

DIAMOND STATE HEALTH PLAN

Section 1115, 2018 Annual Report

Demonstration/Quarter Reporting Period

Demonstration Year: 22 (1/1/2018 –
12/31/2018)

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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.

In 2018, Delaware requested a five-year extension of the DSHP 1115 waiver and an amendment for expenditure authority for IMDs under CMS's substance use disorder 1115 option. The DSHP 1115 waiver was extended through June 30, 2019 while CMS and DMMA negotiate the extension.

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 fairs, special events or school 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.

New initiatives in 2018 for the DSHP MCOs included the introduction of value-based payment performance standards in the MCO contracts, the inclusion of non-residential Lifespan 1915(c) waiver enrollees in MCOs for their acute care Medicaid benefits, and exploration of potential approaches within the MCOs to address social determinants of health.

Enrollment Information

Demonstration Populations	Ever Enrolled
Population 1: TANF Children less than 21	102,491
Population 2: TANF Adults aged 21 and over	37,749
Population 3: Disabled Children less than 21	5,749
Population 4: Aged and Disabled Adults 21 and older	6,782
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	67,282
Population 7: Family Planning Expansion	None; program terminated in 2013
Population 8: DSHP-Plus State Plan	10,654
Population 9: DSHP-Plus HCBS	5,239
Population 10: DSHP TEFRA-Like	0
Population 11: ACA Adults at 101-133% FPL	13,258
Total	249,204
<i>Definition: For most groups, the 1115 enrollment is an annual unduplicated count of clients in the MCO for at least one day in January 2018 through December 2018 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 2018 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.</i>	

MCO Outreach/Innovative Activities

The MCOs continue to be very active in the community and their members, including having a presence at over 25 health fair events. Examples of activities in 2018 include:

On October 15, 2018, Highmark Health Options participated in the Frankford Community Health Fair hosted by Beebe Healthcare. This event was open to the community and offered free health screenings to the attendees. Attendees were able to learn CPR. Some of the health screenings offered were; Bone Density, Blood Pressure, Glucose and Cholesterol screening, Body Mass Index and cancer screenings. Division of Public Health offered flu shots. Highmark Health Options provided an exhibitor table with health and wellness literature.

November 7, 2018: AmeriHealth Caritas DE (ACDE) hosted their first Healthy Hoops Asthma Professional Development and Coaches Workshop in partnership with the American Lung Association. This event took place at the Police Athletic League of Wilmington; the goal of the event was to provide education to coaches regarding the myths and misconceptions of Playing Sports with Asthma. Guest lecturers included Dr. Maureen George, PHD, RN, AE-C, Associate Professor of Nursing at Columbia University and Glenn Ellis, CHCE, President of Strategies for Well-Being, LLC. Fifteen people attended including nine coaches from local recreation centers in Wilmington, DE. In addition, ACDE had a resource table where they provided health literature that focused on asthma and social determinants of health.

The State's Health Benefits Manager (HBM)

2018 was another successful year for the HBM. The HBM continued the process of Member enrollments, Pending Enrollments, BBA Requests, and Card Requests, DHCP premium payment processing or any other HBM process. Throughout the year, the HBM processes a high volume of phone calls, processes various forms and returns mail for thousands of Members. The HBM also enrolled 27,413 Members into an MCO of their choice.

Prior to October, the HBM began to prepare for a full Open Enrollment. The HBM created flyers, letters and packets to send to each Head of Household to provide information about the upcoming Open Enrollment. The HBM also hosted a meeting with the MCOs in October. In October 2018, the HBM conducted a full and robust Open Enrollment.

In 2018, the HBM continued to deliver individualized and outstanding service, and education and outreach continued to play an important role in educating prospective and existing Members about their coverage options. The Outreach Team provided much-needed translation services, and conducted in-person enrollments, in an effort to reach out to uninsured and underinsured Delawareans. During 2018, the Outreach Team also played key roles in the Open Enrollment process, through Member/caseworker education and in-house telephone assistance.

