Delaware Health and Social Services

Delaware Diamond State Health Plan Plus

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

to

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

State of Delaware

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SECTION 1: BACKGROUND

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

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

Cost of Care – Community versus Institutional

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

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

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

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

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

Consumer Preference – Community versus Institutional

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

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

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

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

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

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

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

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

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

SECTION 2: CURRENT ENVIRONMENT and INITIATIVES IN DELAWARE

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

Money Follows the Person (MFP) demonstration

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

Delaware Aging and Disability Resource Center (ADRC)

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

Care Transitions

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

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

Program of All-Inclusive Care for the Elderly (PACE)

Delaware intends to offer a new PACE program option under the Medicaid State plan. Although PACE will not be part of this demonstration proposal, it will be another option that DMMA believes will increase HCBS options and enhance the LTC delivery system.

Medical Homes and Health Homes

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

Balancing Incentives

Upon release of the application requirements from the Centers for Medicare & Medicaid Services (CMS), Delaware anticipates applying for the State Balancing Incentive Payments made available under Section 10202 of the Affordable Care Act.

SECTION 3: PROPOSAL

The current DSHP Section 1115 demonstration is designed to use a managed care delivery system to increase access to high-quality health care for Medicaid enrollees of the demonstration. Since 1996, Delaware has utilized the savings garnered from this more efficient delivery system to expand Medicaid coverage to more than 32,000 adults with income at or below 100% of the federal poverty level.

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

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

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

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

A. Overview

Under DSHP Plus, Delaware proposes to:

- Expand mandatory Medicaid managed care to the elderly and persons with physical disabilities not currently enrolled in DSHP.
- Integrate Medicaid primary, acute, behavioral health and LTC (institutional and HCBS) for Medicaid enrollees in need of institutional and home- and community-based LTC services.
- Administratively streamline and consolidate two section 1915(c) waiver authorities under the 1115 demonstration authority.
- Enhance the existing HCBS benefit package through additional benefits.
- Incentivize managed care organizations (MCOs) to expand HCBS options for the elderly and physically disabled population.
- Revise the current level of care (LOC) review tool to require that anyone who is newly entering a nursing facility needs assistance with at least two activities of daily living (ADLs) rather than the current minimum requirement of assistance with one ADL. (There will be no impact on eligibility as a result of this change.)
- Continue the current LOC criteria for individuals requesting HCBS to require assistance with only one ADL.
- Develop one or more health homes under the Section 2703 ACA option to enhance integration and coordination of care for DSHP enrollees, including enrollees of DSHP Plus.
- Encourage Medicaid managed care contractor participation as Medicare Special Needs Plans in the 2013 Medicare Advantage plan year.
- Explore ways to expand and further integrate community-based mental health services for DSHP and DSHP Plus enrollees through options, such as the Section 1915(i) state plan amendment and Section 2703 health home options. (Options for the expansion of community-based mental health services that can be successfully integrated with primary and LTC services are currently being considered on a separate, but coordinated, track with this 1115 demonstration. These options are not currently being considered for the demonstration amendment proposed for approval on October 1, 2011.)

B. Participating Divisions and Programs

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

Delaware Health and Social Services

DHSS is the Medicaid single State agency in Delaware. DHSS includes 12 divisions, which provide services in the areas of public health, social services, substance abuse and mental health, child support, developmental disabilities, LTC, visual impairment, aging and adults with physical disabilities and Medicaid and Medical assistance. The DHSS is also responsible for four LTC facilities and the State's only psychiatric hospital, the Delaware Psychiatric Center, which is associated with other private psychiatric facilities. In addition, DHSS operates the Long-Term Care Ombudsman Program.

Division of Medicaid and Medical Assistance

In addition to administering the acute care Medicaid program and Children's Health Insurance Program, DMMA also oversees/provides benefits as follows:

- Nursing Facility Services: Individuals receiving this benefit must be in need of a skilled or intermediate level of care provided by a nursing facility. Financial eligibility is set at 250% of the Supplemental Security Income (SSI) standard ($1,685/month for an individual in 2010) and assets are limited to $2,000 for the institutionalized client (there is a higher asset limit for the spouse still living in the community).
- Qualified Medicare Beneficiary Programs for dual eligibles.
- Children's Community Alternative Disability Program: Delaware provides this optional Medicaid coverage to children under section 1902(e)(3) of the Social Security Act with severe disabilities who meet the SSI disability criteria but do not qualify for SSI or other Medicaid-qualifying programs because their parents' income and/or resources are considered as part of the eligibility process. The child's gross monthly income cannot exceed 250% of the SSI standard, and countable assets cannot exceed $2,000. The parent's income and assets are not considered. These children are currently enrolled in DSHP.
- AIDS Home- and Community-Based (AIDS HCB) Waiver Program: Enrollees in this statewide 1915(c) waiver program receive all the regularly covered Medicaid services, plus the following special waiver services: case management, mental health services, personal care services, respite care and supplemental nutrition.
- SSI-related Programs: Including Medical Assistance during Transition to Medicare, Medicaid for Workers with Disabilities under Ticket to Work and Work Incentives Improvement Act of 1999 and Disabled Adult Children.
- Financial Eligibility Determinations: DMMA is responsible for determining financial eligibility for the State's Medicaid home- and community-based waivers.
- Medical Eligibility Determinations: DMMA is also responsible for determining medical eligibility for individuals seeking the following benefits/programs: Nursing Facility services, AIDS HCB Waiver, and the Children's Community Alternative Disability program.

Division of Services for Aging and Adults with Physical Disabilities

In addition to being Delaware's State Unit on Aging, DSAAPD oversees a variety of programs and services. For example:

- Elderly and Disabled Waiver Program: This is a statewide Medicaid 1915(c) waiver that provides an alternative to nursing home care for eligible older persons and adults with physical disabilities. The program includes services to help a person to continue living in his or her home safely. Nurses and social workers coordinate with participants and their caregivers to develop care plans that help to meet individual needs. This waiver recently consolidated the Acquired Brain Injury and Assisted Living Facility Section 1915(c) waivers into a single waiver and added consumer-directed personal care services. Enrollees in this waiver receive all regularly-covered Medicaid services, plus the following additional HCBS services: adult day services, assisted living, case management, cognitive services, day habilitation, personal care services, personal emergency response system, respite care, specialized medical equipment and supplies and support for participant direction.
- Medical Eligibility Determinations: DSAAPD is also responsible for determining medical eligibility for the Medicaid 1915(c) waiver that provides an alternative to nursing home care for eligible older persons and adults with physical disabilities.
- Other Services: DSAAPD also provides the following services, mostly through the use of State funds, but sometimes with other federal funds or block grants: assistive devices, Alzheimer's day treatment, attendant services, home-delivered meals, home modifications, housekeeping services and medical transportation.

Organizational Impact of DSHP Plus

As described above, LTC clients currently receive services provided by two divisions of DHSS. Upon implementation of DSHP Plus on April 1, 2012, DMMA will operate a central intake unit and there will be a single medical and financial determination. As with any implementation of a major managed care expansion, State resources are being reevaluated to align with the new program design and in a manner that will enhance the State's oversight of the managed care contractors (e.g., quality assurance, level of care assessments, contract management). DMMA and DSAAPD are working closely together to identify and effectuate such changes as the design of DSHP Plus evolves.

C. Eligibility and Enrollment

DSHP Plus will be a continuation of Delaware's ongoing Section 1115 demonstration for DSHP and will expand mandatory Medicaid managed care to the elderly and persons with physical disabilities not currently enrolled in DSHP. The implementation of DSHP Plus will add to the demonstration full-benefit dual eligibles, long-term nursing facility residents and participants eligible to receive HCBS waiver services under the current Elderly & Disabled (E/D) and AIDS section 1915(c) waivers.

DSHP Plus Eligibility. In addition to the current DSHP populations, the following persons will be included in DSHP Plus:

Individuals meeting an institutional level of care:

- Individuals enrolled in the E/D and AIDS 1915(c) waiver programs
- Individuals residing in State-operated and private institutions, other than intermediate care facilities for the mentally retarded (ICF/MRs). Children in pediatric nursing facilities

Individuals not meeting an institutional level of care:

- Full benefit dual eligibles: Individuals eligible for both Medicare and Medicaid (all ages)
- Medicaid for Workers with Disabilities

As further described below in the "Benefits" section, Delaware proposes to terminate two existing section 1915(c) waivers while maintaining the eligibility and benefits currently covered under those waivers through section 1115 demonstration authority. Delaware is requesting authority under the DSHP Plus demonstration to continue coverage of individuals who would otherwise be Medicaid-eligible under 42 CFR 435.217 if the services they receive under DSHP Plus were provided under the E/D or AIDS Section 1915(c) waivers as those waivers are currently approved.

Eligibility Exclusions. The following persons will be excluded from DSHP/DSHP Plus:

Individuals enrolled in the Section 1915(c) Division of Disability Determination Services Waiver program.
ICF/MR residents of the Stockley Center and Mary Campbell Center, excluding clients residing in the assisted living portion of the Stockley Center.
Individuals who choose to enroll in PACE when that program becomes operational (estimated to begin in October 2013, though an exact start-up date has not yet been determined.)
Any Medicaid members that DMMA has already authorized for out-of-state placement at time of program implementation will remain in the FFS program. (However, effective with implementation on 04/01/2012, DMMA will no longer authorize and pay for new out-of state placements through FFS. DMMA expects the DSHP MCOs to better coordinate care and services to avoid the need for any new out-of-state placements.)
Dual eligibles other than full-benefit duals.
Presumptively eligible pregnant women.
Breast and Cervical Cancer Treatment Program enrollees.

Unqualified aliens, both documented and undocumented, receiving emergency services as defined in section 1903(v) of the Social Security Act.
Those only in need of the 30-Day Acute Care Hospital program (42 CFR 435.236 group covered on page 19 of Attachment 2.2-A of the State Plan)

Individuals in need of Medicaid LTC services whose income falls within the special income rule for this population (which is 250% of the SSI standard in Delaware) and who are made eligible for Medicaid solely by virtue of their need for home and community based services, will receive State Plan and enhanced home and community based services upon their enrollment in a Managed Care Organization (MCO). Individuals who require nursing facility care will be enrolled with a MCO retroactive to the first day of the month in which they meet all eligibility criteria. As is currently authorized for DSHP, Delaware will not provide retroactive eligibility prior to the date of application to DSHP enrollees with the exception of nursing facility residents.

Eligibility: Expenditure Authority Requested

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1. DSHP Plus 217-Like HCBS Group

Expenditures for DSHP Plus enrollees who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR § 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under DSHP Plus were provided under Medicaid and a HCBS waiver granted to the State under section 1915(c) of the Act, as of the initial approval date of the DSHP Plus component of this demonstration. This includes the application of the spousal impoverishment eligibility rules.

Eligibility: Waiver Authority Requested

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1. Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary to not extend eligibility to individuals (other than nursing facility residents) prior to the date that an application for assistance is made.

D. Benefits

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

except as noted below. The MCOs will also be required to contract with a fiscal employer agent (FEA) for the purpose of continuing the consumer direction under DSHP Plus.

Delaware proposes to offer the following expanded HCBS services under DSHP Plus:

(1) Home modifications for the Plus-HCBS group (see chart below) determined to be cost-effective and medically necessary by the DSHP Plus MCO. Limit: $6,000 per project; $10,000 per benefit year; $20,000 per lifetime.
(2) Community transition services (e.g., bed rails, administrative paperwork, food staples, household set-up, moving expenses, housing application fees, housing security deposits, utility security deposits) for individuals moving from a nursing facility to the community under the MFP program. Limit: $2,500 per lifetime.
(3) Home-delivered meals (up to one meal per day).

