



Delaware Health and Social Services

Delaware Diamond State Health Plan
&
Diamond State Health Plan Plus

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

to

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

State of Delaware

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Section I – Purpose and History

Overview

The Delaware Department of Health and Social Services (DHSS) is submitting this application for an extension of its waiver, under the authority of 1115 of the Social Security Act, and pursuant to the Special Terms and Conditions for Demonstration Approval Period: January 1, 2011 through December 31, 2013, to the Center for Medicare and Medicaid Services (CMS) to continue key components of the Diamond State Health Plan (DSHP) and Diamond State Health Plan Plus (DSHP Plus). This extension request for the statewide demonstration project # 11-W-00036/4 is for the period from January 1, 2014 through December 31, 2018. (See Timeline, ATTACHMENT A)

Since the last extension effective January 1, 2011, and the 2012 amendment for DSHP Plus, the Division of Medicaid & Medical Assistance (DMMA) has maintained primary responsibility for the DSHP. The DMMA continues to work in tandem with the Division of Social Services (DSS) in managing eligibility, systems and staff training responsibilities for the DSHP and DSHP Plus.

The DMMA is requesting an extension of its DSHP and DSHP Plus waiver in order to continue to provide access to PCPs and specialists through a MCO network, retain the current level of behavioral health benefits, and to provide services to the current expanded population. Delaware desires to renew its current waiver and incorporate any federal changes that have been implemented since approval of the original application. Delaware plans to

implement changes to our program in accordance with the ACA to include populations up to 133% of FPL under our expanded Medicaid program.

History of Managed Care in Delaware

In 1994, the Delaware Health Care Commission recommended conversion of most of the Medicaid program to a managed care program. Its intent was the use of Medicaid program savings, along with some additional State funding, to expand health coverage to all uninsured Delawareans at or below one hundred percent (100%) of the Federal Poverty Limit (FPL). After applying to the Health Care Financing Administration (now the Center for Medicare and Medicaid Services [CMS]), DHSS received approval for waivers under section 1115 of the Social Security Act, including:

- a) 1902 (a) (10) (B) Amount Duration and Scope
- b) 1902 (a) (1) State wideness
- c) 1902 (a) (10) and 1902 (a) (13) (C) Payment of Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC);
- d) 1902 (a) (23) Freedom of Choice;
- e) 1902 (a) (34) Retroactive eligibility;
- f) 1902 (a) (30) (A) as implemented by 42 CFR 447.361 and 447.362 Upper payment limits for capitation Contract Requirements

The DHSS first implemented the DSHP in January 1996. Subsequent 3-year renewals were approved and implemented in 2001, 2004, 2007 and 2010. Using savings achieved under managed care, Delaware expanded Medicaid health coverage to additional low-income adults in the State, as well as an expansion of family planning services to women. The goals of the program were and continue to be to improve and expand access to healthcare to more adults and children throughout the State, create and maintain a managed care delivery system emphasizing primary care, and to strive to control the growth of healthcare expenditures for

the Medicaid population. Dual eligibles and individuals receiving institutional and home- and community-based services (HCBS) had been excluded from DSHP and managed care enrollment. These individuals were served through DMMA's Medicaid fee-for-service (FFS) program and through three Section 1915(c) waiver programs.

In March 2012, the Centers for Medicare & Medicaid Services (CMS) approved an amendment to DSHP that enabled Delaware to move its long term care and dual eligible populations – excluding individuals enrolled in its 1915(c) waiver serving Individuals with Developmental Disabilities – to its 1115 Demonstration Waiver. The goal of the amended waiver is to integrate primary, acute, behavioral health, and LTC services for the elderly and persons with physical disabilities into the DSHP statewide program under the name “Diamond State Health Plan Plus” and have one statewide managed care program serving most Medicaid beneficiaries in the state. Delaware leveraged the existing DSHP 1115 demonstration by expanding it to include full-benefit dual eligibles, individuals receiving institutional LTC (excluding the developmentally disabled population), and individuals enrolled in DMMA's Elderly and Disabled and AIDS Section 1915(c) waivers. This enabled the State to begin serving these vulnerable populations through an integrated LTC delivery system effective April 1, 2012.

Over the last 16 years, Delaware has demonstrated that the DSHP can provide quality physical and behavioral health care services through a private and public sector cooperation to a greater number of uninsured or underinsured individuals, and at a lesser or comparable cost than the projected fee-for-service program costs for just the Medicaid eligible population.

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

- Improving access to health care for the Medicaid population, including increasing options for those who need LTC by expanding access to HCBS.
- Rebalancing Delaware's LTC system in favor of HCBS.
- Promoting early intervention for individuals with or at-risk for having LTC needs.

- Increasing coordination of care and supports.
- Expanding consumer choices.
- Improving the quality of health services, including LTC services, delivered to all Delawareans.
- Creating a budget structure that allows resources to shift from institutions to community-based services.
- Improving the coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles.
- Expanding coverage to additional low-income Delawareans.

Evaluation of the success of the DSHP and DSHP Plus goals will be measured through HEDIS performance measures, DMMA's QCMR and other measured reports as described in the Quality Management Strategy.

Section II – Eligibility

Eligible Populations

The DSHP and DSHP Plus waiver includes the following groups of potential eligibles:

- Individuals categorically eligible for Medicaid in Delaware under Title XIX of the Social Security Act. Currently over 167,000 eligibles, or 79% of the Delaware Medicaid population (Title XIX), are enrolled in DSHP. See Chart II.1.a.
- Uninsured non-categorically eligible adult citizens with incomes below 100% of the FPL. There are currently approximately 32,000 in this expanded population. See Chart II.1.a. and Chart II.1.b.
- Women of child-bearing years who lose Medicaid eligibility for non-fraudulent reasons for limited family planning services for 12 additional months (for a total of 24 months). See ATTACHMENT C for eligibility criteria. See Section VII (1) for benefit definitions.

There are currently over 4,252 (Oct '12) women eligible under this demonstration. See Chart II.1.c.

DSHP Plus includes the following populations:

- Institutionalized individuals in Nursing Facilities who meet the Nursing Facility Level Of Care (LOC).
- Aged and/or disabled individuals over age 18 who meet the Nursing Facility LOC and receive Home & Community Based Services (HCBS) as an alternative..
- Aged and/or disabled individuals over age 18 who do not meet the Nursing Facility LOC, but who, in the absence of HCBS, are “at risk” of institutionalization and meet the “at risk” for NF LOC criteria.
- Individuals with a diagnosis of AIDS or HIV over age 1 who meet the Hospital Level of Care criteria and who receive HCBS as an alternative.
- Full benefit dual eligibles: Individuals eligible for both Medicare and Medicaid (all ages) who do not meeting an institutional level of care
- Medicaid for Workers with Disabilities

Delaware’s eligibility groups are shown as they exist currently; DMMA plans on modifying to reflect the new adult group and other MAGI groups as the regulations are finalized and the State plan updated.

Chart II.1.a.

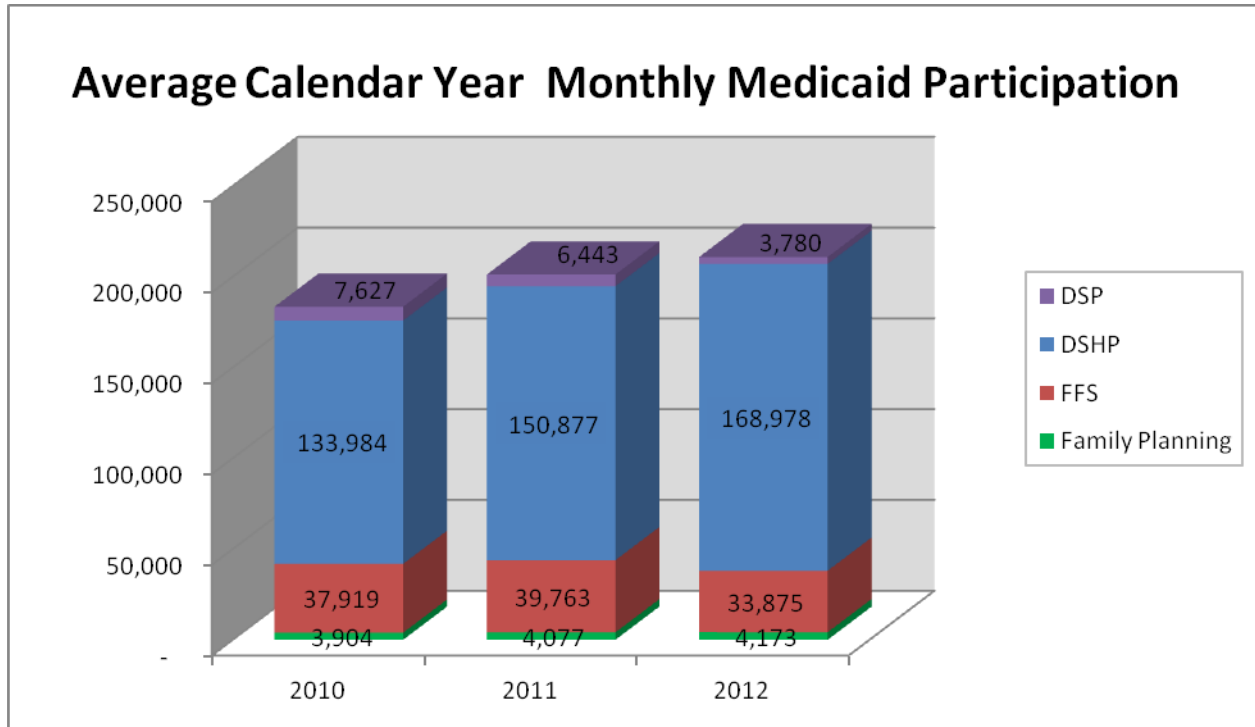


Chart II.1.b.