HBM Ongoing Activities & Objectives

- Maximize the voluntary enrollment percentage, making sure as many Members as possible are educated regarding their benefits
- Closely monitor abandoned call rate and average speed of answer
- Continue to provide responsive, quality service to applicants and enrollees in the Delaware Healthy Children Program (DHCP), Diamond State Health Plan (DSHP) and DSHP Plus.
- Continue to conduct effective Member education for DSHP, DSHP Plus and DHCP in the community and State Service Centers
- Continue to educate caseworkers about DSHP, DSHP Plus, and DHCP
- Continue to help Members understand the Medical Assistance Programs and resolve issues involving their coverage
- Continue to identify issues and trends that affect the quality of and access to medical care provided by the managed care programs
- Continue to provide services in English and Spanish, both in-person and by telephone

Objectives

- Continue to enroll Members effectively into each of the two health plans
- Continue to update the monthly and quarterly reports to provide the most relevant and useful information possible
- Continue to assist Members with completing Medicaid applications, both over the telephone and in-person
- Continue to resolve Member complaints and to assist caseworkers as necessary, and continue to report on these complaints and caseworker assistance calls in HBM reports

Special Interest Meetings/Conferences/Workgroups

Delaware Family Voices

DE Medicaid continues to support Delaware Family Voices. Caring for children with special needs is often complex, and Delaware Family Voices together with the Family to Family Health Information Center, is in the unique position to help. This organization states that “We 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 participate in these 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.

Children with Complex Medical Conditions

In 2018, DMMA released Delaware’s Plan for Managing the Health Care Needs of Children with Medical Complexity and formed a Children with Medical Complexity Advisory Committee to strengthen the system of care, increase collaboration across agencies, encourage community involvement, and ultimately ensure that every child with medical complexity has the opportunity to receive the adequate and appropriate health care services they need. This Advisory Committee is chaired by DMMA. Membership consists of six advocates of children with medical complexity and representatives from providers, MCOs and other stakeholders. The Committee meets quarterly.

National Governor’s Association

The National Governor’s Association hosted an in person meeting for the states working on the “Harnessing the Power of Data to Achieve State Policy Goals in Medicaid” project Oct. 17th and 18th. Steve Groff, Liz Brown, Tyneisha Jabbar-Bey, and Troy McDaniel from DMMA, as well as Steven Costantino and Joe Bryant, represented Delaware. Speakers from other states and federal agencies addressed topics such as data governance, privacy, building analytic capacity, and the power of linking multiple data sources together. During our individual state time, we developed a plan for work groups to use enrollment information and maternal child health data as use cases to work through the steps of dashboard development.

Western Medicaid Pharmacy Administrators Association

The Western Medicaid Pharmacy Administrators Association meeting was held in Tucson October 14th through the 17th. Cindy Denemark attended the meeting. Critical to DMMA were new regulations CMS finalized regarding opioid monitoring for both fee-for-service and

managed care partners. A presentation on the new version of the NCPDP transactions that will need to be in place for 2023 along with the new e-prescribing transaction standard. New drug and pipeline drug information was also presented. Specific clinical presentation covered insulin products, genomics in cardiovascular drugs and dermatitis treatment options.

Operational/Policy Developments/Issues

DSHP Extension and SUD Amendment

The SUD 1115 waiver amendment and 1115-waiver extension have been accepted by CMS for review. CMS received just a few comments on the waiver application all were supportive of Delaware's goals. DMMA is in negotiations with CMS on budget neutrality and the special terms and conditions for the extension.

Regulations

During 2018, DMMA focused on ensuring policy, contractual and operational compliance with the HCBS settings final rule, Mental Health Parity, opioid monitoring, electronic visit verification, and assessing the impact of the 21st Century Cures Act.

MCO Procurement

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 2018 focused on monitoring the implementation of AmeriHealth Caritas as a new MCO.

Value-based purchasing

In 2018, DMMA introduced new value-based payment performance standards for MCOs. The purpose of this initiative is to accelerate the implementation of reforms and innovation within Delaware's health care delivery system to migrate the system away from traditional fee-for-service (FFS)/volume-based care to a system that focuses on rewarding and incentivizing improved outcomes, value, quality improvement and reduced expenditures. Through this initiative DMMA is seeking to align the incentives of the MCOs, providers and members through innovative VBP strategies.