DSHP Plus MCOs will be incentivized to offer cost-effective, innovative services as alternatives to institutional care when appropriate and acceptable to the member. No additional funding is requested under the demonstration for these services, but Delaware will allow for modifications in the capitation rate development process to account for the expected cost and utilization of "in lieu of" services when such services support increased flexibility, consumer acceptance and cost efficiency in DSHP Plus.
Such services will be provided at the option of the DSHP Plus contractor but must be approved by DMMA.

A key goal of DSHP Plus is rebalancing Delaware's LTC system in favor of community-based services. Currently, Delaware's institutional LOC criteria requires one ADL for both Nursing Home and HCB services. To assist in rebalancing, DMMA is proposing to revise the current institutional LOC review tool to encourage appropriate diversion of clients to the community, so that needs are met in the least restrictive setting. DMMA proposes to require that anyone who is newly entering a nursing facility must need assistance with at least two ADLs rather than the current minimum requirement of assistance with one ADL. Although Delaware does not expect a significant change for this population, given the average ADLs of clients residing nursing facilities, this will assist in achieving the goal of greater, appropriate placements in community settings. DMMA has been tracking ADLs since May. Individuals who meet the institutional LOC criteria in place immediately prior to DSHP Plus becoming operational will continue to be evaluated against those earlier criteria. This change will only affect the setting in which an individual's services are provided and will not impact an individual's Medicaid eligibility.

As part of DSHP Plus, these populations are proposed to be included under the demonstration and enrolled in mandatory Medicaid managed care as follows:

DSHP Plus Eligibility Group	Description
Plus-Institutional	Until Plus is operational (i.e., services delivered through MCOs), individuals residing in institutions other than ICF/MRs who meet the institutional LOC criteria (i.e., one ADL) in place at the time of admission. *Once Plus is operational, individuals residing in institutions other than ICF/MRs who (1) were admitted prior to 4/1/12 and met the institutional LOC criteria in place as of 3/30/12 (i.e., at least one ADL); (2) applied for LTC prior to 4/1/12 and met the institutional LOC criteria in place as of 3/30/12 (i.e., at least one ADL); or (3) who meet the revised institutional LOC criteria (i.e., at least two ADLs) in place as of 4/1/12. Includes children in specialty pediatric nursing facilities.
Plus-HCBS	Individuals meeting the institutional LOC requirements in place as of March 30, 2012 (i.e., at least one ADL.) Note: Once Plus is operational on April 1, 2012, there will be a lower LOC requirement for HCBS waiver-like services than for institutional services, except for grandfathered individuals.
Plus-Duals	Full-benefit dual eligibles who are not at a LTC LOC.

**The State may grant an exception for persons in the Plus-HCBS group seeking nursing facility admission or readmission who continue to meet the nursing facility LOC in place as of March 31, 2012, but whose needs can no longer be safely be met in the community.*

Termination and Transition of the Elderly & Disabled and AIDS Waivers:
With the approval of this 1115 demonstration amendment, two of Delaware's three section 1915(c) HCBS waivers will terminate but services will continue as they do today during the transition period from FFS to managed care. DMMA intends to transition the authority for providing the HCBS services currently authorized for the E/D and AIDS waivers under section 1915(c) authority to a section 1115 demonstration authority. The State requests to cease operating these HCBS Waivers under section 1915(c) authority upon approval of the DSHP Plus Section 1115 demonstration amendment, but to

continue these same programs as “transitional” HCBS waivers under the demonstration authority until the DSHP Plus managed care contractors become operational. Once the DSHP Plus managed care contracts become operational, DMMA will cease operating these “transitional” waivers under the demonstration.

Delaware is committed to a seamless process for transitioning the two 1915(c) waiver programs into the section 1115 demonstration and into managed care. Delaware will submit to CMS and to waiver participants the notices required under section 1915(c) waiver rules in order to terminate the E/D and AIDS waivers and is preparing a transition plan for the termination of the waiver authorities. However, as the transition from authorities during the “transitional” waiver period should be seamless to waiver participants, in order to avoid participant confusion, the notices will emphasize that there will be no loss of services, waiver participants will be able to continue seeing their current providers and no action is needed on the part of the waiver enrollees when the authority shifts from section 1915(c) to section 1115 demonstration authority during the “transitional” waiver period. Delaware has recent experience in completing a successful consolidation of three 1915(c) waivers into the single E/D Waiver and proposes to model the language in this notice after consolidation (see attached letter.)

Letter to
articipants about W.

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

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

DSHP Plus Benefits. Benefits provided through this Demonstration for the DSHP Plus population are as follows:

Table 1: DSHP Plus Services Covered in the MCO Benefit Package

Inpatient and outpatient hospital services, including ambulatory surgical centers	Private duty nursing
Clinic services, including rural health clinics and federally qualified health center services and non-hospital affiliated ambulatory surgical centers	Community-based residential alternatives that include Assisted Living Facilities*
Laboratory and x-ray services, including non-invasive and invasive imaging	Personal Care*
Home health services	Respite care, both at home and in Nursing and Assisted Living Facilities*
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21)	Day Habilitation*
Family planning services and supplies	Cognitive Services *
Physicians services, including nurse practitioners and nurse midwife services	Emergency Response System*
Dental services (for individuals under age 21 only)	Consumer-directed Attendant Care*
Physical and occupational therapy	Independent Activities of Daily Living (chore)*
Speech, hearing and language therapy	Nutritional supplements not covered under the State Plan for individuals diagnosed with AIDS*
Durable medical equipment, including prosthetic and orthotic devices, hearing aids and prescription shoes	Specialized durable medical equipment not covered under the State Plan*
Nursing facility services (after the first 30 days of admission) (for individuals not receiving HCBS)	Minor home modifications (up to $6,000 per project; $10,000 per benefit year; and $20,000 per lifetime)*
Hospice care services	Home-delivered meals (up to one meal per day)*
Outpatient behavioral health services (mental health and chemical dependence services): MCO benefit limited to 30 visits for children (w/FFS wraparound for additional visits) and 20 for adults)	Case management services*
Emergency transportation	Community transition services (e.g., bed rails, administrative paperwork, food staples, home modifications, household set-up, moving expenses, housing application fees, housing security deposits, utility security deposits) for individuals moving from a nursing facility to the community under the MFP program. Limit: $2500 per lifetime.
Renal dialysis	Transition workshops for those moving from a nursing facility to the community under the MFP

	program. These workshops prepare the individual and their families and other caregivers for community living.

* Covered for the HCBS-Plus Group

All other state plan services, including mental health and substance abused services above the MCO limits, will be provided in FFS as they are for the DSHP enrollees.

Case management and support coordination model

The DSHP Plus MCOs will be required to establish a LTC case management and support coordination program as directed by the State. DMMA will establish minimum case management program requirements and qualifications for case managers. MCOs will provide case management and support coordination either directly or through contracts with other organizations. Additionally, DMMA will require that each MCO assigns one and only one case manager for every member eligible to receive LTC services.

For those members enrolled at the time of the DSHP Plus implementation that require LTC services, DMMA will establish timelines for the initial contact, care assessment, plan of care, individual service agreement and authorization and implementation of services. DMMA will ensure that the MCO case managers have information pertaining to the individual from the previous 12 months, including the case manager case notes, care assessments, plan of care (most recent) and the types and amount of services currently authorized.

Plan of Care: For each member eligible to receive LTC services, the DSHP Plus MCO will develop and implement a person-centered written plan of care and individual service agreement. It will analyze and describe the medical, social, behavioral and LTC services that the member will receive. In developing the plan of care, the MCO will consider appropriate options for the individual related to his/her medical, behavioral health, psychosocial, case-specific needs at a specific point in time, as well as goals for longer term strategic planning, and the MCO will be expected to emphasize services that are provided in members' homes and communities in order to prevent or delay institutionalization whenever possible.

If, at the time of implementation, an individual is currently receiving HCBS under the E/D or AIDS section 1915(c) waiver and continues to meet a nursing facility level of care, the member will continue to receive HCBS from their current provider(s) for at least 90 days and until a care assessment has been completed by an MCO case manager. Based upon the services in place at the time of DSHP Plus implementation, the services need not be identical to the ones previously received under the Section 1915(c) waiver, but any change must be based upon the care assessment.

Delaware is also in the process of developing one or more health home options under section 2703 of ACA for inclusion under this demonstration. To date, DMMA has formed a workgroup, including representatives from the DMMA, Medicaid MCOs, the Division of Public Health, the Division of Substance Abuse and Mental Health and Nemours to explore the new health home option. A data subgroup has researched which populations would best be served following the CMS guidelines for coverage of health homes. Data collection showed that the following chronic conditions proved to be where efforts could be best focused: diabetes, respiratory conditions (chronic obstructive pulmonary disease, asthma) cardiac diseases (coronary artery disease, myocardial infarctions and hypertension) and behavioral health. Additional providers and stakeholders have been identified for inclusion in ongoing planning activities. While Delaware does not anticipate finalizing the design of its health home model(s) and gaining CMS approval by the time that DSHP Plus is implemented, Delaware is requesting authority under this amendment to implement any approved State plan amendment to provide health homes under section 2703 of ACA to eligible demonstration enrollees.

Delaware currently "carves out" pharmacy from the DSHP MCO benefit package and will continue to do so upon the initial implementation of DSHP Plus. However, as Delaware considers options for encouraging greater integration of care and the impact of the rebates on MCO drugs purchased by Medicaid MCOs under Section 2501(c) of the Affordable Care Act on DSHP and DSHP Plus, the State is requesting authority under this amendment to include pharmacy at a later date by notifying CMS and updating the Special Terms and Conditions regarding the budget neutrality computation.

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

- Pharmacy
- Child dental
- Non-emergency transportation, except for emergency ambulance transportation
- Day habilitation services authorized by the Division of Developmental Disabilities Services
- Medically necessary behavioral health services for both children and adults in excess of MCO plan benefit coverage described in Table 1
- Family Planning and Family Planning-related services and supplies for members of the Family Planning Expansion Group
- Prescribed Pediatric Extended Care (PPEC)
- Day treatment by continuous treatment teams for mental illness or substance abuse

Benefits: Expenditure Authority Requested

Transitional HCBS Services
Expenditures for the continued provision of services provided to individuals enrolled during the transition from FFS to DSHP Plus in Delaware's E/D and AIDS HCB Waiver programs for the period beginning with the effective date of this demonstration amendment until DSHP Plus MCO coverage is operational.

DSHP Plus HCBS Services
Expenditures for the provision of services, through DSHP Plus plans, that could be provided under the authority of section 1915(c) waivers, to individuals who meet an institutional LOC requirement in effect as of March 30, 2012.

Expanded HCBS Services
Expenditures for home modifications, community transition services and home-delivered meals provided to demonstration enrollees determined eligible for HCBS services.

Nursing Facility Expenditures
Expenditures for DSHP Plus-enrolled nursing facility residents who do not meet the nursing facility level of care criteria at the time of DSHP enrollment, but continue to meet the level of care criteria in place at the time of admission/enrollment.

Benefits: Waiver Authority Requested

1. Comparability and Amount Duration and Scope Sections 1902(a)(17) and 1902(a)(10)(B)

To enable the State to determine whether an individual has a continuing need for nursing facility services and home- and community-based services for the elderly and disabled based on the criteria in use when the individual first was determined to need the service.

E. Cost-sharing

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

F. Delivery System

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

Managed Care Enrollment

Informed member choice, continuity of care and shared risk among MCOs will be the priorities for the DSHP Plus enrollment process. DMMA has formed a DSHP PLUS Transition Team whose task it is to focus on the seamless transition of members from FFS into DSHP Plus. This team is developing an outreach and education strategy to ensure that individuals understand the new system, and their choices under DSHP Plus, including the networks and providers available, as well as the importance of making an affirmative choice of managed care plan to ensure continuity of care upon enrollment.

