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Promoting Community-Based Alternatives for Medicaid Long-Term Services and Supports for the Elderly and Individuals with Disabilities

State of Delaware
Division of Medicaid & Medical Assistance

MERCER

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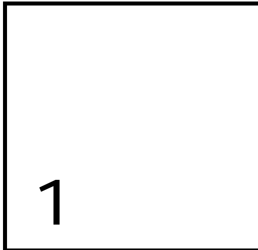

Executive summary

Under the leadership of Governor Jack Markell and Secretary Rita Landgraf, the State of Delaware (State), Department of Health and Social Services (DHSS), Division of Medicaid & Medical Assistance (DMMA) engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health and Benefits LLC, to produce this report. The purpose of this report is to provide information on Delaware's long-term care environment (e.g. demographics, Medicaid spending patterns, nursing home use), facilitate further discussion on options available to the State aimed at increasing community-based Medicaid long-term services and supports, and most importantly serve as a catalyst for implementation of the selected option(s).

There is no getting around the fact that Delaware, 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 2010 and 2030 with the number of people age 85 years or older expected to more than double. As people age, there is a higher proportion of expensive chronic conditions (e.g., heart disease, diabetes, hypertension), a higher probability for 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 in the 20 to 64 age range to either provide direct care services or indirectly support state and federal programs through payroll and other taxes. Moreover, Delawareans want to have alternatives to choose from when it comes to receiving long-term services and supports; to make Delaware a more livable state. Very few people want to be in institutions; the vast majority wishes to stay in their homes and communities for as long as practical.

Currently, for the elderly, Delaware spends nearly all of the associated Medicaid long-term care dollars on institutional care; less than 10 percent is directed to community-based alternatives for this population. This ranks Delaware near the bottom amongst all states. Conversely, even though Delaware has the fewest number of people in developmentally disabled waiver programs (due in part to Delaware's small size); community-based spending on individuals with developmental disabilities is nearly 74 percent as compared to 24 percent spending on institutions which are better than the national average. This presents an interesting dichotomy in how DMMA is serving both

the elderly and individuals with developmental disabilities through Medicaid long-term care programs.

Most studies indicate that on average the per person cost of serving an individual in the community is significantly less than the average per person cost of a nursing facility. The primary driver for this average per person cost differential is the service delivery system – community versus institutional. Other factors that contribute to the cost differential include differences in acuity level and the availability of unpaid family support to those able to be served in community settings. To the extent that community-based care is expanded to more of the population with greater health care needs, both average per person and total spending related to community-based care may increase, but ideally this increase in community-based spending leads to future reductions in facility-based spending to slow the overall growth in Medicaid long-term care expenditures.

DMMA will need to carefully evaluate aggregate spending levels to ensure that increasing community-based service alternatives has a positive impact on diverting or delaying the need for institutionalization to provide program sustainability over the long term horizon. Tools such as stricter level-of-care/eligibility policies, geographic coverage limits, spending caps (individual or aggregate), medical necessity criteria, waiver "slots", waiting lists for waiver services, aggressive look-back/estate recovery activities, moratoriums on new nursing home beds and certificate of need have been used by states to manage the supply and demand for Medicaid long-term care services. While some of these tools help to curtail unnecessary supply of specific services (e.g., nursing home beds); waiting lists for community-based waiver services can be an indicator of unmet need. DMMA should also consider the political and public reaction to policies that might be viewed as restricting access to desired services. Indeed, achieving a better balance and establishing a greater spectrum of non-institutional service offerings is not something that will change in one budget cycle. DMMA will need to take a long-term view to the Medicaid long-term care system.

Spending on nursing facility services in 2008 was over $176 million and most of that spending was on the low-income elderly and individuals with disabilities who have both Medicare and Medicaid (i.e., dual eligibles). Accordingly, the dual eligibles represent a key population in terms of reducing nursing facility spending. Thus one challenge and opportunity for DMMA in balancing the State's Medicaid long-term care system is to coordinate with Medicare more directly either through programs such as Program of All-Inclusive Care for the Elderly (PACE) or Medicare Advantage Special Needs Plans (SNPs). Changes in the very recent Patient Protection and Affordable Care Act (PPACA) make it clear that the federal government realizes the importance of the health and functional status of the 9 million dual eligibles that are now costing the nation around $250 billion a year in combined Medicare and Medicaid services. Due to Medicare's role as the primary caregiver for acute and preventative services, the actions or inactions by Medicare can directly impact DMMA's subsequent Medicaid long-term care expenditures. Finding innovative ways to integrate Medicare/Medicaid services can align financial and operational incentives for both the consumers' and the State's benefit.

To increase options and availability for community-based Medicaid long-term services and supports DMMA can pursue program initiatives in the State's fee-for-service (FFS)

system and/or implement new managed care programs. Changes in federal law have made it easier for states to deploy home- and community-based programs through simple state plan amendments such as 1915(i) or 1915(k) options without the need to develop and submit a Medicaid waiver. However, some state plan amendments lack the flexibility to target the population and services. Accordingly, Medicaid managed long-term care programs implemented under waiver authority such as a combination 1915(b)/(c) program are still an essential tool for most states.

The options presented within this report will fit within Delaware's overall Medicaid long-term care strategy in different ways. For example, if the State's primary objective is to offer additional Medicaid services related to home- and community-based care, most of the FFS state plan amendments are consistent with that goal and relatively easy to implement. However, if the State is seeking a broader strategy of impacting the delivery, management and integration of the Medicaid long-term care system, options involving managed care options and possibly the 1915(k) state plan option are more aligned with transforming the system of long-term services and supports, but will require much longer lead times to implement. Mercer recommends that as part of the next phase of this endeavor that DMMA, in conjunction with both internal and external stakeholders, discuss and evaluate the merits of these options in regards to how Delaware's strategy and objectives can be best complemented by the chosen initiative(s).

Regardless of the program initiatives selected, DMMA will be required to address a myriad of policy and operational design elements; not the least of which will be managing internal and external expectations. Other states that have endeavored to re-balance their Medicaid long-term care systems advise against going into it with the purpose being to "save money." Making more community-based services and supports available should be viewed as an initial investment that will benefit the State in the long run while at the same time improving consumer satisfaction and quality of life. Recent studies indicate that states with large community-based systems of care experienced slower rates of growth in Medicaid spending as compared to other states without established community-based programs.

Addressing imbalances in the Medicaid long-term care system is not an easy undertaking. The following is just a sampling of the types of issues and decision-points pending for DMMA staff: strategic planning, financing/payment options, program design, enrollment and disenrollment rules/processes, consumer/advocate input and reaction, provider comment, procurement and contracting of managed care plans, federal waiver development, and information technology/configuration issues (e.g., claims payment edits/rules, eligibility determinations, capitation payment processing). Accordingly, pursuing any new initiative will require devotion of human, financial and technological resources. The more complex the initiative (e.g., mandatory integrated Medicare/Medicaid manage care), the more skilled staff resources and time will be required to design, develop, implement and monitor.

Depending on the chosen initiative, the State should conservatively assume and plan for up to 24 months of lead time. Regardless of the initiative selected, the timeline for implementation will be heavily influenced by the availability of State resources to devote

the required time and energy. The following examples highlight the key factors that will directly impact the timeline for implementation:

- Availability of DMMA staff resources.
- Political support and prioritization of the State's agenda.
- Level of involvement and support from providers, consumers and families.
- Funding availability to support program start-up.
- Approval/involvement by the Centers for Medicare and Medicaid Services (CMS)/federal government.
- Information technology requirements and changes.

There were many existing priorities confronting DMMA staff prior to the passage of health care reform at the federal level, but now there are new issues and opportunities to address. It is therefore conceivable that the State's limited internal staff will need to be increased and/or augmented with external resources skilled in areas such as:

- Medicaid long-term care policy (e.g., level-of-care determinations, waiver services criteria, nursing facility policy and planning).
- Medicare/Medicaid interaction (e.g., enrollment/disenrollment rules, grievances and appeals, financing, performance reporting).
- Actuarial/financial services.
- Information technology edits and updates.

DMMA will want and need to engage both internal and external stakeholders in the process to ensure consumers and their advocates can offer suggestions and comments on pertinent program design issues. This will require having a solid communication strategy to manage information flow and exchange. Ideally, DMMA will establish a senior program "Champion" to coordinate efforts and be accountable for decision-making.

While the quantitative aspects of Delaware's changing demographics justify the need to take action, the qualitative aspects of a community-based system of Medicaid long-term services and supports can substantiate the benefits of having taken action. Delaware's leadership clearly embraces the need to move through the continuum of assessing the situation, taking action, implementing programs and measuring success so as to achieve a better balance in the State's long-term care system. This will enhance the sustainability of DMMA's programs for those who today or will tomorrow rely on Medicaid services and supports as well as organize State spending in more consumer-oriented ways.

This report is just one part of the means to a bigger end; with the end goal being increased community-based care options for Delaware's elderly and individuals with disabilities. How DMMA ultimately achieves this end goal will be determined based on a series of events, discussions and decisions that will be forthcoming. Making progress towards that end goal may involve implementing managed care programs and/or possibly enhancements to the current FFS delivery system. There may be multiple initiatives pursued to tackle specific issues or populations. At this point, DMMA has a type of "blank canvas" to work with since the existing Medicaid long-term care system is virtually all traditional FFS. To color this canvas with specific program initiatives will require communication, collaboration and compromise with both internal and external stakeholders. Throughout this process, Mercer recommends that those involved remain

mindful that the goal is to improve the quality of life and health status of individual people who lack the financial, physical, or cognitive resources and abilities to completely care for themselves.

2

Introduction

The State of Delaware (State) Division of Medicaid & Medical Assistance (DMMA) engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health and Benefits LLC, to produce this report to facilitate discussion and subsequent implementation of program initiatives aimed at increasing community-based Medicaid long-term services and supports for the State's elderly and individuals with disabilities. To that end, this report intends to review and discuss the following topical issues:

- Why take action now?
- What does Delaware's current Medicaid long-term care system look like?
- How does the federal Medicare program affect Delaware's Medicaid long-term care system?
- What types of Medicaid program initiatives can be implemented to enhance DMMA's program offerings, and given Delaware's limited size, what are potential impacts on quality of care and financial/resource requirements?
- How may federal health care reform impact Delaware and the long-term care market environment?
- What are some of the major policy and operational concerns that will confront DMMA or be on the minds of consumers and stakeholders during this process?

Based on Mercer's experience with other state Medicaid programs, the issues and decision-points will be challenging due to the impact on a diverse group of stakeholders and changes in the landscape of long-term services and supports sponsored by DMMA. However, avoiding the combined challenges of an aging population, a limited amount of fiscal resources and the institutional bias inherent in every state Medicaid program, will undoubtedly result in more drastic decisions required at a later point in time when the options and choices may be more limited. DMMA realizes the urgency to begin to make improvements now in the State's system of care delivery and management so as to enhance consumer choice, quality of life, fiscal accountability and program sustainability.

Much has been written over the years concerning Medicaid's institutional bias and the corresponding concerns over quality of care, negative effect on health outcomes and consumption of a greater share of fiscal resources at the expense of other public programs. Likewise, much has already been written regarding the benefits of having a dynamic and consumer-friendly system of care delivery in which the needs of the elderly and individuals with disabilities are met through various community-based care settings with quality of life, functional health status, and consumer input promoted, measured and evaluated.

These issues are neither unique to Delaware nor unknown to DMMA as an attempt was made nearly 10 years ago to begin to balance the State's Medicaid long-term care system. Unfortunately, that previous effort stalled after much discussion and deliberation. Accordingly, Mercer seeks to assist Delaware in finding the most appropriate alternatives to its long-term care needs and joins other states such as Arizona, Massachusetts, Minnesota and Washington that have successfully developed and deployed innovative programs to serve Medicaid consumers in their homes and communities.

Addressing imbalances in the Medicaid long-term care system is not an easy undertaking. The following is just a sampling of the types of issues and decision-points pending for DMMA staff: strategic planning, financing/payment options, program design, enrollment and disenrollment rules/processes, consumer/advocate input and reaction, provider comment, procurement and contracting of managed care plans, federal waiver development, and information technology/configuration issues (e.g., claims payment edits/rules, eligibility determinations, capitation payment processing). Accordingly, pursuing any new initiative will require devotion of human, financial and technological resources. The more complex the initiative (e.g., mandatory integrated Medicare/Medicaid manage care), the more skilled staff resources and time will be required to design, develop, implement and monitor.

Depending on the chosen initiative, the State should conservatively assume and plan for up to 24 months of lead time. Regardless of the initiative selected, the timeline for implementation will be heavily influenced by the availability of State resources to devote the required time and energy. The following examples highlight the key factors that will directly impact the timeline for implementation:

- Availability of DMMA staff resources.
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- Level of involvement and support from providers, consumers and families.
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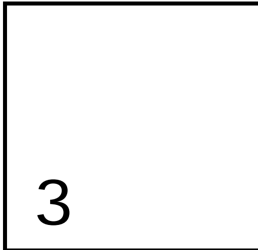
There were many existing priorities confronting DMMA staff prior to the passage of health care reform at the federal level, but now there are new issues and opportunities to address. It is therefore conceivable that the State's limited internal staff will need to be increased and/or augmented with external resources skilled in areas such as:

- Medicaid long-term care policy (e.g., level-of-care determinations, waiver services criteria, nursing facility policy and planning).
- Medicare/Medicaid interaction (e.g., enrollment/disenrollment rules, grievances and appeals, financing, performance reporting).
- Actuarial/financial services.
- Information technology edits and updates.

This report is an initial step, with the end goal of increasing community-based care options for Delaware's elderly and individuals with disabilities. How DMMA ultimately achieves this end goal will be determined based on a series of events, discussions and decisions that will be forthcoming. Mercer suggests that DMMA's next steps include high-level strategic meetings over the next two to three months with key internal and external stakeholders to review and discuss the options available to the State and how those options best fit within the State's overall strategy. The outcome of these meetings should be decisions on what initiatives to pursue further and from there DMMA workgroups can be established to address the implementation and operational details applicable to the selected initiative.

Making progress towards the end goal of increasing community-based care options may involve implementing managed care programs and/or possibly enhancements to the current fee-for-service (FFS) delivery system. There may be multiple initiatives pursued to tackle specific issues or populations. At this point, DMMA has a "blank canvas" to work with. To paint this canvas with specific program initiatives will require communication, collaboration and compromise with both internal and external stakeholders. Throughout this process, Mercer recommends that those involved remain mindful that the goal is to improve the quality of life and health status of individual people who lack the financial, physical, or cognitive resources and abilities to completely care for themselves.



Re-visiting the need for action

It is not uncommon or unexpected that when a state Medicaid agency embarks on an effort to balance and modernize their long-term care system, a common question asked is why? Why now, why at all? Over the years, much has been written to answer this question and support the need to address imbalances in Medicaid long-term care programs across the country before the waves of baby boomers reach ages where use of long-term services and supports becomes inevitable.

Delaware's coming of age

In preparing this paper, Mercer choose to use objective survey and population data to assess and summarize the realities of what Delaware is facing in terms of demographic changes and potential Medicaid fiscal consumption. Additionally, we highlight consumer preferences pertaining to the availability of home- and community-based alternatives for long-term services and supports.

Population growth – age 65 and older

There is no getting around the fact that Delaware, like the United States as a whole, is steadily aging. And as people age, there is a higher proportion of expensive chronic conditions (e.g., heart disease, diabetes, hypertension), a higher probabillity for disability and a corresponding increase in the use of and need for health-related services and supports[1]. The following table clearly shows that Delaware is not unique in the demographic challenges it will be facing in the coming years.

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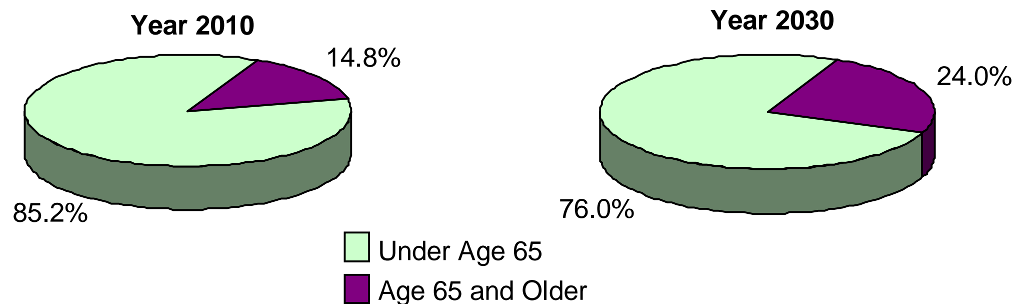
[1] Stanton, MW., Rutherford, MK.; The high concentration of U.S. health care expenditures. Rockville (MD): Agency for Healthcare Research and Quality; 2005. Research in Action, Issue 19, AHRQ Pub. No. 06-0060.

Table 1 – Projected population growth of age 65 and older[2]

Geographic area	Year 2010	Year 2020	Year 2030	Change from 2010 to 2030
State of Delaware	132,041	185,576	252,277	91.1% increase
South Atlantic Region[3]	8,357,101	11,978,028	16,787,108	100.9% increase
United States	40,243,713	54,631,891	71,453,471	77.6% increase

Table 1 makes it clear that whether on a state, regional or national level the percentage of the population that is age 65 and older is growing rapidly; much higher than the forecasted increase of the population in total which is estimated to be only 17.8 percent for Delaware and 17.7 percent nationally between 2010 and 2030[4]. Accordingly, while Delaware is expected to experience a similar percentage increase in total population as the U.S., the number of elderly Delawareans is expected to nearly double over the next 20 years**.** The following chart exhibit illustrates how the composition of Delaware's elderly and non-elderly population is expected to change from 2010 to 2030.

Chart 1 – Changing composition of Delaware's population



Population growth – age 85 and older

While it is clear that Delaware is facing a substantial increase in both the percentage and absolute number of elderly residents age 65 and older, a further drilldown into the population forecasts identifies a more substantial change with the oldest population segment composed of ages 85 and older.

People age 85 and older are typically more likely to experience problems associated with poor health status, more than one chronic illness, functional/cognitive limitations and poor mental health status; and thus are more likely to require institutional care or

[2] Delaware data from the Delaware Population Consortium Population Projection Series October 29, 2009, Version 2009.0. Other population data from the U.S. Census Bureau Population Division Interim State Population Projections, April 21, 2005.

[3] South Atlantic Region includes Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia and West Virginia.

[4] See footnote #2.

assistance with performing activities of daily living (ADLs) or instrumental activities of daily living (IADLs)[5]. Health care spending analyses show that people with multiple chronic conditions cost up to seven times as much as people with only one chronic condition[6]. Furthermore, in 2009 the national average percentage of adults over 85 years old who require help with personal care needs from other persons was 19.9 percent, but only 3.4 percent for those age 65 to 74[7].

As shown below in Table 2, the number of Delawareans age 85 and older is expected to more than double between 2010 and 2030; thus increasing from 2.1 percent to 3.6 percent of the State's total population over this twenty-year time horizon.

Table 2 – Projected population growth of age 85 and older

Geographic area	Year 2010	Year 2020	Year 2030	Change from 2010 to 2030
State of Delaware	18,580	26,509	37,831	103.6% increase
South Atlantic Region	1,201,867	1,493,731	2,095,055	74.3% increase
United States	6,123,458	7,268,908	9,603,034	56.8% increase

Old age dependency ratio

While the previous population figures focus attention on the swelling ranks of the elderly, a less often cited statistic is the number of age 65 and older expressed as a percentage of what is defined as "economically productive" ages 20 to 64[8]. This statistic is commonly referred to as the old age dependency ratio because as people age they typically become more dependent on the younger generations to provide direct care support as paid or unpaid caregivers or indirectly support state and federal programs through payroll and other taxes. Since people are generally healthier, living longer and working past age 65, this statistic is included in this report to only illustrate the significant population changes occurring in Delaware and across the country. For consistency in these statistics at the state, regional and national levels, the data represented in Table 3 is based on the U.S. Census Bureau's Interim State Population Projections.

[5] Beyond 50.09, Chronic Care: A Call to Action for Health Reform, AARP Public Policy Institute.

[6] See footnote #1.

[7] CDC/NCHS, National Health Interview Survey, January-September 2009, Family Core component.

[8] Shrestha, L., Age Dependency Ratios and Social Security Solvency, Updated October 27, 2006, Congressional Research Service Report.

Table 3 – Old age dependency ratios[9]

Geographic area	Year 2010	Year 2020	Year 2030
State of Delaware	23.4%	32.1%	44.7%
South Atlantic Region	23.3%	30.8%	40.5%
United States	21.7%	28.4%	36.3%

The statistics in Table 3 indicate that today Delaware has nearly five "economically productive" individuals for every elderly person, but by year 2030, this ratio drops to just over two "economically productive" individuals for every elderly person. Therefore, as the number of elderly Delawareans increase there will be fewer and fewer people in the younger generations to provide direct and indirect support.

