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MEMORANDUM

DATE: October 28, 2015

TO: Ms. Sharon L. Summers, DMMA
Planning & Policy Development Unit

DMP/ARB

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: 19 DE Reg. 258 (DMMA Proposed Deletion of Personal Care Services from Medicaid Plan Regulation)

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMAs) proposal to delete "personal care services" from the Medicaid State Plan. Instead, DMMA posits that supports currently covered as "personal care services" will be covered as "home health services". The proposed regulation was published as 19 DE Reg. 258 in the October 1, 2015 issue of the Register of Regulations.

DMMA provides the following rationale for the change:

> During review and subsequent approval on December 31, 2014 of Delaware's 1915(i) Home and Community State Plan Option Amendment (Pathways to Employment), the Centers for Medicare and Medicaid Services (CMS) performed a program analysis of corresponding coverage sections not originally submitted with this SPA. This analysis revealed an issue that requires a state plan amendment (SPA) to sunset coverage and reimbursement methodology for Personal Care Services as personal care as a service will be provided as a component of home health services.

SCPD has the following observations.

First, the change may result in a reduction in available providers for non-monetary reasons. Licensing of "personal assistance services agencies" is separate from licensing of "home health agencies". Compare Title 16 Dolce §122x and 16 DE Admin Code 4469 (personal assistance licensing) with 16 Dolce §122lo and 16 DE Admin Code 4406 (home health licensing). Agencies currently providing "personal assistance services" will

ostensibly have to apply for new licenses as "home health agencies".

Second, it would be unfortunate if the change results in a reduction in the scope of currently-covered services. Consider the following:

A. Licensed "personal assistance" agencies can perform any acts individuals could normally perform themselves but for functional limitations consistent with Title 24 Del.C. §1921(a)(15) and Title 16 Del.C. §122x.2. CMS has historically adopted the same broad approach for "personal care assistance" as including "a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they could normally do for themselves if they did not have a disability." See attached CMS, State Medicaid Manual, §4480C. Licensed "home health" agencies lack that authority.

B. Services provided by licensed "personal assistance" agencies are not required to be supervised by a nurse. All services provided by licensed "home health" agencies must be supervised by a registered nurse. See Title 16 Del.C. §122oB(V)2.C.

C. The required qualifications of persons providing "home health services" are much more extensive than the qualifications of persons providing "personal assistance". Compare 16 DE Admin Code 4406.1.1, definition of "home health aide", with 16 DE Admin Code 4469.1.1, definition of "direct care worker".

Third, when SCPD initially reviewed the proposed regulation, it appeared unclear what effect the change would have on attendant services provided under the DSHP+ program. DMMA notes that "personal care services" are also known by other names "such as personal attendant services, personal assistance services, or attendant care services, etc.". At 259. The DSHP+ contracts with MCOs require coverage of "attendant care services" independent of coverage of "home health services". See attached excerpts from 2015 DMMA-MCO contract. One could infer that DMMA's elimination of "personal care services" from the Medicaid program represents either actual program elimination of "attendant services" or is a precursor to such elimination. However, SCPD communicated with the DMMA Director who stated that "(t)here is no actual or planned elimination of attendant services." See attached October 12, 2015 email communication.

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

cc: Mr. Stephen Groff
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

19reg258 dmma-deletion of personal care services Medicaid plan 10-28-15

4480. PERSONAL CARE SERVICES

A. General.--Effective November 11, 1997, HCFA published a final regulation in the Federal Register that removed personal care services from regulations at 42 CFR 440.170 and added a new section at 42 CFR 440.167, APersonal Care Services in a home or other location.@ The final rule specifies the revised requirements for Medicaid coverage of personal care services furnished in a home or other location as an optional benefit. This rule conforms to the Medicaid regulations and to the provisions of '13601(a)(5) of the Omnibus Budget Reconciliation Act (OBRA) of 1993, which added '1905(a)(24) to the Social Security Act to include payment for personal care services under the definition of medical assistance

Under '1905(a)(24) of the Act, States may elect, as an optional Medicaid benefit, personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation (ICF/MR), or institution for mental disease. The statute specifies that personal care services must be: (1) authorized for an individual by a physician in a plan of treatment or in accordance with a service plan approved by the State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual=s family; and (3) furnished in a home or other location.

