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MEMORANDUM

DATE: September 6, 2011

TO: Ms. Lisa Zimmerman
Division of Medicaid and Medical Assistance

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: Diamond State Health Plan Plus

I write on behalf of the State Council for Persons with Disabilities (SCPD) to provide preliminary comments on the proposed Diamond State Health Plan Plus (DSHP+). In July, the Division of Medicaid & Medical Assistance (DMMA) published notice of an initiative to dissolve the Elderly and Disables (E&D) waiver and incorporate its participant base and services into a Diamond State Health Plan Plus program. There were some delays in acquiring specific background information. SCPD has now reviewed the PowerPoint presentation; Concept Paper submitted to CMS in May, 2011; July, 2011 Waiver Amendment Request; DMMA MCO Contract, Exhibit W (Case Management); and Chapter II, Program Description. Council has not had time to review the Quality Management Strategy document. SCPD has the following observations.

BACKGROUND

The Waiver Amendment document is similar to the Concept Paper. DHSS notes that Delaware ranks near the bottom of the states in percentage of Medicaid funds devoted to community-based alternatives. It also notes that Delaware's population is aging and 72% of Delaware residents age 35 or older believe it is extremely important to remain in their current residence for as long as possible. DHSS proposes to expand its current DSHP Section 1115 demonstration waiver by establishing a DSHP+ program which would include dual eligibles; individuals receiving institutional LTC (excluding the DD waiver population); and individuals enrolled in the E&D and AIDS Section 1915(c) waivers. DHSS plans to address mental health services planning on a parallel track but not directly through the DSHP+ at this time. Both adults and children would be affected by the initiative, including the medically fragile children in Voorhees. Since the TBI waiver was consolidated with the E&D waiver in December, 2010, the DSHP+ would also cover

E&D waiver enrollees with TBI.

The PowerPoint provides the following statistics on expected DSHP+ enrollees: dual eligibles, 5000 (65%); nursing home residents, 3,000 (19%); and community HCBS, 1,800 (16%). Thus, the E&D and AIDS waiver populations are actually a small percentage of the overall DSHP+ program. The PowerPoint also contains the attached comparative list of benefits under the existing DSHP and proposed DSHP+ programs.

A community-based model will be promoted. For example, a LTC level of care currently requires a need for assistance with only one ADL (“activity of daily living”). This will be converted to a need for assistance with two ADLs for new institutional admissions effective April 1, 2012. Existing LTC residents will be “grandfathered”, i.e., they will continue to be eligible for institutional LTC by meeting the single ADL limitation standard. Individuals will be able to qualify for community-based services by demonstrating a need for assistance for only one ADL.

There will be a transition period for E&D and AIDS waiver participants. Their services will be maintained for at least 90 days from conversion date (April, 2012). The following services would continue to be excluded from DSHP+: pharmacy, child dental care, and non-emergency medical transportation.

DHSS will implement DSHP+ using only the two current, private MCOs.

DMMA MCO Contract: Exhibit W, Case Management (8/5/11 Draft)

This document covers case management standards for DSHP Plus members meeting the institutional level of care and who either reside in a nursing home or in the community. Since this document and the Chapter II Program Description (critiqued below) overlap in some key contexts, SCPD has sometimes included commentary related to both documents in this section.

Section I.A.1 and 2: The case manager qualification standards could be improved. Consider the following:

- a. An individual with 3 years of unspecified case management experience is not required to have a college degree or even a high school diploma.
- b. The standards treat case managers as “fungible”, i.e., someone with general experience in case management is determined qualified to perform as an expert in TBI, AIDS/HIV, etc. regardless of lack of experience or background in these subpopulations. This is particularly troubling for individuals with TBI. DSAAPD attempted to obtain specific training and certification for in-house TBI case managers in recognition of the special needs of this subpopulation. Case managers have the authority to unilaterally deny services: “Determination to deny or limit non-skilled long term care services for DHSP Plus members may be rendered by a qualified long term care case manager.” [Chapter II Program Description, §13.2.3.1] Granting such power to marginally qualified individuals is a “recipe for disaster”. Moreover, case managers are expected

to make quick decisions which would logically require a solid background in the client's disability: "Case managers must be able to quickly assess/identify a problem or situation as urgent or as a potential emergency and take appropriate action." [§II.E.4]

c. By analogy, MCOs are required to have an adequate network of providers, including specialists and "sub-specialists". [Chapter II Program Description, §§7.2.2g; 9.3c;9.3eiii; and 10b.] See also Chapter II, Program Description, §II.10, which recites as follows: "The Contractor must use specialists with pediatric expertise for children where the need for pediatric specialty care is significantly different from the need for adult specialists (e.g. a pediatric cardiologist for children with congenital health defects)." This requirement is based on the notion that the DSHP Plus population is varied and may have complex needs. It is anomalous to recognize the need for specialists for services while treating case managers as fungible. Under the current standards, someone whose case management experience is limited to the elderly is considered qualified to be a case manager for children with obviously different needs and a different service delivery system. Case managers for nursing home patients are deemed experts in community services and vice versa.

d. The role of the DSHP Plus case managers transcends that of a typical case manager given the breadth of medical and non-medical services being coordinated, including home modifications, specialized DME not included in the Medicaid State Plan, home-delivered meals, and MFP issues such as security deposits, landlord-tenant issues, telephone connection fees, and groceries. [Chapter II Program Description, §7.5].

e. DHSS should consider strengthening the case management standards. For example, there could be separate pediatric and adult case managers. There could be a "carve out" for case managers for individuals with TBI to maintain DSAAPD case managers or to contract with the Brain Injury Association. Chapter II, Program Description, §9.5.2, encourages MCOs to contract with some providers, including DSAAPD. This could be changed to a requirement in some contexts such as using DSAAPD case managers for individuals with TBI. There is already a limited "carve out" for AIDs/HIV case managers: "Under DSHP Plus, the Contractor is required to offer a contract to all previous AIDS Waiver Case Management providers for a period of at least one (1) year from the date of implementation of the DSHP Plus." [Chapter II Program Description, §8.2.1.1c] Finally, Section I.A.2. could be amended to include a Par. "g" to read as follows: "g. the needs and service delivery system for the subpopulation(s) in the case manager's caseload".

Section IA.3: The case manager-client ratios are "thin". Overall, there will be 1 case manager for every 120 nursing facility clients and 1 case manager for every 60 clients in the community. This capacity is diluted further by the authorization to assign unrelated duties to case managers for up to 15% of their time. [§I.F] Thus, the ratios are actually 0.85 case managers per 120 and 60 clients respectively. This is roughly equivalent to a "true" case manager-client ratio of 1 case manager to 138 nursing home clients and 69 community-based clients. Even these ratios can be exceeded with DMMA approval. [§I.D.2] There is obviously some "tension" between these sparse ratios and the requirement that case management be "intensive" and comprehensive:

The case manager provides intensive case management for DSHP Plus members in need of long term care service planning and coordination to identify services; brokering of services to obtain and integrate services; facilitation and advocacy to resolve issues that impede access to needed services; monitoring and reassessment of services based on changes in a member's condition; and gate keeping to assess and determine the need for and cost effectiveness of services to members.

[emphasis supplied] Chapter II Program Description, §7.5.1.

For purposes of comparison, the 12/07 DHSS ABI waiver envisioned 50 waiver clients receiving case management services costing \$200/month for an annual cost of \$120,000 and an individual annual cost of \$2,400 apiece. This was based on national norms ("rate data canvassed from other states"). See attached waiver excerpts. If DHSS paid \$2,400 per client for a case manager with 69 community-based clients, as contemplated by DSHP Plus, the case manager would cost \$165,600! Obviously, the case manager-client ratios will be much "thinner" than the ratio under the former waiver to the detriment of individuals with TBI. Finally, the ratios could be "thinner" if the case manager qualifications were robust. However, as discussed above, individuals can serve as case managers without even a high school diploma.

Section I.B: This section includes the following recital:

Guidelines to be used in developing and implementing an assessment tool or process for personal care/attendant care (including participant-directed services) will be developed as part of the Implementation Team Meeting process.

By law [Title 16 Del.C. §9406], the SCPD is the advisory council for the DHSS attendant services program. This section could be improved by incorporating a reference to development of tools and processes related to attendant services in consultation with the SCPD. Parenthetically, since DHSS is required to prepare an annual report on attendant services [Title 16 Del.C. §9404(7)], it may wish to ensure that adequate data is generated to facilitate completion of the report.

Section I.C:

- a. This section requires "uniform training" to all case managers. As discussed under Section I.A. 1-2, this is consistent with the general approach that all case managers are fungible. The weakness with this approach is that it does not contemplate any specialization.
- b. Under Par. I, it would be preferable to also list "free or low cost legal assistance". CLASI maintains both an Elder Law Program and Disabilities Law Program.

Section I.E: This section includes an expectation of prompt return calls but no analogous expectation for responding to emails.

Section I.H: There are no qualifications provided for case manager supervisors. It would be

preferable to include some qualifications. Moreover, there is an ostensible “disconnect” between this section entitled “Supervision” and Chapter II Program Description, §6.10. The latter section refers to a “Case Management Administrator” which is not mentioned in Exhibit W. Conversely, §6.10 does not mention case manager supervisors.

Section II.B: It would be preferable to include a reference to educating members on the availability of “free or low cost legal assistance”. CLASI maintains both an Elder Law Program and Disabilities Law Program.

Section II.C: The DSHP+ program is ostensibly based on an aggregate cost neutrality system rather than an individual cost basis. However, this section includes some implicit disincentives to provide services to an individual to maintain community residency. A case manager has additional “hoops to jump through” for clients approaching institutional care costs. For example, a supervisor’s approval is necessary to qualify for services which exceed 80% of institutional costs of care. If an individual in the community receives services valued at 100% of the costs of institutional care, the individual is reported to DHSS with a statement of “if and when costs are expected to drop below the cost of institutionalization.” The “message” conveyed by adoption of these standards is that providing services to individuals with more severe disabilities in the community is discouraged. In contrast, CMS has issued long-standing guidance that the Medicaid program should be designed to foster community-based services and policies should be adopted to implement this preference. See attached July 29, 1998 and January 14, 2000 HCFA Letters to State Medicaid Directors.

Section II.D, preface and Pars. 9 and 15: SCPD endorses the “member choice”, “home preference”, “back-up plan” and LRE references.

Section II.D.4: The implication of this section is that the current attendant services agencies (Easter Seals and JEVS) are being supplanted. These agencies have excellent “track records”. There is already a limited “carve out” for AIDs/HIV case managers: “Under DSHP Plus, the Contractor is required to offer a contract to all previous AIDS Waiver Case Management providers for a period of at least one (1) year from the date of implementation of the DSHP Plus.” [Chapter II Program Description, §8.2.1.1c]. At a minimum, a similar provision could be established for attendant services.

Section II.D.7: E&D Waiver participants have typically not contributed financially to their services. SCPD requests clarification of the scope and parameters of patient pay amounts under DSHP Plus. This comment also applies to Chapter II, Program Description, §II.3.1.1.

Section II.D.23: In its commentary on the E&D waiver consolidation last year, SCPD recommended consideration of adding supported employment as an available service. Otherwise, including only “adult day services or day habilitation” in the services menu is inconsistent with the ADA. Such services are typically segregated, austere, and disfavored by

many individuals with disabilities. It would be preferable to offer a supported employment option for DSHP Plus participants.

Section II.E.2: This section and Section II.I.1 contemplate visits to facilities to review services, the member's condition, and progress at 6 month intervals. This does not comport with the expectation of "intensive" case management. [Chapter II Program Description, §7.5.1]

Section II.E.8: CMS previously expressed misgivings about the lack of guardianship and lack of capacity in the Public Guardian's Office. See attached July 30, 2010 Letter from Rosanne Mahaney to CMS, pp. 4-5. This section, which is limited to a referral system, will predictably not result in the availability of decision-makers on behalf of individuals lacking competency. DHSS should consider a more affirmative approach (e.g. contract with Public Guardian to accept DSHP participants who may not qualify as priority by Public Guardian).

Section II.E.13:

a. This section recites that "(t)he case manager is responsible for coordinating physician's orders for those medical services requiring a physician's order." DHSS may wish to consider whether this would be considered the practice of nursing. As discussed under Section I.A, minimum case manager qualifications are somewhat weak. Moreover, as discussed under Section I.A.3, the case manager - participant ratios are so high that it may be dangerous to entrust case managers with the responsibility to coordinate physician orders. Finally, for institutional DSHP Plus members, it may be more appropriate for the facility's nursing staff to coordinate physician's orders.

b. This section would ostensibly authorize a case manager who disagrees with a PCP to simply substitute judgment. Referral to the MCO's Medical Director is discretionary. This is unacceptable. The case manager should either defer to the PCP or refer the matter to another physician for resolution. See Chapter II, Program Description, §II.9.1.b.iv.

Section II.E.15: It would be preferable to include a provision notifying the member or representative of the availability of sources of free or low cost legal services to assist with hearings and appeals. Otherwise, the member or representative will be dissuaded from exercising appeal rights.

Section II.E.18: This section would benefit from inclusion of a reference to State law, i.e., Title 16 Del.C. §1121(18), which includes supplemental limitations on discharge.

Section II.H: DHSS should consider clarifying the role of the ICT in this section. See Title 14 Del.C. §3124. In practice, Medicaid funds are used to support out-of-state placements such as Devereux. Within the State, AdvoServ is also accepting Medicaid funds and accepts ICT

referrals. Other sections that could be affected by the ICT are Chapter II, Program Description, §§ II.2.3; II.3.3.2.b. In a similar context, it is unclear how the DSHP Plus interacts with the school district Medicaid cost recovery system. DHSS could consider inserting some clarifying language in Chapter II, Program Description, §II.7.2.2; §II.7.6.3; and II.9.5.2.

Section II.K.1.e: DHSS may wish to insert “on a non-temporary basis”. Temporary absence from the State does not disqualify an individual from remaining a DSHP Plus participant. The same comment applies to Chapter II, Program Description, §II.5.1.f.

Section II.L:

a. This section omits reporting of child abuse to DFS and the DSCY&F Office of Child Care licensing (which licenses 1500+ facilities). The DSCY&F Website contains information on reporting child abuse. Abuse/neglect of pediatric nursing home residents would be reported to the DLTCRP. See 16 DE Admin Code 3210 and 16 DE Admin Code 3201, §9.8.

b. This section is inconsistent with Chapter II, Program Description, §14.10. The latter section erroneously contemplates reporting all incidents involving adults to APS to the exclusion of the DLTCRP and Ombudsman. The latter section does refer to “Child Protective Services” for children. However, it omits any reference to reporting abuse/neglect of pediatric nursing home patients to the DLTCRP.

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.

c. Freedom of choice is likewise reduced through other features of the plan:

- 1) Participants transferred from 1 MCO to the second MCO are required to stay with the second MCO forever. [§5.2.2, last paragraph]
- 2) MCOs may deny the election of participants with chronic illnesses and disabling conditions to have a specialist serve as their PCP. [§II.6.3.d]
- 3) When an existing DSHP member is determined eligible for DSHP Plus, the member must pursue a good cause exemption or categorically remain with that MCO. [§II.3.2, third paragraph]

Section II.3.3.1.1: It would be preferable to include a reference to incorporation of the following information in enrollment materials: 1) supplemental services offered by each MCO (§§II.7.3.1.a; 7.3.3; and 7.5, final bullet); and 2) list of providers in MCO’s network and their locations. See §II.3.3.5.g and II.9.3e.iii.

Sections II.3.3.4 and II.8.1: SCPD endorses the availability of retroactive coverage. However, in the context of community-based members, it is unclear if members can receive 2 months of retroactive coverage. Chapter II, Program Description, §II.8.1a. recites as follows: “The State will retroactively enroll DSHP members no more than two (2) months if deemed eligible.” Does this mean that a member can obtain retroactive payment of eligible medical bills?

