DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.**, §512)

FINAL

NATURE OF THE PROCEEDINGS

Delaware Medicaid and CHIP Managed Care Quality Assessment & Improvement Strategy Draft

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to announce a thirty (30)-day public comment period regarding the Delaware's Quality Management Strategy Draft. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the November 2010 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by November 30, 2010 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposed announces a thirty (30)-day public comment period on the draft of the Delaware Medicaid and CHIP Managed Care Quality Assessment and Improvement Strategy for healthcare services.

Statutory Authority

- Section 1932(c)(1) of the Social Security Act, *Quality Assurance Standards, Quality Assessment and Improvement Strategy*
- 42 CFR 438, Subpart D, *Quality Assessment and Performance Improvement*

Background

The Delaware Medical Assistance Program (DMAP) is required to develop a Medicaid Managed Care Quality Assessment and Improvement Strategy (Strategy), pursuant to 42 CFR §438.200. A separate strategy has been developed for the Managed Care Organizations (MCOs).

The DMAP Managed Care Quality Assessment and Improvement Strategy incorporates policies; procedures; contract compliance; and input from the public, stakeholder providers, recipient advocates and multiple state agencies that hold an interest in the improvement of access and of clinical and service quality received by the Medicaid recipients.

All quality activities for the DMAP population are integrated into a single Strategy, which applies throughout the Delaware Medicaid Managed Care service area. The Division of Medicaid and Medical Assistance (DMMA) oversees the Strategy to verify that the performance of quality improvement functions is timely, consistent, and effective.

The Strategy is designed with the intent that services provided to recipients meet established standards for access to care; clinical quality of care and quality of service, and that opportunities to improve these areas are identified and acted upon. The Strategy is designed to identify, document, and review access, quality of care, and service issues, and to verify that appropriate corrective actions are taken to address these issues.

The Strategy features:

- Assessment and improvement of quality of care and services through use of monitoring and national benchmarks for the Medicaid population
- Focused audits
- Studies
- Assessment of recipient and provider satisfaction
- Review of potential quality issues, recipient appeals and grievances
- Review of access to care through analysis of provider networks using contract and
- credentialing criteria
- Compliance with contractual operations and organizational structure.

Following public notice, the proposed Quality Strategy will be submitted to the Centers for Medicare and Medicaid Services (CMS) for approval. The finalized Quality Strategy will become effective with the execution of the new Memorandum of Agreement and will be reviewed by the state quarterly, as a standing agenda item, during regularly scheduled Quality Improvement Initiative (QII) Task Force meetings and teleconferences. The State, in turn, will provide quarterly updates to CMS with regard to the status of the State's Quality Strategy for DMAP and will provide CMS with

written revisions to the Quality Strategy whenever significant revisions are made to the Strategy. A copy of the annual Work Plan will be submitted to CMS each year.

The program is reviewed, evaluated and updated annually or more often as additional information becomes available.

Summary of Proposal

DMMA is announcing a thirty (30)-day public comment period on the draft State Quality Strategy. The strategy is designed to monitor and evaluate the quality and appropriateness of healthcare services to enrollees the Delaware Medicaid and CHIP programs.

The specific goals of the Quality Strategy are to:

- Enhance efficiency of care;
- Increase effectiveness of care;
- Promote equity of care;
- Enrich patient-centeredness;
- Ensure safety; and,
- Improve timeliness of care.

Cost/Budgetary Impact

These revisions impose no increase in cost on the General Fund.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGES

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of Medicaid and Medicaid Assistance (DMMA) has considered each comment and responds as follows.

First, on p. 3, Quality Strategy Overview, last paragraph, there is a reference to providing quality care ..."through increased address and appropriate and timely utilization of health care services. The word "address" is erroneous.

Agency Response: The word "address" was corrected to "access".

