



Delaware Health and Social Services

Division of Medicaid & Medical Assistance

DIAMOND STATE HEALTH PLAN

Section 1115 Demonstration Annual Report

Demonstration Year: 19 (1/1/20115 – 12/31/20115)

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Introduction

The Diamond State Health Plan (DSHP) is a mandatory Medicaid managed care program operating under an 1115 waiver from CMS. Diamond State Health Plan covers approximately eighty percent (83%) of Delaware's Medicaid population.

For contract year 1996 forward, all Medicaid clients are eligible for the DSHP except for those clients in Long Term Care, Home and Community based waiver programs and/or dually eligible for Medicare and Medicaid.

All Medicaid benefits are included in the waiver package except, non-emergency transportation, extended mental health and substance abuse benefits and some specialized services for children. January 1, 2015 pharmacy benefits were added to the Managed Care Contract.

The State of Delaware is utilizing a Health Benefits Manager (HBM), enrollment broker, to provide outreach, education and enrollment for the Medicaid clients. The Managed Care Entities are not allowed to direct market to the Medicaid population, but may hold or attend health fairs, special events or school programs.

From July 1, 2002 to June 30, 2004 Diamond State Health Plan had contracted with one Managed Care Entity (First State Health Plan) and Diamond State Partners a Medicaid only, managed fee for service program, developed and implemented by the Division of Medicaid and Medical Assistance.

Diamond State Health Plan also provides for a level of mental health and substance abuse benefits.

On July 1, 2004 Delaware Physicians Care Inc., a subsidiary of Schaller Anderson, became the State's managed care option. This contract was renewed for the SFY 2006, beginning July 2005 and again July 1, 2006 (SFY 07).

On July 1, 2007 Diamond State Health Plan expanded the program by offering a second commercial managed care option. In addition to Delaware Physicians Care Inc. (DPCI) and Diamond State Partners, the Medicaid only, managed fee for service program, enrollees may also choose United Healthcare Community Plan (formerly Unison Health Plan of Delaware). The contracts between the state and these two managed care plans have been extended from July 1, 2011 to June 30, 2013, with additional option years.

On January 1, 2015 Diamond State Health Plan completed a successful RFP process and awarded two contracts to one incumbent MCO, United Healthcare Community Plan and one new MCO Highmark BCBS Health Options. Effective December 31, 2014 Diamond State Partners ended.

Enrollment Information

Demonstration Populations	Annual Ever Enrolled Year
Population 1: Tanf Children less than 21	89084
Population 2: Tanf Adults aged 21 and over	33,402
Population 3: Disabled Children less than 21	5,446
Population 4: Aged and Disabled Adults 21 and older	6611
Population 5: Infants less than one year of age with income levels above 185 percent FPL through 200 percent FPL; optional targeted low income children	None charged to Medicaid/Title XIX
Population 6: Uninsured Adults up to 100% FPL	48,914
Population 7: Family Planning Expansion	None; program terminated in 2013
Population 8: DSHP-Plus State Plan	9,056
Population 9: DSHP-Plus HCBS	3221

Population 10: DSHP TEFRA-Like	0
Population 11: ACA Adults at 101-133% FPL	9319
Total	205,054

Definition: “Ever enrolled” in MCO/PCCM is an unduplicated count of clients in the MCO for at least one day in the October 1 2015 to December 31, 2015 period based on capitation claims and for the PCCM, MC enrollment and eligibility files. Clients who were in more than one eligibility category during the quarter are reported based on their last status (most recent month). Age is calculated as of the first day of the most recent month of enrollment, consistent with reporting of member months.

Outreach/Innovative Activities

United Healthcare Community Plan – (UHC)

The MCOs continue to be very active in the community engaging their client. Some activities include but not limited to”

Health Conferences

Diabetes Quality Expo

2015 World Aids Day Summit

Senior Centers

The State’s Health Benefits Manager (HBM)

HBM Ongoing Activities & Objectives

- Continue to educate clients about the two health plan options
- Continue to provide ongoing caseworker training about DSHP, DSHP Plus and DHCP
- Continue to assist clients with complaints or issues concerning their managed care
- Continue tracking caseworker assistance performed by Outreach representatives
- Continue the process by which Outreach representatives consistently follow-up with caseworkers who need education, based on telephone calls from clients and caseworkers
- Continue to offer translation services for Spanish-speaking clients at selected State Service Centers statewide, for both oral and written translations
- Continue to supply representatives for oral translations by phone, for caseworkers and clients
- Continue to deliver the HBM monthly newsletter and distribute it to all caseworkers

For more detailed information regarding all our activities this quarter please see **Attachment-A** the HBM Annual report and **Attachment B** the HBM Monthly Newsletters.