Section II.4.1: It would be preferable to include the following sentence after “Transfers...DMMA.”: “‘Good cause’ will not be restrictively construed.”

Section II.5.2.1: This section is too limited in identifying potential bases for “good cause”. For example, a member may have relocated to an area of the State in which the current MCO has

minimal provider options; a member may have relied on incorrect information (e.g. provider list; availability of supplemental benefit such as chiropractic treatment) proffered by the existing MCO; the member's primary language is uncommon and another MCO has a case manager or in-network PCP who speaks that language. The bottom line is that there are numerous ways in which "good cause" can arise beyond the 4 listed in this section. At a minimum, DHSS should consider a "catch-all" provision, e.g., "e. Other circumstances reasonably justifying transfer."

Section II. 5.2.2d:

a. This section authorizes the involuntary transfer of a participant from an MCO based on the following:

A member for whom the Contractor has determined that it cannot safely and effectively meet the member's needs at a cost less than the member's cost neutrality cap, and the member declines to transition to a nursing facility.

This is somewhat disturbing. It could have an in terrorem effect on the member to accept nursing home placement. Moreover, since the waiver is based on an aggregate cost benchmark, there should be no individual "member cost neutrality cap". Finally, it is inconsistent with §5.2.2, Par. c ("high cost medical or behavioral health bills" do not justify disenrollment from MCO).

b. This section also authorizes involuntary transfer of a participant from an MCO based on the following:

A member refuses to receive critical home and community-based services as identified through the Contractor's needs assessment and documented in the member's plan of care. This is ostensibly "heavy handed". If a member declines services for religious reasons, that should not justify involuntary transfer. Alternatively, a member could reasonably decline services due to side effects or other health risks (e.g. chemotherapy).

Section II.5.2.2.g: This section allows disenrollment from an MCO if disability-based disruptive behavior seriously impairs the MCO's ability to furnish services to the member or other members. This is problematic since it authorizes disenrollment regardless of fault. For example, an individual with Alzheimer's or a TBI survivor with brain damage may be disruptive based on medical condition. Justifying disenrollment based on difficulty in providing services is overbroad.

Section II.6.6:

a. SCPD recommends that DHSS search the document to eliminate outdated language such as "handicapped" and "handicap" [§9.6d].

b. The "Language" section addresses Title VI standards but does not address ADA-based ASL interpreter services. For example, Par. "a" refers to "spoken" languages. ASL is not a "spoken"

language.

Section II.6.11.2: It would be preferable to include a reference to sources of free or low cost legal assistance, including CLASI's ELP and DLP.

Section II.7.1.1: SCPD endorses the EPSDT reference. However, in §II.7.1.1.3, the reference to "Medicaid- covered services" could easily be misconstrued to include only those services covered in the Delaware Medicaid system. Under EPSDT, providers may be required to cover medically necessary services authorized in the Federal Medicaid system, including optional services, regardless of whether Delaware has incorporated the optional service in its Plan. See attached HHS EPSDT Overview at p. 3.

Section II.7.1.1.5: There is an overlooked DHSS note - "Is this still accurate?"

Section II. 7.2.1.2: It may be implicit in this section that no reduction of services should occur without a face-to-face meeting. However, it would be preferable to make this requirement explicit. The same comment applies to Chapter II, Program Description, §8.2.1. DHSS should also clarify that the requirement of a face-to-face review prior to proposing a reduction in services will apply not only to new members but across-the-board. Compare attached April 8, 1996 letter from Phil Soule, Medicaid Director, to EDS and January 27, 2000 letter from Phil Soule, Medicaid Director, to Brian Hartman.

Section II. 7.2.6: This section should include an explicit reference to Title 16 Del.C. §214.

Section II.7.4: DHSS should consider whether to include a reference to EPSDT services in this section since they are apart from the Basic Benefit Package. See §II.7.1.1.3. DHSS may also wish to substitute "actuarially" for "actually".

Section II.7.5:

- a. The presumptive 14-day respite cap, 20 -session cognitive services cap, home modification caps, and transition services cap can be exceeded. However, there are no standards to guide exceptions.
- b. The last paragraph authorizes MCOs to limit services by invoking "utilization control" apart from medical necessity. This is an open invitation to limit the scope or extent of services based on arbitrary considerations. A similar objectionable recital appears in §II.9.1a.
- c. There is some "tension" between the definition of attendant services in this section and the State statutory attendant services criteria which include bill payment and money management. See Title 16 Del.C. §9403(1). DHSS should consider how to ensure the full availability of State statutory attendant services to individuals enrolled in the DSHP Plus.

Section II.7.5.3: The interaction between the planned DSAAPD assessment of public nursing

home residents and the MCO assessment contemplated by this section is unclear. There could be overlapping and redundant screenings.

Section II.7.6.3: This section contains the following problematic recital: "School-based therapy services (e.g. occupational, physical and speech therapy) are excluded from the MMC and are expected to be provided by the School." This statement is a flagrant violation of federal law. See attached In re A.G., DCIS NO. 5000703852 (DSS June 22, 2000) which rejected an MCO's attempt to deny in-home speech therapy since the school district was providing speech therapy. Moreover, the standards for determining the extent of speech therapy in school are based on educational progress which differ from medical justification.

Sections II.8.2.1 and 8.2.1.1: DHSS is categorically continuing existing payment rates for nursing homes for 3 years. In contrast, no such "hold harmless" provision applies to community providers. The predictable result is that nursing homes will receive relatively higher payment for services than community providers who will be forced to negotiate rates with MCOs. Moreover, the negotiating leverage of current community providers is explicitly undermined by only allowing payment of 80% of the contractual provider rate if the providers decline the MCO's proposed contract rate. See §8.2.3. It may be preferable to consider "carve outs" for long-term community contractors (e.g. Easter Seals) similar to that being established for nursing homes. For example, DHSS has essentially established a "carve out" for Westside, La Red, and Henrietta Johnson which are entitled to at least the Medicaid fee-for-service rate. [§II.8.2.4] A less explicit exhortation to contract with Nemours is contained at §II.9.4.4.

Section II.9.1: DHSS has a regulation defining "medical necessity" [2 DE Reg. 748 (November 1, 1998)] which has traditionally applied to the DSHP. In contrast, §9.1 "muddies the waters" by allowing MCOs to adopt their own definitions of medical necessity. Whether an MCO definition of "medical necessity" is more or less restrictive than the DHSS regulation may result in considerable disagreement and litigation. DHSS should simply require MCOs to abide by the existing regulatory definition of medical necessity.

Section II.9.4: DHSS should ensure that the treatment plan criteria comport with Title 16 Del.C. §9404(6) for anyone receiving attendant services. This includes use of a standard DHSS form.

Sections II.12.1-12.4:

a. DHSS should reiterate its policy of tolling the time period for members to request a fair hearing while pursuing an internal MCO grievance. Under the proposed system, if a member pursues an MCO grievance and appeal, the time frame for resolution is at least 90 days which may be extended to 104 days [§12.4]. As a practical matter, the 90 days to request a fair hearing will often expire by the time the MCO issues its grievance decision. The approach adopted by DHSS under the DSHP was to characterize the MCO grievance decision as a "notice of action" permitting the member to request a fair hearing within 90 days of the new decision. See attached January 27, 2000 letter from Phil Soule, Medicaid Director, to Brian Hartman. Parenthetically, this provides the MCO with an incentive to process its internal grievances without "dragging out the process" so the member "conveniently" loses his/her time to request a fair hearing. An MCO

attack on this interpretation was soundly rejected by a DSS hearing officer. See attached In re A.B., ID 001030240*01 (DSS September 12, 2001). In that case, the hearing officer specifically endorsed the above "Soule" guidance, commenting as follows:

This language clearly indicates that it is the policy of the DMAP to allow requests for State fair hearings after conclusion of the MCO internal review process has been completed subject to the 90-day rule. The language is also consistent with both federal and state law, as indicated above, in that the plain meaning of the federal and state law both allow for requesting a hearing within 90 days of an action....

To maintain that First State's internal process has absolutely nothing to do with the fair hearing process is ludicrous, at best. As written, but not as interpreted by First State, the current fair hearing procedures continue to provide procedural and substantive protection to those parties aggrieved by an adverse decision of the managed care organization. To interpret the regulations in any other manner would deprive members of these protections and provide absolutely no oversight of First State's ultimate determination.

With respect to the mandates of 42 U.S.C. §431.221(d) and DSSM §5305(2), this hearing officer finds that the 90-day rule attaches to the Second denial notice dated March 9, 2001 and not the December 20, 2000 "Service Denial". Therefore, the Appellant's request for a State Fair Hearing dated March 20, 2001 is within the statutorily mandated 90-day period. As such, First State's Motion to Dismiss the request for a State Fair Hearing is denied.

At p. 5. On a practical level, it is also common for an MCO grievance decision to modify its original decision. However, limiting fair hearing requests to 90 days from the original decision renders the "modified" decision exempt from review in a fair hearing even though it is the final or superseding decision. The "Soule" guidance disallows such an absurd result.

b. Section II.12.2 violates standards imposed by Ortiz v. Eichler, 616 F. Supp. 1046, 1061 (D.Del. 1985), aff'd, 794 F.2d 889 (3dCir. 1986), E. v. Department of Health & Social Services, C.A. No. 02A-09-002 HDR (Del. Super. February 25, 2004) and partially reiterated in 16 DE Admin Code 5000, §5300.

First, it omits "the specific regulation supporting such action" contrary to the above precedents.

Second, it substitutes an anemic "(t)he reasons for the action" for the judicially-imposed standard of "detailed individualized explanation of the reason(s) for the action taken which includes, in terms comprehensible to the claimant, an explanation of why the action is being taken." See attached In re A.B., DCIS - (1999), enforcing Ortiz injunction; and 16 DE Admin Code 5000, 5300D.

Parenthetically, it would be preferable to include a requirement that the notice include

information about the availability of free or low cost legal services, including the DLP and ELP.

Section II.12.4: The 90 day time period to issue a grievance decision, which can be extended to 104 days, is too long.

Section II.13.2.3.1 and II.13.2.4.g: These sections may literally allow non-medical staff to issue decisions denying medical benefits. They allow the case manager (who may lack a high school diploma) to “deny or limit non-skilled long term care services”. This suggests that the case manager could deny DME not within a facility’s per diem rate, cognitive services, attendant services, chiropractor services, etc. This authorization should be deleted.

Section II.13.5.2: A maximum penalty of \$1,000 per month for failure to cure systemic deficiencies or submit a corrective action plan is too low to be meaningful.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations or recommendations on the proposed plan.

cc: Ms. Rita Landgraf
Ms. Rosanne Mahaney
Mr. Bill Love
Ms. Beverly Weigand
Mr. Brian Hartman, Esq.
Governor’s Advisory Council for Exceptional Citizens
Developmental Disabilities Council

Benefit Package Comparison

DSHP Benefits

- Acute Care Services
- In Patient Hospitalization
- Out Patient Visits
- 30 days Institutional Care
- Behavioral Health
- Limited Case Management
- Limited Durable Medical Equipment

DSHP-Plus Benefits

- Case Management Services
- Nursing Facility Care
- Assisted Living Care
- Personal Care Services
- Respite Care
- Day Habilitation
- Cognitive Services
- Consumer Directed Attendant Care
- Nutritional Supplements
- Specialized Durable Medical Equipment
- Transition Services
- Behavioral Health
- Adult Day Services
- Personal Emergency Response

Appendix J: Cost Neutrality Demonstration
 HCBS Waiver Application Version 3.3 – Post October 2005

Background

There are three main variables used to estimate the average per client Factor D costs for the waiver services: 1) the estimated number of clients that will utilize each service; 2) the expected average number of units of each service those clients will use; and 3) the estimated cost of each unit of service.

Utilization and cost patterns in the current E&D and AL waivers served as a basis for many of the cost estimates in the ABI waiver. Patterns for the ABI waiver are expected to be comparable to those in these other two waivers, including variations in cost between participants who receive assisted living services and those who do not. The estimated number of participants who will utilize the various services in the ABI waiver is based, in part, on the estimated number of participants in the ABI waiver who will receive assisted living services. (It is estimated that approximately 40% of ABI waiver participants will receive assisted living services, and approximately 60% will not.) This estimate is significant in deriving the cost of services such as personal care, which is a component of the assisted living service in Delaware. Therefore, the personal care services described in Appendix C would not be needed by individuals who are receiving comparable support through their assisted living service providers.

The aforementioned estimated average annual stay of 350 days, or 50 weeks or 12 months was used in the calculation of Factor D.

Service cost estimates

Case Management – All 50 waiver clients will receive case management services each month at an estimated cost of \$200 per month. The \$200 per month figure was determined using rate data canvassed from other states that operate ABI-type waiver programs and that use contracted case managers where a monthly fee is paid. The Delaware rate is within the range of low to high rates based on our understanding of the relationship of the case management functions we will contract for vis a vis what the other states contract for.
 12 months x 50 clients x \$200 per month = \$120,000

Assisted Living – From the present dispersion of potential ABI clients among the present E&D and AL waivers, we estimate that 20 of the 50 ABI waiver (40%) clients will reside in assisted living facilities. We estimate an average length of stay of 350 days per year in the AL facility. Each of the ABI clients in an assisted living facility will be assigned into one of two tiers (Level I – Basic or Level II – Enhanced). Each tier will be paid at a different per diem rate. Of the ABI clients to be residing in an assisted living facility, it is estimated 25% will be in the Level I – Basic tier with the remaining 75% being assigned to the Level II – Enhanced tier. The Level I rate was estimated by taking an average of the 2007 per diem rates in the six Assisted Living waiver Levels of Reimbursement (10, 12, 20, 22, 30, 32) and weighting them by the dispersion of potential ABI clients presently in the Assisted Living waiver and residing at Peachtree Acres or clients with similar care needs residing at Stockley Assisted Living. (Note: Stockley will not be a provider under this waiver. Cost data for this client population is used for calculation purposes only.) The Level II rate was estimated as 15% above the highest “regular” 2007 assisted living rate paid under the AL waiver. This enhanced level of payment is necessary to compensate for the additional staff time in the AL facilities that is necessary to manage the more complex needs of certain participants.

Adult Day Services – In the proposed ABI waiver, there are two (2) sub-types of adult day services:

Adult Day Services: Level 1 – Basic Adult Day Services

State:	Delaware
Effective Date	12-1-07

Appendix J: Cost Neutrality Demonstration
 HCBS Waiver Application Version 3.3 – Post October 2005

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

<input checked="" type="checkbox"/>	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
<input type="checkbox"/>	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management	Month	50	12	\$200.00	\$120,000
Assisted Living (per diem)	* See Two Sub-Categories Below				
Level I (Basic)	Day	5	350	\$97.17	\$65,048
Level II (Enhanced)	Day	15	350	\$64.76	\$339,990
Adult Day Services	* See Two Sub-Categories Below				
Level I (Basic)	Day	5	200	\$79.11	\$79,110
Level II (Enhanced)	Day	18	200	\$100.00	\$360,000
Day Habilitation	Day	17	200	\$79.11	\$268,974
Cognitive Services	* See Two Sub-Categories Below				
Multi-Disciplinary Assessment	Each	50	1	\$230.00	\$11,500
Therapies	1 Hr	50	20	\$120.00	\$120,000
Personal Care	1/4 Hr	26	2,000	\$7.68	\$399,360
Respite Care	1/4 Hr	4	300	\$6.67	\$8,004
Personal/Emergency Response System	Month	23	12	\$31.23	\$8,619
GRAND TOTAL:					\$1,780,605
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					50
FACTOR D (Divide grand total by number of participants)					\$35,612
AVERAGE LENGTH OF STAY ON THE WAIVER					350 Days

State:	Delaware
Effective Date	12-1-07

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ALERT

HCFA Letter Regarding Individuals with Disabilities

On the anniversary of the ADA, Sally Richardson, Director of Medicaid and State Operations for HCFA has issued a letter to State Medicaid Directors informing them that states, including the state Medicaid agency, have an obligation to provide services to people with disabilities in the most integrated setting appropriate to their needs. The letter summarizes three decisions under the Americans with Disabilities Act: *L.C. & E.W. v. Olmstead*, *Helen L. V. Didario* and *Easley v. Snider*, and directs states to undertake and complete the self-evaluation required by the law "to ensure that the state's policies, practices and procedures promote, rather than hinder integration. The letter closes by urging states to "strive to meet the objectives [of the law] by continuing to develop home and community-based service options for persons with disabilities to live in integrated settings." The letter in its entirety is reproduced below.

