

**Delaware Health
and Social Services**

EXCERPT

Office of the Secretary

1901 N. DUPONT HIGHWAY, NEW CASTLE, DE 19720 * TELEPHONE: 302-255-9040 FAX: 302-255-4429

MEMORANDUM

TO: Governor Jack Markell
Members of the General Assembly

FROM: Rita M. Landgraf, Secretary *RML*

DATE: November 17, 2015

SUBJECT: **Delaware Health Fund Advisory Committee
Fiscal Year 2017 Recommendations**

On behalf of the Delaware Health Fund Advisory Committee (HFAC), I present you with our Fiscal Year 2017 (FY17) Health Fund recommendations. The Committee's final decisions reflect several hours of discussion.

The State anticipates receiving \$25,189.6 million (principal payment and interest) in Tobacco Settlement Funds for FY16. The available Reserve balance is \$405,100.

The FY17 recommendation of HFAC is as follows:

- Fund Medicaid and Medical Assistance mandates, the Department of Justice, Wesley College, the Department of Services for Children, Youth, & Their Families, and the Division of Alcohol and Tobacco Enforcement at the levels requested in their applications;
- Use General Fund dollars instead of Health Fund dollars to fund the positions at Delaware Technical and Community College (Del Tech) and to fund the Delaware Healthy Children Program;
- Increase funding for the Division of Public Health's Tobacco Prevention Programs;
- Increase funding for the Delaware Cancer Consortium Sub-Grantees; and
- Fund the remaining applicants at the same level as FY16.

In discussions leading to these recommendations, HFAC members responded to requests they heard from applicants and the public. Del Tech said that they would be asking for the funding for the positions currently supported by the Health Fund to be instead funded as part of their General Fund budget request. HFAC members strongly believe that these Del Tech positions should be funded and do not in any way recommend eliminating funding for them during the budget process. In the event General Fund dollars are not allocated for these Del Tech positions, then HFAC recommends funding Del Tech in the amount of \$1,828.7 from the Health Fund.

However, by transferring these positions to the General Fund, HFAC recognized that those Health Fund dollars could be used instead to avoid reducing funding for most other applicants.

During public comment periods, HFAC received testimony from many members of the public urging an increase in spending on Tobacco Prevention programs. Over the past several years, funding for Tobacco Prevention programs has been falling and these programs provide a documented role in reducing smoking rates. This work is both at the heart of the Tobacco Master Settlement Agreement that is the source of this revenue and saves lives, and money, because fewer people will develop tobacco-related health problems. The HFAC members thus recommend increasing funding for Tobacco Prevention programs and using General Fund dollars for the Delaware Healthy Children Program.

The details of this recommendation are set forth more fully in the attached spreadsheet. This recommendation expends \$25,189.6 million which can be done without spending any funds from the Reserve.

HFAC again recommends establishing an Innovation Fund at the Delaware Community Foundation for the purpose of funding health-related programs in concert with the intent of the Tobacco Master Settlement. Health Fund revenue has been decreasing, due to the decline in cigarette sales, a main goal of the tobacco lawsuit and Master Settlement Agreement. HFAC is extremely concerned about the sustainability of funding for the important work currently funded by the Health Fund in light of the decreasing revenue and thus seeks to explore leveraging private resources to support this important work. This recommendation includes having HFAC serve as the governing body for the Innovation Fund.

The details of this recommendation are set forth more fully in the attached spreadsheet.

As the Chair of the HFAC, I would like to commend the members for their dedication and contribution to the Health Fund process:

Senator Patricia Blevins
Senator David McBride
Senator Bethany Hall-Long
Dr. Charles Reinhardt
Ms. Bettina Riveros, Esq.

Representative Debra Heffernan
Representative Edward Osienski
Mr. Donald Fulton
Ms. Paula Roy

Please contact me if you have any questions.

Enclosure

pc: Health Fund Advisory Committee Members
Ann Visalli, Director, Office of Management and Budget
Michael Morton, Office of the Controller General
Kimberly Reinagel-Nietubicz, Office of the Controller General

FY 2017 Health Fund Advisory Committee Final Recommendations - Details
November 9, 2015 Meeting

EXISTING PROGRAMS	FY '16 Budget	FY '17 Request	FY 17 FINAL HFAC RECOMMENDATION
Cancer Programs			
Cancer Consortium Recommendations (DHSS - DPH)	\$8,365.0	\$8,365.0	\$8,828.5
Consortium Sub-Grantees:			\$0.0
a) DE Breast Cancer Coalition	\$68.3	\$100.0	\$68.3
b) Breast and Cervical Cancer Treatment (DHSS - DMMA)	\$380.0	\$335.0	\$335.0
c) Cancer Care Connection	\$126.8	\$126.8	\$126.8
d) Cancer Support Community (Formerly The Wellness Community)	\$128.0	\$128.0	\$128.0
Subtotal	\$9,068.1	\$9,054.8	\$9,486.6
Disability Programs			
Medical Coverage for SSI Transition (DHSS - DMMA)	\$3,891.3	\$3,120.0	\$3,120.0
Attendant Care/HB 30 (DHSS - DDDS)	\$59.4	\$63.2	\$59.4
Attendant Care/HB 30 (DHSS - DSAAPD)	\$603.8	\$603.8	\$603.8
SSI Supplement (DHSS - DSS)	\$943.4	\$943.4	\$943.4
Money Follows the Person (DHSS - OSEC-\$32.0, DMMA-\$800.0)	\$842.0	\$832.0	\$832.0
Subtotal	\$6,339.9	\$5,562.4	\$5,558.6
Tobacco Prevention and Control Programs			
Tobacco Prevention - Department of Justice	\$243.5	\$223.4	\$223.4
Tobacco Prevention - Department of Services for Children, Youth & Their Families	\$39.9	\$40.0	\$40.0
Tobacco Prevention - Div. of Alcohol and Tobacco Enforcement	\$416.3	\$561.6	\$561.6
Tobacco Prevention (DHSS - DPH)	\$1,740.0	\$3,403.7	\$3,329.9
Mammography Van (Delaware Breast Cancer Coalition) Included in FY 15 DPH Tobacco Contractual Funding and FY 16 HFAC Recommendations	\$294.1	\$294.1	\$294.1
Subtotal	\$2,733.8	\$4,522.8	\$4,449.0
* Delaware Prescription Assistance Program (DHSS - DMMA)	\$2,500.0	\$2,500.0	* \$2,500.0
Subtotal	\$2,500.0	\$2,500.0	\$2,500.0
Workforce Development Programs			
New Nurse Formation Programs - Del Tech	\$1,977.0	\$2,535.0	\$0.0
Nursing Program - Wesley College	\$0.0	\$75.0	\$75.0
Nursing Program - Polytech Adult Education	\$74.4	\$79.1	\$74.4
Delaware State University - Nursing Program	\$101.5	\$101.5	\$101.5
Subtotal	\$2,152.9	\$2,790.6	\$250.9
Behavioral Health Programs			
Heroin Residential Program - Gaudenzia, Inc.	\$287.9	\$287.9	\$287.9
Substance Abuse Transitional Housing	\$140.7	\$140.7	\$140.7
Limen House	\$51.1	\$62.7	\$51.1
Delaware Schools ATODA Survey - University of Delaware	\$19.4	\$20.6	\$19.4
Project Renewal Program - Brandywine Counseling	\$113.0	\$148.0	\$113.0
Subtotal	\$612.1	\$659.9	\$612.1
Consumer Education Programs			
Nurse Family Partnership - Children & Families First	\$158.8	\$158.5	\$158.8

SB 285
FY17 BUDGET

(35-00-00) DEPARTMENT OF HEALTH AND SOCIAL SERVICES

	Personnel				\$ Program		\$ Line Item	
	NSF	ASF	GF		ASF	GF	ASF	GF
1								
2								
3								
4								
5				(35-02-00) Medicaid and Medical Assistance				
6	108.8		78.1	Personnel Costs				5,193.2
7				Travel				0.1
8				Contractual Services				3,964.4
9				Energy				29.3
10				Supplies and Materials				35.7
11				Capital Outlay				6.6
12				Tobacco Fund:				
13				Prescription Drug Program *			2,500.0	
14				Medical Assistance Transition			3,120.0	
15				Medicaid			667.0	
16		1.0		Money Follows the Person			800.0	
17				Delaware Healthy Children Program			1,936.3	
18				Cancer Council Recommendations:				
19				Breast and Cervical Cancer Treatment			335.0	
20				Other Items:				
21				Medicaid			23,000.0	752,301.2
22				Medicaid for Workers with Disabilities			47.5	
23				Medicaid/NonState			200.0	
24				DOC Medicaid			1,500.0	
25				Medicaid Other			500.0	
26				DPH Fees			300.0	
27				Delaware Healthy Children Program Premiums			600.0	
28				Delaware Healthy Children Program - DSCYF			800.0	
29				Cost Recovery			275.1	
30				Renal				729.5
31				Medicaid Long Term Care			20,115.0	
32				Disproportionate Share Hospital				3,901.4
33				Nursing Home Quality Assessment			14,000.0	
34				Technology Operations				1,211.3
35	108.8	1.0	78.1	TOTAL -- Medicaid and Medical Assistance			70,695.9	767,372.7
36								
37	108.8	1.0	78.1	(-01) Medicaid and Medical Assistance	70,695.9	767,372.7		
38	108.8	1.0	78.1	TOTAL -- Internal Program Unit	70,695.9	767,372.7		

145 / E
 HB NO 225
 7/18 BUDGET

(35-00-00) DEPARTMENT OF HEALTH AND SOCIAL SERVICES


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Personnel		
NSF	ASF	GF
107.4		77.0
	1.0	
107.4	1.0	77.0

	\$ Program		\$ Line Item	
	ASF	GF	ASF	GF
(35-02-00) Medicaid and Medical Assistance				
Personnel Costs				6,239.1
Travel				0.1
Contractual Services				3,962.4
Energy				29.3
Supplies and Materials				35.7
Capital Outlay				5.9
Tobacco Fund: *				
Medical Assistance Transition			1,891.0	
Medicaid			667.0	
Money Follows the Person			545.0	
Delaware Healthy Children Program			1,936.3	
Renal			729.5	
Cancer Council Recommendations:				
Breast and Cervical Cancer Treatment			175.0	
Other Items:				
Medicaid			23,000.0	760,112.7
Medicaid for Workers with Disabilities			47.5	
Medicaid/NonState			200.0	
DOC Medicaid			1,500.0	
Medicaid Other			500.0	
DPH Fees			300.0	
Delaware Healthy Children Program Premiums			600.0	
Delaware Healthy Children Program - DSCYF			800.0	
Cost Recovery			275.1	
Medicaid Long Term Care			20,115.0	
Disproportionate Share Hospital				3,901.4
Nursing Home Quality Assessment			18,000.0	
Technology Operations				1,211.3
Pathways			200.0	
Promise			200.0	
TOTAL -- Medicaid and Medical Assistance			71,681.4	775,497.9

107.4	1.0	77.0
107.4	1.0	77.0

(-01) Medicaid and Medical Assistance	71,681.4	775,497.9
TOTAL -- Internal Program Unit	71,681.4	775,497.9

 Total Suspected Overdose Deaths in Delaware for 2017: 132
(<http://www.helpisherede.com/#intro>)



DHSS Menu

(<http://delaware.gov>)

Delaware Prescription Assistance Program

The program has ended and is no longer accepting applications.