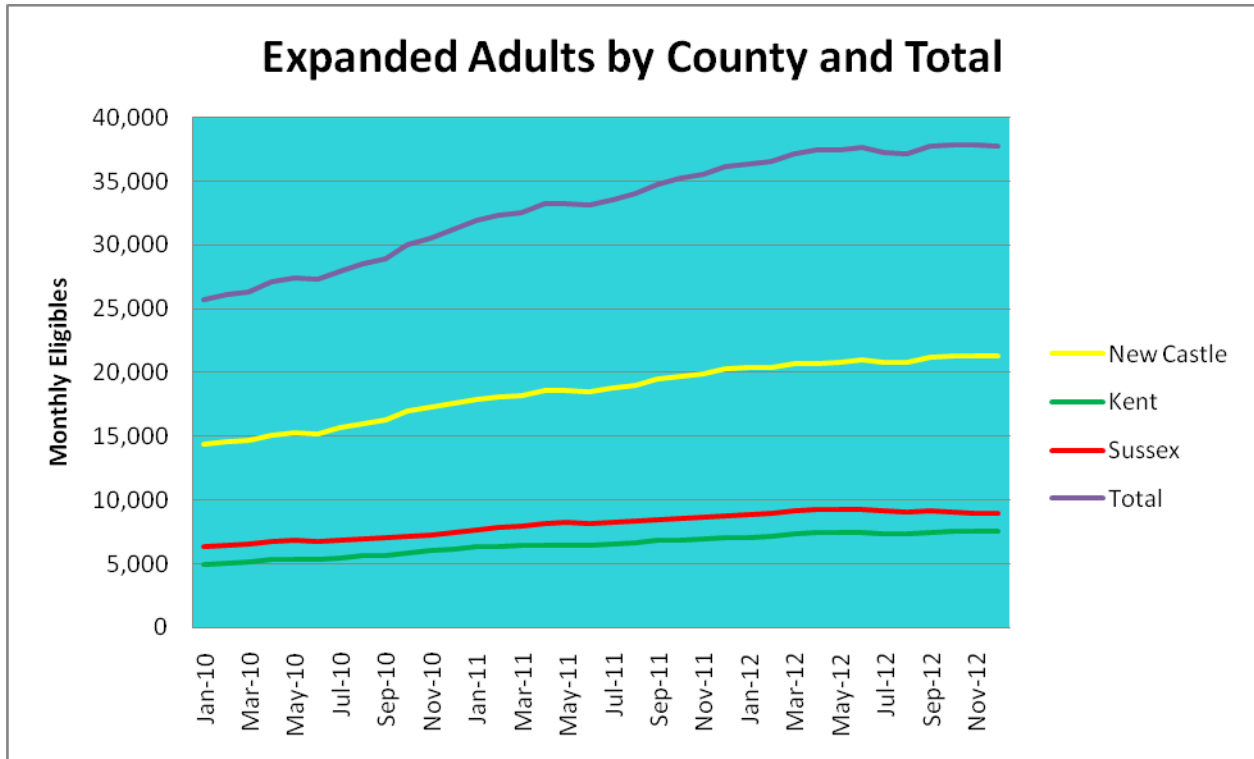
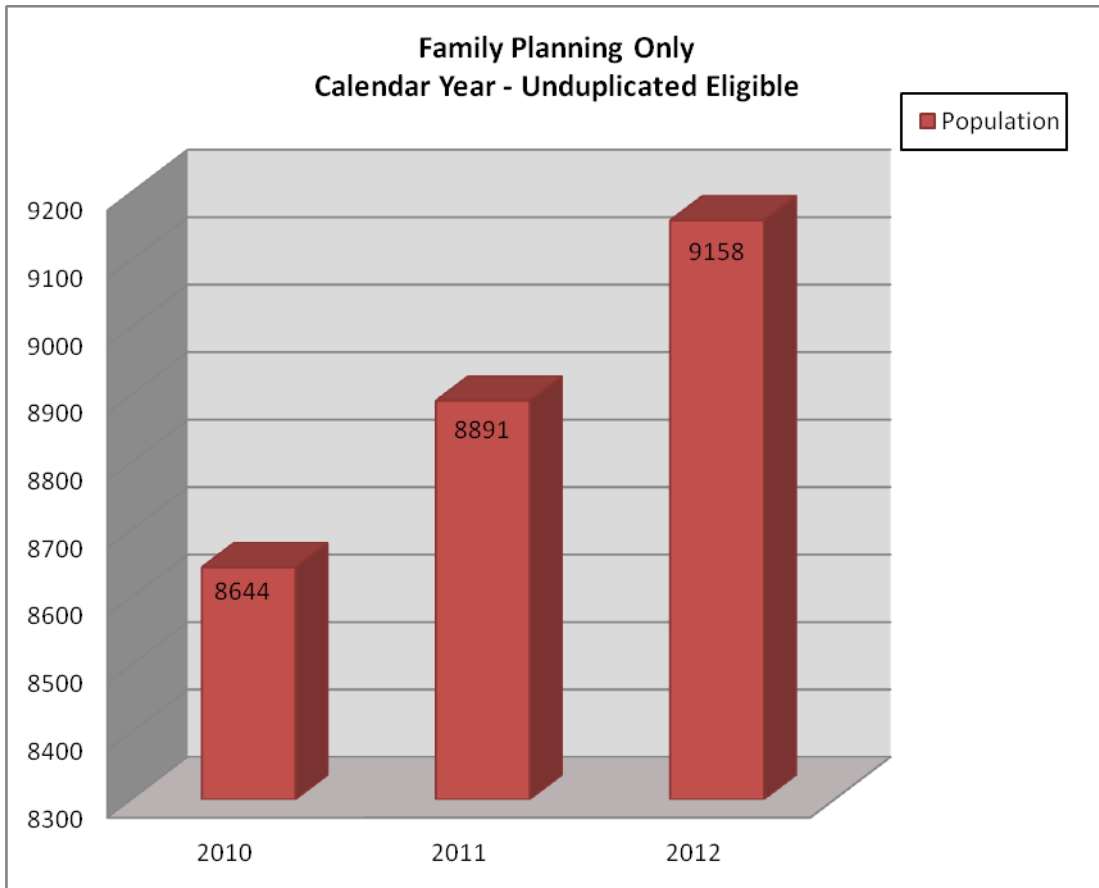


Chart II.1.c.



Excluded Populations

The following persons are excluded from DSHP/DSHP Plus:

- Individuals enrolled in the Section 1915(c) Mental Retardation/Developmental Disability 1915c HCBS Waiver program.
- ICF/MR Residents of the The Stockley Center, not including residents of the Stockley Center Assisted Living who are included in DSHP Plus, and Mary Campbell Center.
- Individuals who choose to enroll in PACE,
- Any Medicaid members that DMMA authorized for out-of-state placement at time of DSHP Plus implementation (4/01/2012) remain in the FFS program.

(However, effective with implementation on 04/01/2012, DMMA no longer authorizes and pays for new out-of state placements through FFS.)

- Dual eligibles other than full-benefit duals (i.e. Qualified Medicare Beneficiaries)
- Presumptively eligible pregnant women
- Breast and Cervical Cancer Treatment Program enrollees
- Unqualified aliens, both documented and undocumented, receiving emergency services as defined in section 1903(v) of the Social Security Act.
- Those only in need of the 30-Day Acute Care Hospital program (42 CFR 435.236 group covered on page 19 of Attachment 2.2-A of the State Plan).

Proposed changes for 2014 and beyond

Beginning January 1, 2014 plans to expand Medicaid eligibility to individuals with income at or below 133% of the Federal Poverty Limit (FPL). Individuals whose eligibility falls into this category will be eligible for the Diamond State Health Plan benefit package (see section VII).

Delaware will provide Medicaid eligibility as of the date of application for DSHP and DSHP Plus enrollees.

As is currently authorized for DSHP and DSHP Plus, Delaware will not provide retroactive eligibility prior to the date of application to DSHP enrollees with the exception of nursing facility residents.

Effective July 1, 2014, Delaware plans to terminate the state-operated primary case management entity, Diamond State Partners (DSP). DSP was created in July, 2002 when Delaware had only one commercial Managed Care Organization (MCO). However, since 2007, Delaware has two viable commercial MCOs for member choice. As a result, DSP enrollment has dropped from a high enrollment number of 17,980 in May of 2004 to less than 3,200 currently. Delaware intends to offer current DSP members their choice of two MCOs in Open Enrollment in May of 2014. Their MCO enrollment will begin July 1, 2014

and DSP will be terminated at that time. Delaware will assure that there is a seamless and non-disruptive transition for these members into DSHP. A more detailed DSP member transition plan can be viewed in Section V of this extension request.

Section III – Benefit Package

DSHP & DSHP Plus Covered Services

Most Medicaid benefits are included in the waiver . These include in-patient and outpatient hospitals, physician/podiatry/nurse midwife, independent laboratory, radiology, home health, emergency transportation, medically necessary durable medical equipment and supplies, rehabilitation, and other covered services.

Also women of child-bearing years who have lost categorical Medicaid eligibility for non-fraudulent reasons, usually due to an increase in income, but are eligible under the special Family Planning eligibility category, may receive a limited benefit package of family planning services (See Section II.1.c.). Covered services do not include procedure for infertility purposes or routine gynecological purposes, such as routine physicals, pap smears, treatment for sexually transmitted disease, or other routine services not required to promote family planning. See ATTACHMENT H for Family Planning Procedure Codes covered for this population. As a result of ACA changes, DMMA believes most of population eligible for Family Planning services will receive those services through a health plan purchased through the Health Care Exchange or fall into expanded population. DMMA will continue to provide Family Planning services for the Health Care Exchange exempted populations.

The DSHP benefit package includes 20 days of inpatient psychiatric services for individuals between the ages of 21-64 in Institutions for Mental Diseases, subject to an aggregate annual limit of 60 days. This service to this population is included in the capitated rates paid to the

managed care companies and, as an “in lieu of service, is claimed for federal share.

