

## MEMORANDUM

DATE: May 30, 2013

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

FROM: Kyle Hodges, Director  
State Council for Persons with Disabilities

RE: 16 DE Reg. 1140 [DMMA Proposed Diamond State Health Plan Renewal Notice]

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) 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. 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.

### **DMMA is requesting an extension for 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 mental health benefits for children enrolled in the DSHP requiring more than a certain threshold of services.

### **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".

### **The document has been corrected.**

**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, SCPDs 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 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.*

**SCPD strongly opposes the discontinuation of the DSP.** SCPD also recommends 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.

**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 of 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.

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.

**The DMMA addressed the SCPD 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.

**Thank you for your endorsement of the expansion. We recognize the importance of offering dental services for both the adult and child population. However, at this time there is no funding available to support this benefit.**

**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.

**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.

**This comment is not clear. DMMA does not understand its intent.**

**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.

**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.

**DMMA has “good cause” exceptions 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”. SCPD questions 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.

**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.

**Thank you for your comments.**

**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 Council has 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.

**Thank you for your comments.**

**Fourteenth**, consistent with the attachment, SCPD appreciates that individuals under the Medicaid Workers with Disabilities program are included in DSHP+.

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

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. Glyne Williams  
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Mr. Brian Hartman, Esq.  
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