Living with disabilities

Even though people are generally living longer, it is statistical facts that as people age the prevalence of disabilities and disease increases. Therefore, with an aging population, there is a strong likelihood that there will be corresponding increases in rates of disability[10], although advances in medical technology and treatment may slow this advancement. Typically individuals with disabilities require more assistance and supportive services whether from unpaid or paid caregivers, private health insurance or government sponsored programs such as Medicare and Medicaid. In a 2008 national survey[11]:

- 36.4 percent of people age 65 and older said that at least one of nine physical activities was very difficult or cannot be done at all compared to only 10.4 percent of people between the ages of 18 and 64.
- Of the under age 65 survey group, those with Medicaid were over four times more likely than those with private health insurance to say that at least one physical activity was very difficult or cannot be done at all.
- Only 42.4 percent of people age 18 and older living below the federal poverty threshold reported their health status as excellent or very good compared to 68.1 percent of people at 200 percent or more of the federal poverty threshold.

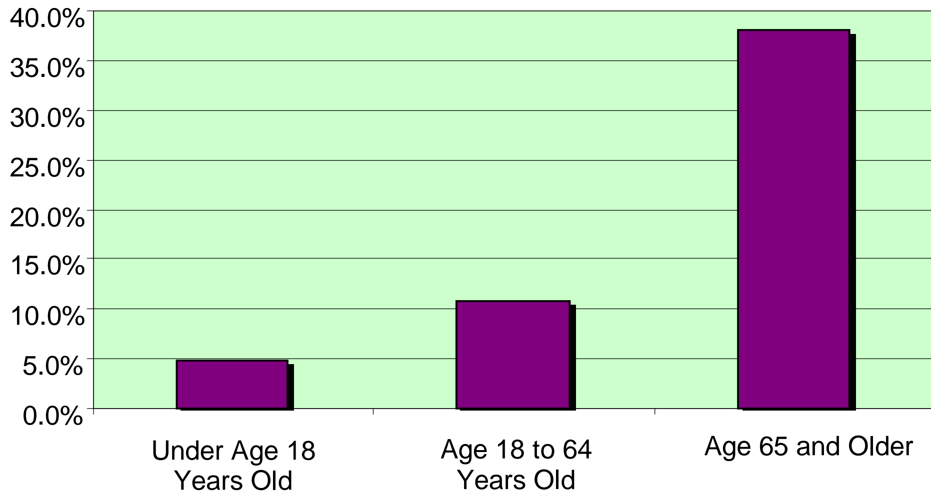
Based on the 2008 American Community Survey, the estimated percentage of Delawareans with one or more disabilities by age group is shown in the following chart.

[9] Old age dependency ratio is calculated by dividing the number of age 65 and older by the total number of age 20 to 64.

[10] Smith, S., Rayer, S., and Smith, E.; Implications for the Housing Industry and Housing Policy, Journal of the American Planning Association, Vol. 74, No. 3, Summer 2008.

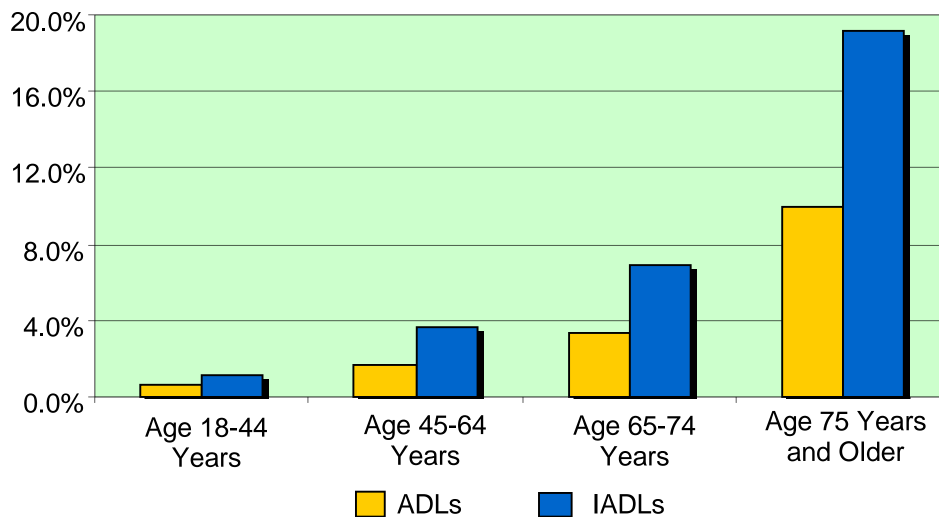
[11] Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2008, Centers for Disease Control and Prevention, Vital and Health Statistics, Series 10, Number 242, Tables 18 and 20.

Chart 2 – Delaware population with one or more disabilities[12]



The Delaware-specific results in the above exhibit correspond to national survey data that a person's ability to perform ADLs and IADLs become more limited with age. As the following chart shows, there is a direct correlation between age and a person requiring assistance/help in performing daily activities.

Chart 3 – Percentage of persons having limitations in ADLs and IADLs by age band – national survey data[13]



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[12] Table C18108 from the U.S. Census Bureau, 2008 American Community Survey 1-year estimates.

[13] Summary Health Statistics for the U.S. Population: National Health Interview Survey, 2008, Centers for Disease Control and Prevention, Vital and Health Statistics, Series 10, Number 243, Table 5.

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 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). Eligibility for community-based waiver programs typically require the same "level-of-care" need associated with nursing homes, so a primary driver for the average per person cost differential is the service delivery system – community versus institutional. Other factors that contribute to the cost differential include differences in acuity level and the availability of unpaid family support to those able to be served in community settings. Therefore, it is worth noting that if more people are served in the community with greater health care needs, DMMA should anticipate an increase in average per person community-based spending. Whereas the annual average cost of nursing home care can be well over $50,000 or in Delaware more like $70,000 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[14]. 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.
- Over 1,600 hours of home health aide services could be purchased[15].
- Over 18 months of assisted living services could be obtained[16].
- Over 1,000 days of adult day care services could be offered[17].
- Over 13,000 home delivered meals could be provided[18].

A survey conducted in December 2008 of 1,000 Delaware residents age 35 and older found the following opinions and concerns[19]:

- 42 percent thought it likely that either they or their family member will need long-term care 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 long-term care.

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[14] 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.

[15] Based on $43 Medicare-certified hourly rate for home health aides, 2008; AARP Across the States, Profiles of Long-Term Care and Independent Living, State of Delaware, 8th edition, 2009.

[16] Based on $3,774 average private pay rate per month in assisted living, 2008; Ibidem.

[17] Based on $67 average private pay daily rate for adult day care, 2008; Ibidem.

[18] Based on $5.14 national average cost; State of Aging: 2009 State Perspectives on State Units on Aging Policies and Practices, National Association of State Units on Aging, October 2009.

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

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[20]. Using population data from Table 1, 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 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 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.

Caution: aggregate spending is more critical than per person spending

The per person cost difference between nursing home and community care is impressive at face value, but there are limitations in the applicability of extrapolating these differentials into real reductions in total Medicaid expenditures. The biggest concern and caveat is that while per person spending is less in the community than institutionalization, if the number of people served by community programs rapidly increases then total long-term care spending will rise more quickly and more substantially than any off-sets in spending reductions for institutionalization can provide (often referred to as the "woodworking" effect)[21].

For example, if two people can be served in the community for the cost of one institutionalization, total spending would be same only if that institutionalization is indeed averted. However, if instead of two, four people actually seek community-based services, total spending is now higher than before (and even higher still if the additional services provided do not avert institutionalization). This dynamic can occur because often there is unmet need for community-based care or family caregivers who are unavailable or may defer to publicly-funded service providers when the opportunity is available[22]. But the existing research is inconclusive on many of these issues, as one recent study concluded that over the long run, state Medicaid programs that invested heavily in home- and community-based long-term care experienced slower increases in the growth of Medicaid long-term care spending as compared to other states; however, even this study noted the large initial outlay of funds to support the development, launching and funding of new programs[23] (e.g., additional staffing requirements, system changes,

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

[21] Grabowski, D.; The Cost-Effectiveness of Noninstitutional Long-Term Care Services: Review and Synthesis of the Most Recent Evidence, Medical Care Research and Review, Vol. 63 No. 1, February 2006.

[22] Ibidem

[23] Kaye, S., LaPlante, M., Harrington, C.; Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending, Health Affairs, January/February 2009.

consulting services, lag time associated with the increase in community services spending prior to any reduction in institutional spending).

Delaware's decision-makers need to remain cognizant of the fiscal impact of pending policy decisions and how increased demand for community-based care can put more pressure on providers, caregivers and the State to continually make more quality services available. To the extent that community-based care is expanded to more of the population with greater health care needs, both average per person and total spending related to community-based care may increase, but ideally this increase in community-based spending leads to future reductions in facility-based spending to slow the overall growth in Medicaid long-term care expenditures.

Notwithstanding the caveats against extrapolating per person spending differences, increasing the availability of community-based alternatives for Medicaid long-term services and supports by most accounts is a socially preferred and more consumer-focused use of public funds.

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 long-term care needs and their families to advocate for opportunities to receive care in a variety of settings[24]. Despite their preferences, consumers may be directed toward institutional services because home care services are neither readily available nor easily accessible or they also may be directed to institutional care because it is an easier placement for health care professionals[25].

The following are examples from the literature on this topic:

- According to a national survey conducted by the AARP, 84 percent of those ages 50 and older want to remain in their homes as they age[26].
- Many people who become disabled due to injury or disease are forced to move into nursing homes or other institutions because their homes lack adequate accessibility features; this imposes high emotional and financial costs on the individual, and most likely inflicts high economic costs on taxpayers as well[27].

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[24] 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.

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

[26] AARP, Beyond 50.05 Survey, A Report to the Nation on Livable Communities: Creating Environments for Successful Aging, April 2005, http://assets.aarp.org/rgcenter/il/beyond_50_communities.pdf.

[27] See footnote #10.

- Most disabled people want to live independently for as long as possible and strongly desire housing features that will allow them to do so[28].

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.
- 86 percent believe that it is either extremely or very important to have long-term care 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.

[28] Ibidem

4

Overview of Delaware's current Medicaid long-term care system

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

Of particular interest, virtually all populations and services composing long-term care are delivered via FFS means. Although DMMA has a mandatory Medicaid managed care program, dual eligibles, nursing home residents, 1915(c) waiver recipients and the corresponding long-term care services are all excluded. This presents opportunities for new and innovative solutions, but also possible resistance to change from a system rooted in traditional FFS.

The following is a brief overview of the major Divisions and programs that Delaware provides to the elderly and individuals with disabilities through its Medicaid system[29].

Delaware Health and Social Services (DHSS)

DHSS is the second largest State agency, employing almost 5,000 individuals in a wide range of public service jobs. DHSS includes 12 divisions, which provide services in the areas of public health, social services, substance abuse and mental health, child support, developmental disabilities, long-term care, visual impairment, aging and adults with physical disabilities, and Medicaid and Medical Assistance. The department includes four long-term care facilities and the State's only psychiatric hospital, the Delaware Psychiatric Center which is associated with other private psychiatric facilities.

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[29] http://dhss.delaware.gov/dhss/, accessed May 3, 2010.

Division of Medicaid & Medical Assistance (DMMA)

The mission of the DMMA is to improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost effective manner. In addition to managing Delaware's acute care Medicaid (Title XIX) and CHIP (Title XXI) programs, DMMA also oversees/provides the following programs and services:

- **Nursing Facility Program:** The applicant 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). The nursing facility program pays for the cost of care provided in Delaware nursing facilities that have Medicaid contracts. These nursing facilities provide room, board and nursing services to persons who are elderly, infirm or have disabilities and receive additional funds to provide psychosocial and rehabilitative services to some clients.
- **Qualified Medicare Beneficiary Programs:** If entitled to Medicare benefits and have low-income, DMMA may pay Medicare's premiums and, in some cases, other "out-of-pocket" expenses such as deductibles and coinsurance. Individuals must be entitled to Medicare Part A to qualify for any of these programs. Recipients under these programs may or may not receive regular Medicaid services.
- **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.
- **AIDS Home- and Community-Based (AIDS HCB) Waiver Program:** This is a statewide 1915(c) waiver that provides 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.
- **Money Follows the Person (MFP) Demonstration[30]:** Together with the DSAAPD (see below), 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 2009, 22 clients were transitioned from institutions to the community. DMMA/DSAAPD intends to transition an additional 60 MFP clients by 2011 with an ultimate goal of 100 individuals over a four-year period.
- **SSI-related Programs:** Including Medical Assistance during Transition to Medicare (MAT), Medicaid for Workers with Disabilities (MWD), Disabled Adult Children (DACs), etc.

[30] March 3, 2010 and March 4, 2010 presentations by Rosanne Mahaney and Guy Perrotti respectively, to Delaware's Joint Finance Committee Hearing.

- **Financial Eligibility Determinations:** DMMA is responsible for the 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)

The mission of the DSAAPD is to improve or maintain the quality of life for Delawareans who are at least 18 years of age with physical disabilities or who are elderly. The Division is committed to the development and delivery of consumer-driven services which maximize independence through individual choice, enable individuals to continue living active and productive lives, and protect those who may be vulnerable and at risk. In addition to being Delaware's State Unit on Aging, DSAAPD oversees/provides a variety of programs and services including, but not limited to the following:

- **Assisted Living Waiver Program:** This is a statewide Medicaid 1915(c) waiver that provides services and supports for eligible older persons and adults with physical disabilities who otherwise would require care in a nursing home, but can be served in assisted living facilities. Waiver services provided include assisted living and case management.
- **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. Waiver services provided include adult day services, case management, personal care, personal emergency response system and respite care.
- **Nursing Home Transition Program:** A state-funded program led by DSAAPD with the overall goal of the program is to identify, inform and assist nursing home residents, especially those who are Medicaid-eligible, who want to move to a community-based setting. The program offers individualized case management to accomplish this goal. In three years, this program has transitioned 55 clients from nursing homes to the community, incurring set-up costs that average under $1,500 per client while promoting increased independence with the use of cost efficient community supports[31].
- **Acquired Brain Injury (ABI) Waiver Program[32]:** This is a new statewide Medicaid 1915(c) waiver that provides supports and services for eligible adults who have sustained an acquired brain injury and who otherwise would require care in a nursing home. The goal of the program is to provide services which respond to each person's needs and allow him or her to live as independently as possible. Waiver services

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[31] G. Perrotti, Ibidem.

[32] ABI waiver received CMS approval on December 1, 2007 and was expected to have approximately 50 participants in its first year growing to 70 by year 3. Delaware is currently evaluating merging the Assisted Living, Elderly and Disabled and ABI waivers.

provided include adult day services, assisted living, day habilitation, case management, cognitive services, personal care, personal emergency response system and respite care services.

- **Long-Term Care Ombudsman Program:** This is a statewide program available to all residents (and their families) of licensed long-term care facilities. The Ombudsman program investigates and resolves complaints made by (or on behalf of) residents of long-term care facilities (for example, nursing homes). The program also provides volunteer opportunities for friendly visitors/advocates in nursing homes.
- **Other Services:** In addition to the aforementioned programs, 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[33].

Delaware Aging and Disability Resource Center (ADRC)

DSAAPD and partner agencies are in the process of developing a statewide, comprehensive Aging and Disability Resource Center (ADRC) in Delaware. The ADRC will provide a one-stop access point for information and services for older persons and adults with physical disabilities throughout the State. It is scheduled to begin operation in September 2010.

Division of Developmental Disabilities Services (DDDS)

The mission of the DDDS is aligned with the vision and the DHSS's mission to improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations. In addition to the Stockley Center which is an intermediate care facility that provides habilitative training, health care, family services, and residential services for individuals with developmental disabilities, DDDS also operates the following program:

- **Mental Retardation/Developmental Disability Waiver Program:** This is a statewide Medicaid 1915(c) waiver for people with intellectual disabilities, autism, Asperger's, Prader-Willi or brain injury during the developmental period with concurrent adaptive limitations. In addition to regular Medicaid services the waiver services provided are case management, clinical support, day habilitation, institutional or in-home respite care and residential habilitation.

Division of Long-Term Care Residents Protection (DLTCRP)

The DLTCRP is responsible for the adult abuse registry, criminal background checks and mandatory drug testing, the Certified Nursing Assistant (CNA) registry, complaint and incident reporting related to long-term care facilities, licensing/certifying long-term care facilities, and developing regulations related to these areas.

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[33] Some other states have opted to provide these types of services through their 1915(c) waivers to obtain federal matching funds.

Delaware health and economic rankings

On most measures, Delaware is a small state[34]:

- 859,800 residents in 2008 rank Delaware 45th in the nation.
- 45 certified nursing facilities in 2008 ranks Delaware 46th in the nation.
- 4,111 total nursing facility residents in 2008 ranks Delaware 46th in the nation.
- Six community hospitals in 2007 (i.e., non-federal, short-term general, and specialty hospitals whose facilities and services are available to the public) was the fewest in the nation.

Although small in size, Delaware is also a relatively prosperous state in terms of various economic indicators[35]:

- $54,610 median household income in 2007 ranks Delaware 15th in the nation and slightly above the national average of $50,740.
- 76.8 percent homeownership rate in 2007 ranks Delaware 2nd in the nation.
- Only 10.5 percent of the population is estimated to be below the federal poverty level in 2007 ($20,650 for a family of four) ranks Delaware 39th lowest in the nation.
- Delaware's standard Federal Medical Assistance Percentage (FMAP) rate for Medicaid medical services is 50.21 percent for federal fiscal year 2010, just slightly above the minimum 50 percent rate (this does not reflect the temporary increase in FMAP associated with the federal stimulus package).

Delaware's Medicaid long-term care spending patterns

Looking more closely at Delaware's Medicaid program based on the most recently available data from 2005 through 2008[36]:

- Total Medicaid medical spending has increased from $868.3 million in 2005 to $1.1 billion in 2008 resulting in an average annual increase of 8.3 percent.
- Medicaid long-term care spending on institutional and waiver services increased from $258.3 million to $321.2 million resulting in an average rate of 7.5 percent; note that the average increase in long-term care spending is less than the average annual increase in total Medicaid program expenditures.
- Spending on Medicaid nursing facility services increased from $154.9 million to $176.3 million for an average annual growth rate of 4.4 percent.
- Spending on ICF-MR services increased from $25.8 million to $29.8 million for an average annual growth rate of 4.9 percent.
- Spending on Medicaid 1915(c) waivers increased from $70.7 million to $106.5 million for an annualized increase of 14.6 percent, but most of this spending has been on Delaware's waiver for individuals with developmental disabilities; spending on

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[34] Kaiser Family Foundation, 50 State Comparisons, http://www.statehealthfacts.org/compare.jsp

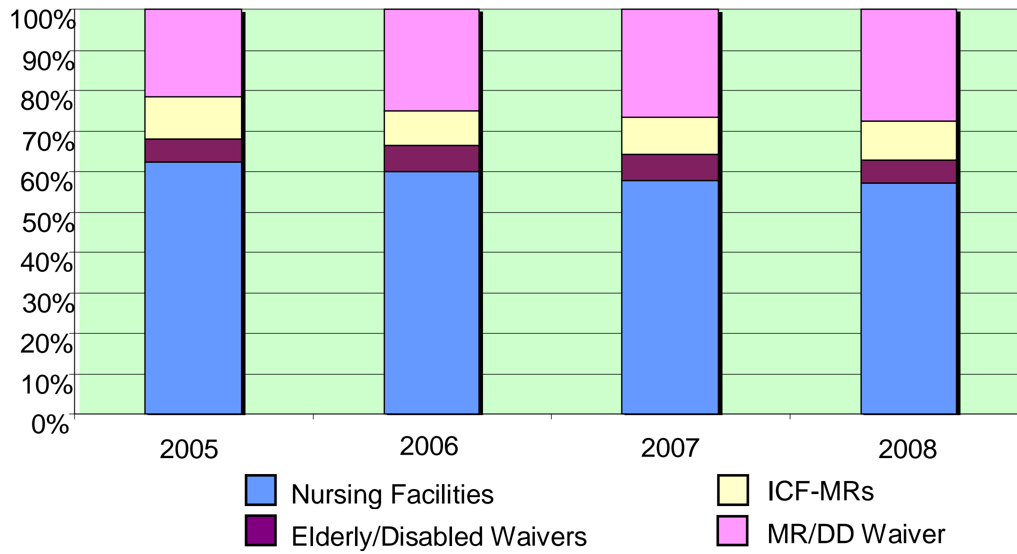
[35] The 2010 Statistical Abstract: State Rankings, U.S. Census Bureau.

[36] Calculated based on CMS-64 data compiled by Thomson Reuters Medicaid Long-Term Care Expenditures in FY 2008, December 1, 2009.

waivers targeted at the elderly and physically disabled increased from $14.4 million to $17.7 million for only a 7.1 percent annualized increase.

The following table displays the distribution of Delaware's spending on the four primary pathways for delivering Medicaid long-term care services.