DEPARTMENT OF HEALTH & HUMAN SERVICES Health Care Financing Administration



Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

July 29, 1998

Dear State Medicaid Director:

In the Americans with Disabilities Act (ADA), Congress provided that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals." 42 U.S.C. § 12101(a)(8). Title II of the ADA further provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs or activities of a public entity, or be the subject of discrimination by any such entity." 42 U.S.C. § 12132. Department of Justice regulations implementing this provision require that "a public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d).

We have summarized below three Medicaid cases related to the ADA to make you aware of recent trends involving Medicaid and the ADA.

In *L.C. & E.W. v. Olmstead*, patients in a State psychiatric hospital in Georgia challenged their placement in an institutional setting rather than in a community-based treatment program. The United States Court of Appeals for the Eleventh Circuit held that placement in an institutional setting appeared to violate the ADA because it constituted a segregated setting, and remanded the case for a determination of whether community placements could be made without fundamentally

altering the State's programs. The court emphasized that a community placement could be required as a "reasonable accommodation" to the needs of disabled individuals, and that denial of community placements could not be justified simply by the State's fiscal concerns. However, the court recognized that the ADA does not necessarily require a State to serve everyone in the community but that decisions regarding services and where they are to be provided must be made based on whether community-based placement is appropriate for a particular individual in addition to whether such placement would fundamentally alter the program.

In *Helen L. v. DiDario*, a Medicaid nursing home resident who was paralyzed from the waist down sought services from a State-funded attendant care program which would allow her to receive services in her own home where she could reside with her children. The United States Court of Appeals for the Third Circuit held that the State's failure to provide services in the "most integrated setting appropriate" to this individual who was paralyzed from the waist down violated the ADA, and found that provision of attendant care would not fundamentally alter any State program because it was already within the scope of an existing State program. The Supreme Court declined to hear an appeal in this matter; thus, the Court of Appeals decision is final. Page 2 - State Medicaid Director

In *Easley v. Snider*, a lawsuit, filed by representatives of persons with disabilities deemed to be incapable of controlling their own legal and financial affairs, challenged a requirement that beneficiaries of their State's attendant care program must be mentally alert. The Third Circuit found that, because the essential nature of the program was to foster independence for individuals limited only by physical disabilities, inclusion of individuals incapable of controlling their own legal and financial affairs in the program would constitute a fundamental alteration of the program and was not required by the ADA. This is a final decision.

While these decisions are only binding in the affected circuits, the Attorney General has indicated that under the ADA States have an obligation to provide services to people with disabilities in the most integrated setting appropriate to their needs. Reasonable steps should be taken if the treating professional determines that an individual living in a facility could live in the community with the right mix of support services to enable them to do so. The Department of Justice recently reiterated that ADA's "most integrated setting" standard applies to States, including State Medicaid programs.

States were required to do a self-evaluation to ensure that their policies, practices and procedures promote, rather than hinder integration. This self-evaluation should have included consideration of the ADA's integration requirement. To the extent that any State Medicaid program has not fully completed its self-evaluation process, it should do so now, in conjunction with the disability community and its representatives to ensure that policies, practices and procedures meet the requirements of the ADA. We recognize that ADA issues are being clarified through administrative and judicial interpretations on a continual basis. We will provide you with additional guidance concerning ADA compliance as it becomes available.

I urge you also, in recognition of the anniversary of the ADA, to strive to meet its objectives by continuing to develop home and community-based service options for persons with disabilities to live in integrated settings.

If you have any questions concerning this letter or require technical assistance, please contact Mary Jean

Duckett at (410) 786-3294.

Sincerely,

/s/

Sally K. Richardson
Director

cc: All HCFA Regional Administrators

All HCFA Associate Regional Administrators for Medicaid and State Operations Page 3 - State
Medicaid Director

Lee Partridge
American Public Human Services Association

Joy Wilson
National Conference of State Legislatures

Jennifer Baxendell
National Governors' Association

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ALERT

HCFA Dear State Medicaid Director Letter Provides Guidance on *Olmstead* Decision Regarding Individuals with Disabilities



**DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration**

**Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850**

January 14, 2000

Dear State Medicaid Director:

The recent Supreme Court decision in *Olmstead v. L.C.*, 119 S.Ct. 2176 (1999), provides an important legal framework for our mutual efforts to enable individuals with disabilities to live in the most integrated setting appropriate to their needs. The Court's decision clearly challenges us to develop more opportunities for individuals with disabilities through more accessible systems of cost-effective community-based services.

This decision confirms what this Administration already believes: that no one should have to live in an institution or a nursing home if they can live in the community with the right support. Our goal is to integrate people with disabilities into the social mainstream, promote equality of opportunity and maximize individual choice.

The Department of Health and Human Services (DHHS) is committed to working with all affected parties to craft comprehensive, fiscally responsible solutions that comply with the Americans with Disabilities Act of 1990 (ADA). Although the ADA applies to all State programs, Medicaid programs play a critical role in making community services available. As a consequence, State Medicaid Directors play an important role in helping their States comply with the ADA. This letter conveys our initial approach to *Olmstead* and outlines a framework for us to respond to the challenge.

The Olmstead Decision

The *Olmstead* case was brought by two Georgia women whose disabilities include mental retardation and mental illness. At the time the suit was filed, both plaintiffs lived in State-run institutions, despite the fact that their treatment professionals had determined that they could be appropriately served in a community setting. The plaintiffs asserted that continued institutionalization was a violation of their right under the ADA to live in the most integrated

setting appropriate. The *Olmstead* decision interpreted Title II of the ADA and its implementing regulation, which obliges States to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." (28 CER 35.130(d)). In doing so, the Supreme Court answered the fundamental question of whether it is discrimination to deny people with disabilities services in the most integrated setting appropriate. The Court stated directly that "Unjustified isolation. . . is properly regarded as discrimination based on disability." It observed that (a) "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated

Page 2 - State Medicaid Director -----

are incapable or unworthy of participating in community life," and (b) "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

Under the Court's decision, States are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when: (a) the State's treatment professionals reasonably determine that such placement is appropriate; (b) the affected persons do not oppose such treatment; and (C) the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others who are receiving State-supported disability services. The Court cautioned however, that nothing in the ADA condones termination of institutional settings for persons unable to handle or benefit from community settings. Moreover, the State's responsibility, once it provides community based treatment to qualified persons with disabilities, is not unlimited.

Under the ADA, States are obliged to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity." (28 CFR 35.130(b)(7)). The Supreme Court indicated that the test as to whether a modification entails "fundamental alteration" of a program takes into account three factors; the cost of providing services to the individual in the most integrated setting appropriate; the resources available to the State; and how the provision of services affects the ability of the State to meet the needs of others with disabilities. Significantly, the Court suggests that a State could establish compliance with title II of the ADA if it demonstrates that it has:

- a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, and
- a waiting list that moves at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated.

Olmstead and the Medicaid Program

Olmstead challenges States to prevent and correct inappropriate institutionalization and to review intake and admissions processes to assure that persons with disabilities are served in the most integrated setting appropriate. Medicaid can be an important resource to assist States in

meeting these goals, We want to work closely with States to make effective use of Medicaid support in your planning and implementation *Olmstead*. As an example of the interface between *Olmstead's* explanation of the State's ADA obligation and your Medicaid program we would point to the State's responsibility, under Medicaid, to periodically review the services of all residents in Medicaid-funded institutional settings. Those reviews may provide a useful

Page 3 - State Medicaid Director -----

component of the State's planning for a comprehensive response to *Olmstead*. States must also be responsive to institutionalized individuals who request that their situation be reviewed to determine if a community setting is appropriate. In such a case the State has a duty to redress the situation, subject to the limits outlined by the Court and the ADA. As another example, States may choose to utilize their Medicaid funds to provide appropriate services in a range of settings from institutions to fully integrated community support.

Comprehensive, Effectively Working Plans

As we have noted, the Supreme Court in *Olmstead* indicated that a State may be able to meet its obligation under the ADA by demonstrating that it has a comprehensive, effectively working plan for placing qualified persons with disabilities in the most integrated setting appropriate, and a waiting list that moves at a reasonable pace not controlled by a State's objective of keeping its institutions fully populated. The Department believes that comprehensive, effectively working plans are best achieved with the active involvement of individuals with disabilities and their representatives in design, development and implementation.

The Court's *Olmstead* decision regarding the integration requirement applies to all individuals with disabilities protected from discrimination by title II of the ADA. Although *Olmstead* involved two individuals with mental disabilities, the scope of the ADA is not limited only to such individuals, nor is the scope of *Olmstead* limited to Medicaid beneficiaries or to services financed by the Medicaid program. In addition, the requirement to provide services in the most integrated setting appropriate applies not only to persons already in institutional settings but to those being assessed for possible institutionalization.

The enclosure to this letter offers some recommendations about key principles and practices for States to consider as they develop plans. We recognize that there is no single plan that is best suited for all States, and accordingly that there are many ways to meet the requirements of the ADA. We certainly hope States and people with disabilities will expand and improve on these ideas. Although these plans encompass more than just the Medicaid program, we realize the important role played by State Medicaid Directors in this area. As just one example, Federal financial participation will be available at the administrative rate to design and administer methods to meet these requirements, subject to the normal condition that the changes must be necessary for the proper and efficient administration of the State's Medicaid program. Because of your significant role, we have taken this opportunity to raise these issues with you.

The principles and practices contained in the accompanying technical assistance enclosure also serve as an important foundation for the DHHS Office for Civil Rights' (OCR) activities in this area. As you know, OCR has responsibility for investigating discrimination complaints involving the most integrated setting issue. OCR also has authority to conduct compliance

Page 4 - State Medicaid Director -----

reviews of State programs and has already contacted a number of States to discuss complaints. OCR strongly desires to resolve these complaints through collaboration and cooperation with all interested parties.

Next Steps for the Department of Health and Human Services

Consultation- We have begun consultation with States (including State Medicaid Directors and members of the long term care technical advisory group, who share responsibility for Medicaid) and with people with disabilities. We look forward to building on this start. Many States have made great strides toward enabling individuals with disabilities to live in their communities. There is much that we can learn from these States. We are interested in your ideas regarding the methods by which we might accomplish such continuing consultation effectively and economically.

Addressing Issues and Questions Regarding Olmstead and Medicaid: As we move forward, we recognize that States may have specific issues and questions about the interaction between the ADA and the Medicaid program. In response to the issues and questions we receive, we will review relevant federal Medicaid regulations, policies and previous guidance to assure that they (a) are compatible with the requirements of the ADA and the *Olmstead* decision, and (b) facilitate States' efforts to comply with the law.

Technical Assistance: In response to any issues raised by the States, the DHHS working group will develop a plan to provide technical assistance and information sharing among States and stakeholders. Responses to questions and technical assistance materials will be published on a special website. We are also funding projects in a number of States to assist with nursing home transition. Finally, we seek your ideas on the additional focus of technical assistance you would find most helpful for home and community-based services and conferences for State policy makers. We will use your suggestions to facilitate the implementation of the integration requirement. We invite all States and stakeholders to submit questions and recommendations to our departmental workgroup co-chaired by the Director of HCFA's Center for Medicaid and State Operations and the Director of the DHHS Office for Civil Rights. Please send such written correspondence to:

DHHS Working Group for ADA/*Olmstead*
c/o Center for Medicaid and State Operations
HCFA, Room S2- 14-26. DEHPG
7500 Security Blvd.
Baltimore, MD 21244-1850

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Conclusion

The Administration and DHHS have a commitment to expanding home and community-based services and offering consumers choices in how services are organized and delivered. Over the past few years, DHHS has focused on expanding and promoting home and community-based

services, offering support and technical assistance to States, and using the flexibility of the Medicaid program. The *Olmstead* decision affirms that we are moving in the right direction and we intend to continue these efforts.

We recognize that this interim guidance leaves many questions unanswered; with your input, we expect to develop further guidance and technical assistance. We recommend that States do the following:

- Develop a comprehensive, effectively working plan (or plans) to strengthen community service systems and serve people with disabilities in the most integrated setting appropriate to their needs;
- Actively involve people with disabilities, and where appropriate, their family members or representatives, in design, development and implementation;
- Use the attached technical assistance material as one of the guides in the planning process;
- Inform us of questions that need resolution and of ideas regarding technical assistance that would be helpful.

We look forward to working with you to improve the nation's community services system.

Sincerely,

/s/

Timothy M. Westmoreland
 Director
 Center for Medicaid and State Operations
 Health Care Financing Administration

/s/

Thomas Perez Director
 Office for Civil Rights

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cc:

All HCFA Regional Administrators

All HCFA Associate Regional Administrators
 Division of Medicaid and State Operations

American Public Human Services Association

National Association of State Directors of Developmental Disabilities Services

National Association for State Mental Health Program Directors

National Conference of State Legislatures

National Governors' Association

Enclosure

**Developing Comprehensive, Effectively Working Plans
Initial Technical Assistance Recommendations**

In ruling on the case of *Olmstead v. L.C.*, the Supreme Court affirmed the right of individuals with disabilities to receive public benefits and services in the most integrated setting appropriate to their needs. The Supreme Court indicated that a State can demonstrate compliance with its ADA obligations by showing that it has a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, and a waiting list that moves at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated.

We strongly urge States to increase access to community-based services for individuals with disabilities by developing comprehensive, effectively working plans for ensuring compliance with the ADA. There is no single model plan appropriate for all States and situations. In developing their plans, States must take into account their particular circumstances. However, we believe there are some factors that are critically important for States that seek to develop comprehensive, effectively working plans. Our intent in this enclosure is to identify some of the key principles, including the involvement of people with disabilities throughout the planning and implementation process. These principles also will be used by the Office for Civil Rights as it investigates complaints and conducts compliance reviews involving "most integrated setting" issues. We strongly recommend that States factor in these principles and practices as they develop plans tailored to their needs.

Comprehensive, Effectively Working Plans

Principle: Develop and implement a comprehensive, effectively working plan (or plans) for providing services to eligible individuals with disabilities in more integrated, community-based settings. When effectively carrying out this principle:

- The State develops a plan or plans to ensure that people with disabilities are served in the most integrated setting appropriate. It considers the extent to which there are programs that can serve as a framework for the development of an effectively working plan. It also considers the level of awareness and agreement among stakeholders and decision-makers regarding the elements needed to create an effective system, and how this foundation can be strengthened.
- The plan ensures the transition of qualified individuals into community-based settings at

a reasonable pace. The State identifies improvements that could be made.

- The plan ensures that individuals with disabilities benefit from assessments to determine how community living might be possible (without limiting consideration to what is currently available in the community). In this process, individuals are provided the opportunity for informed choice. The plan evaluates the adequacy with which the State is conducting thorough, objective and periodic reviews of all individuals with disabilities in institutional settings (such as State institutions, ICFs/MR, nursing facilities, psychiatric hospitals, and residential service facilities for children) to determine the extent to which they can and should receive services in a more integrated setting.
- The plan establishes similar procedures to avoid unjustifiable institutionalization in the first place.

