



Delaware Health and Social Services

Division of Medicaid & Medical Assistance

DIAMOND STATE HEALTH PLAN

Section 1115, 2017 Annual Report

Demonstration/Quarter Reporting Period

Demonstration Year: 22 (1/1/2017 – 12/31/2017)

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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 ninety percent (90%) of Delaware's Medicaid population.

The delivery system for DSHP is mandatory enrollment in MCOs. Individuals eligible for DSHP-Plus receive comprehensive, integrated LTSS and individuals eligible for PROMISE services receive an

enhanced package of behavioral health services. A limited number of benefits, such as children's dental and non-emergency transportation, are delivered through fee-for-service. PROMISE benefits are delivered through the fee-for-service PROMISE program administered through the Division of Substance Abuse and Mental Health (DSAMH).

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.

History of MCO Contracts:

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.

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 April 1, 2012, Diamond State Health Plan expanded to include dual eligibles and managed long term services and support under DSHP Plus through the existing MCOs.

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

On January 1, 2018 Diamond State Health Plan completed another successful RFQ process and awarded two contracts; one incumbent MCO, Highmark Health Options and one new MCO AmeriHealth Caritas DE. Effective December 31, 2017, United Healthcare Community Plan contract ended.

Enrollment Information

Demonstration Populations	Ever Enrolled
Population 1: TANF Children less than 21	101,758
Population 2: TANF Adults aged 21 and over	37,298
Population 3: Disabled Children less than 21	5,705
Population 4: Aged and Disabled Adults 21 and older	6,843
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	66,123
Population 7: Family Planning Expansion	None; program terminated in 2013
Population 8: DSHP-Plus State Plan	10,590
Population 9: DSHP-Plus HCBS	4,787
Population 10: DSHP TEFRA-Like	0
Population 11: ACA Adults at 101-133% FPL	15,555
Total	248,659

Definition: For most groups below, the 1115 enrollment is an annual unduplicated count of clients in the MCO for at least one day in January 2017 thru December 2017 based on Medicaid MCO paid capitation claims. In addition to MCO enrollees, the counts of Uninsured Adults below 133% FPL (Population 6 and 11 below, also referred to as VIII group Newly and Not Newly Eligible Adults) include clients who were Medicaid eligible in 2017 but not enrolled in MCOs (they were awaiting managed care enrollment or were inmates with hospital stays.) DMMA is including all costs (not rebate) for these adults in 1115 Waiver reporting per CMS instructions.

MCO Outreach/Innovative Activities

The MCOs continue to be very active in the community and their members. Some activities include:

- Sixteens Annual Diabetes Wellness Expo
- Annual Breast Cancer Awareness events
- School health and teen health fairs
- Christiana Care Women's Health Navigator annual "Every Women Counts" health screening event
- Community health fairs

The State's Health Benefits Manager (HBM)

HBM Ongoing Activities & Objectives

- Continue to educate clients about the two health plan options
- Conduct annual open enrollment and assist with a smooth transition to the new MCO for 2018
- 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

Delaware Family Voices

DE Medicaid continues to support Delaware Family Voices. Caring for children with special needs is often complex, and Delaware Family Voices and the Family to Family Health Information Center is in the unique position to help. They help families of children with special needs become informed, experienced, and self-sufficient advocates for their children and themselves. DMMA and our managed care organizations, Highmark Health Options and United Healthcare Community Plan participated in monthly calls assisting families to navigate the complex healthcare field. DMMA stays in contact outside of scheduled calls to provide assistance to any Medicaid family in need.

Operational/Policy Developments/Issues

Regulations

During 2016 and 2017, DMMA focused on ensuring policy, contractual and operational compliance with the Medicaid managed care final rule and HCBS settings final rule, as required by the DSHP 1115 special terms and conditions.

MCO Procurement

In April 2017, DMMA issued a Request for Qualifications (RFQ) 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. The purpose of the RFQ was to solicit innovative approaches for improving the quality and delivery of services to Diamond State Health Plan (DSHP) and the Diamond State Health Plan Plus (DSHP Plus) members from organizations that have experience providing comprehensive services to Medicaid beneficiaries and are interested in partnering with DHSS to provide high quality, cost-effective, and integrated services to DSHP and DSHP Plus members. At the end of September 2017, DMMA selected Highmark Health Options Blue Cross Blue Shield (an incumbent) and a new MCO, AmeriHealth Caritas, as the second MCO beginning January 1, 2018. Activities in the remainder of the year were focused on winding down United Healthcare's MCO contract, readiness review for AmeriHealth Caritas, choice counseling, and open enrollment for January 2018.

Delaware Medicaid Enterprise System (DMES)

The Go Live date for our new DMES system was December 29, 2016. As with any new Medicaid Information System, we continue to work closely with our vendor DXC on system changes, updates and enhancements as we work to insure we are able to perform all aspects of our Medicaid program.

