



STATE OF DELAWARE  
**STATE COUNCIL FOR PERSONS WITH DISABILITIES**

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December 19, 2013

The Honorable Rita M. Landgraf  
Secretary – Department of Health & Social Services  
Administration Building  
1901 N. DuPont Highway  
New Castle, DE 19720

RE: DMMA Final Diamond State Health Plan Renewal Notice [17 DE Reg. 225  
(8/1/13)]

Dear Secretary  Landgraf:

The SCPD submitted comments on the proposed renewal of the Diamond State Health Plan (DSHP) waiver in May 2013. The Division of Medicaid and Medical Assistance (DMMA) acknowledged the comments, clarified some aspects of the waiver, and amended a single typographical error. The Division's July 24 memo containing the SCPD's comments and DMMA's response is attached for facilitated reference. SCPD is following-up on two issues below and soliciting the Department's perspective.

First, SCPD observed that the Council had previously shared concerns about lack of specialized expertise among case managers. DMMA responded that case manager standards were previously revised based on Council input and that "all case managers must have knowledge or experience in: ...(t)he needs and service delivery system for all populations in the Case Manager's caseload". DMMA also recites that new case managers receive an orientation and training on ABI. SCPD is interested in assessing how the MCOs implement the requirement that case managers have expertise in "the needs and service delivery system for all populations in the Case Manager's caseload". Would DHSS be able to share further information on whether the MCOs use "generic" case managers or specialized case managers for subpopulations (e.g. children versus adults)? Are there written protocols that would elaborate on the decision-making process for assignment of a participant to a case manager with expertise in the participant's profile?

Second, SCPD noted that few appeals of MCO decisions have occurred and recommended that the notice forms include contact information about the availability of free legal assistance through CLASI. DMMA summarily rejected the recommendation. At 5. SCPD still strongly supports this recommendation. For contrast, attached is an excerpt from the revised July 2013 DDDS Waiver and sample DMMA/DSS notice of right to fair hearing, both of which explicitly promote referrals to CLASI. Moreover, State public policy supports advertising the availability of assistance from CLASI to Medicaid beneficiaries. CLASI is authorized by several statutes to provide advocacy services on behalf of individuals with disabilities and long-term care facilities must notify CLASI of proposed discharges of individuals with disabilities to protect resident rights. See, e.g. Title 16 Del.C. §§1134(e), 5162, and 5185; and 16 DE Admin Code 3102, §3.3.2. Please advise if the Department will reconsider the omission of a reference to CLASI in MCO notices.

Thank you for your consideration of the above requests.

Sincerely,

A handwritten signature in cursive script that reads "Jamie Wolfe". To the right of the signature is a circular stamp containing the initials "KH".

Jamie Wolfe, Vice-Chairperson  
State Council for Persons with Disabilities

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

JUL 31 2013



**DELAWARE HEALTH  
AND SOCIAL SERVICES**  
DIVISION OF MEDICAID AND  
MEDICAL ASSISTANCE

MEMORANDUM

DATE: July 24, 2013

TO: Kyle Hodges  
Director  
State Council for Persons with Disabilities

FROM: Sharon L. Summers *Sharon L. Summers*  
Social Service Administrator

RE: 16 DE Reg. 1140 [DMMA Proposed Diamond State Health Plan Regulation] – May 1, 2013

Thank you for your recent memorandum regarding the Division of Medicaid and Medical Assistance (DMMA) notice soliciting comments on its proposed renewal of the Diamond State Health Plan (DSHP) waiver. This was published as 16 DE Reg. 1140 in the May 1, 2013 issue of the Register of Regulations. DMMA has considered your comments and responds as follows.

You write,

The notice includes links to a 61-page document [hereinafter “Extension Request”] containing the proposed waiver application and several appendices. The DSHP is the Medicaid managed care program first adopted in 1996. The Extension Request (p. 61) indicates that comments and the DMMA responses will be shared with CMS. SCPD has the following observations.

First, the Public Notice is inconsistent with the “Extension Request”. The Notice [16 DE Reg. 1140 (May 1, 2013)] recites that the extension is sought “for an additional three years”. In contrast, the Extension Request is for five years. At pp. 4 and 61.

**Agency Response:** Thank you for pointing out the discrepancy. The Extension Request is correct. DMMA is requesting an extension for five (5) years.

