

Medicaid

- A comprehensive federal/state program that provides medical insurance benefits to qualified individuals.
- Purpose is to allow states “to furnish rehabilitation and other services to help such families and individuals attain or retain capability for independence or self care.”
- Administered by the states, which delegate to managed care organizations (MCOs).

What Does Medicaid Cover?

Mandatory Services

- Inpatient hospitalization
- Outpatient hospital services
- Rural health clinic services
- Federally qualified health center services
- Labs and X-rays
- Nursing facility services for adults
- EPSDT services for children under 21
- Pregnancy related services
- Family planning
- Physician services
- Nurse-midwife services
- Pediatric nurse practitioner services
- Home health services for those eligible for nursing facility services

What Does Medicaid Cover?

Optional Services

- Home health services for those not eligible for nursing facility services
- Private duty nursing services
- Clinic services
- Physical therapy
- Prescribed drugs
- Other diagnostic, screening, preventative and rehabilitative services
- Intermediate care facilities for the mentally retarded
- Durable medical equipment

Waiver Programs

In last 25 years, Delaware developed a hodge-podge of Medicaid home- & community-based waiver programs to serve various populations with disabilities who met nursing home level of care:

- Elderly and Adults with Physical Disabilities
- Assisted Living
- Acquired Brain Injury
- HIV/AIDS
- DD/MR

Waivers, continued

- Waivers differed in scope
 - Varying menu of services
 - Silo effect
 - Waiting lists
- 2010 DSAAPD Consolidated E & D Waiver with Assisted Living and ABI Waiver
 - Streamlined eligibility and expanded service menu.

Diamond State Health Plan Plus (“DSHP+”)

- Mandatory Managed Long Term Care.
- Integrates Nursing Facility Services and Home- & Community-Based Services for the elderly and adults with physical disabilities into existing managed care system.
 - Managed care in Delaware for non-institutional level of care individuals since 1996.

DSHP+ continued

- Purposes:
 - Divert individuals into community based settings
 - Increase care options and choice
 - Improve transitions and coordination of care
 - Shift Medicaid spending from nursing facilities to community
 - Save Money

Included Populations

- 1) Nursing Facilities/institution residents
- 2) Elderly and Disabled Waiver participants
- 3) AIDS Waiver participants
- 4) Money Follows the Person participants
- 5) Other Full Dual eligibles in the community
- 6) Medicaid for Workers with Disabilities
- 7) Out of State Rehabilitation Placements

Excluded Populations

- 1) Developmental Disabilities Waiver participants
- 2) DD ICF/MRs – Stockley Center and Mary Campbell Center
- 3) Partial dual eligibles – QMB, SLMB
- 4) State only/non- Medicaid groups
- 5) PACE program participants (Program for All Inclusive Care for the Elderly)
- 6) Acute Care Hospitalizations (30 Days Minimum)

DSHP+ Implementation

- Program Shift April 2012 for existing enrollees
 - 3000 Nursing Home residents
 - 1800 HCBW Participants
 - 5000 Full Duals (Medicare and Medicaid)
- All new enrollees

DSHP+ Enhanced Services

- Includes all regularly covered Medicaid services
- Waiver Services include:
 - 1) Case Management
 - 2) Nursing Facility Care
 - 3) Assisted Living Care
 - 4) Personal Care Services
 - 5) Respite Care
 - 6) Home Delivered Meals
 - 7) Day Habilitation
 - 8) Cognitive Services
 - 9) Consumer Directed Attendant Care
 - 10) Transition Services
 - 11) Adult Day Services
 - 12) Personal Emergency Response
 - 13) Nutritional Supplements for the AIDS Population
 - 14) Home Modifications

DSHP+ Eligibility

- DMMA handles financial and medical eligibility
- Level of Care Determination
 - DSHP+ recipients must meet skilled or intermediate level of care
 - Community-based services
 - 1 ADL deficit/at risk of institutionalization
 - Nursing Home Services
 - 2 ADL deficits
 - Existing recipients in NF grandfathered
- Financial
 - Income Limit - 250% SSI Standard (\$1775 individual)
 - Miller Trust
 - \$2000 resources (individual)

DSHP Managed Care Organizations

- MCO Contact Information
 - Delaware Physicians Care Incorporated Patti Simpson
Compliance Director
Member Services: 1-888-437-6875
email simpson.p@Aetna.com
– <http://www.delawarephysicianscare.com/Content/Docs/DSHP-PLUSHandbook-ENG-DE.pdf>
 - United Health Community Plan
– Terri Lynn Palmer, Compliance Director
1-877-542-9248
email TerriLynn.Palmer@uhc.com
– <http://www.uhccommunityplan.com/assets/DE-LTC-MemberHandbook-EN.pdf>
 - State Contact
 - Kathleen Dougherty
Program Manager
DSHP & DSHP-Plus
email Kathleen.Dougherty@state.de.us

Post-Eligibility Issues

- Development of Care Plan
 - Collaborative approach to development of the proposed Plan of Care
 - You should not hesitate to ask for additional services, but should make sure your health care provider supports the need for those services
 - You have a right to dispute a proposed Plan of Care and should receive a written notice with appeal rights
 - You should not sign anything you don't agree with, and ask for copies of everything

Medicaid Appeal Procedures

Provide for fair and timely review of adverse decisions

Allow applicants and beneficiaries to seek review of

- eligibility decisions (DMMA)
 - financial eligibility
 - level of care determinations
 - State fair hearing only
- coverage decisions (MCO)
 - reductions in existing services
 - denials of requested services
 - State fair hearing and MCO appeal



Constitutional and Statutory Underpinnings

Due Process Clause of Constitution

- Adequate notice
- Meaningful opportunity for a hearing
- *Goldberg v. Kelley*, 397 U.S. 254 (1970)