During the third quarter DMMA completed the CMS checklist in preparation for certification of the Delaware Medicaid Enterprise System (DMES). DMMA underwent our Delaware Medicaid Enterprise System certification with the CMS Review team December 4, 2017 through December 8, 2017. The certification demonstrations were very well received by review team. DMMA provided DMES system demonstrations on a variety of functional areas.

QCMMR and QCMMR Plus Reporting

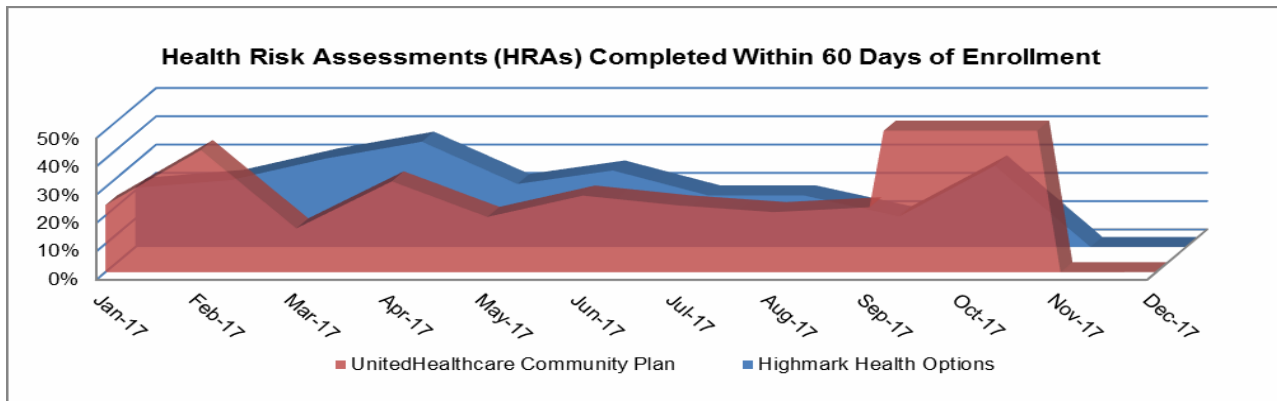
The Medical Management Managed Care Team has developed and refined our **Quality and Care Management Measurement Reporting Templates (QCMMR) and QCMMR Plus**. The QCMMR reports on the DHSP and CHIP Medicaid Populations while the QCMMR Plus reports on the DSHP Plus population. The Managed Care Operations 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.

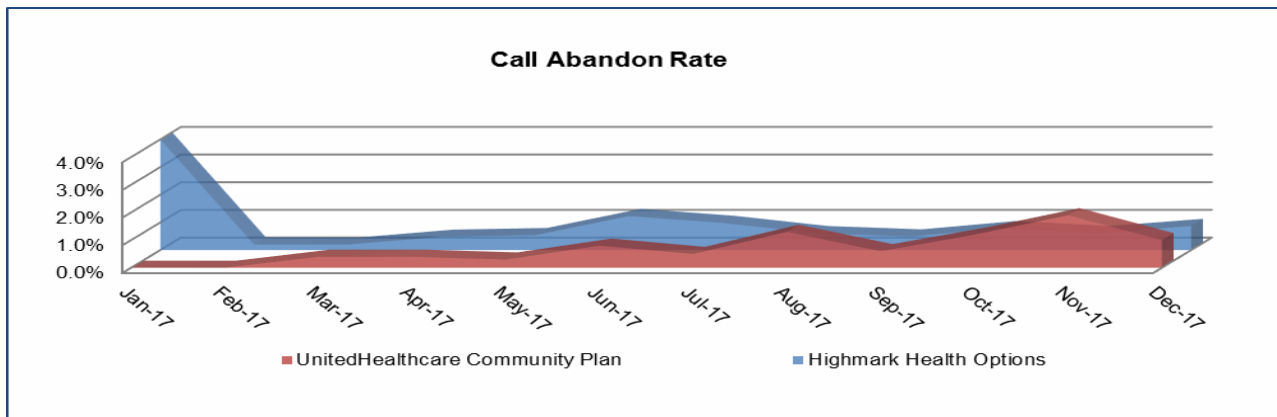
DMMA Managed Care Operations unit developed the full circle approach to the QCMMR and QCMMR Plus reporting. The reports are reviewed by the Managed Care Operations team and an agenda is developed for our monthly meeting with each MCO to discuss the findings from the reports. Managed Care Operation’s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

DMMA continues to evaluate the QCMMR reports for both DSHP and DSHP Plus populations. DMMA has been working in conjunction with the MCOs to redefine and modify the reporting template to assure both MCOs are pulling and reporting the same data.