Special Interest Meeting/Conference

Delawareans with Special Health Care Needs

DE Medicaid continues to support the Delawareans with Special Health Care Needs (DSHCN). The DSHCN host the bi-monthly MCO telephone panel discussion which includes an hour devoted to individuals under Delaware's Diamond State Health Plan Plus program. In addition, they host a bi-monthly MCO telephone panel discussion specifically focusing on child/adolescent behavioral health issues. DE Medicaid provides liaisons from both the policy unit and medical management unit to DSHCN who attend each of these bi-monthly MCO panel discussions and follow up with any topics discussed which require additional action.

Delaware Family Voices (formerly Family to Family Health Information Center)

DE Medicaid continues to support Delaware Family Voices. DE Medicaid provides liaisons to Delaware Family Voices who serve on their Family Leadership Advisory Council (FLAC). FLAC is the body of representatives of stakeholders, partner agencies, and interested community members that make suggestions for the direction and future goals for Delaware Family Voices. These liaisons as well as other DMMA representatives participated in three calls this quarter; October 13th, November 10th and December 8th.

Operational/Policy Developments/Issues

MCO RFP implementation updates

On January 31, 2014 DHSS issued HSS 14-019 for the procurement of MCOs to provide statewide managed care services for the Diamond State Health Plan (DSHP) and the Diamond State Health Plan Plus (DSHP Plus) programs.

Bids were received and evaluated; scored and oral presentations were delivered. DMMA has successfully contracted with two managed care organizations to deliver the Medicaid benefit to our clients. DMMA awarded the contract to one incumbent and one new managed care organization, United Healthcare Community Plan and Highmark BCBS Health Options. The new MCO contract started January 1, 2015.

We continue working closely with the MCO's continuing to monitor contract compliance. We meet monthly with each MCO to discuss any outstanding issues including pharmacy and provider billing concerns and any other operational questions that might arise.

Delaware Medicaid Enterprise System (DMES)

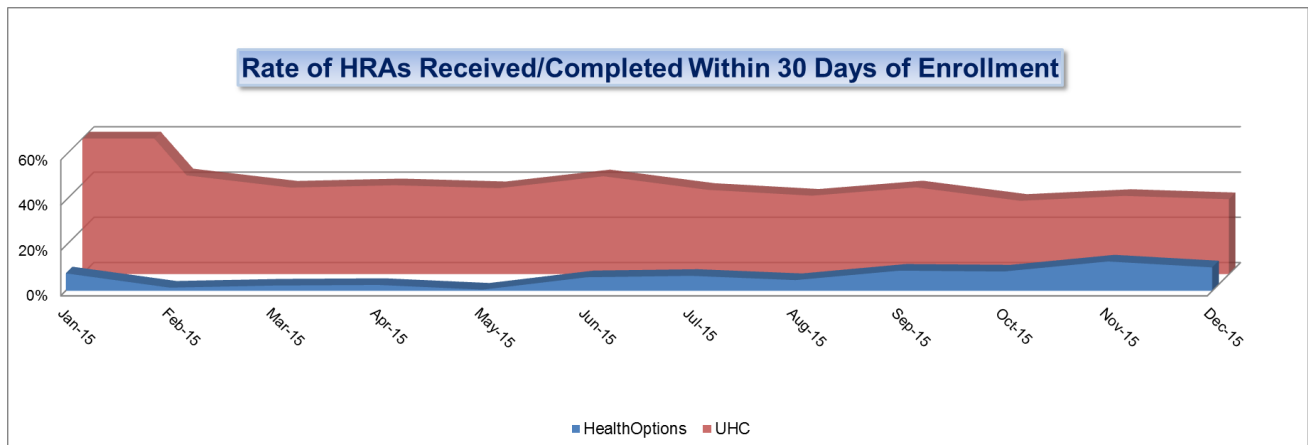
Throughout the year staff and HPE continue to develop DMES or Delaware Medicaid Enterprise system. The target date for 'go-live' is July 1, 2016.

