plan is too low to be meaningful.

Attachments

8g:bilreg/casemgt
F:pub/bjh/legis/2011p&l/dshp+9211critique