Plan Development and Implementation Process

Principle: Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up. When effectively carrying out this principle:

- The State involves people with disabilities (and their representatives, where appropriate) in the plan development and implementation process. It considers what methods could be employed to ensure constructive, on-going involvement and dialogue.
- The State assesses what partnerships are needed to ensure that any plan is comprehensive and works effectively.

Assessments on Behalf of Potentially Eligible Populations

Principle: Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities. When effectively carrying out this principle:

- The State has a reliable sense of how many individuals with disabilities are currently institutionalized and are eligible for services in community-based settings. The plan considers what information and data collection systems exist to enable the State to make this determination. Where appropriate, the State considers improvements to data collection systems to enable it to plan adequately to meet needs
- The State evaluates whether existing assessment procedures are adequate to identify institutionalized individuals with disabilities who could benefit from services in a more integrated setting.
- The State also evaluates whether existing assessment procedures are adequate to identify individuals in the community who are at risk of placement in an unnecessarily restrictive setting.

- The plan ensures that the State can act in a timely and effective manner in response to the findings of any assessment process.

Availability of Community-Integrated Services

Principle: Ensure the Availability of Community-integrated Services. When effectively carrying out this principle:

- The plan identifies what community-based services are available in the State. It assesses the extent to which these programs are able to serve people in the most integrated setting appropriate (as described in the ADA). The State identifies what improvements could be accomplished, including in information systems, to make this an even better system, and how the system might be made comprehensive.
- The plan evaluates whether the identified supports and services meet the needs of persons who are likely to require assistance in order to live in community. It identifies what changes could be made to improve the availability, quality and adequacy of the supports.
- The State evaluates whether its system adequately plans for making supports and services available to assist individuals who reside in their own homes with the presence of other family members. It also considers whether its plan is adequate to address the needs of those without family members or other informal caregivers.
- The State examines how the identified supports and services integrate the individual into the community.
- The State reviews what funding sources are available (both Medicaid and other funding sources) to increase the availability of community-based services. It also considers what efforts are under way to coordinate access to these services. Planners assess the extent to which these funding sources can be organized into a coherent system of long term care which affords people with reasonable, timely access to community-based services.
- Planners also assess how well the current service system works for different groups (e.g. elderly people with disabilities, people with physical disabilities, developmental disabilities, mental illness, HIV-AIDS, etc.). The assessment includes a review of changes that might be desirable to make services a reality in the most integrated setting appropriate for all populations.
- The plan examines the operation of waiting lists, if any. It examines what might be done to ensure that people are able to come off waiting lists and receive needed community services at a reasonable pace.

Informed Choice

Principle: *Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings. When effectively carrying out this principle:*

- The plan ensures that individuals who may be eligible to receive services in more integrated community-based settings (and their representatives, where appropriate) are given the opportunity to make informed choices regarding whether -and how- their needs can best be met.
- Planners address what information, education, and referral systems would be useful to ensure that people with disabilities receive the information necessary to make informed choices.

Implications for State and Community Infrastructure

Principle: *Take steps to ensure that quality assurance, quality improvement and sound management support implementation of the plan. When effectively carrying out this principle:*

- Planners evaluate how quality assurance and quality improvement can be conducted effectively as more people with disabilities live in community settings.
- The State also examines how it can best manage the overall system of health and long term care so that placement in the most integrated setting appropriate becomes the norm. It considers what planning, contracting and management infrastructure might be necessary to achieve this result at the State and the community level.

EXCERPT



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Medicaid & Medical Assistance

July 30, 2010

John E. V. Sorensen
CMS/CMSO/DEHPG/DASI
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Mr. Sorenson:

Thank you for your summary of CMS' findings from your May 2010 review of Delaware's Money Follows the Person program. Please know that we take CMS' concerns regarding our program very seriously. I would greatly appreciate being notified directly by CMS whenever you have such concerns so that we can take timely, appropriate corrective action. While our MFP program is small given Delaware's small size, it is extremely important to Delaware. MFP is critical in our efforts to realign our long term care system to better support community-based care.

In response to your findings we offer the following:

CMS OBSERVATIONS AND RECOMMENDATIONS:

Number of Individuals Transitioned

You note that, ½ way through our third year, we have transitioned approximately 25 individuals (only one quarter of our originally projected number).

We share your concerns with the number of transitions we have accomplished thus far. We strongly agree that we must improve in meeting our benchmark for transitions, which are as follows:

Grant Year (calendar)	Benchmark	Number Transitioned	% of Achievement
CY 2008 (program implemented 7/08)	3	3	100%
CY 2009	25	19	76%
CY 2010 * as of 7/20/10	38	7	18%

In addition, we are in the process of hiring another MFP Administrator this summer to increase our outreach and collaboration efforts.

OPPORTUNITIES:

Competency & Guardianship Issues

In your report you indicate that Delaware state law allows nursing facility staff (Neuropsychologist & Physician) to make a determination of incompetency and that this determination is made without a formal hearing. You note that this declaration establishes a guardianship with family or with the State (family may not have another choice for their loved one, or have a stake in their loved one being kept in the institution). In addition, state facility staff informed you during your site visit that there are only five staff assigned by the court for State Guardianship. You express concern regarding this process, and rightly so.

This representation to you by facility staff of state law, the determination of incompetency and the guardianship process is not correct. A declaration of incompetency by facility staff does not constitute a legal determination of incompetency. Nor does it establish a guardianship with a family member or with the State.

When developing Delaware's MFP Protocol, our MFP Steering Committee researched Delaware's guardianship process. As indicated in our MFP protocol, the age of majority in Delaware is eighteen (18) years. Prior to age 18, unless a child has achieved a status as delineated in the Delaware Code Title 13, Section 707, it is the parent or legal guardian of that child who acts on that child's behalf; i.e. giving informed consent. After the age of majority, every person is considered to be their own legal guardian unless adjudicated through the Court of Chancery to be incompetent and in need of a guardian. Therefore, in Delaware the decision making power lies with each person, his/her legal guardian, or a Durable Power of Attorney for the person who chooses to be in the "Finding a Way Home" Project:

Delaware's Guardianship statute can be located in Title 12, Chapter 39, Sections 3901-3971 of the Delaware Code, which can be found at <http://delcode.delaware.gov/title12/c039/index.shtml>. The Guardianship statute for minors is located in Title 10, Section 925(16). Delaware Code allows for the Court of Chancery and Family Court the power to appoint Guardianship of person or property or both of any disabled person resident of this State. The law requires a hearing and the individual is entitled to representation by counsel. Please note that Facility Administrators are never appointed as legal guardians for their residents in Delaware.

If a potential participant has a legal guardian, that guardian has the authority to sign all consents on behalf of a person interested in being a participant in this project, but the person will always

be an active member of the information sharing and decision making process for "Finding A Way Home."

This month we met with staff from the facility that expressed confusion concerning these regulations along with representatives from the State Ombudsman office. We reviewed with them the state law concerning how individuals must be adjudicated to be incompetent through the Court of Chancery and the legal process via the Court in appointing guardianship. We will continue meeting with facility staff to assure all are familiar with these processes.

Delaware Psychiatric Center (DPC)

During your tour of DPC, staff there reported that they have several individuals who are ready for transition if the State could provide the necessary services in the community. Since your visit, 32 residents of the Carvel Building within DPC have received PASARR assessments to determine if they are appropriate for nursing facility and HCB Waiver level of care. Three individuals are being further assessed for MFP. Additional individuals will be assessed for possible transition in the future.

The State will continue to be involved with the TA group to incorporate the Mental Health population into the MFP demonstration. In addition, we will continue to advocate for the removal of the age criteria for this population, which limits our ability to serve such individuals under the MFP program.

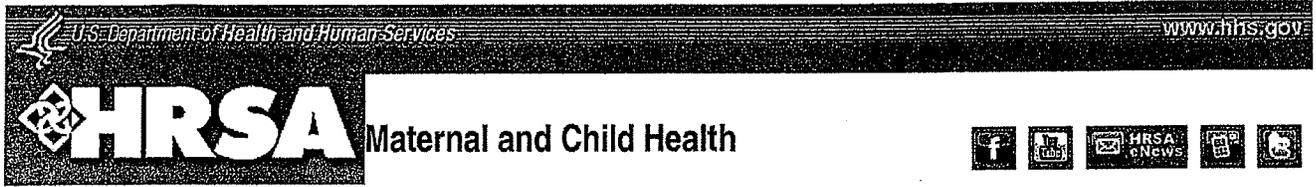
The Stockley Center

You expressed interest in touring the Stockley Center, Delaware's public ICF/MR in the future. We are available to assist with the scheduling of this visit at your convenience.

The Minimum Data Set (MDS)

During your review you identified that the State is not currently utilizing this tool for participant identification.

Unlike many states, Delaware does not use the MDS data in its Medicaid nursing facility reimbursement methodology. However, our MFP staff works closely with the Medicaid nursing facility reimbursement nurses to identify Medicaid recipients that have expressed a desire to return to the community. We are also working with Delaware's Local Contact Agency (LCA), the ADRC within the Division of Services for Aging & Adults with Disabilities, to access MDS data to identify potential program participants. We are on target to meet the October 2010 implementation date.



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EPSDT Overview

EPSDT Program Background

[Printer-friendly EPSDT Program Background \(15 KB\)](#)

Medicaid's child health component, known as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, children has been shaped to fit the standards of pediatric care and to meet the special physical, emotional, and developmental needs of low-income children. Since 1967, the purpose of the EPSDT program has been "to discover, as early as possible, the ills that handicap our children" and to provide "continuing follow up and treatment so that handicaps do not go neglected."

Federal law – including statutes, regulations, and guidelines – requires that Medicaid cover a very comprehensive set of benefits and services for children, different from adult benefits. Since one in three U.S. children under age six is eligible for Medicaid, EPSDT offers a very important way to ensure that young children receive appropriate health, mental health, and developmental services.

To remember the elements of EPSDT, use the name of the program:

Early	Identifying problems early, starting at birth
Periodic	Checking children's health at periodic, age-appropriate intervals
Screening	Doing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
Diagnosis	Performing diagnostic tests to follow up when a risk is identified, and
Treatment	Treating the problems found.

Under the Deficit Reduction Act of 2005 (DRA, enacted February 2006), states were given the option to modify the approach to delivery of services to children enrolled in Medicaid. Two DRA changes Medicaid law may have direct impact on EPSDT .

More Info:

- [CMS EPSDT Web Site](#)
- [GW Health Policy](#)
- [Checklist at MEDIPED](#)
- [GW Tools](#)

The DRA gives states the option to restructure their approach to benefits under Medicaid without a federal waiver, using the state plan amendment process. Under this option, states may enroll certain groups (mainly those in optional eligibility groups) in benchmark or benchmark equivalent benefit packages and wrap-around benefits consisting of EPSDT benefits for any child under age 19 covered under a state plan.

The DRA also includes a more specific definition of case management and places limits on use of targeted case management and administrative case management and. Since State Medicaid agencies use both EPSDT case management and targeted case management for infants, children, and adolescents, such programs may be affected by the DRA provisions.

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EPSDT Requirements

[Printer-friendly EPSDT Requirements \(22 KB\)](#)

EPSDT is a mandatory set of services and benefits for all individuals under age 21 who are enrolled in Medicaid. Think of it as the child health coverage package of Medicaid.

- [Medicaid State Manual Part 5 EPSDT](#)

Screening services "to detect physical and mental conditions must be covered at established, periodic intervals (periodic screens) and whenever a problem is suspected (inter-periodic screens).

Screening includes a comprehensive health and developmental history, an unclothed physical exam, appropriate immunizations, laboratory tests, and health education.

- [Federal EPSDT Coverage Policy Report](#) 

In addition, dental, vision, and hearing services are required, including appropriate screening, diagnostic, and treatment. The treatment component of EPSDT is broadly defined. Federal law states that treatment must include any "necessary health care, diagnostic services, treatment, and other measures" that fall within the federal definition of medical assistance (as described in Section 1905(a) of the Social Security Act that are needed to "correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services."

All medically necessary diagnostic and treatment services within the federal definition of Medicaid medical assistance must be covered, regardless of whether or not such services are otherwise covered under the state Medicaid plan for adults ages 21 and older.



EPSDT is designed to help ensure access to needed services, including assistance in scheduling appointments and transportation assistance to keep appointments. As described in federal program rules: The EPSDT program consists of two, mutually supportive, operational components:

- assuring the availability and accessibility of required health care resources; and
- helping Medicaid recipients and their parents or guardians effectively use them."

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EPSDT Resources

[Printer-friendly EPSDT Resources \(22 KB\)](#)

Much has been written about EPSDT over the past 40 years of the programs existence. The selected titles and links below will guide you to some key resources and references.

GWU Center for Health Services Research and Policy

- [Managed Care Purchasing Specifications](#) ☞
- [Negotiating the New Health System](#) ☞
- [Federal EPSDT Coverage Policy: An Analysis of State Medicaid Plans and State Medicaid Managed Care Contracts. Chapter 3: Analysis of Contract Provisions Relating to EPSDT Services](#) ☞
- [Optional Purchasing Specifications for Child Development Services in Medicaid Managed Care. \(July, 2000\)](#) ☞
- [Optional Purchasing Specifications: Medicaid Managed Care for Children with Special Health Care Needs. \(August, 2000\)](#) ☞
- [National Security and U.S. Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT.](#) ☞ Rosenbaum A, Mauery DR, Shin P, and Hidalgo J. GWU, Department of Health Policy. Policy Brief. (April 2005)
- [Center for Health Care Strategies and George Washington University.](#) ☞ Rosenbaum R, Wilensky S, and Allen K. EPSDT at 40.
- [Child Development Issue Briefs Prepared for The Commonwealth Fund](#) ☞

Federal Oversight Reports

- [U.S. General Accounting Office](#)
 - ["Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services](#)

(July 2001)" (Acrobat/pdf, General Accounting Office, GAO)

- [DHHS Office of the Inspector General](#)

[National Health Law Program \(NHeLP\)](#) ☞

- [Toward a Healthy Future: Medicaid Early and Periodic Screening, Diagnostic and Treatment Services for Poor Children and Youth \(April 2003\).](#)

[National Academy for State Health Policy](#) ☞

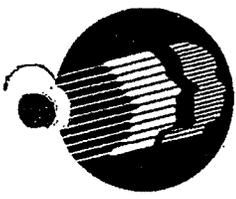
- [VanLandeghem Karen, Curtis Debra, and Abrams Melinda. Reasons and Strategies for Strengthening Childhood Development Services in the Healthcare System. \(October 2002\).](#)

[Milbank Quarterly](#) ☞

- [Gavin et al, The Use of EPSDT and Other Health Care Services by Children Enrolled in Medicaid: The impact of OBRA 89. 1998;76:236-47. \(June\)](#)
- [Sardell and Johnson. The Politics of EPSDT Policy in the 1990s: Policy entrepreneurs, political streams, and children's health benefits. 1998;76:186-89. \(June\)](#)

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25 Copies for
Parents MTING
5/7/96



**DELAWARE HEALTH
AND SOCIAL SERVICES**

DIVISION OF
SOCIAL SERVICES

TELEPHONE: (302)

April 8, 1996

Bonnie Coleman
EDS, Health Benefits Manager
248 Chapman Road, suite 200
Newark, DE 19702

Dear Ms Coleman:

Thank you all for your swift response in getting your staffs to the April 2 meeting with parents of disabled children, and a special thanks to the staff who attended. As you know, disabled children is a population that Medicaid added to the waiver for the DSHP.

Most programs carved these children out of their plans, or included them as voluntary, which we think is a serious mistake. We believe that primary and preventive care is extremely valuable for these clients. We tiered the rate to the MCO's to guard against adverse selection. We asked the HBM to give special attention to this group. We all tried to make this a smooth transition, but obviously we still have a lot to do.

