Delaware Health and Social Services

Delaware Diamond State Health Plan Plus
Concept Paper

for

A Waiver Amendment Request Submitted Under Authority of
Section 1115 of the Social Security Act

to

The Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

State of Delaware

Rita Landgraf, Secretary
Delaware Department of Health and Social Services (DHSS)

Rosanne Mahaney, Division Director
Division of Medicaid & Medical Assistance (DMMA)

May 2011

Table of Contents

SECTION 1: BACKGROUND

The State of Delaware (Delaware or State), like the United States as a whole, is steadily aging. Delaware's population age 65 and older is expected to increase by 91 percent between now and 2030, with the number of people age 85 years and older expected to more than double. Whereas in the nation as a whole the older population (aged 65+) grew by 10 percent between 1996 and 2006, Delaware's older population grew by about 24 percent. The numbers are even more significant for certain subpopulations, for example, the number of persons in Delaware's southern-most county is expected to quadruple in the 30-year span between 2000 and 2030. As people age, there is a higher proportion of expensive chronic conditions (e.g., heart disease, diabetes, hypertension), a higher probability for a disability, and a corresponding increase in the use of and need for health-related services and supports. At the same time, there will be fewer economically active individuals and workers to either provide direct care services or indirectly support state and federal programs through payroll and other taxes. Delawareans want to have alternatives to choose from when it comes to receiving long-term services and supports.

Currently, for the elderly, Delaware spends nearly all of the associated Medicaid long-term care (LTC) dollars on institutional care, with less than 10 percent being directed to community-based alternatives for this population. This ranks Delaware near the bottom amongst all states. Delaware realizes this dichotomy needs to change and priority must be given for the State to develop more community-based alternatives for Medicaid long-term services and supports in lieu of institutionalization.

Cost of Care – Community versus Institutional

- It is widely accepted that, measured on an average per person basis, the cost of serving a Medicaid consumer in their home or community is generally much less than the average cost of nursing home-based care (although community-based care for some individuals, especially those with disabilities, can exceed the cost of institutionalization). Whereas the annual average cost of nursing home care can be well over $50,000, or in Delaware closer to $80,000, a person who is able to be served in their home or community can average less than half this amount. One study indicated a 63 percent reduction in per person spending for a nursing facility waiver program as compared to institutionalization[1]. Expressed in other ways, for the annual cost of one nursing home stay, two to three people can be served in their home or community.

[1] Kitchener, M., Ng, T., Miller, N., & Harrington, C.; Institutional and Community-Based Long-Term Care: A Comparative Estimate of Public Costs; Journal of Health & Social Policy, Vol. 22(2), 2006.

A survey conducted in December 2008 of 1,000 Delaware residents age 35 and older found the following opinions and concerns[2]:

- 42 percent thought it likely that either they or their family member will need LTC services in the next five years.
- 50 percent are not very or not all confident in their ability to afford the annual $81,000 cost of a nursing home in Delaware.
- 51 percent of respondents with incomes less than $50,000 a year say they plan on relying on government programs to pay for their LTC.

In December 2009, the percentage of all nursing facility residents for which Medicaid was the primary payor was just under 57 percent, representing about 2,421 Medicaid residents[3]. The 2,421 Medicaid nursing facility residents translates into a 1.8 percent prevalence rate of institutionalization among Delaware's elderly age 65 and older. Assuming a constant rate of institutionalization, by year 2030 the number of nursing home residents paid by the Division of Medicaid and Medical Assistance (DMMA) will increase to 4,626. On an annualized cost basis, this translates into well over $150 million more in new Medicaid-funded nursing home stays, or a combined total of over $320 million spent on nursing homes per year. This also assumes the annual cost of nursing home services remains static at $70,000; it may be more realistic to assume the cost of care will gradually increase over time and thus push institutional spending to even higher levels.

Consumer Preference – Community versus Institutional

Similar to the previous section on cost of care, virtually all surveys and studies of consumers indicate the same result: people prefer to remain in their homes and communities as compared to being institutionalized. The desire to avoid isolation in institutions and to be active participants in the community has led many individuals with LTC needs and their families to advocate for opportunities to receive care in a variety of settings[4]. Despite their preferences, consumers may be directed toward institutional care because home care services are neither readily available nor easily accessible, or because it is an easier placement for health care professionals[5].