1. DSHP Plus Enhanced Benefits

DSHP Plus members receive all other state plan services offered under DSHP. In addition, DSHP Plus members may receive the following enhanced benefits:

- Community-based residential alternatives that include Assisted Living Facilities
- Personal Care
- Respite care, both at home and in Nursing and Assisted Living Facilities
- Day Habilitation
- Cognitive Services for Individuals with Acquired Brain Injury
- Emergency Response System
- Consumer-directed Attendant Care
- Independent Activities of Daily Living (chore)
- Nutritional supplements not covered under the State Plan for individuals diagnosed with AIDS
- Specialized durable medical equipment not covered under the State Plan
- Minor home modifications (up to \$6,000 per project; \$10,000 per benefit year; and \$20,000 per lifetime)
- Home-delivered meals (up to 1 meal per day)
- Nursing Facility Services
- Case management services
- Community Transition services (e.g., bed rails, administrative paperwork, food staples, household set-up, moving expenses, housing application fees, housing security deposits, utility security deposits) for individuals moving from a nursing facility to the community under the MFP program. Limit: \$2500 per lifetime.
- Transition Workshops for those moving from a nursing facility to the community under the MFP program. These workshops prepare the individual and their families and other caregivers for community living.

Case management and support coordination model

The MCOs are required to establish a long-term care case management and support coordination program for DSHP Plus members as directed by the State. DMMA has established minimum case management program requirements and qualifications for case managers. MCOs provide case management and support coordination either directly or through contracts with other organizations. Additionally, DMMA requires that each MCO assigns one and only one case manager for every member eligible to receive long-term care services.

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

2. Non-included Services

The DSHP/DSHP Plus program does not require MCOs to include pharmacy, non-emergency transportation, extended mental health and substance abuse benefits, and some specialized services for children. These services are covered under the traditional Medicaid system. Pharmacy services are closely monitored through the State's Drug Utilization Review program.

In addition, the following services are neither covered by Medicaid through the traditional program nor required of the MCO plans:

- Infertility service
- Sex transformations and reversals
- Personal Care (except under DSHP Plus)
- Chiropractic services
- Cosmetic services
- Christian Sciences nurses and sanitariums
- Dental services for adults
- Routine eye care and glasses/contacts for adults

Cost Sharing

The only cost sharing in Delaware Medicaid is for pharmacy. All clients, other than those specifically excluded, are liable for sharing the cost of Medicaid covered prescription drugs as well as over-the-counter drugs prescribed by a practitioner. The co-payment is imposed for each drug that is prescribed and dispensed and shall not exceed a cumulative monthly amount of \$15.

The following individuals are excluded from the co-payment requirement:

- Individuals under 21 years of age
- Pregnant women, including the post partum period (90 days)
- Individuals eligible under the long term care nursing facility group or acute care hospital group.
- Family Planning services and supplies
- Hospice services

Planned Changes

There are no changes planned for the renewal period.

Section IV – Health Benefits Manager (HBM)

Enrollment

Determination of eligibility for the Medicaid and expanded populations is done through the DMMA and the DSS client services units. Eligibility is automated through the DCIS II system, which then transmits the appropriate information to the Medicaid Management Information System (MMIS) and the Health Benefits Manager (HBM). The HBM is responsible for an outreach, education, and enrollment system to address the needs of all present and potential DSHP enrollees.

HBM Responsibilities

The HBM has primary responsibility for developing, producing and disseminating educational materials that encourage appropriate use of the services of the managed care plans and their primary care provider (PCP) network for all managed care enrollees. HBM staff assist with access issues such as choosing a PCP, explaining the availability of various services (including those covered under fee-for-service), and accessing those services. In addition, the HBM acts as a client advocate in appropriately directing and/or resolving inquiries and complaints related to the managed care system. The HBM does not participate in, or resolve, formal appeals and grievances that reach the level of fair hearing requests. However, their activities often resolve issues before there is a need for a formal grievance.

These activities are carried out through the following processes:

a) Enrollment

- Open Enrollment

An annual Open Enrollment is held every 12 months. At this time all members may transfer between the managed care plans without cause. The HBM notifies all members of the Annual Open Enrollment and assures that all members have the appropriate information prior to the Open Enrollment period.

- Ongoing enrollment

The HBM is responsible for enrolling all newly eligible Medicaid clients in the target populations into the managed care plan of their choice.

- Enrollment Education

The HBM designs, produces and makes available to clients a comprehensive, culturally sensitive, linguistically appropriate, educational program material that explains all relevant aspects of the DMMA managed care plans from a client perspective. This education material is designed to assure that clients gain a complete understanding of managed care plans in general and the responsibilities of the client under this system. Client education materials and services are integrated with all facets of the enrollment process to enhance client understanding, minimize confusion, and optimize the incidence of voluntary enrollment into health plans.

- Distribution of enrollment application

The HBM distributes to all clients by mail and/or other suitable means a managed care enrollment application. The capability to enroll in the program is available via a toll free telephone system. In addition, HBM staff is present in Division of Social Services eligibility units to assist newly eligible clients in selecting the managed care plan of their choice. HBM staff may also be available via other methods as deemed most effective by the HBM. The enrollment materials are mailed by the HBM to

newly eligible clients no later than three (3) business days after receipt of the roster of potential enrollees from the State. The enrollment packet and telephone enrollment and information support process provides the following information and accomplishes the following activities:

- Present the client's health plan choices in a bi-lingual, objective, non-biased manner that neither favors nor discriminates against any health plan or health care provider.
- Maintain and make available, by internet, toll-free telephone or by mail provider directories to assist clients in identifying health plans in which a particular provider is a participant.
- Assist in the selection of a health plan, encouraging, but not requiring members of the same family to select the same managed care plan.
- Assist in selecting a primary care physician (PCP), providing the managed care plan(s) with that information.
- Collect and report on third party liability resources to both the DMMA and the managed care plan.
- Identify clients who may be potentially excluded or exempted from mandatory enrollment in the DSHP and DSHP Plus.
- Follow-up with clients who have made no choice within twenty (20) days of provision of enrollment information by mail, and if feasible, by telephone or other method, reinforcing the necessity to make a choice in order to assure that medical services may be provided in an efficient and effective manner.

- Confirm enrollment after receipt of enrollment information from the client, including reviewing for accuracy and attempting to contact the client to verify and correct the information provided.

b) Client Advocacy

- Telephone Inquiries

The HBM has responsibility for taking and resolving telephone calls from DSHP members (or potential members). ATTACHMENT D shows a snapshot of one month’s activity in this area. Table III.2.c.1. shows the types of calls received.

Abandoned Calls: The percentage of abandoned calls represents those calls that are disconnected prior to an HBM representative answering the call. The abandoned calls contractual requirement is 5% or less. The HBM has maintained a rate of less than 5%.

Average Speed of Answer: The average answer speed represents how long calls are on hold prior to an HBM representative answering. The average answer speed contractual requirement is 25 seconds or less. On average, the HBM responds to calls in less than 25 seconds.

Table III.2.c.1

MCO Complaints	2010 DSHP Total	2011 DSHP Total	2012 DSHP *Total
MCO system does not show client	0	0	0
Issue with access to doctors or services	14	2	0
MCO ID card missing or incorrect	0	0	3
Billing Issue	0	4	6

Issue with access to member services	1	0	0
Issue with provider directory	0	0	0

Issues worked on by the HBM	2010 DSHP Total	2011 DSHP Total	2012 DSHP Total
TPL error or delay	8	7	1
Enrollment issue	1	9	12
Aid category issue	2	3	0
Eligibility delay	53	34	11
Disenrollment from MCO	37	40	0
Miscellaneous	39	79	6
Total non health plan complaints	140	172	116

Grand total 155 178 125

- Customer Satisfaction Surveys

The HBM conducts Customer Satisfaction Surveys every other year. See ATTACHMENT E which demonstrates responses to these surveys in the most recent three years that surveys were completed.

c) Reporting

The HBM submits monthly, quarterly, annual and special reports (such as Open Enrollment reports) to DMMA to show their activities. The monthly report contains detailed information about complaints or issues raised by potential or current enrollees and the resolution of those issues as well as an Enrollment summary, provider and client outreach report. ATTACHMENT D is an example from the December 2012 monthly report showing the detail provided to DMMA. The DSHP Chief reviews this report and discusses any issues with the HBM during regular meetings.

History and Changes Over the Past 10 Years

The DSHP has used the services of a Health Benefits Manager throughout the history of the waiver. The current HBM contract expires on June 30, 2014. DMMA is currently evaluating our reprocurement efforts for the HBM contract and will complete this process prior to the contract expiration in June, 2014.

Due to a successful HBM process from the beginning of the DSHP waiver, very little has changed in expectations for this contract. There have been some changes in the formats for client satisfaction surveys to determine the quality of the HBM services as well as the services of the managed care plans.

Future Plans

Delaware is evaluating the role of the Patient Navigators and Consumer Assistors as specified under the Patient Protection and Affordable Care Act (ACA). Delaware needs to ascertain how those roles intersect with the responsibilities of the Health Benefits Manager under the Medicaid program.

Section V – Managed Care Organizations (MCOs)

History

Upon waiver approval in 1996, four MCOs were selected for the program: two statewide, one in New Castle County only and one in Kent and Sussex Counties only.

In 1997, upon actuarial calculation of appropriate capitation rates, the contractor serving Kent/Sussex Counties only decided to withdraw from the program. Subsequently in 1998, the New Castle County only contractor became a statewide program.

In July 2000, one other MCO chose to withdraw from participation in the DSHP, leaving two remaining choices for eligible enrollees, both of which provided statewide services.