Many of these parents displayed great fears and concerns, some with horror stories. Most of the problems seem to have been caused by lack of commonsense communication. I cannot emphasize this enough. Some problems may have been deliberately designed to get parents to support HB 321, the "any willing provider" bill. If that is the case, it is a shameful manipulation of these parents.

Whatever the cause, I heard some things that disturbed me greatly. One of these was a case manager telling a parent, "We will be cutting our nurse from 2 times a week to 0, and when I come for a home visit we'll see if it should be two." That is outrageous.

At the meeting, I took full responsibility for the transition issues. Our providers need to do their share as well. I made several commitments which we must keep.

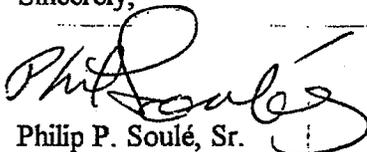
1. No reduction in services will take place until/unless there has been an on-site visit. Then, and only then, will this be put in writing to the parent/guardian with the reason it is being made and the appeal process they may use to present their objections. Please submit a copy of that letter to Kay Holmes. If a reduction or change is under appeal, the benefit will remain the same until the appeal is resolved. This is the procedure Medicaid case managers will use and have used for our "prior authorization care." (Please review Section II.4 on Page II.57 of the RFP.)

2. Another issue is the reduction of nursing services to 4 hours per day, which coincidentally is the amount in the basic benefit package (28 hours a week.) We have made it clear, I thought, that if more nursing care is needed, Medicaid will pay for hours beyond 28 per week. It seems to me that this is not getting across. Just because a plan will only pay for 28 hours does not mean that only 28 hours can be authorized. If a case manager believes that more hours are needed, or if fewer hours represent a major reduction from what is currently authorized, plan case managers should discuss the case with Medicaid case managers before making final recommendations to parents. We do not feel that huge reductions should occur precipitously. Remember, custodial care is appropriate under Medicaid and it has been factored into your rate. Going from 35 hours to 12 hours makes no sense. Even if Medicaid has been excessive in its prior authorizations, we need to look at a weaning process. We don't want children to regress; we don't want to create hardships for parents and, I repeat, the basic capitated rate includes this consideration. Before you even send the notice listed in 1(above), please talk to a Medicaid case manager if you are considering a reduction in hours that goes beyond 15 or 20 %. We expect judgment to be used.

Finally, Delaware Medicaid will be working with DPH, Part H and DMR to apply for a Robert Wood Johnson grant. We will work with Dr. Sol Katz of the Krogmen Growth Center, who has been doing Child Quest 2000 with Nemours and children in our State. We hope to showcase our work with the MCO's and Medicaid to teach other states how to manage care for this difficult population. This will be a wonderful project for Delaware, and I hope we get the grant.

Kay Holmes will be getting all of us-chiefs and Indians together to make this process for disabled children go more smoothly than it has up to now. Thank you again for your cooperation. We are all going through a learning process that I believe ultimately will benefit our clients and all of us.

Sincerely,



Philip P. Soule, Sr.
Medicaid Director

PS/sef

cc: Elaine Archangelo
Kay Holmes
EDS, Health Benefits Manager



**DELAWARE HEALTH
AND SOCIAL SERVICES**

**DIVISION OF
SOCIAL SERVICES**

TELEPHONE: (302)

January 27, 2000

Brian J. Hartman
Disabilities Law Program
Community Legal Aid Society, Inc
913 Washington Street
Wilmington, DE 19801

Dear Attorney ^{Brian}Hartman:

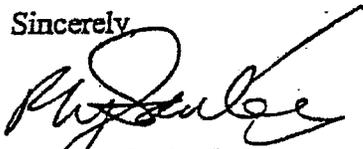
This is in response to your letter dated January 20, 2000 where you requested a policy letter clarifying the position of Delaware Medicaid with regards to the termination or material reduction of services to Medicaid recipients, especially home health or home care services.

Since the inception of the Medicaid Managed Care Program in 1996, we have required that prior to the termination and/or reduction of any services, unless there is an approved plan that calls for a reduction in care or change of service, the MCO, or one of its Agencies (i.e.; a Home Health Agency) must conduct a face to face meeting and/or assessment, preferably at the site the care is given, with the Medicaid recipient or a parent. All four MCO's in our program at the start were aware of this requirement, and to the best of my knowledge the remaining two MCO's, DelawareCare and First State, are not only aware of this, but are following this process.

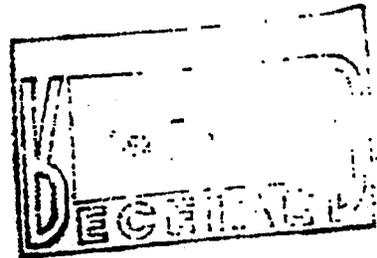
To your second issue. Medicaid has made it clear to the MCO's and to recipients using the Health Benefits Manager (HBM) Contractor that the clients should go through the MCO appeal process before using the State appeal process. This usually gets issues resolved in a more efficient manner, but they can appeal to the State at the same time, or any time during the process or even wait up until 90 days after to final MCO decision to appeal to the State. There are issues for both sides with this; the clients feel that MCO's could drag out the process and therefore not provide care for a long time and the MCO's feel the clients can appeal, ask to keep the benefit, and keep MCO's providing care for months, then loose and never payback the MCO's.

I hope this meets your need. If not just give me a call. I will also copy this to Priscilla Ruebeck at DMR as you requested. I am also faxing copies to Mr. Chaffin of DelawareCare and Mr. Bates at First State.

Sincerely,



Philip P. Soule, Sr.





The Delaware Code (31 Del. C. 520) provides for judicial review of hearing decisions. In order to have a review of the decision expressed below in Court, a notice of appeal must be filed with the clerk (Prothonotary) of the Superior Court within 30 days of the date of the decision. An appeal may result in a reversal of the decision. Readers are directed to notify the DSS Hearing Office, P.O. Box 906, New Castle, DE 19720 of any formal errors in the text so that corrections may be made.

DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES

In re: Alana G. [redacted], a minor

DCIS No.:
5000703852

Appearances: Marybeth Putnick, Disabilities Law Program, Community Legal Aid Society, Inc., Counsel for the Claimant
Ann [redacted], Claimant's Parent, Witness
Donna Carroll, Clinical Social Worker, Brandywine School District, Witness

Jennifer Gimler Brady, Counsel for the First State Health Plan
Tricia Strusowski, R.N., First State Health Plan, Witness
Libby Walker, R.N., Supervisor, Pre-Certification Department, First State Health Plan, Witness¹

I

Alana G. [redacted] (sometimes hereinafter the "claimant"), through counsel and her parent Ann [redacted] opposes a March 16, 2000 decision of the First State Health Plan (sometimes "First State") to deny a request for in-home speech therapy.

First State contends that it is a responsibility of the claimant's school district to provide speech therapy services and not a responsibility of the First State Health Plan.

The claimant contends that speech therapy is medically necessary for her, that First State is obligated to arrange for medically necessary covered services under the Medicaid Program, that her doctors have expressly prescribed speech therapy at home, and that First State may not lawfully deny her claim for speech therapy services on grounds that the services are part of the individualized education plan developed by her school.

¹ Thomas Mannis, M.D., the Medical Director for the First State Health Plan also attended this hearing.

II

In November and December 1999 First State denied requests for speech therapy for the claimant on grounds that "speech therapy for the condition of developmental delays is not a covered benefit" and because the therapy "is already being provided through [the claimant's] school." [Exhibit # 2]

On December 9, 1999, following an appeal to Christiana Care Health Plans, First State affirmed the denial on grounds that "the therapy is not medically necessary in addition to the school based therapy." By notice dated March 16, 2000, Christiana Care reaffirmed the decision. [Exhibit # 2]

On March 29, 2000 ~~Any~~ filed a request for a Fair Hearing with the Division of Social Services. [Exhibit # 1]

The hearing was conducted on June 12, 2000 at the Lewis Building of the Department of Health and Social Services in New Castle.

This is the decision resulting from that hearing.

III

The Division of Social Services of the Department of Health and Social Services operates several medical assistance programs including the State funded Chronic Renal Diseases Program², the Medicaid Program under Title XIX of the Social Security Act, the "QMB" Program³ which is a Medicare Program that is partly funded with Medicaid Program money, and the "Delaware Healthy Children Program"⁴ funded by Title XXI of the Act. The Division derives authority for the operation of the Medicaid Program from 31 Del. C. §502(5), §503 (b), and §505 (3).

The Medicaid Program provides support for medical services received by defined groups of low-income families and individuals. Persons who meet income and status eligibility tests, such as age, citizenship, and residency, may participate in the program. Participants qualify for payment for a wide range of medical services.

The First State Health Plan is a capitated⁵ managed care program offered by Christiana Care Health Services to direct, on behalf of the Division of Social Services, benefits covered under Title XIX of the Social Security Act.

~~Any~~ is a third party beneficiary of a contract between First State and the Division of Social Services. She is a four-year-old

² 29 Del. C. §§ 7932-7935.

³ Section 17300 DSSM.

Section 18000 DSSM.

⁵ See 42 CFR 434.2. A capitation fee is paid by DSS to managed care contractors "for each recipient enrolled under a contract for the provision of medical services under the State plan, whether or not the recipient receives the services during the period covered by the fee."

youngster who receives medical assistance under the DSS Disabled

Children's medical assistance program.⁶ She is diagnosed with bicolingual dyspraxia, expressive and receptive language delays and significant articulation problems.

First State contracts with DSS to provide comprehensive prepaid managed care health services to persons who receive Medicaid. A purpose of managed care is to "stabilize the rate of growth in health care costs."⁷

Jurisdiction for this hearing is under §5304.3 of the Division of Social Services Manual (DSSM). Section 5304.3 provides jurisdiction for a hearing over an adverse decision of a Managed Care Organization.

IV

The essential facts in this case are not in dispute. The claimant resides with her parents in _____ and receives educational services from the Bush Early Education Center of the Brandywine School District. She is enrolled in a specialized education program where she receives speech therapy services twice a week. She is eligible to receive services for an "extended school year." Her school speech therapy is an educational service covered under the Individuals with Disabilities Education Act⁸. She meets the definition of a child with a disability at 20 U.S.C. §1401 (3)(A)(i). She has a specific learning disability.

First State has denied a request for authorization of an additional weekly in-home speech therapy session and speech therapy services during the months of August and September when her school is out of session.

The claimant's pediatric neurologist S. Charles Bean, M.D. has prescribed in-home speech therapy for her. [Exhibits # 2 and # 8] It is thought that in-home speech therapy will improve her functional communication skills; that it serves a different purpose from speech therapy in school, and that therapy in the home environment is less stressful than therapy given in the claimant's school and, therefore, is more beneficial to her. School-based speech therapy is not available to her during the months of August and part of September. It is believed that speech therapy is needed during these months to prevent regression of her language skills.

According to First State, the claim was denied because the speech therapy services are an educational obligation of the claimant's school district. It is undisputed that speech therapy is an educational obligation of the school.

⁶ See §17200 DSSM. The Delaware Disabled Children's program is analogous to the program described in the federal rule at 45 CFR 435.225. The State program requires a level of care determination rather than the determination, found in the federal rule, that the child qualify as a disabled individual under section 1614(a) of the Social Security Act.

⁷ Diamond State Health Plan, July 27, 1994, Chapter 1-1.

⁸ 20 U.S.C. §1400 et seq.

However, the First State position that it, consequently, has no obligation to arrange for speech therapy services that the school does not provide is not supported by the law at 42 U.S.C.A. §1396b, which provides:

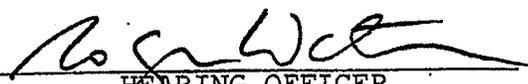
(c) *Treatment of educationally-related services*

Nothing in this subchapter shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) of this section for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to Part B of the Individuals with Disabilities Education Act [20 U.S.C.A. §1411 et seq.] or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part H of such Act [20 U.S.C.A. §1471 et seq.]

United States Code Annotated, Title 42 §§ 1395ee to 1399,
2000 Supplementary Pamphlet, West Group.

Since the Secretary of the United States Department of Health and Human Services is prohibited by law from denying claims for speech therapy services under the Medicaid Program because an individual is able to receive those services from a school district when the services are educationally indicated, it follows that the Delaware Department of Health and Social Services, the Division of Social Services, and the Division's Agent, the First State Health Plan, are likewise prohibited from denying the claimant's claim for medically necessary supplemental speech therapy services.

For this reason, the March 16, 2000 decision of First State, affirming an earlier denial because speech therapy was received at the claimant's school and denying a request for additional speech therapy services on grounds that the services are an obligation of the claimant's school district, is reversed.


HEARING OFFICER

JUNE 22 2000
DATE

THE FOREGOING IS THE FINAL DECISION OF THE DIVISION OF SOCIAL SERVICES

JUN 22 2000

POSTED

For: Marybeth Putkin for the Claimant
Jennifer Gimler Brady for the First State Health Plan

DOCUMENTS FILED IN OR FOR THE PROCEEDING

Exhibit # 1 is a request for a fair hearing dated March 29, 2000.

Exhibit # 2 (six pages) is a two page hearing summary of the First State Health Plan together with four pages of speech therapy denial notices dated November 30, 1999, December 7, 1999, December 9, 1999, and March 16, 2000.

Exhibit # 3 (four pages) is a photocopy of a November 30, 1999 speech therapy evaluation of the claimant. This is offered by First State to show the overlay between the speech therapy and educational goals for the claimant.

Exhibit # 4 (approximately twelve pages) is an individualized education program for the claimant. This is offered by First State to show the overlay between the speech therapy and educational goals for the claimant.

Exhibit # 5 (approximately 22 pages) consists of photocopies of Nurses 'N Kids at Home, Inc. speech therapy weekly progress notes from 11/30/99 to 5/25/00. These are offered by the claimant to show progress made as a result of her in-home speech therapy and to show the difference between at-school and in-home therapies. The latter claim is rejected because there are no comparable school district reports. They are admitted pursuant to §5404 (5).

Exhibit # 6 (three pages) is a photocopy of a Nurses 'n Kids at Home speech therapy progress update dated May 15, 2000. This is offered by the claimant to show progress made as a result of her in-home speech therapy and is admitted pursuant to §5404 (5).

Exhibit # 7 is a statement made outside the hearing by S. Charles Bean, M.D. dated June 9, 2000 about the claimant's need for speech therapy services. It is offered by the claimant and is included over objection for relevance pursuant to §5404 (5).

Exhibit # 8 (four pages) consists of photocopies of a letter from S. Charles Bean, M.D. dated October 28, 1999, a letter from Charles I. Scott, Jr., M.D. dated December 2, 1999, a letter from Joseph DiSanto, M.D. dated January 17, 2000 and a letter from Denise Yeatman dated January 21, 2000. These are offered by the claimant in support of the position that in-home speech therapy one day per week is medically necessary. They are included pursuant to §5404 (5) DSSM.

Exhibit # 9 is a photocopy of a letter dated November 29, 1999 from Donna Carroll to the First State Health Plan. This is included pursuant to §5404 (5).



The Delaware Code (31 Del. C. §520) provides for judicial review of hearing decisions. In order to have a review of this decision in Court, a notice of appeal must be filed with the clerk (Prothonotary) of the Superior Court within 30 days of the date of the decision. An appeal may result in a reversal of the decision. Readers are directed to notify the DSS Hearing Office, P.O. Box 906, New Castle, DE 19720 of any formal errors in the text so that corrections can be made.

**DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES**

In re:

First State ID# 001030240*01

A/ B:

Appearances: Laura J. Waterland, Esq., Community Legal Aid Society, Inc.
family friend, witness
Joe Lucca, P.T., Ph.D., University of Delaware, witness
Edward Shubert, M.P.T., Appellant's physical therapist, witness

Jennifer Gimler Brady, Esq., Counsel for First State Health Plan
Susan L. Riccardi, M.D., Medical Director for First State Health Plan, witness
for First State Health Plan
Joyce Harvey, R.N., Case Manager for First State Health Plan,
witness for First State Health Plan

I.