The December 2008, Delaware survey of residents age 35 and older also found:

- 72 percent believe it is extremely or very important to remain in their current residence for as long as possible.

---

[2] The Road Ahead: AARP Survey on Community Services in Delaware, March 2009.

[3] American Health Care Association, compilation of OSCAR data, December 2009.

[4] Summer, L.; Strategies to Keep Consumers Needing Long-Term Care in the Community and Out of Nursing Facilities, Kaiser Commission on Medicaid and the Uninsured, October 2005, Report #7402.

[5] Long-Term Care Reform Leadership Project, Shifting the Balance: State Long-Term Care Reform Initiatives, Issue Brief No. 1 of 5, February 2009.

- 86 percent believe that it is either extremely or very important to have LTC services that would enable them to stay in their homes as long as possible.
- 74 percent prefer to receive services in their home; only 3 percent reported a desire to live in a nursing home as they age.

These numbers are indicative of why Delaware is seeking to improve access to community-based services for those in their State through a more integrated model of LTC.

SECTION 2: CURRENT ENVIRONMENT and INITIATIVES IN DELAWARE

Delaware's existing Section 1115 demonstration, Diamond State Health Plan (DSHP), has authorized a statewide, mandatory Medicaid managed care program since 1996. Using savings achieved under managed care, Delaware expanded Medicaid health coverage to additional low-income adults in the State, as well as an expansion of family planning services to women. The goals of the program are to improve and expand access to healthcare to more adults and children throughout the State, create and maintain a managed care delivery system emphasizing primary care, and to strive to control the growth of healthcare expenditures for the Medicaid population. Dual eligibles and individuals receiving institutional and home- and community-based services (HCBS) are currently excluded from DSHP and managed care enrollment. These individuals are currently served through DMMA's Medicaid fee-for-service (FFS) program and through three Section 1915(c) waiver programs. Virtually all populations and services comprising LTC are carved out of the current Section 1115 demonstration waiver and delivered through the FFS model.

Money Follows the Person (MFP) demonstration

Together with the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD – see page 8), DMMA was awarded a federal demonstration grant in 2007 to assist with the infrastructure necessary to continue and expand nursing home-to-community transition efforts. From 2008 to 2010, 36 clients were transitioned from institutions to the community. With the extension of the MFP program until 2016, DMMA/DSAAPD intends to transition a total of 231 clients under the MFP program.

Delaware Aging and Disability Resource Center (ADRC)

DSAAPD and partner agencies have developed a statewide, comprehensive ADRC in Delaware. The ADRC is a one-stop access point for aging and disability information and resources. The ADRC provides information and assistance, options counseling, and service enrollment support for older persons and adults with physical disabilities throughout the State.

Care Transitions

Delaware is undertaking major initiatives to strengthen transitions between care settings in order to improve health outcomes and promote individual choice. Specifically, DSAAPD is partnering with hospitals and other organizations to build upon existing discharge planning strategies to reduce hospital readmissions and to prevent unnecessary nursing home placements. In addition, the ADRC has taken a lead role in providing options counseling services to applicants of State-run LTC facilities in order to explore community-based care opportunities. Finally, several entities, including the ADRC, the Delaware MFP program, and a State-funded nursing home transition program, are working together to provide support to nursing home residents who express an interest in relocating to community residences. This initiative includes an

independent assessment of the current residents of the five facilities operated by the DHSS to determine each person's support needs and interest in transitioning to the community.

Program of All-Inclusive Care for the Elderly (PACE)
Delaware intends to offer a new PACE program option under the Medicaid state plan. Although PACE will not be part of this demonstration proposal, it will be another option that DMMA believes will increase HCBS options and enhance the LTC delivery system.

Medical Homes and Health Homes
Delaware is undertaking an initiative to develop enhanced models of care coordination for Medicaid individuals. Delaware has an active Medical Home committee that is considering multiple models of medical homes and the expanded health homes available under Section 2703 of the Affordable Care Act.

Balancing Incentives
Upon release of the application requirements from CMS, Delaware anticipates applying for the State Balancing Incentive Payments made available under Section 10202 of the Affordable Care Act.

SECTION 3: PROPOSAL

The current DSHP Section 1115 demonstration is designed to use a managed care delivery system to increase access to high-quality health care for Medicaid enrollees of the demonstration. Since 1995, Delaware has utilized the savings garnered from this more efficient delivery system to expand Medicaid coverage to more than 32,000 adults with income at or below 100 percent of the Federal Poverty Level (FPL).

