DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

DELAWARE DIAMOND STATE HEALTH PLAN
1115 DEMONSTRATION FIVE-YEAR WAIVER RENEWAL REQUEST

Response to Public Comments Received as of June 12, 2013

Delaware Health and Social Services (DHSS), Division of Medicaid and Medical Assistance (DMMA) received five (5) unique comments related to the proposed request for a five-year extension of the Diamond State Health Plan 1115 Demonstration Waiver, which is scheduled to expire on December 31, 2013.

The Division of Medicaid and Medical Assistance (DMMA) appreciates all of the thoughtful comments submitted related to the 1115 waiver renewal request. Written comments were received from Christiana Care Health Services, Generations Home Care, Inc., Governor's Advisory Council for Exceptional Citizens (GACEC), State Council for Persons with Disabilities (SCPD) and, United Healthcare Community Plan of Delaware.

DMMA believes that it has considered and effectively addressed the comments submitted and has taken action to address many of the commenters' concerns. Our response to each comment is shown below.

Christiana Care Health Services

Inclusion of ESSURE and HSG is encouraged in the Delaware Family Planning Waiver. ESSURE is a minimally invasive procedure for permanent conception. ESSURE (58565) and HSG (58340, 74740) are most effective and the least invasive procedure for permanent birth control. These procedures are safer, require less anesthesia and have quicker recovery than tubal ligation.

DMMA Response: DMMA appreciates and will consider your recommendations. However, no changes to the waiver are needed at this time.

Generations Home Care, Inc.

Two staff members from Generations Home Care attended the public hearing on the waiver extension May 22, 2013 and send these comments regarding the 1115 Demonstration Renewal.

Generations Home Care is a licensed not-for-profit home and community-based service provider incorporated in Delaware in 1968. Generations Home Care has a statewide presence, with three county offices, serving Sussex, Kent, and New Castle Counties. Generations has continuously provided care and

assistance to Delaware residents in need, regardless of their ability to pay, for over 40 years. We provide services that enable individuals to remain in the familiar surroundings of home through home-based care by a cadre of skilled and experienced professionals. Our services allow elderly and disabled adults to maintain their dignity and independence without ever compromising safety or sacrificing quality of care.

Services and supports offered cover all phases of health maintenance and recovery - whether recuperating from a short-term disability or living with a chronic health condition.

Generations Home Care participates in the Delaware Diamond State Health Plan. Generations joined other community-based providers under this Demonstration April 1, 2012. We strongly support Delaware's request for an extension of its waiver for the period January 1, 2014 through December 31, 2016.

We believe the waiver will:

- Expand options for those who need long term care by growing home and community based services
- Rebalance Delaware's Long Term Care System
- Promote early intervention for individuals at risk of requiring institutional long term care
- Respect and expand consumer choices

Generations Home Care encourages a partnership between Generations and the Delaware Department of Health and Social Services to fund a new ***Residential Supported Living Service***, referred to as ***Adult Foster Care Level II***. This program is not a new option for most states. ***Adult Foster Care Level II***, in most states, is a Medicaid-funded home and community-based service for adults with physical disabilities and

older adults who can no longer live alone and who otherwise would have no option but to be placed in a nursing facility for lack of alternative community options. All services are provided in a licensed residential home - a home with less than four (4) adults.

Adult Foster Care Level II is not a group home model, nor is it Assisted Living. ***Adult Foster Care Level II*** assists an adult with Activities of Daily Living (i.e. toileting, bathing, feeding, walking, grooming) and/or Instrumental Activities of Daily Living (i.e., shopping, managing medications, budgeting, preparing meals, handling transportation). In addition, the program provides coordination with social activities.

Elderly and disabled adults accepted into the program require ***Long Term Care*** support, which makes this population appropriate for the Diamond State Integrated Long Term Care Delivery System, which began April 1, 2012.The Diamond State Health Plan Plus already includes this service population: aged and/or disabled individuals over age 18 who meet Nursing Facility level of care, but who prefer to receive home and community-based services as an alternative. Program participants are maintained in the most integrated setting appropriate for their needs. ***Adult Foster Care Level II*** affords choice in remaining in an alternative residential setting versus entering or remaining in an institution. Plus, it is consistent with the demonstration waiver's objective of controlling expenditures while honoring the

preferences of individuals who want to remain in a homelike setting and out of more costly and restrictive institutional settings.