In 2002, with only one contractor to provide commercial managed care services, DHSS elected to create a State operated program of managed medical care, using internal case management with quality measures as an alternative choice for DSHP enrollees. This internal program, known as Diamond State Partners (DSP), will be discussed more fully in Section V.

The decisions of various MCOs to discontinue participation in the DSHP in the past were based largely on their attempts to negotiate exorbitant inflationary increases at contract re-negotiation time, believing that Delaware would have to accept their terms or discontinue the waiver. Despite its relatively small Medicaid population, Delaware has always been able to find one or more MCO willing and able to accept reasonable capitation rates which resulted in no interruption in the provision of services under the DSHP.

In 2004, the MCO contract was re-bid and awarded to one of the current contractors, Delaware Physicians Care Inc., a subsidiary of Schaller Anderson. This contract was renewed in State Fiscal Year 2006 and State Fiscal Year '07.

In 2006, the MCO contract was again re-bid and in March 2007 negotiations were completed with Delaware Physicians Care, Inc. (DPCI), the incumbent MCO and a new MCO, Unison Health Plan of Delaware, Inc. (Unison, whose name was subsequently changed to United Health Care Community Plan). This allowed the DSHP to offer choice of three health plans to the members: the two commercial MCOs, DPCI and Unison and the State operated managed fee for service option, Diamond State Partners (DSP). A contract was executed for DPCI and Unison effective for two years from July 1, 2007 to June 30, 2009 with additional optional one year renewal terms. The negotiated rates for the two commercial managed care plans continued to reflect a savings over a non-managed care model. In addition, the state began a process of budget neutral risk adjustment between the two MCOs to help lessen the impact of any adverse selection during this period.

In 2012, the MCO contracts were amended to accommodate the DSHP Plus program and populations. Strong case management and care plan development requirements were added to the contracts. In addition, Delaware's Quality Management Strategy was enhanced and stringent MCO monitoring provisions were added.

Contracting

Delaware uses a competitive bidding process to select managed care organizations with which to contract. A Request for Proposal (RFP) is developed and subsequently advertised and disseminated through the Procurement Department of the DHSS. Potential contractors are requested to submit separate Technical and Financial Proposals.

Two committees are formed to evaluate the two proposals from each bidder. The Technical Review Committee does not have access to financial data so that cost is not an influencing factor in determining the qualification of a particular bidder.

Evaluation criteria and rules established in the RFP are applied consistently and fairly to all bidders.

During the term of this waiver extension, the State will be re-bidding the contract for commercial MCO services for the DSHP and DSHP Plus programs , with the initial Request for Proposals to be published by December 30, 2013 and contractors selected and finalized by June 30, 2014. It is expected that multiple entities will bid on this contract and it is the intent of the State to select at least two commercial MCOs.

MCO contracts mandate compliance with the requirements specified in 42 CFR Part 438.

Quality Assurance

Overview

A comprehensive plan incorporating quality assurance (QA) monitoring and ongoing quality improvement (QI) processes to coordinate, assess, and continually improve the delivery of quality care is an essential component in achieving the goals and objectives established with the 1115 Waiver demonstration project. Since the beginning of the demonstration project, a quality assurance system has been in place to direct, develop and manage quality processes and to monitor Medicaid program compliance, and track improvement performance over time. In 2003, the State became compliant with Balanced Budget Act of 1997 (BBA) regulations, the Quality Management Unit (QMU) re-

designed the Quality Management Strategy (QMS), updating standards and incorporating BBA revised regulations. Expectation for compliance with BBA regulations were communicated through updated contracts. Yearly External Quality Reviews (EQR) were completed in 2010, 2011, and 2012 (pending finalization) which evaluated the managed care organization(s) (MCO) in compliance with BBA regulations.

The QMS employs a systematic process of ongoing continuous quality improvement (QI) activities, with feedback mechanisms that effect change and improve quality of care to participants. Data is used to identify and prioritize opportunities for improvement and is integrated into performance improvement projects (PIPs) and performance measures (PMs) as part of the overall QI work plan. The data is analyzed to identify trends, sentinel and adverse events. Findings are reviewed and reported to the internal Quality Improvement Initiatives (QII) Task Force. The QII members discuss the findings to identify opportunities for improvement and, when appropriate, the findings and results of QI activities are included in monthly or quarterly reports and shared with State units with oversight responsibilities. In addition, this information is used to assess the effectiveness of quality initiatives or projects. PMs or PIPs are implemented when indicated by findings.

Quality improvement activities are conducted to focus on critical issues that are not meeting established goals or performance measures or that had the potential for high impact on participants. Based upon findings from activities, an analysis of barriers is conducted along with a critical statistical analysis, description of interventions, and

associated reporting. Findings are documented and followed up in accordance with the QMS in an to identify strategies and mechanisms to result in performance improvement and improved member outcomes in a more cost-effective manner.

Medical Management and Delegated Services Unit (MMDS) adopted an enhanced oversight quality improvement approach which required redefining responsibilities and authority. This enhanced approach reflected within the updated QMS, supports the mission of Delaware Department of Health and Social Services (DHSS) and other local divisions within DHSS. Key components within the mission include improving quality, improving health outcomes and in the most cost-effective manner for the vulnerable populations in Delaware. These populations include members in external Medicaid Managed Care organizations and the state run, Diamond State Partners (DSP). Further, the Children's Health Insurance Program (CHIP), and the newly implemented Medicaid Managed Long Term Care (LTC) enrollees in nursing facilities, home and community-based (HCBS) services, assisted living, and dually certified Medicare/Medicaid funded programs. Quality within DSP is managed through internal and external review mechanisms using DMMA, DSS, EQRO and DSP providers and community resources with the goals of improving DSP service delivery and identifying and correcting quality concerns. MMDS continues to rely on the QMS framework to communicate the State's vision, objectives, and monitoring strategies addressing issues of healthcare, cost, quality, and timely access. Quality is further enhanced through an interdisciplinary collaborative approach which involves partnerships with members, stakeholders, governmental departments and divisions, contractors, managed care organizations, community groups,

and legislators. The goal is to strengthen the shift from quality to continuous quality improvement with an internal tracking mechanism to ensure that all quality improvement activities continued to be monitored and evaluated for performance outcomes.

The Strategy employs multi-disciplinary, collaborative approaches to identify, assess, measure, and evaluate access, timeliness, and quality of care and services being provided to Medicaid clients. The goals and objectives integrated into the Quality Strategy serve as the guide to the program direction and scope defined under the 1115 Waiver requirements to achieve the following goals:

- To improve access to care and services for adults and children, with an emphasis on primary and preventive care, and to remain in a safe and least-restrictive environment.
- To improve quality of care and services provided to DSHP, DSHP Plus, and CHIP members.
- To control the growth of health care expenditures.
- To assure member satisfaction with services

Quality Strategy Implementation

DMMA, under DHSS has engaged a variety of methods to assure that MCOs develop and implement quality plans that meet the expectations communicated through the Quality Strategy, the managed care contract, and compliance requirements specified within BBA regulations. A reporting structure exists to support oversight monitoring responsibilities and to act as a mechanism for input and feedback into quality processes. DMMA assures

that it maintains administrative authority and implements DSHP Plus in such a way that the waiver assurances and other program requirements are met, either by the State or by the MCOs through specific contract provisions, including Level of Care (LOC) Determinations; Person-Centered Planning and Individual Service Plans; Qualified Providers; Health and Welfare of Enrollees; and Fair Hearings. The MMDS has identified the Quality Improvement and Initiatives Task Force (QII) as one of the mechanism to accomplish oversight responsibilities and from which to solicit input for improvement. The QII Task Force functions as a central forum for communication and collaboration related to quality strategies, plans, and activities. QII lead by DMMA includes participants from MCOs, other State agencies as well as the EQRO. This multi-disciplinary forum fostered collaborative efforts and created the opportunity for quality activities to cross programs that provided care and services to Medicaid participants. As active participants in the QII Task Force, the MCOs are expected to contribute to discussions regarding quality issues and to present findings or results of quality activities. Ultimately, the QII Task Force presents ongoing reports and status updates to the Medical Care Advisory Committee (MCAC). The MCAC is composed of community representatives, providers and DHSS representatives. The MCAC offers feedback and support for strategic quality issues.

Access to Care

Throughout this demonstration project, DMMA has desired to improve access to care and services for adults and children and to improve the quality of care to all participants. Prior

to the implementation of the demonstration project, primary care providers' (PCPs) and specialty providers', particularly obstetrics/gynecology (OB/GYN), availability and access were limited for the Medicaid population. As the implementation of managed care evolved, larger networks of primary and specialty providers became available. Due to assertive contracting efforts and enhanced partnerships, the network of available OB/GYN providers has continued to improve. The following quality activities have been implemented and validated through the annual EQR process compliant with BBA regulations and contract requirements:

All physicians who are interested in providing Medicaid services through the State's Medicaid MCOs must complete an application process and undergo a credentialing process compliant with Federal and State regulations and documented policy.

Ongoing monthly reporting of network changes and twice yearly Geo-Access updates, allow continuous monitoring of network status. This information is reviewed to assure that the network maintains access and availability standards as communicated in the contract and provider ratios of 1 PCP per 2,500 members.

As noted in Table I¹, the following demonstrates improvements in the provider network to improve access sufficient to meet the needs of the Medicaid population:

¹ See *Quality Improvement Tables document*

- *In 2010, there were 173 OB/GYN providers.*

- *From 2010 to 2011, the number of PCPs has been stable.*

- *Table I is a breakdown of the number of physicians available to the Medicaid Population in Delaware from 2010 through 2012.*

State Quality Assurance Monitoring

State Specific Mandatory Performance Reporting

The implementation design of the Medicaid Managed Care Programs, DSHP, DSHP Plus and CHIP, focuses on providing quality care to members in the State through increased access, and appropriate and timely integration of health care services. The goals of the QMS provide an ongoing reminder of the direction and scope of the 1115 waiver demonstration. The State has implemented a number of quality activities to engage providers and ensure members receive the highest possible quality care and services in a cost-effective manner. These activities include measuring and tracking performance, based upon specific performance measures, performance improvement projects, external compliance reviews by the External Quality Review Organization (EQRO), as well as member/provider surveys.

