



Delaware Health & Human Services System Market Profile



Health & Human Services System Market Profile Overview

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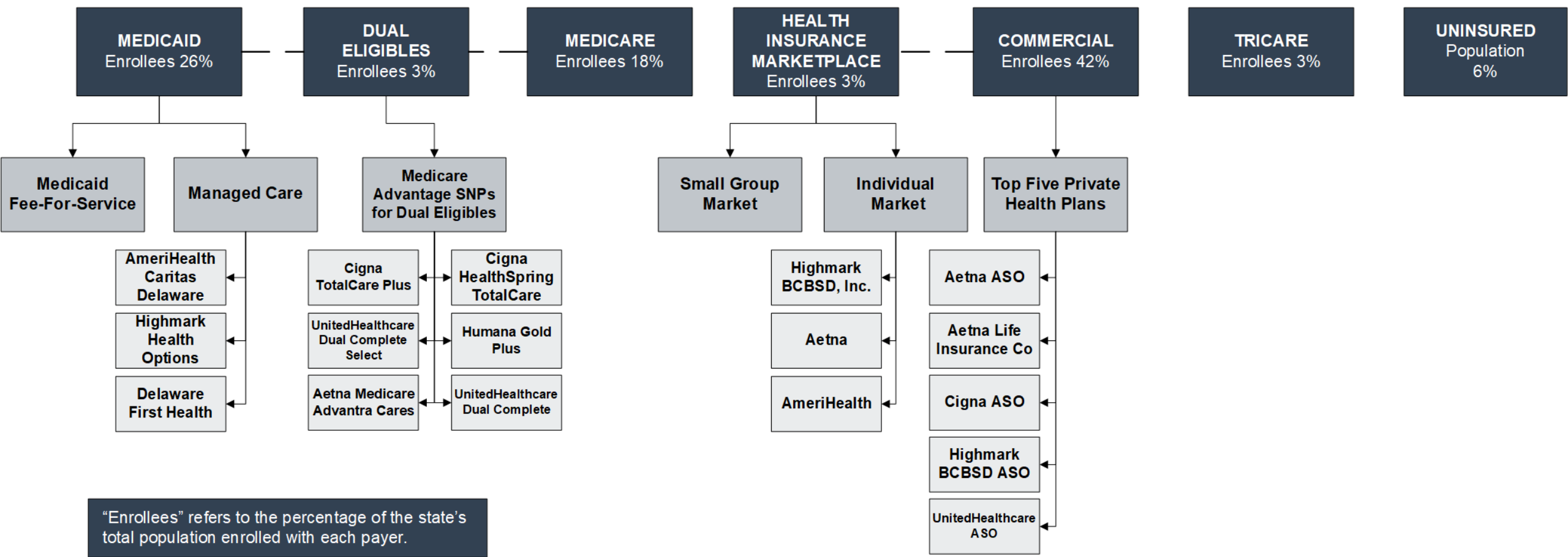
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A. Executive Summary

A.1. Delaware Physical Health Care Coverage by Payer

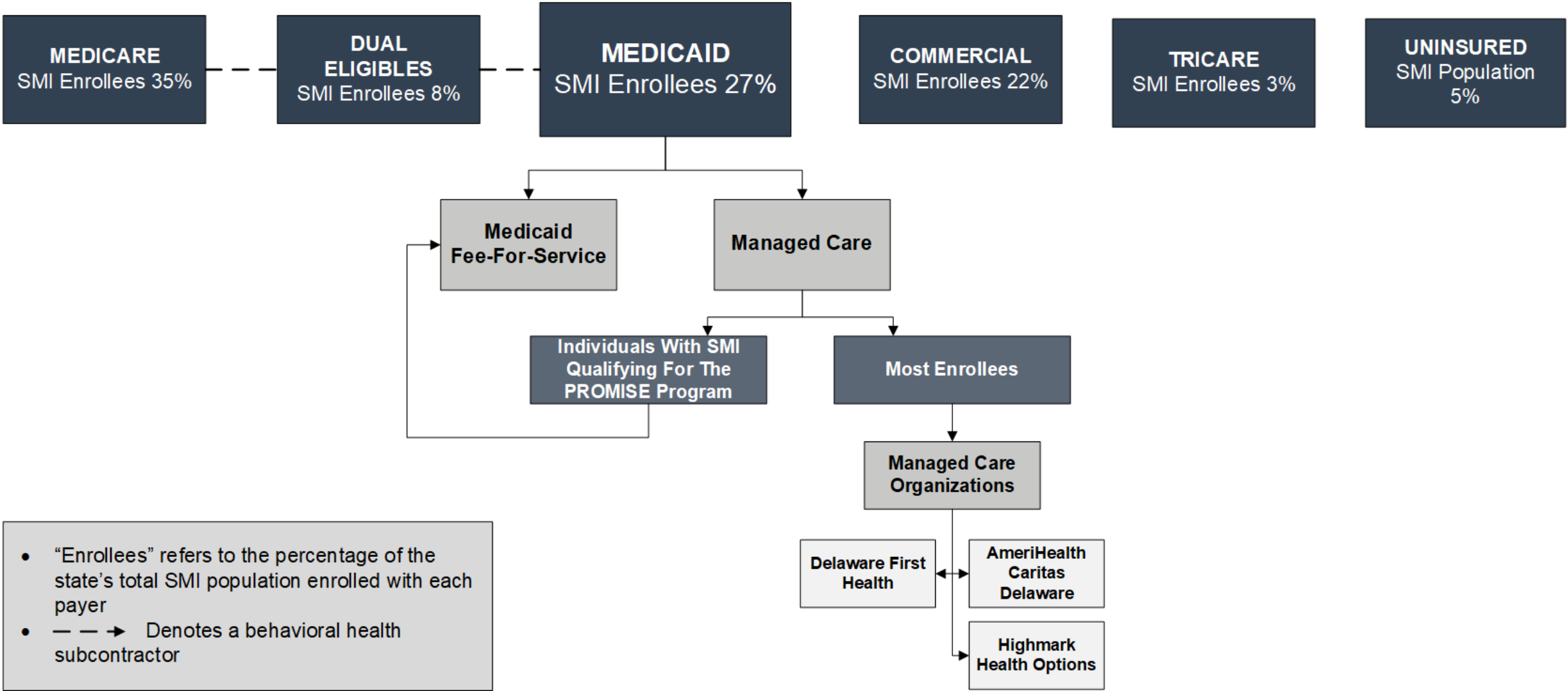
Total Delaware Population- 1,003,384

Estimated SMI Population- 76,887



Totals may not equal 100% due to rounding

A.1. Delaware Behavioral Health Care Coverage by Payer



A.2. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	Active Program	Description
Managed Care Health Plan	✓	The health plans are responsible for care coordination.
Primary Care Case Management (PCCM)		None
Accountable Care Organization (ACO) Program	✓	The state is currently operates four ACOs.
Affordable Care Act (ACA) Model Health Home	✓	As of January 2019, Delaware implemented health homes for individuals in need of SMI and I/DD related services
Patient-Centered Medical Home (PCMH)		None
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)	✓	Yes, the health plans are responsible for most long-term services and supports (LTSS).
Certified Community Behavioral Health Clinics (CCBHC) Grant		None
Other Care Coordination Initiatives	✓	The state implemented Centers of Excellences for opioid treatment in July 2018; however, this initiative remains on hold. In October 2018, the state began the START initiative for addiction treatment services.

A.3. Health Care Safety-Net Delivery System

State Agencies Responsible For Uninsured Citizens & Delivery System Model

Physical Health Services

- Delaware Health and Social Services, Division of Public Health provides safety-net services to uninsured individuals through Community Health Centers.

Mental Health Services

- The Division of Substance Abuse and Mental Health within Delaware Health and Social Services provides mental health treatment to the uninsured population through two state-operated community mental health centers and by contracting with private provider organizations.

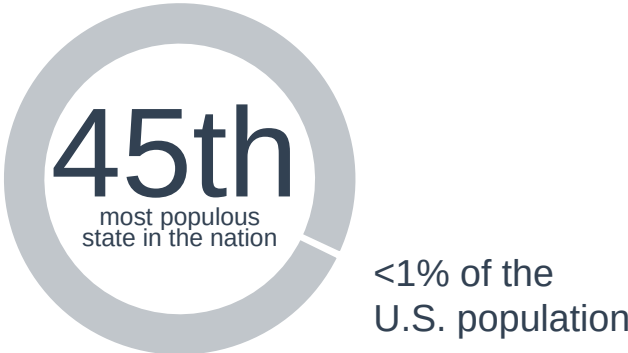
Addiction Treatment Services

- The Division of Substance Abuse and Mental Health within Delaware Health and Social Services provides addiction treatment to the uninsured population through two state-operated community mental health centers and by contracting with private provider organizations.

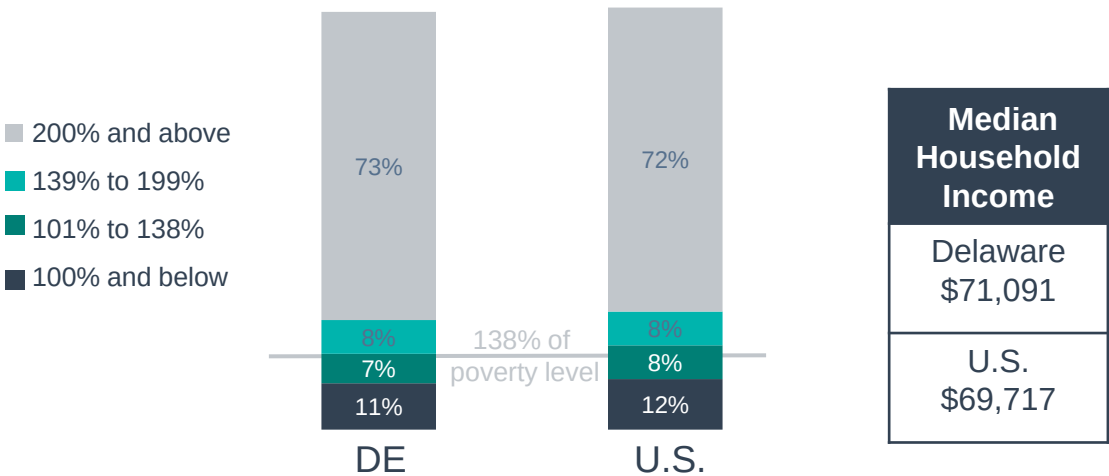
B. Delaware Health Financing System Overview