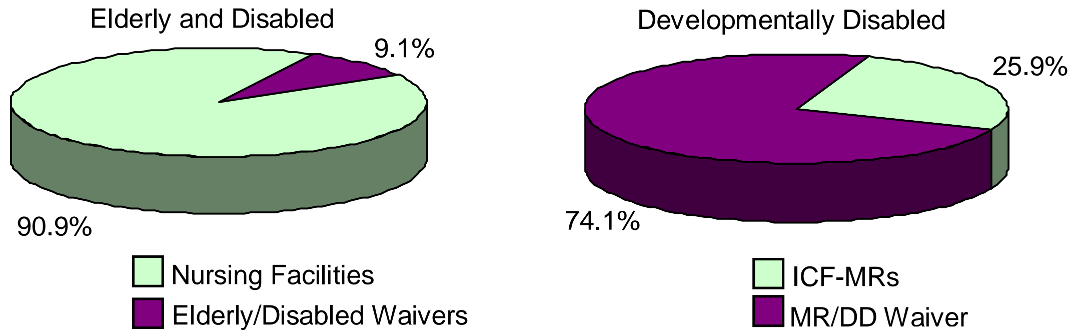
Chart 4 – Distribution of Medicaid long-term care spending[37]



Given these spending patterns, Delaware is exhibiting two distinctly different methods of providing Medicaid long-term care services for the elderly/disabled as compared to the developmentally disabled. As shown in the following chart exhibit, the proportion of 2008 Medicaid funds spent on home- and community-based services versus institutional care is over eight times more for the developmentally disabled as it is for the elderly and disabled. These percentages have been roughly the same in 2006, 2007 and 2008.

[37] Elderly/Disabled waiver data is for Delaware waivers #0136 and #0336; MR/DD waiver data is for Delaware waiver #0009; Ibidem.

Chart 5 – Percent of spending on 1915(c) waivers and institutional care by major population group – 2008[38]



According to the AARP's state profiles of long-term care and independent living[39]:

- Delaware ranks 43rd in the nation for the percentage of spending on aged and disabled through community-based settings in 2007.
- Due to the high home- and community-based spending on the developmentally disabled, when both major population groups are factored in, Delaware's ranking improved to 33rd.

Nursing facility residents and occupancy rates[40]

From 2005 to 2009 the total number of Delaware nursing facility residents increased from 3,799 to 4,256. 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. Over the last few years, the percentage of all nursing facility residents with Medicaid as their primary payor has been consistently between 57 and 60 percent which is below the national average of approximately 65 percent. Occupancy rates at Delaware's nursing facilities have also remained stable at between 85 and 87 percent which closely parallels the national averages indicating that supply is approximating current demand. However, this does not mean that Delaware has an optimal level of nursing facilities. To the extent that people are willing and able to be served in non-institutional settings, but lack the service and support offerings, and availability to do so, results in more nursing facility residents than what is strictly required from a clinical level-of-care need basis.

The following table summarizes data on Delaware's Medicaid long-term care spending for the most recent years for which data was available on all delivery systems[41].

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[38] Ibidem

[39] AARP Across the States Profiles of Long-Term and Independent Living, State of Delaware, 8th edition, 2009.

[40] Harrington, C., Carrillo, H., Blank, B.; Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2003 through 2008, UCSF, November 2009. American Health Care Association, December 2009 OSCAR data.

Table 4 – Delaware Medicaid long-term care program summary

Medicaid delivery system	2004		2005		2006	
	# of people	Total spend	# of people	Total spend	# of people	Total spend
Nursing facilities[42]	2,139	$158.8m	2,260	$154.9m	2,133	$160.0m
E/D waivers	1,304	$13.0m	1,312	$13.7m	1,334	$15.9m
ICF-MRs[43]	194	$28.5m	175	$25.8m	154	$22.8m
MR/DD waiver	685	$48.1m	729	$54.3m	775	$63.9m
ABI waiver	N/A	N/A	N/A	N/A	N/A	N/A
AIDS HCB waiver	557	$2.3m	601	$2.4m	648	$2.7m
TOTAL	4,879	$250.7m	5,077	$251.1m	5,044	$265.3m

Given Delaware's small size, it is not too surprising that in terms of the number of individuals with developmental disabilities served through home- and community-based waiver programs, Delaware's 775 MR/DD waiver participants in 2006 placed the State last in the nation after Connecticut terminated its DD waiver in 2006. However, on a percentage of participants (83.4 percent) and expenditures (73.7 percent), Delaware did better than the national average in serving individuals with developmental disabilities through home- and community-based programs as compared to institutional ICF-MRs. While every state can do more to serve the elderly and individuals with disabilities, Delaware's heavy nursing home institutional bias for the elderly and corresponding poor ranking among the states is a clear area for improvement.

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[41] CMS-372 waiver data compiled from the Kaiser Commission on Medicaid and the Uninsured's Medicaid Home- and Community-Based Service Programs: Data Update, November 2009, December 2008 and December 2007.

[42] Spending from CMS-64 data. Number of Medicaid people from OSCAR data compiled by Harrington et al, UCSF, November 2009.

[43] Spending from CMS-64 data. Number of ICF-MR residents estimated from Prouty et al, Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2007, UMN, August 2008.

5

How does Medicare affect Delaware's long-term care picture[44]?

The 1965 Social Security Act created the two largest national health care programs for the elderly and the poor: the Medicare program as Title XVIII and the Medicaid program as Title XIX, respectively. Based on their original mission statements, Medicare and Medicaid each have their own distinctive characteristics such as:

- Medicare is run by the federal government; Medicaid is administered by states within broad federal guidelines.
- Medicare is limited to those age 65 or older, under age 65 with certain disabilities, or any age with End-Stage Renal Disease; Medicaid covers children, parents, adults (limited), pregnant women, aged and disabled people of all ages.
- Medicare is financed at the federal level by taxes on wages; Medicaid is jointly financed by revenue from both the states and the federal government.
- Medicare eligibility is based on age, disability and work/wage history; Medicaid eligibility is currently based on income, assets and categorical status.

Accordingly, because of these differences, Medicare and Medicaid typically operate in separate environments and have their own respective challenges to address. However, while there are key differences to each program, there are also several key similarities:

- As massive entitlement programs, both Medicare and Medicaid compete for finite public resources.
- As a national program, Medicare's provider fee levels are often a basis of comparison for the Medicaid program.
- Both programs deliver care to beneficiaries through traditional FFS and various forms of managed care.

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[44] Most of the information included in this section was obtained from the 2010 version of the Medicare & You handbook.

The interaction between Medicare and Medicaid is the most pronounced for the low-income elderly and individuals with disabilities who qualify and enroll in both programs concurrently and are commonly referred to as the dual eligibles. In the domain of long-term care, the two programs have often been described as exhibiting a type of "love-hate" relationship for the following reasons:

- While Medicare is a program for the elderly and disabled, it essentially provides only acute and outpatient care services; the bulk of long-term care services are financed by Medicaid.
- Medicare is primarily responsible for an elderly person during their "walking well" period; Medicaid typically takes over after a person's health and financial status has declined to the point of needing extensive services and supports or even institutionalization.
- Medicare's limited responsibility for long-term care services leads to disincentives, fragmentation and a sense of "passing the buck" to Medicaid.
- For most dual eligibles, Medicaid is responsible for paying some portion of Medicare's premiums, deductibles and/or coinsurance under the ironically-named Medicare Savings Program. More information on this important facet of the Medicare/Medicaid relationship is provided later in this Section.
- Medicaid is not responsible for payment of Medicare's drug benefit (i.e., Medicare Part D) copayments for dual eligibles and full-dual eligibles living in an institutional setting have no Medicare Part D copayments. Based on Section 3309 of Title III of PPACA, and no sooner than January 1, 2012, Part D copayments for dual eligibles receiving home- and community-based services (and who would otherwise be institutionalized) will also be eliminated.
- In developing new programs to reduce their Medicaid long-term care costs, state initiatives can often result in reduced acute care costs for the Medicare program (e.g., less inpatient hospital admissions, fewer emergency room visits); however, CMS does not permit states to "take credit" or share in these Medicare savings.

Because of the complex and often confusing rules and regulations associated with both the Medicaid and Medicare programs it is beyond the scope of this paper to describe how the Medicare program interplays with Medicaid in detail. However, if DMMA intends to improve and enhance the State's Medicaid long-term care system, it will be inevitable that Medicare will become a factor in designing and evaluating some program options and initiatives because of Medicare's primary role in providing acute care services. Accordingly, to evaluate Medicaid's options, it is first beneficial to briefly review the parts, delivery systems and cost structure of the Medicare program and then conclude with a description of the dual eligibles.

Medicare Parts A, B, C and D

The Medicare program is composed of four major "Parts" that provide specific program benefits/services to enrolled beneficiaries.

- **Part A Hospital Insurance:** Covers inpatient care in hospitals and limited skilled nursing facility, home health care and hospice services.

- **Part B Medical Insurance:** Covers doctors' services and outpatient care including, but not limited to durable medical equipment, emergency room services, outpatient surgery and laboratory service.
- **Part C Medicare Advantage Plans:** Alternate delivery system where people can voluntarily enroll to receive their Part A, B and usually D services and potentially "extra services" through various forms of managed care such as health maintenance organizations (HMOs), preferred provider organizations (PPOs) or Special Needs Plans (SNPs).
- **Part D Prescription Drugs:** A prescription drug option run by private insurance companies approved by and under contract with the federal Medicare program.

Medicare's long-term care benefits

As noted previously, the Medicare program offers very little coverage for long-term care services. Medicare also does not cover non-skilled "custodial care" support services such as activities of daily living like dressing, bathing and using the bathroom. In limited situations, Medicare will pay for medically necessary skilled nursing facility or home health care services for a specific duration of time under Part A as follows:

- **Skilled Nursing Facility Care:** Medicare helps pay for a person's recovery in a skilled nursing facility, but only after a minimum three-day hospital stay and coverage is for only a maximum of 100 skilled nursing facility days. Services include semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies. To qualify for care, a doctor must certify that daily skilled care like intravenous injections or physical therapy is needed.
- **Home Health Services:** Limited to medically-necessary part-time or intermittent skilled nursing care, physical therapy, speech-language therapy pathology or a continuing need for occupational therapy. A doctor must order the care and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment and medical supplies for use at home. A person must be homebound which means leaving home is a major effort.
- **Hospice:** For people with a terminal illness; a doctor must certify that life expectancy is less than six months. Coverage includes drugs for pain relief and symptom management, medical, nursing, social services and other covered services including grief counseling (not usually covered by Medicare). A Medicare-approved hospice provider usually provides care in a person's home or other facility. Inpatient respite care is also provided so that the usual caregiver can rest.

Medicare out-of-pocket beneficiary cost requirements

To receive Medicare benefits, most people are required to pay a monthly premium, annual deductibles and service-level coinsurance that are updated each year by the federal government. The premiums, deductibles and coinsurance levels vary by Part A and Part B, but are the same across the entire nation. The following are Medicare's premiums and related cost sharing requirements applicable to Part A and B with references to long-term care services where relevant.

The national Medicare premiums for 2010 are:

- $461/month for Part A premium. However, most people do not have to pay a monthly premium to get Part A coverage because they earned Part A coverage through their payroll taxes while working.
- $96.40/month for Part B premium for most people. Higher wage earners pay more.
- For 2010 the national base premium for Part D is $31.94.
- Depending on the Medicare Advantage Plan there may be a separate premium associated with Part C and Part D services.

The national Medicare deductibles for 2010 are:

- $1,100 for each hospital stay per benefit period.
- $0 for the first 20 days of a skilled nursing facility stay.
- $0 for hospice and home health care services provided under Part A.

The national Medicare coinsurance levels for 2010 are:

- $275/day for days 61 – 90 of a hospital stay per benefit period; $550/day after 90 days for up to 60 additional “lifetime reserve days”; all costs for each day after the lifetime reserve days are the responsibility of the individual to pay.
- $137.50/day for days 21 – 100 of a skilled nursing facility stay in each benefit period; all costs for each day after 100 days are the responsibility of the individual to pay.
- 20 percent of the Medicare-approved amount for most Part B services which is the amount the provider agreed to accept from Medicare and is typically less than the provider’s actual billed charges.

Medicare program delivery systems

Medicare delivers services to beneficiaries through two main programs: Original Medicare and Medicare Advantage. A third delivery system called the Program of All-Inclusive Care for the Elderly (PACE) was established in federal law as a separate program.

Original Medicare is a traditional FFS program, much like Delaware’s Medicaid FFS program, where individuals seek services at-will from any Medicare-approved participating provider and the federal government pays the provider’s bill directly less any deductible or coinsurance amounts required from the beneficiary. Everyone enrolled in Medicare defaults into the Original Medicare program to receive services, although Part D drug benefits are provided through private prescription drug plans. Medicaid’s interaction with Original Medicare is generally limited to paying Medicare’s premiums and the applicable out-of-pocket Medicare deductibles and coinsurance for dual eligibles.

By contrast, Medicare Advantage is a managed care program where people voluntarily enroll in and receive services through a managed care entity like an HMO, PPO or SNP. Medicare Advantage plans are required to provide all the same Part A and Part B services that a person would get under the Original Medicare program except hospice care and also provide Part D drug benefits for members. Additionally, in exchange for a more restricted network of providers and possibly an additional monthly premium, plan

enrollees receive assistance with navigating the health care system, personal support from care managers such as registered nurses on staff at the HMO/PPO and possibly additional services not offered under the Original Medicare program such as dental, hearing and wellness services. Some Medicare Advantage Plans may also waive or otherwise modify Medicare deductibles and coinsurance levels.

Generally any Medicare beneficiary is eligible to enroll in a Medicare Advantage plan serving their geographic area. For each person that enrolls in a managed care plan, the federal government pays a monthly capitation rate to the plan for the Medicare risk of the enrolled population (rates vary for Part A and B, ESRD and are risk-adjusted to account for acuity differences). Medicare Advantage capitation rates vary across the country based on a complex formula developed by Congress. Like Original Medicare, Medicaid's interaction with Medicare Advantage HMOs and PPOs is typically limited to applicable premiums and out-of-pocket expenses of dual eligibles.

In Delaware, Medicare Advantage enrollment is quite low. Even though 16 percent of Delaware's population has Medicare (about 145,000), which mirrors the national average of 15 percent, the penetration rate of Medicare Advantage enrollment in 2009 was only 3.6 percent compared to the national average of 23 percent[45]. But less than half of the approximately 5,000 Medicare Advantage enrollment is actually in Medicare HMOs; the majority are enrolled in private FFS plans. So although there is multiple Medicare Advantage plans available in Delaware, consumers have not generally chosen this option for receiving their Medicare benefits.

Medicare Advantage Special Needs Plans (SNPs)

Medicare SNPs are a relatively new type of a Medicare Advantage plan and hence governed by Medicare's rules and regulations pertaining to the Medicare Advantage program just like other Medicare HMOs and PPOs. However, SNPs are not yet a permanent component of the Medicare program; instead SNPs are conditioned on Congress extending the authority for these entities to operate. Until the passage of the Patient Protection and Affordable Care Act (PPACA), SNP authority was set to end on December 31, 2010. Section 3205 of Title III of the PPACA provided a three-year extension of the SNP authority through to December 31, 2013.

The unique aspect of SNPs is that these plans are allowed to limit enrollment (a common practice in Medicaid, but generally prohibited in Medicare) to three different subsets of the Medicare population that has been deemed to have "special needs": 1) people who live in institutions, 2) people who have one or more specific chronic, or disabling conditions and 3) people who are eligible for both Medicare and Medicaid. The different types of SNPs are commonly referred to as Institutional SNPs, Chronic SNPs or Dual SNPs, respectively. The majority of enrollment has been in Dual SNPs.

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[45] Kaiser State Health Facts, Medicare Advantage Plan Penetration, 2009, Delaware.

SNPs are required by Medicare to provide the Part D prescription drug coverage in addition to Medicare's other benefits. Enrollment in SNPs is voluntary just like other Medicare Advantage plans except that Dual SNP enrollees have the added flexibility to enroll/disenroll each month whereas as other Medicare Advantage enrollees are limited to an annual enrollment period. An individual who has both Medicare and Medicaid is not restricted to enrolling in just a Dual SNP; a dual eligible individual can choose to enroll in another type of Medicare Advantage plan or stay in the Original Medicare program. Like other Medicare Advantage plans, all SNPs are paid monthly capitation rates directly from the federal government for the Medicare risk only.

While Dual SNPs enroll people who have both Medicare and Medicaid, the Dual SNP is not financially responsible for any Medicaid covered services. And until the passage of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Dual SNPs were not even responsible for any coordination efforts with the Medicaid program. MIPPA now conditionally requires that Dual SNPs contract with state Medicaid programs to provide for or arrange Medicaid benefits, must provide information on Medicaid benefits to their enrolled members and deploy evidence-based care treatment programs. The contract with a state may or may not involve a financial arrangement between the state Medicaid agency and the Dual SNP. Congress passed MIPPA to strengthen the connection between Medicare and Medicaid for this vulnerable population. Because SNPs are established under the federal Medicare Advantage program, state Medicaid programs have limited ability to make policies and programmatic decisions that impact Medicare's enrollment and coverage rules.

As with the Medicare Advantage program as a whole, SNP activity in Delaware is extremely limited. In 2009, only Evercare and Aetna were listed as offering a Dual SNP product (along with Evercare's separate Chronic and Institutional SNPs) and enrollment was quite small. In the 2010 Medicare Advantage SNP directory, only one SNP was listed, Evercare's Institutional SNP, enrolling approximately 200 people. However, the 2010 directory excluded Dual SNPs that did not have a state Medicaid agreement (a condition in MIPPA for new SNPs or SNP expansion) so it is possible that one or both Dual SNPs still exist.

Program of All-inclusive Care for the Elderly (PACE)[46]

The Balanced Budget Act of 1997 established PACE as a permanent, separate Medicare program and a state plan option under Medicaid. PACE is a voluntary program for individuals age 55 or older who live in the service area of a PACE site and have been certified by the state as meeting the need for nursing home level of care, but can be safely served in the community. The PACE program was one of the first programs to integrate Medicare and Medicaid funding at the provider/organization level to serve all of the needs of enrolled participants and is governed by specific federal regulations. PACE enrollment is open to qualifying individuals who have Medicaid or Medicare or both, but most people who join are dually eligible for Medicare and Medicaid.

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[46] For more details on the PACE program refer to Section 42 CFR 460 in federal regulations.

PACE is organized around a physical site and a team of health care professionals where community interaction and adult day services are provided, although PACE services can be provided in a person's home. While people enrolled in PACE are eligible for nursing home care, typically less than 10 percent of PACE participants reside in institutions. Unlike Medicare Advantage plans that enroll thousands of beneficiaries, PACE sites are typically small – often serving only 50 to 200 members per site.

PACE provider sites receive separate capitation payments from both the federal government and the state Medicaid agency for the provision of all Medicare and Medicaid services, respectively; and are hence financially at-risk for all capitated services. This pooling of resources allows the PACE site to find creative ways to meet the needs of each participant. Separate federal regulations govern the Medicare and Medicaid capitation rates applicable to the PACE program. If a state chooses the PACE state plan option, there is an application process and readiness review that the state must complete to establish a PACE site. Because PACE is an integrated Medicare/Medicaid program, state Medicaid programs do have some policy-decision making and oversight responsibilities in addition to being directly responsible for the Medicaid capitation rate development and payment.

Dual eligibles – few in number, large in cost

As noted previously, people who qualify and enroll in both Medicare and Medicaid are referred to as "dual eligibles" due to their dual enrollment in both government health care programs. Nationally, there are about 9 million low-income elderly and disabled duals which is not a overly large number of people; however, the cost of care for this group is now estimated at a staggering $250 billion annually – approaching half of all Medicaid expenditures and a quarter of Medicare spending[47]. Moreover, this vulnerable population segment is becoming ever more of concern to national and state policy-makers because over 80 percent of dual eligibles remain in uncoordinated and unmanaged FFS programs and this group is most likely to require Medicaid-funded long-term care services due to their low-incomes and generally poor health status.

According to September 2008 monthly and fiscal year Medicaid Statistical Information System (MSIS) enrollment and expenditure data available on Delaware[48]:

- There are 21,356 dual eligibles in Delaware composing 13.8 percent of total Delaware Medicaid enrollment.
- 54 percent of dual eligibles are categorized as Aged with an additional 44 percent categorized as Blind/Disabled.
- Approximately 45 percent of all duals appear to be full Medicaid benefit duals (i.e., entitled to medical benefits under the Medicaid program).
- Delaware's Medicaid spending on all dual eligibles totaled over $310 million.

[47] Center for Health Care Strategies, Inc.; Options for Integrating Care for Dual Eligible Beneficiaries, March 2010.

[48] Analysis of data available from the CMS Medicaid Statistical Information System (MSIS) State Summary Datamart.

- Nearly 50 percent of the total amount spent on dual eligibles was for institutional nursing facility services.
- Over 86 percent of total Medicaid nursing facility spending was related to dual eligibles.
- Spending on dual eligibles accounted for nearly 28 percent of Delaware's $1.1 billion in total Medicaid expenditures.