The MCOs are financially accountable to make meaningful progress through a two-part strategy: (1) Quality Performance Measures (QPM) and (2) Value-Based Purchasing Strategies (VBPS) in which the MCO is required to implement provider payment and contracting strategies that promote value over volume. For CY 2018 through CY 2020, the MCOs will focus on the following QPMs:

- QPM #1: Comprehensive Diabetes Care (HbA1c control <8%) (*HEDIS CDC*)
- QPM #2: Medication Management for People With Asthma (ages 5 – 11, 12 – 18) (*HEDIS MMA*)
- QPM #3: Cervical Cancer Screening (*HEDIS CCS*)
- QPM #4: Breast Cancer Screening (*HEDIS BCS*)
- QPM #5: BMI Assessment (*HEDIS ABA*)
- QPM #6: Prenatal and Postpartum Care (Timeliness of Prenatal Care) (*HEDIS PPC*)
- QPM #7: 30-day Hospital Readmission Rate (*Delaware Measure*)

Social Determinants of Health (SDOH)

In 2018, DMMA began working with the DSHP MCOs to generate ideas and strategies for addressing social determinants of health. The DSHP MCOs presented current and planned strategies and DMMA is continuing this work into 2019. In April 2019, DMMA will host meetings with MCOs, providers, state agencies, and community-based organizations to continue learning where Medicaid can partner to design a strategy for addressing beneficiaries' social needs in efficient and beneficiary-centered ways.

2018 Quality Assurance and Monitoring Activity

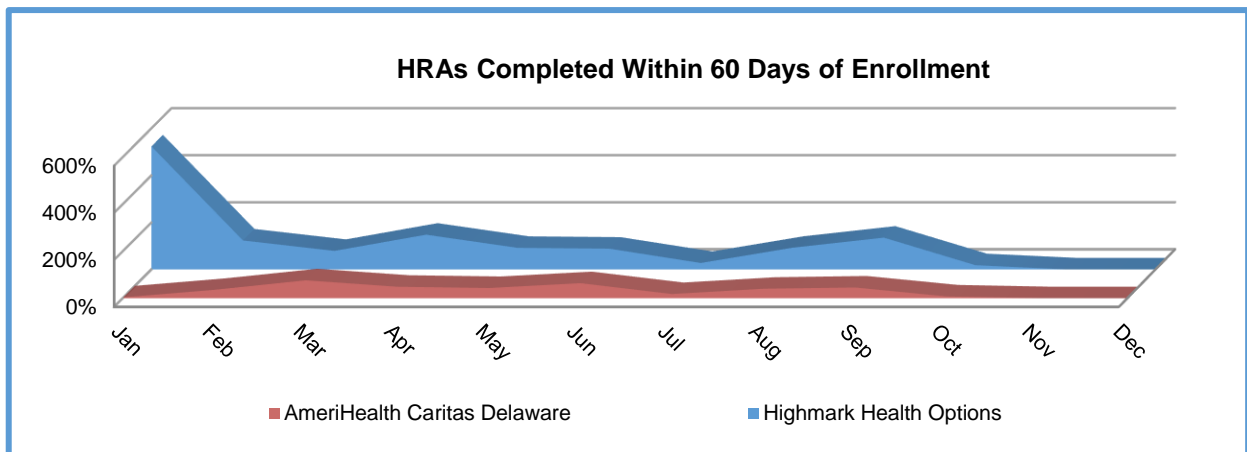
QCMMR and QCMMR Plus Reporting

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 DSHP 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.

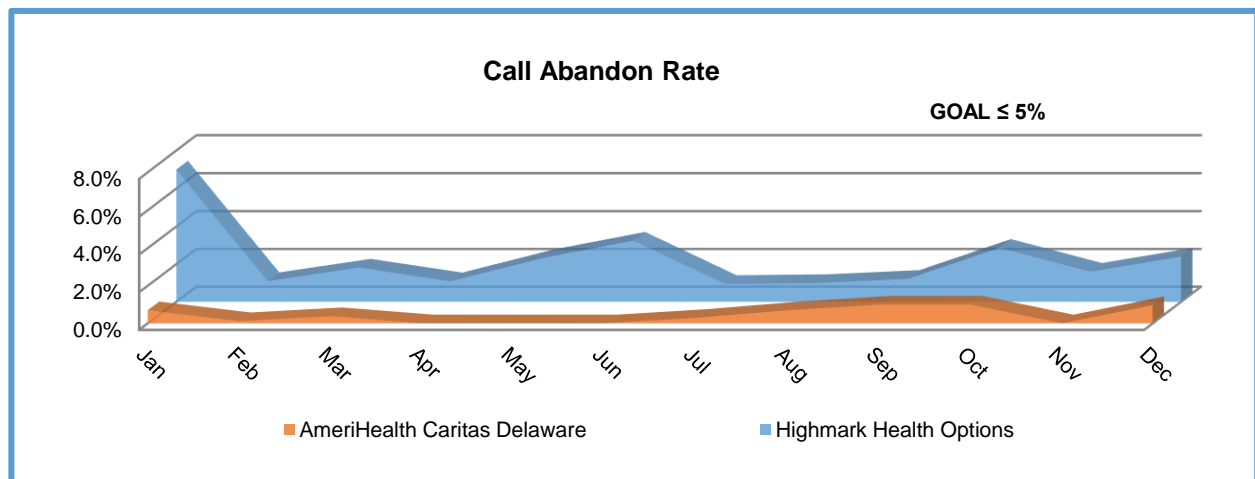
DMMA Managed Care Operations unit developed the full circle approach to the QCMMR and QCMMR Plus reporting. The reports are reviewed by the Managed Care Operations team and an agenda is developed for our monthly meeting with each MCO to discuss the findings from the reports. Managed Care Operation's 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.