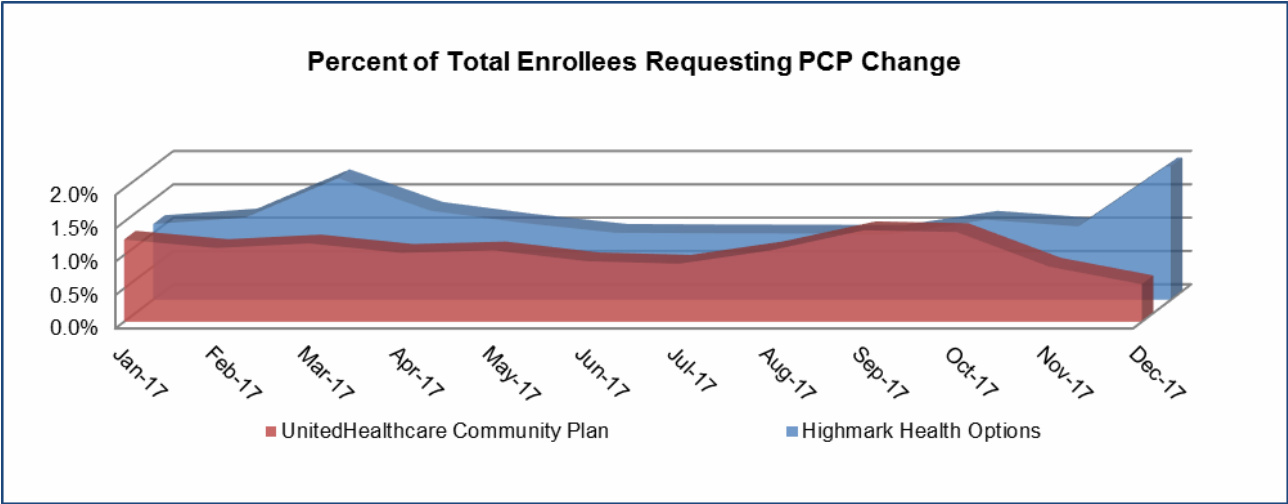
HEALTH RISK ASSESSMENT COMPLETION RATE



Customer Service: Call Abandon Rate



Percent of Enrollees Requesting a Change in Primary-Care Provider



Quality Assurance and Monitoring Activity

Quality Management Strategy (QMS)

During 2017, the QMS was reviewed and revised to include the new managed care rule requirements from 2016. Input was received from both MCOs as well as internal and sister agency supportive comments incorporated.

Quality Improvement Initiative Task Force (QII)

The QII is guided by the Quality Management Strategy. The QII is meant to be a way to improve health outcomes for all Medicaid recipients.

During the first quarter of 2017, Goal 1 of the Quality Management Strategy was reviewed. This forum was used to report on a variety of ways to improve timely access to appropriate care and services for adults and children with an emphasis on primary, preventive, and behavioral health care, and to remain in a safe and least-restrictive environment for DSHP, DSHP Plus, and CHIP members.

The Managed Care Final Rule was discussed as it pertains to access and availability. Improving discharge planning coordination goals was discussed. A process was put in place to communicate and coordinate all authorization requests. This helps make prescribed medications more available and accessible to members. Care coordinators are linked with members about to be discharged. This allows for timely access to care after hospital discharge, while members remain in a safe least restrictive environment. Outcomes of this effort have been: improved quality of life; increased percentage of members who have made progress toward achieving priority goals; positive experience with case management/care coordination services; reduced readmission rates; and unmet needs were addressed.

EPSDT members receive outreach from resource coordinators. These coordinators facilitate consistency with: attending health care appointments; receiving immunizations; and other issues, barriers, and concerns.

A community repository has been developed to engage all members in wellness and healthy behaviors. The contractor maintains an up-to-date registry of all wellness, health education, disease management and self-management programs and activities that are available for members and that are accepting new participants. The web-site contains a suite of applications maintaining a centralized repository of community agencies and services. The agencies are tied to cities, states, counties, and neighborhoods. Each agency can contain one or more services, and will contain service locations, pre-requisites, costs, and descriptions of service. This will link members to education in the community including wellness, prevention, and disease services. It will meet the unique needs of our membership, including

resources for Special Needs, Long Term Services and Support (LTSS), behavioral health and pediatric members.

A partnership with Med Express has been developed to close gaps in primary care for members accessing urgent care services at Med Express locations across the Northeast. Member are being met where they are to facilitate compliance with preventive care. Two hundred seventy transactions were leveraged to identify open gaps in care and were then closed for any member who presented at Med Express for urgent care. Since going live on August 15, 2016, there have been 61 wellness visits at five sites in Delaware. As next steps: embedded practice support; steering consistently non-compliant members to Med Express; re-assessing measures to reduce or add additional measures as the program evolves and; ongoing assessment of effectiveness are under consideration.