Accordingly, in Mercer's opinion, any effort by DMMA to positively impact quality and spending in the State's Medicaid long-term care system will need to recognize the importance of dual eligibles and include this population group in any strategic planning efforts.

While the rules and regulations pertaining to dual eligibles are complex and beyond the scope of this paper; terminology is especially critical and can be confusing. The following sections are intended to provide a brief, educational overview of dual eligibles.

Types of dual eligibles and DMMA's financial obligations

Not all dual eligibles are the same in terms of Medicaid's responsibility and some are not technically even considered a dual eligible. Depending on a person's income and resources, there are several different categories of dual eligibles and each category represents a different level of interaction with Delaware's Medicaid program. In general, states may provide the full set of Medicaid benefits to dual eligibles if they otherwise meet all Medicaid requirements or may provide more limited assistance in the form of payment for Medicare premiums and cost-sharing commonly referred to as the Medicare Savings Program.

As it pertains to eligibility for the Medicare Savings Programs, Section 112 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 increased the resource limits for some dual eligibiles (Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualified Individuals) to conform to the resource limit for individuals who qualify for the full subsidy Medicare Part D low-income subsidy[49] (effectively $6,600 for an individual or $9,510 for a couple). These resource limit increases took effect in 2010 and would result in an increased number of people for which state Medicaid programs pay Medicare's premiums, deductibles and/or coinsurance. However, the increase in resource limits for the Medicare Savings Program did not impact general Medicaid eligibility for receiving Medicaid-funded program services for which states still typically rely on the SSI resource limit.

For Delaware, the MIPPA required resource limit increases should have minimal, if any, impact because Delaware does not impose any resource limit for the impacted populations in determining coverage under the Medicare Savings Program[50] (i.e., Qualified Medicare Beneficiary Programs). Accordingly, Delaware's program can be

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[49] February 18, 2010, State Medicaid Director Letter #10-003, Center for Medicaid and State Operations.

[50] Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities, Table 5, Kaiser Commission on Medicaid and the Uninsured, February 2010, Report #8048.

segmented into two primary classes of dual eligibles: those that receive full Medicaid medical benefits and those that receive only assistance with paying Medicare premiums, deductibles and coinsurance as described below:

- **Full Medicaid benefit dual eligibles (Full Benefit):** In Delaware, these individuals qualify for both Medicare and Medicaid and have incomes up to the SSI level ($674.00/month for an individual or $1,011.00/month in 2010) and resources up to the SSI limit ($2,000 for an individual or $3,000 for a couple). Due to their low incomes and limited resources, DMMA also pays the applicable Medicare premiums, deductibles and coinsurance. Additionally, under the special income rule, Delaware provides full Medicaid medical benefits for individuals up to 250 percent of FPL under the Medicaid nursing facility and home- and community-based waiver programs (resource test is $2,000 and spousal impoverishment rules apply in these cases).
- **Qualified Medicare Beneficiary Only (QMB Only):** These dual eligibles have incomes that do not exceed 100 percent of FPL and are entitled to receive assistance from DMMA in paying only the applicable Medicare premiums, deductibles and coinsurance consistent with the Medicaid state plan policies. The QMB Only group does not receive any supplemental Medicaid medical benefits. As noted previously, Delaware is one of a small number of states that has chosen to have no resource limit in determining eligibility for the Medicare Savings Program.
- **Specified Low-income Medicare Beneficiary Only (SLMB Only):** These dual eligibles have higher incomes between 100 and 120 percent of FPL, but are entitled to receiving Medicaid assistance in paying only the Medicare Part B premium. The SLMB Only group also does not receive any supplemental Medicaid medical benefits and no resource limit applies in Delaware.
- **Qualified Working Disabled Individuals (QWDI):** These individuals have incomes that do not exceed 200 percent of FPL and may have lost Medicare Part A benefits due to returning to work, but are eligible to enroll in and purchase Part A and not otherwise eligible for Medicaid. The only Medicaid benefit offered is payment of the Part A premium. The QWDI group also does not receive any supplemental Medicaid medical benefits and no resource limit applies in Delaware.
- **Qualifying Individuals-1 (QI-1):** This limited financial benefit is available to individuals with incomes between 120 and 135 percent of FPL as an extension of the SLMB Only benefit to pay the Medicare Part B premium only (no Medicaid medical benefits, no resource limit in Delaware). States receive 100 percent federal funding for the QI-1 program; however, funding is limited based on state allotments so financial assistance is typically provided on a “first come, first served” basis. The QI-1 program is subject to renewal by Congress and was most recently renewed through December 31, 2010 as part of the American Recovery and Reinvestment Act (ARRA).

Because of the additional Medicaid medical benefits, the Full Benefit dual eligibles are typically the mostly costly to Medicaid, especially in terms of Medicaid long-term services and supports.

Summary table on the interaction of Medicare and Medicaid for dual eligibles

The following table summarizes the interaction of Medicare and Medicaid for dual eligibles.

Table 5 – Interaction of Medicare and Medicaid for dual eligibles

Dual Eligible Group	Entitled to full Medicaid medical benefits?	Medicaid pays Part A premium?	Medicaid pays Part B premium?	Medicaid may pay deductibles and coinsurance
Full Benefit	Yes	Yes	Yes	Yes
QMB Only	No	Yes	Yes	Yes
SLMB Only	No	No	Yes	No
QWDI	No	Yes	No	No
QI-1	No	No	Yes	No

Delaware's Medicaid program will receive federal matching funds for any payment made pertaining to dual eligibles' Medicare premiums, deductibles or coinsurance at the same Medicaid FMAP rate as would be received for Medicaid provided medical services. Medicaid PACE capitation rates are also matched at the Medicaid FMAP rate like other capitated Medicaid managed care programs.

Conditional payment for Medicare/Medicaid cross-over claims

It is important to know that Medicaid does not pay providers first when it comes to dual eligibles. Medicare is primary; Medicaid's obligation is conditional based on what Medicare covers, the amount of the Medicare payment the provider received and benefits/policies in the state's Medicaid program. If a dual eligible receives a service that is jointly covered by both the Medicare and Medicaid programs, these "cross-over" claims should first be processed for payment by the Medicare program either through the Original or Medicare Advantage plan depending on what Medicare delivery system the person was enrolled in. Subsequently, the provider should submit the claim to the Medicaid program for any additional payment that is permitted under the state Medicaid plan.

Furthermore, Medicaid's payment responsibility for a cross-over claim can be on a conditional basis. Federal law provides that a state Medicaid program is not required to provide payment for any expenses incurred for a Medicare deductible or coinsurance in the event that the Medicare payment for the service exceeds the payment amount that would have been made by the Medicaid program. Therefore, it is possible that Medicaid's payment for a cross-over claim can be zero. Federal law disallows a provider from balance-billing a dual eligible for any unpaid claim amount.

New Federal Coordinated Health Care Office (CHCO) for dual eligibles

As noted previously, states and the federal government have often been at odds over program initiatives, policy issues and credit for savings when Medicaid and Medicare are both involved in the lives of the low-income elderly and disabled dual eligibles. Policymakers are coming to the realization that a vast amount of spending is generated by this one population group and that the separation of Medicare and Medicaid operations and oversight at the federal level has contributed to the fragmentation of care for this vulnerable and costly group. Indeed, this separation has directly led to much frustration for states that have experienced difficulty trying to get the Medicare program administrators to work with state Medicaid agencies more collaboratively and address the myriad of regulatory issues impacting both programs.

In a clear sign that things are changing at the federal level, Section 2602 of Title II of the recently enacted PPACA requires the Secretary to immediately establish a new Federal Coordinated Health Care Office (CHCO) within CMS. The purpose of the new CHCO is to “bring together officers and employees” of CMS in order to:

- More effectively integrate Medicare and Medicaid program benefits.
- Improve the coordination between federal and state entities for dual eligibles to ensure dual eligibles have full access to their entitled items and services.

The PPACA established the following goals for the new CHCO:

- Provide dual eligibles full access to all entitled Medicare and Medicaid services.
- Simplify the process for dual eligibles to access services.
- Improve quality of health care and long-term services for dual eligibles.
- Increase dual eligibles’ understanding and satisfaction with the Medicare and Medicaid programs.
- Eliminate regulatory conflicts between rules governing the Medicare and Medicaid programs.
- Improve care continuity and ensure safe, effective care transitions for dual eligibles.
- Eliminate cost-shifting between the two programs.
- Improve quality performance of providers under both programs.

The PPACA also delineated specific responsibilities for the new CHCO:

- Provide states, SNPs and other providers with education and tools to develop programs that align program benefits for dual eligibles.
- Support state efforts to coordinate and align acute care and long-term care services for dual eligibles.
- Provide support for coordination, contracting and oversight by states and CMS related to the integration of Medicare and Medicaid services.

- Consult and coordinate with the MedPAC and MACPAC[51] commissions regarding relevant issues pertaining to dual eligibles.
- Study the provision of drug coverage for new full-benefit dual eligibles as well as monitor and report annual expenditures, health outcomes and access to benefits.

These changes at the federal level make clear the importance and significance of the dual eligibles in terms of the nation's health care system. While there will still be many policy and operational issues to address in implementing programs targeted at the dual eligibles, the new statutory requirements placed on CMS to collaborate with states indicates that DMMA can now expect to have more cooperation and assistance from CMS in pursuing programs aimed at this costly and vulnerable population.

[51] Mark Hoyt, FSA who is Mercer's National Practice Leader for our Government Consulting Practice was selected as one of the first members of the MACPAC commission.

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Medicaid options for promoting community-based long-term services and supports

As stated previously, DMMA's goal is to develop more community-based alternatives for Medicaid long-term services and supports in lieu of institutionalization. There are several different program initiatives that can be deployed separately or together in both the traditional Medicaid FFS system or through new Medicaid managed care programs to support this goal. For purposes of this paper, we did not want to limit the discussion to just managed care initiatives, although an efficient and effective managed care program may align financial and operational incentives in the best way.

In the following sections, various options are presented and discussed. Along with a description of each option, a brief, qualitative opinion of the potential impact each option may have on fiscal expenditures and quality is also provided. However, it is beyond the scope of this paper to perform any financial/actuarial forecasts of program spending or estimate the specific staffing resources and internal costs associated with each option. Additionally, where applicable, comments are provided regarding the practicality of implementing each option in Delaware including estimates of the lead time required to implement each option.

While we have reflected changes stemming from the recently enacted PPACA in presenting these options, additional guidance from CMS has not been released as of the date on this report. Therefore, the specific references to the PPACA are a preliminary assessment and subject to change or revision in application once further guidance becomes available. At the end of this Section, we provide a table that summarizes and provide brief pros and cons of each option.

It is also important to note that while the following options promote and align fiscal/operational incentives towards community-based care delivery; these options in themselves do not necessarily create tangible alternatives. For example, contracting with Medicaid HMOs to coordinate and manage long-term services and supports does not immediately increase the number of home health care workers in the State or result in

the construction of new affordable housing units. A Medicaid HMO that is held financially and operationally accountable for their members' care will seek to find ways to provide quality and cost-effective services such as more home care, home modifications, medication management and personal outreach and connection to help the member stay active and healthy. Implementing these types of options re-directs the focus of care managers, providers, consumers and State staff to use financial and human resources in more consumer-friendly, cost-effective and innovative ways (e.g., paying for home modifications as a new benefit). Over time, aligning these resources in the right way shifts attention and energy to more proactively addressing health status and functional limitations which will then lead to direct, tangible changes in service offerings and lead to changes in social attitude towards how Medicaid cares for the elderly and individuals with disabilities and delay further functional deterioration.

The options in this Section are organized into three main groups based on the type of delivery system for delivering care as follows:

- Group A options enhance the State's Medicaid FFS long-term care system.
  - Option A1: Coverage of personal care services under the state plan.
  - Option A2: 1915(i) state plan option for home- and community-based services.
  - Option A3: 1915(j) state plan option for consumer-direction of personal care services.
  - Option A4: 1915(k) state plan option for attendant care services in home and community settings (Community First Choice Option).
  - Option A5: 1915(c) home- and community-based waivers.
- Group B describes different Medicaid-only managed care program options.
  - Option B1: 1932(a) state plan managed care option.
  - Option B2: 1915(a) voluntary managed care authority.
  - Option B3: 1915(b) mandatory managed care waivers.
  - Option B4: Concurrent authorities for managed long-term care programs.
  - Option B5: 1115 demonstration waiver.
- Group C present options for integrated Medicare/Medicaid managed long-term care for dual eligibles.
  - Option C1: Program for All-inclusive Care for the Elderly (PACE)
  - Option C2: Medicare Advantage plans – Special Needs Plan (SNPs)

The options presented herein will fit within Delaware's overall strategy in different ways. For example, if the State's primary objective is simply to expand care available in home- and community-based settings, most of the FFS state plan amendments described in Group A are consistent with that goal. However, if the State is seeking a broader strategy of impacting the delivery, management and integration of the Medicaid long-term care system, the managed care options described in Groups B and C and possibly the 1915(k) state plan option are more aligned with transforming the system of long-term services and supports. If the State's goal is to implement a new initiative in less than a year, the more complex options involving managed care development and procurement, 1115 waivers and integrating Medicaid with Medicare are not practical choices.

Mercer recommends that as part of the next phase of this endeavor that DMMA, in conjunction with both internal and external stakeholders, discuss and evaluate the merits

of these options in regards to how Delaware's strategy and objectives can be best complemented by the chosen initiative(s).

Group A options: Enhancing the Medicaid FFS long-term care system

The following options can be implemented through relatively simple state plan amendments that provide DMMA the regulatory authority to offer and pay for alternative services intended to delay or divert the need for institutionalization. However, some of these options have limitations on DMMA's ability to manage the breadth, scope and/or quality of coverage. Therefore, these options should be considered in light of those realities and whether these options represent the best fit for achieving the State's goals.

Even though the act of amending the state plan is significantly less complicated and time consuming than developing a new managed care wavier and/or procuring contractors, the need for DMMA staff to evaluate the ramifications of amending the state plan on fiscal spending, provider supply and payment rates, consumer demand, quality of care, information technology updates and data reporting will still require appropriate staff time and resources.

Option A1: Coverage of personal care services under the state plan

Personal care services (PCS) is an optional Medicaid benefit. PCS encompasses a relatively broad description of unskilled services that include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks such as ADLs or IADLs that they would normally do for themselves if they did not have a disability; assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cueing (prompting the person to perform the task) so that the person performs the task by themselves[52]. PCS are approved as part of person's plan of care and can be provided inside or outside the home, but not in institutions like hospitals or nursing facilities.

Based on 2008 CMS-64 reported expenditures, over 30 states provided PCS (sometimes referred to as personal assistance services or attendant care services) through their Medicaid state plans. Delaware does not currently offer PCS as part of the State's Medicaid plan, instead PCS is available on a limited basis to those who qualify for one of Delaware's existing 1915(c) waiver programs that offers PCS as a special waiver service. However, Delaware does offer adults with physical disabilities a state-funded Personal Attendant Services program that provides similar types of services.

Since this option involves amending the State's Medicaid plan to cover optional PCS, the service would have to be made available statewide to every eligible Medicaid participant.

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[52] State Medicaid Manual, Section 4480(c).

DMMA would have the ability to define medically-necessity criteria, establish provider qualifications, and deploy utilization management techniques, but otherwise the service would be available to everyone. Furthermore, Section 1915(j), discussed later, provides Delaware the option to also allow self-direction of PCS via a state plan option.

Our initial comments on this option in regards to:

- **Potential impact on Medicaid spending:** Because this option involves amending Delaware's state plan to add a new entitlement service, it would be difficult for DMMA to effectively target PCS to those most at-risk of institutionalization to reduce aggregate spending. Moreover, spending on PCS can grow extremely quickly and due to the unskilled nature of the service providers has a high potential to replace unpaid caregivers with public funds. For example, CMS-64 data indicates North Dakota first began reporting PCS expenditures in 2004; in 2005 the state spent $2.0 million and by 2008 the amount reported was a remarkable $12.6 million. Over the same time, North Dakota reported expenditures on nursing facilities increased from $158.2 million to $168.3 million. However, it is possible that Delaware's state-funds spent on personal attendant services could be re-directed to partially off-set the total new spending on PCS which would draw down federal matching funds instead of being completely funded with state dollars only.
- **Potential impact on quality issues:** Since PCS is intended to provide hands-on assistance to people with chronic disease or disabilities, this service would likely be viewed favorably by those beneficiaries who could obtain services. Moreover, if minimal assistance with ADLs or IADLs is all that is needed to maintain home- or community-living in lieu of institutionalization, this service could be helpful in creating a larger continuum of services available under the State's Medicaid program.
- **Practicality of implementing in Delaware:** Delaware can simply cover this service by submitting a state plan amendment. Developing service criteria, provider qualifications, payment rates, claims processing edits, and educating providers, consumers and families about this new benefit would require staff time, but conceivably some of this work has already been completed because of the coverage of PCS in some of Delaware's 1915(c) waivers. An estimate of 6 to 12 months should be reasonable to implement this option. The unskilled nature of the work suggests that caregiver supply issues would be less of a concern as compared to skilled home nursing care, but there is a general shortage of home health/personal care aides today.

Option A2: 1915(i) state plan option for home- and community-based services

Originally created by the Deficit Reduction Act of 2005 and most recently updated in Section 2402 of Title II of PPACA (effective April 1, 2010), Section 1915(i) gives states the option to provide home- and community-based services through a state plan amendment instead of a more burdensome waiver process. Under this option, states are able to do the following:

- Use eligibility criteria that are less restrictive than the state's nursing facility clinical eligibility standard (i.e., target eligibility on a "needs-basis" as defined by the state).
- Cover individuals up to 300 percent of SSI (a limitation prior to PPACA).

- Are not required to demonstrate that community-based care is cost-effective as compared to institutionalization.
- Expands the service offerings available under the 1915(i) state plan option to include the “other services clause” consistent with1915(c) waiver authority. Services must be provided statewide but do not have to be comparable across enrolled populations.
- Prohibits states from setting limits on the number of participants.
- Establish recipients receiving services through 1915(i) as an optional categorical group for Medicaid program coverage purposes.
- Requires a “grandfathering” provision to allow program participants to retain coverage in the event that the state tightens its eligibility criteria as long as the person continues to meet the prior eligibility criteria.
- Can still target specific populations and vary scope of services on a five-year conditional renewal basis; including phasing-in populations and services.

While the 1915(i) state plan option is easier to implement and maintain than a waiver, prior to PPACA, the financial/categorical eligibility requirements for the program were effectively much more restrictive than 1915(c) waivers which could cover individuals up to 300 percent of SSI. Accordingly, only a very limited number of states initially took advantage of the 1915(i) option such as Nevada, Colorado and Washington.

Our initial comments on this option in regards to:

- **Potential impact on Medicaid spending:** The 1915(i) option operates much like 1915(c) waivers where spending is directed towards home- and community-based services to support the functional and health status of individuals and ideally delay or divert the need for costly institutional care (i.e., spend more now to try and save some later). Implementing a 1915(i) option will increase total Medicaid spending if more people seek services than institutional diversion can off-set especially in the early years. This option may also redirect spending under one of Delaware’s existing waivers thus lessening the potential for increases in aggregate spending. Even with no current waiting lists, the relatively small number of the elderly/disabled currently served through 1915(c) waivers, opening a new state plan option to provide community-based services could quickly increase spending if there is a large unmet need presently in the State (unknown at this point).
- **Potential impact on quality issues:** The 1915(i) option allows Delaware to provide additional services that are typically not available under the state plan aimed at assisting people with their needs in community-based settings. Accordingly, these new services would likely impact quality much the same way as Delaware’s 1915(c) waivers have done by promoting more cost-effective and consumer-oriented services to enable consumers to remain in their homes and communities.
- **Practicality of implementing in Delaware:** Because the 1915(i) option closely mirrors many of the facets of existing 1915(c) waivers, it is practical for DMMA to consider the benefits of this option and leverage existing policies and provider rates established in the waiver(s). However, because this option now requires statewide coverage and more importantly no limits on the number of program participants, DMMA would have to carefully consider whether the elimination of the administrative effort of 1915(c) waiver(s) justifies the additional exposure generated by this option. Given these types of policy issues, this option would likely require more time to

implement than Option A1 to cover personal care services. Even though a 1915(i) option can be implemented via a state plan amendment, Mercer suggests a minimum of 9 to 12 months to provide time for deliberation and evaluation. Consideration would also have to be given to whether sufficient workforce exists to meet demand if the service availability becomes part of the state plan on a broader basis. It is feasible that DMMA could define the needs-based criteria sufficiently well to indirectly place some control on the potential population seeking services. But DMMA may be limited to having just a single 1915(i) option whereas today different waivers can target different populations (subject to further CMS guidance).

