October 25, 2016

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RE: DMMA Proposed Targeted Case Management Regulation [20 DE Reg. 247 (October 1, 2016)]

Dear Ms. Xavier:

The Governor's Advisory Council for Exceptional Citizens (GACEC) has reviewed the Division of Medicaid and Medical Assistance (DMMA) proposal to adopt a Medicaid State Plan amendment affecting Division of Developmental Disabilities Services (DDDS) clients. Under the amendment, targeted case management (TCM) would be added as a State Medicaid Plan service with two target groups: 1) DDDS clients who are receiving residential services through the DDDS Medicaid waiver; and 2) DDDS clients who are receiving DDDS services and living in their own homes or with their families. At 248. The State plans to later file an amendment to the DDDS waiver effective January 1, 2017 to allow the second group to enroll in the waiver. The expanded waiver will be called "the Lifespan Waiver". At 248. DDDS will "phase out" the existing "Family Support Specialists" (FSS) who currently provide some case management services to the second group. At 249. Instead, DDDS will issue an RFP to obtain some contract agencies who would hire targeted case managers ("Community Navigators") to serve the second group under the waiver. See Supplement 3 to Attachment 3.1-A, p. 1. This approach should result in no additional cost. At 249. DDDS clients in the first group (residential clients) would continue to receive case management services from DDDS employees who would be designated "Qualified Support Coordinators". Council would like to share the following observations.

First, the minimum credentials of both the "Community Navigators" (serving non-residential clients) and Qualified Support Coordinators" (serving residential clients) are not strong. Apart from some DDDS training, the standard is as follows:

> 1. Have an associate's degree or higher in behavioral, social sciences or a related field OR experience in health or human services support, which includes interviewing individuals and

assessing personal, health, employment, social, or financial needs in accordance with program requirements.

Supplement 3 to Attachment 3.1-A, Page 6; Supplement 4 to Attachment 3.1-A, Page 6

These individuals are responsible for a host of high-level activities requiring expertise and skills, including monitoring health and welfare; ensuring implementation of service plans; responding and assessing emergency situations; participating in investigations of reportable incidents; assistance with linkages to obtaining services available through Medicaid, Medicare, private insurance, and other community resources; and coordination with Managed Care Organization (MCO) representatives, Division of Vocational Rehabilitation (DVR), and educational coordinators. See Supplement 3 to Attachment 3.1-A, Pages 3-6. See also 42 C.F.R. 440.169. It is clear that more robust credentials will be necessary to perform the functions mentioned above in a meaningful way. These individuals must be experts in identifying and facilitating access to support services in complex federal, state, and private systems. Under the proposed standard, someone without even a high school diploma and minimal experience in human services will qualify to be hired as a case manager. Contrast the DMMA standards for a Medicaid MCO case manager:

1) nurse with 2 years of qualifying experience;
2) individual with 4 year degree in human services field plus 1 year experience; or
3) high school diploma plus 3 years of qualifying experience.

2016 DHSS MCO Contract, §3.7.1.2

Second, the level of involvement with the DDDS clients is minimal. A unit of service is "one month" so compensation is paid based on fulfilling the following de minimis activity once per month: "one (1) service contact that can include face-to-face or telephone contacts with the recipient or on behalf of the recipient". See Attachment 4.19-B, Page 27; Attachment 4.19-B, Page 28. Therefore, a case manager meets minimum standards for monthly compensation under the Medicaid program for making a single phone call per month. The combination of case managers with minimal credentials and minimal client contact is inconsistent with the recital that "every jurisdiction in the State will be able to receive high-quality, comprehensive case management services". See Supplement 3 to Attachment 3.1-A, Page 6.

Third, there is no "caseload" benchmark in the Medicaid State Plan Amendment. It would be preferable to include a benchmark such as an upper cap on case manager caseload. Contrast DMMA MCO case management "caseload management" standards, §3.7.1.5.3 of the 2016 DHSS-MCO contract.

Fourth, it would be preferable to have case management provided by State employees rather than contracting with private firms with a profit incentive. There may be minimal or no financial benefit to paying a broker agency which charges overhead and then pays case managers undefined compensation. The fee schedules for government and private providers for case management are the same. See Attachment 4.19-B, Page 27. For example, in practice, MCO case managers have

proven much less responsive to client needs than State case managers. Their primary "loyalty" is to their employer, not the State. If the Centers for Medicare and Medicaid Services (CMS) prefer a "firewall" between case management and direct service provision, the case managers could be placed under the Office of the Secretary. This was the approach adopted to separate the Long-term Care Ombudsman from the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) since DSAAPD provides direct services in public nursing homes [e.g. Delaware Hospital for the Chronically Ill (DHCI; Governor Bacon Health Center (GBHC)].

Fifth, DMMA should consider amending the following reference: "(i)nforms and assists an individual or his or her family to obtain guardianship or other surrogate decision making capability". See Supplement 4 to Attachment 3.1-A, Page 4. Federal Health and Human Services (HHS) is actively promoting alternatives to guardianship such as supported decision-making. Delaware supported decision-making legislation (Senate Bill No. 230), co-authored by DHSS, was signed by the Governor on September 15, 2016. Consider the following substitute for the reference above: "(i)nforms and assists an individual or his or her family with surrogate decision making and assistance options, including supported decision-making agreements, powers of attorney, and guardianship."

Sixth, DMMA should reconsider the following reference: "(f)acilitates referral to a nursing facility when appropriate." See Supplement 4 to Attachment 3.1-A, Page 4. Placement of DDDS clients in nursing homes is highly disfavored. For that reason, DMMA implements the federal Preadmission Screening and Resident Review (PASRR) process. Cf. 16 DE Admin Code 5304.1. Moreover, the Delaware Department of Health and Social Services (DHSS) has been actively prioritizing diversion of individuals from nursing homes through programs such as Money Follows the Person (MFP) and the Diamond State Health Plan Plus (DSHP+). Therefore, it is somewhat unusual to specifically highlight and prioritize facilitation of referrals to nursing homes in the Medicaid State Plan Amendment.

Thank you for your consideration of our observations on the proposed regulations. Please contact me or Wendy Strauss at the GACEC office if you have questions.

Sincerely,

Dafne Carnright

Dafne A. Carnright
Chairperson

DAC:kpc

CC: The Honorable Rita Landgraf, Secretary of the Department of Health and Social Services
Stephen Groff, Director, Division of Medicaid and Medical Assistance
Jill Rogers, Director, Division of Developmental Disabilities Services