Second, the Division of Prevention and Behavioral Health Services (DPBHS), formerly the Division of Child Mental Health Services, was identified as a distinct MCO under the original DSHP. See attachments. If it still enjoys that status, its role should be described in the Extension Request. The Extension Request (p. 15) indicates that “extended mental health” benefits “are covered under the traditional Medicaid system.” To the contrary, my impression is that the DPBHS provides extended

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mental health benefits for children enrolled in the DSHP requiring more than a certain threshold of services.

*Agency Response:* DPBHS does not operate as a Managed Care Organization specified under the requirements in 42 CFR 438. DPBHS does coordinate and provide the extended mental health benefits for children enrolled in the DSHP requiring more than the identified threshold of services.

Third, on p. 7, the word “thought” should be “through”.

*Agency Response:* The waiver document has been corrected with the word “through”.

Fourth, effective July 1, 2014, DMMA “plans to terminate the state-operated primary case management entity, Diamond State Partners (DSP).” See Extension Request, p. 12. The DSHP originally had four MCOs. By 2002, it had only one MCO left. See Extension Request, pp. 22-23. Given the need for “choice”, DMMA essentially established a State MCO, Diamond State Partners (DSP). From 2007 to the present, DMMA has had two private MCOs. DMMA implies that enrollment in DSP has declined dramatically due to the attractiveness of the two private MCOs:

DSP was created in July, 2002 when Delaware had only one commercial Managed Care Organization (MCO). However, since 2007, Delaware has had two viable commercial MCOs for member choice. As a result, DSP enrollment has dropped from a high enrollment number of 17,980 in May, 2004 to less than 3,200 currently.

Enrollment Request, p. 12.

In fact, DMMA has discouraged or barred recent enrollment in DSP. In 2011, when the waiver was being modified to create the DSHP+ program, SCPD strongly objected to DMMA’s decision to bar participation of DSP. The Council viewed a choice among only two MCOs as minimal. SCPD also stressed that the State would lose “leverage” in financial negotiations with two MCOs since the MCOs would realize that withdrawal of either MCO could force the State to create a State MCO. DMMA acknowledges this “dynamic” in the current Extension Request (at p. 23): “The decisions of various MCOs to discontinue participation in the DSHP in the past were based largely on their attempts to negotiate exorbitant inflationary increases at contract negotiation time, believing that Delaware would have to accept their terms or discontinue the waiver.” In pertinent part, SCPD’s September 6, 2011 critique (italicized) of the DSHP+ proposal was as follows:

## CHAPTER II: PROGRAM DESCRIPTION

*Section II.1:* This section recites that “(t)he State wishes to have a maximum of two Contractors to provide a statewide managed care service delivery system...”. This is apart from the State-run MCO,

*Diamond State Partners (DSP) which DHSS notes is closed to new members. See also §II.3.3. There are multiple “concerns” with this approach.*

*a. The Division of Prevention and Behavioral Health Services (DPBHS) is an MCO under the DSHP. This is not clarified in this section or elsewhere in the document. Section II.7.6.2.1, which uses outdated*

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*references to the Division of Child Mental Health Services, does not identify DPBHS as an MCO under the DSHP. Parenthetically, an outdated reference to DCMHS also appears in §9.5.2.*

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

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

*This undermines the important “choice” feature of the Medicaid program and merits opposition. Moreover, given the history of MCO’s dropping out of the DSHP, the representation that discontinuation of participation by 1 MCO is an “unlikely event” is not realistic. The only reason DHSS established a*

*State-run MCO was because MCOs cited monetary losses, dropped out of the DSHP, and left only one private MCO.*

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

**The Council strongly opposes the discontinuation of the DSP.** We recommend that DMMA provide satisfaction survey results on DSP to permit comparison with satisfaction survey results from the two private MCOs described at p. 38 of the Extension Request. If satisfaction results for the DSP are high, this would provide additional support for not diminishing “choice” by terminating the DSP.

*Agency Response:* DMMA appreciates your comments regarding DSP. DMMA endorses freedom of choice. As the commenter points out, however, experience has shown that the small population in Delaware does not support the viability of multiple managed care organizations. We are confident that two managed care organizations effectively and efficiently serve the existing DSHP population without limiting access to services. It is no longer cost-effective to cover services through the State managed program, DSP. Please note that CMS requirement of “choice” is satisfied as long as the State contracts with two MCOs.

