DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

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

FINAL

ORDER

Diamond State Health Plan Plus 1115 Demonstration Waiver Amendment

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend the Diamond State Health Plan 1115 Demonstration Waiver to implement managed long-term care under the name, *Diamond State Health Plan Plus*. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 Delaware Code Section 10115 in the July 2011 Delaware *Register of Regulations* and provided a draft of the waiver amendment application on the Division of Medicaid and Medical Assistance website at http://dhss.delaware.gov/dhss/dmma/, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by August 31, 2011 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposed provides notice to the public that the Delaware Division of Medicaid and Medical Assistance (DMMA) intends to submit an application to the Centers for Medicare and Medicaid Services (CMS) to amend the Diamond State Health Plan (DSHP) Section 1115 demonstration waiver. Specifically, this waiver amendment integrates Nursing Facility (NF) services and Home and Community-Based Services (HCBS) into the existing managed care delivery system.

Statutory Authority

- 42 U.S.C. §1315, *Demonstration projects*
- Social Security Act §1115, *Demonstration projects*

Background

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach has not been demonstrated on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.

Under a waiver authority of Section 1115(a) of the Social Security Act, the Diamond State Health Plan (DSHP) implemented a mandatory Medicaid managed care demonstration program statewide on January 1, 1996. Using savings achieved under managed care, Delaware expanded Medicaid health coverage to additional low-income adults in the State with incomes less than 100% of the Federal Poverty Level (FPL).

Goals of the Diamond State Health Plan 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.

Summary of Proposal

The Division of Medicaid and Medical Assistance (DMMA) intends to amend its 1115 Demonstration Waiver to integrate primary, acute and long-term care (LTC) services for the elderly and persons with physical disabilities into the Diamond State Health Plan (DSHP) statewide program under the name "Diamond State Health Plan Plus." DMMA is proposing to leverage the existing DSHP 1115 demonstration waiver 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.

DMMA is requesting public comment on the 1115 Demonstration Waiver amendment, "Diamond State Health Plan Plus" (DSHP). Operational implementation of DSHP Plus is projected for April 1, 2012.

The provisions of this demonstration waiver are subject to approval by the Centers for Medicare and Medicaid Services (CMS).

Fiscal Impact Statement

There is no increase in cost on the General Fund. Demonstrations must be "budget neutral" over the life of the project, meaning they cannot be expected to cost the Federal government more than it would cost without the waiver.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE

The Delaware Health Care Facilities Association (DHCFA) offered the following observations and recommendations summarized below. The Division of Medicaid and Medical Assistance (DMMA) has considered each comment and responds as follows.

DHCFA Comments Dated June 17, 2011

The Delaware Health Care Facilities Association's membership is extremely concerned with the impact of the proposed Delaware Medicaid Managed Care Program to providers and their long term care patients. Beginning May of 2011, DHCFA corresponded with Secretary Landgraf, DMMA Staff, consultants and other stakeholders. The purpose was to outline serious concerns with process, potential unintended adverse outcomes and the tight implementation timeline proposed. Since that time, we participated in a helpful and informative meeting with DMMA and Mercer representatives on Monday, June 20th and have received answers to preliminary questions. Enclosed herewith are copies of correspondence concerning the proposed new regulations for the Diamond State Health Plan Plus 1115 Demonstration Waiver Amendment published in the July 1, 2011 Proposed *Register of Regulations* for inclusion as written comments.

Question #1: For a dual eligible patient when a patient is covered under Part A Medicare will the Medicare rate be paid at the same rate that was in place prior to the inception of managed care? Or will the integration of Medicare and Medicaid benefits somehow impact the Medicare rate for full-eligible dual eligibles?
Agency Response*:* The Plus program will not impact Medicare rates or payments. Medicare will continue to be primary.

Question #2: How will the current Medicaid rates with all the levels and add-ons on many of these rates be handled under a managed care model?
Agency Response: We are exploring the elimination of the "add-on's" but are just in the preliminary planning stages. We will involve the nursing homes in this process. Should the ultimate decision be made to eliminate the add-ons, it would collapse the virtual 32 levels into 9. The money that would normally be paid out via add-ons could then be folded into the nursing homes' base rates.