A (sometimes hereinafter "Appellant"), through counsel, Laura J. Waterland, Esq., opposes a decision of First State Health Plan ("First State"), acting for the Delaware Medical Assistance Program ("DMAP"), to reduce her physical therapy services from twice per week to once per week, for treatment of symptoms and conditions associated with amyotrophic lateral sclerosis¹ ("ALS").

First State contends that the requested relief fails on both procedural and substantive grounds. They first assert that the hearing officer is without jurisdiction to hear the case as the Appellant failed to request a fair hearing in a timely manner. They next contend that their decision is not a reduction in services, but a decision to change the provider of the physical therapy services. They further contend that services being provided by a physical therapist could be provided by the Appellant's husband.

¹ Amyotrophic later sclerosis, also know as Lou Gehrig's disease, is a serious neurologic disease that results from the progressive degeneration of the motor neurons. www.medical-dictionary.com.

Specifically, First State contends that the requested services, a twice per week visit from the physical therapist, fails to meet the following medical necessity guidelines:

- Be the least costly, appropriate, available health service alternative and will represent an effective and appropriate use of program funds;
- Be the most appropriate care or service that can be safely and effectively provided to the beneficiary, and will not duplicate other services provided to the beneficiary; and
- Be sufficient in the amount, scope and duration to reasonably achieve its purpose.

II.

By letter dated December 20, 2000 (Exhibit 1), First State reduced the Appellant's physical therapy services from twice per week to once per week citing only that the physical therapy notes reflect that the patient is at her maximum level of functioning with no significant improvement noted.

Pursuant to that denial, the Appellant filed an internal appeal and a hearing was held on February 22, 2001. By letter dated March 9, 2001 (Exhibit 1) First State upheld its initial denial, for the first time stating the above-listed medical necessity guidelines.

On March 20, 2001 the Appellant requested a State Fair Hearing. (Exhibit 1) While First State's Fair Hearing Summary notes that benefits have continued, testimony provided by Edward Shubert, MPT, Appellant's physical therapist, indicates that benefits have been reduced to once per week.

On April 6, 2001, First State filed a State Fair Hearing Summary (Exhibit 9). By letter dated April 10, 2001, the Appellant was notified that a fair hearing would take place in New Castle, DE on May 10, 2001. That hearing was rescheduled to June 5, 2001, by letter dated May 8, 2001.

The hearing was conducted on June 5, 2001 in New Castle, Delaware. This is the decision resulting from that hearing.

III.

Pursuant to authority conferred by 31 *Del. C.* §§ 502 (5), 503 (b), and 505 (3), the Division of Social Services ("DSS"), Delaware Department of Health and Social Services, operates the DMAP to provide Medicaid benefits under Title XIX of the Social Security Act to certain qualifying individuals. DSS has contracted with First State, a managed care organization, to administer benefits under the DMAP. As an agent for DSS, First State is governed by the

same rules, regulations, and principles that would otherwise control DSS's operation of the DMAP. In fact, this is explicitly required by regulation. See DSSM § 5304.3.

First State is a capitated² managed care organization ("MCO") that directs, on behalf of the Division of Social Services, benefits covered under Title XIX of the Social Security Act. A is a third party beneficiary of a contract between First State and the Division of Social Services. She is a fifty two-year-old female diagnosed with amyotrophic lateral sclerosis.

IV.

Jurisdiction for this hearing is pursuant to §5304 and §5304.3 of the Division of Social Services Manual (DSSM). Under §5304:

an opportunity for a hearing will be granted to any applicant who requests a hearing because his/her claim ... is denied... and to any recipient who is aggrieved by any action of the Division of Social Services... Only issues described in the notice of action sent to the appellant or issues fairly presented in the appellant's request for a fair hearing or in the Division's response in its hearing summary may be presented for the hearing officer's review at the hearing.

Section 5304.3 provides jurisdiction for a hearing of an adverse decision of a Managed Care Organization.

V.

At the time of the hearing, A was a fifty two-year-old female with a diagnosis of ALS. It is the opinion of her primary care physician and that of her physical therapist that twice per week physical therapy is the appropriate level of care for Ms. (See, Exhibit 7).

After evaluating progress notes prepared by the physical therapist as well as physician notes, First State determined that a reduction to one session per week of physical therapy was appropriate. (Exhibit 9). On December 20, 2000, First State reduced the Appellant's physical therapy services to once per week on the basis that the patient is at her maximum level of functioning with no significant improvement noted. First State's decision was appealed internally. By letter dated March 9, 2001, First State upheld its initial denial determination on the basis that the physical therapy services do not meet the State of Delaware's definition of medical necessity. On March 26, 2001, Appellant filed a request for a Fair Hearing with the Division of Social Services seeking to overturn the reduction of physical therapy services

VI.

Timeliness of Request for State Fair Hearing

² See 42 CFR 434.2. A capitation fee is paid by DSS to managed care contractors "for each recipient enrolled under a contract for the provision of medical services under the State plan, whether or not the recipient receives the services during the period covered by the fee."

First State initially asserts that the Appellant failed to request a Fair Hearing in the time authorized by regulation. First State cites 42 C.F.R. § 431.221(d), as adopted in Delaware Social Services Policy Manual ("DSSM") §5305 (2) as authority for their contention that the filing of the request for a fair hearing in this case was untimely. 42 C.F.R. § 431.221(d) sets forth that,

"The agency must allow the applicant or recipient a reasonable time, not to exceed 90 days from the date that notice of the action is mailed, to request a hearing."

Moreover, DSSM § 5305(2) states that,

"When a request for a hearing is not filed within 90 days of the date notice of an action is given, the hearing officer is without jurisdiction to hear an appeal and the time for taking an appeal will not be enlarged."

First State's reliance on these provisions is not determinative. First State has failed to show where, in the regulations it cites, that a State Fair Hearing must be brought within 90 days of the *original* denial. In fact, they cannot, because such language does not exist. The plain meaning of the regulation dictates that a request for a hearing be filed within 90 days of the notice of an action, not notice of an *original* action. First State argues that since there is no requirement that the Appellant exhaust their administrative remedies before seeking a State Fair Hearing, the time frame for that request is not stayed pending an internal review of the case. Moreover, they note that frequently there are two tracks of appeals going simultaneously and that families generally don't wait until the internal grievance is resolved to file for a State Fair Hearing. Finally, First State notes in their post-hearing papers dated June 19, 2001, that:

"The federal and state regulations relating to the time period for requesting a fair hearing do not take into account a Medicaid managed care organization's internal appeal process in any fashion. Significantly, the federal regulation predates Medicaid managed care and has not been amended since the implementation of managed care. In addition, the state fair hearing procedures were adopted after Medicaid managed care was introduced in Delaware, yet those procedures do not mention or take into account a managed care organization's internal appeal process in any fashion. Under these circumstances, First State is entitled to raise the 90 day rule as a bar to the Member's fair hearing request"³ (Emphasis in original)(See, Exhibit 10).

First State is mistaken as to its interpretation of the law. First State is correct that federal regulation predates Medicaid managed care and has not been amended. This fact does not, however, mandate that as such, federal regulations have not taken into account an MCO's

³ In the original document, First State places a footnote here to explain that because of this analysis, other fair hearing decisions have erroneously interpreted the 90 day rule and should not be entitled to precedential weight. In fact, First State cites that their request for reconsideration of a November 22, 2000 decision is pending before this Hearing Officer. In fact, by letter dated January 15, 2001, that request for reconsideration was denied.

internal review process. In fact, as written, there is no need for an amendment to this legislation, as the current law allows for review if a request is filed within 90 days from an action. Thus, it would appear that by not moving to amend the legislation, especially in light of their knowledge of managed care internal review procedures, to include language relating to both initial decisions and subsequent decisions, that federal legislators believed the law, as written, adequately protected the rights of the members. The same analysis holds true for the drafters of the Delaware fair hearing procedures.

In addition, in a January 27, 2000 response to an inquiry by Brian Hartman of the Disabilities Law Program, Community Legal Aid Society, Inc. (Exhibit 1), Philip P. Soule, Sr., Deputy Director/Medicaid set forth the Division of Social Services policy on the 90 day rule, stating:

"...Medicaid has made it clear to the MCO's and to recipients using the Health Benefits Manager (HBM) Contractor that the clients should go through the MCO appeal process before using the State Appeal process. This usually gets issues resolved in a more efficient manner, but they can appeal to the State at the same time, or any time during the process or even wait until 90 days after to (sic) *final* MCO decision to appeal to the State." (Emphasis added).

This language clearly indicates that it is the policy of the DMAP to allow requests for State fair hearings after conclusion of the MCO internal review process has been completed, subject to the 90-day rule. The language is also consistent with both federal and state law, as indicated above, in that the plain meaning of the federal and state law both allow for requesting a hearing within 90 days of an action.

First State admits that under the DMAP the Delaware Health and Social Services' Division of Social Services ("DSS") is the party responsible for setting Medicaid policy, however, they argue that DSS's interpretation of the 90-day rule is erroneous. As an agent of the DSS for purposes of carrying out the Medicaid program, First State is bound by the policies and regulations promulgated by DSS, until such time that those policies and regulations are found, by a court of competent jurisdiction, to be inconsistent with either federal or state law.

To maintain that First State's internal process has absolutely nothing to do with the fair hearing process is ludicrous, at best. As written, but not as interpreted by First State, the current fair hearing procedures continue to provide procedural and substantive protection to those parties aggrieved by an adverse decision of the managed care organization. To interpret the regulations in any other manner would deprive members of these protections and provide absolutely no oversight of First State's ultimate determinations.

With respect to the mandates of 42 C.F.R. § 431.221(d) and DSSM § 5305(2), this hearing officer finds that the 90-day rule attaches to the Second denial notice dated March 9, 2001 and not the December 20, 2000 "Service Denial." Therefore, the Appellant's request for a State Fair Hearing dated March 20, 2001, is within the statutorily mandated 90-day period. As such, First State's Motion to Dismiss the request for a State Fair Hearing is denied.

VII.

Defective Notice

One of the fundamental principles governing the DMAP is that beneficiaries must receive adequate notice of the termination or reduction of benefits. (See, *Ortiz v. Eichler*, 794 F.2d 889 (3rd Cir.1986); DSSM § 5301. The requirements for an adequate notice have been clearly established:

The guiding principle shall be that the notice must contain any information needed for the claimant to determine from the notice alone the accuracy of the agency's intended action. At a minimum, these notices shall 1) indicate the action to be taken; 2) provide citation(s) to the regulation(s) supporting the action to be taken; 3) provide a detailed individualized explanation of the reason(s) for the action being taken which includes, in terms comprehensible to the claimant, an explanation of why the action is being taken and, if the action is being taken because of the claimant's failure to perform an act required by a regulation, an explanation of what the claimant was required by the regulation to do and why his or her actions failed to meet this standard.

Ortiz v. Eichler, C.A. No. 84-16 MMS, order (D. Del. August 16, 1985), *aff'd*, *Ortiz v. Eichler*, 794 F.2d at 892, 896.

The December 20, 2000 notice fails to meet the requirement of providing a citation to any regulatory support for its' decision to reduce physical therapy services. First State argues in conclusory fashion that the "Member's contentions regarding alleged deficiencies in the notice letters provided by First State should be rejected outright" and that the letters (of reduction) "comply with the criteria required of such letters, as set forth in the relevant federal and state regulations". First State then proceeds to interject a subjective comprehension test into the requirements, stating that, "the letters submitted on behalf of the Member in connection with her appeal demonstrate that the Member understood both the nature of and basis for First State's decision" and attempts to bootstrap an otherwise defective notice into one that is consistent with the mandates of both federal and state regulations.

The court, in *Weaver v. Colorado Department of Social Services*, 791 P.2d 1230, 1233, sets forth that if there is a requirement that an administrative notice make reference to specific regulation(s) involved in making their determination, a notice that fails to comply with such a requirement renders the notice ineffective, even if the interested party participates in the hearing. (Citations omitted). In addition, the court noted that, "The constitutional adequacy of a pre-denial notice cannot be tested on a subjective basis; its validity for due process purposes is dependent upon its adequacy in providing the necessary information to a reasonable person. *Id.*

In this case, First State's December 20, 2000 letter is entitled "Service Denial." The text of the letter goes on to state, that the reason they are denying physical therapy 1 time per week is

that, "a review of the physical therapy progress notes reflect the patient to be at her maximum level of functioning with no significant improvement noted." The letter further adds, First State Health Plan will continue to authorize physical therapy 1 time per week to evaluate and maintain current level of function in coordination with home health aide range of motion exercises and daily home exercise program."

Importantly, there is no citation to any regulation, but merely a conclusory sentence stating that, "Therefore, First State Health Plan will not pay for physical therapy 1 time per week due to not being medically necessary." It is not until the March 9, 2001 letter, upholding the initial reduction in services, that First State, for the first time, sets forth a citation to the medical necessity guidelines it has allegedly relied upon in reducing services.

Moreover, it is important to note that First State maintains that this action is not a reduction of-service case, notwithstanding that the practical and logical effect of the "Service Denial" letter of December 20, 2000 is to reduce the Appellant's physical therapy (especially passive stretching) from twice per week to once per week. First State does not dispute that the Member needs and benefits from some forms of physical therapy services including passive stretching, but states that, "the sole issue presented by this fair hearing is who is the most appropriate provider of the services." (Exhibit 10). That language, provided in First State's letter of June 19, 2001, is not a reasonable or even logical interpretation of their "Service Denial" letter of December 20, 2000. This is especially true in light of the testimony by First State's Medical Director, that passive stretching exercises are indicated and that a home health aide is not allowed to perform these services. The crux of First State's testimony and position is that the Appellant's husband should be performing the passive stretching exercises on his wife in lieu of the physical therapist. By making this statement, First State admits that the reason given for the "Service Denial" on December 20, 2000, is *not accurate*. By their own testimony, it is not that physical therapy services are not medically necessary, as indicated in the "Service Denial," but a question of who will provide those services.

The Department of Health and Social Services ("DHSS"), and thus First State as agent for DHSS, are under an order of the United States District Court for the District of Delaware, which prohibits DHSS from denying federal public assistance without providing adequate notice of the action the agency proposes to take. (*See, Ortiz v. Eichler*, 794 F.2d 889 (3rd Cir.1986)). (Emphasis added).

The Court's order is implemented by DSS in DSSM 5301. The reduction in services letter dated December 20, 2000 (Exhibit 9) does not comply with either the Court's order or the requirements of DSSM 5301 because it does not contain adequate information to allow the Appellant to determine from the notice alone, the accuracy or validity of the agencies intended action. The benefit of citing to the authority, whether it be a regulation, policy or otherwise, is that a beneficiary can review the source of the authority and determine whether the authority has been correctly applied. Requiring a reference to the authority supports the guiding principle identified in *Ortiz, supra*, that the notice provide enough information for the beneficiary to determine the accuracy of the decision from the notice alone.

Since the notice in this case did not comply with the constitutional or regulatory standards for such notices, First State had no authority to reduce Appellant's physical therapy services.

VIII.