B.1. Population Demographics

Total Delaware Population- 1,003,384
Estimated SMI Population- 76,887



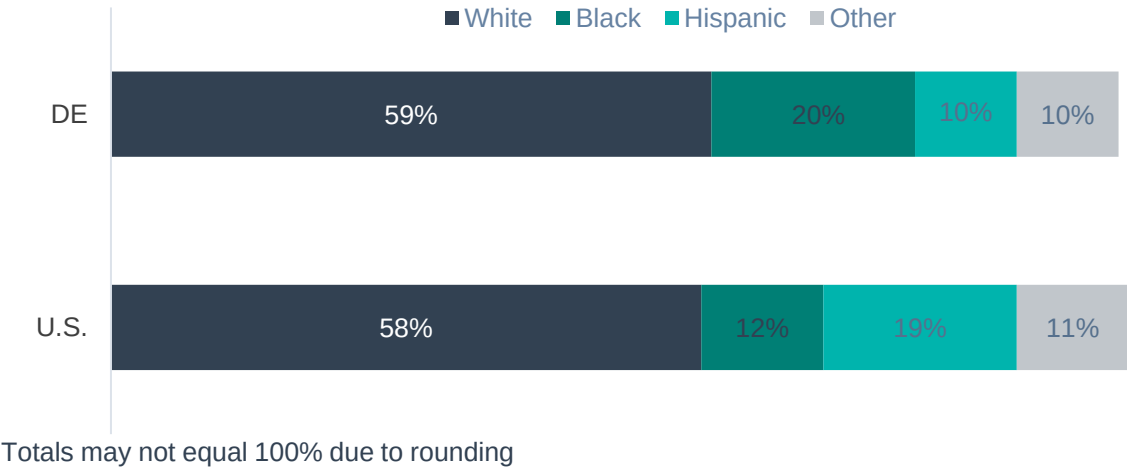
Population Distribution By Income To Poverty Threshold Ratio



Population Distribution By Age

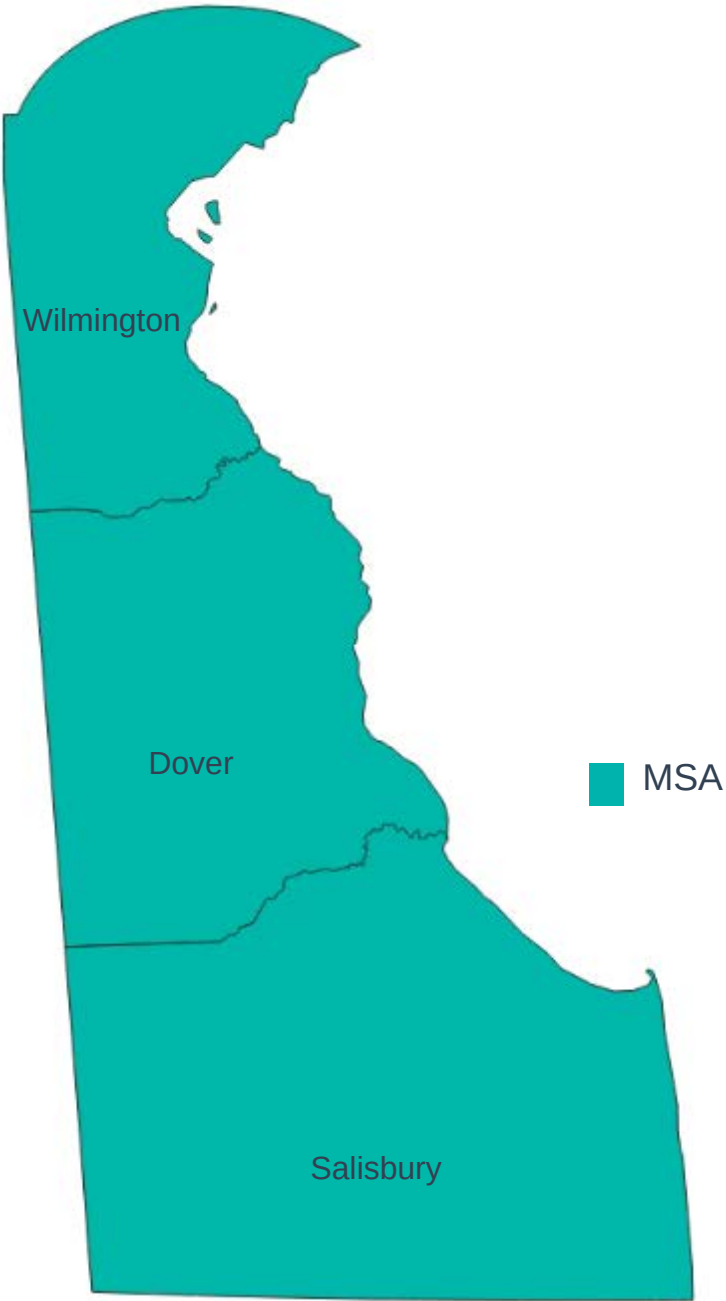


Delaware & U.S. Racial Composition

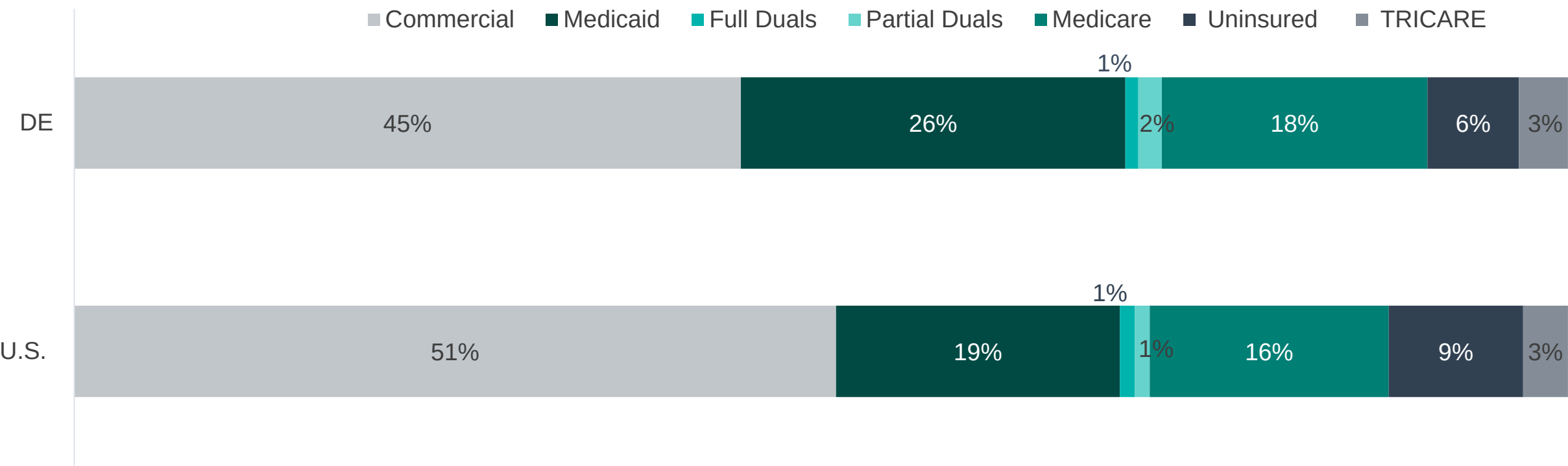


B.2. Population Centers

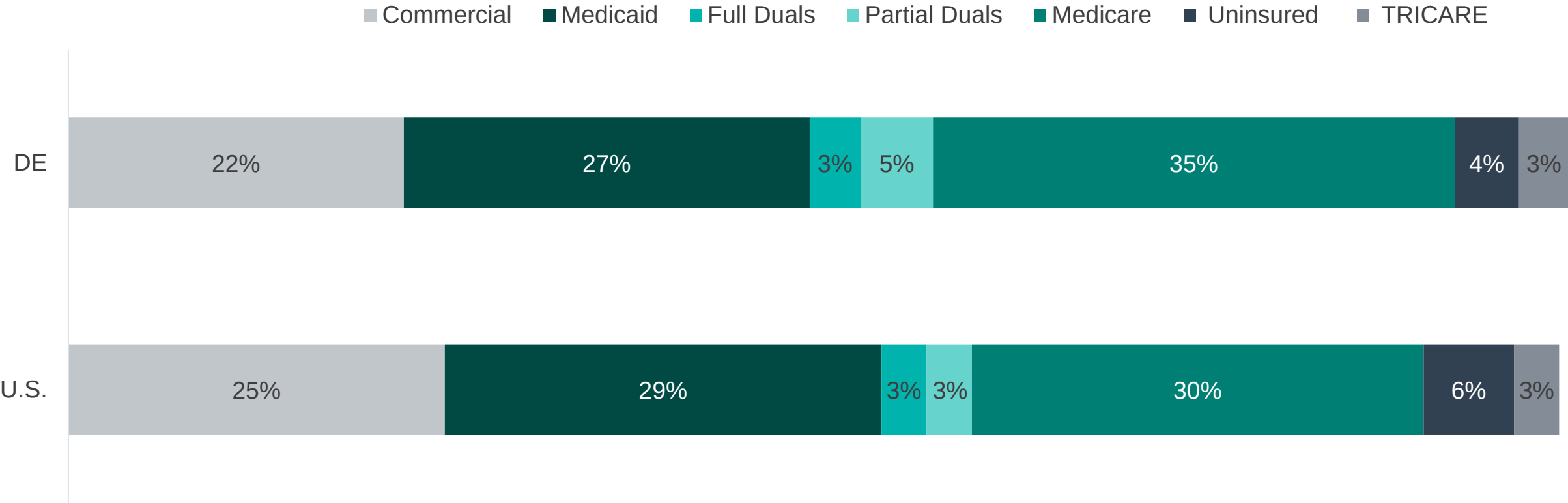
Metropolitan Statistical Areas (MSAs)		
MSA	Delaware MSA Residents	Percent of MSA
Total MSA Population	6,867,142	N/A
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	6,241,164	N/A
Salisbury, MD-DE	439,032	44%
Dover, DE	186,946	19%



B.3. Population Distribution By Payer: National vs. State



B.3. SMI Population Distribution By Payer: National vs. State



B.4. Largest Delaware Health Plans By Enrollment

Plan Name	Plan Type	Enrollment*
Highmark Blue Cross Blue Shield of Delaware	Commercial administrative services organization (ASO)	307,464
Cigna ASO	Commercial ASO	139,189
Highmark Blue Cross Blue Shield Health Options	Medicaid managed care	134,585
Medicare Fee-for-service (FFS)	Medicare	129,595
Medicaid FFS	Medicaid	98,874
Aetna ASO	Commercial ASO	68,586
AmeriHealth Caritas Delaware	Medicaid managed care	64,762
TRICARE	Other public	35,072
UnitedHealthcare ASO	Commercial ASO	14,876
Aetna Medicare	Medicare advantage	13,912

*Medicaid enrollment as of May 2023; TRICARE as of December 2022; Commercial as of March 2023; Medicare enrollment as of March 2023

B.4. Largest Delaware Health Plans By Estimated SMI Enrollment

Plan Name	Plan Type	Enrollment*	Estimated SMI Enrollment
Medicare FFS	Medicare	129,595	20,735
Highmark Blue Cross Blue Shield Delaware	Commercial ASO	307,464	12,606
Highmark Blue Cross Blue Shield Health Options	Medicaid managed care	134,585	11,574
Medicaid FFS	Medicaid	98,874	8,503
Cigna ASO	Commercial ASO	139,189	5,707
AmeriHealth Caritas Delaware	Medicaid managed care	64,762	5,570
TRICARE	Other public	35,072	2,911
Aetna ASO	Commercial ASO	68,586	2,812
Aetna Medicare	Medicare advantage	13,912	2,226
Humana Gold Plus	Medicare advantage	10,176	1,628

*Medicaid enrollment as of May 2023; TRICARE as of December 2022; Commercial as of March 2023; Medicare enrollment as of March 2023

B.5. Health Insurance Marketplace

Health Insurance Marketplace	
Health Plan Marketplace Percentage	3%
Type of Marketplace	State & Federal run marketplace
Individual Enrollment Contact	https://www.healthcare.gov/
	1-800-318-2596
Small Business Enrollment Contact	No small group plans are available through the marketplace. Employers must purchase coverage directly from an insurance carrier or through an insurance broker.