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

DMMA's goal is that all individuals will make an informed, affirmative choice of a DSHP Plus MCO. Similar to DSHP members, DSHP Plus members will be pre-assigned to an MCO and will have up to 30 days (45 days during initial implementation) to choose another MCO or keep their pre-assigned selection. All individuals will have the opportunity to choose a DSHP Plus MCO prior to enrollment. However, recognizing that some members do not make such a choice, this pre-assignment process is a means of ensuring that an individual understands the MCO to which they will be assigned only if no affirmative choice is made. Further, this pre-assignment process will consider continuity of care with current providers, so that there is a better chance that the assigned MCO will meet the member's needs.

For nursing facility and HCBS members, DMMA is also developing a more refined pre-assignment process that considers both continuity of care as well as the distribution of members between the two MCOs. For example, if in the pre-assignment process, ten (10) members are nursing facility residents and six (6) are residing in the community, each MCO may initially be assigned five (5) nursing facility residents and three (3) community-based members. DMMA's goal is to allow for shared risk between the

MCOs. Dual eligibles not yet in need of LTC services may be pre-assigned into an MCO evenly across all participating MCOs.

Once assigned to a DSHP-Plus MCO, DMMA will provide service and provider utilization for the member to the MCO. For those members receiving services under the E/D or AIDS HCB waivers, the MCOs and existing case managers will work closely together to ensure that all case management records, plans of care and other information are communicated to the MCOs in advance of enrollment. Once enrolled in DSHP Plus, new members will have 90 days to transfer to another MCO without cause. Further, upon initial implementation of DSHP Plus, DMMA will require the MCOs to allow members to continue receiving the services authorized in an existing plan of care through current providers for up to 90 days.

DMMA is in the process of reviewing its current contract with the MCOs for revisions to reflect the Plus population, benefit package and increased quality, monitoring and reporting requirements. These contract amendments will comply with all requirements under 42 CFR Part 438, except as expressly waived under the DSHP Plus waiver and expenditure authorities and approved Special Terms and Conditions. As part of this contract review and DMMA's Transition Planning Team efforts, DMMA is developing contract requirements, policies and procedures and standards regarding:

(1) Plan Readiness and Reporting (e.g., enrollment, informing, assessments and care planning, provider contracting and outreach, claims payment, encounter data)
(2) Comprehensive network adequacy that includes case management standards
(3) Strategies for continuity of care (e.g., 90-day access to out-of-network providers upon DSHP Plus implementation or longer until a plan of care is in place, State case manager meetings with MCO case managers, transfers of care plans and claims data to MCOs)
(4) Provider and consumer education and outreach strategies (see "Public Input" section), including outreach to every provider currently submitting claims for the DSHP Plus population
(5) Person-centered planning and care delivery, as well as facilitation of self-direction within managed care
(6) Coordination with services that are "carved-out" of DSHP Plus (e.g., non-emergency transportation)
(7) Revisions to the State Quality Improvement Strategy (including performance measures specific to the DSHP Plus populations)
(8) Post-Implementation Monitoring Needs (e.g., dashboard reports, grievance and appeals, service approvals/denials, prompt payment, critical incident reporting, placement changes/transitions)

DMMA will continue to update CMS on the details of this transition plan as the Transition Team's efforts mature.

DMMA is requesting a very limited exception to the requirements at 42 CFR 438.52(a) that require a choice of Medicaid MCOs. DMMA intends to offer a choice of plans through the availability of two MCOs and has secured a commitment from both plans of their interest in DSHP Plus. However, in the unlikely event that one MCO should discontinue participation in DSHP Plus, DMMA seeks to proactively plan for continuity of care for enrollees and requests authority to continue mandatory managed care for up to 15 months under a single MCO while DMMA seeks participation from a second qualified MCO. DMMA will require six months notice of intent to not participate in DSHP Plus, so that the situation described would not occur. However, having this authority is critical to DMMA's ability to attract, maintain and provide adequate oversight and monitoring of its contracted MCOs. In the event that one MCO should decide to discontinue participation in DSHP/DSHP Plus, Delaware would take proactive measures to:

(1) Notify CMS of the planned departure of an MCO and submit a transition plan that addresses continuity of care for that plan's members and a procurement plan for a second contractor.
(2) Conduct an emergency procurement for a new health plan within six months window to ensure a choice of two plans and ensure a smooth transition of members to a new MCO.
(3) If an emergency procurement for a new plan within the six months window is not feasible, Delaware will extend the timeframe for up to 15 months in order to have a second MCO contractor operational at the end of the 15 month period.
(4) If, at any time during this 15-month window, only one MCO is available for enrollment, DMMA will:
    - Evaluate the capacity and network overlap of the remaining plan to assess the feasibility of transitioning the departing plan's members to the remaining (or new) plan with the least amount of interruption in care.
    - Ensure that members have a choice of at least two PCPs, at least at the times as described in 42 CFR 438.56(c).
    - Provide a minimum of 30 days notice to the departing plan's members.
    - Require the departing plan to transition member records, including case management and plans of care to the remaining (or new) MCO.
    - Require the departing plan to adequately notify its contracting providers.
    - Provide a FFS option on a case-by-case basis for any members who cannot be successfully transitioned to the remaining MCO until a second MCO becomes available.

Delivery System: Expenditure Authority Requested

Choice of Managed Care Plans
Section 1903(m)(2)(A) for expenditures to MCOs for up to 15 months if the State does not offer a choice of at least two MCOs in the DSHP/DSHP Plus program due to early contract termination by an MCO, as long as enrollees have a choice of at least two primary care providers and may request a change of primary care provider at least at the times as described in 42 CFR 438.56(c).

Delivery System: Waiver Authority Requested

1. Amount, Duration and Scope of Services **Section 1902(a)(10)(B)**
To the extent necessary, to enable Delaware to offer a different benefit package to DSHP PLUS participants than is offered to other populations.

2. Freedom of Choice **Section 1902(a)(23)**
To the extent necessary, to enable Delaware to restrict freedom-of-choice of provider for DSHP Plus participants.

G. Quality

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

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

H. Waiver and DSHP Plus Implementation

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

SECTION 5: PUBLIC INPUT

Delaware is committed to seeking input from consumers, families, providers, various state operating components and other interested stakeholders on the design of Plus.
Delaware has been planning for DSHP Plus since 2000 and engaged stakeholders in the in the design of DSHP Plus by:

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

DMMA has posted the 1115 Demonstration Concept Paper for DSHP Plus to a website designed to keep interested stakeholders informed and has established a mailbox to solicit comments and feedback on the program.

DMMA has also posted the draft CMS waiver application on the website for additional public input.

Since planning began, DMMA has met with or received input from the following groups:

Beneficiaries
E/D Waiver Providers
AIDS Waiver Providers
Current MCO contractors (United Healthcare and Delaware Physicians Care/Aetna)
Delaware Health Care Facilities Association
Nursing Facilities
Hospitals
Public Health
Other stakeholders

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

SECTION 6: BUDGET NEUTRALITY

Delaware's 1115 waiver began in 1996. A major focus of the waiver was the introduction of managed care for most of the Medicaid population. However, throughout the life of the waiver, certain groups were not enrolled in managed care and remained in the fee-for-service program. These groups included dual eligibles (who have health care coverage through both Medicare and Medicaid), persons in long term care facilities and persons served in Delaware's 1915(c) home and community based and AIDS waivers. Now Delaware is planning to expand the existing 1115 waiver to include these groups with the exception of individuals served in ICF/MR institutions and in the DDDS 1915(c) waiver. Therefore, the existing 1115 waiver budget neutrality documents need to be revised to reflect the spending impact of the new populations being added to the waiver.

Delaware is proposing that budget neutrality for the 1115 waiver maintain the same basis of identified Medicaid Eligibility Groups (MEG's) with a per member per month (PMPM) cost and a trend rate based on actual historical spending data. Under this approach, Delaware is held harmless for growth in the numbers of people in the program. The State must maintain budget neutrality on an average cost per person basis.

In light of the planned expansion of the 1115 waiver, to begin the budget neutrality analysis, Delaware analyzed the new coverage group and identified three sub groups, i.e., three new MEG's:

1. Nursing Home and Community Based Dual Eligibles (Medicare and Medicaid with nursing home level of care)
2. Nursing Home and Community Based Non Dual Eligibles (Medicaid only with nursing home level of care)
3. Community Based Dual Eligibles (Medicare and Medicaid without nursing home level of care)

Once the new MEG's were identified, Delaware analyzed available data sources to collect historical spending and member month information. Spending was captured for each MEG for calendar years 2007 through 2010. Under the proposed waiver expansion, most spending will be in the form of capitation payments to managed care companies. However, some spending, such as pharmacy and non-emergency transportation, will remain fee-for-service. Consistent with the existing 1115 waiver budget neutrality calculations, the spending data utilized for purposes of budget neutrality includes virtually all Medicaid spending for persons in each MEG regardless of whether or not the spending will be fee-for-service or covered under a capitation payment once the waiver expansion begins. Also consistent with the existing 1115 waiver, spending data is based on date of service. For calendar years 2011 through 2013, without waiver and with

waiver spending is trended forward. Table 1 below summarizes the without waiver PMPM's and trend rates for 2007 through 2013:

TABLE 1

New MEG's To Be Added To The 1115 Waiver

Historical and Projected PMPM Data

		Nursing Facility & Community Based Duals		Nursing Facility & Community Based Non Duals		Community Based Duals (not nursing home level of care)	
CY		PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate
2007	Actual	$3,951.98		$5,578.91		$279.18	
2008	Actual	$4,221.99	6.83%	$6,488.84	16.31%	$283.28	1.47%
2009	Actual	$4,213.80	-0.19%	$6,841.85	5.44%	$291.58	2.93%
2010	Actual *	$4,262.27	1.15%	$6,657.56	-2.69%	$309.24	6.06%
2011	Projected	$4,368.83	2.5%	$7,057.02	6.0%	$320.07	3.5%
2012	Projected	$4,478.05	2.5%	$7,480.44	6.0%	$331.27	3.5%
2013	Projected	$4,679.56	4.5%	$8,004.07	7.0%	$344.52	4.0%

* 2010 data is adjusted to account for IBNR as claims continue to be paid for that time period.

Delaware is only able to retrieve MMIS claims data back to 2007. However, before the major part of the expansion is implemented in April 2012, spending data for CY2011, modified with an IBNR adjustment factor, could be used to update the projections if CMS deems it necessary or desirable to consider an additional year of data.

In estimating the trend rates for each new MEG, Delaware took into account not only the historical spending data, but changes that are likely to affect future spending regardless whether or not the 1115 waiver is expanded. A major issue that needs to be considered is the recent prohibition on rate increases in the Delaware Medicaid program. In general, annual rate increases have been a usual and customary part of the Delaware Medicaid program. However, due to the poor economy, the last annual rate increases were given in 2008 for nursing facilities and most other providers. This policy change had a significant impact on the spending growth rate. As the economy slowly improves, and in order to assure access to care and quality of care, Delaware anticipates that rate increases will be influencing future spending trends in the fee-for-service program. Therefore, they need to be factored into the without waiver costs projections.

In addition, in order to improve the state's ability to maintain people in community settings, the state would have planned to add two services to the current 1915(c) waiver program: home based meals and home modifications. These are not currently Medicaid covered services, but can be added under a 1915 (c) waiver program. Therefore, Delaware believes it is reasonable that these services and costs should be factored into the without waiver cost projections as they will be covered under the proposed 1115 waiver expansion.

By expanding the 1115 waiver and placing the long term care population into a managed care program, the expectation is that over time, institutional care will decline and more people will be served in the community. There is a hope that this rebalancing will result in reduced costs per member (i.e., reduced rate of growth in spending). However, considering that the MCO's will be working with and managing the care of a new member population through relationships with new and diverse providers, Delaware is not expecting savings to materialize before the end of 2013. Therefore, in assessing the with waiver spending projections for the April 2012 through December 2013 period, the State assumes that spending will be the same as the without waiver spending projections.