Option A3: 1915(j) state plan option for consumer-direction of personal care services

The Deficit Reduction Act created the new Section 1915(j) state plan option, effective January 2007, to permit states to provide individuals with the option to self-direct their personal assistance services already offered under either the state plan or a waiver. This option has sometimes been referred to as “cash and counseling.” Section 1915(j) does not create any new service; it only provides a new delivery model for an already covered service that is intended to promote greater consumption and use of community-based long-term services and supports. As noted previously, Delaware does not offer personal care services under the state plan, so this option would only be applicable to the respective 1915(c) waivers (unless DMMA implemented PCS as a regular state plan service). States that have submitted and received approval for state plan amendments for the self-direction option includes Alabama, Arkansas, California, Florida, New Jersey, Oregon and Texas.

Consumer participation in 1915(j) self-direction is voluntary and for those consumers who do elect self-direction their responsibilities include:

- Qualifications of workers who will furnish their services.
- Train, hire and fire appropriate service providers (including family relatives).
- Authority for determining provider payment rates.
- Managing their budgets with the ability to purchase permissible personal assistance and related items to increase independence or substitute for human assistance.

The State’s responsibilities under the Section 1915(j) option include:

- Providing assurances that the necessary safeguards have been taken to protect the health and welfare of the Medicaid participants.
- Assuring the financial accountability for funds expended for self-directed services. Most states employ fiscal intermediaries to provide accounting/administrative support services to participants (this would be a new cost for Delaware).
- Providing support to the participants with information, counseling, training in regards to the participant’s employer-related responsibilities.

If electing self-direction via a state plan option instead of through a 1915(c) waiver, states can still limit the availability of self-direction to certain geographic areas as well as just a targeted population. This flexibility enables states to retain some control and

discretion over the availability of self-direction in comparison to other state plan options that have to be made available statewide to everyone.

Our initial comments on this option in regards to:

- **Potential impact on Medicaid spending:** If Delaware wanted to provide self-direction as an optional service under the State's regular Medicaid state plan, the availability of personal assistance services would first have to be covered by the state plan. Accordingly, previous comments pertaining to PCS impact on spending are relevant. Whereas the self-direction option can be limited on a geographic or population basis, the availability of PCS cannot; therefore, this option carries with it prerequisites that might expand spending beyond what DMMA may want to see happen. Contracting with a fiscal intermediary to provide support functions would be a new cost to the State. Notwithstanding these concerns, the self-direction option is intended to involve consumers more actively in their own service utilization and spending patterns. The ability to offer consumers a monthly budget for which they direct, use and could possibly save to purchase other related goods and services is intended to better direct funds to best meet the needs of consumers and conceivably reduce the level of ineffective or unnecessary spending.
- **Potential impact on quality issues:** Since the 1915(j) option gives a level of authority and decision-making ability to Medicaid consumers for their personal assistance services, these programs are typically viewed favorably as the consumers obtain a sense of independence and empowerment over their own lives. Furthermore, if the consumers can use funds in ways that they view as best meeting their needs (within a framework established by the state), quality of life and satisfaction should correspondingly increase. Indeed, the Agency for Healthcare Research and Quality, cash and counseling programs resulted in increased access to personal care services, significantly fewer unmet personal care needs, and enhanced beneficiary satisfaction[53].
- **Practicality of implementing in Delaware:** Without the coverage of personal care services under the Medicaid state plan, application of this option is limited to specific 1915(c) waivers that offer personal care services that can be subject to self-direction. To the extent that self-direction has been an aspect of the state-funded Personal Attendant Services program, the groundwork and experience may exist to expand this option to Medicaid-funded services. DMMA would be required to establish the required assurances and support functions to carry-out the Section 1915(j) requirements. Given these policy issues and the potential need to procure a fiscal intermediary, Delaware would likely need a minimum of 12 to 16 months to effectively implement a 1915(j) option. As noted before, self-direction does not result in any new service being available, instead like other options being discuss herein, the different delivery model is intended to alter the landscape of Delaware's long-term care

[53] AHRQ, Self-Directed, Self-Controlled Budget for Personal Assistance Services Reduces Unmet Needs, Improves Quality of Life for Medicaid Beneficiaries, http://www.innovations.ahrq.gov/content.aspx?id=1800, April 14, 2008.

system by empowering consumers to take their health care needs more into “their own hands”.

Option A4: 1915(k) state plan option for attendant care services in home and community settings (Community First Choice Option)

Section 2401 of Title II of the PPACA created a completely new state plan option program for home- and community-based attendant care services called the Community First Choice Option. Beginning in October 2011, states can provide community-based attendant services and supports via a simple state plan amendment instead of obtaining waiver authority and are given an enhanced FMAP as an incentive. The following are key provisions of the new 1915(k) option (some provisions resemble those in 1915(c) waivers):

- Institutional level of care requirements apply to the 1915(k) option.
- Financial eligibility is limited to 150 percent of the FPL; however, if the state has opted to use the special income rule for nursing facility eligibility, the 1915(k) financial eligibility can default to this higher standard which could be up to 300 percent of SSI. Delaware uses a 250 percent of SSI financial requirement for Medicaid nursing facility services[54].
- Services must be provided in non-institutional settings consistent with a person-centered plan based on an assessment of the functional need and agreed to in writing.
- Mandatory community-based attendant services must be provided to assist individuals in ADLs, IADLs, and health-related tasks through hands-on assistance, supervision or cueing.
- Optional services that can be provided include institution-to-community transitional costs such as; rent and utility deposits, bedding, basic kitchen supplies, and other necessities identified in the person’s care plan.
- Services specifically excluded are room and board, special education and vocational rehabilitation services, most assistive technology devices, medical supplies and equipment, and home modifications.
- Services can be provided either through an agency-model or some other model as long as services are selected, managed and dismissed by the individual (or their representative) to the maximum extent practical.

In order for a state plan amendment to be approved under the 1915(k) option, the PPACA contained specific conditions that the state must satisfy:

- State must work in collaboration with a Development and Implementation Council established by the state that includes a majority of members with disabilities, elderly individuals and their representatives.

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[54] Kaiser Commission on Medicaid and the Uninsured, Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities, Publication #8048, February 2010.

- Services must be provided statewide in the most integrated setting without regard to the person's age or disability.
- In the first full year of operations, states must maintain or exceed their level of expenditures on the aged and disabled as was made in the preceding year.
- Establish and maintain a comprehensive, continuous quality assurance system that includes standards for training, appeals for denials, incorporates feedback from consumers, maximizes consumer control, monitors the health and well-being of each individual, mandatory reporting and investigation of abuse/neglect allegations, and provides information on these quality issues to each individual receiving services.
- Collection and reporting of cost, utilization and enrollment data to the federal government.

If all of the aforementioned conditions are met, states that select this option will receive an increase in FMAP rate of six percentage points on related 1915(k) attendant services and support expenditures.

Our initial comments on this option in regards to:

- **Potential impact on Medicaid spending:** Since this is a brand new option, there is no related experience from other states or within Delaware to base an opinion on. The mandatory 1915(k) services resemble the services available in Delaware's elderly/physically disabled waiver which also does not cover home modifications. The financial and functional eligibility requirements mirror those of Delaware's Medicaid waivers/nursing facilities suggest that the eligible population may be several thousand, but this number is almost double the total enrollment in all of Delaware's 1915(c) waivers and the 1915(k) option does not permit caps on the number of people served. The six percentage point increase in FMAP is attractive, but can be quickly off-set by only a small increase in the number of people accessing services.
- **Potential impact on quality issues:** The 1915(k) option allows Delaware to provide additional services that are not available under the state plan aimed at assisting people with their needs in community-based settings. Accordingly, these new services would likely impact quality much the same way as Delaware's 1915(c) waivers have done by promoting more cost-effective and consumer-oriented services to enable consumers to remain in their homes and communities. The focus on person-centered planning and individual control of services combines elements found in both the 1915(i) and 1915(j) options so as to maximize consumer satisfaction and involvement in decision-making.
- **Practicality of implementing in Delaware:** The federal government created the 1915(k) option to make it easier for states to provide home- and community-based services through their state plans. However, the conditional elements of establishing a Development and Implementation Council (unless one already exists) and the quality/data requirements suggests that this new option will carry a significant amount of administrative effort to implement and oversee. Due to these reasons and the lack of detailed federal guidance, Delaware should conservatively assume a minimum of 18 months to launch a 1915(k) program option. Based on current elderly/disabled waiver spending, the six percentage point FMAP increase is tantalizing, but may not be sufficient to make the decision any easier on whether this is a viable option for

DMMA. As with all other options, offering community-based services requires sufficient workforce numbers to meet the increased demand.

Option A5: 1915(c) home- and community-based waivers

Delaware is quite familiar with the Medicaid 1915(c) waiver in that the State currently operates five different waivers applicable to elderly/disabled, MR/DD, HIV/AIDS, assisted living and acquired brain injury. As noted in Section 4, Delaware's elderly and disabled waiver has the largest number of persons served, but spending on the MR/DD waiver dwarfs all other waivers.

States may offer a variety of services to consumers under a 1915(c) waiver program and the number of services that can be provided is not limited These programs may provide a combination of both traditional medical services (e.g., dental services, skilled nursing services) as well as non-medical services (e.g., respite, case management, environmental modifications). Family members and friends may be providers of waiver services if they meet the specified provider qualifications. However, in general spouses and parents of minor children cannot be paid providers of waiver services.
Within the parameters of broad federal guidelines, states have the flexibility to develop 1915(c) waiver programs designed to meet the specific needs of targeted populations. Federal requirements for states choosing to implement a 1915(c) waiver program include:

- Demonstrating that providing waiver services to a target population is no more costly than the cost of services these individuals would receive in an institution.
- Ensuring that measures will be taken to protect the health and welfare of consumers.
- Providing adequate and reasonable provider standards to meet the needs of the target population.
- Ensuring that services are provided in accordance with a plan of care.

Section 2402(a) of Title II of PPACA requires the Secretary to further promulgate regulations related to the administration of home- and community-based services, including ensuring that states allocate resources that are responsive to consumers, support individualized self-directed services, improve coordination among and regulation of providers such as coordination of eligibility determinations, development of quality systems, and assuring an adequate number of qualified direct care workers.
States have the discretion to choose the number of consumers to serve in a 1915(c) waiver program and limit the program to a specific geographic area. Once approved by the federal government, a state is held to the number of persons estimated in its application, but has the flexibility to serve greater or fewer numbers of consumers by submitting an amendment for approval. The 1915(c) waiver provisions allow a state to make waiver services available to people at risk of institutionalization, without being required to make waiver services available to the Medicaid population at large. Virtually every state in the nation operates at least one 1915(c) waiver and many states operate as many 10 or more different waivers aimed at different populations and service offerings.

Our initial comments on this option in regards to:

- **Potential impact on Medicaid spending:** As Delaware has already experienced, spending on Medicaid 1915(c) waivers can grow rapidly as consumers access and use these additional services to meet their needs. While the per person costs for most 1915(c) waivers is much less than the per person institutional costs (DD waivers can be quite expensive even in comparison to ICF-MR costs), often the number of people served in waiver programs or the utilization of services can create its own challenges causing states to place limits on services or waiver "slots" to contain spending growth. Ideally, the financial benefit of 1915(c) waivers is to provide cost-effective community-based long-term services and supports to those who are at-risk of needing institutionalization to divert or delay the institutionalization.
- **Potential impact on quality issues:** As noted in previous Sections of this paper, virtually all consumer surveys and studies indicate that individuals are much happier and satisfied with being able to receive support services in their homes or communities. Community-based care positively impacts social interaction, self-esteem and quality of life. Very few people want to be institutionalized.
- **Practicality of implementing in Delaware:** Delaware already has several 1915(c) waivers in operation and is thus quite familiar with the operational protocols for developing and supporting this option. The challenge is whether these waivers are providing the right services to the appropriate populations. As noted earlier in this paper, Delaware directs very little spending on the elderly/disabled via home- and community-based care in relation to nursing facilities. This suggests there is great potential to increase the amount of community-based care directed at this population. However, to do this through 1915(c) waivers would entail either amending the State's existing elderly/disabled waiver to cover many more people, increasing the number of services available under the waiver (e.g., home modifications) or creating new waivers targeted at different segments of the population. More waivers increase the administrative burden and internal State staff resources required to oversee the program and can create challenges to effectively coordinate and focus the State's finite resources. Other states have also experienced "competition" between waivers as the number of community caregivers is limited yet the demand is great, which can lead to preferential treatment of different waivers and even different provider reimbursement rates for similar services in different waivers. To some degree, consolidating waivers can streamline operations, focus resources more directly and alleviate inconsistencies in polices and procedures that may exist across different waivers. Accordingly, DMMA should conservatively assume a minimum of 9 to 12 months to develop and launch a new 1915(c) waiver program.

Group B options: Medicaid-only managed long-term care programs

Unlike the preceding options that focused on traditional FFS, the following options pertain to what DMMA can do in regards to using managed care and waiver flexibilities to advance the State's goal of increased community-based long-term services and supports. Through these following options, DMMA would contractually partner with external third-party managed care entities who would be financially and operationally

accountable for the provision of Medicaid services and quality of care received by their enrolled members.

Although 1932(a), 1915(a) and 1915(b) programs are presented in the sections that follow; in reality these programs are not necessarily viable as stand-alone options for increasing community-based Medicaid long-term services and supports because these programs generally include only state-plan covered services. Instead, these options should be viewed as separate, but complimentary authorities that can enable delivery system changes, including managed care, for persons in need of institutional or home- and community-based long-term care. Regardless of the authority, Delaware should assume a minimum of 18 to 24 months to successfully implement a managed long-term care program.

A benefit of capitated managed care is the flexibility to adjust the capitation rates and contracts to reflect the provision of home- and community-based services even if these services are not covered in the state plan and the managed care program is effectively a "stand-alone" program (i.e., without a concurrent 1915(c) waiver or 1915(i) option). This rate-setting approach can be accomplished in one of the following ways:

- If there is a separate 1915(c) waiver or 1915(i) state plan amendment available in the same geographic area that contains the same community-based services that would be available to the same population enrolled in the managed care program, CMS will allow the community-based services to be included in the managed care contract and rates.
- The managed care capitation rates can be explicitly built on the assumption that cost-effective, non-state plan community-based services will be provided "in lieu of" more costly covered state-plan services such as institutional care. The managed care contract cannot require the plans to provide these alternative services, but contract language can be written to encourage a plan to provide more cost-effective services.
- Under a 1915(b) waiver that utilizes the authority in section 1915(b)(3), states can use the savings in state plan services from managed care to contractually require the plan to provide additional non-state plan services such as home- and community-based services. A state must have processes in place to summarize the specific 1915(b)(3) expenditures each and the savings must be sufficient to justify the additional services.

Along with the benefits of risk-based managed care comes the cash-flow challenge of transitioning from post-paid FFS to prepaid capitation, often referred to as the "claims tail lag." This results in a limited period of time during which a state pays FFS claims on behalf of individuals for past periods while making prepaid capitation payments. However, Mercer has worked with other states to mitigate the cash-flow impact of transitioning to prepaid capitation.

As compared to the prior FFS options that amend the state plan, developing, launching and supporting a new managed care program require additional dedicated and skilled staff time and resources. Not only do managed care plans have to be procured and contracted, specific policies and procedures must be developed and implemented to support the managed care enrollment process, service coverage, grievance system,

quality strategy, data reporting, financial oversight, and plan monitoring. Managed care programs also typically have more extensive information technology requirements related to eligibility determination, edits to deny claims submitted via FFS for a capitated service, capitation payment processes and managed care encounter data collection. Therefore, the following options generally require longer lead times than the options presented in Group A and will put further strain on DMMA's limited staff resources. To the extent that DMMA seeks to transform the delivery system for Medicaid long-term care, the options presented below may fit better within that strategy as compared to the FFS state plan options presented previously.

Option B1: 1932(a) state plan managed care option

Under the authority of Section 1932(a), states are permitted to selectively contract with certain types of managed care plans and mandatorily enroll certain population groups such as Temporary Assistance for Needy Families (TANF), pregnant women and some children into managed care organizations without a formal waiver and the associated administrative burden of demonstrating cost-effectiveness and renewal of a waiver. The ease associated with the 1932(a) authority is attractive to states that want to mandatorily enroll traditional families and children into managed care to receive their standard Medicaid state-plan services. However, in the realm of long-term care, 1932(a) authority may only be used to voluntarily enroll special needs children, children receiving SSI benefits and dual eligibles[55]. Furthermore, under this authority, states are not able to offer the special home- and community-based services found in 1915(c) waivers.

Accordingly, this option is very limited, but may be suitable for programs that voluntarily enroll allowable individuals in need of long-term services and supports into managed care and want to contract with fewer than all qualified managed care providers. Given these limitations, we do not comment on the potential impact on spending, quality or practicality of implementing in Delaware. However, this option may be part of a more comprehensive consideration of authorities.

Option B2: 1915(a) voluntary managed care authority

Under 1915(a), states can implement voluntary Medicaid managed care programs. 1915(a) is not a waiver program and hence does not carry with it the administrative burden of supporting a waiver including not being subject to a cost-effectiveness test. Nor is a 1915(a) a state plan amendment either. Instead, 1915(a) provides separate operating authority (implemented through CMS approval of a contract) to permit voluntary enrollment into managed care plans for any Medicaid population a state may select including dual eligibles, the elderly and individuals with disabilities, or special needs children. New York uses 1915(a) authority to operate a voluntary HMO program for long-term care services for its disabled adults and elderly population.

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[55] Refer to 42 CFR 438.50 in for more information.

However, similar to the 1932(a) and 1915(b) programs, states cannot use 1915(a) authority to provide non-state plan home- and community-based services. Accordingly, states would be limited to only including Medicaid state plan acute, behavioral or long-term care services in a 1915(a) managed care program. Unlike 1932(a) and 1915(b) programs, 1915(a) programs may not be used to selectively contract with fewer than all qualified managed care providers. Given the limited state plan long-term care services in Delaware, as a stand-alone program option this would do very little in terms of increasing the options available for community-based Medicaid long-term services and supports and therefore we do not comment on the potential impact on spending, quality or practicality of implementing in Delaware. Later in this Section we do comment on a combination 1915(a)/(c) waiver program as part of a more comprehensive consideration of authorities.

Option B3: 1915(b) mandatory managed care waivers

States may request section 1915(b) waiver authority to operate programs that impact the delivery system of some or all of the individuals eligible for Medicaid by mandatorily enrolling beneficiaries into Medicaid managed care programs or creating a separate delivery system for specialty care, such as behavioral health care. Several states operate 1915(b) waivers such as Pennsylvania, New Jersey and Connecticut; this is a common avenue for states to operate large and comprehensive managed care programs.

Section 1915(b) waiver programs do not have to be operated statewide and there is no authority to expand eligibility to cover individuals not otherwise eligible for Medicaid. To implement a 1915(b) waiver program, the federal government may waive certain Medicaid requirements (statewideness, comparability of services and freedom of choice of provider).

In regards to long-term care services, 1915(b) waivers do not provide the special services found in 1915(c) waivers. Typically states use 1915(b) waivers to move large populations into capitated managed care where the managed care plan is financially at-risk for the provision of services. Services usually include most Medicaid state plan acute care (e.g., hospital, physician, drugs and outpatient) and/or behavioral health (e.g., counseling, alcohol/drug abuse services and inpatient mental health) services.

Due to the difference in services and needs of the elderly and disabled, many states completely exclude or severely limit any long-term care populations and services from being included in their 1915(b) waiver programs because the contracted plans can lack experience with serving this unique group. For example, Pennsylvania does not permit adult dual eligibles to enroll in the mandatory Medicaid acute care program and disenrolls any nursing facility resident or aging waiver participant from both the mandatory behavioral health and acute care programs after 30 days. Furthermore, the inability to offer any additional non-state plan community-based services under 1915(b) waivers would limit the capitated entities to being responsible for institutional costs, but not have the tools and alternative services available to care for those at-risk of institutionalization. Accordingly, by itself, a 1915(b) managed care program alone would

do little in terms of increasing the options available for community-based Medicaid long-term services and supports; therefore, we do not comment on the potential impact on spending, quality or practicality of implementing this option in Delaware. Later in this Section we do comment on 1915(b)/(c) combination waivers.

Option B4: Concurrent authorities for managed long-term care programs

As the name suggests, the multiple managed care authorities discussed above may be used in conjunction with home- and community-based authorities, such as the 1915(c) authority or even the 1915(i) state plan option to use a managed care delivery system to provide community-based services. This option most directly equates to DMMA's goals. States may opt to simultaneously utilize managed care authorities along with home- and community-based program authorities to provide a continuum of services to all or specifically-defined elderly and/or individuals with disabilities (DMMA can select what populations to include in the program). In essence, states use the managed care authority to allow for voluntary enrollment or mandatory enrollment into managed care and the home- and community-based authority to target eligibility for the program as well as provide non-state plan community-based services in addition to whatever state-plan services are also included in the program (e.g., acute, behavioral health, home health and institutional care).