The EQRO reviews and technical reports are used to identify opportunities for process and systems improvement. These reports also helps the State determine levels of MCO

compliance with Federal and State requirements and assist with identifying strategies for continuous performance improvement.

The State has identified specific measures/HEDIS measures according to the overall goals of the QMS; access standards specific to access to care, structure and operations in accordance to the MCO contract and federal regulations; as well as a structured monitoring and evaluation process to assure ongoing oversight.² The MMDS Leadership Team monitors compliance with reporting requirements, selects measures and metrics for review to ensure that the MCOs are operating in the most efficient and effective manner consistent with federal and State requirements. The desired result is to seek out evidence of ongoing improvement efforts and improved member outcomes.

Currently the State requires a number of performance metric results to be reported on an annual, bi-annual, quarterly and monthly basis. The measures are submitted by the MCO in a State mandated format using State specific definitions by which to calculate and report. The metrics are submitted via an approved population based template titled, “Quality and Care Management Measure Report (QCMMR). The separate templates are specific to DSHP/CHIP populations, and DSHP-Plus population.³

Delaware Performance Improvement Projects

Performance Improvement Projects (PIPs) are an essential component of a MCOs quality program and are used to identify, access, and monitor improvement processes or

² See Table IV in *Quality Improvement Tables document*

³ See Table VI in *Quality Improvement Tables document*

outcomes of care. DMMA had mandated that each MCO conduct three PIPs. During the 2011 compliance review cycle, the State selected all three PIPs for independent validation by the EQRO. The State had mandated that topics for two of the PIPs: Prenatal/Postpartum Care and Inappropriate Emergency Department Utilization. The third required PIP was a topic that the State permitted the MCOs to select, based on the relevancy to its population and approval by DMMA as pertinent to the needs of the Delaware Medicaid and CHIP populations served. One MCO selected “Lowering Asthma related ED and Inpatient Utilization” while the other MCO focused on Lead Screening for Children. The State now mandates five PIPS. Going forward, the State has mandated that one of the five PIPs must be specific to the pediatric population, and two PIPs are related to the DSHP Plus population and encompass both clinical and service topics. Behavioral Health will be the focus for one of the PIPs for the Managed Long Term Care population.⁴

State Access Standards⁵

The State has incorporated all standards for access to care, structure and operations, and quarterly measurement and improvement in the MCO contract/RFP which is in accordance with federal regulations. This is done in an effort to demonstrate the State’s plan to provide adequate access to care for the Delaware DSHP, DSHP Plus and CHIP

⁴ See Table II & Table III for summary of PIP Validation conducted by the EQRO.

⁵ See Table VII in *Quality Improvement Tables* document

populations. DSHP Plus population has the same appointment standards as all other populations with Special Health Care Needs (SHCN).

State-selected, mandatory, HEDIS-specific reporting Metrics for MCOs

The EQRO validated the following PMs (Performance Measures for both MCOs)

Table VIII

MCO: 1	Measure	Topic
	1	Childhood Immunizations Status
	2	Comprehensive Diabetes Care
	3	Weight Assessment and Counseling for Nutrition and Physical activity for Children/Adolescents
	4	Antidepressant Medication Management

MCO: 2	Measure	TOPIC
	1	Childhood Immunization Status
	2	Breast Cancer Screening
	3	Comprehensive Diabetes Care
	4	Antidepressant Medication Management

Data contained within the tables below represents State-specific domains related to the use of services, access and availability of care and effectiveness of care. The associated national 75th percentiles provide benchmarks from which DMMA establishes ongoing performance targets. DMMA utilizes the HEDIS national Medicaid HMO 25th percentile for all utilization measures. The change in percentiles is due to the inverse nature of how

HEDIS reports the data. The performance measures have been broken down to reflect those pertinent to the adult population and those specific to the pediatric population. The State began a phase in of the full set of Pediatric Core Measures over three years, starting in 2011. The State will phase in the full set of Adult Core Measures over three years in a similar process, starting in 2014. Additional charts specific to DSHP Plus will be added as the program evolves.

MCO Quality Assurance Monitoring

The MCOs annually review their quality plans and results in an effort to evaluate their plan's effectiveness and to identify barriers to success and future opportunities. MCO annual evaluations and quality work plans are presented to DMMA for review and prior approval each year. In addition, the MCO and the Health Benefit Manager (HBM) are required to periodically submit status reports to assure ongoing efforts and status of progress to date. The MMDS Unit continues to review reports and used this information for early identification of issues, identification of timely resolution processes, or referral to the QII Task Force for further analysis.

Quality activities and results are communicated to providers through the provider newsletter or made available on the provider website. Quality information is

communicated to members by means of the Member Newsletter and educational information is disseminated to members during enrollment.

DMMA works closely with the MCOs and other partners through a variety of collaborative forums. Through these meetings, issues are identified, resolutions planned, and potential QIAs surfaced. The collaborative forums are:

- External: Managed Care Meeting: This is an open forum with participation by DMMA, other State agencies, MCOs, and the HBM. These monthly meetings are open to a public advocacy group and individuals with an interest in managed care.
- Internal Managed Care Meeting: These are monthly internal meetings designed to improve communication and coordination between DMMA managed care and each individual MCO.
- QII Task Force

Managed Care Organization reporting requirements

Quality Care Management Measurement and Reporting – QCMMR and QCMMR Plus

DMMA has developed separate QCMMR reporting templates, one for the DSHP and CHIP population and one for the DSHP- Plus population. All applicable reports will specify the DSHP-Plus population separately.

All MCO reports are provided on the following schedule

- Monthly reports will be due to the State on the 18th day of the following month.
- Quarterly reports will be provided to the State on the 18th day of the month following the end of each quarter.
- Annual reports will be submitted to the State on the 30th day of the month following the end of the calendar year.
- Exceptions to this schedule will be identified with the applicable report.⁶

The MCOs report on or provide the following:

HRAs – QCMMR and QCMMR Plus

CM and DM – QCMMR CM – QCMMR Plus

Timely access to provider appointments – QCMMR

EPSDT Access Reporting – QCMMR

Network availability – QCMMR

Customer service statistics – QCMMR and QCMMR Plus

UM - Inpatient services – QCMMR and QCMMR Plus

UM— Outpatient services and physician visits – QCMMR and QCMMR Plus

Education and Outreach – QCMMR

Choice/Community Tenure – QCMMR Plus

Access/Availability of HCBS – QCMMR Plus

⁶ See Table V in *Quality Improvement Tables document*

Safety and Welfare

Critical Incidents

Gaps in care

Quarterly reports – QCMMR and QCMMR Plus

GeoAccess updates are due every six months—February & August

Annual Quality Management Plans

The MCO reports HEDIS PMs, applying State specifications Financial Reporting

Provider Surveys: Both MCOs conduct Provider Satisfaction Surveys annually to help them determine how well they are meeting their provider expectations and needs. The findings are used to assist in identifying plan strengths and opportunities for improvement. The composites or attributes surveyed include: Utilization review, claims payment process, appeal process, care management, coordination of care, and overall satisfaction and ranking.

Results indicate that provider satisfaction levels during this period 2009 to 2012 are positive for both plans. Plans receive high results in the areas of call center services, provider relations, utilization and overall satisfaction.

Summary of EQRO Results

To further ensure MCO accountability, an independent External Quality Review (EQR) process is used. In 2010, 2011, and 2012, Mercer Health and Benefits LLC (Mercer) continued as the External Quality Review Organization for the State of Delaware's

Medicaid Managed Care program.

Individual and Side by Side MCO Comparison Dashboards

Mercer, as the EQRO, was requested by the State to develop both individual MCO and Side by Side MCO Comparison “Dashboard” reports using the mandatory monthly templates for Quality and Care Management Monitoring Report. These reports serve as an Executive Summary or “snap shot” of key indicators pertinent to assess the MCO’s performance in areas specific to the healthcare needs of the Delaware Medicaid population. Additionally, the State’s Actuarial Contractor produces similar reports from the financial templates.

Table VIII

Mercer conducted the following EQR and EQR-related activities:

2010	2011	2012
DPCI Compliance Review	DPCI Compliance Review	DPCI Compliance Review
DPCI Performance Measure Validation	DPCI Performance Measure Validation	DPCI Performance Measure Validation
DPCI Performance Improvement Project Validation DPCI Performance Measure Validation	DPCI Performance Improvement Project Validation	DPCI Performance Improvement Project Validation
	MCO Technical Assistance	MCO Technical Assistance
Unison (Now known as United Healthcare) Compliance Review	Unison (Now known as United Healthcare) Compliance Review Performance Measure Validation	UHCCP Compliance Review
*United Performance Measure Review	United Performance Measure Validation	UHCCP Performance Measure Validation
*United Performance Improvement Project Review	United Performance Improvement Project Validation	UHCCP Performance Improvement Project Validation
	DPCI Information Systems Capabilities Assessment (ISCA)	
	United Information Capabilities Assessment (ISCA)	

	MCO Comparison Reports: Quality & Care Management Performance Metrics	MCO Comparison Reports: Quality & Care Management Performance Metrics
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*2008 was the Baseline Line Year for Unison which became known as United Healthcare Plan in 2010.

To complete the EQR process, Federal Regulations for Medicaid Managed Care and Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) EQR Activity protocols were applied as well as State specific regulations, standards and requirements communicated to the MCO through its contract/Request for Proposal. EQR Technical Reports address detailed results of all processes reviewed. Corrective action processes are implemented for any areas not achieving full compliance and are monitored by the State and reviewed by the EQRO during the compliance cycle. EQR results and Technical Reports are integrated through the QII Task Force and the MMDS Unit. This information is used to identify potential areas of improvement or additional study.