TITLE 16

Health and Safety

Regulatory Provisions Concerning Public Health

CHAPTER 30B. PRESCRIPTION DRUG PAYMENT ASSISTANCE PROGRAM

§ 3001B Short title.

72 Del. Laws, 1st Sp. Sess., c. 259, § 1; repealed by 81 Del. Laws, c. 58, § 40, eff. July 3, 2017.;

§ 3002B Purpose.

72 Del. Laws, 1st Sp. Sess., c. 259, § 1; 75 Del. Laws, c. 17, § 1; repealed by 81 Del. Laws, c. 58, § 40, eff. July 3, 2017.;

§ 3003B Definitions.

72 Del. Laws, 1st Sp. Sess., c. 259, § 1; 75 Del. Laws, c. 17, § 2; repealed by 81 Del. Laws, c. 58, § 40, eff. July 3, 2017.;

§ 3004B Eligibility.

72 Del. Laws, 1st Sp. Sess., c. 259, § 1; 70 Del. Laws, c. 186, § 1; 75 Del. Laws, c. 17, §§ 3-7; 76 Del. Laws, c. 7, §§ 1, 2; repealed by 81 Del. Laws, c. 58, § 40, eff. July 3, 2017.;

§ 3005B Program administration.

72 Del. Laws, 1st Sp. Sess., c. 259, § 1; 75 Del. Laws, c. 17, §§ 8, 10; 75 Del. Laws, c. 363, § 1; repealed by 81 Del. Laws, c. 58, § 40, eff. July 3, 2017.;

§ 3006B Annual report.

72 Del. Laws, 1st Sp. Sess., c. 259, § 1; 75 Del. Laws, c. 17, § 11; repealed by 81 Del. Laws, c. 58, § 40, eff. July 3, 2017.;

§ 3007B Pharmacist duty.

72 Del. Laws, 1st Sp. Sess., c. 259, § 1; repealed by 81 Del. Laws, c. 58 § 40, eff. Mar. 7, 17. ;



STATE OF DELAWARE

PUBLIC NOTICE AND NOTICE OF PUBLIC HEARINGS

DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

**DELAWARE DIAMOND STATE HEALTH PLAN
1115 DEMONSTRATION WAIVER AMENDMENT**

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code) and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) intends to submit two requests to the Centers for Medicare and Medicaid Services (CMS) to amend Delaware's Section 1115 Diamond State Health Plan Demonstration Waiver.

Purpose

The purpose of this posting is to provide public notice and receive public input for consideration regarding Delaware's 1115 Diamond State Health Plan (DSHP) Waiver amendments. Delaware is proposing two amendments to the 1115 waiver that will be submitted to CMS at the same time. These amendments cover two separate populations. Amendment 1 addresses DDDS Lifespan Waiver enrollees in Managed Care. Amendment 2 addresses Out-of-State Former Foster Care Youth.

Background

Delaware's 1115 DSHP Waiver demonstration was initially approved in 1995, and implemented on January 1, 1996. The demonstration mandatorily enrolls eligible Medicaid recipients into managed care organizations (MCOs) to create efficiencies in the Medicaid program and enable the expansion of coverage to certain individuals who would otherwise not be eligible for Medicaid. Beginning January 1, 2014, DSHP expanded eligibility for individuals with incomes up to and including 133 percent of the Federal Poverty Level (FPL). The demonstration also provides long-term care services and support (LTSS) to eligible individuals through a mandated managed care delivery system, entitled DSHP-Plus. Beginning January 1, 2015, the state implemented Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE), a voluntary program that provides enhanced behavioral health services and supports for targeted Medicaid beneficiaries.

Additionally, On May 25, 2017, CMS approved an amendment to Delaware's Home and Community-Based Services (HCBS) 1915(c) waiver that serves individuals with intellectual and developmental disabilities (IDD). The waiver was rebranded as the Divisions of Developmental Disability Services (DDDS) Lifespan Waiver and amended to allow Delaware to expand the waiver's target criteria to enroll

individuals who live with their family. The amendment also added HCB services designed to meet the needs of families who support a loved one with intellectual and developmental disabilities in the family home.

Overview and Summary of Proposed 1115 DSHP Waiver Amendments

Proposed Amendment 1: DDS Lifespan Waiver enrollees in Managed Care

Under the current design of the 1115 DSHP Waiver, individuals enrolled in the 1915(c) Lifespan Waiver are excluded from the 1115 waiver as a result of a state policy decision made at the time the 1115 waiver was implemented in 1996. All benefits for individuals enrolled in the 1915(c) Lifespan Waiver, both waiver and non-waiver, are paid as fee for service. When an individual enrolls in the 1915(c) Lifespan Waiver, they are dis-enrolled from the 1115 waiver and are, therefore, also dis-enrolled from their Managed Care Organization. Individuals who are not enrolled in the 1915(c) waiver but have a diagnosis of IDD and live in their homes or family home, are enrolled in the in the 1115 Waiver— Managed Care program. Under this amendment, Delaware desires to enable individuals to remain enrolled in the 1115 DSHP Waiver in order to receive their State Plan benefits from a managed care organization if they also choose to enroll in the DDS Lifespan waiver. If Delaware does not amend the 1115 waiver, new enrollees in the DDS Lifespan 1915(c) waiver who have previously been enrolled in the 1115 waiver will be forced to dis-enroll from the Managed Care Organization. This amendment is needed to avoid unnecessarily disrupting the lives of prospective DDS Lifespan waiver enrollees who live with their family. These individuals have established relationships with the Managed Care Organizations and their network of providers to whom they have become accustomed.

Proposed Amendment 2: Out-of-State Former Foster Care Youth

On November 21, 2016, CMS published the final rule clarifying that states can provide coverage to former foster care youth who were in Medicaid and foster care in a different state with income up to 133 percent of the federal poverty level (FPL) under the new adult group identified in the ACA. Additionally, states can use 1115 demonstration authority to provide coverage for former foster care youth who were in foster care under the responsibility of other states and have income higher than 133 percent of the FPL. States that provide coverage under the new adult group have the option of covering former foster care youth with MAGI-based income above 133 percent of the FPL, under the eligibility group described in section 1902(a)(10)(ii)(XX) of the Act and implementing regulations at 42 CFR 435.218.

Delaware currently provides coverage to former foster care youth under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care in Delaware when they turned age 18 or “aged out” of foster care. Delaware also currently provides coverage to individuals with income up to 133 percent of FPL under the new adult group identified in the ACA. The purpose of this amendment is to provide coverage on a state-wide basis to former foster care youth who currently reside in Delaware and were in foster care and enrolled in Medicaid at age 18 or when they “aged out” of the system in a different state.

Public Comment Submission Process

As required by 42 CFR Part 441.304, DHSS/DMMA must establish and use a public input process for any changes in the services or operation of the waiver. Per Del. Code, Title 29, Ch. 101 §10118 (a), The opportunity for public comment shall be held open for a minimum of 30 days after the proposal is published in the Register of Regulations. The opportunity for public written comment shall be extended for a minimum of 15 days after the final public hearing when 1 or more public hearings are held on the proposal. The public is invited to review and comment on the proposed Lifespan Waiver Amendment. Comments must be received by 4:30 p.m. on September 11, 2017. Comments may be submitted in the following ways:

This public notice and the Amendment are posted DHSS/DMMA website at:
<http://dhss.delaware.gov/dhss/dmma/>

Comments and input may be submitted in the following ways:

By email: Nicole.M.Cunningham@state.de.us
By fax: 302-255-4413 to the attention of Nicole Cunningham
By mail: Nicole Cunningham
Division of Medicaid and Medical Assistance
Planning, Policy & Quality Unit
1901 North DuPont Highway
P.O. Box 906
New Castle, Delaware 19720-0906

Public Hearings

Notice will be published regarding the amendments in the August 1, 2017 Delaware Register of Regulations. The comment period begins on August 1, 2017 and ends on September 11, 2017.

This timeframe allows an additional period of 15 days for the public to comment after the last public meeting. Following the comment period, the State reviews, considers, and responds to all comments received.

1. NEW CASTLE COUNTY

Date: August 25, 2017
TIME: 2:30 PM – 3:30 PM
LOCATION: DDDS Fox Run Center
2540 Wrangle Hill Road
Suite 200, Bear, DE 19701

2. KENT COUNTY

Date: August 22, 2017
TIME: 2:30 PM – 3:30 PM
LOCATION: Legislative Hall
411 Legislative Avenue
Dover, DE 19901

SUSSEX COUNTY

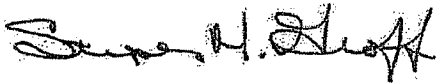
Date: August 22, 2017
TIME: 10:45 AM – 11:45 AM
LOCATION: Thurman Adams State Svc Center
546 S. Bedford St.
Georgetown, DE 19947

Any public feedback received will be summarized including any changes that will be made as a result of the public comment to the proposed 1115 DSHP Waiver Amendments that will be submitted to CMS.

If you require special assistance or auxiliary aids and/or services to participate in the public hearing (e.g., sign language or wheelchair accessibility), please call the following contact at least ten (10) days prior to the hearing for arrangements:

Lauren Gunton at (302) 255-9561

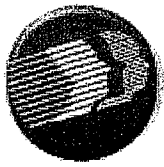
The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations in advance.



Stephen M. Groff
Director
Division of Medicaid and Medical Assistance

July 10, 2017

Date



Delaware Health and Social Services

A Proposed Amendment to the Delaware
Section 1115 Demonstration Waiver

to

The Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

State of Delaware

Stephen Groff, Director
Division of Medicaid & Medical Assistance (DMMA)

Section I – Program Description

On May 25, 2017, the State of Delaware received approval to amend its Division of Developmental Disability Services (DDDS) 1915(c) Home and Community-Based Services Waiver effective July 1, 2017. As part of the amendment process, Delaware renamed the 1915(c) DDDS Waiver to the 1915(c) DDDS Lifespan Waiver to reflect the continuum of waiver enrollment across the lifespan of the recipients.

The Division of Developmental Disabilities Services (DDDS) Home and Community Based Services Lifespan Waiver provides services and supports as an alternative to institutional placement for individuals with intellectual developmental disabilities (IDD) (including brain injury), autism spectrum disorder or Prader-Willi Syndrome.

The goal of these services is to support individuals to live healthy, independent and productive lives in the community. In addition, the amended waiver provides new flexible person-centered supports designed to assist the families to enable the waiver participant to remain in his/her family home for as long as possible. Services are intended to promote independence through strengthening the individual's capacity for self-care and self-sufficiency while respecting their needs and preferences. DDDS also offers the option for individuals to transition from ICF/IID institutions to the community using the waiver to provide residential and other supports.