Through the combined use of these authorities, states can provide long-term services and supports in a targeted managed care environment as long as all federal requirements applicable to both program elements are met. For example, states must demonstrate cost neutrality in the 1915(c) waiver and cost effectiveness in the 1915(b) waiver. States must also comply with the separate reporting requirements for each waiver which significantly raises the administrative burden associated with combination waiver programs. However, the ability to develop an innovative managed care program that integrates home- and community-based services with traditional state plan services is appealing enough to some states to outweigh the potential barriers. While less of an administrative burden due to the lack of a second waiver, the combination 1915(a)/(c) voluntary managed long-term care program may be less viable in Delaware since the program likely needs to have significant enrollment to attract interest from private-sector managed care plans. Texas has operated a concurrent 1915(b)/(c) waiver program for many years; and Minnesota operates a combined 1915(a)/(c) waiver for its Minnesota Senior Health Options program.

Our initial comments on this option in regards to:

- **Potential impact on Medicaid spending:** A combination of Medicaid authorities delivers Medicaid home- and community-based services through capitated managed care. Accordingly, these programs have the potential to align fiscal and operational incentives for the benefit of the consumer as well as the State's budget. Through this option, DMMA would work through and with the contracted managed care plans to develop and increase community-based alternatives. Cost and quality controls are shifted to the managed care plans. Expected savings can be included as part of the capitation rate negotiations, although the additional managed care administrative

costs would partially off-set these expectations. However, this option applies to the Medicaid program only, there is still no integration with Medicare for the dual eligibles.

- **Potential impact on Medicaid quality:** As with all other Medicaid managed care programs, quality and performance monitoring is a required element in all Medicaid managed care and 1915(c) authorities. Consumers sometimes have mixed feelings about managed care, but if the DMMA can effectively monitor plan performance, these combination programs can be very successful in meeting consumer needs and provide more flexibility for the capitated managed care plans to use funds in new and innovative ways.
- **Practicality of implementing in Delaware:** Delaware has already been able to successfully deploy both mandatory managed care and home- and community-based waivers in the State. This option combines those two program/delivery systems so it should be possible for Delaware to implement such a combined program. However, combination programs, especially 1915(b)/(c) programs involve significant staff resources and time to develop and apply for each waiver as well as procure and contract with manage care plans and thus would require additional staff resources to implement. Attracting qualified health plans with experience in effectively managing long-term care services may also be a challenge for DMMA. Although, it is possible that one or both of DMMA's existing Medicaid MCOs would be interested in this new business opportunity. Because of Delaware's small population size, it may not be practical to do a voluntary 1915(a)/(c) program even though the associated administrative burden and oversight is less than a combination 1915(b)/(c) waiver. Additionally, given that Medicaid long-term care is virtually all FFS in Delaware today, a mandatory 1915(b)/(c) initiative may be viewed by providers and some consumers as creating the most disruption and change in a system rooted in its ways. Accordingly, it is reasonable for DMMA to assume a minimum of 18 to 24 months to launch a concurrent Medicaid managed long-term care program under 1915(a)/(c) or 1915(b)/(c) authority.

Option B5: 1115 demonstration waiver

Under the flexibility provided by 1115 Medicaid waivers, DMMA could test new and innovative long-term care solutions. By nature, 1115 waivers permit a range of new ideas, delivery systems and care coordination programs to be tried. For example, Delaware could evaluate the possibility of becoming a capitated entity to be at-risk for both Medicare and Medicaid benefits for dual eligibles. This would enable the State to act as the managed care plan and be responsible for all services provided to dual eligibles. This concept has never been tested before so it is unclear if federal regulations would permit such a plan, but this is an example of the interesting options available under 1115 waiver authority.

Arizona and Vermont are examples of two states that have used 1115 waiver authority for their Medicaid long-term care programs. The Arizona Long Term Care System (ALTCS) is a statewide program implemented in 1988 that combines Medicaid acute, behavioral health and long-term care services through mandatory managed care. ALTCS contractors include managed care plans as well as some counties acting as the

managed care entity. Arizona's Division of Developmental Disabilities contracts with ALTCS as a capitated entity to serve the developmentally disabled. ALTCS uses a blended capitation rate for all enrollees that promotes use of home- and community-based services. Arizona has achieved success with the ALTCS with a majority of Medicaid consumers residing in home or community settings.

In October 2005, Vermont implemented a new 1115 waiver authority to create their Choices for Care program[56]. This program effectively places Vermont at-risk for changes in Medicaid program expenditures (i.e., global cap) in exchange for greater freedom from federal regulatory oversight. If actual costs exceed the agreed to funding level, Vermont is responsible for any additional costs or it will have to limit services provided to stay under the funding cap.

Vermont's waiver was designed to increase access to home- and community-based services while reducing the use of institutional services and controlling overall costs. The demonstration is operating as a managed care program, but Medicaid providers are not capitated and providers are not at-risk financially. The waiver established the following three levels (or groups) of need for long-term care based on an independent living assessment: highest need, high need and moderate need.

- "Highest need" individuals meet specific functional criteria and are entitled to either nursing home or community services.
- "High need" individuals have access to long-term care services within the waiver as funds become available. This group consists of individuals who do not meet the criteria for the highest need group, but have extensive needs for personal care and rehabilitation services.
- The "moderate need" group is an expansion population not previously receiving Medicaid long-term care services. It consists of persons who do not qualify for an institutional level of care. The moderate need program was designed to test the theory that early interventions can be cost-effective by helping to prevent increased disability and maintain people in community settings.

Since implementing Choices for Care, Vermont has significantly expanded the number of people receiving community-based services, while experiencing a modest reduction in people receiving services in nursing facilities. Since October 2005, nursing home enrollment has declined by ten percent from 2,286 to 2,059 adults. During the same period, enrollment in all community-based programs has increased. In the home- and community-based waiver program, enrollment has increased 50 percent, from 998 to 1,494 individuals. Additionally, Vermont now provides a limited package of services to 1,100 "moderate need" individuals who were not receiving Medicaid long-term care services prior. Satisfaction with the program appears high among state officials. Many stakeholders, however, reported tighter financial management and reductions to

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[56] Most of the information provided on Vermont's Choices for Care program was obtained from the Kaiser Commission's report: Vermont's Choices for Care Medicaid Long-Term Services Waiver: Progress and Challenges as the Program Concluded its Third Year, November 2008.

individual plans of care. Waiting lists are also present for “high need” and “moderate need” individuals, and even this program is not immune to budget cuts during difficult economic times.

Due to the vast range of options permissible under 1115 waivers, it is beyond the scope of this paper to assess the practicality or impact on spending associated with unknown program ideas and the timeline for launching an 1115 program is often be measured in years not months. While replicating Vermont’s Choices for Care program is theoretically possible in Delaware (there are some similarities between Delaware and Vermont) evaluating the feasibility and impact of a similar program being implemented in Delaware would require a much more intensive and in-depth analysis than what can be covered in this one paper.

Group C options: Integrated Medicare/Medicaid managed long-term care programs for dual eligibles

As discussed in Section 5, dual eligibles are a costly group of low-income elderly and disabled who are entitled to services under both the Medicare and Medicaid programs. Whereas Medicare primarily covers acute and preventative care services, Medicaid is the primary payer for long-term care services. Accordingly, the actions or inactions of Medicare impacts DMMA’s spending and failures by Medicare to meet the health care needs of dual eligibles directly leads to significant (albeit potentially preventable) Medicaid long-term care spending.

Unfortunately, because of the regulatory conflicts and complex policy issues (e.g., grievance and appeals), lack of permanent authority for SNPs, and the inability of states to share in any savings that Medicaid interventions might cause to accrue to Medicare, most states have not taken action to effectively integrate Medicare and Medicaid care for dual eligibles through managed care programs. Instead, dual eligibles remain mostly in uncoordinated and unmanaged FFS programs for both Medicaid and Medicare services. Indeed, as noted previously, DMMA spent over $150 million on nursing facility services for dual eligibles, representing nearly half of all dual eligible spending and over 86 percent of total Medicaid nursing facility expenditures.

In the absence of major regulatory changes that would fully transfer all financial and operational responsibility for dual eligibles to either Medicaid or Medicare (not likely to happen in the foreseeable future), DMMA will need to use the program options available today to find innovative solutions for this important segment of the population. There are some good program and demonstration options available to DMMA and the new attitude at CMS to be more supportive and helpful to states in regards to integrating Medicare and Medicaid should be an encouraging sign to DMMA to pursue one or more of these initiatives.

As with the Group B options, the managed care options presented in Group C have the benefits of risk-based managed care along with the cash-flow challenge of transitioning from post pay FFS to prepaid capitation.

PACE is a well-established program throughout the country with standard operational protocols and "checklists" from CMS to assist states through the implementation process. PACE programs are open to both dual and non-dual beneficiaries although experiences in other states indicate that the vast majority of PACE enrollees are dual eligibles. On the other hand, integrating Medicare/Medicaid benefits through Medicare Advantage SNPs is relatively new and very complex with just a few examples from other states to draw upon. Furthermore, since there is no standard design for an integrated Medicare/Medicaid program there is a wealth of opportunities to customize the program to fit Delaware's strategy, but correspondingly a host of policy issues to decide upon. The benefit of integrated Medicare/Medicaid managed care is the ability to extend the program to potentially cover all dual eligibles in the State as compared to the PACE program which has scalability limits. Both options have an extended timeline due to the Medicare application review and approval process that DMMA will not have direct authority over.

Option C1: Program for All-inclusive Care for the Elderly (PACE)

PACE is a permanent, separate Medicare program and a state option under Medicaid organized around a physical site and a team of health care professionals where community interaction and adult day services are provided. Many states offer PACE as one alternative in the spectrum of Medicaid long-term services and supports including California, Massachusetts, New York, Pennsylvania and Virginia. States will typically contract with multiple distinct PACE sites to service different geographic areas.

A unique advantage of the PACE program is that the regulations provide for one set of requirements regarding eligibility, application procedures, administrative requirements, services, payment, participant rights, quality assurance and marketing. These regulations allow an organization to enter into a PACE agreement with both CMS and DMMA for the operation of a PACE program. A PACE organization can be an entity of a city, county, state, tribal government or a private 501(c)(3) not-for-profit entity. Also, because PACE is an integrated Medicare/Medicaid program, state Medicaid programs do have some policy-decision making and oversight responsibilities in addition to being directly responsible for the Medicaid capitation rate development and payment. Federal PACE regulations do not require Medicaid PACE capitation rates to comply with the actuarial-soundness requirements associated with other forms of Medicaid managed care. Instead, the Medicaid PACE rate must be less the FFS equivalent upper payment limit (UPL) for an equivalent population taking into consideration the relative frailty of the PACE population. Some states have their actuary develop PACE UPLs, but it is not required that an actuary develop the PACE UPL.

Our initial comments on this option in regards to:

- **Potential impact on Medicaid spending:** Medicaid capitation rates to PACE providers are required by regulation to be less than the amount DMMA would have paid in FFS if the person was not enrolled in PACE (which can be the cost of institutionalization). This results in a FFS-equivalent UPL that must be calculated to assure CMS that the PACE Medicaid rates are compliant with federal rules. Typically, the monthly Medicaid PACE capitation rates are less than the monthly cost of a

nursing facility by 5 to 15 percent depending on the state. This ensures that PACE is cost-effective as compared to institutionalization, but due to the unique delivery model, PACE is typically more expensive than a standard 1915(c) waiver on a per member per month (PMPM) basis. Therefore, from a financial perspective, PACE does not generate much "savings", but does provide a socially-focused alternative to institutionalization.

- **Potential impact on Medicaid quality:** Participants in PACE generally express high levels of satisfaction with the program due to the interdisciplinary team of health care professionals, social activity, personal interaction and communal atmosphere associated with the focus being placed on a physical site where adult day/social activities occur.
- **Practicality of implementing in Delaware:** Given Delaware's small population and geographic size, PACE could be an excellent option for the DMMA to consider. Most PACE sites are small (50 to 100 or more participants) so this would fit well with Delaware's already small population base and the relative proximity of all major urban areas makes this a feasible option to add diversity to DMMA's system of Medicaid long-term services and supports. A potential challenge for DMMA will be identifying a willing provider entity interested and skilled to become a full PACE provider, willing to make the upfront capital outlays and be capitated for the Medicare and Medicaid risk. DMMA will also be required to devote internal staff time to the PACE application and readiness review process required to start a PACE site and the annual contract, payment and monitoring activities will need to be supported for a relatively small program. The timeline for launching a new PACE site will depend on DMMA's actions, the provider's responsiveness and the CMS review and approval process. Accordingly, it is difficult to estimate how quickly a PACE provider will become a viable program option. Mercer suggests that DMMA assume a minimum 24 months to launch a PACE site.

Option C2: Medicare Advantage plans – Special Needs Plan (SNPs)

Medicare Advantage plans include HMOs, PPOs and SNPs. DMMA can develop capitated managed care programs to integrate Medicare and Medicaid services with any of these entities because dual eligibles can enroll in any Medicare Advantage plan. However, for purposes of integration, because federal regulations require Dual SNPs to establish agreements with state Medicaid agencies and hence state Medicaid agencies have some authority over Dual SNPs, it makes the most sense for DMMA to consider an integrated care program with Dual SNPs. Otherwise, DMMA will have very little influence or authority with all other types of Medicare Advantage plans. Other states that have successfully deployed or transitioned programs to integrate care with Dual SNPs include Massachusetts, Minnesota and New York.

While other states have had the benefit of relatively large existing Dual SNP enrollment, a challenge for DMMA will be determining the potential for a Dual SNP partner in Delaware. It is quite possible that if DMMA surveyed the marketplace and made some inquiries there could be entities who would express interest in becoming Dual SNPs and equally important, interested in contracting with DMMA for the additional Medicaid risk.

Because the PPACA requires that Dual SNPs have capitated contract agreements with states for Medicaid benefits including long-term care as a condition of receiving higher frailty-adjusted Medicare capitation rates, DMMA may find more interest from the marketplace now than prior to the PPACA.

Implementing an integrated Medicare/Medicaid managed care program with Duals SNPs requires much of the same steps and approvals as it would to implement a Medicaid-only managed care program (as discussed in Group B), but has more complex issues to address because of the intention to integrate with Medicare as much as practical (e.g., enrollment/disenrollment policies, grievance/appeals, consumer information/marketing). DMMA would need to decide whether to seek mandatory 1915(b) or voluntary 1915(a) enrollment for the Medicaid side and decide whether to use 1915(c) waiver authority or possibly state plan option under 1915(i) or 1915(k) to provide Medicaid home- and community-based services based on the desired target population. For purposes of achieving DMMA's goal, the State would definitely want to include Medicaid institutional and home- and community-based services.

Much of this decision-making will be based on DMMA's goals and objectives. Given Delaware's small size and relatively small number of dual eligibles, Mercer recommends that DMMA opt for mandatory enrollment to increase the level of attraction in the marketplace (although this requirement would not extend to the Medicare side of the program). Mandatory enrollment mitigates some concern about selection issues, but the only-voluntary enrollment rule in Medicare Advantage still poses a challenge to ensure that Dual SNPs are not "cherry picking" members.

Additionally, DMMA must decide whether to capitate the Dual SNPs for the risk and provision of Medicaid acute, behavioral health and/or long-term care services. If the goal is to integrate care as much as possible, consideration should be given to including all services; however, some states have expressed concern about the experience and sophistication of Dual SNPs to appropriately manage Medicaid's behavioral and/or long-term care benefits. Another issue is whether Dual SNPs will be willing to accept financial risk and responsibility for the full gamut of Medicaid services. To the extent that Medicaid services are partially capitated and partially paid for by FFS will impact the information technology requirements needed to support this type of program. If not fully integrated, dual eligibles would still have to navigate both the Medicare/Medicaid managed care program and the traditional Medicaid FFS program to obtain all services.

Although Dual SNPs provide a viable platform to integrate Medicare and Medicaid, the two programs still operate under distinct rules and hence are not truly integrated in terms of regulatory requirements (although as noted in Section 5, the new CHCO office is specifically intended to help integrate the two programs better). One notable challenge is that while DMMA can mandate dual eligibles to enroll from the Medicaid side, present law precludes dual eligibles from mandatory Medicare enrollment into Dual SNPs. Furthermore, Medicare allows dual eligibles to enroll/disenroll in any given month. This presents a logistical challenge to coordinating this type of program. So while this option better integrates and aligns incentives, quality and funding for dual eligibles, it still presents some obstacles that would need to be overcome.

Our initial comments on this option in regards to:

- **Potential impact on Medicaid spending:** Depending on what Medicaid services DMMA included in the Medicaid capitation rates will directly impact the potential for positive impact on Delaware's cost over the long-term. The more integrated the care is, the more the Dual SNPs will be incentivized to maintain the health and functional status of enrolled members because Medicaid capitation rates can be designed to promote home- and community-based services over institutionalization. DMMA also needs to realize that integrating care may have more immediate impact on Medicare's costs than Medicaid's cost. For example, use of the emergency room or hospital inpatient may decline which will save Medicare money, but savings in Medicaid long-term care will take much longer to realize.
- **Potential impact on Medicaid quality:** As with most managed care programs, federal regulations require robust quality reporting and monitoring. CMS requires quality metrics and now NCQA approval (effective in 2012 per PPACA) for SNPs and existing Medicaid managed care regulations require quality assurances and external quality reviews as Delaware has experienced under the State's current Medicaid managed care program. Dual eligible consumers value the "one stop shopping" approach that comes with integration because navigating the complex world of both Medicare and Medicaid can be extremely daunting. Successful integrated care programs in other states focus attention on the individual through consumer feedback sessions, personal connection with case managers and continuity in care managers creating relationships between the consumer and the Dual SNP.
- **Practicality of implementing in Delaware:** Since Delaware's Medicare Advantage enrollment is quite low (less than four percent in 2009) and it is unclear whether there are any Dual SNPs currently operating in the State, it is difficult to assess whether this option is viable for DMMA. The national attention being placed on integrating care for dual eligibles suggests that there may be some momentum that DMMA can take advantage of. The low number of dual eligibles in Delaware, relative to other states, implies that any integrated managed care program would likely need to have mandatory Medicaid enrollment and hence a 1915(b)/(c) combination waiver authority which will increase the burden on DMMA staff to develop and implement. The large Medicaid spending on dual eligibles and significant amount of nursing facility use makes this option attractive as a way to reduce Medicaid program expenditures by improving the health and functional status of dual eligibles in their homes and communities. Due to the complex issues involving both Medicaid and Medicare, DMMA should assume a minimum of 24 months to launch this type of integrated program. This timeline can be impacted by the Medicare Advantage contracting and bid process which begins early in the calendar year for the contract period beginning the following January 1. Interested Medicare Advantage plans will likely want to know details of the State's integrated Medicare/Medicaid program design to formulate their Medicare bids, so if the State is "out of sync" with the Medicare Advantage process, there could be a longer timeline for implementation. DMMA should also closely monitor the status of the statutory expiration of the SNP authority.

Summary table of options with pros and cons

The following table summarizes the options presented in this Section along with selected pros and cons. Due to similarity in some options, not all pros or cons are repeated for each option.

Table 6 – Summary of options with pros and cons

Option	Pros	Cons
Option A1: Cover personal care services under the Medicaid state plan – estimate 6 to 12 months to implement	▪ Easy to implement. ▪ Expands community-based service offerings under the Medicaid state plan. ▪ Possibly get federal match for currently state-funded services. ▪ Cost and utilization data captured through the FFS MMIS system.	▪ Creates new entitlement service. ▪ Difficult to control/target spending and may result in higher aggregate spending without diverting/delaying institutionalizations. ▪ Difficult to manage/monitor quality of care provided. ▪ Delivery system is still unmanaged.
Option A2: 1915(i) state plan option for home- and community-based services – estimate minimum of 6 to 9 months to implement	▪ Relatively easy to implement. ▪ Eligibility based on a state-defined “needs basis” that is less restrictive than nursing facility requirements. ▪ Offer full range of home- and community-based services like 1915(c) waivers. ▪ Cost and utilization data captured through the FFS MMIS system. ▪ Allows for a phase-in of services and eligibility over five years.	▪ No detailed guidance from CMS yet available. ▪ Creates new entitlement service. ▪ Difficult to control/target spending due to statewide requirements and no limits on number of participants.

Option	Pros	Cons
Option A3: 1915(j) state plan option for consumer-direction of personal care services – estimate minimum of 12 to 16 months to implement	▪ Relatively easy to implement. ▪ Empowers consumers to be more active in their own care. ▪ Consumers may use funds more efficiently and effectively. ▪ Can limit consumer-direction to certain geographic areas as well as targeted populations. ▪ DMMA may have some infrastructure to leverage from the existing state-funded personal attendant services program. ▪ Cost and utilization data captured through the FFS MMIS system.	▪ Does not create any new community-based service, just a different delivery system for existing service. ▪ Personal care services are not covered in Delaware's state plan, so only available under applicable 1915(c) waiver unless state plan is changed or if 1915(i) option selected. ▪ Requires DMMA to provide safeguards and financial accountability. ▪ Cost of a third-party entity to provide fiscal intermediary services. ▪ More administrative oversight responsibilities on DMMA staff.
Option A4: 1915(k) state plan option for attendant care services – estimate minimum of 18 months to implement	▪ Easier to implement than a waiver, but would likely have the longest lead time of the non-managed care program options. ▪ Expands community-based service offering. ▪ Range of attendant care service offerings available. ▪ Focus on consumer involvement. ▪ Enhanced FMAP on related expenditures. ▪ Cost and utilization data captured through the FFS MMIS system.	▪ No detailed guidance from CMS yet available. ▪ Administrative burden to work collaboratively with Development and Implementation Council. ▪ Administrative burden of collecting and reporting data. ▪ Need for sufficient workforce numbers to meet demand/provide services. ▪ Enhanced FMAP benefit could be off-set by increased users and/or unit cost of services.