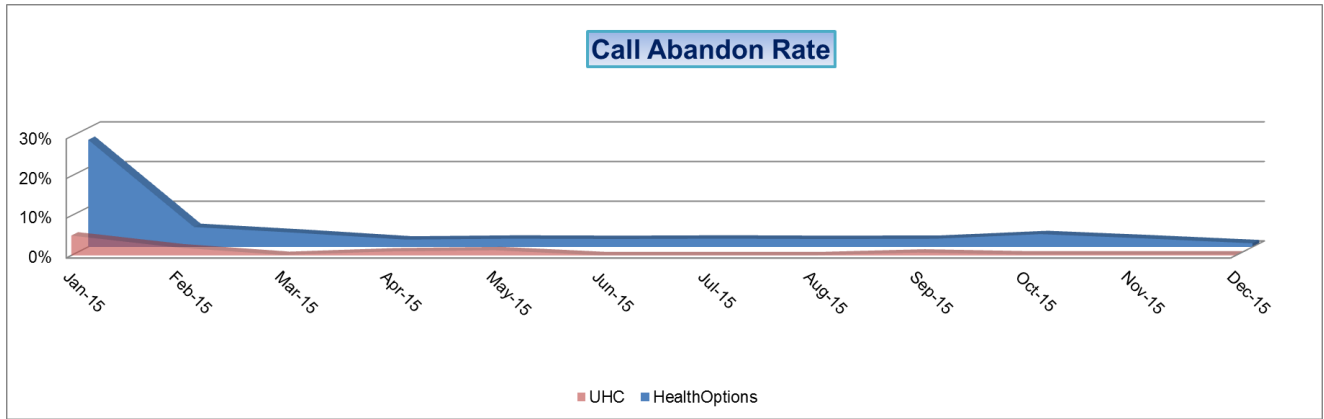
QCMMR and QCMMR Plus Reporting

The Medical Management Managed Care Team has developed and refined our **Quality and Care Management Measurement Reporting Templates (QCMMR) and QCMMR Plus**. The QCMMR reports on the DHSP and CHIP Medicaid Populations while the QCMMR Plus reports on the DSHP Plus population. The Medical Management Managed Care Team worked in conjunction with Mercer, our EQRO contractor and the MCOs in developing the guidelines and reporting templates. The QCMMR and QCMMR Plus was developed as a method to specify the metrics to be reported monthly, compare metrics for the two commercial health plans, monitor the results at the State level, and roll up the results quarterly and annually for executive level reporting on the managed care program. The metrics or measures flow from contractual requirements or federal or state regulations contained in the Managed Care program contract.

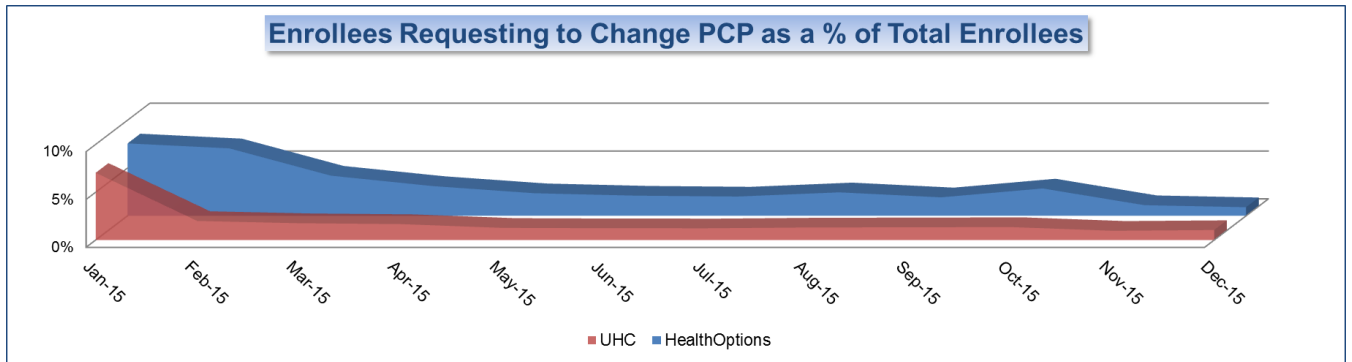
DMMA Medical Management unit developed the full circle approach to the QCMMR and QCMMR Plus reporting. The reports are reviewed by the Medical Management team and an agenda is developed for our monthly meeting with each MCO to discuss the findings from the reports. Medical Management's goal is to establish a partnership with the MCOs to improve quality of care for our Medicaid population.