During the second quarter of 2017, Goal 2 of the Quality Management Strategy was reviewed. The QII forum was used to report on an assortment of ways to improve the quality of care and services to DSHP, DSHP PLUS, and CHIP members. Some of the ways the MCOs reported successes are described below:

In a population of 250-300 members, the HIV Viral load suppression increased from a rate of 3.6% in FFY 2015 to a rate of 29.2% in FFY 2016. This suppression rate also caused decreased transmission rates within the community. Interventions included pharmacy reminders at 80% of all pharmacies where members got their medications. Forty-four percent of members got their medications at the Wilmington Annex where the pharmacists were pro-active. Not only did members receive reminders but the pharmacy made sure the members took their medications. Members can also receive all their services at the Annex, including case management. Case management for the HIV population made a big difference in care and in viral load suppression. Case managers helped manage necessary care, medication issues, and keeping track of members. The continuum of care works with MCOs. Clinicians prioritized care and reached out to administrators within the MCOs if there are issues that they could not resolve.

A Diabetes Report Card was discussed and has been developed for diabetic members aged 18-75 years-old. This report card was mailed to 2,777 members every thirty days. It contained the member's most recent HbA1C, most recent LDL- C, BUN and creatinine, and urine screen for protein, BMI, Blood Pressure, and the normal limits for these measures. It also contains the most recent date that a dilated eye exam was performed. These report cards educate and empower members to own their chronic health issue and helps promote discussion regarding the appropriate problems and concerns with their primary care provider (PCP) for their diabetes. The report card also helps keep the PCP up to date on the latest recommendations from the American Diabetes Association. Rapid cycle analysis has found an overall 27% improvement in A1C measurements, 2% increase in eye exam rates, 6% increase in members who had nephropathy screening, and 30% increase in members who had statin prescriptions refilled.

During the third quarter of 2017, Goal 3 of the Quality Management Strategy was reviewed. The QII forum was used to report on a variety of ways to control the growth of health care expenditures.

The LANE (Low Acuity Non-Emergent) ED Avoidance workgroup meets monthly and consists of representatives from: Quality, Analytics, and Health Care. Their goal is to decrease LANE ED use for physical and behavioral health issues. They have developed the following interventions to avoid LANE ED use: Embedded Clinical Care Coordinators; Single Point of Contacts (SPOC) at Federally Qualified Health Clinics (FQHCs); partnership with Envolve People Care, a 24 hour nurse hotline; LANE outreach and education on proper ED use; 24 hour on call access for Care Coordination; Member Handbook; and Member Website and Newsletter. Envolve People Care showed a 40% successful outreach in the first quarter. People are calling and are directed back to their PCP. They showed a 37% successful outreach in the second quarter. SPOCs are present at La Red, Bowling Green, Rockford Center, and Westside Family Health Center.

Quality Management to Reduce Hospital Readmissions utilized team interventions, which follow. Transition assessments, or outreach within 48 hours of discharge to review discharge instructions, medications, and appointment assistance. Embedded staff at health care systems perform UM, identify/reduce barriers to discharge, and facilitate gentle transition to alternate locations of care. Weekly UM rounds in NICU and Non-NICU, further identifying/reducing discharge barriers and facilitating transition. Risk stratification admission predictor model to identify and impact members at high risk for admission/readmission. Provider education on readmission avoidance: gentle transitions, there's "no place like home," targeting high census participating hospitals. Utilization of Home Health Skilled Visits, DME, and PDN Benefits. Behavioral Health efforts include: a SPOC embedded at behavioral health facilities; weekly behavioral health rounds; identifying behavioral health outlier members impacting readmission rates; and enhancing care coordination. In the LTSS population: they are making rounds on members with greater than three hospitalizations in six months; and transition assessments for all LTSS hospitalized members. This has decreased readmission rates in this population by 2%. Next steps include monthly reporting, weekly NICU and Non-NICU rounds, improved LTSS reports, and examining strategies to impact and engage facilities with higher readmission rates.

Milford Memorial Hospital had improved 30 day readmissions for DSHP and DSHP Plus and LTSS populations. Christiana Care and St. Francis Hospitals had improved 10 day readmission rates for DSHP and DSHP Plus and LTSS respectively. Dover Behavioral Hospital and Rockford Center have improved readmission rates at 10 days for DSHP and DSHP Plus and 30 days for LTSS. Bowling Green had an improved readmission rate at 30 days for DSHP and DSHP Plus.

The consumer-directed philosophy is designed to maximize the autonomy and independence of persons with physical dependencies by giving them greater choices and control over personal care and other in home services and providers. Participants express greater satisfaction over the services they

choose. Members in these state programs perceived either that quality improved or at least care did not suffer. The use of independent home care workers including family members was frequently associated with increased hours of service per participant as well as lower total cost of in-home care. By offering fully informed choices: cost of services is 50% less per unit; and year on year savings is approximately 10% for all HCBS clients. While abuse and fraud are a concern, electronic sign-in makes it easier to track.

During the fourth quarter of 2017, goal four of the Quality Management Strategy was reviewed. The QII forum was used to report on an assortment of ways to assure membership satisfaction with services.

