December 27, 2017

Nicole M. Cunningham
Planning, Policy & Quality Unit
Division of Medicaid & Medical Assistance
1901 N. DuPont Hwy.
P.O. Box 906
New Castle, DE 19720-0906

RE: DMMA Proposed Medicaid LTC Prior Medical Costs Submission Limitation Regulation [21 DE Reg. 475 (December 1, 2017)]

Dear Ms. Cunningham:

The Governor's Advisory Council for Exceptional Citizens (GACEC) has reviewed the Delaware Health and Social Services/Division of Medicaid and Medicare Assistance (DMMA) proposal to adopt a new long-term care Medicaid regulation which will limit the time period for submission of proof of medical costs to "within one (1) year of the date(s) of coverage". At 471. Council would like to share the following observations.

A one year time frame may seem reasonable taken at face value, however, it does not account for delays attributable to some common issues. For example, determination of a "final" medical cost may be delayed by several factors:

I. Processing of Insurance Claims

First, if the individual has multiple forms of insurance (e.g. Medicare; Medicaid; private insurance), sequential claims may have to be submitted and processed based on the order of financial responsibility. This process can easily take several months to complete for even clean claims. Second, a medical provider may not issue a bill in timely fashion which delays the processing of insurer claims and identification of the individual's final financial responsibility. Third, if the individual has invoked internal and/or external appeals of insurer denials, that process could easily take several months to resolve. Consider the following timetables for health insurer determinations covered by the Delaware Department of Insurance: 1) the health insurer can delay issuing a claim decision by requesting more information (18 DE Admin Code 1310.6.0; 2) once a patient eventually receives the "final" insurer decision, the patient can request mediation or, within 4 months of the final insurer decision, request IHCAP review

which takes another 45 days (18 DE Admin Code 1301.4.0, 5.1, and 5.7); and 3) in lieu of IHCAP review, the patient can opt for arbitration with the Insurance Department within 60 days of an insurer's final decision and, subject to continuances, expect a decision within 45 days (18 DE Admin Code 1315.3.1 and 13.15.6.1).

II. Beneficiary Capacity

Second, the institutionalized Medicaid LTC patient will often have compromised health and cognitive capacity resulting in delayed processing of medical cost determinations and submission of such information to DMMA.

The bottom line is that a "no-exceptions" 1-year time period may result in injustice. DMMA could consider alternative revisions to mitigate the potential for an unjust result:

A. The following sentence could be added to proposed §20620.2.3.1: "This limitation may be extended for good cause (e.g. significant delay in final cost determination due to insurer processing or appeals)."

OR

B. DMMA could adopt a longer submission period. For example, the Division could substitute "18 months" for "one (1) year" in the regulation.

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

Sincerely,

Dafne A. Carnright
Chairperson

DAC:kpc