DMMA continues evaluate the QCMMR reports for both DSHP and DSHP Plus populations.





<p>Variance from goal:</p>	<p>Improvement actions to address variances: HO (Dec) We have identified trends in abandoned calls which appear to point to a systematic issue with dropped calls. We are working with our IT business partners to identify and resolve the issue, which is dramatically negatively impacting our results. New CSRs will be added as of 12/14 for support of improvement of stats and we are continuing with mandatory overtime Monday-Thursday of each week in order to help pick up service level across. We are refining the overtime by hour in order to maximize available staff.</p>
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Variance from goal; (UHC): The PCP change request data has been updated to reflect the correct count for the month of July, due to date entry error.

Quality Assurance and Monitoring Activity

The Delaware Quality Management Strategy (QMS), under the Medicaid Managed Care 1115 Waiver, incorporates Quality Assurance (QA) monitoring and ongoing Quality Improvement (QI) processes to coordinate, assess and continually improve the delivery of quality care. The Quality Improvement Initiative (QII) Task Force is a dynamic collaboration between community partners, professional organizations, State agencies, advocacy groups, and Managed Care Organizations (MCOs). The Task Force, facilitated by the Division Medicaid and Medical Assistance (DMMA) participates in oversight and monitoring of quality plans and improvement activities of Medicaid and Title XXI DHCP funded programs based upon the goals of the State of Delaware Health & Social Services/ Division of Medicaid and Medical Assistance/Quality Management Strategy 2015. These goals are: 1 To improve timely access to care and services for adults and children with an emphasis on primary and preventive care, behavioral health and to remain in a safe and least-restrictive environment; 2 To improve quality of care and services provided to DSHP, DSHP Plus, and CHIP members; 3 To control the growth of health care expenditures; and 4 To assure member satisfaction with services.

These goals serve as a basis for guiding the QII Task Force activities and quarterly discussions. The Task Force guiding values and principles are: to seek to achieve excellence through on-going QII activities; to employ a multi-disciplinary approach; to identify, measure and access timeliness and quality of care of services to members; to hold providers of care accountable; to identify collaborative activities; to achieve cultural sensitivity; to link the community and other advocacy and professional groups; and to create a forum for discussion and open exchange of ideas.

DMMA Medical Management unit developed the full circle approach to the QCMMR and QCMMR Plus reporting. The reports are reviewed by the Medical Management team and an agenda is developed for our monthly meeting with each MCO to discuss the findings from the reports. Medical Management's goal is to establish a partnership with the MCOs to improve quality of care for our Medicaid population.

MCOs are required to conduct Performance Improvement Projects (PIPs) that are designed to achieve through rapid interventions and measurements, significant improvement, sustained over time, in clinical and non-clinical areas are expected to have a significant effect on health outcomes and/or member satisfaction. MCOs may create as many PIPs as they wish, but they must have a minimum of five. DMMA defines the requirements for two of the PIPs; a third is the MCO's choice; a fourth pediatric, and a fifth related to a service provided. The mandatory PIPs are Oral Health and Behavioral Health and Physical Health Integration. A series of Technical Assistance sessions were developed and the first of the series was provided by the External Quality Review Organization to

assist with incorporating Rapid Cycle Analysis methodology and techniques into the performance improvement project process.