Fifth, DMMA describes case management as follows:

DMMA has established minimum case management program requirements and qualifications for case managers. ...Additionally, DMMA requires that each MCO assign one and only one case manager for every member eligible to receive long-term care services.

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Extension Request, p. 15.

The Council has previously shared concerns with case manager-participant ratios under the DSPH+ and the lack of specialized expertise among case managers for distinct subpopulations, particularly TBI.

*Agency Response:* The DMMA addressed the Councils' concerns previously and revised the case management qualifications to ensure that case managers were not treated as fungible, therefore all case managers must have knowledge or experience in:

1. The needs and service delivery system for all populations in the Case Manager's caseload
2. Newly hired case managers must be provided orientation and training in a minimum of the following areas:
  - a. Case Management techniques for specialty populations, such as individuals with Acquired Brain Injuries.

The MCOs are required to establish a long-term care case management and support coordination program for DSHP Plus members as directed by the State. Coupled with the minimum case management program requirements and qualifications for case managers, these requirements attempt to address the distinct subpopulations such as TBI.

Sixth, the planned expansion of eligibility to individuals with countable income at or below 133% of the FPL merits endorsement. See Extension Report at p. 12. However, it would also be preferable if the benefits menu could be enhanced to cover adult dental services. Such services are currently excluded. See Extension Request at p. 16. Such expansion has some legislative support. See S.B. 56, introduced on April 30, 2013.

*Agency Response:* Thank you for your endorsement of the expansion. We recognize the importance of offering dental services. However, at this time there is no funding available to expand coverage to the adult population.

Seventh, DMMA indicates that its Health Benefits Manager (HBM) "encourages" members of the same family to select the same MCO. The rationale for such "encouragement" is not disclosed. "Steering" of participants to a single MCO based on the choice of other family members is ostensibly an odd approach. It would be preferable to prioritize other factors, including whether the MCO includes the PCP and specialist used by the participant.

*Agency Response:* DMMA's decision to encourage family members to select the same MCO is based on the benefits to the family including, but not limited to: better navigation of the healthcare system and provider availability. Participants always have the option to select an alternative MCO within 90 days of enrollment.

Eighth, on p. 29 of the Extension Request, the reference to "QII lead by DMMA" merits revision.

*Agency Response:* We cannot respond to this comment because we do not know what revisions the commenter wants.

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Ninth, p. 38 of the Extension Request contains the following recital: “Results indicate that provider satisfaction levels during this period 2009 to 2012 are positive in both plans. “This is somewhat cryptic since a 51% satisfaction rating could be viewed as “positive”. It would be preferable to provide more specific results. Consistent with the “Fourth” comment above, it would also be useful to include satisfaction statistics for the DSP.

*Agency Response:* Both attachments “D” and “E” break out specifics for satisfaction levels. Additionally, the QMS provides more details concerning the MCOs’ satisfaction levels.

Tenth, the restriction to change MCOs to once annually (Extension Report, p. 60) should be subject to exceptions for cause. Indeed, Attachment “D”, which collects client complaints, describes a request to change an MCO since the PCP was no longer enrolled with the current MCO. It should be regarded as “good cause” to switch to an MCO in which the PCP is a participating provider.

*Agency Response:* “Good Cause” exceptions are incorporated as outlined in 42 CFR 438.56.

Eleventh, the Extension Report, p. 60, recites as follows: “DSHP applicants are always approved retroactively to the first of the month in which they apply for coverage if they meet all Medicaid qualifying criteria”. We question the accuracy of this representation. The DLP is currently involved in a case in which DMMA has declined retroactive eligibility to the first of the month in which the applicant applied for coverage. DMMA identifies the first of the month in which the participant enrolls with an MCO as the initial date of coverage. Moreover, the excerpt from the March, 22, 2012 CMS approval of the DSHP identified a concern with 6-8 week delays in initiating Medicaid eligibility for approved applicants.

*Agency Response:* DMMA appreciates the comment noting that our currently approved 1115 waiver permits the State to begin providing services to certain population groups upon enrollment in an MCO. As part of this waiver renewal, DMMA proposes to begin providing medical services to all applicable populations beginning with their month of application.

Twelfth, Attachment P, Table IV, Goal 4, establishes a benchmark of “number and percent of members who rate their experience of care as ‘Good’ or ‘Very Good’.” This could be improved. For example, if the only 2 choices are “Good” and “Very Good”, the results are not valid. The other categories in the survey (e.g. poor, fair, excellent) should be identified.