Option	Pros	Cons
Option A5: 1915(c) waiver for home- and community-based services – estimate minimum of 9 to 12 months to implement	▪ Expands home- and community-based services offerings. ▪ Can target eligibility and service offerings. ▪ Can include consumer-direction option to empower consumers. ▪ Wide range of special waiver services to select from. ▪ Strong quality monitoring requirements of waiver. ▪ Cost and utilization data captured through the FFS MMIS system. ▪ Familiarity to DMMA.	▪ Administrative effort to develop and support more waivers. ▪ Delivery system is still unmanaged. ▪ Contrary to a goal of consolidating waivers to streamline program management. ▪ Concern over sufficient workforce numbers to meet demand/provide services. ▪ Demand for services can lead to higher provider fees. ▪ Can initially increase aggregate spending.

Option	Pros	Cons
Option B1: 1932(a) state plan option for managed care – not recommended as a stand alone authority	▪ Administratively easier to implement and maintain as compared to waivers. ▪ Mandatory enrollment allowed (limited). ▪ No cost-effectiveness or other administrative burden of a waiver. ▪ Benefits of more coordinated system of managed care. ▪ Strong quality and performance monitoring requirements. ▪ Prepaid capitation can provide more budget stability than FFS. ▪ Flexibility in capitation rate development for community-based services. ▪ DMMA can partner with entities experienced in service delivery and care management. ▪ Leverage applicable contract language from existing Medicaid managed care program. ▪ Allows for selective contracting with fewer than all qualified providers.	▪ Cannot mandatorily enroll dual eligibles or special needs children. ▪ Does not authorize non-state plan home- or community-based services. ▪ Does not directly create new community-based service offerings. ▪ Limited impact on achieving end goal. ▪ Prepaid capitation with FFS lag may put cash-flow strain on Delaware. ▪ Administrative resources and lead time to procure and contract with managed care plans and do managed care systems updates. ▪ Cost and utilization data must be reported by the managed care plans via encounter data submittals. ▪ Additional administrative efforts/costs related to external quality reviews, actuarial rate development and other managed care regulations. ▪ DMMA not directly responsible for care delivery, but must oversee health plan performance.

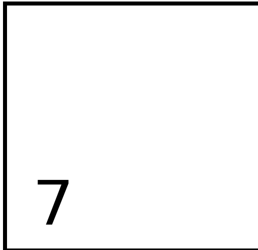
Option	Pros	Cons
Option B2: 1915(a) operating authority for voluntary managed care – not recommended as a stand alone authority	▪ Administratively easier to implement and maintain as compared to waivers. ▪ No cost-effectiveness or other administrative burden of a waiver. ▪ Can apply to all populations. ▪ Benefits of more coordinated system of managed care. ▪ Strong quality and performance monitoring requirements. ▪ Prepaid capitation can provide more budget stability than FFS. ▪ DMMA can partner with entities experienced in service delivery and care management. ▪ Flexibility in capitation rate development for community-based services. ▪ Leverage applicable contract language from existing Medicaid managed care program.	▪ Voluntary enrollment only (may not be sufficient to induce plans to participate). ▪ Does not directly create new community-based service offerings. ▪ Prepaid capitation with FFS lag may put cash-flow strain on Delaware. ▪ Small State population coupled with voluntary managed care may not induce plans to participate. ▪ Limited impact on achieving end goal. ▪ Administrative resources and lead time to procure and contract with managed care plans and do managed care systems updates. ▪ Cost and utilization data must be reported by the managed care plans via encounter data submittals. ▪ Additional administrative efforts/costs related to external quality reviews, actuarial rate development and other managed care regulations. ▪ Does not allow for selective contracting with providers. ▪ DMMA not directly responsible for care delivery, but must oversee health plan performance.

Option	Pros	Cons
Option B3: 1915(b) waiver for mandatory managed care – not recommended as a stand alone authority	▪ Mandatory enrollment allowed (all populations). ▪ Prepaid capitation can provide more budget stability than FFS. ▪ Benefits of more coordinated system of managed care. ▪ Strong quality and performance monitoring requirements. ▪ Flexibility in capitation rate development for community-based services. ▪ 1915(b)(3) authority permits savings from managed care to fund additional non-state plan community-based services. ▪ Leverage applicable contract language from existing Medicaid managed care program.	▪ Does not directly create new community-based service offerings. ▪ DMMA not directly responsible for care delivery, but must oversee health plan performance. ▪ Administrative burden to develop waiver, program policies, procure and contract with managed care plans, and system edits/updates to support managed care enrollment/payment processes. ▪ Prepaid capitation with FFS lag may put cash-flow strain on Delaware. ▪ Cost and utilization data must be reported by the managed care plans via encounter data submittals. ▪ Additional administrative efforts/costs related to external quality reviews, actuarial rate development and other managed care regulations.

Option	Pros	Cons
Option B4: Concurrent 1915(a)/(c) or (i), or 1915(b)/(c) or (i) program – estimate minimum of 18 to 24 months to implement	▪ Expands home- and community-based services offerings. ▪ Delivers all capitated services including community-based services through more coordinated system of managed care. ▪ Can target eligibility and service offerings under the waiver. ▪ Better aligns fiscal and operational incentives via capitated managed care. ▪ Voluntary or mandatory managed care enrollment. ▪ Leverage applicable contract language from existing Medicaid managed care program.	▪ Longer lead time due to multiple operating authorities/program design issues. ▪ Administrative effort associated with potentially two waivers. ▪ Administrative effort of managed care policies and more extensive system edits to combine acute and long-term care data inputs. ▪ Prepaid capitation with FFS lag may put cash-flow strain on Delaware. ▪ May be viewed as most significant change to existing FFS system (concerns to consumers or providers). ▪ Cost and utilization data must be reported by the managed care plans via encounter data submittals. ▪ Procuring qualified health plans to efficiently and effectively manage the spectrum of acute, behavioral health and long-term care services. ▪ Does not explicitly integrate with Medicare for dual eligibles. ▪ Mandatory enrollment needed to attract plans.
Option B5: 1115 waiver for new and innovative ideas – time to implement is difficult to estimate; assume minimum of 24 to 36 months	▪ Can test and deploy new and innovative solutions. ▪ Familiarity to DMMA.	▪ Lengthy process of working with CMS. ▪ Administrative effort to support and monitor waiver. ▪ Some ideas may be unproven and could be risky for DMMA.

Option	Pros	Cons
Option C1: Program of All-inclusive Care for the Elderly (PACE) – estimate minimum of 24 months to implement	▪ Proven delivery model. ▪ Relatively standardized process for launching new site. ▪ Focus on community-based services and social interaction. ▪ Multi-disciplinary team of health care professionals. ▪ Well-received by consumers. ▪ Integrates Medicare and Medicaid funding and all services. ▪ Standardized regulations. ▪ Most PACE sites are small which is suitable to Delaware's population.	▪ Administrative effort to develop new PACE site(s) due to 3-way agreement between DMMA, the provider and CMS. ▪ CMS approval process for the Medicare application will impact timeline. ▪ Voluntary enrollment only. ▪ Small participating numbers limits overall impact. ▪ Monitoring and Medicaid capitation rate development requirements. ▪ Procuring qualified entities to be a PACE site in Delaware who are willing to invest the upfront capital to develop a site. ▪ Prepaid capitation and FFS lag may put cash-flow strain on Delaware. ▪ Cost and utilization data must be reported by the PACE sites via encounter data submittals. ▪ PACE Medicaid capitation rates are typically near the cost of a nursing facility.

Option	Pros	Cons
Option C2: Medicare Special Needs Plans (SNPs) for dual eligibles – estimate minimum of 24 months to implement	▪ Ability to integrate Medicare and Medicaid funding for a costly and vulnerable population group. ▪ Potential for ease of one-stop shopping for consumers and focus on personal connection between SNP and member. ▪ Dual SNPs specialize in caring for the needs of dual eligibles. ▪ Opportunity for Medicaid to benefit from Medicare savings. ▪ Stronger federal regulations on connection of Dual SNPs and state Medicaid agencies. ▪ CMS recognizing the importance of caring for the dual eligibles and more willing to provide assistance to DMMA. ▪ Can use 1915(a)/(c) or 1915(b)/(c) for Medicaid enrollment and expanded community-based long-term care services.	▪ Medicare and Medicaid still operate as separate programs subject to their respective regulations. ▪ Potentially even longer lead time to implement due to Medicare Advantage contracting/bid process. ▪ Complex set of policies and operational protocols to develop and communicate including Medicaid capitation rate setting. ▪ Prepaid capitation and FFS lag may put cash-flow strain on Delaware. ▪ Medicare Dual SNP enrollment is voluntary, regardless of what Medicaid requires leading to concerns over selection and inconsistent enrollment. ▪ May reduce Medicare service expenditures more quickly than Medicaid long-term care services, especially in the early years. ▪ If all Medicaid services not fully integrated, dual eligibles still need to navigate Medicaid FFS system. ▪ Cost and utilization data must be reported by the managed care plans via encounter data submittals. ▪ Dual SNPs are not a permanent part of the Medicare program. ▪ May be difficult for Delaware to attract/retain SNPs.



Major policy and operational subject matter

Based on Mercer's experience with other Medicaid programs, depending on what program initiatives are pursued, a myriad of policy and design issues will occur as DMMA progresses through the planning, designing, implementing, monitoring and measuring stages of each respective endeavor. This report addressed the initial phases of this process and accordingly DMMA will need to engage a variety of stakeholders (e.g., consumers, advocates, providers, legislators, managed care entities) to make informed decisions. While the following is not meant to be an exhaustive discussion of all possible issues DMMA will face or concerns stakeholders will raise, these are the types of policy and operational issues likely to require DMMA's attention in the coming months.

Establishing realistic expectations

DMMA will need to establish and then manage realistic expectations on issues involving financial costs/savings, timeline for implementation and staffing resources needed to support any new initiative. Mercer recommends, from first-hand experience with other states such as Massachusetts, Minnesota and New Mexico, that Delaware should not go into this endeavor with the sole objective to save money. Increasing community-based alternatives for long-term services and supports requires several years to show meaningful results and involves financial matters as well as quality of life issues. While some initiatives like amendments to the state plan can be accomplished relatively quickly over a few months, other more complex programs like capitated managed long-term care can take a minimum of 18 to 24 months or even longer to fully implement. As noted previously, Delaware should take a long-term view on the Medicaid long-term care system and devote the necessary, skilled staff resources to make any new initiative successful in a systematic, but not rushed manner.

Results may also be difficult to document conclusively because it often involves assuming what would have happened in absence of actions having been taken by DMMA. For example, community-based alternatives should enable more institutional

diversions or delays in the need for institutional care. Nursing home diversions are akin to compound interest on money, it is an easy concept to grasp, yet it takes years for the effects to pay off. And as presented in Section 3, actually achieving nursing home diversions or delays is essential to achieve any form of reduction in total Medicaid spending, but can prove elusive if the program is not managed/operated properly.

Potential for woodworking and snowball effect

On a purely financial basis, if home- and community-based services are provided to people who would not otherwise require institutional care or even seek services, there are no aggregate spending reductions and spending may actually increase. This is commonly referred to as the "woodworking effect." Some states have struggled to operate programs that benefit those who are most at-risk for institutionalization as often the enrollment and eligibility criteria are broad enough to encompass a larger portion of the population who do benefit from the additional programs, but essentially produce no cost savings to fund the program's existence[57]. However, on a moral and social basis, this may be acceptable to DMMA, but the State should be aware of this dichotomy before proceeding with program development.

A related issue involves the potential for internal and/or external sources to push DMMA to adopt less restrictive level-of-care and/or medical necessity policies and requirements pertaining to home- and community-based long-term services and supports. While the intentions are good, adopting this strategy can lead to a "snowball effect" where it becomes increasingly easier for more and more individuals to qualify for services. The ramifications on administrative oversight, fiscal sustainability, workforce sufficiency, quality of care and regulatory oversight should be weighed in the policy decision-making process.

Other states have used tools such as stricter level-of-care/eligibility policies, geographic coverage limits, spending caps (individual or aggregate), medical necessity criteria, waiver "slots", waiting lists for waiver services, aggressive look-back/estate recovery activities, moratoriums on new nursing home beds, and certificate of need to manage the supply and demand for Medicaid long-term care services. While some of these tools help to curtail unnecessary supply of specific services (e.g., nursing home beds); waiting lists for community-based waiver services can be an indicator of unmet need. DMMA should also consider the political and public reaction to policies that might be viewed as restricting access to desired services. Moreover these tools and related policies add to the administrative burden of supporting a new program initiative.

Some may contend that given Delaware's relatively high incomes, homeownership rates and educational levels that more emphasis should be placed on long-term care insurance partnerships, but these avenues can be difficult to gain mass appeal

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[57] See footnote #22.

especially given the specific socioeconomic factors attributed to the Medicaid population. A challenge for DMMA will be in designing new programs that can effectively meet the needs of the elderly and individuals with disabilities without creating an equally unsustainable new increase in Medicaid expenditures.

Role of external stakeholders

As DMMA pursues ways to improve the Medicaid long-term care system, proactively seeking input and collaboration from stakeholders is essential for effective planning and program development. The more innovative and far-reaching the program enhancements are, the more stakeholders, especially consumers and their advocates, will seek to have their voices heard and considered. DMMA should be open to this input because consumers and advocates have first-hand experience with the present system – its good points and its shortcomings. Some stakeholders may also have experience from other markets that could be of value to DMMA.

DMMA will need to determine, upfront, the role non-governmental stakeholders have in the process: decision-making or advisory. Given Delaware's small size and communal atmosphere, DMMA likely already knows who the advocates and consumers will be in pursuing any new program initiative. Opting to give these players decision-making authority can have advantages and disadvantages. The biggest advantage is that these parties will be responsible for developing and implementing any new initiative and hence will have a strong sense of ownership in the process. A challenge for DMMA in ceding decision-making to external consumers/stakeholders is to make timely progress knowing that it may be difficult to get consensus on what to do, how to do it, why to do it or when to do it.

On the other hand, collaborating with these external parties in an advisory role enables DMMA to retain primary responsibility for program design and operational decisions. An advantage to this approach for DMMA is the ability to leverage input from the key players within the overall framework for implementation, utilizing their knowledge and experience to make final decisions in an objective manner. A downside to this approach is that some players may feel that their input is being trumped by State objectives resulting in more resistance than support for the new initiatives.

Based on Mercer's experience, we recommend that DMMA engage consumers and their advocates in an advisory manner. For this to be successful, DMMA will need to work collaboratively with these external groups, keeping the lines of communication open and realize that on some issues compromise will be required from all involved.

Communication strategy

Stakeholders, whether internal or external, will want to be informed in a timely manner on the progress DMMA is making towards the goal of increasing community-based alternatives for long-term services and supports. DMMA will need to have a

communication strategy to not only provide this information to stakeholders in practical and appropriate forums, but also a process to manage and coordinate the input and questions from stakeholders. To that end, Mercer recommends that DMMA empower a "Champion" with sufficient DMMA seniority to actively oversee the initiative, serve as a change-manager and move those involved in a coordinated action. If multiple initiatives are pursued that are sufficiently complex and resource consuming, multiple Champions could be assigned to ensure accountability and coordination.

Although sometimes difficult to arrange and time-consuming to conduct, face-to-face meetings with key stakeholders are often very helpful, especially in the early stages of program development when it is vital to achieve buy-in and personal connection with key stakeholders and other interested parties. Once momentum is obtained, more interaction could be held via teleconference and even written correspondence to streamline the process and add flexibility for participation (conference calls are easier to attend than in-person meetings). Mercer also recommends that DMMA document meetings and calls and make appropriate information available publicly such as through a web location on the DHSS internet site.

DMMA should also recognize that different stakeholders and constituencies will likely have different concerns and priorities as well as a need for different levels and amount of information. For example:

- **Consumers/Advocates:** In addition to generally being more sensitive to government actions related to health care, these groups will be less concerned with the intricacies of Delaware's budget cycle as compared to what these new programs will do for them or their families including any applicable caregiver support programs. Therefore, Mercer recommends that DMMA simplify the message as practical, laying out clear and easily understandable objectives and desired outcomes.
- **Providers:** Providers will be keenly interested in what role they will have under any new initiative and whether their responsibilities will be increasing or decreasing and in what ways. Since DMMA's long-term care system is currently all FFS, providers will wonder whether any new initiative will require them to do business with entities other than DMMA and how those new arrangements will impact their bottom line, administrative duties and level of autonomy. Traditional facility-based providers (e.g., nursing facilities) may see their role diminishing as other providers such as home health care agencies and personal care aides gain more attention. This can raise concerns and resistance to change among these traditional facility-based providers.
- **Managed care entities:** As potential new contractors with DMMA, managed care entities will want to know specifically; what their contractual responsibilities will be, how they will be judged on performance, what will be the basis for and the amount of financial compensation, and how DMMA will operationalize any new program initiative? DMMA should expect detailed and technical questions from this group. If an initiative is pursued that involves managed care contracting, DMMA must realize that it is effectively becoming business partners with these entities and the managed care plans, not DMMA, will be responsible for care delivery.

- **Elected/Appointed officials:** This group will need to be effectively managed and informed as they will either support or suspend any potential initiative through funding allocations, political will and program prioritization. Due to their elected or appointed status, these individuals are accountable to their voting constituencies or senior leaders and hence will want details and perspectives on the impact of any new initiative on consumers, providers and the State's budget both short- and long-term. Delaware, like most states, is still reeling from the effects of the great recession, so legislators will be more attuned to the State's cash-flow position. DMMA should establish and then actively manage realistic expectations with this group and discuss options that might mitigate cash-flow concerns (e.g., capitation payment delay).
- **CMS:** Depending on what initiative DMMA pursues, involving CMS in the process may be limited or quite extensive. Simple state plan amendments require little interaction with CMS whereas as more complex initiatives involving waivers or coordination with Medicare will require DMMA to make more visits to Baltimore. The important thing for DMMA to remember is that CMS typically does not like surprises and appreciates being kept in the loop. Indeed, CMS may be a valued partner in evaluating specific policy and regulatory decisions, especially when it involves provisions stemming from the PPACA.

Workforce and affordable housing supply issues

Increasing community-based alternatives for long-term services and supports is not practical unless there is a supply of caregivers to render services and affordable housing options in which beneficiaries can receive services. The interdependency of these two issues will impact the feasibility and level of success of some of the options DMMA will be evaluating.

As described in Section 3, the aging population will contribute to a greater demand for services as well as shift the composition of the workforce from younger to older workers. Demand for services typically leads to competition for resources and DMMA could find itself competing with Medicare, the private sector, managed care plans and other entities for the supply of workers. Indeed, the U.S. Bureau of Labor and Statistics (BLS) expects that health care and social assistance will be the largest contributor to job creation over the next 10 years growing by 24 percent and adding 4 million new jobs; ranking home health aides and personal/home care aides as the third and fourth fastest growing occupations behind only biomedical engineers and network/data systems analysts[58].

While the demand is expected to be great, the standard wage and work environments for these occupations present challenges to attract and retain qualified workers who can excel in the one-on-one caregiver role, meet the frequent travel requirements and handle the emotional and physical job requirements. According to the AARP, Delaware's 2007 median hourly wage for home health aides and personal/home care aides was $11.50

[58] U.S. Bureau of Labor Statistics, Occupational Handbook, 2010-11 Edition; Overview of the 2008-18 projections.

and $10.83[59], respectively, which pales in comparison to Delaware's $54,610 median income. Accordingly, there may be more pressure to increase provider payment rates for home- and community-based services which can further increase Delaware's community-based long-term care spending.

Section 3 also noted that Delaware has the 2nd highest home ownership rate in the nation. This is a good indicator that personal residential settings are prevalent within the State. However, an underlying issue is whether existing residential units are appropriately equipped and constructed (e.g., stairs versus wheelchair accessibility) to facilitate home-based care delivery and whether DMMA will need to allocate funds to invest in enabling home modifications.

Assisted living

Assisted living helps fill the gap between facility-based institutionalization and unsupervised home-based residence and provides another option in the continuum of care for Delaware's elderly and individuals with certain disabilities. Assisted living allows a resident more independence than a nursing home and provides care in a more homelike setting. While community-based assisted living can be less expensive and more consumer-friendly than institutionalization, Medicaid rules allow for payment of only certain services provided to residents; typically Medicaid is precluded from paying the room and board. Therefore, even though assisted living may be an appropriate care setting for certain individuals who can safely reside in this type of living arrangement, the room and board cost can make it a difficult financial choice for the low-income elderly and individuals with disabilities. According to a report from the National Center for Assisted Living, Delaware had 12 assisted living facilities serving 179 participants through 1915(c) Medicaid waivers[60] in 2009.