Adult Foster Care Level II services are provided under the direction of a licensed Home Health Agency and supervised by a Registered Nurse and Masters prepared staff with degrees in social work, rehabilitation, psychology or a related field. Further, all Level II sponsors and resident managers have high school diplomas and receive specialized training to meet the needs of the at-risk adult. To assure safety and quality, this program can and should be licensed by DHSS. The process exists today to make this happen and should be included in this application.

Using "Best Practice" models from other states, Delaware can expeditiously implement this new option. Forty-four (44) states use Medicaid funds to support a continuum of home and community-based services, from Assisted Living Residences to Adult Foster Care Homes.

Generations Home Care avidly agrees with DHSS, the provider community, and at -risk individuals, and their families, that it is critical to Delaware to continue the successful implementation of programs and services that rebalance Long Term Care resources. The ***Adult Foster Care Level II*** program respects individual choice by offering quality, cost-effective, humane, non-institutional alternatives. Would any one of us want anything less for our loved ones and for ourselves?

We sincerely believe Delaware must expand its long term services and supports options in the community. Partnering with CMS and expanded options under the Affordable Care Act and use federal grant money, states can transition Medicaid beneficiaries out of institutions and back to their homes or another qualified community based setting.

Adult Foster Care or rest residential homes with fewer than four unrelated individuals should be a community based option. According to the ***Kaiser Family Foundation***, individuals in the Money Follows

the Person Program most often transitioned to an apartment setting; Delaware has a shortage of housing settings appropriate for this population. AFC Tier II offers an additional housing setting with support services.

*****Twenty states worked with CMS to reclassify supplemental services as demonstration services to receive the enhanced federal match. Twenty-seven (27) states reported housing to be the most significant issue facing MFP (Money Follows the Person).***

*****Qualified community settings in some MFP demonstrations include a home, apartment, or group home with less than four non related residents. Under the Affordable Care Act (ACA), MFP was extended by five years through 2016 and additional funding was set aside for the demonstration.***

*****As more Medicaid beneficiaries transition to the community, one critical component of a successful community placement is multiple housing options, etc. a program like Adult Foster Care II.***

*****Across all target populations, seniors are the group most likely to be re-institutionalized. This outcome provides an ideal opportunity for Delaware to partner with CMS to support a community option that includes Adult Foster Care II.***

Housing remains the biggest challenge facing states in the year ahead. States have repeatedly cited the lack of safe affordable and accessible housing as the biggest barrier to MFP transitions since the demonstration program began in 2008 ***(The Kaiser Commission on Medicaid and the Uninsured)***.

In a review of the Federal Register Volume 77, Number 38, Monday February 27, 2012, we encourage Delaware to show evidence of the following:

(1) Stakeholder involvement that includes the medical advisory committee, beneficiaries and diverse provider group representatives and other stakeholders involved in the demonstration; are homecare provider groups at the table?

(2) Transparency regarding comments made during the public comment period and how these comments were addressed by the State. ***How were public comments considered in the Waiver Demonstration extension? Will the state ask for an amendment to the demonstration, etc.?***

(3) Transparency regarding complaints, how the State reviews and responds to complaints; is this information available for public access?

(4) Post-approval public forum.

(5) Information on access to the State's evaluation design, including information on the demonstrations' impact of access to care, cost of care, quality of care and how the demonstration impacts the outcome of care; what is the impact on the beneficiary and the provider community; is any group ***"harmed"*** by the demonstration?

(6) Public access to the State's draft and final annual reports regarding the extended demonstration.

(7) Access to the State's summary of types of grievances and appeals, trends discovered and actions taken or to be taken.

(8) Process in which inquiries and comments from the public may be directed to CMS by mail or email.

(9) Public information on any policy or administrative difficulties in the operation of the waiver extension.

(10) Since the State's Demonstration depends heavily on two Managed Care Organizations, how does the state provide information or access to information on the State's monitoring and supervision of the MCO organizations responsible for much of the demonstration; were policy and administrative actions by the MCO the same or interpreted differently? If not, what is the State's process for corrective action?

In summary, we support Delaware Diamond State Health Plan & Diamond State Health Plan Plus Waiver extension request, especially if it includes more community housing options for beneficiaries.

***DMMA Response*:** Thank you for your comments and support. DMMA concurs with your support of diverse long term service options and the critical role of safe, affordable, and accessible housing. In response to your specific question regarding compliance with federal regulations, DMMA has adhered to the federal requirements for transparency by publishing the renewal request for public comment, holding public hearings and, publishing the comments received and the agency's response on the DMMA website at http://dhss.delaware.gov/dhss/dmma/.