Statutory and Regulatory Sources

- Federal Medicaid Statute, 42 USC Section 1396(a)(3)
- Federal Regulations, 42 CFR Sections 431.200-431.246 and 42 CFR Sections 438.400-424
- State Regulations and Policy Manuals (DSSM 5200)
- Federal and state case law

Adequate Notice

State Agency Actions:

- Written notice is required any time the state takes action that affects a person's claim for benefits or makes a decision regarding eligibility
- The notice must be issued 10 days in advance of any adverse action

The Notice must state, in understandable language:

- The intended action
- The reasons for the action
- A Citation/Regulation supporting the decision.
- The right to request a fair hearing
- How to request a fair hearing
- The ability to represent oneself or bring legal counsel, or any other advocate
- How to receive benefits continuation

MCO Notice Requirements

Medicaid MCOs must have internal appeal procedures

- Grievance process also required for minor qualitative complaints

MCOs must send a written notice of action which must contain:

- An explanation of the action
- Reasons for the action
- Right to file an MCO appeal
- Right to request a state fair hearing
- Procedures for exercising MCO Appeal Rights
- Right to benefits continuation pending appeal (including potential liability)
- How to obtain expedited appeal process

Timeframes for notices vary depending on action taken

- Terminate, reduce, suspend existing services - generally 10 days prior, unless fraud
- Deny new request for service - generally not more than 14 days

	MCO Appeal	State Fair Hearing	MCO Grievance
State denial of eligibility for Medicaid and/or Long Term Care Medicaid		X	
MCO denial or limited authorization of requested service	X	X	
MCO reduction, suspension or termination of previously authorized service	X	X	
MCO denial of payment, in whole or in part	X	X	
MCO failure to provide services in timeframe established by state	X	X	
MCO failure to resolve grievances or appeals in timeframe established by state	X	X	
Enrollee dissatisfaction about quality of care or services provided			X
Provider or MCO employee failure to respect enrollee rights			X
MCO denial of request for expedited appeal			X

State Fair Hearing and MCO Appeal Procedures

Medicaid MCO enrollees have access to two appeal procedures

- State Fair Hearing**
 - Appeal deadline is 90 days from notice of action
 - If appeal requested within 10 days of the notice, benefits will continue pending the appeal
- MCO Internal Appeal Process**
 - Appeal deadline is 90 days from notice of action
 - Can be requested by Member or Provider
 - Benefits continue if three conditions are all met
 - Authorization has not expired, and services are from authorized provider
 - enrollee has made appeal request within 10 days of the mailing of the notice of action or by the effective date,
 - the enrollee asks for benefits continuation
 - Appeal deadline is 90 days from Notice of Action
 - Decision must be issued within 45 days, extended only to benefit enrollee
- No exhaustion requirement
- 90 day appeal period runs concurrently

MCO Appeal Process

- MCO must process appeal within 45 days
- This allows an enrollee to utilize the internal appeal before turning to a state fair hearing
 - however benefits continuation may be lost unless fair hearing is requested within 10 days of receipt of MCO decision

Summary of MCO Appeal Rights

- To request an MCO appeal, within applicable time limits.
- To request a state fair hearing, within applicable time limits.
- To file an MCO grievance.
- To receive adequate timely written notice of MCO decisions.
- To have oral inquiries about appeals treated as appeals; must be converted to written, signed request
- To receive reasonable assistance from the MCO in completing appeal forms and other procedural steps.
- To request that services continue until an appeal decision, within applicable time limits.
- To request expedited review of appeals.
- To have a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing
- To have the opportunity before and during the appeals process to examine the enrollee's case file, including medical records, and any other documents and records considered during the MCO appeals process.
- To have MCO appeal decided by individual who was not involved in any previous review and in certain circumstances, who is a health care professional with appropriate clinical expertise. There will be a doctor, a nurse, compliance staff from the MCO, and Medicaid program staff.
- To receive written notice of the MCO appeal decision.
- To have services authorized or provided promptly and as expeditiously as the enrollee's health condition requires, and to have services received while the appeal was pending paid, if the enrollee wins her appeal.

Summary of Fair Hearing Rights

- To a state fair hearing, if requested within applicable time limits.
- To receive adequate written notice of state agency decisions.
- To represent oneself or be represented by legal counsel, a relative, friend or other spokesperson.
- To request that services continue until a hearing decision, if requested within applicable time limits.
- To receive written notice of the hearing, which is to be scheduled at a reasonable time, date and place.
- To have appeals decided by an impartial hearing officer.
- To examine the case file and all documents and records to be used by the agency at the hearing, before and during the hearing.
- At the discretion of the hearing officer, to obtain an independent medical assessment, at the program's expense, of the medical issues presented by the appeal.
- To bring witnesses.
- To establish all pertinent facts and circumstances.
- To present argument without undue interference.
- To question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.
- To receive a written hearing decision based exclusively on the evidence at the hearing.
- To access the hearing record at a convenient time and place.
- To receive corrective payments retroactive to the date of an incorrect action.
- To seek judicial review as available.

Contact Information

- Disabilities Law Program, Community Legal Aid Society, Inc.**
 - New Castle County**
 - Laura Waterland
 - lwaterland@declasi.org
 - (800) 292-7980 Ext. 231
 - (302) 575-0660 Ext. 231
 - (302) 575-0696 (TTY)
 - Kent County**
 - Dan Atkins
 - datkins@declasi.org
 - (800) 292-7980 Ext. 229
 - (302) 575-0660 Ext. 229
 - (302) 575-0696 (TTY)
 - Sussex County**
 - Neil Himelein
 - nhimelein@declasi.org
 - (800) 292-7980 Ext. 222
 - (302) 575-0660 Ext. 222
 - (302) 575-0696 (TTY)