Every year, one MCO evaluates experience within its management program by obtaining feedback from members and analyzing member complaints. Members must be enrolled in the program for at least 60 days and the cases must be closed when interventions are completed. Eligible members contacted within one week of case closure, thru an automated telephonic outreach company. The company provides satisfaction surveys to the members. The company makes six phone call connect attempts and 3 voice mails to attempt to connect with the member. To date 95% of goals have been met and satisfaction rates are good to excellent (89.75%). But response rate was poor (26.1%). Education of members re: importance of survey needs to be done. There also needs to be additional methods to obtain member feedback on the program.

Experience of Care and Health Outcomes (ECHO) baseline data was obtained this year. The Adult ECHOs have three statistical performance rates. The results align with the SPH Book of Business. The Child ECHO results look favorable but there are no results to benchmark them against. Both surveys will be used as baseline data for trending future performance.

UES Survey has been redesigned to a 3-question format that aligns with NPS and invites members to leave recorded feedback. The new survey asks: how likely are you to recommend us to others; thinking about the conversation you just had, overall, how satisfied are you with the level of service you received today; and how satisfied are you that your issue was resolved? Delaware UES results show close to 90% satisfaction for 1/2017-9/2017. With the new UES survey the question to learn about your experience, please tell us what we could have done better to serve you? All answers were positive. For improvement, if an advocate scores lower than “7” on a survey they will be coached within 24 hours. Outbound follow up calls for a member issue will be completed within 24 hours. RISE – Redesigned Individual Service Experience was launched July 1, 2017 to focus on member experience and issue resolution. The core quality for this is: issue resolution, connection, compliance, and business requirements.

Performance Improvement Projects (PIPs)

The Quality Department oversees the development and improvement of PIPs for the Managed Care Organizations. Currently, five PIPs are required of the MCOs. There are two mandatory PIPs: one prescriptive, which is oral health; one which the topic is prescriptive, however, the MCOs develop on their own the operations of the PIP, which is physical and behavioral health integration. Of the three other PIPs: one must be in the field of pediatrics; one must be a service oriented PIP (non-clinical); and one has to do with the LTSS/HCBS community.

A reporting template and procedure for its use to assist with accurate and appropriate reporting of PIPs was developed. The MCOs were educated on the use of the template. DMMA has provided technical assistance to help develop the PIPs and further assistance to help develop Rapid Cycle Analysis.

The Oral Health PIP is in the LTSS/HCBS community. While there have been many barriers faced in education and data collection, there has been an increase in daily oral care in the elderly population. The Diabetes Report Card PIP created by one of the MCOs, where 5,112 diabetics were mailed a *report card* that gave them their HbA1c levels, LDL- C, BUN and creatinine, and urine screen for protein, BMI, Blood Pressure, and the normal limits for these measures. This empowered members with the knowledge to discuss their disease with their primary care providers and take an active role in their care. In the LTSS Case Management Outreach PIP the goal is to provide LTSS members with a Case Manager who puts services for them in place within 14 days. This goal has helped LTSS members get services in a timely manner.

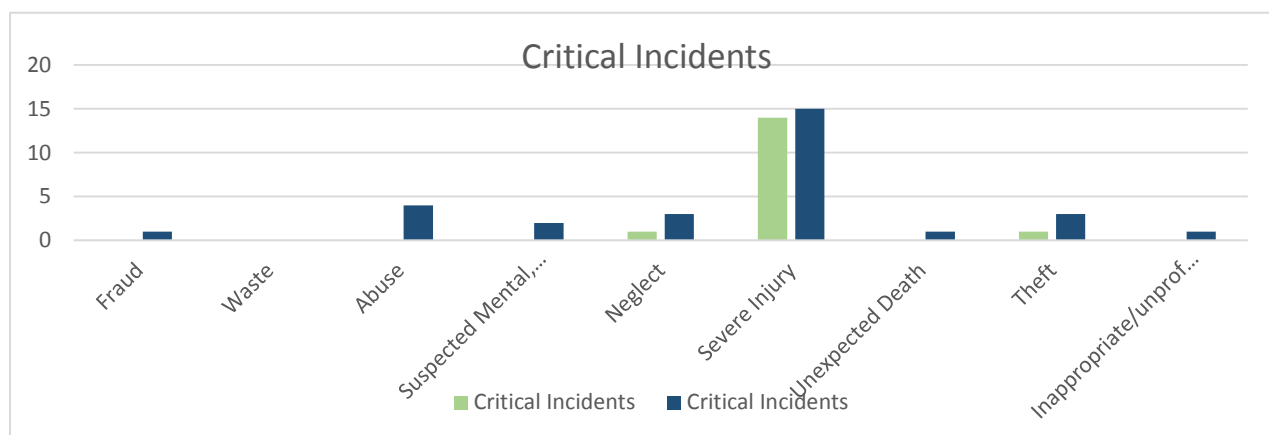
The PIPs are turned in to the DMMA quarterly. Initial feedback provided to the MCOs concerning the PIP submissions was assuring appropriate, specific, measurable, attainable, relevant, and time bound lead and lag measures. As the PIPs matured the feedback changed a bit to barrier analysis and use of Ishikawa diagrams, and changing goals in keeping with rapid cycle analysis.