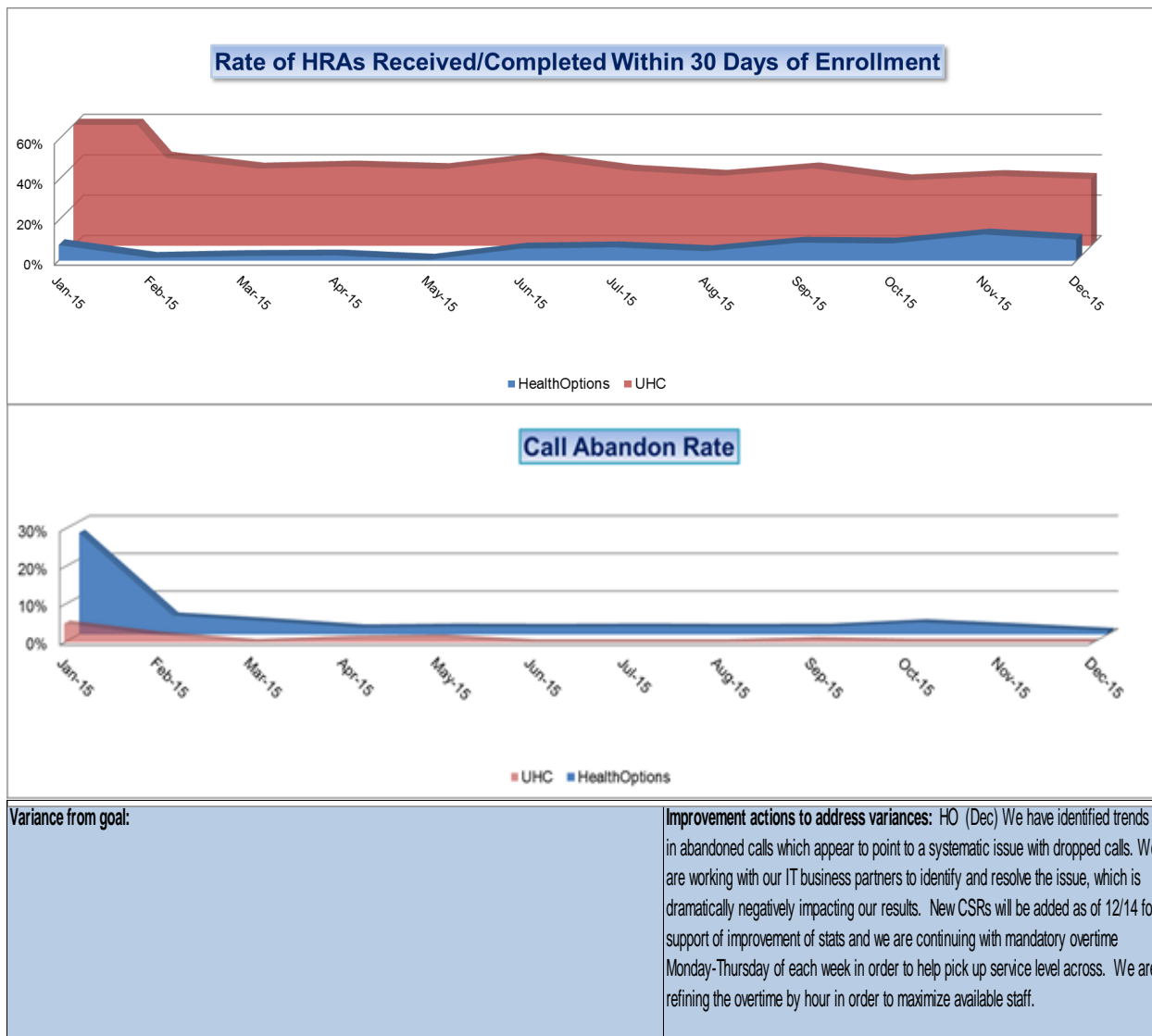
Medicaid HIT projects with the MCOs DHIN, and DMMA monthly technical meetings to discuss HIT initiatives and current projects has been reinstated. We are discussing a process for Highmark Health Options to receive the Emergency Department (ED) Admissions, Discharge and Transfer (ADT) messages from several Delaware hospitals. UHC continues to receive the messages. Both MCOs must execute an agreement with the DHIN to pay a PM/PM fee for the connection to this and other types of member data. In addition, the DHIN will set up a process for clinical viewing of patient data for the MCOs based on a “watch list” of prioritized members. Our initial meetings the week of March 13th established representatives from the MCOs and the DHIN to begin setting up implementation and planning work groups for HIT projects.

The **Medical Case Management Unit/DMMA** has continued with oversight of the DSHP Plus population and oversight of Care Coordination of those members identified by the MCO’s in their Risk Stratification. This oversight has been accomplished through site reviews at the MCO’s and joint State/MCO visits with members of the DSHP Plus population. We continue to monitor the required Case Management and Care Coordination reporting from the MCO’s. Including, but not limited to the Care Coordination Reports, Case Management Plans and improvement strategies, Over and Under Utilization Reports and Service Coordination Reports. DMMA continues with monthly meetings with each MCO. This provides a forum to discuss any case management issues in a collaborative manner. DMMA has also initiated bi-monthly meetings with the LTC Units and the MCO’s to facilitate efficient and timely MCO enrollment of eligible members.