*Agency Response:* DMMA appreciates and has considered the recommendations expressed and thank you for your comments. However, we have not proposed any changes to the waiver as a result of this comment.

Thirteenth, Attachment P, Table IV, Goal 1, includes a quality measure based on “appeals both pre-service and post-service per 1,000 members”. The Councils have expressed concern with the negligible number of appeals of DSHP+ participants. Based on participant descriptions of proposed reductions in services without MCO disclosure of appeal rights, this measure may be of questionable validity. Moreover, it would be preferable if DMMA would honor CLASI’s request to require contact information about the availability of free legal assistance in MCO notice forms.

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*Agency Response:* DMMA appreciates and has considered the recommendations expressed and thank you for your comments. However, we have not proposed any changes to the waiver as a result of this comment.

Fourteenth, consistent with the attachment, we appreciate that individuals under the Medicaid Workers with Disabilities program are included in DSHP+.

*Agency Response:* Thank you for your comments. DMMA continues to support efforts to move individuals from institutional settings to community based settings.

DMMA is pleased to provide the opportunity to receive public comments and greatly appreciate the thoughtful input given.

Cc: Stephen M. Groff, Director, DMMA

the choice of home or community-based services as an alternative to institutional care or who are denied the service(s) of their choice, or the provider(s) of their choice. DDDS requires a letter indicating the individual's right to a Fair Hearing be sent to the individual and/or their legal guardian.

When an individual applies for services under this waiver, he or she is assessed to determine medical and financial eligibility. Following the eligibility determination process, written correspondence is mailed to this individual related to his or her eligibility to receive services through this waiver. Included in this information is the Fair Hearing notice. Notices of adverse action and the opportunity to request a Fair Hearing, at the time of entrance to the waiver, are maintained in the DDDS Office of Applicant Services.

The Fair Hearing notice indicates: denial of service, reduction of service, suspension of service, or termination of service can generate a Fair Hearing. The individual has the right to appeal and to be heard in a Fair Hearing if he/she is dissatisfied with the action. The individual must present a written request if he/she wishes to obtain a Fair Hearing. The individual may be represented by legal counsel (referrals are made to Community Legal Aid in instances where private legal counsel is not financially feasible) or other persons of his/her choice at the Fair Hearing. The individual may discuss this action with a member of the agency's staff. Filing a grievance does not interfere with the individual's Fair Hearing rights. The individual's benefits continue during the fair hearing process if the issue in question is not one of state or federal law. If the individual's benefits continue, they may be responsible for repayment, if they lose the Fair Hearing.

In order for Medicaid to continue, the actual receipt of a written request for a Fair Hearing is required within 10 days from the date of the notice/action being disputed. The individual may write directly to the agency or detach a portion of the notice and mail it to his/her local DMMA office.

Fair Hearing notices accompany notification of all other adverse actions and notify the individual of his/her right to a Fair Hearing. Notices are sent by case managers and/or providers by mail to individual. While not all of these actions are typically carried out in this waiver program, any adverse action, including action related to choice of HCBS vs. institutional service; choice of provider of service; and the denial, reduction, suspension or termination of service would be accompanied by the Fair Hearing notice described above. Case managers assist individuals in pursuing Fair Hearings by assisting the individual with the completion of forms or referrals to Community Legal Aid, as needed.

Documentation concerning Fair Hearing notifications are kept on file by DMMA via the quarterly State Fair Hearing Report.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply.

Yes. The State operates an additional dispute resolution process

- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

DDDS operates an appeals process for individuals and/or their guardian or advocate to aggrieve any DDDS decision to which satisfactory resolution cannot be reached. DDDS appeals process is a dispute resolution mechanism requested in conjunction with or in addition to a State Medicaid Fair Hearing request. DDDS sends the individual and/or their guardian or advocate a written explanation of the disputed decision, the reason for such and notification of their right to request a DDDS appeal.

Instructions for requesting the DDDS appeal are provided and includes sending the appeals request form (included with the notification letter) to the Appeals Committee Chairperson.

Significant timelines regarding the request for and processing of a DDDS appeals request are as follows:

- 30 days from receipt of adverse notification letter to request an appeal;
- 5 working days from date of receipt of appeal request to schedule the appeal;