Governor's Advisory Council for Exceptional Citizens (GACEC) Comments

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

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***DMMA 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.

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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.

GACEC 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.

***DMMA 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.

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.

***DMMA Response*:** The DMMA addressed the Council's 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.

***DMMA 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.

***DMMA 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.

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

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.

***DMMA 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.

***DMMA 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.

***DMMA 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.

***DMMA 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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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.

***DMMA 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+.

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

United Healthcare Community Plan of Delaware

As a partner in serving Delaware's Medicaid enrollees, UnitedHealthcare Community Plan is proud to have supported the State in meeting its defined goals through the Diamond State Health Plan (DSHP) and Diamond State Health Plan Plus (DSHP-Plus) programs. Delaware serves as national model for how managed care can help promote independence, expand choices, and control costs in the Medicaid program.

UnitedHealthcare Community Plan has been a partner in these efforts since 2007 and currently serves 65,000 individuals in Medicaid. Working collaboratively with DHSS and the communities we serve, we have developed programs to improve outcomes and expand access for the most vulnerable Delawareans. These include programs that support prenatal care access and education for pregnant women, disease management programs for diabetics and others with chronic disease, behavioral health programs to support the holistic needs of members, and hands on care coordination to ensure elderly and disabled members can live safely in their preferred home setting. We were also able to assist the State and community to ensure the safety and recovery of our members after Hurricane Sandy.

As DHSS looks to renew its existing DSHP 1115 demonstration waiver with CMS, Delaware has a unique opportunity to continue the success of the current model while re-evaluating key elements of its Medicaid managed care delivery system. To assist the State with identification of these elements, UnitedHealthcare is pleased to offer the following comments for your consideration. We offer our comments and support to both this and future CMS waiver renewal discussions.

Section III Benefits

- Consider carving in benefits to Diamond State Health Plan (DSHP) and Diamond State Health Plan-Plus (DSHP-Plus). The State currently carves certain portions of the benefit out of the managed care benefit and provides these services in a fee for service environment. Carve in arrangements have the benefit of improving care delivery in that they allow all benefits to be managed by one entity, allowing for a more holistic focus on the individual and decreased confusion for beneficiaries.

- Allow for broader flexibility for home and community based services (HCBS) benefits. By allowing greater flexibility for HCBS benefits, health plans can ensure that they are able to provide beneficiaries with the most appropriate services possible. This will allow individuals to remain in their homes and communities for longer periods of time with the appropriate supports. We can work with the State to identify additional HCBS supports that may not exist under current waivers and can offer beneficiaries a wider and richer set of community-based placement alternatives. In addition, we can work with the State to identify possible opportunities to develop a tiered waiver benefit approach to enable the alignment of the least costly benefits to a broader population

- Allow DHSP-Plus beneficiaries to have budget-authority over self-direction of personal care attendant (PCA) services. Under the current 1115 waiver, DSHP-Plus beneficiaries have employer authority for PCA services which gives them control over who provides services and how they are administered. Expanding this control to include budget-authority for DSHP-Plus beneficiaries receiving PCA services will provide these individuals with greater decision-making authority over how their budgeted funds are spent.

Section V Managed Care Organizations

- Partner in development of alternative delivery models. We are supportive of the State's waiver amendment request to implement any state plan amendment to provide health homes for eligible demonstration enrollees, per the ACA. As Delaware looks towards implementation options, we urge the State to involve the health plans in all aspects of program design and development. Given that health homes and other alternative models are in their infancy and policy implications have not been closely examined in all instances, we would appreciate opportunities to work with the State, providers, and other stakeholders in an ongoing manner to thoughtfully discuss design and implementation considerations, as well as create transparency in the planning process. We would also welcome the opportunity to work closely with the State to monitor the development and implementation of these types of models across the country and leverage relevant lessons learned from those experiences.

UnitedHealthcare values our relationship with the State and appreciates the opportunity to provide comments as Delaware looks to the renewal of its current 1115 demonstration waiver. We look forward to our continued partnership with DHSS and are certainly available to discuss our comments and the waiver further.

***DMMA Response*:** Thank you for your comment. DMMA appreciates the opportunity to work with you in serving the Medicaid population of Delaware.