Based on the current plan and schedule, the expansion of the 1115 waiver to include all of the new groups will begin on April 1, 2012. However, there will be a transition period of October 2011 through March 2012 during which the people being served under Delaware's current 1915(c) home and community based and AIDS waivers will be transferred into the 1115 waiver. This group is a sub set of groups (new MEG's) 1 and 2 above. Consequently, the budget neutrality documents also need to be revised to reflect the transfer of the current 1915(c) home and community based waiver and AIDS groups to the 1115 waiver for two calendar quarters (Oct 2011 through Mar 2012). Table 2 shows the historical and projected spending on a PMPM basis for the two current 1915(c) waiver groups:

TABLE 2

Transition Of 1915(c) Home and Community Based and AIDS Waiver Persons

Historical and Projected PMPM Data

		1915(c) Home and Community Based Waiver Group	
CY		PMPM	Trend Rate
2007	Actual	$1,794.95	
2008	Actual	$1,832.80	2.11%
2009	Actual	$1,872.26	2.15%
2010	Actual	$1,906.35	1.82%
2011	Projected	$1,964.12	2.0%
2012	Projected	$2,003.40	2.0%

The 1115 budget neutrality spreadsheets and calculations are being submitted as an Excel workbook. The base documents are basically the ones approved by CMS in January 2011 as part of the extension through December 2013. One change is that the CY 2010 and prior year data has been updated to reflect actual spending data for those years (since spending is based on date of service and prior year claims are sometimes adjusted and new claims continue to come in). The base documents have also been revised to:

a) reflect the addition of the current 1915(c) home and community based and AIDS waiver populations for one quarter of 2011 and one quarter of 2012 (October 2011 through March 2012), and

b) reflect three (3) new MEGS added to the waiver for CY2012 (3/4 of the year) and CY2013.

These changes are highlighted in green background on the Excel budget neutrality documents in Appendix K. The January 2011 budget neutrality documents showed that the program is projected to be under the without waiver spending cap by $850.3 million (total computable) for the life of the waiver as of December 2013. The revised documents reflecting the updated actual 2010 and prior year spending data and the DSHP Plus expansion with the addition of the three new MEG's shows a projection $882.0 million as of December 2013.

SECTION 7: EVALUATION

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

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

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

Calendar Year 2011 Member Months and Costs By Date of Service for DSHP Plus Eligible MEGS

Revised January 26, 2012

Nursing Home and 1915 C Waiver Duals

2011	Member Months	Costs	PMPM Cost
January	3,986	$ 17,546,009	$ 4,402
February	3,982	$ 15,420,749	$ 3,873
March	3,984	$ 17,145,331	$ 4,304
April	3,973	$ 16,444,942	$ 4,139
May	3,999	$ 17,358,541	$ 4,341
June	4,008	$ 16,625,582	$ 4,148
July	4,025	$ 17,309,360	$ 4,300
August	4,055	$ 17,509,431	$ 4,318
September	4,068	$ 16,957,357	$ 4,168
October	4,134	$ 17,516,922	$ 4,237
November	4,117	$ 16,269,097	$ 3,952
December	4,135	$ 11,780,061	$ 2,849
Total	**48,466**	**$ 197,883,381**	**$ 4,083**

Community Duals

2011	Member Months	Costs	PMPM Cost
January	5,538	$ 1,936,591	$ 350
February	5,573	$ 1,695,523	$ 304
March	5,619	$ 1,770,878	$ 315
April	5,619	$ 1,693,783	$ 301
May	5,634	$ 1,678,280	$ 298
June	5,630	$ 1,641,489	$ 292
July	5,647	$ 1,698,732	$ 301
August	5,661	$ 1,664,234	$ 294
September	5,691	$ 1,520,866	$ 267
October	5,713	$ 1,552,982	$ 272
November	5,736	$ 1,306,579	$ 228
December	5,716	$ 562,529	$ 98
Total	**67,777**	**$ 18,722,466**	**$ 276**

Nursing Home and 1915 C Waiver Non Duals

2010	Member Months	Costs	PMPM Cost
January	619	$ 4,394,339	$ 7,099
February	628	$ 3,991,002	$ 6,355
March	622	$ 4,303,562	$ 6,919
April	625	$ 4,174,476	$ 6,679
May	637	$ 4,675,094	$ 7,339
June	627	$ 4,126,013	$ 6,581
July	625	$ 4,573,173	$ 7,317
August	627	$ 4,437,176	$ 7,077
September	631	$ 4,132,554	$ 6,549
October	645	$ 4,314,395	$ 6,689
November	656	$ 3,996,509	$ 6,092
December	690	$ 3,038,731	$ 4,404
Total	**7,632**	**$ 50,157,023**	**$ 6,572**

Notes:

1. Nursing Home and 1915 C Waiver Duals - are DSHP Plus people with a nursing home level of care who are in a nursing home or in the 1915 C Waiver and have Medicare

2. Nursing Home and 1915 C Waiver Non Duals - are DSHP Plus people with a nursing home level of care who are in a nursing home or in the 1915 C Waiver and do not have Medicare

3. Community Duals - are DSHP Plus people who do not have a nursing home level of care and they have Medicare

4. Annual rate increases were typical for nursing homes and other services in 2008 and earlier. Due to the recession, rate increases were not given in 2009 & 2010.

5. In July 2011, a 2% rate increase was approved for providers of community based services, but not for nursing homes or other services/providers.

Calendar Year 2010 Member Months and Costs By Date of Service for DSHP Plus Eligible MEGS

Revised January 26, 2012

Nursing Home and 1915 C Waiver Duals			
2010	**Member Months**	**Costs**	**PMPM Cost**
January	3,991	$ 17,233,280	$ 4,318
February	3,979	$ 15,090,341	$ 3,792
March	4,008	$ 17,244,421	$ 4,303
April	3,985	$ 16,545,382	$ 4,152
May	3,993	$ 17,100,211	$ 4,283
June	3,994	$ 16,820,087	$ 4,211
July	4,018	$ 17,424,299	$ 4,337
August	4,056	$ 17,585,530	$ 4,336
September	4,040	$ 17,134,527	$ 4,241
October	4,061	$ 17,650,793	$ 4,346
November	4,035	$ 16,842,396	$ 4,174
December	4,030	$ 17,351,587	$ 4,306
Total	**48,190**	**$ 204,022,853**	**$ 4,234**

Community Duals			
2010	**Member Months**	**Costs**	**PMPM Cost**
January	5,359	$ 1,848,812	$ 345
February	5,366	$ 1,516,773	$ 283
March	5,384	$ 1,794,856	$ 333
April	5,395	$ 1,720,061	$ 319
May	5,417	$ 1,751,321	$ 323
June	5,442	$ 1,783,943	$ 328
July	5,453	$ 1,723,935	$ 316
August	5,457	$ 1,681,919	$ 308
September	5,460	$ 1,626,400	$ 298
October	5,478	$ 1,652,595	$ 302
November	5,496	$ 1,607,162	$ 292
December	5,532	$ 1,672,155	$ 302
Total	**65,239**	**$ 20,379,933**	**$ 312**

Nursing Home and 1915 C Waiver Non Duals			
2010	**Member Months**	**Costs**	**PMPM Cost**
January	657	$ 4,159,278	$ 6,331
February	658	$ 4,454,388	$ 6,770
March	645	$ 4,254,932	$ 6,597
April	652	$ 4,179,590	$ 6,410
May	635	$ 4,495,474	$ 7,079
June	633	$ 4,130,096	$ 6,525
July	624	$ 4,037,366	$ 6,470
August	623	$ 4,291,212	$ 6,888
September	628	$ 3,954,361	$ 6,297
October	626	$ 3,938,094	$ 6,291
November	620	$ 3,910,551	$ 6,307
December	619	$ 4,243,895	$ 6,856
Total	**7,620**	**$ 50,049,239**	$ 6,568

Notes:

1. Nursing Home and 1915 C Waiver Duals - are DSHP Plus people with a nursing home level of care who are in a nursing home or in the 1915 C Waiver and have Medicare

2. Nursing Home and 1915 C Waiver Non Duals - are DSHP Plus people with a nursing home level of care who are in a nursing home or in the 1915 C Waiver and do not have Medicare

3. Community Duals - are DSHP Plus people who do not have a nursing home level of care and they have Medicare

4. Annual rate increases were typical for nursing homes and other services in 2008 and earlier. Due to the recession, rate increases were not given in 2009 & 2010.

Calendar Year 2009 Member Months and Costs By Date of Service for DSHP Plus Eligible MEGS

Revised January 26, 2012

Nursing Home and 1915 C Waiver Duals					Community Duals					Nursing Home and 1915 C Waiver Non Duals			
2009	MM	Costs	PMPM Cost		2009	MM	Costs	PMPM Cost		2009	MM	Costs	PMPM Cost
January	3,950	$ 17,539,545	$ 4,440		January	5,204	$ 1,744,547	$ 335		January	619	$ 5,155,288	$ 8,328
February	3,934	$ 15,359,433	$ 3,904		February	5,210	$ 1,494,309	$ 287		February	625	$ 3,623,439	$ 5,798
March	3,956	$ 17,224,416	$ 4,354		March	5,230	$ 1,608,267	$ 308		March	628	$ 7,105,841	$ 11,315
April	3,962	$ 16,428,033	$ 4,146		April	5,243	$ 1,587,553	$ 303		April	639	$ 4,653,167	$ 7,282
May	3,969	$ 17,063,313	$ 4,299		May	5,246	$ 1,570,688	$ 299		May	645	$ 4,542,580	$ 7,043
June	3,970	$ 16,586,149	$ 4,178		June	5,225	$ 1,530,170	$ 293		June	648	$ 4,417,962	$ 6,818
July	3,976	$ 17,180,439	$ 4,321		July	5,252	$ 1,642,519	$ 313		July	650	$ 4,304,743	$ 6,623
August	4,007	$ 17,122,418	$ 4,273		August	5,274	$ 1,594,836	$ 302		August	644	$ 4,190,038	$ 6,506
September	4,018	$ 16,540,186	$ 4,117		September	5,278	$ 1,709,674	$ 324		September	651	$ 4,329,406	$ 6,650
October	4,032	$ 17,237,456	$ 4,275		October	5,328	$ 1,664,601	$ 312		October	660	$ 4,724,330	$ 7,158
November	4,027	$ 16,401,982	$ 4,073		November	5,361	$ 1,587,157	$ 296		November	659	$ 3,987,861	$ 6,051
December	4,015	$ 17,027,238	$ 4,241		December	5,371	$ 1,566,287	$ 292		December	660	$ 4,446,321	$ 6,737
Total	**47,816**	**$ 201,710,608**	**$ 4,218**		**Total**	**63,222**	**$ 19,300,608**	**$ 305**		**Total**	**7,728**	**$ 55,480,976**	**$ 7,179**

Notes:

1. Nursing Home and 1915 C Waiver Duals - are DSHP Plus people with a nursing home level of care who are in a nursing home or in the 1915 C Waiver and have Medicare

2. Nursing Home and 1915 C Waiver Non Duals - are DSHP Plus people with a nursing home level of care who are in a nursing home or in the 1915 C Waiver and do not have Medicare

3. Community Duals - are DSHP Plus people who do not have a nursing home level of care and they have Medicare

4. Annual rate increases were typical for nursing homes and other services in 2008 and earlier. Due to the recession, rate increases were not given in 2009 & 2010.