DMMA has concentrated its efforts on ensuring complete reporting of the required Case Management, Utilization and Care Coordination report from the MCO’s, ensuring the MCO’s are identifying members at the highest risk for adverse health outcomes and providing clinical care coordination. DMMA continues to provide ongoing case management oversight to ensure all the populations served are receiving the highest quality and comprehensive services in the most cost effective manner. DMMA has now completed over 200 joint State/MCO visits, initiated our Second quarter Case File reviews at both MCO’s. All findings are reviewed with the MCO’s to identify issues and plan resolution.

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Variance from goal:

Improvement actions to address variances: HO (Dec) We have identified trends in abandoned calls which appear to point to a systematic issue with dropped calls. We are working with our IT business partners to identify and resolve the issue, which is dramatically negatively impacting our results. New CSRs will be added as of 12/14 for support of improvement of stats and we are continuing with mandatory overtime Monday-Thursday of each week in order to help pick up service level across. We are refining the overtime by hour in order to maximize available staff.

PROMISE (Quality Program)

The 1115 Waiver demonstration DSHP Medicaid section was approved for amendment. This approval allowed the State of Delaware to assist Medicaid beneficiaries with their behavioral health and functional needs by creating the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) program which began January 1, 2015. The Division of Medicaid and Medical Assistance (DMMA) worked with the Division of Substance Abuse and Mental Health (DSAMH) who restructured a portion of the service delivery system for persons with persistent mental illness (SPMI) and functional limitations through a case management structure. PROMISE requires DSAMH to assess and refer clients to community-based services in an effort to decrease the potential for unnecessary hospitalization. These additional services are funded via the State Plan Amendment, as a CMS Medicaid waiver option. The PROMISE waiver went into effect on January 1, 2015. The DMMA, through its Quality Management Strategy and structure maintains

quality oversight responsibilities for the PROMISE programs. The following is a summary of the results of the annual evaluations and lessons learned from the first year of this initiative.

The oversight of this program is evaluated following the goals of the State of Delaware Health & Social Services/ Division of Medicaid and Medical Assistance/Quality Management Strategy 2015:

- To improve timely access to appropriate care and services for adults and children with an emphasis on primary, preventative, and a behavioral healthcare, and to remain in a safe and least-restrictive environment.
- To improve quality of care and services provided to Medicaid and CHIP enrollees
- To control the growth of health care expenditures
- To assure member satisfaction with Services

The PROMISE has four major components: Client Assessment, Client Enrollment, Client Monitoring and Client Billing. The following information will provide detail regarding implementation, monitoring and analysis of the system’s performance in these areas.

Performance Area (s)	Successes	Identified Opportunities for Improvement	Lessons Learned / Strategic Planning
Client Assessment <u>Current Status:</u> Moderate backlog 510 Clients <ul style="list-style-type: none"> • 382 NCC • 39 Kent • 89 Sussex 	<ul style="list-style-type: none"> • Clients are receiving individualized, person-centered evaluations designed to ensure their care needs are met in a community-based setting 	<ul style="list-style-type: none"> • Decrease time for conducting assessments • Maximize coordination efforts with community providers to increase opportunities to assess clients 	<ul style="list-style-type: none"> • Conducting client assessments has proven to be a time consuming process. DSAMH recently redesigned the assessment tools to gain efficiencies. • DSAMH has partnered with community providers to increase the number of opportunities available to complete assessments
Client Enrollment <u>Current Status:</u> Moderate backlog 510 Clients <ul style="list-style-type: none"> • 382 NCC • 39 Kent 89 Sussex	<ul style="list-style-type: none"> • Clients are enrolled in the PROMISE system within an average of 5 business days after being identified as eligible for PROMISE services 	<ul style="list-style-type: none"> • Strengthen collaboration between the Eligibility and Enrollment Unit (EEU) and the fiscal department. 	<ul style="list-style-type: none"> • Client enrollment is a shared function between the EEU and the fiscal department. The EEU confirms the client’s eligibility and the fiscal unit enters the client’s information into to the PROMISE payment system. DSAMH used its Management Information Systems unit to automate processes thereby creating internal audit functions to reduce the likelihood of client enrollment errors.
Client Monitoring	<ul style="list-style-type: none"> • Client monitoring for 	<ul style="list-style-type: none"> • Organize survey findings 	<ul style="list-style-type: none"> • The monitoring process

Performance Area (s)	Successes	Identified Opportunities for Improvement	Lessons Learned / Strategic Planning
<p><u>Current Status:</u> Care standards for enrolled clients are being monitored as intended</p>	<p>individuals enrolled in PROMISE is completed by DSAMH care managers to ensure clients receive quality treatments. Any issues or concerns identified during the survey process are immediately investigated and addressed as appropriate.</p>	<p>in manner that identifies trends related to systemic performance.</p>	<p>yields rich data. DSAMH mines these data elements to identify trends regarding both strengths and weaknesses in the PROMISE delivery system.</p>
<ul style="list-style-type: none"> Client Billing : 	<ul style="list-style-type: none"> Medicaid Clients are not billed directly for any portion of their services. 	<ul style="list-style-type: none"> Continue to monitor to ensure Medicaid clients are not billed for services. 	