Delaware now seeks to build upon this success by seeking an amendment to its DSHP Section 1115 demonstration project in order to integrate primary, acute, and LTC services for the elderly and persons with physical disabilities into the DSHP statewide program under the name "Diamond State Health Plan Plus." DMMA is proposing to leverage the existing DSHP 1115 demonstration by expanding it to include full-benefit dual eligibles, individuals receiving institutional LTC (excluding the developmentally disabled population), and individuals enrolled in DMMA's Elderly and Disabled and AIDS Section 1915(c) waivers. This presents opportunities for new and innovative solutions to serving these vulnerable populations through an integrated LTC delivery system. Delaware is requesting an October 1, 2011 amendment approval date with DSHP Plus to be operational on April 1, 2012.

The goals of DHSP with the addition of DSHP Plus are:

- Improving access to health care for the Medicaid population, including increasing options for those who need LTC by expanding access to HCBS.
- Rebalancing Delaware's LTC system in favor of HCBS.
- Promoting early intervention for individuals with or at-risk for having LTC needs.
- Increasing coordination of care and supports.
- Expanding consumer choices.
- Improving the quality of health services, including LTC services, delivered to all Delawareans.
- Creating a budget structure that allows resources to shift from institutions to community-based services.
- Improving the coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles.
- Expanding coverage to additional low-income Delawareans.

SECTION 4: DIAMOND STATE HEALTH PLAN PLUS PROGRAM DESIGN and IMPLEMENTATION

A. Overview

Under DSHP Plus, Delaware proposes to:

- Expand mandatory Medicaid managed care to the elderly and persons with physical disabilities not currently enrolled in DSHP.
- Integrate Medicaid primary, acute, and LTC (institutional and HCBS) for Medicaid enrollees in need of institutional and home- and community-based LTC services.
- Enhance the existing HCBS benefit package if financially feasible.
- Incentivize managed care organizations (MCOs) to expand HCBS options for the elderly and physically disabled population.
- Revise the current level of care (LOC) review tool to require that anyone who is newly entering a nursing facility need assistance with at least two activities of daily living (ADLs) rather than the current minimum requirement of assistance with one ADL. (DMMA recognizes that this request may necessitate additional discussion with CMS around the Affordable Care Act (ACA) maintenance of effort requirements.)
- Continue the current LOC criteria for individuals requesting HCBS to require assistance with only one ADL.
- Develop one or more health homes under the Section 2703 ACA option to enhance integration and coordination of care for DSHP enrollees, including enrollees of DSHP Plus.
- Explore the option of requiring the current Medicaid MCO contractors to become Medicare Special Needs Plans in the 2013 Medicare Advantage plan year.
- Explore ways to expand and integrate community-based mental health services for DSHP and DSHP Plus enrollees through options such as the Section 1915(i) state plan amendment and Section 2703 health home options. (Options for the expansion of community-based mental health services that can be successfully integrated with primary and LTC services are currently being considered on a separate, but coordinated, track with this 1115 demonstration amendment.)

B. Participating Divisions and Programs

Delaware's Medicaid LTC program is currently operated out of multiple divisions within Delaware Health and Social Services' overall organizational structure. There are no Area Agencies on Aging (AAAs) in Delaware and funding for Medicaid services is managed at the State level.

Delaware Health and Social Services (DHSS)

DHSS is the Medicaid single State agency in Delaware. DHSS includes 12 divisions, which provide services in the areas of public health, social services, substance abuse and

mental health, child support, developmental disabilities, LTC, visual impairment, aging and adults with physical disabilities, and Medicaid and Medical Assistance. The DHSS is also responsible for four LTC facilities and the State's only psychiatric hospital, the Delaware Psychiatric Center, which is associated with other private psychiatric facilities. In addition, DHSS operates the Long-Term Care Ombudsman Program.