The objectives of the DDDS Lifespan Waiver are to: Promote independence for individuals enrolled in the waiver and promote the engagement of family and other natural supports whenever possible; Offer an alternative to institutionalization through the provision of an array of services and supports that promote community integration and independence; Protect the health and safety of the participants receiving services under the waiver; and Ensure the highest standards of quality and best practices, through a network of qualified providers.

A summary of the services covered include:

- Day Habilitation
- Personal Care *
- Prevocational Services
- Respite *
- Supported Employment (Individual and Small Group)
- Assistive Technology for Individuals not otherwise covered by Medicaid *
- Clinical Consultation (Nursing and Behavioral)
- Community Transition *
- Home or Vehicle Accessibility Adaptations *
- Specialized Medical Equipment and Supplies not otherwise covered by Medicaid *
- Supported Living

* Added via May 25th amendment

The purpose of the 1915(c) DDDS Lifespan Waiver amendment is to increase the waiver enrollment limits to include individuals with intellectual and developmental disabilities, autism, and/or Prader-Willi Syndrome who have left school but who do not require a residential support as of the time of enrollment. These individuals that are the target of the waiver expansion typically live in the family home and are currently enrolled in Delaware's 1115 Diamond State Health Plan (DSHP) Waiver to receive their regular Medicaid State Plan benefits via enrollment with a Managed Care Organization.

Since the inception of Delaware's 1115 waiver in 1994, individuals enrolled in the 1915(c) waiver have been carved out of the 1115 DSHP Waiver as a result of a state policy decision. If we do not amend the 1115 waiver, individuals living in the family home who wish to enroll in the DDDS Lifespan Waiver, who have been receiving their State Plan benefits from a Managed Care Organization, would have one of two options:

- be dis-enrolled from managed care, or
- delay enrolling in the Lifespan Waiver

Delaware desires for these individuals to continue to receive their non-1915(c) waiver benefits from an MCO. To that end, Delaware seeks CMS approval to amend the current 1115 DSHP Waiver to enable the individuals that do not live in a provider-managed residential setting to remain enrolled in the DSHP 1115 Waiver in order to continue to receive their acute care benefits from their MCO. If Delaware does not make this amendment, the lives of these individuals will be needlessly disrupted.

Members that are receiving DSHP Plus LTSS under the 1115 Waiver will be unaffected by this change if they choose to remain enrolled in DSHP Plus. DSHP Plus LTSS members with intellectual and developmental disabilities cannot be concurrently enrolled in the 1115 waiver and the DDDS Lifespan 1915(c) waiver. Individuals must choose the LTSS program that will best meet his or her needs. Individuals will be assisted to make that choice by the MCO case manager and a DDDS Community Navigator.

Section II – Demonstration Eligibility

The population affected by this Demonstration is comprised of individuals who are enrolled in the 1115 DSHP Waiver that qualify to be enrolled in the 1915(c) DDDS Lifespan Waiver on or after July 1, 2017 and are not receiving Residential Habilitation. This population will receive their regular Medicaid State Plan benefits via enrollment with a Managed Care Organization. Individuals who are enrolled in the 1915(c) DDDS Lifespan Waiver and are receiving Residential Habilitation will continue to be carved out of the 1115 DSHP Waiver and will receive their acute care benefits via fee for service. It is our plan to eventually include this population among the individuals who receive their State Plan benefits from an MCO but we were not able to perform the necessary up front work to do this concurrent with the amendment to the DDDS Lifespan Waiver.

Delaware has added 1122 unduplicated recipients to the DDDS waiver enrollment cap for WYE 4, the first year of the Lifespan amendment to allow enrollment of all individuals graduating from school that year and those who have already graduated and continue to living with their family. All of these newly enrolled individuals are currently enrolled in the 1115 DSHP Waiver.

The following optional eligibility group is being added to the 1115 DSHP Waiver to allow for this population to be enrolled in the 1915(c) DDDS Lifespan Waiver while receiving their regular Medicaid State Plan benefits via enrollment with a Managed Care Organization.

State Plan Medicaid Group	Optional Eligibility	Description/ Social Security Act and CFR Citations	Income Level/FPL	Resource Standard	Benefit Package
Individuals with IDD, autism, and/or Prader-Willi Syndrome enrolled in the 1915(c) DDDS Lifespan Waiver who are not receiving Residential Habilitation		§§1902(a)(10)(A)(ii)(VI)	250% of SSI Standard	\$2,000 individual \$3,000 couple	Diamond State Health Plan (DSHP)

Additionally, the excluded eligibility group, *Community-based individuals who meet the ICF/MR level of care (DDDS/MR 1915(c) Waiver)*, which is currently excluded under the 1115 DSHP Waiver is being modified to included only those individuals in the 1915(c) Lifespan Waiver that are receiving Residential Habilitation who meet ICF/IID level of care.

Exclusions from the DSHP and DSHP-Plus	Description/ Social Security Act and CFR Citations	Income Level/FPL	Resource Standard	Benefit Package
Community-based individuals living in a provider-managed residential setting to receive Residential Habilitation who meet ICF/IID level of care (DDDS Lifespan 1915(c) Waiver)	§1902(a)(10)(A)(ii)(VI)	250% of SSI Standard	\$2,000 individual \$3,000 couple	N/A

Section III – Demonstration Benefits and Cost-Sharing Requirements

Benefits provided to the population included in this application will be the same benefits that are provided for the current Medicaid population under Delaware’s Medicaid State plan.

1. Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

Yes No

2. Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

Yes No

Section IV – Delivery System and Payment Rates for Services

The health care delivery system for Demonstration participants will be no different than the healthcare delivery system that is in place today for Delaware's Medicaid population.

1. Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

Yes No

If this amendment is approved, individuals who will be newly enrolled in the DDDS Lifespan 1915(c) waiver will continue to receive their State Plan benefits from a Managed Care Organization. Lifespan waiver benefits will continue to be carved out of the 1115 demonstration. This is to ensure that their lives are not needlessly interrupted.

If CMS approves this change to the 1115 waiver, Delaware will revise the language in the 1915(c) DDDS Lifespan waiver to indicate that that waiver is operated concurrent with the 1115 waiver authority.

Section V – Implementation of Demonstration

Delaware is requesting approval, under Section 1115 Demonstration authority, to continue to provide coverage to individuals who are enrolled in the 1115 DSHP Waiver that are newly enrolled in the 1915(c) DDDS Lifespan Waiver and are not receiving Residential Habilitation in a provider-managed setting.

This amendment is needed to ensure that these individuals can continue to receive the Medicaid State Plan benefits they are eligible for via enrollment with a Managed Care Organization, concurrent with receipt of services and supports from the 1915(c) DDDS Lifespan Waiver in lieu of institutionalization to enable them to remain living with their family.

Section VI – Demonstration Financing and Budget Neutrality

Delaware is requesting to continue the Section 1115 expenditure authority for State Plan benefits received by individuals who will be newly enrolled in the 1915(c) DDDS Lifespan waiver. This

population is comprised of a Medicaid State Plan eligibility group described in §1902(a)(10)(A)(ii)(VI) of the Social Security Act. This group is already receiving Medicaid State Plan benefits via enrollment with a Managed Care Organization.

Section VII – List of Proposed Waivers and Expenditure Authorities

Expenditure Authorities:

Delaware is requesting to continue the Section 1115 expenditure authority for State Plan benefits received by individuals who will be newly enrolled in the 1915(c) DDDS Lifespan waiver. The 1915(c) waiver services received by individuals enrolled in that waiver will be delivered under the authority of the 1915(c) waiver.

Waiver Authorities:

Delaware is requesting approval, under Section 1115 Demonstration authority, to continue to provide coverage to individuals who are enrolled in the 1115 DSHP Waiver that are newly eligible for the 1915(c) DDDS Lifespan Waiver and are not receiving Residential Habilitation.

Section VII – Public Notice

1. Delaware provided an open comment period from November 1, 2016 to December 19, 2016 for the amendment to the DDDS HCBS 1915(c) waiver at which this proposed change to the 1115 waiver was presented.
2. Delaware published a Notice of Public Comment and Hearing in the Delaware Register of Regulations, the Delaware News Journal, and the Delaware State News on November 1, 2016 for the proposed amendment to the DDDS HCBS 1915(c) waiver. The publication in the Delaware Register can be found at: <http://regulations.delaware.gov/default.shtml>
3. A draft of the DDDS HCBS 1915(c) waiver amendment application was posted on the Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) and Division of Developmental Disabilities (DDDS) websites on November 1, 2016 as well.
4. Delaware conducted three public hearings on the amendment to the DDDS HCBS 1915(c) waiver at which this proposed change to the Section 1115 demonstration waiver was presented. The information for these hearings is as follows:
 - a. NEW CASTLE COUNTY
Monday, November 28, 2016, 6-7PM
Fox Run Large Training Conference Room 2nd floor
2540 Wrangle Hill Rd. Suite 200 Bear, DE 19701

b. SUSSEX COUNTY

Tuesday November 29, 2016, 1-2 pm
Thurman Adams State Service Center Conference Room 100
544 South Bedford Street Georgetown, DE 19947

c. KENT COUNTY

Wednesday, November 30, 2016, 3-4 pm
Dover Public Library Multi-Purpose Room A
15 Loockerman Plaza Dover, DE 19901

In addition to the public hearings and notice in the Delaware Register of Regulations, information about the proposed Lifespan Amendment to the DDDS HCBS 1915(c) waiver was also shared at the following public meetings:

- 4/17/16 and 10/26/16 Medical Care Advisory Committee (MCAC) quarterly meetings
- 9/21/16 DDDS Quarterly Provider Meeting
- 10/6/16 and 12/1/16 DDDS Day Service Provider meeting
- 11/15/16 DMMA's Bi-monthly joint MCO meeting
- 11/16/16 Governor's Council for Exceptional Citizens
- 11/17/16 Governor's Advisory Committee to DDDS, monthly meeting
- 11/18/16 Governor's Commission on Community Based Alternatives, quarterly meeting
- 11/21/16 State Council for Persons with Disabilities, monthly meeting

A number of changes were made to the amendment as a result of feedback received from the public during the comment period.

- The attached power point presentation about the proposed changes was used at the public hearings and the other public meetings outlined above. Slide 15 of the power point presentation indicated that, *For individuals living with their family: They will continue to be enrolled with an MCO who will cover their regular (i.e. non-waiver) healthcare needs.*

5. Delaware certifies that it used an electronic mailing list to notify the public.

6. A list of comments received and associated responses that pertain to this amendment is attached as Appendix A. This document was posted on the DDDS and DMMA websites along with the revised amendment that was submitted to CMS. Most of the public comment/questions requested clarification regarding elements of the waiver.