Necessity of Face-to-Face Assessment

Appellant maintains that as a condition precedent to termination or reduction of services, the MCO is required to conduct a timely face-to-face assessment of the patient. They base this contention on the January 27, 2000 Medicaid Policy Letter attached as Exhibit "A" to Exhibit 1. This letter, in pertinent part, states:

"...the MCO, or one of its Agencies (i.e.; a Home Health Agency) must conduct a face to face meeting and/or assessment, preferably at the site the care is given, with the Medicaid recipient or a parent." (Emphasis added)

Appellant reads into this policy letter a requirement that is not present. Appellant asserts, through her post-hearing letter of July 12, 2001 (Exhibit 11), that an MCO or one of its Agencies be directed to perform an assessment of the appropriateness of a reduction in services. The policy does not require this action, only that a face-to-face assessment take place. In this case, the Physical Therapist, Ed Shubert, MPT, was providing regular and timely assessments of the Appellant. While First State may not have properly utilized those assessments, which is a separate issue, there is no question that a timely face-to-face assessment has been performed.

IX.

Failure to Make a Prima Facie Case

Next, Appellant maintains that First State has failed to establish that there was a change in the Member's medical condition or needs prior to reducing the Member's physical therapy authorization to one visit per week. This contention defies the nature of the ALS disease process as well as the position and acknowledgement by the Appellant that the Appellant's condition has, in fact, deteriorated (which is ongoing and part of the disease process). In fact, while Appellants maintain that in order, "To justify termination of benefits, the MCO generally must rely on a change in the law or in the Appellant's *improved* medical condition," (Emphasis added) this reading is inconsistent with the requirements under the law.

The basis for the rule, which requires that Medicaid benefits can not be terminated or reduced absent a *demonstration of a change in circumstances* or other good cause (*See, Collins v. Eichler*, C.A. Mo. 90A-JL2 (Del.Super.1991)(Emphasis added), is the protection of the Appellant's property interest in medical care from arbitrary decisions by the state Medicaid offices and their agents. In this case, there is a clear and undisputed change in the Appellant's medical condition, although her treatment goals and needs may not have changed. Since it is admitted by Appellant that her disease process necessarily includes a naturally occurring

deterioration, and that in fact, her condition has changed since the original authorization for twice per week physical therapy services, First State has met its burden of proving that there was a change in circumstances.

While the burden of proof issue may have been met with respect to the change in circumstances, the analysis is not complete. First State must also show how they arrived at the conclusion that the services originally authorized for the Appellant are no longer medically necessary. This they cannot do.

Initially it must be noted that First State objected to the introduction of the Appellant's Home Health Certification and Plan of Care records dating back to July 2000 (Exhibit 7) and a packet of other medical records, including VNA Therapist Daily Report of Visit sheets and Christiana Care Visiting Nurse Association Physical Therapy Visit Notes dating back to October 1999 (Exhibit 8). First State maintains that this is the first time they have seen these records and that these records were not utilized in making the initial reduction determination. Specifically, First State cites their denial letter of December 20, 2000, which states, "Please be sure to give us all of the information you have to support your appeal. When you write, please send copies of all letters, medical records or forms to us to help solve any problems and evaluate your appeal", to support their objection to the introduction of these documents. That objection is over-ruled.

The fact that First State maintains this is the first time they have seen these documents is beyond belief. These documents, prepared by agencies performing therapy and on-going assessments of the Appellant for First State, and integral to the care and management of the Appellant, would have had to have been both in the possession of First State and reviewed in order to make the determination to reduce physical therapy benefits to the Appellant. These records served as the basis for continued authorization of service up until the time services were reduced to once per week.

Dr. Riccardi, Medical Director for First State and also a licensed physical therapist, testified that the purpose of physical therapy was to maintain the patient's function, position and comfort, and to prevent further losses. She states that her review of the progress notes, physician notes (Exhibits 2 & 3) and her general knowledge of the disease lead to her conclusion that once per week physical therapy, including passive range of motion and passive stretching were indicated. While there is no question that the Appellant has, over time, continued to deteriorate, the treating physical therapist and her primary care physician both certified that twice per week physical therapy was the appropriate course of treatment. While the primary care physician did not see the patient regularly, he was continuously provided with progress notes from the physical therapist, the very same documents that First State maintains that they saw for the first time at the hearing. Moreover, the Appellant's treatment goals did not change over time, they were and continue to be maintenance related, as no improvement is expected. Dr. Riccardi testified that she never examined the Appellant.

At a minimum, "due process requires that government officials refrain from acting in an irrational, arbitrary or capricious manner." (*Mayer v. Wing*, 922 F.Supp. 902, 911 (S.D. New York 1996)). Here, the Appellant received a notice to reduce her physical therapy benefits while

in a worse condition than when benefits were initially authorized, and was provided with no explanation of why she was assessed differently this time. The question here remains; based upon what information did First State determine that benefits were no longer necessary to the extent previously provided. Information that became available after the initial determination is irrelevant in deciding whether the initial denial notice complied with the mandates of due process. A review of this information indicates that First State's decision is not consistent with the requirements of due process.

Here, it is admitted by all parties that the Appellant's condition has worsened since the time of the initial authorization for twice per week physical therapy services. It is also admitted by First State that passive stretching is indicated in this case, so as to prevent further contractures and to minimize muscle spasticity. Finally, it is stipulated that a Home Health Aide is not permitted to perform passive stretching on the Appellant. First State maintains that Ed Shubert, the Appellant's physical therapist, should have instructed the Appellant's husband on passive stretching techniques to be performed under his indirect supervision so as to alleviate the need for First State to provide a physical therapist more than once per week. As such, First State is maintaining that the physical therapy services that they reduced in their letter of December 20, 2000 (Exhibit 9) are actually necessary, only not to the extent previously enjoyed by the Appellant, as they believe an unskilled and unlicensed party can provide the appropriate level of service. They further maintain that this result is based upon an analysis of the Appellant's medical records. These records indicate that there is no change in the treatment plan for the Appellant based upon the physical therapist and primary care physician's notes and orders. Because these medical records do not indicate that a change in services is indicated and First State failed to produce any documentation whatsoever upon which they relied in making their determination, it would appear that First State's decision to reduce physical therapy benefits was both arbitrary and irrational.

The court in *Eichler v. Collins, supra*, noted that,

"... it is clear that in administrative hearings a finder of fact *must* give more weight to evidence from treating physicians than to evidence from reviewing physicians," (Emphasis added).

In this case, the progress notes and physician notes First State should have relied upon show no change in treatment plan or goals of therapy that would justify First State's reduction of physical therapy benefits to the Appellant. Due process demands that decisions affecting government benefits be made according to "ascertainable standards" that are applied in a rational and consistent manner. *Mayer v. Wing, supra* at 911. Here, there are simply no ascertainable standards articulated by First State.

A review of the testimony and documentary evidence dictates that First State has failed to provide a reasonable or rational basis for its' decision to deny authorization for payment for twice per week physical therapy services. Since First State's decision to reduce physical therapy benefits to once per week does not comply with the protections afforded under due process the decision to reduce authorization to once per week physical therapy is not sustained on the record.

X.

For these reasons, the decision of First State to deny authorization for payment of twice per week physical therapy services for A: _____ is REVERSED.

Date: September 7, 2001

Michael L. Steinberg/vmd
MICHAEL L. STEINBERG
HEARING OFFICER

THE FOREGOING IS THE FINAL DECISION OF THE DIVISION OF SOCIAL SERVICES

SEP 12 2001

POSTED

MLS/vmd

cc: Jennifer Gimler Brady, Esq., for First State
Laura J. Waterland, Esq., counsel for A

EXHIBITS FILED IN OR FOR THE PROCEEDING

EXHIBIT #1 – Memorandum of Points and Authorities in Opposition to Reduction of Denial of Twice-Weekly Physical Therapy Services, consisting of 30 pages, dated June 5, 2001.

EXHIBIT #2 – Copy of Appellant's medical records consisting of 22 pages, by facsimile transmission dated December 12, 2000.

EXHIBIT #3 – Copy of Appellant's medical records consisting of 12 pages, by facsimile transmission dated January 31, 2001.

EXHIBIT #4 – Copy of Appellant's medical records (progress record) consisting of two (2) pages from Dr. Bean.

EXHIBIT #5 – Copy of one page letter from primary care physician, Khaja Yezdani, M.D., dated February 2, 2001.

EXHIBIT #6 – Copy of Case Management Worksheet consisting of 12 pages.

EXHIBIT #7 – Copy of multiple Home Health Certification and Plan of Care documents, consisting of 14 pages.

EXHIBIT #8 – Copy of VNA Therapist Daily Report of Visit and other medical records, consisting of 16 pages.

EXHIBIT #9 – First State Fair Hearing Summary consisting of ten (10) pages dated April 6, 2001. This is admitted as a business record pursuant to s. 5312 of the Division of Social Services.

EXHIBIT #10 – Copy of post-hearing argument by First State in reply to Memorandum of Points and Authorities in Opposition to Reduction of Denial of Twice-Weekly Physical Therapy Services, dated June 19, 2001.

EXHIBIT #11 – Copy of reply by Appellant to post-hearing argument by First State in reply to Memorandum of Points and Authorities in Opposition to Reduction of Denial of Twice-Weekly Physical Therapy Services, dated July 12, 2001.

IN THE SUPERIOR COURT OF THE STATE OF DELAWARE
IN AND FOR KENT COUNTY

E. V. L
As next friend of C. L.
Appellant,

v.

DEPARTMENT OF HEALTH
AND SOCIAL SERVICES

Appellees.

C.A. No. 02A-09-002 HDR

Submitted: December 19, 2003
Decided: February 25, 2004

E. V. L., Marydel, Delaware, *pro se*.

A. Ann Woolfolk Esq., DAG, Wilmington, Delaware, for Appellee DHSS.

OPINION

Upon Appeal from a Fair Hearing Decision
of the Department of Health and Social Services
REVERSED

RIDGELY, President Judge

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02A-09-002 HDR
February 25, 2004

This is an appeal by the Claimant from a 'fair hearing' decision of the Department of Health and Social Services denying Medicaid benefits for orthodontic treatment of a minor child. Because the procedural due process requirements for notice and a fair hearing were not met, the decision of the hearing officer must be reversed and this matter remanded for the fair hearing required as a matter of law.

I. BACKGROUND

E. L., mother of C. L., contacted the Delaware Health and Social Services (hereinafter "DHSS") clinic concerned that her daughter may need orthodontic treatment. C. L. is eligible for Medicaid benefits. She was referred for an evaluation by the clinic's dentist to an orthodontist, Dr. Robert Kidd. Dr. Kidd examined C., took X-rays, and made molds of her teeth. Dr. Kidd then determined that C. needed orthodontic treatment and concluded that this treatment was necessary to avoid future skeletal problems. He diagnosed a Class 1 malocclusion. However, state guidelines require orthodontic treatment only when medically necessary to correct a "handicapping" malocclusion.¹

On July 16, 2002, E. L. received a letter from DHSS denying benefits for Crystal declaring that her condition was neither handicapping nor health threatening. Ms. L. requested a second independent consultation. Upon her request, DHSS sent C.'s records, X-rays, and molds to another orthodontist, Dr.

¹ DE ADC 40 800 108, § 5124(2)(b) (WESTLAW) (1990) *The Early Periodic Screening, Diagnosis, and Treatment Manual* (hereinafter "EPSDTM"); See also 42 C.F.R. § 441.56 (1984).

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Stephanie Steckel. Dr. Steckel did not examine C but based her diagnosis on the information provided by Dr. Kidd. She concurred with Dr. Kidd's evaluation of a Class 1 malocclusion.

On March 25, 2002 a second letter denying orthodontic treatment for C was sent by DHSS to E. L. This letter stated denial was based on failure to fall within Medicaid orthodontic guidelines of handicapping or health threatening. Ms. L. filed a request for a 'fair hearing' on June 20, 2002. A hearing was set for August 16, 2002.

DHSS made a Motion for Summary Judgment on August 1, 2002 for failure of the Appellant to show cause that she was harmed by the agency's action because no benefits had been conferred and then removed. The motion was denied by the Hearing Officer. On August 2, 2002, DHSS filed a Motion to Dismiss. This motion was also denied by the Hearing Officer.

At the August 16, 2003 hearing neither Dr. Kidd, nor Dr. Steckel were present or available for cross-examination or inquiry by Ms. L. In addition, the hearing transcript indicates that each time Ms. L. attempted to present her argument that C's treatment was medically necessary she was interrupted and her concern dismissed.

DHSS contends that the procedural defects of notice are outweighed by the fact that orthodontic treatment would be denied whether or not proper notice was given and that the 'fair hearing' fully explains all denial of benefits and that no harm has been done in that treatment has not begun.

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A final denial of benefits was issued by the Hearing Officer on August 22, 2002 stating that since neither Dr. Kidd nor Dr. Steckel found that the Claimant had a handicapping malocclusion and since the Claimant did not offer documentary or testimonial evidence from professionals to contradict these findings, the coverage was denied. This appeal follows.

II. STANDARD OF REVIEW

The Delaware Social Services Manual (hereinafter "DSSM") Section 5405(5) provides that the decision of the Hearing Officer is the final decision of DHSS. That decision is subject to judicial review pursuant to 31 *Del. C.* § 520. The statute provides:

Any applicant for or recipient of public assistance benefits under this chapter or Chapter 6 of this title against whom an administrative hearing decision has been decided may appeal such decision to the Superior Court if the decision would result in financial harm to the appellant. The appeal shall be filed within 30 days of the day of the final administrative decision. The appeal shall be on the record without a trial de novo. The Court shall decide all relevant questions and all other matters involved, and shall sustain any factual findings of the administrative hearing decision that are supported by substantial evidence on the record as a whole. The notice of the appeal and all other matters regulating the appeal shall be in the form and according to the procedure as shall be provided by the rules of the Superior Court.

The appropriate standard of review is whether the decision of the Hearing

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Officer is supported by substantial evidence and free of legal error.² The Superior Court reviews the de novo application of the law by DHSS in determining the qualifications of the applicant for assistance through the Medicaid program.³ If the procedure of eligibility determination is legal, the Court proceeds to the question of sufficiency of the evidence to support the decision.⁴ Thus, the analysis begins with a review of the procedure applied in making the determination of eligibility before any substantive evidence is analyzed.⁵ In its review, the Court shall decide all relevant questions and matters involved.⁶ The Court will sustain any factual findings of the Hearing Officer that are supported by substantial evidence in the record as a whole.⁷ This Court may not remand on appeal a case brought to it under 31 *Del. C.* § 520 for further findings as the statute does not grant the Court that power.⁸

² *Bowden v. Delaware Department of Health and Social Services Division of Social Services*, 1993 WL 390480 at *2 (Del. Super. Ct. 1993).

³ *Id.*

⁴ *Id.* See also, *Zdziech v. Delaware Department of Health and Social Services*, 2000 WL 1211562, at *2 (Del. Super. Ct. 2000).

⁵ *Id.*

⁶ *Dean v. Delaware Department of Health and Social Services*, 2000 WL 33201237, at *3 (Del. Super. Ct. 2000).

⁷ *Id.*

⁸ *Collins v. Eichler*, 1991 WL 53447, at *4 (Del. Super. Ct. 1991).

III. DISCUSSION

The Medicaid program was established in 1965 to provide federal funds to help the needy pay for their medical treatment.⁹ The federal government shares the cost of Medicaid with states that elect to participate in the program.¹⁰ In return for federal funds, the state must comply with requirements imposed by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396r.¹¹ To be valid and enforceable, the state criteria must comply with the federal eligibility guidelines.¹²

In Delaware, the Medicaid program is generally overseen by DHSS.¹³ Delaware has opted to participate in the Supplemental Security Income for the Aged, Blind and Disabled (hereinafter "SSI") and offers additional coverage under an optional categorically needy provision.¹⁴ Under this program, individuals who qualify or receive SSI are automatically eligible for Medicaid while other applicants must meet additional state and federal requirements.¹⁵ Title XIX of the Social Security Act also requires participating states to provide early and periodic screening,

⁹ *Dean*, 2000 WL 33201237, at *3.