Question #3: Will there be a hold harmless built-in for some period of time for providers so their Medicaid payments with managed care are not lower than the Medicaid rates in place prior to the implementation of managed care?
Agency Response: As a matter of policy, DMMA will require the managed care organizations (MCOs) to pay nursing facilities (NFs) rates equivalent to what fee-for-services (FFS) would have paid for the first three years of the DSHP Plus program and the capitation rates will reflect this policy.

Question #4: How will rate changes occur under a managed care level?
Agency Response: The Medicaid Reimbursement Team will continue to set the reimbursement level for nursing home residents. DMMA will continue to establish the rates using the nursing homes' cost reports and following the normal process.

Question #5: Will January still be the effective date for rate changes?
Agency Response: Yes, the reimbursement schedule will remain the same.

Question #6*:* When is it anticipated that the payments for the nursing homes under a managed care model will be lower than payments that would be made to nursing homes under the current payment system?
Agency Response: DMMA will continue to set the nursing homes' payment rates for at least three years. We will revisit this as we approach the three year mark.

Question #7: One of the exclusion mentioned is "Dual eligibles other than full-benefit duals". Can you please provide a definition of this type of Dual Eligible versus what providers may typically think of as a Dual Eligible?
Agency Response: A partial dual eligible is a typical QMB (Qualified Medicare Beneficiary). Under this program Medicaid pays the patient's Medicare Premium, co insurance and deductibles only. The patient is not eligible for full Medicaid benefits. A full dual is someone who has full Medicaid and full Medicare coverage.

Question #8: What does it mean that "patients whose needs can no longer be safely handled in the community can be

granted an exception"? That note is a foot note to the table listed above.
Agency Response: This is in reference to a possible change in the activities for daily living (ADL) requirement for nursing home placement. This has not been approved by the Centers for Medicare and Medicaid Services (CMS). This is still under exploration.

Question #9: Will ADLs of 3 or more automatically qualify an individual for nursing home admission?
Agency Response: We are still exploring the possibility of changing the ADL requirement from the individual having to need assistance with one ADL to qualify medically for Medicaid nursing home coverage to having to need assistance with two or more ADLs. Should that change occur, we would expect that individuals needing assistance with 3 or more ADLs who prefer to receive their care in a nursing home would qualify medically for Medicaid nursing home coverage.

Question #10: Will the reimbursement rates for nursing homes at of the inception of managed care be impacted in any way?
Agency Response: As a matter of policy, DMMA will require the MCOs to pay nursing facilities rates equivalent to what FFS would have paid for the first three years of the DSHP Plus program and the managed care capitation rates will reflect this policy.

Question #11*:* Has statutory language been drafted addressing Medicaid Managed Care Long Term Care Policy considerations? If so, can it the language please be provided.
Agency Response: Not at this time. The DMMA policy unit is working on amending DMMA's policy as needed. Every policy change will be published for comment.

Question #12*:* Can you provide a more detailed implementation timeline?
Agency Response: This timeline was provided at our meeting and a copy can be found on the web site.

Question #13: Will the Plans be allowed to exclude any provider from their network at any time? If so, for what reasons?
Agency Response: The Plans will be required to contract with all current Delaware Medicaid enrolled nursing facilities. It is possible that a nursing home would refuse to contract with a MCO. If this should occur and the nursing facility has Medicaid patients, the MCO would pay the facility as a non-participating provider at a reduced rate.

Question #14*:* Will there be two types of plans for recipients or only one?
Agency Response: We are not certain if you are asking about Health Plans or Plan Benefits. If you are asking about Health Plans, then there will be two Health Plans for recipients to choose from.

If you are asking about Health Benefits, then full duals in the community that do not qualify medically and financially for Long Term Care Medicaid services will receive the same benefit package that current Diamond State Health Plan programs recipients receive and will not receive the enhanced long term care services that those that qualify medically and financially for Long Term Care Medicaid services. Those that qualify for Long Term Care Medicaid services will receive all of the services that current Diamond State Health Plan members receive plus the enhanced long term care services.