Section IX – Demonstration Administration

Name and Title: Glyne Williams, Social Services Chief Administrator,
Policy Planning, and Quality Unit, DMMA
Telephone Number: 302-255-9628
Email Address: Glyne.Williams@state.de.us

- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input checked="" type="checkbox"/>	Autism	14		<input checked="" type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Intellectual Disability	14		<input checked="" type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

In order to be enrolled in the Lifespan waiver, individuals must have been determined to meet the following criteria:

1) Must be determined eligible for DDDS services per the criteria delineated in Title 16, Section 2100 of the Delaware Administrative Code. This eligibility criteria requires a diagnosis of an intellectual developmental disability (including brain injury), autism spectrum disorder or Prader Willi Syndrome assigned in the developmental period and also documented functional limitations.

2) Must meet established priority criteria for selection of entrance into the waiver or meet the criteria for one of the groups for which capacity has been reserved

3) Must meet level of care and financial eligibility for ICF/IID Services (as described in Appendix B-4)

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (select one):

- Not applicable. There is no maximum age limit
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

Nemours-UnitedHealthcare feud leaves families stuck

The News Journal Published 10:47 p.m. ET March 6, 2014 | Updated 11:52 p.m. ET March 6, 2014



(Photo: JENNIFER CORBETT/THE NEWS JOURNAL)

The letters – all 21 of them – arrived in the mailbox of Kyer and Ashley Sabo on the same day, Feb. 10.

All were from UnitedHealthcare, and all carried the same disturbing message: They would need to find new doctors, specialists and other medical professionals to care for their little girls – Anna, 4, and Lucy, 1 – by April 1, the day United's contract with Alfred I. duPont Hospital for Children/Nemours expires.

It was their first clue that such a breakup was under consideration, let alone likely and imminent. Each letter named a specific professional Anna and Lucy had seen at some point who no longer would be in United's network – cardiologists, surgeons, anesthesiologists, hearing specialists, orthopedic specialists, gastro-intestinal specialists, to name a few. The hospital and its satellite facilities – no longer in the insurer's network.

"It was sickening," Ashley Sabo said. "It was like a sucker punch to the stomach. These are the doctors, in our case at least, who have provided life-saving surgery. Now we're told arbitrarily that we can't go there."

Anna, especially, has needed the expertise found at the hospital, which has a reputation for pediatric excellence. She already has had two open-heart surgeries there in her young life.

33,000 children

The contract impasse was made public last month, when state officials announced they had a plan for the 33,000 children whose Medicaid coverage was provided by United. Because state Medicaid officials considered it a major change, arrangements were made to ensure those children could switch to the state's other Medicaid provider – Aetna-owned Delaware Physicians Care – if their caregivers wanted them to remain with Nemours physicians.

Through February, about 10 percent of those kids – 3,511 of them – had moved to the Aetna network, according to figures supplied Thursday night by Lt. Gov. Matt Denn.

Denn also issued a list of things parents should do if their children are caught in this snag, including a review of their legal rights under the plan that covers their children. If answers are not available from United or the answers are not satisfactory, Denn urged families to contact the state Insurance Commissioner's office.

Almost 6,000 children covered by a United policy have been seen or treated at DuPont in the past couple of years, hospital officials say. It is unclear how many children United covers statewide – children who might want the hospital's services in the future but have not been there recently. But United spokeswoman Mary McElrath-Jones said the insurer covers more than 130,000 people in Delaware.

The contract change was not seen as major to those in the Insurance Commissioner's office, though.

"A change in the provider network is not a major life change," said Linda Nemes, assistant director of market regulation.



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Those covered under an individual policy – not through their employer – could cancel those policies and buy a plan in the state's insurance marketplace (at choosehealthde.com (<http://choosehealthde.com/>)), which has open enrollment through March 31, Nemes said.

Four facilities

Nemours-UnitedHealthcare feud leaves families stuck

in its letter to policyholders, United noted four other facilities where care could be offered, including Christiana Hospital, St. Francis Hospital, Wilmington Hospital and Children's Hospital of Philadelphia (CHOP).

Most of those places send children straight to A.I. duPont, Ashley Sabo said. And CHOP – in center city Philadelphia – is a long ride from their home near Prices Corner. It takes about nine minutes to get to DuPont Hospital, Kyer Sabo said. It took him 90 minutes to get to south Philadelphia last week, he said.

"It's disruptive for the whole family," he said, "financially, emotionally, everything."

Why should families be forced to drive an extra hour to reach a Philadelphia facility when a superb pediatric hospital is minutes away, asked Linnea Messina of Hockessin, whose two children – Lachlan, 5, and Hadley, 18 months – have been treated for hearing conditions at DuPont.

"It's certainly not a lunch-hour appointment," she said.

Denn said he remains hopeful that an agreement will be reached, but wanted families to know it may not be resolved.

"The reason I still have hope is that it makes a great deal of sense for both Nemours and United to resolve this, from a purely business perspective," Denn said. "And it's clearly the best thing for the children who need medical care."

Not a done deal

Chris Manning, spokesman for Nemours, said hospital officials do not consider the matter closed.

"However, our most recent conversations with United have been focused on issues relating to transitions of care for our patients and families in anticipation of the April 1 termination date," he said.

McElrath-Jones said United has many providers in its network.

"We are fully committed to arranging for necessary pediatric care and will work with providers both within the Delaware provider community as well as outside the state to ensure timely access to medical services," she said.

Kyer Sabo said he asked hospital officials if this was a game of "brinkmanship." Their answer to him, he said, was to urge him to get the ball rolling with CHOP.

"That was very telling to me," he said. "It doesn't sound like someone who is bluffing or withholding information."

If this situation is being used as leverage, Messina said, it's heartless.

"You can mess with me – and that's one thing," she said. "But use these kids as leverage?"

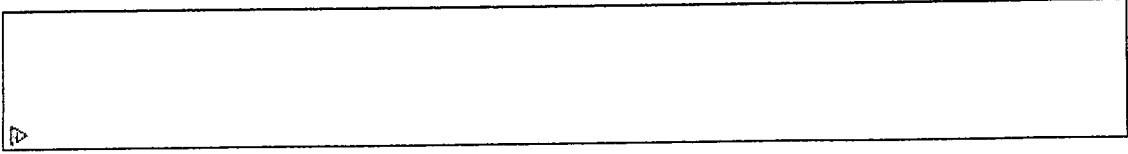
Contact Beth Miller at 324-2784 or bmiller@delawareonline.com. Follow on Twitter @BMiller57.

What to do

If your family is caught in the Nemours-United contract snag, Lt. Gov. Matt Denn on Thursday issued these recommendations:

- **Children receiving Medicaid or CHIP benefits administered by UnitedHealthcare:** Parents can ensure their children continue to have access to Nemours and A.I. duPont Hospital by calling the Delaware Medicaid Health Benefit Manager at (800) 996-9969 and asking to switch their Managed Care Organization to DPCI. The deadline for transfers is March 15. Parents who wish to remain with United Healthcare must select a new provider.
- **Children whose parents get self-insured benefits from UnitedHealthcare through a private employer:** Delawareans who work for companies that are self-insured may offer benefits through other insurance carriers. Ask your employer if you can switch to a carrier that has Nemours in its network. If your company does not use more than one carrier, you should talk to your employer about any medical conditions your child has that make it important that he or she be seen at A.I. duPont, so your employer can make an informed decision about how to address the situation with UnitedHealthcare.
- **Children whose parents are insured by UnitedHealthcare through employer group health insurance or individually purchased health insurance:** You have legal rights that include a minimal level of medical care that your child is entitled to receive. Find out what UnitedHealthcare's plan is for your child's future medical care. If you do not receive a prompt response or are unsatisfied with the response, contact the Delaware Insurance Department at (800) 282-8611 or (302) 674-7310.

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Nemours Foundation sues United Healthcare of Delaware

April 20, 2015

DOVER, Del. (AP) — The foundation that owns the Alfred I. du Pont Hospital for Children in Wilmington filed a federal lawsuit against United Healthcare of Delaware on Monday over pediatric care provided to children covered by Medicaid and another state-subsidized health care program.

In its lawsuit, the Nemours Foundation is seeking more than \$15 million in damages from United Healthcare for breach of contract and unjust enrichment.

The lawsuit stems from United Healthcare's termination last year of an agreement with Nemours under which UHC members received in-network coverage at the du Pont Hospital and other Nemours pediatric facilities.

Despite termination of the in-network agreement, Nemours says it has an obligation and responsibility under the agreement, as well as state law, to continue to treat United's members under certain conditions and for certain periods of time.

But Nemours claims that the Medicaid rate it has been receiving from United for those services is not adequate, and that it has not been paid in full for providing medically necessary services, including emergency care, to United members, including those on Medicaid and Delaware Healthy Children Program.

"Instead, United has wrongly taken advantage of its position as a provider of health insurance for Delaware's underprivileged children to enrich itself at the expense of Nemours, a longstanding provider of and advocate for medical services for all of Delaware's children," the lawsuit claims.

In a statement, United suggested that Nemours resorted to litigation after making a failed money grab.

"Nemours has repeatedly asked to be paid up to 50 percent more than other comparable children's hospitals in the region for providing the same inpatient services, which would significantly raise costs for the Delaware Medicaid program and the taxpayers who help fund Medicaid," United Healthcare spokeswoman Alice Ferreira said in the statement. "Nemours is now using litigation to respond to our refusal of their excessively high rates, but our focus remains on ensuring the Medicaid members we serve have continued access to the specialized care they need through the many other care providers who have committed to improving patient quality and outcomes."

But Nemours claims that United has failed to maintain a complete network of pediatric primary care physicians and pediatric specialists who are available to its Medicaid and DHCP members within 60 miles of their homes, as required by United's contract with the state Department of Health and Social Services.

Nemours also claims that United has been slow to identify in-network physicians to which Nemours should refer United members.

DHSS spokeswoman Jill Fredel said agency officials had not seen the lawsuit and would need time to review it before commenting.

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Nemours, UnitedHealthcare reach agreement

Nemours, UnitedHealthcare reach agreement

Jen Rini, The News Journal 9:25 p.m. EDT September 19, 2016



(Photo: SAQUAN STIMPSON/SPECIAL TO THE NEWS JOURNAL)

After a two-year feud, Nemours Children's Health System and UnitedHealthcare have negotiated a contract so thousands of Delawareans with UnitedHealthcare insurance now will be able to see Nemours doctors.

The contract applies only to private or employee-sponsored commercial plans run by UnitedHealthcare. Delawareans who are enrolled in UnitedHealthcare's Medicaid plan will ultimately still need to find new doctors, but could use the hospital's emergency room as well as certain doctors if services were previously approved.

According to the new agreement, health care services and procedures rendered by Nemours-affiliated doctors in Delaware, New Jersey, Pennsylvania and Maryland will be covered at an in-network rate for those with a commercial plan beginning Oct. 1, hospital officials said late Monday. Services that are classified in an insurance plan as "in-network" are typically less expensive than if patients are forced to go out-of-network or

pay out of pocket.

Chris Manning, Nemours' senior manager of public and media relations, said there will be "extensive outreach" to interested patients and families. He said the health system doesn't anticipate that there will be any issues with families receiving care.