5. January 2009 Nursing Home and Waiver NonDual Group includes a hospital claim of approximately $1 million

Calendar Year 2008 Member Months and Costs By Date of Service for DSHP Plus Eligible MEGS

Revised January 26, 2012

Nursing Home and 1915 C Waiver Duals					Community Duals					Nursing Home and 1915 C Waiver Non Duals			
2008	**Member Months**	**Costs**	**PMPM Cost**		**2008**	**Member Months**	**Costs**	**PMPM Cost**		**2008**	**Member Months**	**Costs**	**PMPM Cost**
January	3,840	$ 16,539,447	$ 4,307		January	5,141	$ 1,743,866.33	$ 339.21		January	594	$ 4,054,882	$ 6,826
February	3,831	$ 15,107,713	$ 3,944		February	5,116	$ 1,517,116.15	$ 296.54		February	587	$ 3,275,829	$ 5,581
March	3,815	$ 16,168,084	$ 4,238		March	5,146	$ 1,544,034.76	$ 300.05		March	587	$ 3,802,270	$ 6,477
April	3,838	$ 15,766,566	$ 4,108		April	5,178	$ 1,505,512.53	$ 290.75		April	592	$ 3,491,821	$ 5,898
May	3,857	$ 16,486,779	$ 4,275		May	5,161	$ 1,650,606.83	$ 319.82		May	596	$ 3,877,724	$ 6,506
June	3,856	$ 15,855,170	$ 4,112		June	5,205	$ 1,536,060.41	$ 295.11		June	602	$ 3,798,157	$ 6,309
July	3,871	$ 16,635,213	$ 4,297		July	5,193	$ 1,541,714.36	$ 296.88		July	595	$ 3,506,012	$ 5,892
August	3,950	$ 17,552,687	$ 4,444		August	5,194	$ 1,580,014.78	$ 304.20		August	598	$ 4,089,309	$ 6,838
September	3,919	$ 16,431,396	$ 4,193		September	5,192	$ 1,476,717.45	$ 284.42		September	604	$ 3,373,052	$ 5,585
October	3,929	$ 17,249,848	$ 4,391		October	5,221	$ 1,558,049.88	$ 298.42		October	614	$ 3,793,186	$ 6,178
November	3,903	$ 16,452,886	$ 4,216		November	5,230	$ 1,472,106.80	$ 281.47		November	624	$ 3,859,749	$ 6,185
December	3,930	$ 17,214,183	$ 4,382		December	5,244	$ 1,545,007.70	$ 294.62		December	625	$ 4,068,493	$ 6,510
Total	**46,539**	**$ 197,470,838**	**$ 4,243**		**Total**	**62,221**	**$ 18,670,807.98**	**$ 300.07**		**Total**	**7,218**	**$ 44,990,483**	**$ 6,233**

Notes:

1. Nursing Home and 1915 C Waiver Duals - are DSHP Plus people with a nursing home level of care who are in a nursing home or in the 1915 C Waiver and have Medicare

2. Nursing Home and 1915 C Waiver Non Duals - are DSHP Plus people with a nursing home level of care who are in a nursing home or in the 1915 C Waiver and do not have Medicare

3. Community Duals - are DSHP Plus people who do not have a nursing home level of care and they have Medicare

Calendar Year 2007 Member Months and Costs By Date of Service for DSHP Plus Eligible MEGS

Revised January 26, 2012

Nursing Home and 1915 C Waiver Duals				Community Duals				Nursing Home and 1915 C Waiver Non Duals			
2007	Member Months	Costs	PMPM Cost	2007	Member Months	Costs	PMPM Cost	2007	Member Months	Costs	PMPM Cost
January	3,844	$ 15,614,954	$ 4,062	January	5,080	$ 1,663,958	$ 328	January	577	$ 3,093,082	$ 5,361
February	3,844	$ 13,777,389	$ 3,584	February	5,057	$ 1,453,971	$ 288	February	577	$ 3,212,125	$ 5,567
March	3,838	$ 15,281,337	$ 3,982	March	5,043	$ 1,548,984	$ 307	March	572	$ 2,875,653	$ 5,027
April	3,819	$ 14,603,820	$ 3,824	April	5,066	$ 1,504,179	$ 297	April	578	$ 2,990,352	$ 5,174
May	3,812	$ 15,292,501	$ 4,012	May	5,066	$ 1,754,559	$ 346	May	585	$ 3,144,014	$ 5,374
June	3,803	$ 14,747,292	$ 3,878	June	5,095	$ 1,389,197	$ 273	June	586	$ 3,020,165	$ 5,154
July	3,839	$ 15,445,399	$ 4,023	July	5,094	$ 1,438,333	$ 282	July	590	$ 3,422,265	$ 5,800
August	3,865	$ 15,673,310	$ 4,055	August	5,125	$ 1,461,147	$ 285	August	597	$ 3,276,276	$ 5,488
September	3,857	$ 15,186,585	$ 3,937	September	5,146	$ 1,564,833	$ 304	September	599	$ 3,406,351	$ 5,687
October	3,876	$ 15,993,971	$ 4,126	October	5,123	$ 1,506,740	$ 294	October	602	$ 3,398,809	$ 5,646
November	3,867	$ 15,272,023	$ 3,949	November	5,142	$ 1,408,264	$ 274	November	593	$ 3,235,630	$ 5,456
December	3,866	$ 15,585,191	$ 4,031	December	5,142	$ 1,424,091	$ 277	December	592	$ 3,293,222	$ 5,563
Total	**46,130**	**$ 182,473,773**	**$ 3,956**	**Total**	**61,179**	**$ 18,118,256**	**$ 296**	**Total**	**7,048**	**$ 38,367,944**	**$ 5,444**

Notes:

1. Nursing Home and 1915 C Waiver Duals - are DSHP Plus people with a nursing home level of care who are in a nursing home or in the 1915 C Waiver and have Medicare

2. Nursing Home and 1915 C Waiver Non Duals - are DSHP Plus people with a nursing home level of care who are in a nursing home or in the 1915 C Waiver and do not have Medicare

3. Community Duals - are DSHP Plus people who do not have a nursing home level of care and they have Medicare

Annual Data and Percent Changes -- Revised 1/26/2012

Nursing Home and 1915 C Waiver Duals	MM	Costs	PMPM
CY2007	46,130	$182,473,773	$3,956
CY2008	46,539	$197,470,838	$4,243
CY2009	47,816	$201,710,608	$4,218
CY2010	48,190	$204,022,853	$4,234
CY2011	48,466	$197,883,381	$4,083
CY2010 -Jan to june	23,950	$100,033,721	$4,177
CY2011 - Jan to June	23,932	$100,541,153	$4,201
(CY2011 data is as of 1/25/2012 and lacks run out claims data)			

Community Duals	MM	Costs	PMPM
CY2007	61,179	$18,118,256	$296
CY2008	62,221	$18,670,808	$300
CY2009	63,222	$19,300,608	$305
CY2010	65,239	$20,379,933	$312
CY2011	67,777	$18,722,466	$276
CY2010 -Jan to june	32,363	$10,415,766	$322
CY2011 - Jan to June	33,613	$10,416,544	$310
(CY2011 data is as of 1/25/2012 and lacks run out claims data)			

Nursing Home and 1915 C Waiver Non Duals	MM	Costs	PMPM
CY2007	7,048	$38,367,944	$5,444
CY2008	7,218	$44,990,483	$6,233
CY2009	7,728	$55,480,976	$7,179
CY2010	7,620	$50,049,239	$6,568
CY2011	7,632	$50,157,023	$6,572
CY2010 -Jan to june	3,880	$25,673,759	$6,617
CY2011 - Jan to June	3,758	$25,664,486	$6,829
(CY2011 data is as of 1/25/2012 and lacks run out claims data)			

Nursing Home and 1915 C Waiver Duals			
Annual Percentage Increase (Decrease)			
	MM	Cost	PMPM
CY2007	% Change	% Change	% Change
CY2008	0.89%	8.22%	7.27%
CY2009	2.74%	2.15%	-0.58%
CY2010	0.78%	1.15%	0.36%
CY2011	0.57%	-3.01%	-3.56%
CY2011 - Jan to June	-0.08%	0.51%	0.58%
(CY2011 data is as of 1/25/2012 and lacks run out claims data)			
CY2007 to CY2010	4.47%	11.81%	7.03%
Average Annual 07 - 10	1.49%	3.94%	2.34%

Community Duals			
Annual Percentage Increase (Decrease)			
	MM	Cost	PMPM
CY2007	% Change	% Change	% Change
CY2008	1.70%	3.05%	1.32%
CY2009	1.61%	3.37%	1.74%
CY2010	3.19%	5.59%	2.33%
CY2011	3.89%	-8.13%	-11.57%
CY2011 - Jan to June	3.86%	0.01%	-3.71%
(CY2011 data is as of 1/25/2012 and lacks run out claims data)			
CY2007 to CY2010	6.64%	12.48%	5.48%
Average Annual 07 - 10	2.21%	4.16%	1.83%

Nursing Home and 1915 C Waiver Non Duals			
Annual Percentage Increase (Decrease)			
	MM	Cost	PMPM
CY2007	% Change	% Change	% Change
CY2008	2.41%	17.26%	14.50%
CY2009	7.07%	23.32%	15.18%
CY2010	-1.40%	-9.79%	-8.51%
CY2011	0.16%	0.22%	0.06%
CY2011 - Jan to June	-3.14%	-0.04%	3.21%
(CY2011 data is as of 1/25/2012 and lacks run out claims data)			
CY2007 to CY2010	8.12%	30.45%	20.65%
Average Annual 07 - 10	2.71%	10.15%	6.88%

Notes:

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3. Community Duals - are DSHP Plus people who do not have a nursing home level of care and they have Medicare

4. Annual rate increases were typical for nursing homes and other services in 2008 and earlier. Due to the recession, rate increases were not given in 2009 & 2010.

5. In July 2011, a 2% rate increase was approved for providers of community based services, but not for nursing homes or other services/providers.

6. In CY2012, more rate increases are expected including a significant rate increase for nursing homes.

Diamond State Health Plan Budget Neutrality Limit
For All Waiver Services
(without waiver cap)

Revised to Show Impact of April 2012 DSHP Plus Expansion MEG's (see CY2011 - 2013; sections in green are new MEG's)

I. CALCULATION OF BUDGET NEUTRALITY LIMIT (Without Waiver Ceiling)

Medicaid Eligibility Group	FFY 1994 PM/PM (Base Year)	FFY 1995 Trend Rate	FFY 1995 PMPM	Total		FFY 1995
TANF/REL CHILD	$ 104.63	1.135	$ 118.80		N/A	
TANF/REL ADULT	$ 203.83	1.108	$ 225.78		N/A	
SSI/REL CHILD	$ 645.95	1.105	$ 713.78		N/A	
SSI/REL ADULT	$ 595.05	1.188	$ 706.93		N/A	

Note: The State did not implement until January 1, 1996, the beginning of the 2nd Quarter of FFY 1996

Medicaid Eligibility Group	FFY 1996 Trend Rate	FFY 1996 PMPM	Total		FFY 1996	
TANF/REL CHILD	1.127	$ 133.90	323,845	$	43,362,846	
TANF/REL ADULT	1.088	$ 245.62	88,406	$	21,714,282	
SSI/REL CHILD	1.098	$ 783.76	28,379	$	22,242,325	
SSI/REL ADULT	1.135	$ 802.08	37,721	$	30,255,260	
			478,351	**$**	**117,574,712**	(Total Computable)
					0.5033	FMAP
				$	**59,175,353**	(Federal Share)

Medicaid Eligibility Group	FFY 1997 Trend Rate	FFY 1997 PMPM	Total		FFY 1997	
TANF/REL CHILD	1.0679	$ 142.99	460,970	$	65,914,100	
TANF/REL ADULT	1.0617	$ 260.76	142,592	$	37,182,290	
SSI/REL CHILD	1.0685	$ 837.45	39,981	$	33,482,088	
SSI/REL ADULT	1.0685	$ 857.04	49,498	$	42,421,766	
			693,041	**$**	**179,000,245**	(Total Computable)
					0.50	FMAP
				$	**89,500,122**	(Federal Share)

Medicaid Eligibility Group	FFY 1998 Trend Rate	FFY 1998 PMPM	Total		FFY 1998	
TANF/REL CHILD	1.0679	$ 152.69	446,436	$	68,166,313	
TANF/REL ADULT	1.0617	$ 276.85	139,057	$	38,497,930	
SSI/REL CHILD	1.0685	$ 894.81	40,734	$	36,449,191	
SSI/REL ADULT	1.0685	$ 915.74	50,507	$	46,251,280	
			676,734	**$**	**189,364,714**	(Total Computable)
					0.50	FMAP
				$	**94,682,357**	(Federal Share)