2012 External Quality Review Summary of Findings

UHCCP Strengths

- Successfully implemented DE’s managed long term care (MLTC) program, DSHP Plus on April 1, 2012.
- With hiring , added a more robust compliment of senior staff to oversee the plan’s business operations.
- Implemented CM model of targeting members based on risk for adverse medical outcomes. Comprehensive assessments which provide the care manager with

information to build an individualized plan of care with the member

- DSHP Plus PIPs demonstrated an excellent understanding of the LTC population. Study topics relevant, well defined and clearly documented.
- UHCCP made improvements to the grievance process using a member –centric approach including member outreach activities.
- Compliance with Program Integrity Requirements

UHCCP Opportunities

- Building processes and mechanisms to stabilize senior level staffing and ensure continuity of business operations.
- Improvement in consistency in case file documentation of care coordination and outreach.
- Development of a more robust quantitative analysis of the measure eligible populations and ongoing qualitative analysis of interim measure results.
- Development of a more timely information systems solutions and implementation of updates to claims processing. Closure of communication and coordination gaps within the grievance system.

DPCI Strengths

- Successfully implemented DE's managed long term care program, DSHP Plus on April 1, 2012.
- Stable and dedicated senior leadership team with demonstrated commitment to integrity, excellence, inspiration.

- Strong partnership with and engagement with the provider community.
- Upgraded clinical platform to include additional disease specific assessments
- Improvements to the grievance process using a more member-centric approach.
- Improved documentation of provider selection processes.

DCPI Opportunities

- Timely implementation of interventions as well as critical evaluation and analysis of existing interventions.
- Maintain efforts with past corrective action.
- Sufficient training on new system for grievance processing.
- Supplemental education to providers on the appeal process

EQR Review Summary 2012

Table IX

	UHCCP	DPCI
Program Integrity	Compliant with regulations	Compliant with regulations
PIPs	<p>Maternity Care and outcomes: Decline in outcomes for all four measures. Need for a critical assessment of interventions and an evaluation of the existing CM approach to improve outcomes and increase validity of PIPs year over year.</p> <p>Reduction of Emergency Department Utilization:</p>	<p>Prenatal /postpartum care: Lack of data from Department of Vital Stats; results for 2011 could not be calculated for the two non-HEDIS measures: NICU and low birth weight. No statistically sig quantifiable improvements in outcomes documented. Interventions passive. Needs robust barrier analysis.</p> <p>Reduction of Emergency Department Utilization: ED utilization up but incidence of inappropriate utilization of the</p>

	<p>Year over year results of the overall ER department utilization improved. Identified dental access as a potential driver in ER utilization, Additional interventions need to be developed.</p> <p>Lead Screening: Rate of screening decreased from re-measurement year two (2010). Need to identify more robust and aggressive interventions to address all defined barriers at the member, provider, and plan level. Need to report PIP results based on combined Medicaid/CHIP population.</p>	<p>ED decreased in this third measure phase. Good discussion around dental access. Needs to identify community alternatives for services not part of benefit plan.</p> <p>Asthma Care: Second year of measurement with improvement in percent of members age 5 to 11 with an ED visit. All other measures show poorer performance. Initial re-measurement period results encouraging and demonstrate improvements from baseline measurement.</p>
Performance Measures Validation	<p>Lead Screening : Fully compliant Comprehensive Diabetes Care: Fully compliant Antidepressant Med Management: Fully compliant URI (Appropriate Treatment for Children): Fully compliant Mental Health Utilization: Fully compliant Ambulatory Care: ED visits: Fully compliant</p>	<p>Lead Screening: Fully compliant Comprehensive Diabetes Care: Fully compliant Antidepressant Med Management: Fully compliant URI: Fully compliant</p> <p>Mental Health Utilization</p> <p>Ambulatory Care: ED visits: Fully compliant</p>
ISCA	<p>Proper procedures in place for info system testing. Partial compliance in ISCA compliance level: systems; Met compliance with ISCA CAP compliance level.</p>	<p>Proper procedures in place for info system testing. Collection of newborn weight via claims on target. Partial compliance in ISCA compliance level; Met ISCA CAP compliance level.</p>

Findings & Evaluation

Progress toward Goal Achievement: Program Strengths and Accomplishments

Use of Benchmarks: Measures were historically calculated with Health Plan Employer Data and Information Set (HEDIS)-like specifications. Since January 2008, the selected Medicaid

performance measures were updated to change all measures to be HEDIS rather than HEDIS – like.

- Overall results reflect improvements in access across all measures and increases in screening or preventive care rates. For example, Well-Child visits in the third, fourth, fifth, and sixth years of life increased above the 75th percentile for Medicaid HMOs for the period ending in 2011. Improvement noted in Adults’ Access to preventive/Ambulatory Health Services for the age bands of 20-44 years and 45-64 years. There appears to be no measurable impact seen in HEDIS rates for immunizations, well visits and access in 2012, despite implementation of Healthy Living Program Incentives expansion.
- Breast and cervical cancer were still considered a high priority for the State and the intent has been to focus on prevention by increasing screening rates. These programs are coordinated with DPH and supported in part by tobacco funding. Breast cancer screening rates reflect a measurement period of one year and were collected from administrative data. Overall results from the two age bands (ages 42-51 and 52-69), while not yet above the 75th percentile for Medicaid HMOs, did show a slight increase in performance combined show a slight increase in the future, consideration could be given to supplementing data collection methods by adding chart reviews. Improvement in Breast and Cervical Cancer screening seen in 2012.

- Both Plans continue to focus on Cervical cancer screening rates. Going forward, both Plans will be held accountable to focus on improving screening results as with all HEDIS measures below the 75th percentile in performance.
- These rates had been stable and near the 75th percentile.
- Delaware continues to have a high volume of Medicaid participants with a diagnosis of diabetes, many of which are children. There is a sustained high level of interest throughout the State focused toward improving quality of care for those with diabetes. Three measures related to diabetic care continue to be included in the metrics and are still being addressed to enhance performance improvement levels. Those measures are HbA1c screening rates, retinal exams, and lipid screenings. The MCOs are conducting ongoing activities and strategies to improve compliance within this population known for non-compliance and co-morbidity issues related to overweight and obesity. A statewide collaborative effort with the Medical Society commercial MCOs, and other State agencies like Division of Public Health have been ongoing to work on improving this area. Interventions have included implementation of a Diabetes Member Incentive Program, member and provide outreach and education, as well as partnership with the Division of Public Health Diabetes Prevention and Education Program. Antidepressant Medication Management (AMM) which measures the percentage of members with major depression who were treated with antidepressant medication and who remained on antidepressant medication treatment. This measure continues to be an area of focus. Interventions have included:

Ongoing HEDIS provider Wellness Tool outreach, case management services for members hospitalized for major depression, as well as quality-intensified reviews to further analyze measure results which show marginal and not sustained improvement. Further interventions are planned to include more intense study of performance results.

- The rate of lead screening and lead levels has also demonstrated improvement.
- For the measurement period of 2009 – 2012 overall, measure performance showed slight improvement such as Appropriate Treatment for Children with Upper Respiratory Infection (URL). Diabetes Care has been identified as an area that will still require new strategies to combat the identified barriers across the spectrum for both member and providers.
- Performance Improvement Projects

Start Program, and its efforts to positively impact pregnancy and birth outcomes. The measures that result from this process will be presented to the QII Task Force and evaluated by the QA Unit. Barriers or opportunities to improve any aspects of the Mandatory PIP will be identified at that time. And DMMA in partnership with DPH and the Infant Mortality Task Force will assist in development of future next steps to improve the quality of perinatal care for Medicaid

participants. The Infant Mortality Task Force plans to work with the QII Task Force in analyzing and developing future opportunities.

Future Monitoring

Managed Care Organization reporting requirements: Quality Care Management and Monitoring Report: QCMMR and QCMMR Plus

Quality Assurance

The Quality Strategy has continued to provide the roadmap for quality assurance and quality improvement activities for improving the health outcomes of the Medicaid populations served in Delaware under this 1115 demonstration project. The specific goals identified within the strategy remain the focus going forward. Improvements have resulted in enhanced care and services Medicaid participants receive.

During the period 2009 through 2012, noticeable progress from both MCOs has been evident. It has been evident that the expertise of the corporate resources of both MCOs has made a positive impact on their local operations. Also evident is the dedication and commitment of the staff and the staff support which greatly facilitates the many tasks and activities necessary on an almost daily basis to ensure quality. The beneficiaries of this effort are the vulnerable population served as a result of this 1115 demonstration project, Delaware's Medicaid and CHIP enrollees. Efforts to successfully provide and achieve the best quality care and services possible, is the result of

much hard work and collaborative efforts in Delaware. While there is still room for improvement, efforts have been undertaken to refine the processes that have been stagnant so that more robust data review and analysis is conducted for more effective interventions and performance outcomes.

The Plans demonstrate full engagement at the senior leadership level which translates into full support of a continuous quality improvement program which continually explores efforts to improve beyond established goals for improvement and despite barriers that may be identified but challenging to overcome.

Accomplishments include, but are not limited to:

- * Deficiency-free file review for credentialing/re-credentialing as a result of improved processing.
- * Consistent Provider Satisfaction with associated increases in “Overall satisfaction and Loyalty” ratings of 92.4% in 2010. The 2009 rating was 90.5% for this same Plan.
- * Significant process improvement related to the Grievance System.
- * Both plans focusing on a number of interventions to improve HEDIS performance measurements. Interventions have focused on working with members to increase compliance with treatment plans; provider and member education programs, including Diabetic Education Courses offered through the Division of Public Health. Increased member outreach has been effective in providing member education.
- * Enhanced collaborative efforts with MCOs to address performance measure and identification of interventions for improvement.
- * Successful implementation of the new Managed Long Term Care Program for the Plus population in April 2012. The success included expansion of home delivered meals for this vulnerable

population. Additional accomplishments include the provision of Behavioral Health Services as part of the program,.