Question #15*:* What incentives will be established with individual health plans as part of the procurement/contracting process to maximize appropriate safe community placement?
Agency Response: The details are being worked out now. The state will retain strict oversight of the quality for this program.

Question #16*:* What performance measures will there be in place to ensure quality care is being provided to clients (outside of skilled nursing facility settings) and what checks and balances will there be in place to ensure that the client is placed in the most appropriate setting and not the least costly setting.
Agency Response: The MCO contract and quality strategy is currently being developed. Delaware is committed to finding the most appropriate and safe setting for clients.

Question #17: How many levels of care are envisioned for the program? Who will determine these levels of care?
Agency Response: We need clarification regarding what you are asking. DMMA will determine if DSHP Plus applicants meet the medical eligibility requirement for the program. If you are asking about nursing home reimbursement rates, please see the response to question #2.

Question #18: Who will provide the counseling to clients who have to make a decision regarding placement?
Agency Response: This will be the responsibility of the Managed Care Companies with oversight by the State. In addition, the Aging & Disability Resource Center (ADRC) staff within the Division of Services for Aging & Adults with

Physical Disabilities provides options counseling for individuals facing these types of decisions. Ultimately, placement is the client's decision.

Question #19: How will assignment to the MCO work? If the recipient fails to choose a plan, how will this work?
Agency Response: There will be a 50/50 auto assignment to the plans if the client fails to choose a plan within 30 days. The client will have a 90 day period to change plans for any reason. In addition, a client can change Plans for "good cause" at any time. Finally, all clients can change Plans for any reason during the annual Open Enrollment process.

Question #20: How will this work if the client is enrolled in a Medicare Advantage Plan or special needs Plan?
Agency Response: Medicare and the Advantage or Special Needs Plan will be primary and the Medicaid MCO will pay co-pays, deductibles and for services not covered by Medicare. DMMA will be exploring how to better coordinate care between SNPs and Medicaid MCOs in the future.

Question #21: Has language been drafted to establish an independent appeal process for denial of claims and/or coverage?
Agency Response: The MCOs are already required to have an internal appeal process for members and for providers. DMMA has staff on the MCO's member appeal board. In addition, members may also appeal separately through the State's appeal process.

Question #22: Who will set the rates?
Agency Response: Delaware Medicaid will set the nursing home rates.

Question #23: Will the Plans be allowed to pay higher rates for patients requiring medically complex services such as ventilator care?
Agency Response: Delaware Medicaid will set the nursing home rates. DMMA may at a later date consider allowing the MCOs to contract for specialty care that does not align with one of the current 9 primary rate categories.

Question #24*:* How will the establishment of a Delaware Quality Improvement Fund (provider tax) be incorporated into the program?
Agency Response: Funds from the tax would be taken into account by the DMMA when it establishes the nursing home rates.

Question #25: How will this be designed and protected? Prompt payment contract must be part of the contract with the MCOs and be set at 14 days for clean claims.
Agency Response: There are prompt pay requirements in the MCO contracts.

Question #26: What contractual obligations will be imposed on the MCOs with regard to billing systems and claims processing?
Agency Response: There are contractual requirements regarding billing systems and prompt pay requirements.

Question #27: What is the plan or process to ensure that Medicare crossover claims are processed properly and that documentation is sufficient to support federal requirements for Medicare bad debt?
Agency Response: This will be a part of the discussion with the MCOs.

Question #28: What are the proposed retroactive Medicaid eligibility standards?
Agency Response: Eligibility rules will remain the same and should Medicaid approve a nursing home resident for retroactive Medicaid eligibility, the MCO will be required to pay the nursing home for the care provided retroactively.

Question #29: What are the plans for including quality outcomes data reporting by the MCOs?
Agency Response: This will be addressed in the Quality Strategy that is being developed now.

Question #30: MCOs must be held accountable alongside providers for outcomes.
Agency Response: DMMA agrees.