B. Changes Made by Final Regulation.--Personal care services may now be furnished in any setting except inpatient hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or institutions for mental disease. States choosing to provide personal care services may provide those services in the individual's home, and, if the State so chooses, in settings outside the home.

In addition, services are not required by Federal law to be provided under the supervision of a registered nurse nor does Federal law require that a physician prescribe the services in accordance with a plan of treatment. States are now permitted the option of allowing services to be otherwise authorized for the beneficiary in accordance with a service plan approved by the State.

C. Scope of Services.--Personal care services (also known in States by other names such as personal attendant services, personal assistance services, or attendant care services, etc.) covered under a State=s program may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self. Such assistance most often relates to performance of ADLs and IADLs. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

1. Cognitive Impairments.--An individual may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. For example, an individual may no

longer be able to dress without someone to cue him or her on how to do so. In such cases, personal assistance may include cuing along with supervision to ensure that the individual performs the task properly.

2. Consumer-Directed Services.--A State may employ a consumer-directed service delivery model to provide personal care services under the personal care optional benefit to individuals in need of personal assistance, including persons with cognitive impairments, who have the ability and desire to manage their own care. In such cases, the Medicaid beneficiary may hire their own provider, train the provider according to their personal preferences, supervise and direct the provision of the personal care services and, if necessary, fire the provider. The State Medicaid Agency maintains responsibility for ensuring the provider meets State provider qualifications (see E below) and for monitoring service delivery. Where an individual does not have the ability or desire to manage their own care, the State may either provide personal care services without consumer direction or may permit family members or other individuals to direct the provider on behalf of the individual receiving the services.

D. Definition of Family Member.--Personal care services may not be furnished by a member of the beneficiary=s family. Under the new final rule, family members are defined to be Alegally responsible relatives.@ Thus, spouses of recipients and parents of minor recipients (including stepparents who are legally responsible for minor children) are included in the definition of family member. This definition necessarily will vary based on the responsibilities imposed under State law or under custody or guardianship arrangements. Thus, a State could restrict the family members who may qualify as providers by extending the scope of legal responsibility to furnish medical support.

E. Providers.--States must develop provider qualifications for providers of personal care services and establish mechanisms for monitoring the quality of the service. Services such as those delegated by nurses or physicians to personal care attendants may be provided so long as the delegation is in keeping with State law or regulation and the services fit within the personal care services benefit covered under a State=s plan. Services such as assistance with taking medications would be allowed if they are permissible in States= Nurse Practice Acts, although States need to ensure the personal care assistant is properly trained to provide medication administration and/or management.

States may wish to employ several methods to ensure that recipients are receiving high quality personal care services. For example, States may opt to a criminal background check or screen personal care attendants before they are employed. States can also establish basic minimal requirements related to age, health status, and/or education and allow the recipient to be the judge of the provider=s competency through an initial screening. States can provide training to personal care providers. States also may require agency providers to train their employees. States can also utilize case managers to monitor the competency of personal care providers. State level oversight of overall program compliance, standards, case level oversight, attendant training and screening, and recipient complaint and grievance mechanisms are ways in which States can monitor the quality of their personal care programs. In this way, States can best address the needs of their target populations and develop unique provider qualifications and quality assurance mechanisms.

EXCERPTS: DHSS—MCO CONTRACT 2015

members who are in DHCP are eligible to receive the DSHP benefit package except as described in Section 3.4.4 below.

3.4.2.2 The Contractor shall provide the following DSHP benefit package services as Medically Necessary (as defined in Section 3.4.5 of this Contract, below) and subject to the listed limitations herein.