- * Successful monitoring of MCOs during the initial implementation year with joint State/MCO visits to members in the MLTC program. This monitoring has also included monitoring of member assessments/reassessments as well as MCO service plans for members.
- * System enhancements result in stronger care management functions including member identifications and health assessments.
- * Quality of Care and Services
- * DMMA strongly believes in its ability to positively impact the quality of care and services provided to Delaware Medicaid participants. This remains another driving force behind this demonstration project. There continues to be ongoing efforts to seek out opportunities for improvement through coordination and collaboration.
- * The selection of quality metrics has evolved over time and was influenced by multiple factors including the initial 1115 Waiver intent to improve access for children and adults, to focus on preventive care, and to improve access to care for pregnant participants to improve birth outcomes. Metrics have been selected based upon overall goals of the QMS, improvement levels and identification of additional and competing quality activities. The series of tables and metrics charts below have been updated to reflect overall quality performance goals, performance standards, and reporting requirements for the time period from 2009 to 2011⁷

Next steps to continue the identification of barriers and opportunities to achieve ongoing improvement will include:

⁷ See Table XII in *Quality Improvement Tables Attachment P*

- * A comprehensive review of the current set of quality metrics and PIPs and a more robust analysis of the performance of each.
- * Research more robust ways to identify and implement strategies and interventions which can be sustained over time and result in greater performance improvement..This will include full activation of an internal quality review team of subject-matter experts to monitor and review the quality data reports submitted by the MCOs with timely feedback and close monitoring of the implementation and evaluation of interventions for performance improvement.
- * Decisions will be made to retire, continue, or expand the measures based upon Medicaid program priorities reflecting participants' health care needs.
- * DMMA has submitted a report of the Children's Core Measures Set and is schedule to report on the Adult Core Measures Set starting in January 2014. The MCOs will be part of this reporting. .
- * DMMA elected to now require two Mandatory PIPs from each MCO specific to the Managed Long Term Care population. The topics will focus on a clinical aspect (Behavioral Health) and a service aspect..
- * Continue to expand the scope of the QII Task Force.
- * Maintain standardized and comprehensive reporting process on quality plans and activities with a more robust tracking mechanism for ongoing evaluation and improvement.
- * Continue QII Task Force reports to stakeholders to solicit feedback and collaboration with opportunities for improvement in quality plans in individual agencies and programs.

- * The QII Task Force will leverage member's resources to mentor and aid agencies in developing quality plans that meet CMS standards.
- * Work with the MCOs in the area of Care Management. The ERQ review has assessed that both plans have an opportunity to identify strategies and enhance care plan development and engage the collaboration between the primary care provider and the specialist (including those in the behavioral health field) to work along with the case manager in providing quality care to the enrollees.

DSP Quality Assurance

Quality within the DSP is managed through internal and external review mechanisms using DMMA, DSS, EQRO, and DSP providers and community resources with the goals of improving DSP service delivery and identifying and correcting quality concerns.

The DSP quality management program is under continual development to promote efficiency, integrating a more streamline plan under the current Quality Initiative Improvement (QII) Task Force (see Section IV.3. for more information on this task force).

Payment Methodology

Commercial Managed Care Organizations are paid on an actuarially sound per member per month capitated fee allocated to a tier system based on the complexity and medical demographics of various segments of the eligible population. Section VIII (3) contains a detailed description of this process.

Section VI – Diamond State Partners (DSP)

Description and Purpose of DSP

The State implemented Diamond State Partners (DSP) in July 2002 as an alternative to contracting with only one commercial managed care company. This program is a State operated managed care, case management program that currently enrolls under 3,300 clients. DSP, together with two other commercial plans, currently provides the network of care for the Delaware Medicaid managed care population. CMS has approved DSP as a Fee-for-Service primary care case management program. As stated earlier, it is the plan of the State to transition clients into one of two managed care organization; effective July 1, 2014.

- Member and Provider Services for DSP are contracted out. The current contractor is Hewlett Packard (HP) Enterprise Services. The responsibilities of the contractor to provide customer service to ensure that members and providers get the information and resources they need to expedite medically necessary services.
- As part of the transition plan for clients enrolling into managed care; coordinate with DMMA staff to communicate the changes to the current DSP membership. This population has not been accustomed to open enrollment changes; awareness training will be provided by the DMMA staff to HP to assist in ensuring that clients have a smooth transition into the new managed care organization of their choice.

1. Payment Methodology

DSP is a fee-for-service reimbursement program based on DMAP reimbursement rates.

Section VII – Plan Comparisons EQRO report comparing UHC and DPCI

The commercial Managed Care Organizations (MCOs) and Diamond State Partners (DSP) are very different delivery systems and, in general, are not comparable.

Chart VI.1 shows that both the MCO's and DSP are meeting and exceeding their goals in speed of answering calls from members.

Chart VI.1

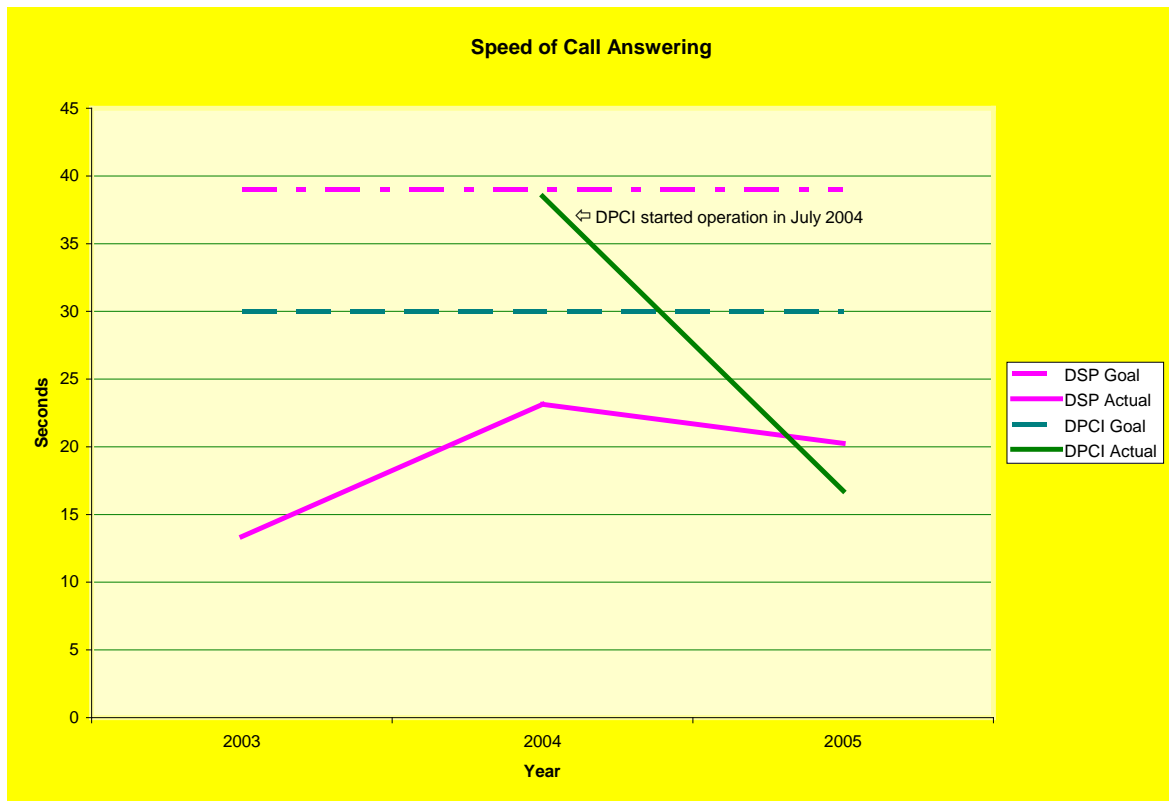
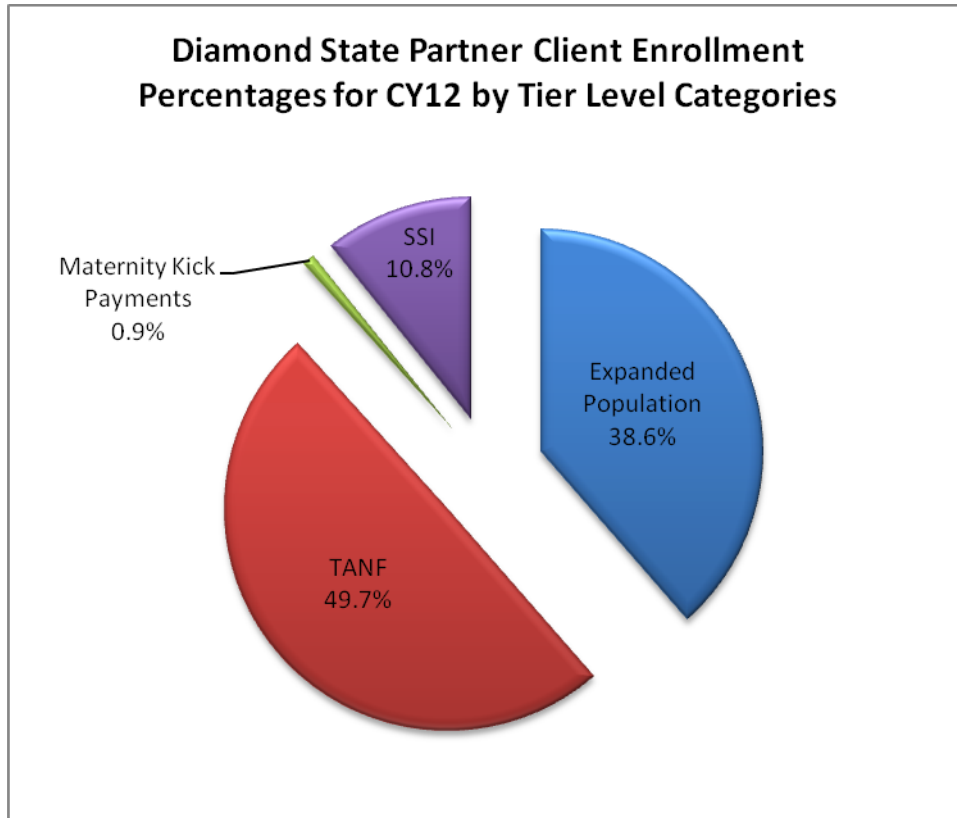


Chart VI.3 shows a comparison of the distribution of cases for 2012 in both the DSP and DPCI

plans.