Division of Medicaid and Medical Assistance (DMMA)
In addition to administering the acute care Medicaid and CHIP Programs, DMMA also oversees/provides the following programs and services:

- Nursing Facility Program: Individuals in this program must be in need of a skilled or intermediate level of care provided by a nursing facility. Financial eligibility is set at 250 percent of the Supplemental Security Income (SSI) standard ($1,685/month for an individual in 2010) and assets are limited to $2,000 for the institutionalized client (there is a higher asset limit for the spouse still living in the community).
- Qualified Medicare Beneficiary Programs for dual eligibles.
- Children's Community Alternative Disability Program: This program provides Medicaid coverage to children with severe disabilities who meet the SSI disability criteria, but do not qualify for SSI or other Medicaid-qualifying programs because of their parents' income and/or resources. The child's gross monthly income cannot exceed 250 percent of the SSI standard and countable assets cannot exceed $2,000. The parent's income and assets are not considered. These children are currently enrolled in DSHP MCOs.
- AIDS Home- and Community-Based (AIDS HCB) Waiver Program: Enrollees in this statewide 1915(c) waiver program receive all the regularly covered Medicaid services, plus the following special waiver services: case management, mental health services, personal care services, respite care, and supplemental nutrition.
- SSI-related Programs: Including Medical Assistance during Transition to Medicare (MAT), Medicaid for Workers with Disabilities (MWD), and Disabled Adult Children (DACs).
- Financial Eligibility Determinations: DMMA is responsible for determining financial eligibility for the State's Medicaid home- and community-based waivers.
- Medical Eligibility Determinations: DMMA is also responsible for determining medical eligibility for the Nursing Facility, AIDS HCB Waiver, and Children's Community Alternative Disability programs.

Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)
In addition to being Delaware's State Unit on Aging, DSAAPD oversees a variety of programs and services including, but not limited to, the following:

- Elderly and Disabled Waiver Program: This is a statewide Medicaid 1915(c) waiver that provides an alternative to nursing home care for eligible older persons and adults with physical disabilities. The program includes services to help a person to continue living in his or her home safely. Nurses and social workers coordinate with

participants and their caregivers to develop care plans that help to meet individual needs. This waiver recently consolidated the Acquired Brain Injury and Assisted Living Facility Section 1915(c) waivers into a single waiver and added consumer-directed personal care services. Enrollees in this waiver receive all regularly-covered Medicaid services, plus the following additional HCBS services: adult day services, assisted living, case management, cognitive services, day habilitation, personal care services, personal emergency response system, respite care, specialized medical equipment and supplies, and support for participant direction.

- Medical Eligibility Determinations: DSAAPD is also responsible for determining medical eligibility for the Medicaid 1915(c) waiver that provides an alternative to nursing home care for eligible older persons and adults with physical disabilities.
- Other Services: DSAAPD also provides the following services, mostly through the use of State funds, but sometimes with other federal funds or block grants: assistive devices, Alzheimer's day treatment, attendant services, home-delivered meals, home modifications, housekeeping services, and medical transportation.

C. Eligibility and Enrollment

DSHP Plus will be a continuation of Delaware's ongoing Section 1115 demonstration for DSHP. In addition, the following populations are proposed to be included under the demonstration:

DSHP Plus Eligibility Group	**Description**
Plus-Institutional	Until Plus is operational (i.e., services delivered through MCOs), individuals residing in institutions other than ICF/MRs who meet the institutional LOC criteria (i.e., one ADL) in place at the time of admission. *Once Plus is operational, individuals residing in institutions other than ICF/MRs who (1) were admitted prior to 4/1/12 and met the institutional LOC criteria in place as of 3/30/12 (i.e., at least one ADL); (2) applied for LTC prior to 4/1/12 and met the institutional LOC criteria in place as of 3/30/12 (i.e., at least one ADL); or (3) who meet the revised institutional LOC criteria (i.e., at least two ADLs) in place as of 4/1/12. Includes children in specialty facilities (Exceptional Care for Children and Voorhees).
Plus-HCBS	Individuals meeting the institutional LOC requirements in place as of March 30, 2012 (i.e., at least one ADL.)

DSHP Plus Eligibility Group	Description
	Note: Once Plus is operational on April 1, 2012, there will be a lower LOC of requirement for HCBS wavier-like services than for institutional services, except for grandfathered individuals.
Plus-Duals	Full-benefit dual eligibles who are not at a LTC LOC.