Service	Limitations
Inpatient hospital services	
Inpatient behavioral health services in a general hospital; in a general hospital psychiatric unit; in a psychiatric hospital (including an institution for mental disease) for members over age 65 and under age 21; and in a private residential treatment facility (PRTF) for under age 21 (In lieu of inpatient behavioral health services in a general hospital or a general hospital psychiatric unit, the Contractor may, pursuant to Section 3.4.8 of this Contract, provide behavioral health services in alternative inpatient settings licensed by the State)	• For members age 18 and older (inpatient behavioral health services to members under age 18 are provided by DSCYF)
Outpatient hospital services, including emergency rooms	
Behavioral health crisis intervention services, including facility-based crisis services and mobile crisis teams	• 30 unit behavioral health benefit for members under age 18 (thereafter provided by DSCYF)
Pharmacy including physician administered drugs	• Pharmacy does not include Medication Assisted Treatment (MAT) for substance use disorders (SUDs); MAT is included in the SUD benefit below
Clinic services including ambulatory surgical centers and end stage renal disease clinics	
Federally Qualified Health Center services	
Substance use disorder services, including all levels of the American Society of Addiction Medicine (ASAM), Medication Assisted Treatment (MAT) and licensed opioid treatment programs	• 30 unit behavioral health benefit for members under age 18 (thereafter provided by DSCYF) • For members participating in PROMISE, these services, except for medically managed intensive inpatient detoxification, are the responsibility of the State and paid through the State's MMIS

Service	Limitations
Licensed behavioral health practitioner services, including licensed psychologists, clinical social workers, professional counselors and marriage and family therapists	• 30 unit behavioral health benefit for members under age 18 (thereafter provided by DSCYF) • For members participating in PROMISE, these services are the responsibility of the State and paid through the State's MMIS
Laboratory and radiology services, including invasive and non-invasive imaging	
Nursing facility services	• Up to 30 calendar days, then services are covered by the Contractor as part of the DSHP Plus LTSS benefit package
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including periodic preventive health screens and other necessary diagnostic and treatment services for members under age 21	
Preventive services, including the services specified in 45 CFR 147.30	
Outpatient behavioral health services for members under age 18, including assessment, individual/ family/group therapy, crisis intervention, intensive outpatient and behavioral health rehabilitative services for children	• For members under age 18 • 30 unit behavioral health benefit for members under age 18 (thereafter provided by DSCYF) • See Appendix 1
Family planning services (including voluntary sterilization if consent form is signed after member turns age 21)	
Physician services, including certified nurse practitioner services	• For members participating in PROMISE, the following physician oversight and direct therapy that is considered to be a part of the following PROMISE services are included in the PROMISE rates and paid FFS through the State's MMIS: Assertive Community Treatment (ACT) services, Intensive Case Management (ICM) services, and supervision of group home services
Administrative fee for vaccines to children	
Podiatry services	
Optometry/optician services	
Home health services	

3.4.3.4 The Contractor shall provide the following long term services and supports to DSHP Plus LTSS members when the services have been determined by the Contractor to be Medically Necessary:

Service	Definition/Limitation
Nursing facility services	The services provided by a nursing facility to residents of the facility, including skilled nursing care and related services, rehabilitation services, and health-related care and services.
Community-based residential alternatives that include assisted living facilities	• Community-based residential services offer a cost-effective, community based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes assisted care living facilities. Community-based residential services include personal care and supportive services (homemaker, chore, attendant services, and meal preparation) that are furnished to participants who reside in a homelike, non-institutional setting. Assisted living includes a 24-hour onsite response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). As needed, this service may also include prompting to carry out desired behaviors and/or to curtail inappropriate behaviors. Services that are provided by third parties must be coordinated with the assisted living provider. Personal care services are provided in assisted living facilities as part of the community-based residential service. To avoid duplication, personal care (as a separate service) is not available to persons residing in assisted living facilities.
Attendant care services	• Attendant care services includes assistance with ADLs (bathing, dressing, personal hygiene, transferring, toileting, skin care, eating and assisting with mobility). • Not available to persons residing in assisted living or nursing facilities.