Second, on p. 6, DMMA describes a QII Task Force which includes "representatives from all CHIP funded programs and waivers, MCO's, Health Benefits Manager, Pharmacy Benefits Manager (PBM), the External Quality Review Organization (EQPO), State agencies receiving Medicaid and CHIP funding, and the MMDS leadership team." DMMA may wish to consider whether the Task Force could be strengthened through addition of a representative from the SCPD, CLASI, or similar organization.

Agency Response: DMMA appreciates your comments on this issue.

Third, on p. 8, the chart lists "Division of Child Mental Health Services". The reference should be updated to "Division of Prevention and Behavioral Health Services".

Agency Response: The division name has been updated to "Division of Prevention and Behavioral Health Services".

Fourth, p. 10 describes the MCOs under the Diamond State Health Plan. It omits the Division of Prevention and Behavioral Health Services which serves as an MCO under the Plan. This is a major concern with the entire document. There are simply no references to the Division. For example, performance data is only generated for Unison and DPCI. See pp. 65-67. The Plan should address quality assurance within the Division acting as an MCO.

Agency Response: The QMS has been written to be generic enough to be all inclusive of the many groups which spend Medicaid dollars. The quality management structure diagram has been updated to reflect the new name change for the Division of Prevention and Behavioral Health Services. DMMA appreciates your comments on this issue.

Fifth, on p. 11, CHIP section, second paragraph, there is a reference to "infants (under age 1) under 200% covered through a Medicaid expansion program..." We believe the reference should be to "under 200% of the

Federal Poverty Level (FPL)".

Agency Response: QMS updated to correctly reflect the reference to "under 200% of the Federal Poverty Level (FPL)".

Sixth, on p. 11, last paragraph, there is a reference to a 5 year bar on child eligibility if the child entered the United States after 8/22/96. We believe DMMA rescinded that bar earlier this year. See 13 DE Reg. 1540 (June 1, 2010).

Agency Response: Delaware has implemented the option under Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) known as CHIPRA, to provide coverage to noncitizen children regardless of their date of entry into the U.S. This has been updated in the QMS.

Seventh, p. 17 recites that MCOs are required to develop a treatment plan for all beneficiaries qualifying as persons with special health care needs, including those with a "serious or chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally". Does DMMA have a template for such plans or does each MCO have its own criteria? If DMMA does not have a template or standards, it could consider adopting them.

Agency Response: DMMA does not have a template for the treatment plan. Both MCOs contracted by DMMA are nationally certified by the National Committee for Quality Assurance (NCQA) and operate under their nationally approved and recognized standards. DMMA accepts the standards approved by this national accrediting body.

Eighth, on p. 22, it appears that information on "grievances" and "appeals" is reviewed. It is unclear if fair hearing results are included in this assessment. If not, we recommend that DMMA include such review in assessing MCOs.

Agency Response: DMMA does include fair hearing results in its assessment of MCOs.

Ninth, p. 22 refers to an MCO requirement of ensuring the availability of a no-cost second opinion from a qualified health care professional. We have not seen this aspect of MCO coverage advertised. Are there standards which define eligibility for a second opinion? If so, we respectfully request a copy.

Agency Response: Any member is eligible for a second opinion. The requirement is a Prior Authorization if the provider is out of network. This information is discussed in the Member Handbook provided to all members.

Tenth, p. 33 refers to the following MCO duty: "(s)atisfactory methods for ensuring their providers are in compliance with Title II of the Americans with Disabilities Act". Title II covers public agencies. Title III covers private entities. It would be preferable to amend the reference to read "Titles II and III of the Americans with Disabilities Act". Consistent with the attachments, the accessibility of health care provider offices and equipment (e.g. height adjustable examination tables) has historically been a barrier to effective health care, particularly for persons who must transfer from a wheelchair or use a restroom. How does DMMA assess MCO compliance with the mandate? Do MCOs survey their providers on accessibility, provision of interpreters for the Deaf, etc?

Agency Response: DMMA has amended the reference to read "Titles II and III of the Americans with Disabilities Act". MCOs provide site visits for all new PCPs to assure wheelchair accessibility. Translation services are provided to members as outlined in the Member Handbook.