DHCFA Comments Dated August 31, 2011
DHCFA has reviewed the DHSS Waiver Amendment Request (“Waiver”) regarding the creation of the “Diamond State Health Plan Plus” (“Plus”). The Waiver proposes to integrate primary, acute, behavioral health and long term care (“LTC”) services for the elderly and persons with physical disabilities into the State’s existing Medicaid managed care program. The integration will include individuals who currently receive institutional long term care (“LTC”) services (excluding the developmentally disabled population) and individuals enrolled in DMMA’s Elderly and Disabled and AIDS waivers. A goal of

the Waiver Amendment is to achieve efficiencies through an integrated LTC delivery system. Another goal is to "rebalance" Delaware's LTC delivery system in favor of home and community based services ("HCBS") and away from institutional LTC. The State has indicated its desire to have the Waiver approved by October 1, 2011, and to "go live" with Plus on April 1, 2012. We have concerns with this ambition timetable as we believe it will create many unintended problems, given the Waiver's recognition that a number of issues remain unresolved and "in progress." It appears that the intention is to work-out the details in the months leading up to implementation, but we do not believe this is realistic, given the scope and complexity of the Waiver.

We ask that you consider the following comments and questions regarding the Waiver.

Question #1: We are concerned about the reliability of the expected costs savings that will be realized by shifting care to home-based settings and out of institutional LTC settings (discussed under the Cost of Care section on page 1) simply because we have not seen meaningful assessments of just how many individuals currently residing in LTC facilities really would be capable of living at home with supports. We find the lack of assessment to be a significant flaw in the justification for the Waiver.
Agency Response: The Cost of Care section at the beginning of the Waiver amendment is one component of the general background and context in which the waiver was developed. DMMA does not agree that there is "a significant flaw in the justification for the Waiver" since the primary goal of the waiver amendment is to enhance community-based supports and improve care coordination for individuals with disabilities. Budget Neutrality is, of course, a requirement for CMS waiver approval. Cost estimates are provided in that section of the waiver amendment and do assume slowed cost growth over the duration of the waiver due to increased availability of less expensive service options and improved health outcomes.

Question #2: The Delaware MFP program has not uncovered numerous nursing facility residents who are capable of living in the community with (reasonable, i.e., not round-the-clock) supports, so we are concerned with the assumption of projected cost savings associated with the waiver. Of course, the targeted cost savings may be associated with minimizing *future* nursing facility admissions, and if that is the basis for the estimate, the Waiver should be clarified.
Agency Response: DMMA would disagree with DHCFA's characterization of the Delaware MFP program. The MFP Program has, in fact, been quite successful in identifying individuals who could transition to the community and the program continues to grow with additional resources, changes in federal MDS reporting, and establishment of the ADRC. Regardless, as noted in question 1, cost savings is not the primary goal of the program and cost assumptions are clearly articulated in the Budget Neutrality section of the waiver amendment.

Question #3: The current level of care ("LOC") review tool, discussed on page 7 of the Waiver, requires that anyone who is entering a nursing facility must need assistance with at least one activity of daily living ("ADL"). New admissions under Plus will need assistance with at least two ADLs to be eligible for nursing facility admission. (The new criteria will not be applied to individuals who already are in institutional LTC settings immediately prior to Plus going into effect.) While we understand that the average nursing facility resident today requires assistance with greater than two ADLs, the Waiver does not address whether there will be any other restrictive revisions to the LOC assessment process or whether participating managed care organizations ("MCOs") will be able to implement additional restrictive admission criteria going forward.
Agency Response: The waiver amendment includes all planned changes regarding level of care requirements.

We also inquire whether the assessment process will recognize a level of ADL assistance that *requires* institutional care for safety reasons (i.e., a recognition that a person could require so much assistance that it does not make sense (from the perspectives of safety, quality and expense) for the person to remain in a community setting, even if they would prefer to do so.
Agency Response: The MCOs will be responsible for working with the member and their representatives to determine the appropriate services and supports so that the member may reside safely in the setting of their choice. A member's level of need along with the desire and ability to reside in the community is frequently dependent upon the availability of family and informal supports to assist with the member's care.