Medicaid Eligibility Group	FFY 1999 Trend Rate	FFY 1999 PMPM	Total		FFY 1999	
TANF/REL CHILD	1.0679	$ 163.06	470,527	$	76,724,133	
TANF/REL ADULT	1.0617	$ 293.93	137,042	$	40,280,755	
SSI/REL CHILD	1.0685	$ 956.09	49,611	$	47,432,581	
SSI/REL ADULT	1.0685	$ 978.46	53,399	$	52,248,786	
			710,579	**$**	**216,686,254**	(Total Computable)
					0.50	FMAP
				$	**108,343,127**	(Federal Share)

Medicaid Eligibility Group	FFY 2000 Trend Rate	FFY 2000 PMPM	Total		FFY 2000
TANF/REL CHILD	1.0679	$ 174.14	505,948	$	88,105,785
TANF/REL ADULT	1.0617	$ 312.08	161,213	$	50,311,353
SSI/REL CHILD	1.0685	$ 1,021.60	52,496	$	53,629,914

Diamond State Health Plan Budget Neutrality Limit
For All Waiver Services
(without waiver cap)

Revised to Show Impact of April 2012 DSHP Plus Expansion MEG's (see CY2011 - 2013; sections in green are new MEG's)

I. CALCULATION OF BUDGET NEUTRALITY LIMIT (Without Waiver Ceiling)

SSI/REL ADULT	1.0685	$ 1,045.48	52,963	$ 55,371,757	
			772,620	**$ 247,418,809**	(Total Computable)
				0.50	FMAP
				$ 123,709,404	(Federal Share)

Medicaid Eligibility Group	FFY 2001 Trend Rate	FFY 2001 PMPM	Total	FFY 2001	
TANF/REL CHILD	1.0679	$ 185.96	546,871	$ 101,696,131	
TANF/REL ADULT	1.0617	$ 331.33	201,174	$ 66,654,981	
SSI/REL CHILD	1.0685	$ 1,091.58	51,505	$ 56,221,828	
SSI/REL ADULT	1.0685	$ 1,117.09	52,830	$ 59,015,865	
			852,380	**$ 283,588,805**	(Total Computable)
				0.50	FMAP
				$ 141,794,403	(Federal Share)

Medicaid Eligibility Group	FFY 2002 Trend Rate	FFY 2002 PMPM	Total	FFY 2002	
TANF/REL CHILD	1.0679	$ 198.59	585,955	$ 116,364,803	
TANF/REL ADULT	1.0617	$ 351.77	225,216	$ 79,224,232	
SSI/REL CHILD	1.0685	$ 1,166.34	52,966	$ 61,776,364	
SSI/REL ADULT	1.0685	$ 1,193.62	55,234	$ 65,928,407	
			919,371	**$ 323,293,807**	(Total Computable)
				0.50	FMAP
				$ 161,646,904	(Federal Share)

Medicaid Eligibility Group	FFY 2003 Trend Rate	FFY 2003 PMPM	Total	FFY 2003	
TANF/REL CHILD	1.0679	$ 212.07	625,987	$ 132,753,063	
TANF/REL ADULT	1.0617	$ 373.47	240,181	$ 89,700,398	
SSI/REL CHILD	1.0685	$ 1,246.24	54,439	$ 67,844,059	
SSI/REL ADULT	1.0685	$ 1,275.38	58,382	$ 74,459,235	
			978,989	**$ 364,756,756**	(Total Computable)
				0.50	FMAP
				$ 182,378,378	(Federal Share)

Medicaid Eligibility Group	**October 2003 to December 2003 - 1 quarter only** Trend Rate	PMPM	Total	Oct-Dec 03	
TANF/REL CHILD	1.0679	$ 215.58	161,847	$ 34,890,976	
TANF/REL ADULT	1.0617	$ 379.11	62,254	$ 23,601,114	
SSI/REL CHILD	1.0685	$ 1,267.05	13,460	$ 17,054,493	
SSI/REL ADULT	1.0685	$ 1,296.68	14,714	$ 19,079,350	
			252,275	**$ 94,625,933**	(Total Computable)
				0.50	FMAP
				$ 47,312,966	(Federal Share)

Medicaid Eligibility Group	Calendar Year 2004 Trend Rate	PMPM	Total	CY 2004	
TANF/REL CHILD	1.0679	$ 230.22	671,412	$ 154,572,471	
TANF/REL ADULT	1.0617	$ 402.50	263,256	$ 105,960,540	
SSI/REL CHILD	1.0685	$ 1,353.84	55,445	$ 75,063,659	
SSI/REL ADULT	1.0685	$ 1,385.50	59,787	$ 82,834,889	
			1,049,900	**$ 418,431,558**	(Total Computable)
				0.50	FMAP
				$ 209,215,779	(Federal Share)

Diamond State Health Plan Budget Neutrality Limit
For All Waiver Services
(without waiver cap)
Revised to Show Impact of April 2012 DSHP Plus Expansion MEG's (see CY2011 - 2013; sections in green are new MEG's)

I. CALCULATION OF BUDGET NEUTRALITY LIMIT (Without Waiver Ceiling)

Medicaid Eligibility Group	Calendar Year 2005 Rate	PMPM	Total		CY 2005	
TANF/REL CHILD	1.0679	$ 245.85	687,031	$	168,906,571	
TANF/REL ADULT	1.0617	$ 427.33	272,275	$	116,351,276	
SSI/REL CHILD	1.0685	$ 1,446.59	57,182	$	82,718,909	
SSI/REL ADULT	1.0685	$ 1,480.41	61,404	$	90,903,096	
			1,077,892	**$**	**458,879,852**	(Total Computable)
					0.50	FMAP
				$	**229,439,926**	(Federal Share)

Medicaid Eligibility Group	Calendar Year 2006-updated 2/2009 Rate	PMPM	Total		CY2006	
TANF/REL CHILD	1.0679	$ 262.55	703,109	$	184,601,268	
TANF/REL ADULT	1.0617	$ 453.69	271,478	$	123,166,854	
SSI/REL CHILD	1.0685	$ 1,545.68	58,089	$	89,787,006	
SSI/REL ADULT	1.0685	$ 1,581.83	60,280	$	95,352,712	
			1,092,956	**$**	**492,907,840**	(Total Computable)
					0.50	FMAP
				$	**246,453,920**	(Federal Share)

DEMO YEAR 12

Medicaid Eligibility Group	Calendar Year 2007 Updated August 2010 Rate	PMPM	Total		CY2007	
TANF/REL CHILD	1.0679	$ 280.38	704,110	$	197,418,362	
TANF/REL ADULT	1.0617	$ 481.68	259,501	$	124,996,442	
SSI/REL CHILD	1.0685	$ 1,651.56	59,533	$	98,322,321	
SSI/REL ADULT	1.0685	$ 1,690.19	61,495	$	103,938,234	
			1,084,639	**$**	**524,675,359**	(Total Computable)
					0.50	FMAP
				$	**262,337,680**	(Federal Share)

Medicaid Eligibility Group	Calendar Year 2008 As of November 2010 Rate	PMPM	Total		CY2008	
TANF/REL CHILD	1.0584	$ 296.75	739,388	$	219,413,389	
TANF/REL ADULT	1.0516	$ 506.54	272,233	$	137,896,904	
SSI/REL CHILD	1.0542	$ 1,741.07	60,885	$	106,005,047	
SSI/REL ADULT	1.0542	$ 1,781.79	64,287	$	114,545,934	
			1,136,793	**$**	**577,861,274**	(Total Computable)
					0.50	FMAP
				$	**288,930,637**	(Federal Share)

Medicaid Eligibility Group	Calendar Year 2009 Updated May 2011 Rate	PMPM	Total		CY2009	
TANF/REL CHILD	1.0584	$ 314.08	795,507	$	249,852,839	
TANF/REL ADULT	1.0516	$ 532.68	294,976	$	157,127,816	
SSI/REL CHILD	1.0542	$ 1,835.44	62,266	$	114,285,507	
SSI/REL ADULT	1.0542	$ 1,878.37	67,606	$	126,989,082	
			1,220,355	**$**	**648,255,244**	(Total Computable)
					0.50	FMAP
				$	**324,127,622**	(Federal Share)

Medicaid Eligibility Group	Calendar Year 2010 Updated May 2011 Rate	PMPM	Total		CY2010
TANF/REL CHILD	1.0584	$ 332.40	872,285	$	289,947,534
TANF/REL ADULT	1.0516	$ 560.21	337,602	$	189,128,016

Diamond State Health Plan Budget Neutrality Limit
For All Waiver Services
(without waiver cap)

Revised to Show Impact of April 2012 DSHP Plus Expansion MEG's (see CY2011 - 2013; sections in green are new MEG's)

I. CALCULATION OF BUDGET NEUTRALITY LIMIT (Without Waiver Ceiling)

SSI/REL CHILD	1.052	$ 1,930.89	64,533	$ 124,606,124	
SSI/REL ADULT	1.052	$ 1,976.02	72,188	$ 142,644,932	
EXPANSION POP	1.0502	$ 763.70	273,545	$ 208,906,317	
FAMILY PLANNING EXPANSION	1.0383	$ 6.89	35,085	$ 241,736	
			1,655,238	**$ 955,474,659**	(Total Computable)
				0.50	FMAP
				$ 477,834,024	(Federal Share)

Medicaid Eligibility Group	Calendar Year 2011 Projected Rate	PMPM	Total		CY2011	
TANF/REL CHILD	1.0584	$ 351.81	902,227		$ 317,412,481	
TANF/REL ADULT	1.0516	$ 589.12	337,721		$ 198,958,196	
SSI/REL CHILD	1.052	$ 2,031.30	65,416		$ 132,879,521	
SSI/REL ADULT	1.052	$ 2,078.77	74,256		$ 154,361,145	
FORMER 1915 (c) WAIVER ADULTS (Oct - Dec only)		$ 1,964.12	5,433	*	$ 10,671,064	
EXPANSION POP	1.0502	$ 802.05	418,939		$ 336,010,025	
FAMILY PLANNING EXPANSION	1.0383	$ 7.15	46,520		$ 332,618	
			1,850,512		**$ 1,150,625,049**	(Total Computable)
* Projected member months for 1/4 of the year.					0.50	FMAP
					$ 575,445,572	(Federal Share)

Medicaid Eligibility Group	Calendar Year 2012 Projected Rate	PMPM	Total		CY2012	
TANF/REL CHILD	1.0584	$ 372.36	960,872		$ 357,790,298	
TANF/REL ADULT	1.0516	$ 619.52	361,362		$ 223,870,986	
SSI/REL CHILD	1.052	$ 2,136.93	67,052		$ 143,285,430	
SSI/REL ADULT	1.052	$ 2,186.87	77,821		$ 170,184,410	
FORMER 1915 (c) WAIVER ADULTS (Jan - Mar only)	1.020	$ 2,003.40	5,450	*	$ 10,918,029	
NUR HOME AND COMMUNITY BASED DUALS (April to Dec only)		$ 4,478.05	38,264	**	$ 171,345,866	
NUR HOME AND COMMUNITY BASED NON DUALS (April to Dec only)		$ 7,480.44	6,389	**	$ 47,794,401	
COMMUNITY BASED DUALS (not NH eligible) (April to Dec only)		$ 331.27	54,433	**	$ 18,031,937	
EXPANSION POP	1.0502	$ 842.33	485,969		$ 409,346,268	
FAMILY PLANNING EXPANSION	1.0383	$ 7.43	46,520		$ 345,644	
			2,104,131		**$ 1,552,913,270**	(Total Computable)
* Projected member months for 1/4 of the year.					0.50	FMAP
** Projected member months for 3/4 of the year.					**$ 776,594,892**	(Federal Share)