Of the total $814 a month in combined federal SSI and State-supplemental payment, DMMA's policies cap assisted living charges to $692 a month with a $122 personal needs allowance according to 2009 data. Not all states cap the amount assisted living facilities can charge Medicaid recipients which makes Delaware more attractive from the recipient's perspective, but it is unclear from available literature as to effect this has on provider willingness to accept a Medicaid recipient. Additionally, some advocates cite concerns that they want addressed regarding the absence of substantive federal Medicaid requirements placed on assisted living facilities in comparison to nursing homes such as: accepting Medicaid-specified payment as payment in full from the resident, medically-needy eligibility, requirement to accept Medicaid payment from

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[59] AARP, Across the States Profiles of Long-Term And Independent Living; State of Delaware; 8th Edition, 2009.

[60] Mollica, Robert L.; State Medicaid Reimbursement Policies and Practices in Assisted Living, National Center for Assisted Living, September 2009.

Medicaid-eligible residents, quality of care standards, equivalent “bed hold” policies and private occupancy[61].

An advanced notice of proposed rule making released by CMS in the June 22, 2009 edition of the federal register was a good indication that CMS is interested in providing clearer guidance and policy standards around “identifying the home and community character” of settings of care. Taken together with the new focus on home- and community-based care at the federal level suggests that this might be a good opportunity for DMMA to explore discussions with CMS about maximizing community-based care alternatives involving assisted living. Ideally, if DMMA could effectively obtain CMS approval to apply the Medicaid institutional payment policies related to such things as room and board for assisted living services, there could be a wider range of non-institutional service offerings available to Delaware’s elderly and individuals with disabilities. The supply, licensing and quality monitoring of assisted living arrangements would concurrently become a larger issue for DMMA’s staff to address.

Delivery system design choices

Section 6 described the various options for achieving DMMA’s goal of a more robust system of Medicaid long-term services and supports. To that end, DMMA will need to decide whether the State should take direct actions to improve options and alternatives that are delivered through the traditional Medicaid FFS channel or contract with separate managed care plans to carry-out DMMA’s goals or some sort of hybrid such as accountable care collaborations where providers are collectively held responsible for health outcomes and spending.

Pursuing refinements to the FFS system continues to put DMMA in the forefront of any endeavor and directly engaged with both the providers and consumers which will require staff time and devotion. However, the system will still be rooted in FFS which has inherent challenges with fragmentation and misaligned financial incentives for the provision of more care, not necessarily the right care.

Conversely, the various forms of managed care available can allow DMMA to contract with external qualified entities that will operate on behalf of DMMA. This takes DMMA off of the “front lines” of consumer and provider interaction and thus will require DMMA staff to change focus to enforcing contract requirements and contractor management in the realm of long-term care. Providers and consumers will also view managed care as a significant change from the present status quo, for better or for worse.

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[61] Medicaid Payment for Assisted Living: Current State Practices, And Recommendations For Improvement, National Senior Citizens Law Center, January 2010.

Decisions on program design should be geared towards aligning financial, clinical and operational incentives to promote improved health outcomes, fiscal accountability and informed evaluation among providers, consumers and program managers.

Mandatory or voluntary – operating authority

DMMA will need to decide if any new initiative will require mandatory enrollment or if beneficiaries will be given the choice to participate or even opt-out if the default is set at enrollment. While some programs like PACE are small and voluntary by design, other programs can be set up as mandatory. If DMMA elects to engage Medicaid managed care entities, most likely the program will need to be mandatory due to Delaware's small population size. A typical private sector managed care plan will be less likely to invest resources in the systems and operational overhead necessary to comply with state/federal regulations if the potential enrollment numbers are small. Furthermore, risk-based capitation has more appeal when large numbers of people are involved so as to mitigate the potential for large swings in financial gains or losses that create program instability. Indeed, Delaware's small size may even make it a challenge to find willing partners even if the program is mandatory.

If an initiative is pursued that involves integrating Medicare and Medicaid for dual eligibles through some form of capitated managed care (e.g., SNPs), DMMA will need to be cognizant of the fact that Medicare Advantage is voluntary and dual eligibles can disenroll from their Medicare Advantage plan at any time. Obtaining a Medicare waiver to require mandatory Medicare Advantage is technically possible, but not practical. Accordingly, there may be limits to the extent of DMMA's options in integrating Medicaid with Medicare.

Medicaid managed care programs that involve the elderly and individuals with disabilities typically require federal waiver authority (e.g., 1915(b) or possibly an 1115) to require mandatory enrollment. This adds an additional level of administrative effort by DMMA to implement and operate a new program. Although the recent PPACA provided Delaware more flexibility to offer home- and community-based services through state plan amendments, DMMA may elect an initiative that still requires a formal 1915(c) waiver which again will add administrative burden to implement and renew.

Covered populations and services

Existing Medicaid regulations coupled with the new provisions in the PPACA offers DMMA many choices on what populations and services will be included in any new initiative. Some program options, like PACE or Medicare SNPs, have firm rules governing eligibility requirements and benefits provided. However, there will still be many design decisions to make. For example:

- Electing a state plan option is simpler than a waiver, but may result in a much broader impact than a more targeted solution. Which is a better solution for DMMA?
- Should a managed care initiative be limited to just the elderly and not open to individuals with disabilities?

- How is disability defined in terms of program exclusion: physically, mentally or developmentally, and what entity will be responsible for making this determination?
- Can additional populations be phased-in over time?
- Of Medicaid's acute, behavioral and long-term care services, what services will be capitated and what services will still pass through to FFS?
- If DMMA partners with managed care plans, what level of due diligence will be required to ensure the plans are capable of providing such a diverse array of services and how much financial risk is DMMA able to transfer to these plans?
- To what extent will DMMA's information technology systems need to be modified and coordinated to support changes to the existing FFS long-term care system?
- How will any new home- and community-based services be defined and paid for to ensure CMS compliance and federal funding?
- Are there existing state-funded services that can be "federalized" thus allowing DMMA to do more with the same amount of state dollars?

Information technology requirements

Since DMMA's current long-term care system is FFS-based, the systems requirements are focused on adjudicating claims, confirming eligibility and making level-of-care determinations. If new initiatives are implemented that remain rooted in FFS, there could be less information technology changes forthcoming and hence a smoother implementation horizon. However, as DMMA knows from its experience with the Diamond State Health Plan (DSHP), implementing managed care programs involves more extensive system logic, edits and information exchanges. For example:

- Provider claims for long-term care services that are the responsibility of the managed care plans should be rejected by the State, so new programming edits will be required.
- Level-of-care determinations are a central aspect of long-term care programs and can be used to adjust capitation rates: who completes these determinations, how timely is the information uploaded, where is the data stored for reference and how will requests for new determinations be processed?
- Personal plans-of-care outline the service needs of individuals and are used to approve specific services. Will these plans-of-care be accessible on-line to DMMA's managed care partners through secure interfaces?
- Similar to DSHP, edits and logic will be required to only permit those eligible for the respective program to enroll and/or receive appropriate services and if disability status is a condition for eligibility systems will need to be designed to collect and determine disability status.
- Integrated Medicare/Medicaid programs involve additional complex policies and procedures on coordinated enrollment and outreach within the framework of the Medicare Advantage program.

Return on investment – quality and health outcomes

Achieving DMMA's stated goals will require investments of time, staff and fiscal resources – significantly more if the initiative is complex and multi-faceted like mandatory managed long-term care. Improving the lives and functional health status of the elderly and individuals with disabilities is not something that can be changed within one budget cycle. Instead, DMMA will need to take a long-term view on long-term care. These are investments that must be considered within the context of what is important to the consumer as well as what will result in a positive long-term investment. Changes in quality of life measures, distribution and patterns of spending and consumer and advocate feedback are just a sampling of the types of qualitative and quantitative metrics DMMA will need to develop to monitor progress, make adjustments along the way and report successes to external stakeholders.

Timeline for implementation

To reiterate, the purpose of this report is to stimulate and facilitate further discussion and most importantly decision-making on initiatives that DMMA will pursue to better balance the State's system of long-term services and supports. DMMA should devote appropriate time and resources in discussion and consensus building with key constituents, but discussion without measurable progress and action can be ultimately self-defeating as momentum succumbs to stagnation and collaboration to dissent. Accordingly, DMMA should establish a reasonable timeline for implementation that is not overly aggressive and a cause for concern (e.g., moving too fast), but does create a need for purposeful action.

Depending on the chosen initiative, implementation will likely take up to 24 months of lead time and this timeline will be heavily influenced by the availability of State resources to devote time and energy to the new initiative. As noted previously, amendments to the state plan to implement new FFS options are less complex and time consuming than managed long-term care waivers and integrated care programs. Regardless of the initiative selected, the following factors will directly impact the timeline for implementing a new program initiative:

- Availability of DMMA staff resources.
- Political support and prioritization of the State's agenda.
- Level of involvement and support from providers, consumers and families.
- Funding availability to support program start-up.
- Approval/involvement by CMS/federal government.
- Information technology requirements/changes.

There were many existing priorities confronting DMMA staff even prior to the passage of health care reform at the federal level, but now there are new health reform issues, requirements and opportunities to address. Consideration could be given to phasing-in a new long term-care program over time and/or doing a pilot program if practical given Delaware's demographics. Compromise will be required at times and DMMA may want to value the virtue of not letting the perfect prevent the very good from happening.

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Other relevant long-term care provisions in the PPACA

In addition to the options presented in the previous Section, the PPACA contained provisions that pertain to long-term care that may be of interest to DMMA. These other provisions could indirectly influence DMMA's assessment of program initiatives and/or provide a sense of how the marketplace may change in coming years. Some provisions within the PPACA target new demonstration programs for the Medicare program that may be of just informational interest to DMMA.

Since the PPACA was signed into law on March 23, 2010, additional guidance from CMS has not been released as of the date on this report. Therefore, the following provisions are subject to change or revision in application once further guidance becomes available and/or the required regulations have been promulgated.

Extension of the Money Follows the Person (MFP) rebalancing demonstration

Delaware is already participating in the second allocation of MFP demonstration funding, so this option is already being deployed to help transition individuals from institutions to the community. Delaware is able to receive an enhanced FMAP for the long-term services and supports provided in the first year in which an individual is successfully transitioned back into the community. Section 2403 of Subtitle E in Title II of the PPACA extended the MFP demonstration through September 2016 and modified eligibility rules for participation. Whereas the original MFP required that individuals reside in a hospital, nursing facility or ICF-MR for not less than six months and not more than two years, the PPACA now lowers the criteria to not less than 90 consecutive days. To support additional transitions, the PPACA provides an additional $2.25 billion in appropriations through 2016.

State balancing incentive payments program

Section 10202 of Subtitle B in Title X of the PPACA allows states to submit an application for a higher FMAP rate on Medicaid long-term services and support expenditures if the following structural reforms are made within six months after application:

- Development of a statewide system to enable consumers to access all long-term services and supports through a single entry point (i.e., No Wrong Door).
- Adopt conflict-free case management services to develop a service plan, arrange for services, support the beneficiary (and caregivers) in directing the provision of services, and conduct ongoing monitoring.
- Implement uniform core standardized assessment instruments statewide to be used in determining beneficiary’s needs for training, support services, medical care, transportation and other services as well as for developing individual service plans.

The following conditions apply:

- Only states where less than 50 percent of Medicaid long-term care spending was spent on non-institutionally-base services can be selected for this program.
- Application must include a budget that details the state’s plan to expand and diversify non-institutionally-based long-term services and supports.
- Eligibility standards and methodologies for non-institutional services cannot be more restrictive than what were in effect on December 31, 2010.
- The state must collect data on service utilization, core quality measures and outcome measures.

For states selected, the following conditional FMAP incentives are provided:

- If non-institutional long-term spending was less than 25 percent in fiscal year 2009, the state will receive a five percentage point increase in FMAP for federal fiscal years 2011 – 2015. These states will be expected to reach 25 percent spending on non-institutional services by October 1, 2015.
- For other selected states with less than 50 percent non-institutional long-term spending, the state will receive a two percentage point increase in FMAP and be expected to reach 50 percent spending level by October 1, 2015.
- The increased FMAP rate is applicable on only the non-institutional Medicaid long-term services and support expenditures.
- The balancing incentive period ends on September 30, 2015, and there is an aggregate limit of $3 billion for the program.

Due to the relatively large percentage of community-based services for the developmentally disabled, Delaware is likely to be one of the “less than 50 percent” non-institutional long-term spending states.

Five-year demonstration projects to improve coordination for dual eligibles

Section 2601 of Subtitle H in Title II of the PPACA appears to allow 1915 or 1115 waivers that include dual eligibles (including any non-dual populations that may be enrolled as well) to be on a five-year renewal cycle.

Community Living Assistance Services and Supports (CLASS) plan

Section 8002 of Title VIII of the PPACA establishes a new national voluntary insurance program for purchasing community living assistance services and support. The program will be financed by voluntary payroll deductions or contributions from eligible adults age 18 and older who opt to remain in the program after an initial automatic enrollment. Regulations must be promulgated to implement the CLASS act.

- Premiums will be set by the federal government at a level necessary to maintain program solvency for 75 years.
- Monthly premiums for low-income individuals (less than the federal poverty level) will not exceed $5.00 – increased by the percentage increase in the consumer price index for all urban consumers for each year occurring after 2009.
- Persons in a hospital, nursing facility or ICF-MR and receiving Medicaid medical assistance are not eligible to participate.
- To be eligible for benefits, a person must have paid premiums for at least 60 months, have a disability expected to last at least 90 days and meet specific functional/cognitive criteria.
- Benefits are in the form of cash payments to eligible individuals. Minimum amount is not less than an average of $50.00 per day, but the benefit is scaled based on functional ability. There are no lifetime or aggregate limits on benefits.
- Institutionalized Medicaid recipients (as well as institutionalized PACE participants) are permitted to retain five percent of the cash benefit, the remaining 95 percent applies towards the facility's cost of care.
- Home- and community-based Medicaid recipients (as well as community-based PACE participants) are permitted to retain 50 percent of the cash benefit, the remaining 50 percent applies towards their cost of care, but only to the extent that case management, personal care, habilitation and respite care services are provided under either a waiver or state plan amendment.

Medicaid health homes for people with chronic conditions

Section 2703 of Subtitle I in Title II of the PPACA gives state Medicaid programs the option to provide coordinated care through medical health homes to individuals with chronic conditions through a state plan amendment beginning January 1, 2011. Health homes involve a team of health care professionals providing services such as comprehensive care management, care coordination, transitional care, and referrals to community and social support services.

- Planning grants are available beginning January 2011. States will have flexibility to propose alternate methods of paying providers in lieu of standard PMPM rates.
- States that elect this option will receive 90 percent FMAP rate on payments related to the health homes for the first eight quarters of services.
- An independent evaluation will be conducted by the federal government on the effect of health homes on reducing hospital admissions, emergency room visits and nursing facility admissions.

Educational training opportunities for direct care workers

Section 5302 of Subtitle D in Title V of the PPACA provides grants directly to certain institutions of higher learning to provide new training opportunities for direct care workers employed in long-term care settings such as nursing homes, assisted living facilities, ICF-MRs, and home- and community-based settings.

- Awarded grants will be used to off-set tuition costs and other required academic enrollment fees.
- A condition of receiving assistance is that the individual agrees to work in the field of geriatrics, disability services, long-term services and supports or chronic care management for a minimum of two years following completion of the training program.
- There is a total of $10 million in grant funding available for years 2011 through 2013.

State demonstration project to develop training and certification programs for personal and home care aides

Section 5507 of Subtitle F in Title V of the PPACA provides grant funding for demonstration programs in up to six states to develop core training competencies and certification programs for personal and home care aides including written materials and protocols for training and a certification test. Demonstration project will not be less than three years and $5 million is available per year. However, to qualify to receive funding, states must offer personal care services through the Medicaid state plan which Delaware currently does not.

Funding for Aging and Disability Resource Centers (ADRCs)

Section 2405 of Subtitle E in Title II of the PPACA appropriates $10 million for each fiscal year from 2010 through 2014 to carry out (expand) ADRC initiatives as provided by the Older Americans Act.

Nursing facilities – accountability requirements

Section 6102 of Subtitle B in Title VI of the PPACA requires nursing facilities to have compliance and ethics programs in effect three years after the date of enactment. These compliance and ethics programs will be effective in preventing and detecting criminal, civil and administrative violations as well as promote quality of care. Additionally, not later than December 31, 2011, the federal government will establish a quality assurance

and performance improvement (QAPI) program for nursing facilities. Regulations must be promulgated to implement this Section of the PPACA.

Nursing facilities – comparison and reporting of expenditures

Sections 6103 and 6104 of Subtitle B in Title VI of the PPACA require the collection and disclosure of specific nursing facility metrics.

- Section 6103 requires the federal government not later than one year after enactment to make available on the internet nursing facility staffing turnover and tenure data, relationships between nurse staffing levels and quality of care, links to related state websites, summary information on nursing facility complaints, and the number of criminal violations by a facility or its employees.
- Section 6104 requires the federal government within one year of enactment to revise the nursing facility cost report forms to separately report expenditures for direct care staff, indirect care services, capital assets (building/land costs) and administrative costs. Facilities will be required to complete these new reports on or after two years following enactment. The information collected via Section 6104 will be made available to “interested parties.”

Nursing facilities – standardized complaint form

Section 6105 of Subtitle B in Title VI of the PPACA requires the federal government to develop a standardized complaint form for use by a resident (or person acting on behalf of a resident) in filing complaints with a state survey and certification agency and a state long-term care ombudsman program. States must also establish a complaint resolution process. This provision is effective one year after enactment of the PPACA.

Medicare FFS – accountable care organizations

Section 3022 of Subtitle A in Title III of the PPACA creates the Medicare Shared Savings program effective not later than January 1, 2012, that promotes accountability for a patient population and coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.

- Groups of providers of services and suppliers can form accountable care organizations (ACOs) that work together to manage, coordinate and be accountable for the quality, cost and overall care of the Medicare FFS beneficiaries assigned to them.
- ACOs will be required to promote evidence-based medicine, patient-centered processes, and report data on cost and quality of care.
- Medicare will continue to pay providers under the Original Medicare program via FFS.
- ACOs will also be eligible to receive extra payments based on shared savings.

Medicare FFS – independence at home medical practice demonstration

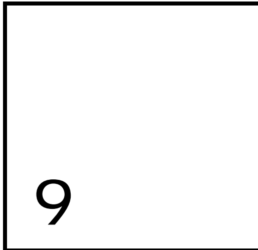
Section 3024 of Subtitle A in Title III of the PPACA creates a new Medicare demonstration program to test a payment incentive and service delivery model that uses physician and nurse practitioner directed home-based primary care team to care for and provide services to the chronically ill.

- Eligible Medicare beneficiaries may not be enrolled in either Medicare Advantage or PACE.
- Demonstration begins January 1, 2012, and may cover not more than a three-year period.
- The number of Medicare beneficiaries is capped at 10,000.

Medicare FFS – community-based care transitions program

Section 3026 of Subtitle A in Title III of the PPACA provides funding to hospitals and community-based organizations that provide transition services across a continuum of care to high-risk Medicare beneficiaries (e.g., chronic disease, depression, cognitive impairment) who are not enrolled in Medicare Advantage plans.

- The program commences on January 1, 2011, and will be conducted for a five-year period.
- The scope and duration of the program can be expanded if it would reduce Medicare spending without reducing quality.



Conclusion

We hope that the information compiled and presented within this report stimulates further discussion among DMMA, and its internal and external stakeholders. Moreover, our primary goal is to see Delaware make measurable strides in deploying programs that promote better health outcomes, enhance the sustainability of DMMA's programs and organize State spending in more consumer-oriented ways for the elderly and individuals with disabilities who are or will rely on Medicaid's long-term services and supports.

Whereas the aspects of Delaware's current financing of care for the elderly and individuals with disabilities in relation to changing demographics justify the need to take action, the qualitative aspects of more community-based alternatives for Medicaid long-term services and supports can substantiate the benefits of having taken action. Addressing imbalances in the Medicaid long-term care system is not an easy undertaking. The following is just a sampling of the types of issues and decision-points pending for DMMA staff: strategic planning, financing/payment options, program design, enrollment and disenrollment rules/processes, consumer/advocate input and reaction, provider comment, procurement and contracting of managed care plans, federal waiver development and information technology/configuration issues (e.g., claims payment edits/rules, eligibility determinations, capitation payment processing). Accordingly, pursuing any new initiative will require devotion of human, financial and technological resources.

Delaware's leadership clearly embraces the need to move through the continuum of assessing the situation, taking action, implementing programs and measuring success so as to achieve a better balance in the Medicaid program's system of long-term services and supports.

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