Critical Incidents

The Critical Incident reporting system in Delaware requires that all critical incidents be reported by the MCO to the appropriate reporting agency. These agencies include Adult Protective Services, Division of Family Services (DFS), Division of Long Term Care and Residents Protection (DLTCRP), and the Office of Health Facilities Licensing and Certification (OHFLC). The MCOs have been trained on reporting on Critical Incidents and that training includes the definition of a Critical Incident, Reporting processes, as well as care coordination activities which must occur surrounding the Critical Incident. The MCO's track, trend, and analyze their incidents and put processes in place to make necessary changes in order to prevent reoccurrence.

Individually, Critical Incidents are reviewed at the MCO level for care coordination and case management approaches to assist members into care. A 30 day report is also reviewed at the DMMA for trends. As an added safeguard, using the Critical Incident Reporting Form, the Incident is also reported to the Delaware Aging and Disability Resource Center (ADRC) who will check to ensure that the incident is reported to the appropriate agency.

The graph below shows types of critical incidents where the colors blue and green represent Delaware’s two MCOs. *Severe Injuries* which stand out in the graph have been reviewed at the Quality Improvement Initiative Task Force (QII). These have been documented injuries post member falls. A performance improvement project around falls initiated to address the problem of falls. Performance Improvement Projects are then reported on quarterly in the QII quarterly meetings.



Incidents are tracked and trended quarterly for progressions and patterns and also compared between MCOs to see if there is a difference in processes or procedures that may make a difference in number or type of occurrences. They are also reviewed for opportunities for quality improvement. To maintain or insure quality care for members, cases are reviewed on an advanced quality level to determine necessary prevention and/or corrective measures so that these incidents do not recur.

CHIP Annual Report Template System (CARTS)

CARTS was successfully completed for FFY 2017 and submitted to CMS. This was made possible with assistance from the following departments: Policy, Planning, and Quality Unit, Medical Surveillance Administration; Information Systems Unit; and Financial Management.

Child and Adult Core Measures

Twenty-eight combined Adult Core Measurements were entered successfully into MACPro for FFY 2017. Twenty-three combined Child Core Measurements were entered successfully into MaCPro for

FFY 2017. These represent two contracted MCOs (one of which is no longer contracted with the State of Delaware.)

CAHPS

This measure provides information on beneficiaries’ experiences with their health care and gives a general indication of how well the health care meets the beneficiaries’ expectations. Results summarize beneficiaries’ experiences through ratings, composites, and question summary rates. Four global rating questions reflect overall satisfaction: rating of all health care; rating of health plan; rating of personal doctor and rating of specialist seen most often. Five composite scores summarize responses in key areas: customer service; getting care quickly; getting needed care; how well doctors communicate; and shared decision making.

Item-specific question summary rates are reported for the rating questions and each composite question, the “written materials/Internet provided needed information” question, and the “forms were easy to fill out” question. Question summary rates are also reported individually for two items summarizing the following concepts: health promotion and education; and coordination of care.

2017 Survey on Adult Medicaid enrollees’ age 18-65 yrs. old experiences with care

	MCO 1	MCO 2
<i>Rating of All Health Care</i>	78%	89.1%
<i>Rating of Personal Doctor</i>	79.1%	89.7%
<i>Rating of Specialist Seen Most Often</i>	81.7%	NA
<i>Rating of Health Plan</i>	78.6%	86.9%
<i>Customer Service</i>	86.5%	84.8%
<i>Getting Care Quickly</i>	84.1%	89.8%
<i>Getting Needed Care</i>	84.1%	80.7%
<i>How Well Doctors Communicate</i>	91.9%	NA
<i>Shared Decision Making</i>	80.5%	NA
<i>Health Promotion and Education</i>	71.1%	NA
<i>Coordination of Care</i>	84.1%	NA

HEDIS Submissions

HEDIS data is submitted by the MCOs quarterly for those measures that have not met the 75th percentile within their organizations. The Quality team reviews those measurements and also reviews the MCOs interventions for improving the measurements. A comparison document was created to compare the two MCOs measurements. A decision was made to have the MCOs report for next reporting year those measures that did not meet the 50th percentile quarterly as well as what PIPs and interventions have been put into practice to assist in improving these measurement reports.