2023 Individual Market Health Plans
1. Highmark BCBSD, Inc. 2. Aetna 3. AmeriHealth

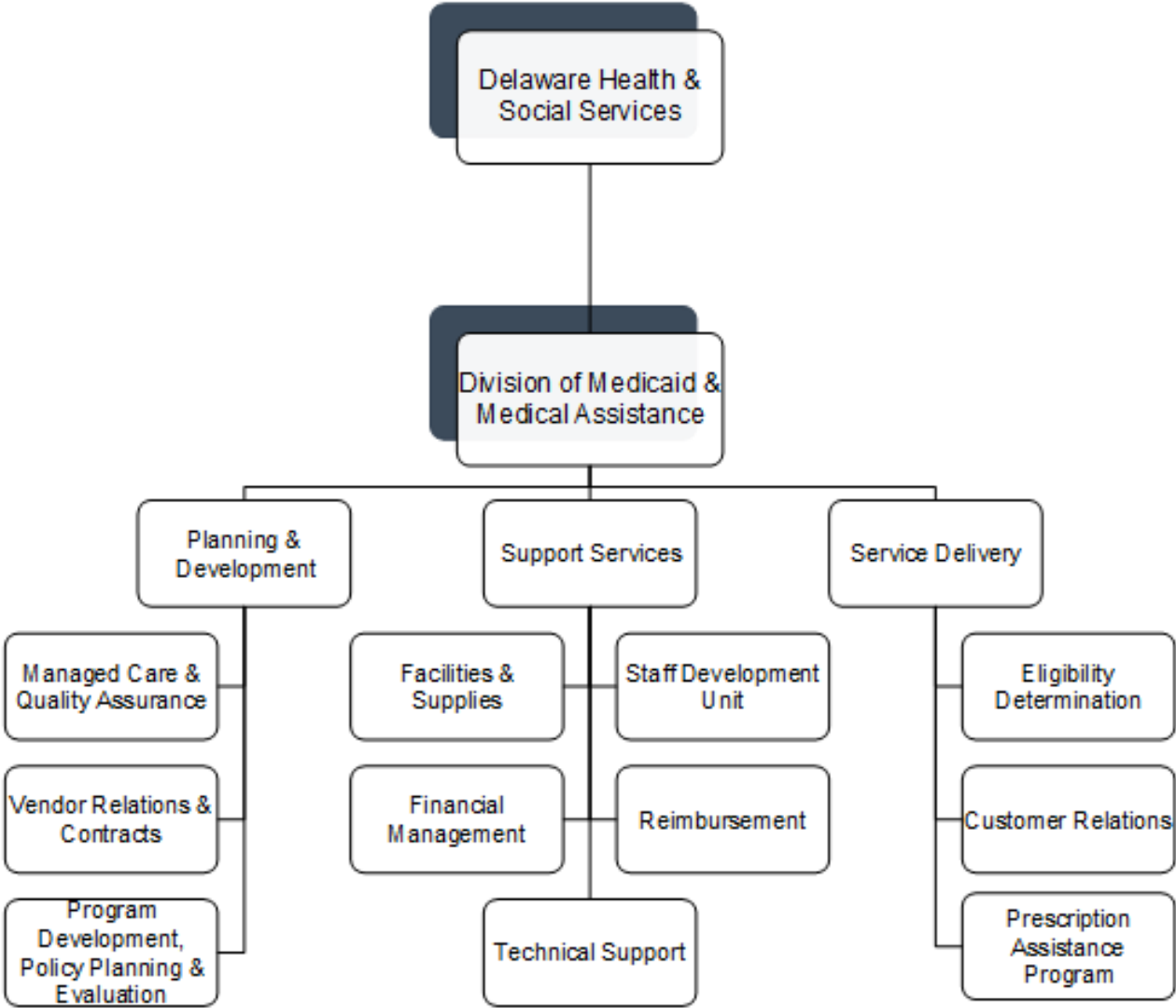
2023 Small Group Market Health Plans
None

B.6. Accountable Care Organizations (ACOs)

Medicare Shared Savings ACOs	Medicaid ACOs
1. Aledade Accountable Care 22, LLC 2. Aledade Accountable Care 80, LLC 3. Aledade Delaware ACO 4. Christiana Care Quality Partners ACO, LLC 5. Delaware Care Collaboration DCC LLC 6. LTC ACO, LLC 7. Peninsula Regional Clinically Integrated Network LLC 8. Crozer ACO/ Prospect Health Services PA, Inc 9. United Medical, LLC	1. Aledade Delaware ACO 2. Delaware Care Collaboration 3. Delaware Children's Health Network 4. Delaware Medicaid Quality Partners ACO
	End-State Renal Disease ACOs
	1. Fresenius Seamless Care of Delaware

C. Medicaid Administration, Governance & Operations

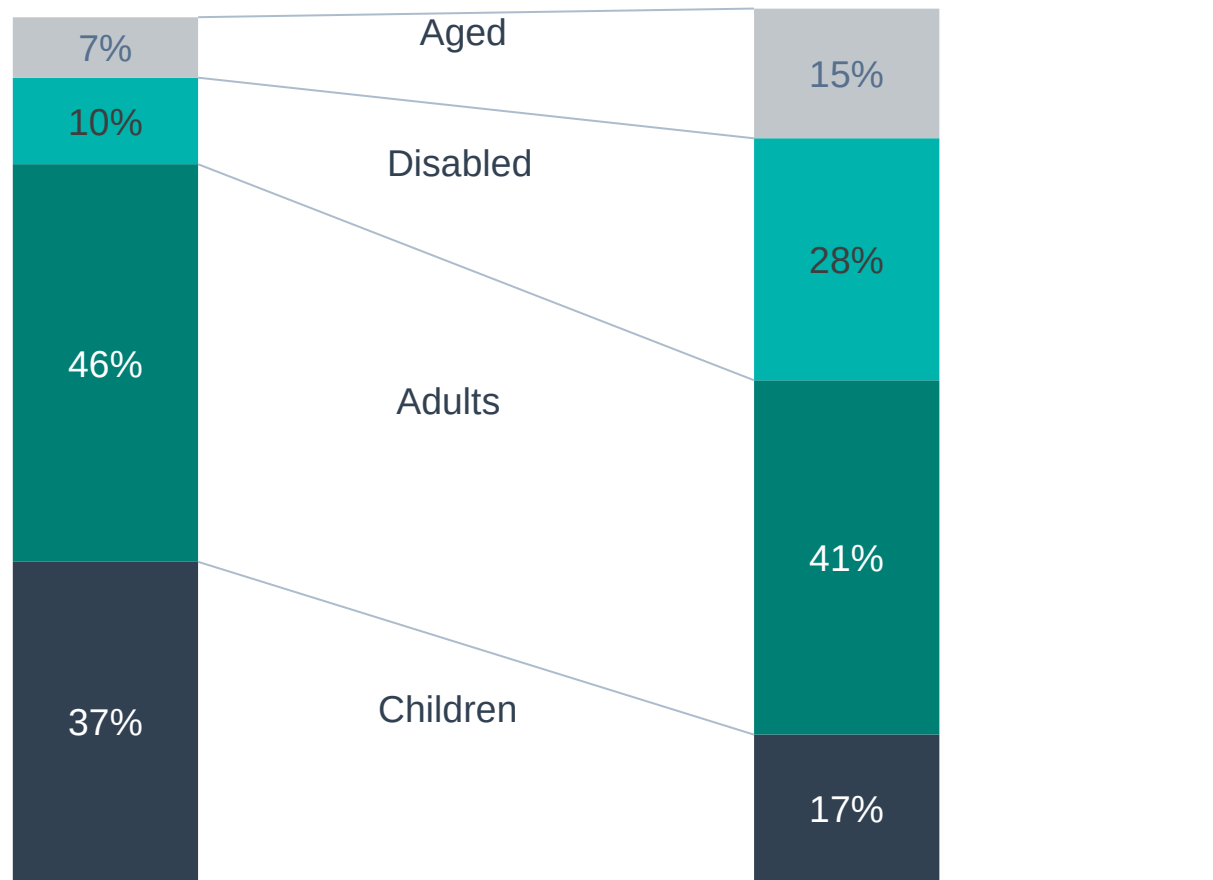
C.1. Medicaid Governance: Organization Chart



C.1. Medicaid Governance: Key Leadership

Name	Position	Department	Email
Josette Manning	Secretary	Department of Health and Social Services (DHSS)	josette.manning@delaware.gov
Dava Newnam	Deputy Secretary	DHSS	dava.newnam@delaware.gov
Daniel Walker	Deputy Secretary	DHSS	daniel.walker@delaware.gov
Theodore Mermigos, Jr	Acting Division Director	DHSS, Division of Medicaid and Medical Assistance	theodore.mermigos@delaware.gov
Janneen Boyce	Deputy Director	DHSS, Division of Medicaid and Medical Assistance	janneen.boyce@delaware.gov
Kimberly Xavier	Chief of Policy Planning and Quality	DHSS, Division of Medicaid and Medical Assistance	kimberly.xavier@delaware.gov
Kathleen Dougherty	Chief of Managed Care Operations	DHSS, Division of Medicaid and Medical Assistance	kathleen.dougherty@delaware.gov
Staci Marvel	Chief of Training and Long-Term Care Eligibility and Services	DHSS, Division of Medicaid and Medical Assistance	Not available
Michele Stant	Chief of Financial Management	DHSS, Division of Medicaid and Medical Assistance	michele.stant@delaware.gov

C.2. Medicaid Program Spending By Eligibility Group



Medicaid Spending Per Enrollee, FY 2020		
	U.S.	DE
All populations	\$8,718	\$9,939
Children	\$3,495	\$4,508
Adults	\$5,461	\$8,051
Expansion adults	\$7,227	\$9,470
Blind and disabled	\$23,123	\$25,901
Aged	\$18,552	\$19,064