Question #4: In addition, at page 14, the Waiver notes that "State staff will continue to perform the initial and annual LOC assessments for those being considered for the LTC institutional LOC benefits." It then states: "Using the State's approved tool, the MCOs will be responsible for assessments to determine LOC for reimbursement and care planning." It is unclear whether this means that going forward; the State will retain authority over LOC assessments for purposes of admission determinations or whether MCOs will take over that responsibility eventually, with freedom to develop their own admission criteria.
Agency Response: The State will retain responsibility for performing LOC assessments and making the medical eligibility determinations.

If so, when will the MCOs take over the responsibility?

Agency Response: The MCOs will be responsible for working with the member and their representatives to determine the appropriate services and supports so that the member may reside safely in the setting of their choice.

Question #5: Page 12 discusses two separate home modification budgets ("home modifications" and an additional allowance under "community transition services") to assist with transitions out of (and avoiding) institutional LTC. Are these intended to be separate pools of money?
Agency Response: DMMA agrees and reference to home modifications under Community Transition Services will be removed. Home modifications are a separate service.

Question #6: Page 12 includes a benefits table for Plus. It is noted that nursing facility services are covered after the first 30 days of admission. Who is responsible for the cost of the first 30 days, especially if the patient already is Medicaid-qualified and is not dual-eligible (and there is no prospect for Medicare coverage)? Will those expenses be covered by Medicaid fee-for-service?
Agency Response: Thirty (30) days of nursing facility services is an existing benefit for the clients who are enrolled in the Diamond State Health Plan. The MCOs are already responsible for covering the first thirty (30) days of nursing facility services for those already in receipt of Medicaid and already enrolled with them.

Those individuals who are not already in receipt of Medicaid and who are not already enrolled with a MCO, and who need more than thirty (30) days of nursing facility services, will need to apply for DSHP Plus program and can be found eligible for retroactive nursing home coverage.

Question #7: The benefits table also refers to outpatient behavioral health benefits. We are concerned whether there will be any enhancements to the behavioral health services available to LTC facility residents, given the tremendous need for such services. While meetings with the MCOs have pointed to the intent of this service being provided, the waiver language does not seem to reflect that this will be a mandatory service to be provided by MCOs.
Agency Response: As stated earlier, the primary goal of the waiver amendment is to enhance community based support services to reduce unnecessary hospitalization or institutionalization. Individuals in LTC facilities with behavioral health needs will continue to receive the active treatment services to which they are entitled.

Question #8: The footnote on page 13 refers to an exception for persons 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. Does this refer to *new* admissions as of 4/1/12 and thereafter, and is it an acknowledgment that the State may grant an exception where the person has only one ADL limitation per the LOC assessment, but nonetheless cannot be safely cared for in the community? If so, what types of situations would warrant a "safety" exception?
Agency Response: DMMA wishes to retain sufficient flexibility to respond to individual consumer needs and preferences. No specific situation is envisioned at this time where such an exception would need to be made.

Question #9: Under the Plan of Care section on page 16, it is unclear what is meant by the reference to "longer term strategic planning" under the MCO's responsibility for developing the plan of care.
Agency Response: This references the goals of the client for their care.

Also, the Waiver characterizes the MCO's responsibility with respect to care plans as: "[T]he MCO will be expected to emphasize services that are provided in member's homes and communities in order *to prevent or delay institutionalization whenever possible."* Does the Waiver include financial incentives for delayed / avoided institutional placements?
Agency Response: Capitation payments under the waiver are actuarially determined based on program costs. There are no incentive payments related to institutional placements.

Question #10: On page 17, the Waiver notes that Delaware currently carves out pharmacy from the Diamond State Health Plan MCO benefit package and will continue to do so "*upon the initial implementation of DSHP Plus."* The Waiver goes on to state, however, that the State is requesting authority to include pharmacy under Plus at a later date.We inquire whether this could change the manner in which LTC facilities obtain medications for patients (for example, would all facilities that participate with MCOs be required to obtain medications from pharmacies that have contracts with the MCOs?).
Agency Response: There are no specific plans at this time to include pharmacy as a MCO-covered benefit. However, this is something that the State may explore in the future.

Also, will all necessary medications be included in the facility payment rate under Plus?
Agency Response: No, medications would continue to be reimbursed as a separate service.