Delaware HEDIS 2017		Rate MCO1	Rate MCO2
AAP - Adults Access to Preventive/Ambulatory Health Services	20 - 44	83.51%	85.49%
AAP - Adults Access to Preventive/Ambulatory Health Services	45 - 64	88.91%	91.11%
AAP - Adults Access to Preventive/Ambulatory Health Services	65+	81.25%	86.19%
CAP - Children's and Adolescents' Access to Primary Care Practitioners	12 - 19yrs	90.69%	91.45%
CAP - Children's and Adolescents' Access to Primary Care Practitioners	12 - 24mos	94.81%	96.21%
CAP - Children's and Adolescents' Access to Primary Care Practitioners	25 mos. - 6yrs	89.55%	89.57%
CAP - Children's and Adolescents' Access to Primary Care Practitioners	7 - 11yrs	92.05%	93.34%
CIS - Childhood Immunization Status	Combination 2 Total	50.92%	67.15%
CIS - Childhood Immunization Status	Combination 10 Total	27.35%	40.15%
CIS - Childhood Immunization Status	DTaP/DT Total	65.71%	79.81%
CIS - Childhood Immunization Status	Hepatitis A Total	80.86%	91.24%
CIS - Childhood Immunization Status	Hepatitis B Total	66.30%	76.89%
CIS - Childhood Immunization Status	HiB Total	82.56%	89.78%
CIS - Childhood Immunization Status	Influenza Total	47.60%	61.80%
CIS - Childhood Immunization Status	IPV Total	81.30%	89.54%
CIS - Childhood Immunization Status	MMR Total	83.44%	93.67%
CIS - Childhood Immunization Status	Pneumococcal Conjugate Total	68.14%	78.83%
CIS - Childhood Immunization Status	Rotavirus Total	66.22%	71.53%
CIS - Childhood Immunization Status	VZV Total	83.37%	93.67%
CDC - Comprehensive Diabetes Care	Blood Pressure level < 140/90 mm Hg Total	0.09%	46.17%
CDC - Comprehensive Diabetes Care	Eye Exam Total	42.46%	51.82%
CDC - Comprehensive Diabetes Care	HbA1c <7% for Selected Populations Total	18.85%	22.87%
CDC - Comprehensive Diabetes Care	HbA1c <8% Total	25.03%	31.20%

PROMISE Behavioral Health

Delaware amended the DSHP 1115 to create a new program for Medicaid beneficiaries who have a severe and persistent mental illness (SPMI) and/or substance use disorder and require home and community-based services to live and work in integrated settings. The Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) program began January 1, 2015 and operates as a fee-for-service (FFS) program through the DHSS/Division of Substance Abuse and Mental Health (DSAMH) with coordination on care management between DSAMH and the MCOs.

In 2017, Delaware conducted an assessment of Medicaid behavioral health services, including PROMISE. Below is a summary of the key PROMISE observations:

1. **Stakeholder Commitment:** State staff, MCOs and providers across the behavioral health landscape are invested in system improvements and are willing to contribute to ongoing planning processes.
2. **Benefit Design:** Despite the comprehensive benefit design, with opportunities to provide a wide range of evidence-based practices, PROMISE has not yet been fully operationalized to achieve the benefit design potential. While DHSS can address some of these challenges, other factors such as provider workforce are more difficult to address.
3. **Navigating Service Eligibility and Access:** Stakeholders uniformly reported confusion about eligibility and access to services offered in the MCO or PROMISE programs, despite the presence of clear information from the some sources (e.g., MCO websites.) PROMISE stakeholders reported confusion about obtaining services other than assertive community treatment (ACT).
4. **Care Coordination and Care Transitions:** Stakeholders reported a need for improvements in transitions of care across the different service delivery systems and between levels of care within systems (e.g., from ACT to Intensive Case Management (ICM) or routine outpatient services for PROMISE adults.)
5. **Provider Network and EBPS:** Stakeholders reported access to evidence-based practices (EBP's) and other services varies widely due to: gaps in the provider network, unequal access to EBPs between counties, and limited communication and messaging about service availability and how to access it.
6. **Quality and Outcomes Measurement:** While each delivery system reports they capture a variety of metrics, there currently is no shared set of common metrics for measuring access to care and other quality performance measures across DSAMH, DSCYF, and the MCOs.

7. **Care Coordination/Care Management:** PROMISE members have an assigned DSAMH care manager as well as care management support through the MCO for their physical health needs, necessitating coordination between DSAMH and MCO. However stakeholders reported members have a difficult time navigating the system and accessing the BH services they need. Delaware's EQRO noted some MCO improvement in care coordination, but the need for additional corrective action going forward.

Case Management Oversight

The Medical Case Management Unit of DMMA has continued with Case Management oversight of the Diamond State Health Plan Plus, DSHP Plus population and oversight of Diamond State Health Plan, DSHP members identified by the Managed Care Organizations, MCO's, through Risk Stratification as requiring Care Coordination Services. As DMMA contracted with a new MCO, AmeriHealth Caritas, AHC effective January 1, 2018 and provided oversight to an existing MCO, United Health Care, our team worked to ensure our members were transitioned with continuity and coordination of care. We developed a definition and criteria for High Needs members to ensure those most at risk were identified. This and our Member Transfer Coordination of Care form were shared with both MCOs, UHC and Highmark Health Options, HHO. Our secure information sharing site, Movelt was utilized to transfer this and other transition of care files to AHC and HHO for their newly enrolled members. Our team participated in the Readiness Review discussion and onsite Review at AHC with our EQRO team and implementation activities. Our Medical Case Management team provided technical assistance to the AHC Case Management team for DMMA Oversight activities, submission of files and weekly joint visits through Movelt.