Percent of Total Medicaid Population

Based on FY 2020 data

Percent of Total Medicaid Spending

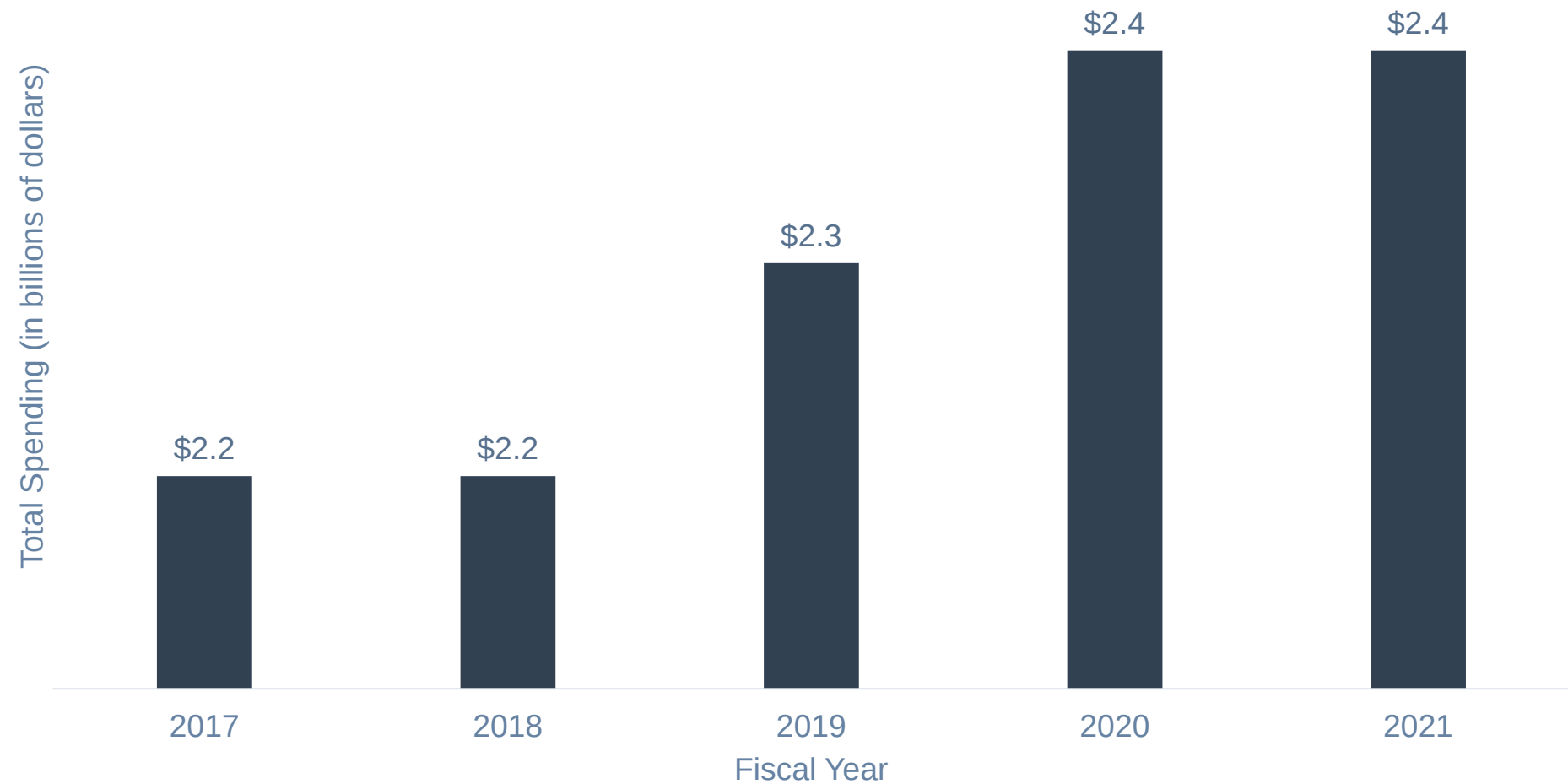
Totals may not equal 100% due to rounding

C.2. Medicaid Program Spending: Budget

Budget Item	SFY21 Est. Spending	Percent Of Budget
Managed care and premium assistance	\$1,936,000,000	80%
Home- and community-based LTSS	\$183,000,000	8%
Other acute services	\$99,000,000	4%
Hospital	\$66,000,000	3%
Institutional LTSS	\$50,000,000	2%
Dental	\$48,000,000	2%
Medicare premiums and coinsurance	\$34,000,000	1%
Physician	\$8,000,000	<1%
Clinic and health center	\$2,000,000	<1%
Budget Total: \$2,426,000,000		

Federal & County Financial Participation	
FY 2023 Federal Medical Assistance Percentage (FMAP)	64.7%
CY 2023 Newly Eligible FMAP (expansion population)	88%
Counties contribute to state Medicaid share	No

C.2. Medicaid Program Spending: Change Over Time



C.3. Medicaid Expansion Status

Medicaid Expansion	
Participating In Expansion	Yes
Date Of Expansion	January 2014
Medicaid Eligibility Income Limit For Able-Bodied Adults	133% of the Federal Poverty Level (FPL) Note: The Patient Protection and Affordable Care Act (PPACA) requires that 5% of income be disregarded with determining eligibility.
Legislation Used To Expand Medicaid	House Bill 200, 147th General Assembly, which is the FY 2014 enacted budget.
Number Of Individuals Enrolled In The Expansion Group (September 2022)	91,734
Number Of Enrollees Newly Eligible Due To Expansion	14,322
Benefits Plan For Expansion Population	The alternative benefit plan contains all state plan benefits plus additional benefits, such as chiropractor benefits.

C.4. Medicaid Program Benefits

Federally Mandated Services	
1.	Inpatient hospital services other than services in an institution for mental disease (IMD)
2.	Outpatient hospital services
3.	Rural Health Clinic services
4.	Federally Qualified Health Center (FQHC) services
5.	Laboratory and x-ray services
6.	Nursing facilities for individuals 21 and over
7.	Early and Periodic Screening and Diagnosis and Treatment (EPSDT)
8.	Family planning services and supplies
9.	Free standing birth centers
10.	Pregnancy-related and postpartum services
11.	Nurse midwife services
12.	Tobacco cessation programs for pregnant women
13.	Physician services
14.	Medical and surgical services of a dentist
15.	Home health services
16.	Nurse practitioner services
17.	Non-emergency transportation to medical care

Delaware's Optional Services	
1.	Podiatry services
2.	Optometry services
3.	Chiropractor services
4.	Private duty nursing
5.	Clinic services
6.	Physical and occupational therapy
7.	Services for individuals with speech, language, and hearing disorders
8.	Prescribed drugs
9.	Prosthetic devices
10.	Diagnostic, preventive, and rehabilitative services
11.	Services for individuals ages 65 or older in IMDs
12.	Intermediate care facility services
13.	Inpatient psychiatric facility services for individuals under age 22
14.	Nursing facility services for consumers under age 21
15.	Adult Dental Services

D. Medicaid Financing & Service Delivery System

D.1. Medicaid Financing & Service Delivery System

Medicaid System Characteristics		
Characteristics	Medicaid Fee-For-Service (FFS)	Medicaid Managed Care
Enrollment (May 2023)	45,389	276,253
SMI Enrollment	- Delaware does not specifically preclude individuals with SMI from enrolling in managed care; therefore, the majority of the SMI population is enrolled in managed care. <i>OPEN MINDS</i> estimates 14% of the SMI population in FFS, 86% in managed care	
Management	Division of Medicaid & Medical Assistance	- Physical health: Three health plans - Behavioral health for non-PROMISE members: Three health plans - Behavioral health for PROMISE eligible members: Division of Medicaid & Medical Assistance
Payment Model	FFS	- Physical health: Capitated rate - Behavioral health for non-PROMISE members: Capitated rate - Behavioral health for PROMISE eligible members: FFS
Geographic Service Area	Statewide	Statewide

Total Medicaid: 321,642 | Total Medicaid With SMI: 27,661

D.1. Medicaid System Overview

Medicaid Financial Delivery System Enrollment	
Total Medicaid population distribution	As of May 2023: 14% in fee-for-service (FFS), 86% in managed care
SMI population inclusion in managed care	• Delaware does not specifically preclude individuals with SMI from enrolling in managed care; therefore, the majority of the SMI population is enrolled in managed care. • Estimated 14% of population in FFS, 86% in managed care
Dual eligible population inclusion in managed care	• Managed care is mandatory for full benefit dual eligibles. • Estimated 100% in managed care

Medicaid Financing & Risk Arrangements: Behavioral Health		
Service Type	FFS Population	Managed Care Population
Traditional behavioral health	Covered FFS by the state	• Managed care adults: All traditional and specialty mental health services are included in the health plan's capitation rate, unless an individual qualifies for PROMISE services. PROMISE services are provided FFS by the state. • Managed care children: 30 outpatient visits are included in the health plan's capitation rate. If the limit is exceeded, behavioral health services are provided FFS by the state, along with all behavioral health inpatient services.
Specialty behavioral health	Covered FFS by the state	
Pharmaceuticals	Covered FFS by the state	Included in the health plan's capitation rate
Long-term services and supports (LTSS)	Covered FFS by the state	Included in the health plan's capitation rate

D.1. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	Active Program	Description
Managed Care Health Plan	✓	The health plans are responsible for care coordination.
Primary Care Case Management (PCCM)		None
Accountable Care Organization (ACO) Program	✓	The state is currently accepting applications for a new ACO program.
Affordable Care Act (ACA) Model Health Home	✓	As of January 2019, Delaware implemented health homes for individuals in need of SMI and I/DD related services
Patient-Centered Medical Home (PCMH)		None
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)	✓	Yes, the health plans are responsible for most long-term services and supports (LTSS).
Certified Community Behavioral Health Clinics (CCBHC) Grant		None
Other Care Coordination Initiatives	✓	In October 2018, the state began the START initiative for addiction treatment services.

D.1. Medicaid Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Parents and caretakers			X
Children			X
Blind and disabled individuals			X
Aged individuals			X
Dual eligibles	X (partial benefit)		X (full benefit)
Medicaid expansion			X
Individuals residing in nursing homes			X
Individuals residing in ICF/IDD			X
Individuals in foster care			X
Other populations	• Aliens eligible for emergency medical services only • Individuals enrolled in the Breast and Cervical Cancer program for uninsured women • Inmates of a public institution • Individuals in the PROMISE program.	Individuals enrolled in the state's I/DD HCBS waiver	

D.2. Medicaid FFS Program: Overview

- As of May 2023, FFS enrollment was 45,389.

D.2. Medicaid FFS Program: Behavioral Health Benefits

- All behavioral health benefits are covered FFS by the state.
- The state also provides additional benefits through the PROMISE program.

FFS Mental Health Benefits	
1.	Inpatient treatment
2.	Outpatient services
3.	Crisis intervention
4.	Residential rehabilitation services
5.	PROMISE services

FFS Addiction Treatment Benefits	
1.	Acute detoxification
2.	Crisis Intervention
3.	Outpatient services
4.	Residential services
5.	Medication assisted treatment (MAT)
6.	PROMISE Services

D.2. Medicaid FFS Behavioral Health Benefits: PROMISE Program

- Promoting Optimal Mental Health for Individuals Through Supports and Empowerment (PROMISE) was developed in response to an Olmstead Act settlement and was implemented in 2015. The program is part of the state’s section 1115 demonstration waiver, Diamond State Health Plan.
- In order to qualify for enrollment in the PROMISE program, individuals:
 - Must be over the age of 18;
 - Have a qualifying behavioral health diagnosis (i.e., schizophrenia, bipolar disorder, major depressive disorder); and
 - Meet needs-based criteria as established by the Delaware-Specific American Society for Addiction Medicine assessment tool that evaluates for both mental health and substance use disorder conditions.
- Anyone who meets the above criteria, regardless of insurance type, is eligible to voluntarily enroll in PROMISE.
 - For individuals with Medicaid, PROMISE services are reimbursed FFS by the state.