About 240,000 residents in Delaware and Southeastern Pennsylvania have commercial plans through UnitedHealthcare, said Mary McElrath-Jones, UnitedHealthcare's director of public relations. A specific breakout of the number of Delaware plans was not immediately available late Monday.

New contract aside, Nemours is still going forward with a lawsuit filed against UnitedHealthcare in 2015 seeking \$15 million in damages for providing unpaid health care to Delaware's Medicaid recipients. Manning said in a statement that the lawsuit is still progressing according to the schedule established by the court. A teleconference is scheduled for Sept. 26.

STORY: Nemours-UnitedHealthcare feud leaves families stuck (/story/news/local/2014/03/06/nemours-united-healthcare-feud-leaves-families-stuck/6148771/)

STORY: UnitedHealthcare-Nemours feud lingers (/story/news/local/2015/03/25/united-nemours-feud-lingers/70458540/)

Nemours has maintained that UnitedHealthcare's Medicaid contract with the state is not adequate and has forced thousands of families to travel out-of-state without access to Delaware's only children's hospital. UnitedHealthcare said previously that Nemours has repeatedly asked to be paid up to 50 percent more than other comparable children's hospitals in the region for providing the same inpatient services and has used litigation to respond to the insurer's refusal of "excessively high rates."

Nemours won settlements with UnitedHealthcare of Pennsylvania, UnitedHealthcare of the Mid-Atlantic and UnitedHealthcare Community Plan of New Jersey on similar issues.

The two had not been able to negotiate a contract since 2014. The contract impasse forced Delawareans who have a UnitedHealthcare commercial or Medicaid plan and want access to Nemours primary doctors, specialists and their emergency care to either switch their children's plan or pay the difference.

When issues began two years ago, the Sabo family of Wilmington received over 20 letters saying the Nemours-affiliated doctors and specialists their young daughters had been seeing would no longer be in UnitedHealthcare's network.

Anna, now 6, needed the care since she had two open-heart surgeries at the children's hospital by age 4. Her mother, Ashley, said that they needed to drop UnitedHealthcare and switch their private insurance so the girls could still see Nemours doctors, but is thrilled with the resolution Monday.

"It just goes to show that even though it's two years later, it's still worth continuing the fight for what your kids need," she said.

Though they go to Nemours less frequently, Ashley said, "it's just important that it came to this conclusion."

Editor's note: An earlier version of this story incorrectly stated how much Delawareans with UnitedHealthcare's Medicaid plan would need to pay to see Nemours physicians.

Jen Rini can be reached at (302) 324-2386 or jrini@delawareonline.com. Follow @JenRini on Twitter.

<http://www.delawareonline.com/story/news/health/2016/09/19/nemours-united-reach-agreement/906828...> 9/21/2016



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
Margaret M. O'Neill Bldg., Suite 1, Room 311
410 Federal Street
Dover, Delaware 19901
302-739-3621

The Honorable John Carney
Governor

John McNeal
SCPD Director

MEMORANDUM

DATE: March 20, 2017

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

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

RE: 20 DE Reg. 694 [DMMA Proposed Medicaid Eligibility of Former Foster Youth Regulation (3/1/17)]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMA's) proposed regulation to expand the eligible population to young adults who aged out of the foster care system of another state. The proposed regulation was published as 20 DE Reg. 694 in the March 1, 2017 issue of the Register of Regulations.

Consistent with federal law, DMMA currently provides Medicaid coverage to former foster care youth who have aged out of Delaware's foster care system until age 26. The financial impact of this initiative would be modest:

In state fiscal year 2016 there were approximately 150 former foster youth that aged out of Delaware's foster care system that were eligible for Medicaid under the ACA. Extending this rule to former foster youth from other states would most likely result in very few new clients and therefore won't have a significant fiscal impact.

At 696.

There would be no income or resource cap for this population. Id.

A disproportionate number of foster care youth have disabilities and transition to adulthood is often

difficult. The availability of Medicaid to this constituency would be a significant support and is analogous to the option of youth who remain on their parent's private health insurance through age 26.

The SCPD is endorsing the proposed regulation. may wish to consider endorsement with a courtesy copy to the Office of the Child Advocate and Steve Yeatman at DSCY&F.

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

cc: Mr. Stephen Groff
Ms. Tania M. Culley, Esq.
Mr. Steve Yeatman, DSCYF
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

20reg694dmma-medicaid eligibility former foster youth 3-20-17

Section I – Program Description

Title IV-E foster care youth have been a mandatory Medicaid eligibility category since the Adoption Assistance and Child Welfare Act of 1980 (Pub. L. 96-272). On March 23, 2010, the Affordable Care Act (ACA) was signed into law, making a number of changes to Medicaid eligibility effective, January 1, 2014. The ACA includes many provisions designed to expand and streamline Medicaid eligibility, such as the option to extend coverage to a new adult group of non-disabled, non-elderly citizens with income under 133 percent of the Federal Poverty Level (FPL). Additionally, to further the overall goal of the ACA to expand health coverage, it included a new provision to allow youth to maintain coverage under their parents' or guardians' health insurance plan until age 26 (to the extent that such plan extends coverage to dependents). Section 2004 of the ACA added a new mandatory Medicaid eligibility group at section 1902(a)(10)(A)(i)(IX) of the Act to provide a parallel opportunity for former foster care youth to obtain Medicaid coverage until age 26 from the state responsible for the individual's foster care.

On January 22, 2013, the Center for Medicaid Services (CMS) issued a notice of proposed rulemaking that proposed to implement the former foster care eligibility group in regulations at 42 CFR 435.150. As part of that provision, CMS proposed to provide states the option to cover youth who were in foster care under the responsibility of another state, and enrolled in Medicaid, upon turning 18 or "aging out" of foster care in the other state. On November 21, 2016, CMS published the final rule clarifying that the Department of Health and Human Services (HHS) had determined that the state option to cover youth who were in foster care under the responsibility of another state was not available under section 1902(a)(10)(A)(i)(IX) of the Act. That section provides that, to be eligible under this group, an individual must have been "in foster care under the responsibility of the state" and to have been "enrolled in the state plan under this title or under a waiver of the plan while in such foster care [.]" Because the provision requires coverage specifically for youth in foster care under the responsibility of "the state"—not "a" or "any" state—CMS does not believe the provision provides states with the option to cover youth who were not under the responsibility of the state while in foster care under the former foster care eligibility group.

However, states can provide coverage to former foster care youth who were in Medicaid and foster care in a different state with income up to 133 percent of the federal poverty level (FPL) under the new adult group identified in the ACA. Additionally, states can use 1115 demonstration authority to provide coverage for former foster care youth who were in foster care under the responsibility of other states and have income higher than 133 percent of the FPL. States that provide coverage under the new adult group have the option of covering former foster care youth with MAGI-based income above 133 percent of the FPL, under the eligibility group described in section 1902(a)(10)(ii)(XX) of the Act and implementing regulations at 42 CFR 435.218 (the "XX" group). States would receive their standard Federal Medical Assistance Percentage (FMAP) for coverage of the "XX" group.

Delaware currently, and will continue to, provides coverage to former foster care youth under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care in Delaware when they turned age 18 or "aged out" of foster care. Delaware also currently provides coverage to individuals with income up to 133 percent of the federal poverty level (FPL) under the new adult group identified in the ACA.

The purpose of this Demonstration is to provide coverage on a state-wide basis to former foster care youth who currently reside in Delaware and were in foster care and enrolled in Medicaid at age 18 or when they "aged out" of the system in a different state. As such, Delaware will cover former foster care youth from a different state who have income at or below 133 percent Federal Poverty Level (FPL) under a mandatory coverage group or under the new adult group identified in the ACA. Additionally, on May 26, 2017, Delaware submitted an eligibility State Plan Amendment (SPA) electing to provide coverage to the optional eligibility group described under 1902(a)(10)(A)(ii)(XX) of the state plan. Delaware is also seeking an amendment and requests waivers of sections 1902(a)(8) and 1902(a)(10), to its current 1115 Demonstration Waiver, to the extent necessary, to permit the state to limit the provision of medical assistance (and treatment as eligible) for individuals described in the eligibility group under 1902(a)(10)(A)(ii)(XX) of the state plan, to former foster care youth who currently reside in Delaware, are under 26 years of age, were in foster care under the responsibility of another state, and were enrolled in Medicaid at age 18 or when they "aged out" of foster care.

Delaware proposes to test and evaluate how including former foster care youth who "aged out" of foster care in a different state increases and strengthens overall coverage for former foster care youth and improves health outcomes for these youth. Delaware expects that this hypothesis will be proven correct.

Section II – Demonstration Eligibility

The population affected by this Demonstration is former foster care youth who were in foster care under the responsibility of another state and enrolled in Medicaid at age 18 or when they "aged out" of foster care. Individuals who meet these criteria and have income at or below 133 percent FPL will be covered under a mandatory coverage group or under the new adult group. Individuals with income above 133 percent FPL require Section 1115 Demonstration authority.

- Delaware currently serves approximately 150 former foster care youth that "aged out" of foster care in Delaware. Therefore, Delaware does not anticipate a large number of individuals who "aged out" of foster care in a different state to seek Medicaid coverage in Delaware. Additionally, Delaware estimates that a large percentage of those individuals will fall under a different mandatory coverage or new adult group.

Eligibility Group	Description/ Social Security Act and CFR Citations	Income Level/FPL	Resource Standard	Benefit Package
Former foster care youth who were in foster care under the responsibility of another state and enrolled in Medicaid at age 18 or when they "aged out" of foster care.	§1115 of the Social Security Act; Demonstration Authority	>133%	N/A	Diamond State Health Plan (DSHP)

Section III – Demonstration Benefits and Cost-Sharing Requirements

Benefits provided to the population included in this application will be the same benefits that are provided for the current Medicaid population under Delaware's Medicaid State plan.

1. Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:
 Yes No
2. Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:
 Yes No

Section IV – Delivery System and Payment Rates for Services

The health care delivery system for Demonstration participants will be no different than the healthcare delivery system that is in place today for Delaware's Medicaid population.

1. Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:
 Yes No

Currently, there are approximately 150 former foster care youth who were in foster care under the responsibility of Delaware and enrolled in Medicaid at age 18 or when they "aged out" of foster care. Delaware does not anticipate that there is a large number of former foster care youth who currently reside in Delaware, are under 26 years of age, were in foster care under the responsibility of another state, and were enrolled in Medicaid at age 18 or when they "aged

out” of foster care, and that are not covered under another type of State Plan covered group. However, all former foster youth who were in foster care under the responsibility of a different state, and enrolled in Medicaid while in foster care, will receive benefits through the same managed care delivery system described in the state’s approved Section 1115 Demonstration.

Section V – Implementation of Demonstration

Delaware is requesting approval, under Section 1115 Demonstration authority, to provide coverage for former foster care youth who were in foster care under the responsibility of other states and have income higher than 133 percent of the FPL. Delaware does not currently provide Medicaid coverage to this population, but is prepared to begin upon approval of the 1115 Demonstration.