**The State may grant an exception for persons in the Plus-HCBS group seeking nursing facility admission or readmission who continue to meet the nursing facility LOC in place as of March 31, 2012, but whose needs can no longer be safely be met in the community at a cost that does not exceed nursing facility care.*

DMMA will include the services of two of Delaware's three 1915(c) HCBS waivers into the DSHP Plus demonstration authorized managed care plans. The former waivers include the E/D Waiver and AIDS Waiver. The State will cease operating these HCBS Waivers upon approval of the DSHP Plus Section 1115 demonstration amendment, but will continue these same programs as "transitional" HCBS waivers under the demonstration authority until the DSHP Plus managed care contractors become operational. Once the DSHP Plus managed care contracts become operational, DMMA will cease operating these "virtual" waivers under the demonstration.

The following populations will be **excluded** from DSHP Plus:

- Individuals enrolled in the Section 1915(c) Mental Retardation/Developmental Disability Waiver program.
- Individuals residing in ICF/MRs (The Stockley Center and Mary Campbell Center).
- Individuals who choose to enroll in PACE when that program becomes operational (an exact start-up date for this program is unknown at this time).
- Any Medicaid members that DMMA has already authorized for out-of-state placement at time of program implementation will remain in the FFS program. However, effective with implementation on 04/01/2012, DMMA will no longer authorize and pay for new out-of state placements through FFS. DMMA expects the Plans to better coordinate care and services to avoid the need for any new out-of-state placements.
- Dual eligibles other than full-benefit duals.
- Presumptively eligible pregnant women.
- Breast and Cervical Cancer Treatment Program enrollees.
- Other illegal non-qualified/non-citizens/non-Medicaid groups.
- Those in need of just the 30-Day Acute Care Hospital program.

State staff will continue to perform the initial and annual level-of-care assessments for those being considered for the LTC level-of-care benefits. Using the State's approved tool, the MCOs will be responsible for assessments to determine level-of-care for reimbursement and care planning. Delaware will delegate the level-of-care responsibility for reimbursement to the MCOs once there has been sufficient inter-rater reliability between the plans' and DMMA's findings. DMMA will periodically continue to sample MCO determinations to ensure consistency.

Once a member has been enrolled an MCO, an eligibility change from DSHP to DSHP Plus will not result in a managed care disenrollment. Instead, the member will remain enrolled with the MCO, but DMMA will adjust the eligibility category and trigger movement from one rate tier to another. The member will receive additional information about the new benefit package and enrollment in Plus at this point and have an opportunity to change plans if the member so chooses.

D. Benefits

DSHP Plus will be a continuation of Delaware's ongoing Section 1115 demonstration for DSHP. All waiver enrollees will receive the current DSHP benefit package of primary, acute and behavioral health care services. Under DSHP Plus, the current Medicaid state plan institutional, Elderly and Disabled 1915(c) Waiver, and AIDS Section 1915(c) Waiver home and community-based LTC services will be made available to individuals as they are today.

As noted earlier, Delaware is exploring, via a parallel process to this Section 1115 demonstration amendment, options for expanding community-based mental health services and how such services can be integrated or coordinated with the DSHP/DSHP Plus populations. Depending on the outcomes of those discussions, Delaware may modify the demonstration design at a later date.

Delaware currently "carves out" pharmacy from the DSHP MCO benefit package and will continue to do so upon the initial implementation of DSHP Plus. However, Delaware is requesting authority under this amendment to include pharmacy at a later date with an updated budget neutrality agreement.

The following Medicaid State Plan Services will be carved out of the Medicaid managed care programs and will continue to be paid directly by FFS for both the DSHP Plus populations:

- Pharmacy
- Child Dental
- Non-emergency medical transportation
- Day Habilitation Services authorized by the Division of Developmental Disabilities Services

Delaware is currently reviewing the feasibility of adding additional HCBS services to the existing benefits available today. Additionally, MCOs will be encouraged to offer additional cost-effective alternatives to institutional care when appropriate and acceptable to the member.

E. Cost-sharing

Cost-sharing under DSHP and DSHP Plus will be consistent with any changes approved in the State plan.

F. Delivery System

DMMA intends to amend the existing DHSP contracts with its two Medicaid MCOs to include the DSHP Plus population and benefit package. Accordingly, the LTC expansion and the existing DSHP program will effectively be a single, combined managed care program referred to as DSHP Plus. DMMA will also require the MCOs to contract with the State's current fiscal employer agent (FEA) for the purpose of continuing the consumer direction under DSHP Plus.