PROMISE Program Benefits	
1.	Care management
2.	Individual employment supports
3.	Short-term small group supported employment
4.	Financial coaching
5.	Benefits counseling
6.	Peer support
7.	Non-medical transportation
8.	Community-based residential supports (excluding assisted living)
9.	Nursing
10.	Community psychiatric support and treatment
11.	Psychosocial rehabilitation
12.	Respite
13.	Independent activities of daily living/chores
14.	Personal care
15.	Community transition services

D.2. Medicaid FFS Program: SMI Population

- Delaware does not specifically preclude individuals with SMI from enrolling in managed care based on a diagnosis of SMI; however, individuals with SMI may be enrolled in FFS based on other criteria.
- As of May 2023, *OPEN MINDS* estimates that 14% of the SMI population was enrolled in FFS.
- Individuals with SMI are eligible for PROMISE services.
- Individuals with SMI and I/DD may receive assertive community integration and support services through Delaware's health home program.

D.2. Medicaid FFS Program: Pharmacy Benefit

Delaware FFS Program Pharmacy Benefit & Utilization Restrictions	
State Uses Pharmacy Benefit Manager	No
Responsible For Financing General Pharmacy Benefit	Medicaid FFS
Responsible For Financing Mental Health Pharmacy Benefit	Medicaid FFS
State Uses A Preferred Drug List (PDL) For General Pharmacy	Yes
State Uses A PDL For Mental Health Drugs	Yes, antidepressants, antipsychotics, anxiolytics, and mood stabilizers are included on the pharmacy PDL.
State Uses A PDL For Addiction Treatment Drugs	Yes, opioid dependence related drugs are included on the pharmacy PDL.
Coverage Of Antipsychotic Injectable Medications	Antipsychotic injectable medications are covered as a pharmacy benefit.
Utilization Restrictions For Mental Health Or Addiction Treatment Drugs	Restrictions vary by drug and may be subject to prior authorization requirements, quantity limits, dosing limits, and age limits.
State Has A Pharmacy Lock-In Program Or Other Restriction Program	Individuals suspected of medication misuse may be enrolled in the lock-in program. Under the lock-in program, member's health records are closely monitored by a team of physicians, and members are restricted to one provider organization and one pharmacy for all of their medications.

D.3. Medicaid Managed Care Program: Overview

- As of May 2023, managed care enrollment was 276,253.
- Delaware operates two managed care programs:
 - Diamond State Health Plan (DSHP): Provides Medicaid state plan benefits to individuals who do not require LTSS.
 - Diamond State Health Plan Plus (DSHP-Plus): Provides Medicaid state plan benefits and LTSS to qualifying individuals and all dual eligibles, regardless of whether they qualify for LTSS. Individuals receiving SSI who are not eligible for Medicare may enroll in either program. The state does not cap the number of individuals who may receive home- and community-based services (HCBS).
- In January 2018, the state's new managed care contracts went into effect. The two health plans serve both the DSHP and DSHP-Plus populations:
 - AmeriHealth Caritas Delaware
 - Highmark Health Options
- The managed care contract includes a requirement for the health plans to move 30% of all medical and service expenditures to value-based arrangements in calendar year 2019. This amount will increase to 60% by 2022.
 - Value-based arrangements include shared savings, bundled/episodic payments, total risk/capitation, and other innovative payment arrangements.
 - If the health plan does not meet the requirements, they forfeit up to 1% of total net revenue received from the state.
- The health plan is also responsible for meeting physical health performance measures. Failure to meet the benchmarks will result in a forfeit of 1% of total net revenue from the state.
- DMMA's procurement awards were announced in June 2022, and will start serving members on January 1, 2023.
- For 2023 Delaware First Health (Centene) has been added as a new health plan option.

D.3. Medicaid Managed Care Program: Health Plan Characteristics

AmeriHealth Caritas Delaware	
1.	Profit status: For-profit
2.	Parent company: Independence Health Group
3.	Behavioral health subcontractor: None
4.	Pharmacy benefits manager: PerformRx
5.	Enrollment share: 23%

Highmark Health Options	
1.	Profit status: Non-profit
2.	Parent company: Highmark Blue Cross Blue Shield of Delaware and Gateway Health
3.	Behavioral health subcontractor: None
4.	Pharmacy benefits manager: None
5.	Enrollment share: 49%

Delaware First Health	
1.	Profit status: For-profit
2.	Parent company: Centene
3.	Behavioral health subcontractor: None
4.	Pharmacy benefits manager: None
5.	Enrollment share: 28%

D.3. Medicaid Managed Care Program: Behavioral Health Overview

- Inpatient and outpatient behavioral health services for adults are included in the health plan's capitation rate, unless the individual is referred to the PROMISE program. PROMISE services are provided FFS by the state.
- Inpatient behavioral health services and psychiatric rehabilitation services for children are provided FFS by the state through the Department of Services for Children, Youth, and Their Families (DSCYF).
- Thirty outpatient visits for children are included in the health plan's capitation rate. If the limit is exceeded, the state provides behavioral health services on an FFS basis through DSCYF.
- Individuals with SMI and I/DD may receive assertive community integration and support services through Delaware's health home program.
- Pharmacy benefits are included in the health plan's capitation rate.

D.3. Medicaid Managed Care Program: Behavioral Health Benefits

Mental Health Benefits Provided By The Health Plans	
1.	Inpatient treatment
2.	Outpatient services
3.	Crisis intervention and stabilization
4.	Emergency services
5.	Psychiatric rehabilitation

Addiction Treatment Benefits Provided By The Health Plans	
1.	Inpatient detoxification
2.	Outpatient services
3.	Residential services
4.	Crisis intervention and stabilization
5.	Emergency services
6.	Medication assisted treatment

Managed Care Behavioral Health Benefits Provided FFS By The State	
1.	Licensed behavioral health practitioner services for persons enrolled in the PROMISE program
2.	For persons enrolled in the PROMISE program, addiction treatment services except for medically managed inpatient detoxification
3.	PROMISE program services
4.	Children’s inpatient services
5.	Children’s behavioral health outpatient visits after the 30 th visit

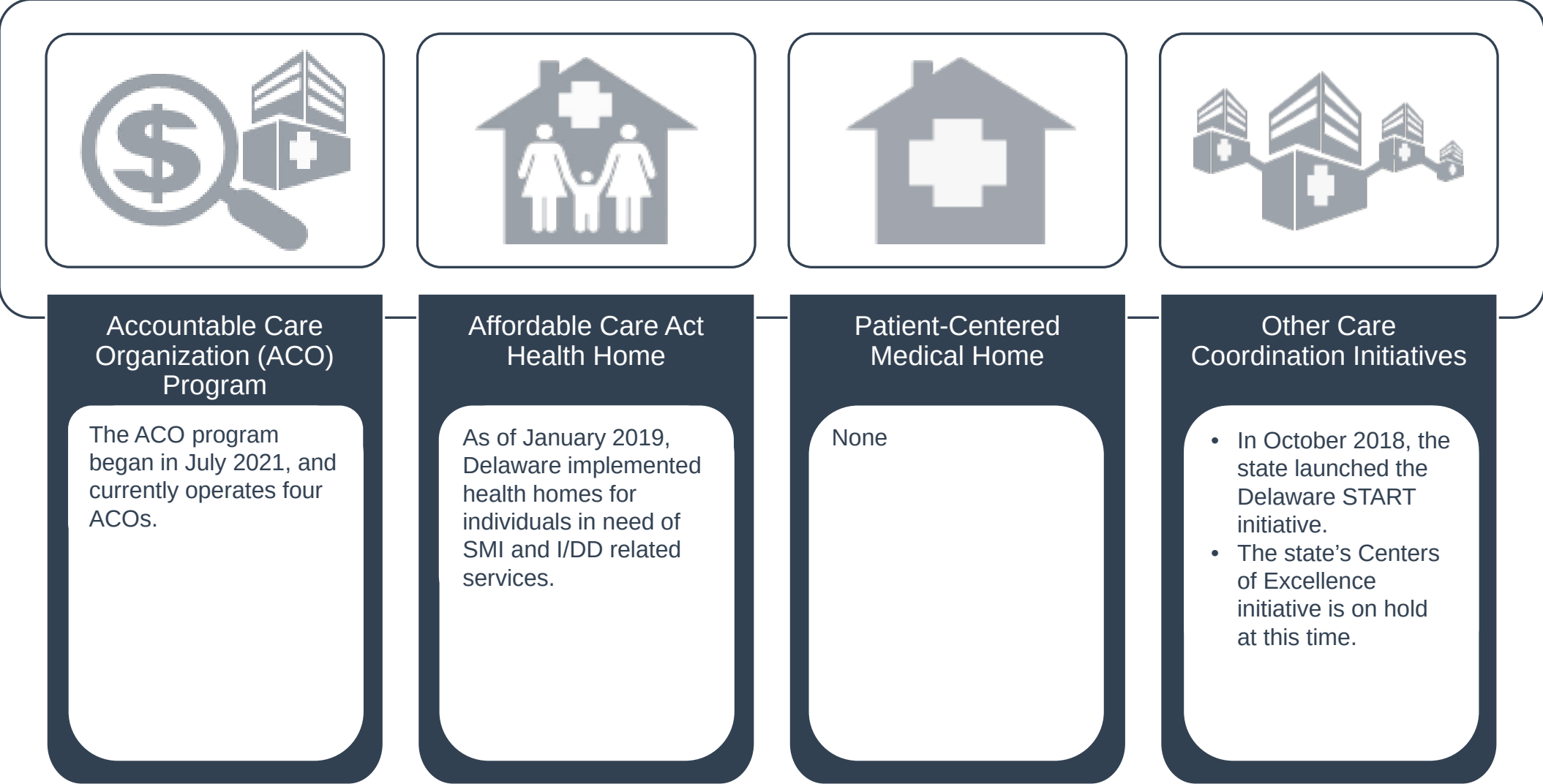
D.3. Medicaid Managed Care Program: SMI Population

- Delaware does not specifically preclude individuals with SMI from enrolling in managed care based on a diagnosis of SMI; however, individuals with SMI may be enrolled in FFS based on other criteria.
- As of May 2023, *OPEN MINDS* estimates that 86% of the SMI population is enrolled in managed care.
- Individuals with SMI are eligible for PROMISE services.
- Individuals with SMI and I/DD may receive assertive community integration and support services through Delaware's health home program.

D.3. Medicaid Managed Care Program: Pharmacy Benefit

Delaware Managed Care Program Pharmacy Benefit	
Responsible For Financing General Pharmacy Benefit	Health plan
Responsible For Financing Mental Health Pharmacy Benefit	Health plan
Health Plan Uses A Preferred Drug List (PDL) For General Pharmacy	Health plans may set their own PDL if it includes an appropriate selection of drugs from therapeutic classes that are accessible and are sufficient in amount, duration, and scope to meet the medical needs of members.
Health Plan Uses A PDL For Mental Health Drugs	
Health Plan Uses A PDL For Addiction Treatment Drugs	
Health Plan Use Of Utilization Restrictions For Mental Health & Addiction Treatment Drugs	The health plans may set their own utilization controls including, but not limited to, age/gender limits, quantity limits, and prior authorization.
Health Plan Allowed To Implement Pharmacy Lock-In Program	Health plans may, but are not required to, implement a pharmacy lock-in program. Under the lock-in program, members may be restricted to one provider organization and one pharmacy.