On May 26, 2017, Delaware submitted a State Plan Amendment to CMS to elect the option to provide coverage to individuals with income above 133% of FPL and requests waivers of sections 1902(a)(8) and 1902(a)(10) to limit this state plan group coverage to former foster care youth who were in Medicaid and foster care in a different state. Additionally, Delaware published a final order on May 1, 2017 to amend eligibility requirements for the Former Foster Children Group effective May 21, 2017.

Section VI – Demonstration Financing and Budget Neutrality

Delaware is not requesting Section 1115 expenditure authority as the affected population is comprised of a Medicaid State Plan eligibility group described in section 1902(a)(10)(ii)(XX) of the Social Security Act (new adult group); therefore, no budget neutrality agreement is needed in conjunction with this Demonstration since expenditures will be reported under its State Plan.

Section VII – List of Proposed Waivers and Expenditure Authorities

Expenditure Authorities:

Delaware does not need expenditure authority for former foster care youth who are at least 21 years old through age 26, were in foster care under the responsibility of another state, and were enrolled in Medicaid at age 18 or when they “aged out” of the system, and have income above 133% of FPL as this population is covered under the eligibility group described in section 1902(a)(10)(ii)(XX) of the Social Security Act (new adult group), and is served under the State Plan.

Waiver Authorities:

Delaware submitted a State Plan Amendment to CMS on May 26, 2017 to elect the option to provide coverage to individuals with income above 133% of FPL and requests waivers of sections 1902(a)(8) and 1902(a)(10) to limit this state plan group coverage to former foster care youth who were in Medicaid and foster care in a different state.

Section VII – Public Notice

1. Delaware provided an open comment period from August 1, 2017 to September 5, 2017.
2. Delaware published a Notice of Public Comment and Hearing in the Delaware Register of Regulations, the Delaware News Journal, and the Delaware State News on August 1, 2017. The publication in the Delaware Register can be found at:
<http://regulations.delaware.gov/default.shtml>
3. A draft of this Section 1115 Demonstration Waiver application was posted on the Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) website on August 1, 2017 as well.
4. Delaware conducted three public hearings on this Section 1115 Demonstration Waiver. The information for these hearings is as follows:
 - a. NEW CASTLE COUNTY
Date: August 25, 2017
Time: 2:30 PM – 3:30 PM
Location: DDDS Fox Run Center
2540 Wrangle Hill Road
Suite 200, Bear, DE 19701
 - b. KENT COUNTY
Date: August 22, 2017
Time: 2:30 PM – 3:30 PM
Location: Legislative Hall
411 Legislative Avenue
Dover, DE 19901
 - c. SUSSEX COUNTY
Date: August 22, 2017
Time: 10:45 AM – 11:45 AM
Location: Thurman Adams State Svc Center
546 S. Bedford St.
Georgetown, DE 19947
5. Delaware certifies that it used an electronic mailing list to notify the public.
6. The following is a list of comments received and associated responses that pertain to the 1115 Demonstration submission:

TBD after hearing

Section IX – Demonstration Administration



CCIIO Home > Other Insurance Protections > The Mental Health Parity and Addiction Equity Act (MHPAEA)

The Center for Consumer Information & Insurance Oversight

The Mental Health Parity and Addiction Equity Act (MHPAEA)

Contents

- Introduction
- Summary of MHPAEA Protections
- Key changes made by MHPAEA
- MHPAEA Regulation
- Fact Sheets & FAQs
- Regulations and Guidance

Introduction

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

MHPAEA originally applied to group health plans and group health insurance coverage and was amended by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the "Affordable Care Act") to also apply to individual health insurance coverage. HHS has jurisdiction over public sector group health plans (referred to as "non-Federal governmental plans"), while the Departments of Labor and the Treasury have jurisdiction over private group health plans.

Employment-related group health plans may be either "insured" (purchasing insurance from an issuer in the group market) or "self-funded." The insurance that is purchased, whether by an insured group health plan or in the individual market, is regulated by the State's insurance department. Group health plans that pay for coverage directly, without purchasing health insurance from an issuer, are called self-funded group health plans. Private employment-based group health plans are regulated by the Department of Labor. Non-Federal governmental plans are regulated by HHS. Contact your employer's plan administrator to find out if your group coverage is insured or self-funded and to determine what entity or entities regulate your benefits.

MHPAEA does not apply directly to small group health plans, although its requirements are applied indirectly in connection with the Affordable Care Act's essential health benefit (EHB) requirements as noted below. The Protecting Affordable Coverage for Employees Act amended the definition of small employer in section 1304(b) of the Affordable Care Act and section 2791(e) of the Public Health Service Act to mean generally an employer with 1-50 employees, with the option for states to expand the definition of small employer to 1-100 employees. The Employee Retirement and Income Security Act and the Internal Revenue Code also define a small employer as one that has 50 or fewer employees. (Some states may have mental health parity requirements that are stricter than federal requirements. To view State specific information visit www.ncsl.org, and on the right hand side of the page enter "mental health parity" then select "State Laws Mandating or Regulating Mental Health Benefits".)

Summary of MHPAEA Protections

The Mental Health Parity Act of 1996 (MHPA) provided that large group health plans cannot impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits.

MHPAEA preserves the MHPA protections and adds significant new protections, such as extending the parity requirements to substance use disorders. Although the law requires a general equivalence in the way MH/SUD and medical/surgical benefits are treated with respect to annual and lifetime dollar limits, financial requirements and treatment limitations, MHPAEA does NOT require large group health plans or health insurance issuers to cover MH/SUD benefits. The law's requirements apply only to large group health plans and health insurance issuers that choose to include MH/SUD benefits in their benefit packages. However, the Affordable Care Act builds on MHPAEA and requires coverage of mental health and substance use disorder services as one of ten EHB categories in non-grandfathered individual and small group plans.

Key changes made by MHPAEA

Key changes made by MHPAEA, which is generally effective for plan years beginning after October 3, 2009, include the following:

- If a group health plan or health insurance coverage includes medical/surgical benefits and MH/SUD benefits, the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to MH/SUD benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits (this is referred to as the "substantially all/predominant test"). This test is discussed in greater detail in the MHPAEA regulation (linked below) and the summary of the MHPAEA regulation found below.
- MH/SUD benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to such benefits;
- If a group health plan or health insurance coverage includes medical/surgical benefits and MH/SUD benefits, and the plan or coverage provides for out-of-network medical/surgical benefits, it must provide for out-of-network MH/SUD benefits; and
- Standards for medical necessity determinations and reasons for any denial of benefits relating to MH/SUD benefits must be disclosed upon request.

Exceptions

There are certain exceptions to the MHPAEA requirements.

Except as noted below, MHPAEA requirements do not apply to:

- Self-insured non-Federal governmental plans that have 50 or fewer employees;
- Self-insured small private employers that have 50 or fewer employees;
- Group health plans and health insurance issuers that are exempt from MHPAEA based on their increased cost (except as noted below). Plans and issuers that make changes to comply with MHPAEA and incur an increased cost of at least two percent in the first year that MHPAEA applies to the plan or coverage or at least one percent in any subsequent plan year may claim an exemption from MHPAEA based on their increased cost. If such a cost is incurred, the plan or coverage is exempt from MHPAEA requirements for the plan or policy year following the year the cost was incurred. The plan sponsors or issuers must notify the plan beneficiaries that MHPAEA does not apply to their coverage. These exemptions last one year. After that, the plan or coverage is required to comply again; however, if the plan or coverage incurs an increased cost of at least one percent in that plan or policy year, the plan or coverage could claim the exemption for the following plan or policy year; and
- Large, self-funded non-Federal governmental employers that opt-out of the requirements of MHPAEA. Non-Federal governmental employers that provide self-funded group health plan coverage to their employees (coverage that is not provided through an insurer) may elect to exempt their plan (opt-out) from the requirements of MHPAEA by following the Procedures & Requirements for HIPAA Exemption Election posted on the Self-Funded Non-Federal Governmental Plans webpage (See http://www.cms.gov/CCIIO/Resources/Files/hipaa_exemption_election_instructions_04072011.html) and issuing a notice of opt-out to enrollees at the time of enrollment and on an annual basis. The employer must also file the opt-out notification with CMS.

Note, these exceptions do not apply to those non-grandfathered plans in the individual and small group markets that are required by Affordable Care Act regulations to provide EHB that comply with the requirements of the MHPAEA regulations.

MHPAEA Regulation

A final regulation implementing MHPAEA was published in the Federal Register on November 13, 2013. The regulation is effective January 13, 2014 and generally applies to plan years (in the individual market, policy years) beginning on or after July 1, 2014. See <http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf> for the full text of the final regulation. This followed an interim final regulation, which was published in the Federal Register on February 2, 2010 and generally applies to plan years beginning on or after July 1, 2010. See <http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf> for the full text of the regulation.

The final regulation applies to non-Federal governmental plans with more than 50 employees, and to group health plans of private employers with more than 50 employees. It also applies to health insurance coverage in the individual health insurance market. It does not apply to group health plans of small employers (except as noted above in connection with the EHB requirements). Like the statute, it does not require group health plans to provide MH/SUD benefits. If they do, however, the financial requirements and treatment limitations that apply to MH/SUD benefits cannot be more restrictive than the predominant requirements and limitations that apply to substantially all of the medical/surgical benefits.

The provisions of the regulation include the following:

1. The substantially all/predominant test outlined in the statute must be applied separately to six classifications of benefits: inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network;

emergency; and prescription drug. Sub-classifications are permitted for office visits separate from all other outpatient services, as well as for plans that use multiple tiers of in-network providers. The regulation includes examples for each classification. Additionally, although the regulation does not require plans to cover MH/SUD benefits, if they do, they must provide MH/SUD benefits in all classifications in which medical/surgical benefits are provided.

2. The regulation requires that all cumulative financial requirements, including deductibles and out-of-pocket limits, in a classification must combine both medical/surgical and MH/SUD benefits in the classification. The regulation includes examples of permissible and impermissible cumulative financial requirements.
3. The regulation distinguishes between quantitative treatment limitations and nonquantitative treatment limitations. Quantitative treatment limitations are numerical, such as visit limits and day limits. Nonquantitative treatment limitations include but are not limited to medical management, step therapy and pre-authorization. There is an illustrative list of nonquantitative treatment limitations in the regulation. A group health plan or coverage cannot impose a nonquantitative treatment limitation with respect to MH/SUD benefits in any classification unless, under the terms of the plan (or coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification. The final regulation eliminated an exception that allowed for different nonquantitative treatment limitations "to the extent that recognized clinically appropriate standards of care may permit a difference."
4. The regulation provides that all plan standards that limit the scope or duration of benefits for services are subject to the nonquantitative treatment limitation parity requirements. This includes restrictions such as geographic limits, facility-type limits, and network adequacy.



Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) are not group health plans or issuers of health insurance. They are public health plans through which individuals obtain health coverage. However, provisions of the Social Security Act that govern CHIP plans, Medicaid benchmark benefit plans, and managed care plans that contract with State Medicaid programs to provide services require compliance with certain requirements of MHPAEA. See <https://www.federalregister.gov/articles/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of> for the final rule regarding application of requirements of MHPAEA to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans.

We anticipate issuing further responses to questions and other guidance in the future. We hope this guidance will be helpful by providing additional clarity and assistance.

If you have concerns about your plan's compliance with MHPAEA, contact our help line at 1-877-267-2323 extension 6-1565 or at phig@cms.hhs.gov. You may also contact a benefit advisor in one of the Department of Labor's regional offices at www.askebsa.dol.gov or by calling toll free at 1-866-444-3272.

Fact Sheets and FAQs

Regulations and Guidance

CMS.gov

A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services. 7500 Security Boulevard, Baltimore, MD 21244





MHPAEA REPORT FOR PUBLIC COMMENT

I. INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) issued a final rule that applies requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) to Medicaid managed care organizations (MCOs), the Children's Health Insurance Program (CHIP), and Medicaid alternative benefit plans (ABPs). Delaware and its contracted Medicaid/CHIP MCOs must be in compliance with the final Medicaid/CHIP parity rule on or before October 2, 2017. This includes providing documentation of parity compliance to the general public and posting this information to the State's Medicaid website by October 2, 2017. Though not required by the rule, the Division of Medicaid and Medical Assistance (DMMA) is providing this draft documentation of compliance for public notice and comment.

In addition to providing documentation of parity compliance to the general public, the State will need to submit documentation of parity compliance to CMS. Therefore, the State has prepared this report based on CMS guidance for the documentation to be submitted to CMS so that the final report can be used to provide documentation of parity compliance to both the general public and CMS.

This draft report reflects over nine months of work by the State and its MCOs to conduct a review of the State's Medicaid/CHIP delivery system to assess compliance with the final Medicaid/CHIP parity rule. This process started in the fall of 2016 with the establishment of a cross-agency workgroup tasked with conducting the parity analysis. The workgroup included representatives from state agencies involved in the administration of the State's Medicaid/CHIP program, including:

- The Division of Medicaid and Medical Assistance (DMMA)
- The Division of Substance Abuse and Mental Health (DSAMH)
- The Department of Services for Children, Youth and Their Families (DSCYF)
- The Division of Developmental Disabilities Services (DDDS)

II. METHODOLOGY

The approach and results of each component of the analysis are discussed in detail in later sections of this report. Delaware's approach to conducting the parity analysis followed CMS guidance as outlined in the CMS parity toolkit, *"Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs"*¹ and included the following steps:

1. Identifying all benefit packages to which parity applies.
2. Determining whether the State or MCO is responsible for the parity analysis (by benefit package).

¹ Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs, <https://www.medicare.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf>

3. Determining which covered benefits are mental health or substance use disorder (MH/SUD) benefits and which are medical/surgical (M/S) benefits.
4. Defining the four benefit classifications (inpatient, outpatient, prescription drugs, and emergency care) and mapping MH/SUD and M/S benefits to these classifications.
5. Determining whether any aggregate lifetime or annual dollar limits (AL/ADLs) apply to MH/SUD benefits.
6. Determining whether any financial requirements (FRs) or quantitative treatment limitations (QTLs) apply to MH/SUD benefits and testing the applicable financial requirement (prescription drug copayment) for compliance with parity.
7. Identifying and analyzing non-quantitative treatment limitations (NQTLs) that apply to MH/SUD benefits.

III. MEDICAID/CHIP DELIVERY SYSTEM AND BENEFIT PACKAGES

Medicaid/CHIP Delivery System

Over 90% of Medicaid/CHIP beneficiaries in Delaware are enrolled in MCOs. This includes 100% of beneficiaries in Delaware's alternative benefit plan (ABP) and 100% of beneficiaries in Delaware's separate CHIP (S-CHIP) program.² Delaware's Medicaid/CHIP managed care program, comprised of the Diamond State Health Plan (DSHP) and DSHP Plus, is authorized under the authority of a Section 1115 demonstration. DSHP was implemented in 1996 and requires most Medicaid/CHIP beneficiaries to receive acute physical and behavioral health care services through an MCO. In 2012, Delaware implemented the DSHP Plus program, which expanded the populations required to enroll in managed care to include dual eligibles and individuals receiving nursing facility or home and community-based services (HCBS) as an alternative to nursing facility services. It also expanded the MCO benefit package to include long-term nursing facility services and HCBS for Medicaid clients who meet the applicable level of care.

DMMA currently contracts with two MCOs: Highmark Health Options (HHO) and United Healthcare Community Health Plan (UHCP) to serve DSHP and DSHP Plus beneficiaries. Certain services, including some MH/SUD benefits, are provided fee-for-service (FFS).

Delaware has a complex MH/SUD delivery system, with MH/SUD services being covered by MCOs and/or FFS (managed by two different agencies) for different populations. MCOs are responsible for providing 30 units of MH/SUD outpatient services to members under 18; all MH/SUD benefits for members 18 and older who are not enrolled in PROMISE; and inpatient, crisis, and pharmacy services (other than medication assisted treatment for SUD) to members who are enrolled in PROMISE.³ The MH/SUD benefits for

² Delaware's CHIP program, called the Delaware Healthy Children Program (DHCP), is a combination of Medicaid expansion and a separate program. All S-CHIP beneficiaries are enrolled in MCOs as a condition of eligibility. MCOs are responsible for covering EPSDT for S-CHIP enrollees. However, the State does not currently cover non-emergency medical transportation (NEMT) for S-CHIP beneficiaries.

³ Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) is a program authorized under the State's Section 1115 demonstration that is administered by DSAMH and provides home and community based services (HCBS) in the most integrated setting to adults 18 and older meeting targeted behavioral health diagnostic and functional limitations.

children under age 18 that are carved out of the MCOs are managed by DSCYF, and the MH/SUD benefits for adults 18 and older enrolled in PROMISE are managed by DSAMH. While there is some overlap in covered services and provider network, DSAMH and DSCYF manage separate delivery systems. In addition, while the MCOs provide many of the MH/SUD state plan benefits provided by DSCYF and DSAMH and there is some overlap in provider networks among DSCYF, DSAMH, and the MCOs, each MCO manages its own delivery system.

Benefit Packages

Delaware identified 12 benefit packages subject to the requirements in the final Medicaid/CHIP parity rule. For each benefit package, Delaware covers MH and SUD benefits in each classification in which there is an M/S benefit (all four benefit classifications).

For the purposes of the NQTL analysis, Delaware structured the benefit packages into three groups based on how MH/SUD benefits are delivered (see Tables 1 below). As noted above, the MCO is responsible for providing MH/SUD benefits to adults who are not in PROMISE, and DSAMH is responsible for providing the majority of MH/SUD benefits to adults in PROMISE. The MCO is responsible for providing 30 units of outpatient MH/SUD benefits to children, and DSCYF is responsible for providing services to children who need services beyond the 30 units of outpatient or require more intensive services than those provided by the MCO. Note that as part of the NQTL request for information (see Section VIII) both the State agencies and MCOs were asked to identify any differences in the application of an NQTL within a benefit package group.

TABLE 1 – BENEFIT PACKAGE GROUPS

Adults not in PROMISE	Adults in PROMISE	Children
<ul style="list-style-type: none"> • DSHP adults who are not ABP nor PROMISE 	<ul style="list-style-type: none"> • DSHP adults who are not ABP but are PROMISE 	<ul style="list-style-type: none"> • Medicaid children under age 18
<ul style="list-style-type: none"> • DSHP adults who are ABP but not PROMISE 	<ul style="list-style-type: none"> • DSHP adults who are also ABP and PROMISE 	<ul style="list-style-type: none"> • Medicaid children age 18 – 21
<ul style="list-style-type: none"> • DSHP Plus adults who are not LTSS and not PROMISE 	<ul style="list-style-type: none"> • DSHP Plus adults who are not LTSS but are PROMISE 	<ul style="list-style-type: none"> • Children in separate CHIP (under Age 18)
<ul style="list-style-type: none"> • DSHP Plus LTSS adults who are not PROMISE 	<ul style="list-style-type: none"> • DSHP Plus LTSS adults who are PROMISE 	<ul style="list-style-type: none"> • Children in separate CHIP(18+)

IV. DEFINITION OF MH/SUD AND M/S BENEFITS

For the purposes of the parity analysis, Delaware adopted the most recent version of the International Classification of Diseases (ICD), the ICD-10-CM, as its standard for defining MH/SUD and M/S benefits. ICD-10-CM is the current version of the ICD, which is identified in the final Medicaid/CHIP parity rule as an example of a "generally recognized independent standard of current medical practice" for defining M/S, MH, and SUD conditions.

Delaware defined MH/SUD conditions as those conditions listed in ICD-10-CM, Chapter 5 "Mental, Behavioral, and Neurodevelopmental Disorders" with the exception of:

- The conditions listed in subchapter 1, "Mental disorders due to known physiological conditions" (F01 to F09);
- The conditions listed in subchapter 8, "Intellectual disabilities" (F70 to F79); and
- The conditions listed in subchapter 9, "Pervasive and specific developmental disorders" (F80 to F98).

Delaware defined M/S conditions as those conditions listed in ICD-10-CM Chapters 1-4, subchapters 1, 8 and 9 of Chapter 5, and Chapters 6-20.

Delaware excluded subchapter 1 from the definition of MH/SUD because these mental disorders are due to known physiological conditions (e.g., dementias, delirium, psychosis and mood disorders due to known physiological conditions) and all except one require that the physiological condition be coded first, indicating that the physiological (rather than the MH) condition is the focus of services. Delaware excluded subchapters 8 and 9 from the definition of MH/SUD because these chapters identify neurodevelopmental disorders as opposed to mental or behavioral disorders.

Excluding subchapters 8 (intellectual disabilities) and 9 (developmental disorders) from the definition of MH/SUD is consistent with the State's current structure and practice. Services for these conditions are managed by DDDS, not by DSAMH or DSCYF. In addition, not including these disorders as MH/SUD disorders is consistent with CMS' definition of "mental disease" in the State Medicaid Manual (SMM) Section 4390.D, which provides as follows: "...the term 'mental disease' includes diseases listed as mental disorders in the [ICD-9-CM], with the exception of mental retardation, senility, and organic brain syndrome."⁴ Also, not including F70 to F79 (intellectual disabilities) and F80 to F98 (pervasive and specific developmental disorders) is consistent with the definition of "Persons with related conditions" in 42 CFR 435.1010: "Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions: (a) It is attributable to (1) Cerebral palsy or epilepsy; or (2) Any other condition other than mental illness, found to be closely related to Intellectual Disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons..." (sections (b) through (d) omitted; emphasis supplied).⁵

⁴ State Medicaid Manual – Part 4 Services, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R74SMM.pdf>

⁵ 42 CFR § 435.1010 - DEFINITIONS RELATING TO INSTITUTIONAL STATUS, <https://www.gpo.gov/fdsys/pkg/CFR-2015-title42-vol4/xml/CFR-2015-title42-vol4-sec435-1010.xml>

V. BENEFIT CLASSIFICATIONS

Delaware developed the following definitions for each of the four benefit classifications identified in the Medicaid/CHIP parity rule.