Hodges, Kyle (DSHS)

From: Groff, Stephen (DHSS)
Sent: Monday, October 12, 2015 2:24 PM
To: Hodges, Kyle (DSHS); Daniese McMullin-Powell (imbest222@aol.com); Jamie Wolfe (j.wolfe6@icloud.com); Brian Hartman (bhartman@declasi.org)
Cc: Zimmerman, Lisa (DHSS); Williams, Glyne (DHSS); Jabbar-Bey, Tyneisha S (DHSS); Dougherty, Kathleen (DHSS)
Subject: RE: 19 DE Regulations 253 and 258

Kyle – we would be happy to discuss but I think I can reassure you with a simple response:

1. Financial concerns re. Home Health Services – the figures reported are actual dollars (Eight Thousand Dollars). The new methodology was implemented at a level intended to achieve budget neutrality and avoid any significant reduction to providers.
2. The proposed deletion of personal care services in the State Plan will result in no change in our programs. It is intended to eliminate confusion by clarifying that the services offered via State Plan Authority are home health services. Personal Care Services, including Attendant Services, are offered under the 1115 demonstration waiver authority. There is no actual or planned elimination of attendant services.

I hope this helps. If you have remaining questions or concerns, please let me know.

Thanks,
Steve

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DMMA: Dedicated Minds, Open Hearts, Helping Hands.

Stephen M. Groff, Director
Division of Medicaid and Medical Assistance
302-255-9626

From: Hodges, Kyle (DSHS)
Sent: Monday, October 12, 2015 11:57 AM
To: Groff, Stephen (DHSS); Zimmerman, Lisa (DHSS)
Cc: Daniese McMullin-Powell (imbest222@aol.com); Jamie Wolfe (j.wolfe6@icloud.com); Brian Hartman (bhartman@declasi.org)
Subject: 19 DE Regulations 253 and 258

Hi Steve and Lisa –

SCPD has reviewed DMMAs proposed regulations regarding reimbursement of providers for home health services and its proposal to delete "personal care services" from the Medicaid State Plan. The proposed regulations were published

as 19 DE Reg. 253 and 258, respectively, in the October 1, 2015 issue of the Register of Regulations. SCPD is sharing the preliminary observations below and would like to meet with you to discuss these important issues before formally publishing any comments. Given that comments are due by October 30th, a meeting to promptly address these issues would be beneficial. Please let me know your thoughts. Thanks.

1. **DMMA Prop. Medicaid Home Health Services Reimbursement Reg. [19 DE Reg. 253 (10/1/15)]**

The Division of Medicaid & Medical Assistance proposes to amend its standards for reimbursing providers for home health services. Home health services include skilled nursing services; home health aide services; therapies (OT: PT; ST); durable medical equipment; and medical supplies. CMS is prompting the initiative:

> During review and subsequent approval on December 31, 2014 of Delaware's 1915(i) Home and Community State Plan Option Amendment (Pathways to Employment), the Centers for Medicare and Medicaid Services (CMS) performed a program analysis of corresponding coverage sections not originally submitted with this SPA. This analysis revealed that the reimbursement language for home health services fails to comply with 42 CFR 430.10 and 42 CFR 447.252 which implement in part Section 1902(a)(30)(A) of the Social Security Act, to require collectively that States comprehensively describe the methodologies that they use to reimburse service providers. The methodologies must be understandable, clear, unambiguous and auditable. This amendment proposes to revise the payment methodology language for home health services.

At 255.

In general, the new methodology is a universal rate for each Home Health service type. All providers would receive the same rate for each procedure code and rates would be increased annually based on an inflation factor derived from a CMS source. Id. Reimbursement standards for durable medical equipment (DME) are being revised to reflect the discontinuation of the EPIC Plus pricing software.

SCPD has the following preliminary observations.

First, in the section on AAC systems, first paragraph, the word "devise" should be "device".