Enrollment

DMMA will arrange for enrollment contractor assistance to offer managed care enrollment choice counseling and assist potential enrollees with a choice of DSHP Plus managed care plan. DMMA intends to engage Medicaid eligibility staff as well as in the informing process as individuals apply for Medicaid LTC benefits. Upon initial start-up of DSHP Plus, individuals will have 45 days to choose a plan. After initial start-up, enrollment for new DSHP Plus members will continue to follow the current DSHP enrollment process.

DMMA is in the process of reviewing its current contract with the MCOs for revisions to reflect the Plus population, benefit package, and increased quality, monitoring, and reporting requirements. These contract amendments will comply with all requirements under 42 CFR Part 438 except as expressly waived under the DSHP Plus waiver and expenditure authorities and approved Special Terms and Conditions.

DMMA is requesting a very limited exception to the requirements at 42 CFR 438.52(a) that require a choice of Medicaid MCOs. DMMA intends to offer a choice of plans through the availability of two MCOs. However, in 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. DMMA will require sufficient notice of intent to not participate in DSHP Plus so that the situation described would not occur. However, having this authority is critical to DMMA's ability to attract, maintain, and provide adequate oversight and monitoring of its contracted MCOs.

G. Quality

DMMA will also be updating the approved State Quality Improvement Strategy to reflect DSHP Plus. DMMA is in the process of redesigning its current quality assurance / monitoring system in order to capture critical information for the DSHP Plus population. A significant focus of the redesign will be on the new population that meets the institutional level of care criteria since this will be the most vulnerable of all the new subgroups. DMMA believes that most of the current quality assurance / monitoring system design will accommodate the dually eligible population that does not meet an institutional level of care. However, the State will examine changes that might be needed to the current design for this dual population and others that do not meet the institution level of care. Part of the redesign will be to separately track and report information on the institutional level of care population since this group is so uniquely different from all other population subgroups.

DMMA will submit to CMS an integrated quality improvement strategy which builds upon managed care quality requirements in 42 CFR 438 and incorporates those elements of Section 1915(c) Waivers and the regulatory assurances of those waivers. DMMA intends to establish reporting, performance measurement, and performance improvement projects that are appropriate for the LTC/HCBS populations that will be enrolled in DSHP Plus.

H. Waiver and DSHP Plus Implementation

Delaware is seeking approval of this amendment to the current DSHP Section 1115 project by October 1, 2011 and is planning for operational implementation of DSHP Plus on April 1, 2012.

SECTION 5: PUBLIC INPUT

Delaware is committed to seeking input from consumers, families, providers, various state operating components, and other interested stakeholders on the design of Plus. Delaware has begun engaging various stakeholders in the design of DSHP Plus by:

- Establishing a Communication Subcommittee to develop the Communication Plan for all stakeholders and interested parties.
- Establishing a website to post information about the program and its timeline and status.
- Creating a State e-mail box to gather questions and concerns.
- Developing a PowerPoint presentation outlining the program initiative and details.
- Developing a stakeholders list with contact information.
- Scheduling 25 information opportunities for all stakeholders and interested parties.
- Mailing a letter to all stakeholders informing them of the program initiative and dates / times for upcoming information sessions and webinars that will be held twice per month beginning in June 2011.
- Presenting program design and implementation schedule to the Nursing Home Association, Medical Care Advisory Committee (MCAC), Governor's Commission and MCOs.

DMMA will be posting this Concept Paper to a website designed to keep interested stakeholders informed and will establish a mailbox to solicit comments and feedback on the program.

Delaware is also required to publish publicly any changes to their program and be open for comments as required by the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code). This process, known as the APA, will take approximately 90 days from posting to receiving and responding to public comments. DMMA intends to start the APA process in July 2011.

SECTION 6: BUDGET NEUTRALITY

(To be submitted at a later date)

SECTION 7: EVALUATION

Delaware will incorporate provisions related to DSHP Plus into the demonstration evaluation design. Potential evaluation concepts include:

- The rebalancing of the LTC system including impacts on outcomes, utilization and cost.
- The expansion and development of a more robust HCBS infrastructure under managed care.
- Implementation of Consumer Directed options under managed care.
- Enrollee satisfaction, based on surveys that include feedback on assessment and care planning processes, quality of care coordination, actual service delivery, and when relevant, the appeals process.
- Provider satisfaction with integrated managed LTC.

Delaware is also evaluating how to develop a common approach that is consistent with the MFP evaluation.