The Medical Case Management Team participated in the development of a DE Transition Work plan, implementation and transition calls with our exiting plan, UHC to assure all members would be transitioned with continuity of care. Member files requested included, but not limited to; the last Level of Care Re-determination, lists of members identified as potential candidates for transition from a nursing facility to a community setting, members receiving Self Directed Care, member's identified in need of Care Coordination thru their Risk Stratification process. All member files were screened by the Medical Case Management team and submitted to the member's newly identified MCO through our secure site, Movelt.

Additional files included a list of all open prior authorizations for services to ensure those authorizations/services continued during the transition process, again the files were screened and

submitted to the member's newly identified MCO.

We completed our 4th Quarter onsite reviews, Case File Review and Level Of Care Redetermination and reviewed our findings with the MCO's, highlighting area's identified as exceeding goals and those area's with room for improvement. DMMA's ongoing case management oversight activities ensure all the populations served are receiving the highest quality and comprehensive medical services in the most cost effective manner.

DMMA continues with monthly meetings with each MCO, this provides a forum to discuss any case management issues in a collaborative manner, identify issues and plan resolutions. Our Medical Case Management Unit also meets bi-monthly with our MCO's and our DMMA Long Term Care, LTC units to discuss any LTC issues, again in a collaborative manner to identify issues and plan resolutions. Sr. Social Service Administrator RN, from our Managed Care Operations Oversight Team is working with our policy team and representatives from the Division of Public Health to update our Memorandum of Understanding, MOU. The goal of the MOU is to provide coordination between DMMA and Delaware Public Health for the provision of Title V and Title XIX services. This will include provisions to prevent duplication of services, joint access to data, improve identification of eligible infants, children and women and assist individuals with applying for services.

Pharmacy Focus Study

In 2017, Delaware's EQRO conducted a pharmacy focused study to identify differences in treatment outcomes between the MCOs for members prescribed buprenorphine, a prescription drug used in medication-assisted treatment to treat opioid dependence. The results of this study will be made available as part of the 2017 EQRO reports.

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. These meetings are used to collaborate on common practices, identify issues, plan resolutions and identify potential Quality Improvement Activities.

Medicaid Special Bulletin

This bulletin is given to our Medicaid Providers on a quarterly basis. Throughout the year, topics included (but were not limited to):

- MCO Provider credentialing
- Program integrity/provider self-auditing
- EPSDT best practices

- VFC billing
- LTC eligibility verification
- New Medicare ID cards
- PERM
- Efforts to expand access to treatment of Substance Use Disorder (SUD) treatments

We have attached the entire Fourth Quarter 2017 Medicaid Special Bulletin: **Attachment C.**

Expenditure Containment Initiatives

DMMA doesn't have any cost containment initiatives to report.

Financial/Budget Neutrality Development/Issues

Budget Neutrality Workbook:- To be submitted under separate cover.

Member Month Reporting

A. For use in budget neutrality calculations – To be submitted under separate cover.

Eligibility Group

Program Integrity

Delaware Medicaid is in the final phase of the second contract year with our Fraud, Waste, and Abuse Contractor, Health Integrity. The process has begun to access year-end results and to perfect effective measure towards continued improvement. Provider training was completed allowing for a Centers for Medicare and Medicaid Services (CMS) approved overpayment calculation method to be successfully introduced to the provider community. The review of provider actions is steady and remains a priority. Several audits of specific provider types have concluded with positive results. The educational needs of Delaware providers and other persons of interest are continually being assessed. The provider risk areas previously identified by Health Integrity have moved into a realm of strategic discussions. DMMA's collaborative efforts with Health Integrity has established a focus point towards strengthening policy and guidance for Delaware Medicaid and the provider community.

In 2017, Delaware conducted an assessment of each of the State's Medicaid managed care contractor's overall program integrity (PI) compliance efforts. The objective of the review was to evaluate each MCO's processes for the prevention, detection, and recoupment of improper payments to ensure compliance with regulatory and contractual responsibilities.

The key performance indicators used to complete the evaluation included the following 11 PI standards:

- Standard 1 Written Policies and Procedures
- Standard 2 Corporate Staffing
- Standard 3 Training
- Standard 4 Communication
- Standard 5 Disciplinary Guidelines
- Standard 6 Claims Monitoring and Recoupment Process
- Standard 7 Auditing (Provider Compliance Reviews)
- Standard 8 Response to Offences
- Standard 9 Member Verification
- Standard 10 Payment Suspension and Excluded Providers
- Standard 11 Report Submittal and compliance with contractual obligations

Opportunities for improvement varied across the contractors but each MCO was required to submit a corrective action plan to DMMA for review and approval. A follow up review will be performed in 2018.

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 is developing an interim evaluation to be submitted in June 2018.

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