Page 17 also notes that "medically necessary behavioral health services in excess of MCO plan benefit limits" will remain paid directly by fee-for-service Medicaid. Given the collapse of LTC Medicaid into one program (including residents in

institutional settings), does this mean that the State will be responsible for providing enhanced behavioral health services – at the State's expense -- to Medicaid-covered facility residents? As we have discussed previously, many nursing facility residents would benefit greatly from enhanced behavioral health services, as geriatric psychological services are severely limited in Delaware.
Agency Response: Individuals in LTC facilities with behavioral health needs will continue to receive the active treatment services to which they are entitled.

Question #11: Page 19 of the Waiver describes how members will be assigned to an MCO plan. This section states that members will be pre-assigned to an MCO in a manner that allows for "shared risk." This section notes the desire for "continuity of care with current providers," but with respect to 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." This raises a few questions/issues. First, the Waiver does not describe how nursing facilities will become contracted MCO providers.
Agency Response: All providers should contact the MCOs to begin the MCO enrollment/contract process.

Is it possible that facilities could be under contract with one plan but not the other(s)? If so, for current facility residents, will pre-assignment determinations take into account whether their facility is a contracted provider with the particular MCO? We also inquire whether the MCOs will be required to enter into provider agreements with all Medicaid-certified facilities that want to enter into managed care agreements, or is it possible that facilities could be excluded. If MCOs are not required to contract with all willing providers, it could dramatically impact each facility's planning process, as a facility could suddenly find itself unable to provide care for Medicaid beneficiaries.
Agency Response: The State is requiring both MCOs to contract with all Medicaid enrolled nursing facilities. However, it is possible that a nursing facility may refuse to contract with a MCO despite the requirement that the MCO pay the nursing facility the rates that the State will continue to set. Should that occur and should that nursing facility have residents that are members of that particular MCO, the MCO would pay the nursing facility as a non-participating provider and would not be required to pay the facility at the Medicaid established rates. We expect the MCOs would pay the non-participating provider a reduced rate.

Pre-Assignment determinations will not take into account whether the Medicaid client's nursing facility is enrolled with a particular MCO. However, the Health Benefits Manager and DMMA staff will educate the client and his/her family regarding the MCOs' provider network so that they may make an informed choice regarding an MCO.

Question #12: The Waiver is silent about how LTC facilities will be paid. In a July 2011 "Q&A" document, the State represented that it will continue to set rates for nursing homes (and MCOs will be required to pay these State-approved rates for 3 years), but the "Q&A" document also notes that "[t]his will be revisited as the program progresses." We inquire why the Waiver does not mention these understandings regarding facility rates. We feel that it is important for the State to provide as much detail as possible about how nursing facility rates will be set going forward, including after the 3-year period is over. Will MCOs then be negotiating rates with each contracted facility provider?
Agency Response: A Waiver document is not intended to include all details regarding processes. Some of these processes will be articulated in the MCO contract. We agree that it is important that the facilities receive details regarding the reimbursement process and will share those details and obtain your input as soon as practical and possible.

After the State ends its requirement that the MCOs pay nursing facilities at the rates established by the State (after the three year period), the nursing facilities and MCOs will negotiate their own rates.

Question #13: Moreover, we have received notification that the 3-year rate setting period is problematic for providers looking to refinance loans, as financial institutions traditionally request projections for 5, 8 and 10 years regarding financial stability. The 3-year plan will hinder the ability of providers to be able to manage their businesses, and we request that consideration be given to extending the rate setting period to a minimum of 5 years.
Agency Response: We are considering this request, although we are puzzled as to why facilities are able to now project forward 5, 8 and 10 years, but would not be able to make assumptions required of such projections with a managed care service delivery.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the July 2011 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Diamond State Health Plan 1115 Demonstration Waiver to implement managed long-term care under the name, *Diamond State Health Plan Plus* is adopted and shall be final effective November 10, 2011.

Rita M. Landgraf, Secretary, DHSS

Diamond State Health Plan 1115 Demonstration Waiver

15 DE Reg. 666 (11/01/11) (Final)