Medicaid Eligibility Group	Calendar Year 2013 Projected Rate	PMPM	Total	CY2013	
TANF/REL CHILD	1.0584	$ 394.11	1,023,329	$ 403,304,192	
TANF/REL ADULT	1.0516	$ 651.49	386,657	$ 251,903,169	
SSI/REL CHILD	1.052	$ 2,248.05	68,728	$ 154,503,980	
SSI/REL ADULT	1.052	$ 2,300.59	81,556	$ 187,626,918	
NUR HOME AND COMMUNITY BASED DUALS	1.045	$ 4,679.56	52,038	$ 243,514,943	
NUR HOME AND COMMUNITY BASED NON DUALS	1.070	$ 8,004.07	8,775	$ 70,235,714	
COMMUNITY BASED DUALS (not NH eligible)	1.040	$ 344.52	74,029	$ 25,504,471	
EXPANSION POP	1.0502	$ 884.63	554,005	$ 490,089,443	
FAMILY PLANNING EXPANSION	1.0383	$ 7.71	46,520	$ 358,669	
			2,295,637	**$ 1,827,041,501**	(Total Computable)
				0.50	FMAP
Trend				**$ 913,664,218**	(Federal Share)

COMPARISON OF ACTUAL SPENDING AND SPENDING LIMIT FOR ALL SERVICES
(Excluding rebates and other adjustments)
Revised to Show Impact of April 2012 Expansion MEGS (sections in green)

BUDGET NEUTRALITY LIMIT - STATE AND FEDERAL FUNDS Revised August 2011

								April 2012 DSHP Plus Expansion MEG's				
	FMAP	State/Fed Funds TANF/REL CHILD	State/Fed Fund TANF/REL ADULT	State/Fed Funds SSI/REL CHILD	State/Fed Funds SSI/REL ADULT	State/Fed Funds EXPANSION POPL	State/Fed Funds FP EXPANSION	State/Fed Funds 1915 C Adults	State/Fed Funds Nur Home & Community Duals	State/Fed Funds Nur Home & Community Non Duals	State/Fed Funds Community Duals	TOTAL
FFY 1996	1.0000	$ 43,362,846	$ 21,714,282	$ 22,242,325	$ 30,255,260							$ 117,574,712
FFY 1997	1.0000	$ 65,914,100	$ 37,182,290	$ 33,482,088	$ 42,421,766							$ 179,000,245
FFY 1998	1.0000	$ 68,166,313	$ 38,497,930	$ 36,449,191	$ 46,251,280							$ 189,364,714
FFY 1999	1.0000	$ 76,724,133	$ 40,280,755	$ 47,432,581	$ 52,248,786							$ 216,686,254
FFY 2000	1.0000	$ 88,105,785	$ 50,311,353	$ 53,629,914	$ 55,371,757							$ 247,418,809
FFY 2001	1.0000	$ 101,696,131	$ 66,654,981	$ 56,221,828	$ 59,015,865							$ 283,588,805
FFY 2002	1.0000	$ 116,364,803	$ 79,224,232	$ 61,776,364	$ 65,928,407							$ 323,293,807
Oct02toDec03	1.0000	$ 167,644,039	$ 113,301,512	$ 84,898,552	$ 93,538,585							$ 459,382,688
CY2004	1.0000	$ 154,572,471	$ 105,960,540	$ 75,063,659	$ 82,834,889							$ 418,431,558
CY2005	1.0000	$ 168,906,571	$ 116,351,276	$ 82,718,909	$ 90,903,096							$ 458,879,852
CY2006	1.0000	$ 184,601,268	$ 123,166,854	$ 89,787,006	$ 95,352,712							$ 492,907,840
CY2007	1.0000	$ 197,418,362	$ 124,996,442	$ 98,322,321	$ 103,938,234							$ 524,675,359
CY2008	1.0000	$ 219,413,389	$ 137,896,904	$ 106,005,047	$ 114,545,934							$ 577,861,274
CY2009	1.0000	$ 249,852,839	$ 157,127,816	$ 114,285,507	$ 126,989,082							$ 648,255,244
CY2010		$ 289,947,534	$ 189,128,016	$ 124,606,124	$ 142,644,932	$ 208,906,317	$ 241,736					$ 955,474,659
CY2011		$ 317,412,481	$ 198,958,196	$ 132,879,521	$ 154,361,145	$ 336,010,025	$ 332,618	$ 10,671,064				$ 1,150,625,049
CY2012		$ 357,790,298	$ 223,870,986	$ 143,285,430	$ 170,184,410	$ 409,346,268	$ 345,644	$ 10,918,029	$ 171,345,866	$ 47,794,401	$ 18,031,937	$ 1,552,913,270
CY2013		$ 403,304,192	$ 251,903,169	$ 154,503,980	$ 187,626,918	$ 490,089,443	$ 358,669	$0	$ 243,514,943	$ 70,235,714	$ 25,504,471	$ 1,827,041,501
TOTAL		$ 3,271,197,554	$ 2,076,527,534	$ 1,517,590,348	$ 1,714,413,057	$ 1,444,352,052	$ 1,278,666	$ 21,589,093	$ 414,860,809	$ 118,030,116	$ 43,536,408	$ 10,623,375,638

*Actual expenditures include some services that were assigned an Unknown category of service on EDS reports and are assumed to be services provided to PCCM enrollees.

**Figures for 1996 to 2010 reflect actual payments made through March 31, 2011.

***Total MCO capitation payments of $33,776,880 for July 2008 were reported on the CMS-64 report for April-June 2008.

**** IMD costs for MCO enrollees ages 21 to 64, as reflected in capitation payments , are eligible for federal match for dates of service in or after July 2009.
These costs are included in the figures above.

***** Expenditures for Family Planning Expansion program reflect payment dates, not date of service.

STATE AND FEDERAL ACTUAL EXPENDITURES BY DATE OF SERVICE-Revised August 2011

April 2012 DSHP Plus Expansion MEG's

	FMAP	State/Fed Funds TANF/REL CHILD	State/Fed Fund TANF/REL ADULT	State/Fed Funds SSI/REL CHILD	State/Fed Funds SSI/REL ADULT	State/Fed Funds XPANSION GROUP	State/Fed Funds FP EXPANSION	State/Fed Funds 1915 C Adults	State/Fed Funds Nur Home & Community Duals	State/Fed Funds Nur Home & ommunity Non Dua	State/Fed Funds Community Duals	State/Fed Funds TOTAL	State/Fed Funds VARIANCE
FFY 1996	1.0000	$ 31,774,968	$ 15,234,043	$ 20,369,449	$ 32,714,225	$ 8,186,435	$ 285					$ 108,279,405	$ 9,295,307
FFY 1997	1.0000	$ 51,962,224	$ 20,247,402	$ 32,379,907	$ 46,148,300	$ 25,957,823	$ 6,965					$ 176,702,622	$ 2,297,623
FFY 1998	1.0000	$ 53,790,121	$ 18,847,357	$ 34,329,892	$ 47,737,909	$ 32,730,685	$ 9,694					$ 187,445,658	$ 1,919,056
FFY 1999	1.0000	$ 65,790,409	$ 32,693,744	$ 38,239,064	$ 43,268,045	$ 36,282,502	$ 27,332					$ 216,301,096	$ 385,158
FFY 2000	1.0000	$ 75,085,784	$ 45,713,589	$ 41,498,581	$ 42,860,638	$ 39,792,045	$ 102,001					$ 245,052,638	$ 2,366,171
FFY 2001	1.0000	$ 83,583,909	$ 58,282,828	$ 43,209,967	$ 44,151,802	$ 43,867,540	$ 102,747					$ 273,198,793	$ 10,390,013
FFY 2002	1.0000	$ 95,658,690	$ 68,882,506	$ 47,534,367	$ 49,599,979	$ 53,874,770	$ 146,871					$ 315,697,183	$ 7,596,624
Oct02toDec03	1.0000	$ 119,216,632	$ 90,171,769	$ 58,626,922	$ 66,287,770	$ 78,443,658	$ 311,874					$ 413,058,625	$ 46,324,063
CY2004	1.0000	$ 135,101,837	$ 81,657,637	$ 50,172,908	$ 57,033,579	$ 84,468,259	$ 213,067					$ 408,647,287	$ 9,784,271
CY2005	1.0000	$ 136,410,126	$ 102,445,151	$ 58,006,374	$ 64,139,837	$ 115,623,026	$ 242,252					$ 476,866,766	$ (17,986,914)
CY2006	1.0000	$ 150,250,932	$ 116,447,333	$ 58,602,665	$ 66,420,683	$ 133,613,799	$ 240,202					$ 525,575,614	$ (32,667,774)
CY2007	1.0000	$ 167,423,820	$ 119,110,263	$ 64,204,553	$ 72,217,625	$ 147,663,541	$ 262,258					$ 570,882,060	$ (46,206,701)
CY2008	1.0000	$ 170,350,608	$ 129,861,652	$ 72,976,297	$ 84,838,127	$ 176,102,915	$ 249,907					$ 634,379,506	$ (56,518,232)
CY2009	1.0000	$ 194,659,282	$ 139,349,369	$ 81,286,529	$ 95,398,422	$ 214,994,137	$ 306,755					$ 725,994,493	$ (77,739,250)
CY2010		$ 222,477,454	$ 158,451,474	$ 85,429,877	$ 105,366,163	$ 256,320,072	$ 337,739					$ 828,382,779	$ 127,091,880
CY2011							$ 332,786	$ 10,671,064				$ 951,853,121	$ 198,771,928
CY2012							$ 345,532	$ 10,918,029	$ 171,345,866	$ 47,794,401	$ 18,031,937	$ 1,319,500,220	$ 233,413,050
CY2013							$ 358,766	$ -	$ 243,514,943	$ 70,235,714	$ 25,504,471	$ 1,553,929,177	$ 273,112,324
TOTAL							$ 3,597,033	$ 21,589,093	$ 414,860,809	$ 118,030,116	$ 43,536,408	$ 9,931,747,041	$ 691,628,597

Diamond State Health Plan
Revised to Show Impact of April 2012 DSHP Plus Expansion MEG's

SUMMARY BY BUDGET NEUTRALITY YEAR AND CUMULATIVELY (including pharmacy, behavioral health,managed care costs, extended family planning services, and "other" services for expansion population only.)