D.4. Medicaid Program: Care Coordination Initiatives



D.4. State Medicaid Health Home Characteristics

Delaware Health Homes Overview	
Target Population	Individuals with a diagnosis of SMI and individuals with a diagnosis of I/DD
Enrollment Model	- Members are referred to health home provider organizations with the option to opt-out of services. - Referrals may include, but are not limited to: Self-referral, community navigators, professionals that provide day or residential treatment services, medical and psychiatric professionals, hospitals, and psychiatric facilities. - Individuals are given the option to opt out of enrollment.
Geographic Service Area	Statewide
Care Delivery Model	- Health home services are provided by Assertive Community Integration Support Teams (ACIST). The ACIST teams are composed of a team leader (master’s level clinical professionals), prescriber (psychiatrist or psychiatric nurse practitioner), registered nurse, and a case manager to deliver comprehensive mental and physical health services. - Organizations eligible to act as health homes must have ACISTs and must be certified by the Division of Developmental Disabilities to serve as a qualified health home provider organization. - ACIST provider organizations are responsible for providing crisis intervention, intensive case management, behavior analysis, psychiatric supports, and medical monitoring. - Delivery of six core health home services
Payment Model	- Health home services are provided FFS. - The per member per month (PMPM) rate is based on the cost to operate a full ACIST team.
Practice Performance & Improvement	- ER and hospital readmissions - Monitoring of quality and performance measures to the state annually - Health home standards established by the Centers for Medicare & Medicaid Services (CMS).

D.4. Medicaid Program: Delaware START Initiative

- In October 2018, Delaware launched the Substance Use Treatment and Recovery Transformation (START) Initiative to increase access to care for individuals with addiction disorders.
 - Individuals with mental health or addiction disorders are usually referred to the START program by certified recovery peers. The certified recovery peers work in a variety of settings including, but not limited to, hospitals, emergency medical services, urgent care facilities, police officers, department of corrections, or primary care physicians (PCPs).
 - Afterwards, a level-of-care assessment and personalized treatment referrals are made. During this time, individuals in need have 24/7 access to peer support.
 - Once the referral is made, individuals can receive either acute, subacute, or ongoing care for addiction disorders at one of the provider organizations aligned with the START initiative.
- At the program launch, the Division of Substance Abuse and Mental Health (DSAMH) contracted with 24 treatment provider organizations to deliver 66 mental health and addiction treatment services.
 - In November 2018, DSAMH awarded Connections Community Support and Brandywine Counseling & Community Services Level 4 provider organization status. These provider organizations can offer every level of addiction treatment services including all three forms of the FDA's approved medication assisted treatment (MAT).
- In addition to the START initiative, Delaware launched a new online referral treatment system called the Delaware Treatment and Referral Network (DTRN).
 - The DTRN allows clinical professionals and PCPs to refer individuals for mental health or addiction treatment services with one of the 24 provider organizations.
 - In April 2019, the START Initiative started recruiting new PCPs to participate in the program. Recruitment closed on April 12, 2019.

D.5. Medicaid Program: Demonstration & Care Management Waivers

Waiver Title	Waiver Description	Waiver Type	Enrollment Cap	Effective Date	Expiration Date
Delaware Diamond State Health Plan	Authorizes the provision of Medicaid state plan benefits and LTSS through a mandatory managed care delivery system and implements an enhanced behavioral health benefit package for individuals with SMI or addiction disorder.	1115	None	01/01/1996	12/31/2024
Pathways to Employment (DE-01)	Authorizes the state to offer individually-tailored employment support services for individuals with visual impairments, physical disabilities, I/DD and autism spectrum disorder who are between 14 and 25 years of age.	1915(b4)	None	12/31/2019	06/30/2024

1. CMS approved the extension of the state’s 1115 waiver, Delaware Diamond State Health Plan. The extension also authorizes the state to expand addiction treatment services.
 - The waiver was effective on August 1, 2019 and will run until December 31, 2024.
2. Under the waiver amendment, members will have access to addiction treatment services in institutions for mental disease (IMDs).
 - The following services will be available in IMDS: Residential treatment, medically supervised withdrawal management, and medication assisted treatment (MAT).
 - Additionally, the waiver extends and authorizes addiction treatment for individuals aged 19 to 64 via the PROMISE program.

D.5. Medicaid Program: Section 1915 (c) HCBS Waivers

Waiver Title	Target Population	2023 Enrollment Cap	Operating Unit	Concurrent Management Authority
DE DDDS Lifespan Waiver (0009.R08.00)	Individuals ages 12 and older that are diagnosed with autism or an intellectual disability.	3,136	Delaware Division of Developmental Disabilities Services	Yes, individuals enrolled in the DDDS Lifespan Waiver and living with their family can be concurrently enrolled in the 1115 Waiver under the Diamond State Health Plan to receive their acute care benefits.

D.6. Medicaid Program New Initiatives: ACOs

- In February 2019, Delaware released a request for information (RFI) to explore the implementation of ACOs.
- In March 2020, Delaware released the application for interested ACO's with an anticipated end date of April 2020. This was later extended to June 2020 due to the public health emergency caused by COVID-19. The program began in July 2021.
 - The main purpose is to extend the state's value-based payment initiative and will be a TCOC arrangement.
- The state currently plans for the ACO's to run through December 2024.
 - Each ACO are required to have a minimum of 5,000 members.
 - Dual eligibles, individuals in LTSS, and long-term care facility residents are exempt from being included in the ACO's.
- Services offered by the ACO's will be the same as the services currently offered by the Managed Care Contract. Any supplemental or additional care management or coordination will be included in the TCOC calculation.
- Individuals will be assigned to the ACO's based on individual selection. If the individual does not pick one, their MCO will assign them.
- The payment model is a two-track model intended to promote value-based payment and deployment of more APM to providers. For more information, see the next slide.
 - The ACO payments will be tied to quality measures that will be provided at a later point.

D.6. Medicaid Program: ACO Tracks

Year (as of 2021)	Track One	Track Two
Year 1 (18 month period due to COVID-19)	Upside-only shared savings, 50/50 shared savings split between the ACO and MCO, Maximum savings rate of 10% of target.	Shared savings and risk, 60/40 shared savings and risk split, maximum savings rate 10% of target, downside risk capped at 5% of target.
Year 2	Shared savings and risk, 60/40 shared savings split, 25/75 shared risk split, maximum savings rate 10% of target, downside risk capped at 5% of target.	Shared savings and risk, 75/25 shared savings and risk split, maximum savings rate 10% of target, downside risk capped at 10% of target.
Year 3	Shared savings and risk, 60/40 shared saving split, 50/50 shared risk split, maximum savings rate 10% of target, downside risk of 5% of target.	Full Risk, Maximum savings rate 10% of capitation rate, downside risk capped at 10% of capitation rate.

E. Dual Eligible Financing & Service Delivery System

E.1. Dual Eligible Medicaid Financing & Service Delivery System

Dual Eligible* Medicaid System Characteristics		
Characteristics	Medicaid Managed Care	PACE
Enrollment (June 2022)	17,448	269
Estimated SMI Enrollment	5,583	86
Management	- Physical health: Three health plans - Behavioral health for non-PROMISE members: Three health plans - Behavioral health for PROMISE eligible members: Division of Medicaid & Medical Assistance	One program
Payment Model	- Physical health: Capitated rate - Behavioral health for non-PROMISE members: Capitated rate - Behavioral health for PROMISE eligible members: FFS	Blended capitated rate
Geographic Service Area	Statewide	Select ZIP codes in New Castle County

Total Dual Eligible Enrollment: 17,717 | Total Dual Eligible Enrollment With SMI: 5,669

*Unless otherwise noted, the term *dual eligibles* in this section refers to Medicare enrollees with full Medicaid benefits.

E.2. Largest Dual Eligible Health Plans By Estimated SMI Enrollment

Health Plans	Parent Company	Plan Type	May 2022 Enrollment	Estimated SMI Enrollment
UnitedHealthcare Dual Complete	UnitedHealthcare	Medicare Advantage D-SNP	4,696	1,503
Humana Gold Plus	Humana, Inc	Medicare Advantage D-SNP	2,176	696
Cigna-HealthSpring TotalCare	Cigna, Inc	Medicare Advantage D-SNP	1,975	632
Aetna Medicare Advantra Cares	Aenta/CVS Health	Medicare Advantage D-SNP	847	271
UnitedHealthcare Dual Complete Select	UnitedHealthcare	Medicare Advantage D-SNP	568	182
Saint Francis LIFE	Trinity Health – Saint Francis Medical Center	PACE	269	86
Cigna TotalCare Plus	Cigna, Inc	Medicare Advantage D-SNP	41	13

E.3. Dual Eligible Medicaid Financing & Delivery System: Overview

- As of June 2022, dual eligible enrollment was 17,717.
- Medicare covers most acute services (which may include psychiatric care), while Medicaid, the payer of last resort, covers LTSS and non-physician behavioral health services.
- All full benefit dual eligibles that do not select a D-SNP are enrolled in Diamond State Health Plan Plus (DSHP-Plus), the state Medicaid managed care program, to receive Medicaid services.
- D-SNP enrollment as of March 2023 was 10,303, SMI enrollment for D-SNP was 3,297.

E.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives

- Delaware does not currently have a financial alignment initiative with CMS.

F. Long-Term Services & Supports Financing & Service Delivery System

F.1. LTSS Financing & Service Delivery System

LTSS Medicaid System Characteristics	
Characteristics	Medicaid Managed Care
Enrollment (May 2023)	15,460
Estimated SMI Enrollment	4,947
Management	- Physical health and TBH: 11 health plans - Specialty behavioral health: County mental health plans
Payment Model	- Physical and TBH: Blended capitation - Specialty behavioral health: FFS
Geographic Service Area	Seven demonstration counties

F.1. Medicaid LTSS Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Disabled adults			X
Disabled children			X
Blind individuals			X
Aged individuals			X
Dual eligibles	X (Partial Benefit)		X
Individuals with I/DD			X
Individuals residing in nursing homes			X
Individuals residing in ICF/IDD			X
Other HCBS Recipients			X
Other populations	• Aliens eligible for emergency medical services only • Individuals enrolled in the Breast and Cervical Cancer program for uninsured women • Inmates of a public institution	Individuals enrolled in the state's I/DD HCBS waiver	

F.2. LTSS Medicaid Financing & Delivery System: Overview

- Diamond State Health Plan Plus (DSHP-Plus): Provides Medicaid state plan benefits and LTSS to qualifying individuals and all dual eligibles, regardless of whether they qualify for LTSS. Individuals receiving SSI who are not eligible for Medicare may enroll in either program. The state does not cap the number of individuals who may receive home- and community-based services (HCBS).
- In January 2018, the state's new managed care contracts went into effect. Three health plans serve both the DSHP and DSHP-Plus populations:
 - AmeriHealth Caritas Delaware
 - Highmark Health Options
 - Delaware First Health
- The managed care contract includes a requirement for the health plans to move 30% of all medical and service expenditures to value-based arrangements in calendar year 2019. This amount increased to 60% in 2022.
 - Value-based arrangements include shared savings, bundled/episodic payments, total risk/capitation, and other innovative payment arrangements.
 - If the health plan does not meet the requirements, they forfeit up to 1% of total net revenue received from the state.
- The health plan is also responsible for meeting physical health performance measures. Failure to meet the benchmarks will result in a forfeit of 1% of total net revenue from the state

F.3. Medicaid LTSS Program: Health Plan Characteristics

AmeriHealth Caritas Delaware

1. Profit status: For-profit
2. Parent company: Independence Health Group
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: PerformRx
5. Enrollment share: 23%