Inpatient: All covered services or items (including medications) provided to a member while in a setting (other than a home and community-based setting as defined in 42 CFR Part 441) that requires an overnight stay.

Outpatient: All covered services or items (including medications) provided to a member that do not otherwise meet the definition of inpatient, emergency care, or prescription drugs.

Emergency Care: All covered services or items (including medications) delivered in an emergency department (ED) setting or free standing emergency room.

Prescription Drugs: Covered medications, drugs and associated supplies and services that require a prescription to be dispensed. These products are claimed using the National Council for Prescription Drug Programs (NCPDP) format.

As noted above, Delaware's state plan covers MH and SUD benefits in each classification in which there is an M/S benefit.

VI. AGGREGATE LIFETIME AND ANNUAL DOLLAR LIMITS (AL/ADLS)

No aggregate lifetime or annual dollar limits apply to Medicaid/CHIP-MH/SUD benefits in any benefit package. Note that the 2017 MCO contract prohibits the MCOs from applying aggregate lifetime and annual dollar limits to MH/SUD benefits (see MCO contract section 3.4.12.2).

VII. FINANCIAL REQUIREMENTS (FRS) AND QUANTITATIVE TREATMENT LIMITATIONS (QTLs)

Financial Requirements

Only one financial requirement (FR), a tiered copayment for prescription drugs, applies to Medicaid/CHIP benefits. Delaware's tiered copayment for prescription drugs is based on the Medicaid cost/payment for the prescription. This tiered copayment applies to all prescription drugs and to both Medicaid FFS beneficiaries and MCO enrollees who are not exempt from the copayment. See below for the copayment schedule. The copayment amount is based on the Medicaid payment for the drug and not whether the drug is used for the treatment of a MH/SUD or M/S condition, and the same level of copayment is applied across each tier without regard to whether the drug is for the treatment of a MH/SUD or M/S condition.

There is an out-of-pocket monthly maximum of \$15. This out-of-pocket maximum applies to all prescription drugs; the out-of-pocket maximum does not apply separately to M/S and MH/SUD drugs.

Medicaid Payment for the Drug	Copayment
\$10.00 or less	\$.50
\$10.01 to \$25.00	\$1.00
\$25.01 to \$50.00	\$2.00
\$50.01 or more	\$3.00

The 2017 MCO contract requires that any cost sharing comply with parity (see Section 3.4.9.1.2), prohibits the MCO from applying cumulative financial requirements separately for MH/SUD benefits (see Section 3.4.12.5), and prohibits the MCO from applying any FRs to MH/SUD benefits that do not comply with parity requirements (see Section 3.4.12.3 of the MCO contract).

Quantitative Treatment Limitations

Delaware does not apply any quantitative treatment limitations to MH/SUD benefits that cannot be exceeded based on medical necessity. Thus, these limitations were analyzed as NQTLs (see Section VIII). In addition, the 2017 MCO prohibits the MCO from applying any QTLs to MH/SUD benefits that do not comply with parity requirements (see Section 3.4.12.3 of the MCO contract).

VIII. NON-QUANTITATIVE TREATMENT LIMITATIONS (NQTLs)

Identifying NQTLs and Information Collection

Based on the illustrative list of NQTLs in the final Medicaid/parity rule, the parity toolkit, information provided through the Substance Abuse and Mental Health Services Administration (SAMHSA) Medicaid/CHIP parity policy academy,⁶ written guidance from the Department of Labor regarding the commercial parity rule (including FAQs, MHPAEA enforcement updates, and a document identifying potential "red flag" NQTLs), information from the State's consultant, and discussion during the workgroup meetings, Delaware identified a list of potential NQTLs, including NQTLs related to medical management, benefits coverage, and provider admission, and a couple of NQTLs specific to prescription drugs. DSAMH and DSCYF reviewed the list to determine which NQTLs applied to MH/SUD benefits managed by their agency. The State developed a request for information (RFI) for each agency to complete with information needed to conduct the NQTL analysis, including information on the processes, strategies, and evidentiary standards in both writing and operations for each of the NQTLs the agency applies to MH/SUD benefits managed by the state agency, by classification and benefit package. This RFI included prompts to help identify the type of information relevant to the parity analysis. Separate prompts were provided for processes, strategies, and evidentiary standards for each part of the NQTL analysis (comparability and stringency) and to collect information on how the factors apply both in writing and in operation. The information provided by each state agency was reviewed by the workgroup, which conducted follow up as necessary.

⁶ Delaware applied for and was accepted as a participant in SAMHSA's Medicaid/CHIP parity policy academy (MPPA), which was designed to provide technical assistance to states to ensure compliance with parity requirements.

In addition to collecting information on NQTLs that apply to MH/SUD benefits managed by the State (referenced as the FFS MH/SUD NQTLs), the State developed a request for information (RFI) to collect information from each MCO on how the MCO applies the FFS NQTLs to MH/SUD and M/S benefits managed by the MCO as well as any additional NQTLs applied by the MCOs to MH/SUD benefits (including information on how the MCO applies those NQTLs to M/S benefits). The RFI included the list of NQTLs identified by the State as described above but also asked the MCOs to identify any other NQTLs that they apply to MH/SUD benefits. The MCOs completed a summary grid that identified which FFS MH/SUD NQTLs and other NQTLs they apply to MH/SUD benefits, by benefit package and classification, and provided information, by benefit package and classification, on the MH/SUD and M/S benefits to which the NQTL applies and the processes, strategies, and evidentiary standards for each of the NQTLs. As in the State RFI, the MCO RFI included prompts to help the MCOs provide the information needed for the parity analysis. The information provided by each MCO was reviewed by the workgroup, and the State conducted follow up as needed.

Conducting the NQTL Analysis

The State used the information from the RFIs to compare the processes, strategies, evidentiary standards and other factors for each MH/SUD NQTL as it applies to MH/SUD benefits and M/S benefits, in writing and in operation, in a classification, for each benefit package. The processes, strategies, evidentiary standards and other factors were reviewed for comparability and stringency in writing and in operation.

The NQTL analysis consisted of the following steps:

- Consolidation of the NQTL information collected from the state agencies and the MCOs into a side-by-side structure with information on MH/SUD on one side and M/S on the other side for each NQTL, by benefit package and classification. The information included the MH/SUD and M/S benefits to which the NQTL applies and a summary of the NQTL's processes, strategies, and evidentiary standards.
- Review of the side-by-side information to develop a preliminary determination for each NQTL, by benefit package and classification.
- Review and revision of the side-by-side summary information and preliminary determinations.
- MCO review of the side-by-side summary information and preliminary determinations.
- Workgroup review of the side-by-side summary information and preliminary determinations and final determination of compliance.

List of MH/SUD NQTLs

Table 2 and 3 lists the NQTLs that apply to MH/SUD benefits and the State has determined comply with parity. The table also identifies the applicable benefit package groups and classification. In the tables below, a "i" indicates the NQTL applies to a certain benefit package(s) and classification(s). Grayed out sections in the tables below indicate the NQTL does not apply to a certain benefit package or classification.

TABLE 2 – NQTLs – MCO A

NQTL Name	Adults not in PROMISE				Adults in PROMISE				Children			
	IP	OP	EC	PD	IP	OP	EC	PD	IP	OP	EC	PD
Development/Modification/Addition of Medical Necessity/ Medical Appropriateness/Level of Care Guidelines*	ü	ü			ü	ü			ü	ü		
Prior Authorization*	ü	ü			ü	ü		ü	ü	ü		ü
Concurrent Review*	ü	ü			ü	ü			ü	ü		
Retrospective Review	ü	ü			ü	ü			ü	ü		
Requiring Use of Preferred Drugs before Approving Non-preferred Agents (Step Therapy)				ü				ü				ü
Experimental/Investigational Determinations	ü	ü	ü	ü	ü	ü	ü	ü	ü	ü	ü	ü
Provider Reimbursement (in-network)*	ü			ü	ü	ü			ü	ü		ü
Usual, Customary and Reasonable (UCR) Determinations (out-of-network provider reimbursement)	ü	ü			ü	ü	ü		ü	ü	ü	
Provider Credentialing Requirements*	ü	ü	ü		ü	ü	ü		ü	ü	ü	
Geographic Restrictions	ü	ü	ü		ü	ü	ü		ü	ü	ü	
Standards for Out-of-Network Coverage	ü	ü	ü		ü	ü	ü		ü	ü	ü	
Drugs not Covered Pursuant to Section 1927(d)(2)				ü				ü				ü
Early Refills				ü				ü				ü
Copay Tiers				ü				ü				ü
Pharmacy Lock-In				ü				ü				ü

* Applies to FFS MH/SUD
IP=Inpatient, OP=Outpatient, EC=Emergency Care, PD=Prescription Drugs

TABLE 3 – NQTLS – MCO B

NQTL Name	Adults not in PROMISE				Adults in PROMISE				Children			
	IP	OP	EC	PD	IP	OP	EC	PD	IP	OP	EC	PD
Development/Modification/Addition of Medical Necessity/ Medical Appropriateness/Level of Care Guidelines*	ü	ü			ü	ü			ü	ü		
Prior Authorization*	ü	ü			ü	ü			ü	ü		ü
Concurrent Review*	ü	ü			ü	ü	ü		ü	ü	ü	
Retrospective Review	ü	ü			ü	ü	ü		ü	ü	ü	
Requiring Use of Preferred Drugs before Approving Non-preferred Agents (Step Therapy)				ü				ü				ü
Experimental/Investigational Determinations	ü	ü	ü	ü	ü	ü	ü	ü	ü	ü	ü	ü
Provider Reimbursement (in-network)*	ü	ü			ü	ü			ü	ü		ü
Usual, Customary and Reasonable (UCR) Determinations (out-of-network provider reimbursement)	ü	ü			ü	ü	ü		ü	ü	ü	
Provider Credentialing Requirements*	ü	ü	ü		ü	ü	ü		ü	ü	ü	
Geographic Restrictions	ü	ü	ü		ü	ü	ü		ü	ü	ü	
Standards for Out-of-Network Coverage	ü	ü	ü		ü	ü	ü		ü	ü	ü	
Drugs not Covered Pursuant to Section 1927(d)(2)				ü				ü				ü
Early Refills				ü				ü				ü
Copay Tiers				ü				ü				ü
Pharmacy Lock-In				ü				ü				ü

* Applies to FFS/MH/SUD

IP=Inpatient, OP=Outpatient, EC=Emergency Care, PD=Prescription Drugs

The 2017 MCO contract prohibits the MCO from applying NQTLs to MH/SUD benefits unless the NQTL meets the applicable requirements of the Medicaid/CHIP parity rule (see Section 3.4.12.6).