Monthly reports are provided to the DMMA for review which includes total enrollees into the program, care management assessments, choice for individualized care planning needs assessed and service plans reflect services authorized are appropriate to the level of care. The initial evaluation tool was not streamlined and, while captured good data, clients were often unwilling to complete the entire evaluation. The tool was redesigned and currently, captures the salient data and is not over burdensome to the client.

Critical Incident reporting is also provided monthly which is tracked according to timeframes and outcomes of the Critical Incidents; whether a Critical Incident was substantiated or unsubstantiated.

The Division of Substance Abuse Mental Health is gathering data on satisfaction of their clients and plan to report this information annually.

Survey

Hewlett Packard Enterprise (HPE), Delaware’s Health Benefits Manager (HBM) conducted an annual survey of 3000 clients during open enrollment. Of that number, 95 clients replied. Ninety-five percent found the process helpful; 85% reported that the HBM answered all of their questions and concerns regarding their health insurance; and 87% found written enrollment materials easy to read. Seventy-eight percent knew they could call the HBM at its toll-free number with questions or concerns about their benefits. Seven to nine percent reported that the HBM handled their complaint or question “somewhat” to their satisfaction. Fifty percent 50% knew service center reps were there to help. One person wrote, *I like how they treat me.*

Survey Questions. The information below compares 2014 with 2015.
Question Parameter Results

HBM survey 2015 Results			Results: 2 years	
Q#	Survey Question		2014	2015
1	How helpful was the person you talked to when enrolling in your Health Plan?	very helpful	81%	79%
2	When you joined your health plan did the person you spoke with talk about a primary care doctor, specialist referrals, emergency room use, and insurance cards?	yes	64%	77%
3	Did the person you spoke with answer all your questions /concerns regarding your health plan?	yes	60%	67%
4A	Did you find the enrollment materials easy to read?	yes	90%	87%
4B	Did you understand the information?	yes	87%	87%
5	Do you know you can call 1-800-996-9969, the health benefits manager (HBM) for help or information about your health services?	yes	83%	78%
6	If you have called the HBM with a complaint or question, was your complaint or question handled to your satisfaction?	yes	80%	79%
7	Do you know what to do if you have a complaint or a problem with your health services?	yes	58%	67%

OII Activity

In the fourth quarter reporting cycle, the second of the series of Technical Assistance on Rapid Cycle Assistance (RCA) methodology was provided to all quality program participants; those responsible at DMMA for quality oversight, MCO oversight, MCO organizations staff and team members as well as to key leadership positions. The two mandatory performance improvement projects (PIPs), Oral Health and Behavioral Health and Physical Health Integration, were submitted to the Division of Medicaid and Medical Assistance Quality team using the RCA techniques learned. These submissions will be reviewed by the Subject Matter Experts and feedback provided to the MCOs on their submissions.

Case Management Oversight

The Medical Case Management Unit continues with Case Management oversight of the DSHP Plus population and has increased the Care Coordination oversight of members identified thru Risk Stratification by the MCO's.

Our Medical Case Management team has completed two of our 4th Quarter MCO site reviews, our Case File Review and LOC Redetermination review. We continue to complete an exit interview and report after each review, which we have received positive feedback from the MCO's. We are working with the MCO's to improve timely LOC redeterminations and all members are reported when due for redetermination. Both MCO's have implemented internal process's to improve timely

and accurate LOC redetermination dates and are utilizing the MoveIt file to transmit member information.

We have expanded our MCO Joint Visits to include the DSHP members receiving face to face visits. Our Joint Visit Nurses are averaging 2 visits per day, they are completing the majority of those visits in community settings and averaging 1-2 Nursing Facility visits/week. We have a workgroup drafting updates to our Joint Visit tool. We continue to work closely with the MCO Compliance Officers to ensure the reports are complete and submitted timely.