Highmark Health Options

1. Profit status: Non-profit
2. Parent company: Highmark Blue Cross Blue Shield of Delaware and Gateway Health
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: None
5. Enrollment share: 49%

Delaware First Health

1. Profit status: For-profit
2. Parent company: Centene
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: None
5. Enrollment share: 28%

F.4. Medicaid LTSS Program: Program Benefits

Mental Health Benefits Provided By The Health Plans	
1.	Inpatient treatment
2.	Outpatient services
3.	Crisis intervention and stabilization
4.	Emergency services
5.	Psychiatric rehabilitation

Addiction Treatment Benefits Provided By The Health Plans	
1.	Inpatient detoxification
2.	Outpatient services
3.	Residential services
4.	Crisis intervention and stabilization
5.	Emergency services
6.	Medication assisted treatment

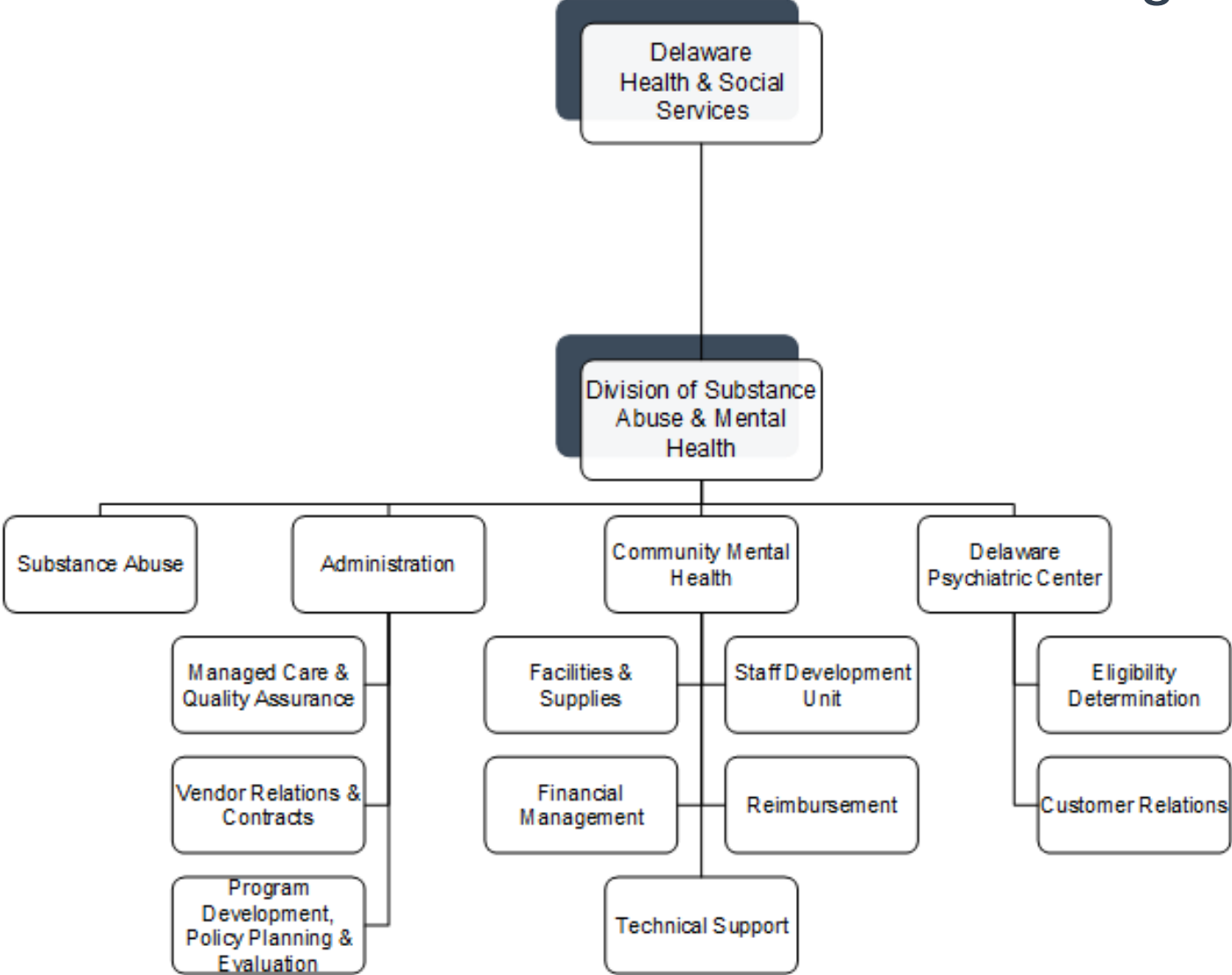
Managed Care Behavioral Health Benefits Provided FFS By The State	
1.	Licensed behavioral health practitioner services for persons enrolled in the PROMISE program
2.	For persons enrolled in the PROMISE program, addiction treatment services except for medically managed inpatient detoxification
3.	PROMISE program services
4.	Children’s inpatient services
5.	Children’s behavioral health outpatient visits after the 30 th visit

F.5. LTSS Medicaid Financing & Delivery System: New Initiatives

- Delaware does not currently have any new initiatives related to their MLTSS program.

G. State Behavioral Health Administration & Finance System

G.1. Division Of Substance Abuse & Mental Health: Organization Chart



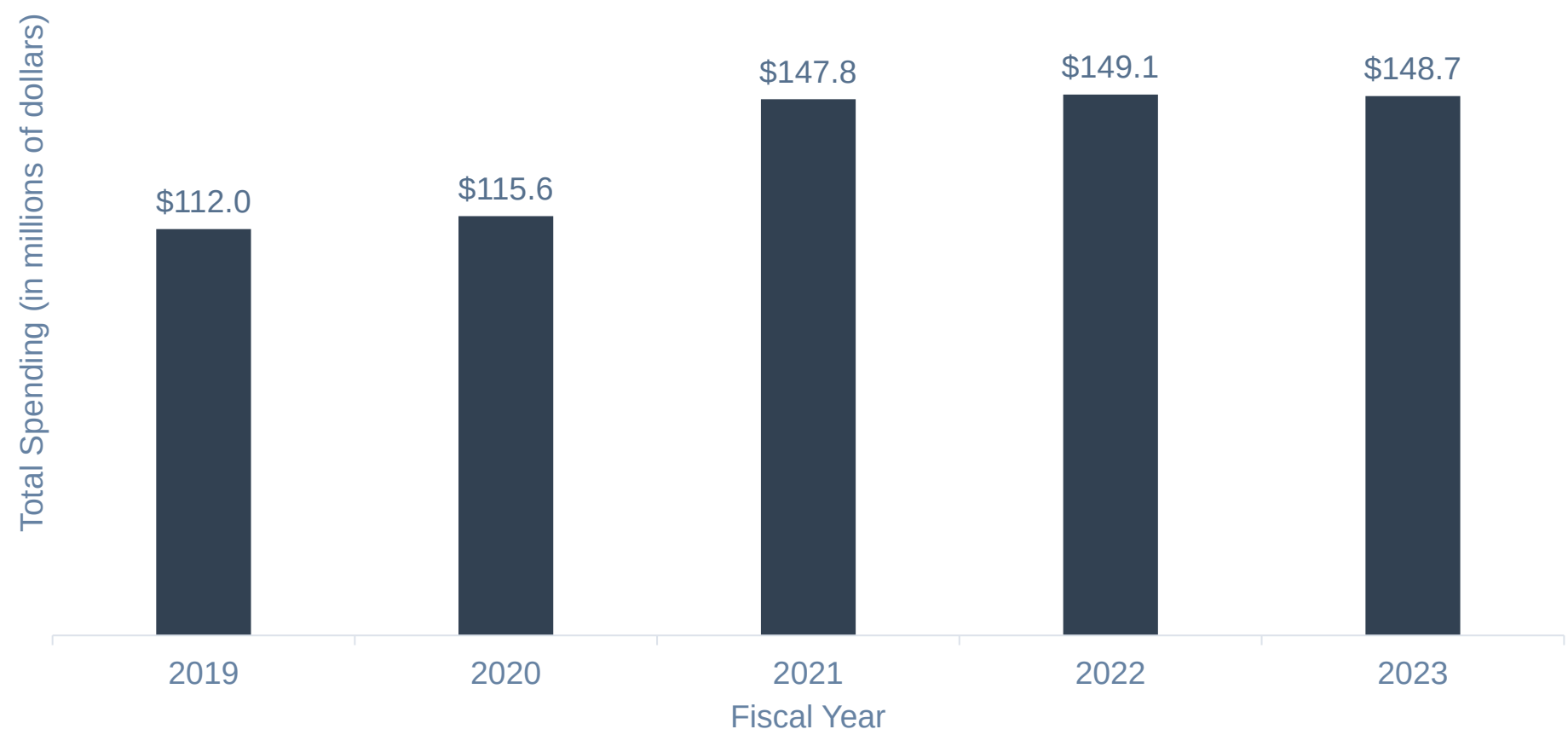
G.1. Division Of Substance Abuse & Mental Health: Key Leadership

Name	Position	Department	Email
Josette Manning	Secretary	Department of Health and Social Services (DHSS)	josette.manning@delaware.gov
Dava Newnam	Deputy Secretary	DHSS	dava.newnam@delaware.gov
Joanna Champney	Director	DHSS, Division of Substance Abuse and Mental Health	joanna.champney@delaware.gov
Michele Twyman-Singletary	Deputy Director	DHSS, Division of Substance Abuse and Mental Health	michelle.twyman@delaware.gov

G.2. Division Of Substance Abuse & Mental Health: Spending

Budget Item	SFY 2023 Budget	Percent Of Budget
Community mental health	\$59,060,000	40%
Substance abuse	\$42,985,200	29%
Delaware Psychiatric Center	\$38,539,100	26%
Administration	\$8,161,800	5%
Total Budget: \$149,120,500		

G.2. Division Of Substance Abuse & Mental Health: Spending Over Time



G.3. State Psychiatric Institutions

State Psychiatric Institutions			
Institution	Location	Beds	Avg daily census (2023)
Delaware Psychiatric Center	New Castle	160	110

G.4. Behavioral Health Safety-Net Delivery System

- The Division of Substance Abuse and Mental Health within the Department of Health and Social Services is responsible for coordinating safety-net services for the uninsured population.
- Behavioral health services are delivered through a network of provider organizations, including the state's two community mental health centers (CMHCs), New Castle County CMHC and Kent/Sussex CMHC.
- Individuals with and without insurance are able to access PROMISE services.
- The state operates the “Projects for Assistance in Transition from Homelessness” (PATH) for individuals who are homeless that have a serious mental illness
- In September 2019, the Department of Health and Social Services received a \$3.58 million federal grant for addiction treatment services.
 - Delaware is one of 15 states to receive this grant, and must allocate funds towards:
 - Assessing the addiction treatment needs of individuals within the state; recruitment, training, and technical assistance for current and future Medicaid provider organizations that provide addiction treatment services; and provide reimbursement to expand the treatment capacity and number of Medicaid provider organizations providing addiction treatment.