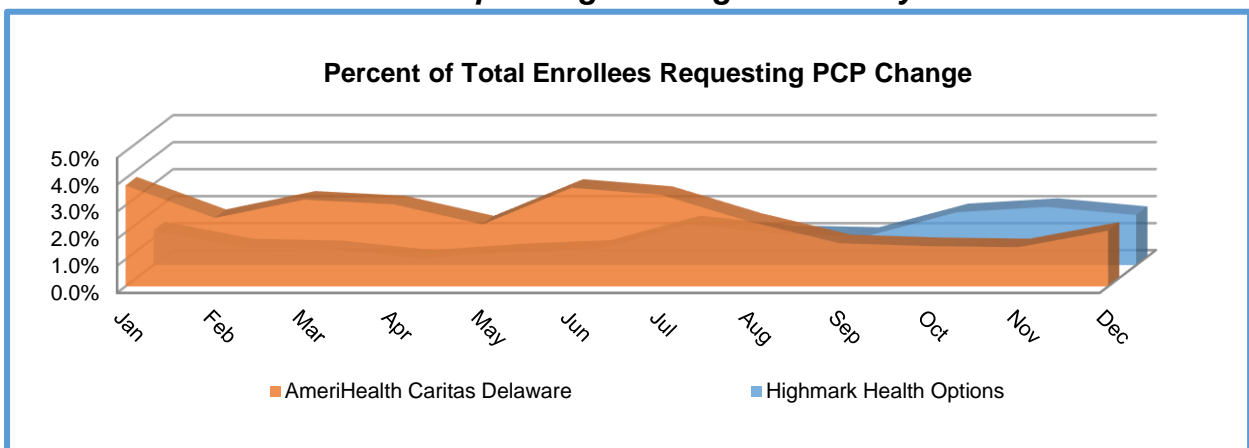
2018 Health Risk Assessment Completion Rate



2018 Customer Service: Call Abandon Rate



2018 Percent of Enrollees Requesting a Change in Primary-Care Provider



Quality Management Strategy (QMS)

The Delaware Quality Management Strategy (QMS) 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, whose membership includes a multi-disciplinary state-wide group of external contractors and state agencies, participates in oversight and monitoring of quality plans and

improvement activities of Medicaid and Title XXI DHCP funded programs based upon the goals identified in the QMS. The four goals of the 1115 managed care demonstration waiver, in which over 90% of Delaware's Medicaid and CHIP members are enrolled, are monitored through the QII Task Force:

- **Goal 1:** To improve timely access to care and services for adults and children with an emphasis on primary care and preventive care, and to remain in a safe and least-restrictive environment;
- **Goal 2:** To improve quality of care and services provided to DSHP, DSHP Plus, and CHIP members;
- **Goal 3:** To control the growth of health care expenditures.
- **Goal 4:** To assure member satisfaction with services

During 2018, the QMS has been reviewed and revised. The Quality Management Strategy was revised and renamed to the Quality Strategy. Input was received from both MCOs as well as internal and sister agency supportive comments incorporated. The Quality Strategy was posted for public comment onto the website for comment. The Quality Strategy continues to guide the activities of our programs as we collect data and assess our outcomes.

Quality Improvement Initiative Task Force (QII)

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

During 2018, DMMA took the opportunity to review the goals of the Quality Strategy as well as review the operating mission of the Quality Improvement Initiative Task Force (QII). During this reporting year there is a new contracted MCO as well as new participants to the QII Task Force. The QII Task Force is one of the various mechanisms to accomplish oversight and solicit input for improvement of the Quality Strategy activities.