We have coordinated with the Operations team and developed a workgroup to review our current QCMMR and update our metrics to ensure we are collecting meaningful data that is not duplicative of our reporting requirements. We continue to work with our EQRO team to ensure quality data.

We are coordinating MCO Appeal hearings with the Operations team; evaluating Death Investigation Assessments involving members enrolled in MCO's to ensure the MCO's are providing consistent Care Coordination.

We are working with our EQRO team to facilitate the MCO's participation and completion of the member surveys and MCO self-assessments per the Home and Community-based Setting Requirements mandated by CMS.

Managed Care Meeting

Throughout the year, the State conducts Bi-Monthly Managed Care meetings, used to provide a forum to discuss issues in a collaborative manner. The meeting is used to collaborate on common practices, identify issues, plan resolutions and identify potential Quality Improvement Activities.

DMMA was very involved with both MCOs during implementation of the new contract meeting with the MCOs on a daily basis during the first quarter 2015 which caused us to delay the start of the bi-monthly MCO meetings. DMMA continues to meet individually with the MCOs on a variety of issues, questions and concerns. DMMA is starting the MCO Bi-Monthly meetings on March 15, 2016.

Medicaid Special Bulletin

This bulletin is given to our Medicaid Providers on a quarterly basis. Throughout the year, the following topics were addresses

Exciting Changes are coming in 2016

Electronic Health Records (E H R) Incentive Payment Program Update

Important Preadmission Screening and Resident Review (PASSR) information

DMAP Implements ICD-10

Ordering/Referring/Prescribing (O/R/P) Provider Enrollment

Take Action Now – Be Prepared for ICD-10 This October
Medicaid Pharmacy Prior Authorization Information for Members in Managed Care
Attention: Providers Enrolled Under the Division of Developmental Disabilities Services Program
Delaware is getting a New Medicaid Enterprise System
Initiative to Decrease Unintended Pregnancies
Electronic Health Records Incentive Payment Program Update
Oral Health Screening and Floride Varnish for Medical Professionals
Delaware Cancer Treatment Program Update
Payment Error Rate Measurement (PERM) Update
Provider Manual Updates
Phone and Fax Contacts
New Payment Error Rate Measurement (PERM) Cycle
Provider Manual Updates
Phone and Fax Contacts
Managed Care Program Changes
Pharmacy Benefit Change
Electronic Health Records Update
VFC Program update
Delaware Cancer Treatment Program Update
Dental
New Payment Error Rate Measurement (PERM) Cycle
ICD-10
2015 Disclosure
Provider Manual Updates
Phone and Fax contacts

We have attached the entire Fourth Quarter 2015 Medicaid Special Bulletin: **Attachment C.**

Expenditure Containment Initiatives

DMMA doesn't have any new cost containment initiatives to report for this quarter.

Financial/Budget Neutrality Development/Issues

Budget Neutrality Workbook – not attached at this time.

Member Month Reporting

A. For use in budget neutrality calculations –

<u>Eligibility Group</u>	Average 2015
DSHP TANF CHILDREN	252,228
DSHP TANF ADULT	156,374
DSHP SSI CHILDREN	16038
DSHP SSI ADULTS	19418
DSHP MCHP (Title XIX match)	0
Expansion Group <100% FPL	125,810
New ACA Adults 101 to 133% FPL	25,357
FP Expansion	0
DSHP-Plus State Plan	26,310
DSHP-Plus HCBS	9,355
DSHP TEFRA-Like	0
MCHIP Title XXI Chip Funds	0

Consumer Issues

HP, our Health Benefits Manager (HBM), continued to assist us in several ways:

Program Integrity

DMMA continues to work closely with our MCOs on reporting fraud, waste and abuse. Program Integrity has quarterly meetings with both MCOs and other outside agencies.

Family Planning Expansion Program

Delaware's Family Planning waiver was discontinued per the 1115 Waiver on December 31, 2013.

Demonstration Evaluation

DMMA has submitted a draft evaluation for CMS' review.

Enclosures/Attachments

Attachment A–

- Health Benefits Manager Annual Report 2015
- DSHP Enrollment Summary
- Telephone Summary
- Outreach Report
- DHCP Report
- HBM Objectives

Attachment B –

- 2015 HBM Monthly Newsletters

Attachment C–

- 2015 Medicaid Special Bulletin

State Contact(s)

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