H. Appendices

H.1. *OPEN MINDS* Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Commercial	4.1% of the commercially insured population over age 18	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved December 2022 from https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip
Medicaid	8.6% of individuals enrolled in traditional Medicaid	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved December 2022 from https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip
Medicare	16% of persons in the Medicare population, not dually eligible for Medicaid	Centers for Medicare and Medicaid Services. (2021). Medicare-Medicaid Coordination Office Report to Congress. Retrieved January 2023 from https://www.cms.gov/files/document/mmco-report-congress.pdf

H.1. OPEN MINDS Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Medicare-Medicaid Dual Eligibility	25% of persons in the Medicare population dually eligible for partial Medicaid benefits	Congressional Budget Office. (2013, June). Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spends, and Evolving Policies. Retrieved December 2022 from https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308_DualEligibles2.pdf
	32% of persons in the Medicare population dually eligible for full Medicaid benefits	U.S. Department of Health and Human Services. (2019, May 9). Analysis of Pathways to Dual Eligible Status: Final Report. Retrieved December 2022 from https://aspe.hhs.gov/basic-report/analysis-pathways-dual-eligible-status-final-report
Other Public	5.6% of persons served by the Veterans Administration health care system or the TRICARE military health system	Military Health Systems. (2020, August). Examination of Mental Health Accession Screening: Predictive Value of Current Measures and Report Processes. Retrieved December 2022 from https://www.health.mil/Reference-Center/Presentations/2019/11/04/Examination-of-Mental-Health-Accession-Screening-Update
No Health Care Insurance	6.2% of uninsured persons over age 18	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved December 2022 from https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Alternative Benefit Plan	ABP	State designed benefit package for the Medicaid expansion population (childless adults with income below 138% of the FPL). The benefit package must include the ten essential benefits as laid out in the PPACA. The Medicaid expansion population deemed medically frail (including those with SMI) are exempt from receiving benefits through the ABP.
Accountable Care Organizations	ACO	ACOs are groups of provider organizations—such as physicians and hospital systems—that form an agreement to coordinate care for a set group of individuals. If the ACO delivers high quality care—measured through performance metrics—and lowers the cost of providing care against a baseline, then the organization receives a portion of the savings generated. ACOs can exist alongside all payment structures (fee-for-service and managed care delivery systems) and payers (Medicare, Medicaid, commercial).
Administrative Services Organization	ASO	An arrangement in which an organization hires a third party to deliver administrative services to the organization, such as claims processing and billing. The ASO is not at-risk.
Capitation		A set amount of money paid per enrollee per month to a health care entity to cover the cost of health care services. Capitation can cover the cost of all health care services or subset of services, such as care coordination or home- and community-based services.
Carve-out		A carve-out is a Medicaid managed care financing model where some portion of Medicaid benefits—dental services, pharmacy services, behavioral health services, etc.—are separately managed and/or financed. Carve-out services can be financed on an at-risk basis by another organization or retained by the state Medicaid agency on a fee-for-service basis.
Certified Community Behavioral Health Clinic	CCBHC	Behavioral health clinics specially certified in a demonstration established by section 223 of the Protecting Access to Medicare Act of 2014. The clinics are designed to provide community-based mental health and addiction treatment services, to advance the integration of behavioral health with physical health care, and to provide care coordination across the full spectrum of health services.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Community Mental Health Center	CMHC	An organization that can demonstrate that it is actively providing all services in section 1913(c)(I) of the Public Health Services Act, including a.) Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC's mental health service area who have been discharged from inpatient treatment at a mental health facility; b.) 24 hour-a-day emergency care services; c.) Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and d.) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. Additionally, the organization must meet the specifications for the state where it provides services.
Dual Eligible		An individual who is eligible for Medicare (Part A and B) and Medicaid. Medicare serves as the individual's primary insurance, and Medicaid acts as a supplement. Dual eligibles are sometimes referred to as Medicare-Medicaid enrollees (MMEs).
Federal Poverty Level	FPL	The U.S. Department of Health and Human Services sets a standard level of income that is used to determine eligibility for services and benefits, including Medicaid. In 2023, the FPL is \$13,590 for an individual and \$27,750 for a family of four.
Fee-For-Service	FFS	A system where the payer, in this case Medicaid, contracts directly with provider organizations and pays for providing care on a unit by unit basis. Health plans may also reimburse provider organizations on a FFS basis meaning they pay for each unit of care or test.
Health Home		A "whole person" care coordination model that specifically targets populations with chronic conditions including those with SMI. Health homes provide six essential functions: 1.) Comprehensive care management; 2.) Care coordination and health promotion; 3.) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4.) Individual and family support; 5.) Referral to community and social support services; 6.) Use of health information technology to link services. Health homes were originally developed as a Medicaid program, but have been adopted by other payers. For a state to have an official health home program they must have an approved state plan amendment.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Health Insurance Marketplace	HIM	Created by the PPACA, the health insurance marketplace is an online platform where individuals and small businesses can purchase health insurance. The federal government subsidizes coverage purchased on the marketplace through premium tax credits for individuals with income up to 400% of the FPL.
Home- & Community-Based Services	HCBS	Long-term services and supports provided in the home or community in order to avoid institutionalization. Traditionally provided through 1915(c) waivers, HCBS services are usually limited to specific populations and a specific number of people. HCBS services include skilled nursing care, personnel care services, assistance with activities of daily living, and custodial care.
Institutions For Mental Disease	IMD	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including addiction. Federal financial participation is available for Medicaid IMD services for individuals under the age of 21 and age 65 and over. In recent years, CMS has relaxed the rules prohibiting payments in IMDs for individuals ages 21-64. Medicaid health plans may provide up to 15 days of IMD services per month in lieu of state plan services if medically appropriate, cost effective, and consented to by the individual. Additionally, states may be granted a 1115 waiver authority to allow individuals to receive addiction and mental health treatment in IMDs.
Long-Term Services & Supports	LTSS	Services provided in the home, community, or institutional setting to those who experience difficulty living independently and completing activities of daily living as a result of cognitive disabilities, physical impairments, disabling chronic conditions, and/or age.
Managed Care		A health care delivery and financing system designed to manage cost, utilization, and quality. In Medicaid, states generally implement managed care through contracts with health plans, which provide a limited set of benefits to enrollees through a capitated or per person per month (PMPM) rate. The health plans generally assumes full-risk for the cost of treatment, and therefore contracts with a network of provider organizations to provide care at the most efficient rate possible while still maintaining member health.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicaid		Medicaid is a joint federal-state program that provides health coverage to economically disadvantaged populations, such as low-income adults, children, and aged, blind, and disabled (ABD) individuals. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines. Financing is a shared responsibility of the federal government and the states.
Medicaid Waiver		Granted by CMS, waivers allow states to make temporary changes to their Medicaid program in order to test out new ways to deliver health coverage.
Medicaid Waiver Section 1115	1115 waiver	Known as research and demonstration waivers, states can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
Medicaid Waiver Section 1915(b)	1915(b) waiver	States can apply for waivers to provide services through managed care delivery systems, or otherwise limit an individual's choice of health plan or provider organization.
Medicaid Waiver Section 1915(c)	1915(c) waiver	States can apply for waivers to provide long-term care services in home- and community-based settings, rather than institutional settings.
Medical Home		A medical home is not a physical place, but a model for care coordination. Medical homes provide primary care services, care coordination, enhanced access to care, and care that is culturally and linguistically appropriate. Medical homes exist across multiple payers.
Medicare		Federal health insurance for individuals over the age of 65, individuals with certain disabilities, and individuals with end stage renal disease. Medicare covers most acute care services (which may include psychiatric care), but does not cover LTSS or non-physician behavioral health services.
Medicare Advantage	MA	Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicare Advantage Special Needs Plan	SNP	A special type of Medicare Advantage plan that is designed to provide targeted coordinated care to individuals who are a) institutionalized; b) dual eligible; and/or c) meet the severe chronic disabled conditions set forth by CMS. Plans emphasize improved care primarily through continuity of care and care coordination.
Medicare Part A		Hospital Insurance: Covers hospital, skilled nursing care, hospice, and home health care for most eligible individuals at no cost. Financed through payroll tax and deductibles, copayments are only charged if a stay becomes long-term.
Medicare Part B		Supplementary Medical Insurance: Covers most outpatient services, and consumers pay a premium based on income level.
Medicare Part C		Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.
Medicare Part D		Outpatient Prescription Drug Benefit: Private plans contract with Medicare to provide coverage for prescription drugs. Most consumers pay premiums based on their income.
Metropolitan Statistical Area	MSA	An urbanized area with a population of at least 50,000 plus adjacent territory that has a high degree of social and economic integration as measured by commuting ties.
Patient-Centered Medical Home	PCMH	See Medical Home.
Patient Protection & Affordable Care Act	PPACA or ACA	U.S. health care reform signed into law in 2010. The legislation regulates certain aspects of private and public health insurance programs and authorizes an individual mandate to secure essential health coverage, premium tax credits for the purchase of private health insurance, and increased insurance coverage of preexisting conditions. In 2012 the Supreme Court ruled that state participation is optional for provisions of the law expanding Medicaid coverage to adults ages 18 to 64 with incomes under 138% of the FPL. In 2017, Congress repealed the tax penalties associated with the individual mandate essentially ending the mandate.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Primary Care Case Management	PCCM	A health care delivery system model with limited utilization and cost control. Under the PCCM model, Medicaid enrollees choose a primary care physician who acts as a gatekeeper for more intensive services. The primary care physician generally receives a per person per month (PMPM) fee for care coordination, and is reimbursed fee-for-service for all medical services provided.
Program Of All Inclusive Care For The Elderly	PACE	PACE serves populations over the age of 55 who are eligible for skilled nursing home care by utilizing a comprehensive delivery system of social, medical, and long-term care services to keep enrollees in the community for as long as possible. PACE is an optional state Medicaid program, and may only be available in certain states, or regions within states.
Serious Mental Illness	SMI	A mental, behavioral, or emotional disorder that lasts for a sufficient duration of time and causes impairment of major life activities. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.
Supported Employment		Provides services and supports to help individuals with disabilities become employed in an integrated or competitive work environment, and retain that employment.
Supported Housing		Housing provided for as long as needed at little or no cost to individuals with mental illness, or other vulnerable populations who are homeless or at-risk for homelessness. Mental health and social services are offered to participants, but are not a condition for participation in the program. The goal is to allow individuals to live as self-sufficient, independent lives as possible.
Value-Based Reimbursement	VBR	Reimbursement model in which payers financially reward or penalize health care provider organizations for performance on quality and cost of care. VBR payment mechanisms include P4P; capitation; shared savings models; shared risk models; and payments based on clinically-defined episodes, called episodes of care or bundled payments.

H.3. Sources

A. Executive Summary

1. Information compiled from sources provided throughout the profile.

B.1. Population Demographics

1. United States Census Bureau. (2022). 2023 American Community Survey 1-Year Estimates S0101 Population By Age and Sex. Retrieved July 2023 from <https://data.census.gov/cedsci/table?q=S0101>
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3. United States Census Bureau. (2022). 2023 American Community Survey 1-Year Estimates S1901 Median Income In the Past 12 Months. Retrieved July 2023 from <https://data.census.gov/cedsci/table?q=S1901>
4. Kaiser Family Foundation. (2022). 2023 Population Distribution by Race/Ethnicity. Retrieved July 2023 from <https://data.census.gov/cedsci/table?q=Race%2FEthnicity&q=0100000US.04000.001&tid=ACSDP1Y2019.DP05&hidePreview=false>

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