Chart VI.3.



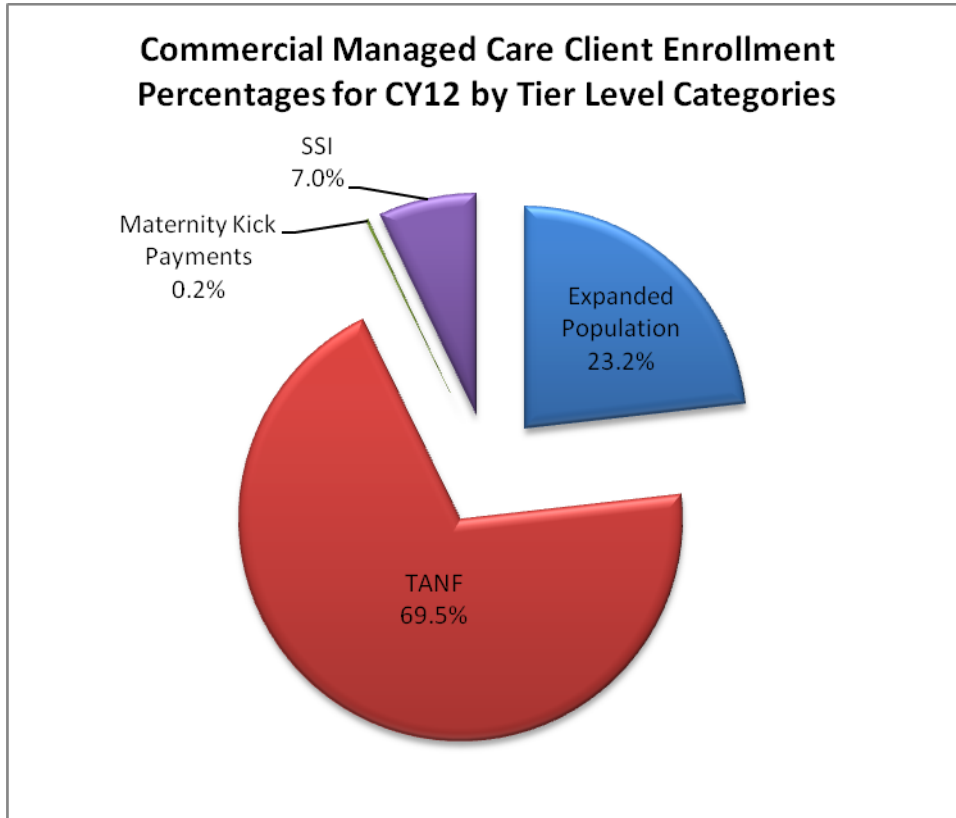


Table 1

2010				
	DSP	DPCI	Unison	Total Enrollment
January	7,863	82,637	42,693	133,193
February	7,822	82,926	42,911	133,659
March	7,699	82,763	42,650	133,112
April	7,820	84,550	43,927	136,297
May	7,797	85,606	44,646	138,049
June	7,847	86,689	45,031	139,567
July	7,429	88,201	45,591	141,221
August	7,367	89,803	46,641	143,811
September				

The Diamond State Health Plan
The Diamond State Health Plan Plus
2014 Extension Application

	7,414	90,975	47,116	145,505
October	7,432	93,309	48,714	149,455
November	7,500	94,806	49,671	151,977
December	7,535	95,689	50,267	153,491

Table 2

2011				
	DSP	DPCI	Unison	Total Enrollment
January	7,489	95,832	51,045	154,366
February	7,528	97,055	51,153	155,736
March	7,466	96,882	50,797	155,145
April	7,332	97,084	50,989	155,405
May	7,214	97,020	50,956	155,190
June	7,050	97,351	50,936	155,337
July	6,140	98,027	51,081	155,248
August	5,828	99,027	51,846	156,701
September	5,590	100,128	53,063	158,781
October	5,402	101,293	54,029	160,724
November	5,238	101,791	54,736	161,765
December	5,040	102,914	55,485	163,439

Table 3

2012				
	DSP	DPCI	Unison	Total Enrollment
January	4,852	103,490	55,935	164,277
February	4,741	103,434	55,996	164,171
March	4,529	103,803	56,314	164,646
April	4,284	109,097	60,824	174,205
May	4,140	109,490	60,711	174,341
June	3,892	109,755	60,833	174,480
July	3,492	109,851	60,520	173,863
August	3,316	110,613	60,837	174,766
September	3,191	110,961	61,181	175,333
October	3,070	112,200	61,796	177,066
November	2,977	112,725	62,129	177,831
December	2,881	113,129	62,107	178,117

Section VIII – DSHP and DSHP Plus Reporting and Evaluation

Reporting

The State's MMIS is HIPAA compatible and meets all of the criteria related to the 837 billing format. The 837 information is the minimum data set for all Encounter information. Encounter data is submitted to CMS via the MSIS tape.

The MMIS contractor (EDS) and the Project Manager at DMMA are responsible for monitoring the submitted data and ensuring that it is complete and meets all of the necessary criteria . Encounter data is monitored using the same edits and audits required of Fee-for-Service claims.

Encounter data is used by the State for rate setting and quality reporting among other reporting needs. Encounter data will continue to be submitted via the MSIS tape to CMS. The State contract with DPCI contains a shared risk arrangement. Encounter data is used to calculate this risk arrangement.

The State works with its MCOs and the EQRO to develop statistics relative to Health Care Quality Improvement. That data is submitted to CMS in the Quarterly Reports to monitor Quality Improvement. The Quality Improvement Initiative Committee (QII) meets every month to develop new performance measures for the next fiscal year.

Each report contains baseline data and comparison data based on the requirements set by the QII committee. Data is available electronically and Paper reports are also provided.

Validity of encounter data is tested and demonstrated to be accurate, as is all claims data. It must meet the same requirements that claims data meets for payment. Encounters that do not meet the necessary edits and audits must be resubmitted by the MCO. Since some payment and almost all performance measures rely on the accuracy of the Encounter Data the State expects that it will be highly valid.

1. Evaluation

The State has used the EQRO extensively to evaluate both the DPCI and the DSP portions of the DSHP. In this process, the entire operation of the DSHP waiver is evaluated.

- **2012:** DMMA submitted a draft evaluation design to CMS according to the Terms and Conditions of the 2011 – 2013 renewal application. The evaluation design is being reviewed by CMS.

Section IX - Conclusion

Health Status of Expanded Population Pre- and Post-DSHP Waiver

Prior to the implementation of the DSHP in 1996, medically uninsured individuals with incomes below 100% of the FPL received necessary medical care only when their condition reached a crisis level and they were treated on an emergency basis through the State's hospitals and clinics. This neglected population would have no choice but to decrease hours of, or cease, employment and put a strain on the resources of the State and on the ability of cooperating medical institutions to improve or ameliorate their health status. By allowing the State to add this population to a managed care program through this DSHP 1115 Waiver, this population, for the first time in many instances, has access to preventive health care and

coordinated services.

Waivers Requested for Extension

The requests continuance of the following waivers in order to efficiently and effectively administer the DSHP and DSHP Plus Programs:

a) 1902 (a) (10) (B) Comparability and Amount Duration and Scope

The managed care plan(s) offer a somewhat enhanced benefit package to the DSHP population than is offered to the traditional Medicaid population.

b) 1902 (a) (1) State wideness

With the re-bidding of the MCO contract, the DSHP may select contractors who wish to provide services only in certain geographical regions of the State.

c) 1902 (a) (23) Freedom of Choice

Delaware wishes to continue restricting freedom-of-choice of medical providers for the DSHP population to a single plan of choice for a period of one (1) year.

d) 1902 (a) (34) Retroactive eligibility

Delaware wishes to continue to exclude DSHP and DSHP Plus participants from receiving retroactive eligibility for up to 3 months prior to the date that an application for assistance is made, excluding individuals in Nursing Facilities. DSHP applicants are always approved retroactively to the first of the month in which they apply for coverage if they meet all Medicaid qualifying criteria.

Summary Statement

As demonstrated in this document, it is critical to Delaware to continue the successful 1115 Waiver in order to protect services for the expanded population. Delaware, through the Diamond State Health Plan and Diamond State Health Plan Plus, has done a remarkable job of maintaining and expanding health care for Delaware's citizens while other states have had to cut back on, or even curtail, some of their Medicaid and related services. Continuation of the demonstration waiver will allow the funding to keep this program viable.

Public Notice

Notice was published, in the May, 2013 Delaware Register of Regulations in accordance with the State's Administrative Procedures Act, of the intent to submit an application for renewal of this waiver for the five additional years. See ATTACHMENT L (*to be added). This waiver application document was published on the DMMA website effective 5/1/2013 for public viewing in accordance with the transparency regulations set forth by CMS. Public hearings will be held on 5/22/2013 and 5/23/2013. Comments submitted in writing as a result of the notice and subsequent responses will be provided to CMS as they become available as ATTACHMENT M (*to be added).

We look forward to ongoing cooperation with CMS in assuring that Delaware citizens continue receiving this much needed service enhancement/ expansion.