Second, the changes will ostensibly result in significant reductions in compensation to providers. The fiscal impact table (p. 256) projects the following savings to the State and federal government:

	Federal Fiscal Year 2016	Federal Fiscal Year 2017
General (State) Funds	$(2,951.00)	$(2,752.00)
Federal Funds	$(7,543.00)	$(7,948.00)

This has both positive and negative implications. On the one hand, it saves almost $3 million annually in the State budget. On the other hand, it reduces by almost $8 million Federal funds coming to State providers and may depress the availability of home health services. The effect of the lowered reimbursement methodology will be magnified by a related initiative in the October Register of Regulations. DMMA is proposing to eliminate "personal care services" altogether from the Medicaid State Plan based on the rationale that such services will be subsumed under a "home health services" category. See 19 DE Reg. 258 (10/1/15). It is inferable that this will result in an expansion of home health services formerly covered as "personal care" with low reimbursement rates. In turn, low reimbursement rates may result in worker shortages and fewer Medicaid providers.

2. **DMMA Prop. Deletion of Personal Care Services from Medicaid Plan [19 DE Reg. 258 (10/1/15)]**

The Division of Medicaid & Medical Assistance (DMMA) proposes to delete "personal care services" from the Medicaid State Plan. Instead, DMMA posits that supports currently covered as "personal care services" will be covered as "home health services".

DMMA provides the following rationale for the change:

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> During review and subsequent approval on December 31, 2014 of Delaware's 1915(i) Home and Community State Plan Option Amendment (Pathways to Employment),the Centers for Medicare and Medicaid Services (CMS) performed a program analysis of corresponding coverage sections not originally submitted with this SPA. This analysis revealed an issue that requires a state plan amendment (SPA) to sunset coverage and reimbursement methodology for Personal Care Services as personal care as a service will be provided as a component of home health services.

At 260.

SCPD has the following preliminary observations.

First, DMMA estimates that the change "imposes no increase in cost on the General Fund as home health services is already a covered benefit..." At 260. I infer that the change will result in a decrease in both State and federal costs since DMMA is contemporaneously reducing reimbursement for home health services. See 19 DE Admin Code 253, 256 (10/1/15). In turn, reduced reimbursement for home health services may result in fewer providers.

Second, the change may also result in a reduction in available providers for non-monetary reasons. Licensing of "personal assistance services agencies" is separate from licensing of "home health agencies". Compare Title 16 Dolce §122x and 16 DE Admin Code 4469 (personal assistance licensing) with 16 Dolce §122lo and 16 DE Admin Code 4406 (home health licensing). Agencies currently providing "personal assistance services" will ostensibly have to apply for new licenses as "home health agencies".

Third, it would be unfortunate if the change results in a reduction in the scope of currently-covered services. Consider the following:

A. Licensed "personal assistance" agencies can perform any acts individuals could normally perform themselves but for functional limitations consistent with Title 24 Del.C. §1921(a)(15) and Title 16 Del.C. §122x.2. CMS has historically adopted the same broad approach for "personal care assistance' as including "a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they could normally do for themselves if they did not have a disability." See attached CMS, State Medicaid Manual, §4480C. Licensed "home health" agencies lack that authority.

B. Services provided by licensed "personal assistance" agencies are not required to be supervised by a nurse. All services provided by licensed "home health" agencies must be supervised by a registered nurse. See Title 16 Dolce §122oB(V)2.C.

C. The required qualifications of persons providing "home health services" are much more extensive than the qualifications of persons providing "personal assistance". Compare 16 DE Admin Code 4406 .1.1, definition of "home health aide", with 16 DE Admin Code 4469.1.1, definition of "direct care worker".

Fourth, it is unclear what effect the change will have on attendant services provided under the DSHP+ program. DMMA notes that "personal care services" are also known by other names "such as personal attendant services, personal assistance services, or attendant care services, etc.". At 259. The DSHP+ contracts with MCOs require coverage of "attendant care services" independent of coverage of "home health services". See attached excerpts from 2015 DMMA-MCO contract. One could infer that DMMA's elimination of "personal care services" from

the Medicaid program represents either actual program elimination of "attendant services" or is a precursor to such elimination.

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