Eleventh, p. 35, Notice of Adverse Action section, contains the following sentence: "The MCO's notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing." The attached 42 C.F.R. §438.404 does not contain an exemption from the written notice requirement for notices to providers. DMMA may wish to reassess the accuracy of the sentence.

Agency Response: Language is consistent with 42 CFR §438.210(c).

Twelfth, on p. 40, Confidentiality section, second bullet, some words appear to have been omitted. The second "sentence" reads as follows: "And shall be afforded access within thirty (30) calendar days to all members' medical records whether electronic or paper".

Agency Response: The sentence has been revised to " The State is not required to obtain written approval from a member before requesting the member's record from the primary care provider or any other provider and

she be afforded access within thirty 30 calendar days to all members' medical records whether electronic or paper.

Thirteenth, on p. 45, General Requirements section, last bullet, second "sentence", some words appear to have been omitted and the 59-word "sentence" is awkward and difficult to understand. The second "sentence" reads as follows: "And who if deciding an appeal of a denial that is based upon lack of medical necessity...disease."

Agency Response: DMMA agrees that this sentence is awkward, but it follows the CFR language without changing the intent of the regulation. DMMA clarifies that the intent is for the MCOs to ensure that those individuals who make decisions on grievances and appeals are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

Fourteenth, on p. 40, Duration of Continued or Reinstated Benefits section, the reference to "within 10 days from when the MCO mails an adverse MCO decision" is not the correct timeframe. The federal regulation [42 C.F.R. 438.420(c)] and 16 DE Admin Code, Part 5000, §5303 clarify that the relevant period is "the period between the date a notice is mailed and the effective date of the action". Thus, if an MCO provides 15 days notice prior to the effective date of an action, there are 15 days to request a hearing and maintain benefits. The reference could be amended to read "within the timely notice period between mailing of the notice and the effective date of the action".

Agency Response: Language in the QMS is consistent with the 42 CFR §438.420.

Fifteenth, p. 55 addresses oral interpreter services for foreign languages. It would be preferable to also include a reference in the document to interpreter services for the Deaf.

Agency Response: DMMA has reviewed the C. F. R. 438.10 and references section (d)Format, (1), (i), and (ii), and which includes that "The State expects the MCO will assure that written material uses : (i) easily understood language and format at a sixth grade level; and (ii) written materials are available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited…… and (2) The MCO will inform all enrollees and potential enrollees that information is available in alternative formats. The MCOs provide Interpretive Services which are designed to assist members who have special needs including speech, hearing, sight, etc. The Delaware Relay Services for Hearing –Impaired Members is a free service available 24 hours a day.

Sixteenth, the data on p. 67 suggest a significant disparity in mental health inpatient and outpatient services between DPCI and Unison. Moreover, pp. 68-69 contains the following recital:

The benchmark for Antidepressant medication management has not been met for either MCO. DPCI showed a decrease in compliance with effective acute phase treatment from 2008 (46.92 percent) to 2009 (45.58). Unison, on the other hand, made some progress toward the benchmark with an increase from 2008 (41.84) to 47.64 percent in 2009. Effective continuation phase treatment showed a slight decline for DPCI from 2008 (31.51 percent) to 28.05 percent in 3009 (sic "2009) while Unison stayed steady at 27.55 percent in 2008 and 27.95 percent in 2009.

We respectfully request more specifics on mental health treatment data since it appears that MCOs may be "falling short".

Agency Response: DMMA appreciates this feedback and will explore ways to include in the MCO monitoring and evaluation processes going forward.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the November 2010 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to regarding the Delaware's Quality Management Strategy Draft is adopted and shall be final effective January 10, 2011.

Rita M. Landgraf, Secretary, DHSS

14 DE Reg. 650 (01/01/11)

***Please Note: Due to the size of the final regulation, it is not being published here. A PDF version of the regulation is available at:**

http://regulations.delaware.gov/register/january2011/final/14 DE Reg xxx 01-01-11.htm