REVISED August 2011

Year of Service	Federal & State Share of Budget Neutrality Limit	Fed & State Share Gross Actual Costs By Date of Service Managed Care, Pharm, MH,FP	Cost Savings From Fed & State Share of Supplemental Rebate	Fed &State Share of Federal Rebate Expansion Popl (By Pay Date)	Net Fed & State Share of Actual Costs	Annual Variance	As % of Annual Budget Neutrality Limit	Cumulative Fed & State Share of Budget Neutrality Limit	Cumulative Fed & State Share Waiver Costs	Cumulative Fed State Share Of Variance	As % of Cumulative Budget Neutrality Limit
FFY 1996	$ 117,574,712	$ 108,279,405			$ 108,279,405	$ 9,295,307	7.91%	$ 117,574,712	$ 108,279,405	$ 9,295,307	
FFY 1997	$ 179,000,245	$ 176,702,622		$ (951,124)	$ 175,751,498	$ 3,248,747	1.81%	$ 296,574,957	$ 284,030,903	$ 12,544,054	4.23%
FFY 1998	$ 189,364,714	$ 187,445,658		$ (1,329,972)	$ 186,115,686	$ 3,249,028	1.72%	$ 485,939,671	$ 470,146,589	$ 15,793,082	3.25%
FFY 1999	$ 216,686,254	$ 216,301,096		$ (1,685,268)	$ 214,615,828	$ 2,070,426	0.96%	$ 702,625,925	$ 684,762,417	$ 17,863,508	2.54%
FFY 2000	$ 247,418,809	$ 245,052,638		$ (2,320,021)	$ 242,732,617	$ 4,686,192	1.89%	$ 950,044,733	$ 927,495,034	$ 22,549,700	2.37%
FFY 2001	$ 283,588,805	$ 273,198,793		$ (2,796,642)	$ 270,402,151	$ 13,186,655	4.65%	$ 1,233,633,539	$ 1,197,897,184	$ 35,736,354	2.90%
FFY 2002	$ 323,293,807	$ 315,697,183		$ (3,043,013)	$ 312,654,170	$ 10,639,637	3.29%	$ 1,556,927,346	$ 1,510,551,354	$ 46,375,992	2.98%
Oct02 to Dec03	$ 459,382,688	$ 413,058,625		$ (6,425,425)	$ 406,633,200	$ 52,749,488	11.48%	$ 2,016,310,034	$ 1,917,184,554	$ 99,125,480	4.92%
CY 2004	$ 418,431,558	$ 408,647,287		$ (5,379,002)	$ 403,268,285	$ 15,163,273	3.62%	$ 2,434,741,592	$ 2,320,452,839	$ 114,288,753	4.69%
CY 2005	$ 458,879,852	$ 476,866,766	$ (2,042,426)	$ (5,918,079)	$ 468,906,261	$ (10,026,409)	-2.18%	$ 2,893,621,444	$ 2,789,359,100	$ 104,262,344	3.60%
CY 2006	$ 492,907,840	$ 525,575,614	$ (5,473,330)	$ (8,155,085)	$ 511,947,199	$ (19,039,359)	-3.86%	$ 3,386,529,284	$ 3,301,306,299	$ 85,222,985	2.52%
CY 2007	$ 524,675,359	$ 570,882,060	$ (7,854,422)	$ (10,565,023)	$ 552,462,614	$ (27,787,255)	-5.30%	$ 3,911,204,643	$ 3,853,768,914	$ 57,435,729	1.47%
CY2008	$ 577,861,274	$ 634,379,506	$ (5,825,902)	$ (12,654,028)	$ 615,899,576	$ (38,038,302)	-6.58%	$ 4,489,065,916	$ 4,469,668,489	$ 19,397,427	0.43%
CY2009	$ 648,255,244	$ 725,994,493	$ (4,067,793)	$ (14,458,141)	$ 707,468,559	$ (59,213,316)	-9.13%	$ 5,137,321,160	$ 5,177,137,049	$ (39,815,889)	-0.78%
CY2010	$ 955,474,659	$ 828,382,779	$ (6,257,315)	$ (20,213,315)	$ 801,912,149	$ 153,562,510	16.07%	$ 6,092,795,819	$ 5,979,049,197	$ 113,746,621	1.87%
CY2011	$ 1,150,625,049	$ 951,853,121	$ (4,000,000)	$ (17,000,000)	$ 930,853,121	$ 219,771,928	19.10%	$ 7,243,420,868	$ 6,909,902,318	$ 333,518,550	4.60%
CY2012	$ 1,552,913,270	$ 1,319,500,220	$ (3,500,000)	$ (17,500,000)	$ 1,298,500,220	$ 254,413,050	16.38%	$ 8,796,334,138	$ 8,208,402,538	$ 587,931,600	6.68%
CY2013	$ 1,827,041,501	$ 1,553,929,177	$ (3,000,000)	$ (18,000,000)	$ 1,532,929,177	$ 294,112,324	16.10%	$ 10,623,375,638	$ 9,741,331,715	$ 882,043,924	8.30%
TOTAL	$ 10,623,375,638	$ 9,931,747,041	$ (42,021,188)	$ (148,394,138)	$ 9,741,331,715	$ 882,043,924	8.30%	$ 10,623,375,638	$ 9,741,331,715	**$ 882,043,924**	8.30%

Diamond State Health Plan

Revised to Show Impact of April 2012 DSHP Plus Expansion MEG's

SUMMARY BY BUDGET NEUTRALITY YEAR AND CUMULATIVELY (including pharmacy, behavioral health,managed care costs, extended family planning services, and "other" services for expansion population only.)

REVISED August 2011

Year of Service	FMAP	Federal Share of Budget Neutrality Limit	Federal Share of Actual Costs by Date of Service Managed Care, Pharm, MH,FP	Federal Share of Supplemental Rebate @50%	Federal Share@50% Federal Rebate Expansion Popl By Payment Date (DRAFT)	Federal Share of All Actual Costs	Annual Variance	As % of Annual Budget Neutrality Limit	Cumulative Federal Share of Budget Neutrality Limit	Cumulative Federal Share of Waiver Costs	Cumulative Federal Share Variance	As % of Cumulative Budget Neutrality Limit
FFY 1996	50.33%	$ 59,175,353	$ 54,497,138			$ 54,497,138	$ 4,678,215	7.91%	$ 59,175,353	$ 54,497,138	$ 4,678,215	
FFY 1997	50%	$ 89,500,122	$ 88,354,097		$ (475,562)	$ 87,878,535	$ 1,621,587	1.81%	$ 148,675,475	$ 142,375,672	$ 6,299,802	4.24%
FFY 1998	50%	$ 94,682,357	$ 93,726,707		$ (664,986)	$ 93,061,721	$ 1,620,636	1.71%	$ 243,357,832	$ 235,437,393	$ 7,920,439	3.25%
FFY 1999	50%	$ 108,343,127	$ 108,161,481		$ (842,634)	$ 107,318,847	$ 1,024,280	0.95%	$ 351,700,959	$ 342,756,240	$ 8,944,719	2.54%
FFY 2000	50%	$ 123,709,404	$ 122,567,119		$ (1,160,011)	$ 121,407,109	$ 2,302,296	1.86%	$ 475,410,363	$ 464,163,349	$ 11,247,014	2.37%
FFY 2001	50%	$ 141,794,403	$ 136,640,495		$ (1,398,321)	$ 135,242,174	$ 6,552,229	4.62%	$ 617,204,766	$ 599,405,523	$ 17,799,243	2.88%
FFY 2002	50%	$ 161,646,904	$ 157,907,340		$ (1,521,507)	$ 156,385,833	$ 5,261,070	3.25%	$ 778,851,669	$ 755,791,356	$ 23,060,313	2.96%
Oct02 to Dec03	50%	$ 229,691,344	$ 206,654,062		$ (3,212,713)	$ 203,441,350	$ 26,249,995	11.43%	$ 1,008,543,014	$ 959,232,706	$ 49,310,308	4.89%
CY 2004	50%	$ 209,215,779	$ 204,408,870		$ (2,689,501)	$ 201,719,369	$ 7,496,410	3.58%	$ 1,217,758,793	$ 1,160,952,075	$ 56,806,718	4.66%
CY 2005	50%	$ 229,439,926	$ 238,530,284	$ (1,021,213)	$ (2,959,040)	$ 234,550,031	$ (5,110,105)	-2.23%	$ 1,447,198,719	$ 1,395,502,106	$ 51,696,612	3.57%
CY 2006	50%	$ 246,453,920	$ 262,883,888	$ (2,736,665)	$ (4,077,543)	$ 256,069,680	$ (9,615,760)	-3.90%	$ 1,693,652,639	$ 1,651,571,787	$ 42,080,852	2.48%
CY 2007	50%	$ 262,337,680	$ 285,545,933	$ (3,927,211)	$ (5,282,512)	$ 276,336,210	$ (13,998,531)	-5.34%	$ 1,955,990,318	$ 1,927,907,997	$ 28,082,321	1.44%
CY2008	50%	$ 288,930,637	$ 317,289,716	$ (2,912,951)	$ (6,327,014)	$ 308,049,751	$ (19,119,114)	-6.62%	$ 2,244,920,955	$ 2,235,957,748	$ 8,963,207	0.40%
CY2009	50%	$ 324,127,622	$ 363,119,949	$ (2,033,897)	$ (7,229,071)	$ 353,856,982	$ (29,729,360)	-9.17%	$ 2,569,048,577	$ 2,589,814,729	$ (20,766,153)	-0.81%
CY2010	50%	$ 477,834,024	$ 414,326,485	$ (3,128,658)	$ (10,106,658)	$ 401,091,170	$ 76,742,854	16.06%	$ 3,046,882,600	$ 2,990,905,899	$ 55,976,701	1.84%
CY2011	50%	$ 575,445,572	$ 476,059,675	$ (2,000,000)	$ (8,500,000)	$ 465,559,675	$ 109,885,897	19.10%	$ 3,622,328,172	$ 3,456,465,574	$ 165,862,598	4.58%
CY2012	50%	$ 776,594,892	$ 659,888,323	$ (1,750,000)	$ (8,750,000)	$ 649,388,323	$ 127,206,570	16.38%	$ 4,398,923,064	$ 4,105,853,897	$ 293,069,167	6.66%
CY2013	50%	$ 913,664,218	$ 777,108,095	$ (1,500,000)	$ (9,000,000)	$ 766,608,095	$ 147,056,123	16.10%	$ 5,312,587,282	$ 4,872,461,992	$ 440,125,291	8.28%
TOTAL		$ 5,312,587,282	$ 4,967,669,655	$ (21,010,594)	$ (74,197,069)	$ 4,872,461,992	$ 440,125,291	8.28%	$ 5,312,587,282	$ 4,872,461,992	**$ 440,125,291**	8.28%

STATE OF DELAWARE — **FAMILY PLANNING SPENDING AND CAP INFORMATION**

Actual Costs of Extended Family Planning Services for Clients
Eligible for 24 Months of Additional Family Planning Services
Based on Payment Dates (Not Year of Service)

Revised Spending January 10, 2012

	State/Federal Total	Federal Share (90%)	Budget Neutrality Limit (Cap)
FFY 1996	$285	$257	Not Allowed in Cap Claculation
FFY 1997	$6,965	$6,269	Not Allowed in Cap Claculation
FFY 1998	$9,694	$8,725	Not Allowed in Cap Claculation
FFY 1999	$27,332	$24,599	Not Allowed in Cap Claculation
FFY 2000	$102,001	$91,801	Not Allowed in Cap Claculation
FFY 2001	$102,747	$92,472	Not Allowed in Cap Claculation
FFY 2002	$146,871	$132,184	Not Allowed in Cap Claculation
Oct 2002 to Dec 2003 *	$311,874	$280,687	Not Allowed in Cap Claculation
CY2004	$213,067	$191,760	Not Allowed in Cap Claculation
CY2005	$242,252	$218,027	Not Allowed in Cap Claculation
CY2006	$240,202	$216,182	Not Allowed in Cap Claculation
CY2007	$262,258	$236,032	Not Allowed in Cap Claculation
CY2008	$249,907	$224,916	Not Allowed in Cap Claculation
CY2009	$306,755	$276,080	Not Allowed in Cap Claculation
CY2010	$337,739	$303,965	Allowed in Cap Claculation Eff Apr 2010
CY2011	$372,272	$335,045	Allowed in Cap Claculation
CY2012 **	$386,530	$347,877	Projection
CY2013 **	$401,334	$361,201	Projection
TOTAL	**$3,318,751**	**$2,986,876**	

Without Waiver PMPM and Growth Rate

CY	Family Planning Total Yearly Member Months	PMPM Avg Monthly Cost p/Person	Growth Rate
2005	46,555	$5.20	
2006	46,777	$5.14	-1.32%
2007	48,941	$5.36	4.35%
2008	45,614	$5.48	2.24%
2009	46,229	$6.64	21.11%
2010	47,210	$7.15	7.81%
2011	49,047	$7.59	6.10%
2012	49,047	$7.88	3.83%
2013	49,047	$8.18	3.83%

*** This is a 15 month period, not an annual amount.**

MCPI Trend Information

Year	CPI - Medical Care
2005	$ 323.20
2009	$ 375.61
# steps	4
avg. growth	3.83%

Source for CPI data:
Conusmer Price Index - All Urban Consumers - Item: Medical Care
http://data.bls.gov/cgi-bin/surveymost?cu