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

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diagnosis and treatment, to eligible individuals under the age of 21 years.¹⁶ This is known as the Early Periodic Screening, Diagnosis and Treatment Program ("EPSDT"). Regulations of the United States Department of Health, Education and Welfare (HEW) promulgated under 42 U.S.C. § 1396(a)(4)(B) require that participating states establish an administrative mechanism to identify available screening and diagnostic facilities and to assure eligible children receive EPSDT services.¹⁷ Under the EPSDT program, children are screened for medical abnormalities by physical examinations and a battery of specified medical tests.¹⁸ Any problems detected by the screening are then treated under the EPSDT program by either the examining physician or by other participating doctors.¹⁹ The federal guidelines for administering this program are set forth in 42 C.F.R. § 441.56. These guidelines require DHSS, to provide upon request, periodic comprehensive child health assessments to eligible EPSDT recipients.²⁰ This screening consists of regularly scheduled examinations and evaluations of general physical and mental health, growth, development, and nutritional status of infants, children and youth.²¹

¹⁶ *Philadelphia Welfare Rights Organization v. Shapp*, 602 F.2d 1114, 1116 (3d Cir. 1979).

¹⁷ *Id.* at 1121-22.

¹⁸ *Id.*

¹⁹ *Id.* at 1116.

²⁰ 42 C.F.R. at § 441.56(b)(1).

²¹ *Id.*

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creates the injury and as such, E L, on behalf on her daughter C, has standing to challenge the denial of orthodontic treatment. DHSS also contends that the violation of procedural and substantive due process in its denial of benefits letters to Ms. L were remedied through the explanation of the reasons for denial during the hearing. However, according to *Goldberg v. Kelly*, a 'fair hearing' after the fact does not alter the result and the violations of due process are not remedied.³³

Procedural due process requires notice to be both adequate and timely. The federal regulations regarding the requirements for notice are set forth in 42 C.F.R. § 431.206. The State regulations for Medicaid are found in DSSM Section 5300. According to the federal regulations, the agency must inform every applicant or recipient in writing of any action affecting his or her claim or when an individual receives an adverse determination by the state with regard to pre-admission screening.³⁴ This notice must include the reasons for the intended action, the specific regulations that support it, or the federal or state law that requires the action.³⁵ Additionally, proper notice must include an explanation of the individual's right to request an evidentiary hearing if one is available or a state agency hearing.³⁶ The state regulations add that the agency's notice must also contain the method by which

³³ *Goldberg*, 397 U.S. at 261.

³⁴ 42 C.F.R. § 431.206(c)(2)&(4) (1993).

³⁵ 42 C.F.R. § 431.210(b)&(c) (1992).

³⁶ *Id.* at § 431.210(d)(1).

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(s)he may request a 'fair hearing' and a statement that (s)he may be represented by counsel or another person.³⁷ Written notice must adequately describe what action the agency intends to take, the reasons for the intended agency action, the specific regulations supporting each action, and an explanation of the individual right to request a 'fair hearing'.³⁸

Notice, in addition to being adequate, must also be timely.³⁹ The state or local agency must mail a notice by certified mail at least ten days before the date of action or ten days before the intended change would be effective.⁴⁰ This ten day notice is to permit all parties to have adequate preparation of the case.⁴¹

All notices must contain information needed by the claimant to determine from the notice alone the accuracy of the Division's action or intended action.⁴² At a minimum all notices must indicate the proposed action to be taken, including denial of benefits; provide citation(s) to the regulation(s) supporting the action being taken, and provide a detailed individualized explanation of the reason(s) for the action being

³⁷ DSSM at § 5300.

³⁸ DSSM at § 5301(1).

³⁹ 42 C.F.R. § 431.211; DSSM at § 5301(2).

⁴⁰ 42 C.F.R. at § 431.211; DSSM at §§ 5302(2), 5311.

⁴¹ DSSM at § 5311.

⁴² DSSM at § 5301(4).

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taken.⁴³ This includes, in terms comprehensible to the claimant, an explanation of why the action is being taken, and if the action is being taken because of the claimant's failure to perform an act required by the regulation, an explanation of what the claimant was required by the regulation to do and why his or her actions failed to meet this standard.⁴⁴

DHSS maintains that these federal and state notice requirements do not apply to C. because the decision as to whether or not the Claimant is entitled to orthodontic services is not an "action" that triggers the notice requirement. DHSS concedes that the notice requirements were not given and that the Claimant was entitled to a "fair hearing." DHSS supports its contention that denial of EPSDT orthodontic services is not an action by claiming that this denial was not a challenge to the recipient's Medicaid eligibility, rather only a finding that the individual services sought were not medically necessary within the meaning of state and federal law.

In *Maheer v. White*, Pennsylvania argued that foster children were not entitled to notice when federal benefits were denied because state benefits automatically kicked in and the children were never negatively affected.⁴⁵ The Eastern District of Pennsylvania found this argument unpersuasive because the fact that federal

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ 1992 WL 122912, at *7. (E.D. Pa. 1992)

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benefits were denied, perhaps wrongfully, gave rise to the requirements of notice and a hearing, regardless of any other benefits conferred.⁴⁶ The Court emphasized that due to the importance of the EPSDT preventive medicine program, it is not only required to have notice of fair hearing opportunities, but there must also be notice of the availability of the program itself.⁴⁷

There is nothing in the applicable regulations which states that a change in services must be "detrimental" for it to constitute an action.⁴⁸ In *Catanzo v. Dowling*, the court held that the "state plan must provide for requisite notice and hearing," and that under Federal regulation, the State Medicaid agency must provide proper notice and the right to a hearing "at any time the Medicaid agency takes any action affecting his claim."⁴⁹ The Court emphasized that the federal regulations could not be any clearer and a state Medicaid agency must comply with these notice and hearing requirements that are federal law conditions of participation in the Medicaid program.⁵⁰

⁴⁶ *Id.*

⁴⁷ *Id.* at *6.

⁴⁸ *Granato v. Bane*, 74 F.3d 406, 412 (2d Cir. 1996), reversing *Granato v. Bane*, 841 F.Supp. 64, 71 (N.D.N.Y. 1994) for the proposition that only a detrimental change constitutes an agency action as defined by 42 C.F.R. § 431.201.

⁴⁹ *Catanzo*, 847 F.Supp. at 1081.

⁵⁰ *Id.* at 1082.

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DHSS cites, *Perry v. Chen*,⁵¹ an Arizona case, to stand for the proposition that federal notice regulations are only required when the amount or type of services are reduced. DHSS claims that the regulations do not create a specific right to notice and a hearing when a particular requested service was not medically necessary.⁵² *Perry* is about Medicaid denials based on lack of medical necessity.⁵³ In *Perry*, the Arizona agency argued that the system would collapse under the increased paperwork for this written notice.⁵⁴ Additionally, the Arizona agency argued that Subpart E of the Medicaid Regulations prescribes the procedures for a fair hearing for applicants and recipients, arguing that notice is only required in eligibility decisions.⁵⁵ In that case, the Arizona agency cited 42 C.F.R. § 431.200 to support the contention that a state must provide opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.⁵⁶ However, the Court pointed out that this view ignores the next sentence of the regulation which prescribes procedures for an opportunity for hearing if the Medicaid agency takes action to suspend,

⁵¹ 985 F.Supp. at 1203.

⁵² *Id.* at 1201.

⁵³ *Id.* at 1199.

⁵⁴ *Id.*

⁵⁵ *Id.* at 1202.

⁵⁶ *Id.*

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terminate or reduce services.⁵⁷ The *Perry* court then defined action under 42 CFR § 431.200 to mean termination, suspension, or *reduction of Medicaid eligibility or covered services* (emphasis added).⁵⁸ The state may place limits on a service based on such criteria as medical necessity but state agencies are required to adopt a hearing system that satisfies the due process standard established by *Goldberg v. Kelly* and additional standards established by the regulations.⁵⁹ The *Perry* Court specifically stated that notice means a written statement meeting the requirements of § 431.210 and that the State must mail a notice at least ten days before the date of the action.⁶⁰ Section 431.210 requires: a) a statement of what action the State intends to take; b) the reasons for the intended action; c) the specific regulation of law that supports the change; d) an explanation of the right to a hearing; e) an explanation of the circumstances under which Medicaid is continued pending the hearing.⁶¹

The Plaintiffs in *Perry* were not advised of their right to appeal nor any of their appeal rights.⁶² The Plaintiff's argued that they were denied any meaningful notice

⁵⁷ *Id.* at 1203.

⁵⁸ *Id.*

⁵⁹ *Id.* citing 42 C.F.R. §§ 440.230(d), 431.205(d)

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.* at 1203-4.

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and an opportunity to challenge an adverse decision.⁶³ The *Perry* Court concluded that the state agency must comply with sufficient written notice and a right to a fair hearing and that these requirements will not cause the system to grind to a halt as the state contends.⁶⁴ These requirements allow beneficiaries to exercise a right that has always been available to them.⁶⁵

Notice and hearing requirements must be met for the state to participate in the Medicaid program. Therefore, DHSS's contention that denial of EPSDT benefits is not an 'action' entitled to federal and state notice requirements is unsupported.

I conclude that the notices sent by letter to E. L. regarding the denial of benefits were not adequate. Both letters merely informed her that benefits were denied because C.'s condition was not handicapping or health threatening. There was no mention of a right to appeal, right to any type of hearing, nor of any citations to any regulation or guideline. The only information given was a phone number to call if there were any questions.

Federal Regulation, 42 C.F.R. § 431.220, which implements Section 1902(a)(3) of the Social Security Act, requires a state to provide an opportunity for a 'fair hearing' to any person who's claim for assistance is denied, not acted upon promptly,

⁶³ *Id.* at 1204.

⁶⁴ *Id.*

⁶⁵ *Id.* at 1205.

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or who believes the agency has taken action erroneously.⁶⁶ The State regulations add that the request for this 'fair hearing' must be made in a clear written expression stating that the appellant wishes to present his/her case to a higher authority.⁶⁷ Only those issues presented in the appellant's request for 'fair hearing' may be presented for the hearing officer's review.⁶⁸ Upon learning of her right to a 'fair hearing', E. La. filed her request. DHSS contends that a fair hearing occurred and therefore it is irrelevant that the prior due process violations occurred. However, even if a later constitutionally fair proceeding occurred, that will not alter a procedural due process violation that preceded the hearing.⁶⁹

Once the request for a 'fair hearing' is received, the agency shall prepare and submit a hearing summary to the Hearing Officer within five working days.⁷⁰ The hearing summary must be easily read and understood and include in concise statements all actions being appealed as well as citations to the policy upon which the decision is based.⁷¹ It must also include the names and addresses of all persons that

⁶⁶ 42 C.F.R. § 431.220(a)(1)&(2) (2002).

⁶⁷ DSSM at § 5304.

⁶⁸ *Id.*

⁶⁹ *Goldberg*, 397 U.S. at 261.

⁷⁰ DSSM at § 5312(4).

⁷¹ *Id.*

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the agency expects to call to testify.⁷² Once the report/summary is received it is recorded and forwarded immediately to the hearing officer.⁷³ The hearing officer will then review the hearing summary, set a prompt date for the hearing, and send a notice to all parties and witnesses stating the date, time and place of the hearing.⁷⁴

E. L. received notice by certified mail of this hearing on August 6, 2002. This was nearly sixty days after the 'fair hearing' was requested on June 20, 2002. Yet, state guidelines mandate that within five working days of receiving the request for a 'fair hearing', the agency, DHSS, will prepare the 'fair hearing' summary that will be forwarded to the hearing officer who upon receipt will set a date and notify all parties.⁷⁵ In addition, the notice received of the 'fair hearing' was neither dated nor signed, although the hearing transcript indicates that the notice was issued August 1, significantly later than five days after request. The date of the hearing was also set in violation of the requirements mandated by both federal and state law. The hearing was scheduled for August 16, nine days after receipt of notice of the hearing. Both federal and state law require a minimum of ten days notice.⁷⁶

As a general rule, procedural due process requirements are flexible, requiring

⁷² *Id.*

⁷³ *Id.* at § 5312(5).

⁷⁴ *Id.*

⁷⁵ *See id.* at § 5312(4).

⁷⁶ DSSM at § 5311.

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a balancing of interests.⁷⁷ The United States Supreme Court in *Mathews v. Eldridge*, gave a three factor balancing test to consider in reaching a decision as to the extent of due process.⁷⁸ These factors are: 1) the private interest at stake for the individual, 2) the risk of erroneous deprivation of that interest by the official procedures used as well as the probable value of additional or different procedural safeguards and 3) the interest of the government including fiscal and administrative burdens in using the current procedures rather than additional or different procedures.⁷⁹ Although due process is flexible, Congress has spoken and tipped the scales in favor of the private interest through 42 C.F.R. § 431.205 which mandates compliance with the standard set forth in *Goldberg v. Kelly* for a 'fair hearing' before the agency.⁸⁰ Additionally, the DSSM defines a 'fair hearing' as an administrative hearing held in accordance with the principles of due process which include: Timely and adequate notice; the right to confront and cross-examine adverse witnesses; the opportunity to be heard orally; the right to an impartial decision maker and the opportunity to obtain counsel.⁸¹

The Appellant must have the following opportunities at the 'fair hearing': the

⁷⁷ *Perry*, 985 F. Supp. at 1254.

⁷⁸ *Mathews v. Eldridge*, 424 U.S. 319, 334 (1976).

⁷⁹ *Id.* at 334-35.

⁸⁰ *Perry*, 985 F. Supp. at 1203-04.

⁸¹ DSSM at § 5000.

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appellant may examine the case records and documents; present his or her case by him/herself or with the aid of representative or counsel; may bring witnesses, cross examine witnesses and submit evidence as well as establish all pertinent facts and circumstances.⁸² The appellant has the right to advance any argument without interference and may question or refute testimony or evidence.⁸³

The hearing transcript here reveals that each time Ms. L. attempted to raise an argument regarding the medical necessity of her daughter's condition she was interrupted and the argument dismissed. In addition, when Ms. L. wished to address the possibility of exceptions to the EPSDT rating that allow payment of orthodontic benefits, as indicated at the bottom of the Handicapping Labiolingual Deviation (HLD) Index sheet, she was told by DHSS that no such exceptions exist in the Federal EPSDT guidelines. No one addressed the exceptions on the scoring sheet. Yet, the state guidelines on due process require *all* concerns to be addressed in the 'fair hearing'.⁸⁴

DHSS contends that despite the procedural defects there is ample evidence in the record to support a lack of medical necessity for the orthodonture because the condition was not a handicapping malocclusion. EPSDT services which are mandatory, must at a minimum include relief of pain, infections, restoration of teeth

⁸² *Id.* at § 5404.

⁸³ *Id.*

⁸⁴ DSSM at § 5404 (2000).

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and maintenance of dental health.⁸⁵ Medical necessity may exist even if the scale on the index used by the orthodontist fails to indicate a handicapping malocclusion.⁸⁶ The fact that a malocclusion interferes with a patient's ability to chew and talk would show that orthodontic treatment was medically necessary.⁸⁷

IV. CONCLUSION

In conclusion, the procedural due process requirements established by the United States Supreme Court in *Goldberg v. Kelly*, as well as the federal requirements of 42 C.F.R. § 431 and the State requirements set forth in DSSM section 5000 were not followed in this case. The 'fair hearing,' itself, also violated the standards set forth in *Goldberg v. Kelly* as well as the federal and state Medicaid requirements for a 'fair hearing.' Because the procedural due process requirements were violated, the decision of the hearing officer must be REVERSED. This matter is REMANDED.

⁸⁵ DE ADC 40 800 108 (2003).

⁸⁶ *Chappell v. Bradley*, 834 F.Supp. 1030, 1034-35 (N.D. Ill. 1993).

⁸⁷ *Id.*

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for a new hearing consistent with this opinion.

IT IS SO ORDERED.

/s/ Henry duPont Ridgely
President Judge

dk
cc: Prothonotary
xc: Order distribution