The QII Task Force chose to focus on one goal throughout this reporting year and have all reports throughout the year focus on this goal. QII will be reviewing one primary goal while continuing to review the quarterly goals throughout the reporting year. The primary goal will be access to care and will be discussed in every quarter. The representatives will discuss each goal and how their teams have worked to improve access.

One MCO discussed their Early Periodic Screening Diagnostic and Treatments were below their benchmark performance goals. The MCO developed a two-pronged approach after barrier analysis was completed. The approach included dashboards to Providers and education on billing and proper coding techniques. Members also received education on the importance of receiving Early Periodic Screening and Diagnosis with subsequent treatment.

Delaware's Public Health participant spoke to the group on the Delaware Contraceptive Access Now (CAN) initiative. CAN is available in all three counties through a public/private partnership

called Upstream USA. Delaware CAN aims to reduce Delaware's unintended pregnancy rate by increasing access to the full range of contraceptive methods for all women.

Upstream USA's mission is to change health care so that all women receive the highest quality services and have convenient access to the full range of contraceptive methods, including the most effective IUDs and the implant. Upstream USA provided training to everyone in all three sites, in all three counties on how to insert IUDs and the implant.

The group is partnering with the following: Henrietta Johnson, Christian Health Care, La Red, Brandywine School District, and West Side Family Clinic. The University of Delaware and The University of Maryland are providing a rigorous evaluation program of Delaware CAN.

Access Issues Survey: The QII group was also asked to provide the top 3 access issues that they are dealing with within their organizations and agencies and send to the Chairperson by the next Quarterly meeting. The Chairperson will have themes of the issues collated and presented and the group will discuss appropriate and effective interventions.

During the 2nd Quarter of this monitoring period, The Access Issues Survey Results were presented and reviewed with the QII group. During the 1st Quarter, the QII group was asked to provide the top 3 access issues that they are dealing with within their organizations and agencies. The following were the themes presented by those who responded to the survey:

- Substance Abuse Treatment -Lack of availability of programs and supportive housing for members needing a level of care lower than residential substance abuse treatment. For example, Partial Hospital Programs that include boarding are limited to out-of-state facilities.
- Behavioral Health Bed availability – Limited availability of treatment programs and beds in the State.
- Nursing Agencies- Limited availability of nursing agencies in Delaware can lead to a need for dual or multiple agencies to staff a case and may increase the possibility for missed shifts. As Delaware is a compact nursing licensure state we are able to utilize providers in Maryland, but not in Pennsylvania or New Jersey.

Discussion around interventions and how these topics are being addressed were presented. Telemedicine was discussed as an intervention to greatly impact the behavioral health and substance abuse treatment access issues in Delaware.

The QII will continue to seek out interventions and barriers to the reaching of successful outcomes to the Access to Care goals and bring back to the next meeting interventions.

The Access Goal of the Quality Strategy was also discussed further with presentations by the MCOs. One MCO presented a review of the Maternity/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Pod as well as the Model of Care. The EPSDT approach to care and improving Access to Services and Care were also discussed.

During the 3rd Quarter of this monitoring period, Goal 2 of the Quality Strategy was discussed: To improve quality of care and services provided to DSHP, DSHP Plus, and CHIP members.

The agencies and Managed Care Organizations presented interventions and any barriers to care within the discussions and presentations.

The QII participants continued the Access Survey discussion, highlighting the interventions (including technology) to address the issues identified by the MCOs in their access surveys. In addition, transportation issues were identified as an issue and a Mobile Van service was described as a way to improve Access to Care. One MCO described The Embedded Care Coordination model to the QII participants. This model assists in identifying and providing care coordination to the hospitalized members. It collaborates both internally and externally with a large pediatric hospital provider and the MCO's staff to address and to remediate barriers to discharge. A goal is to assist in ensuring follow-up care is coordinated prior to discharge and to educate members regarding the Care Coordination program and benefits, EPSDT and applicable community resources. This goal is also ensuring access to care and resources.

During the 4th Quarter of this monitoring period, Goal 3 of the Quality Strategy was discussed: To Control the growth of healthcare expenditures.

The Enhanced Behavioral Health Care Coordination Program was described at Delaware IMD facilities as well as staff responsibilities when meeting face to face with hospitalized members. A review of the outcome measures from evaluation completed by Population Health Analytics Report Team was also provided. The objective of the report was to provide a comprehensive evaluation of the Delaware Enhanced Care Coordination Program. Key metrics that were provided:

- 7 day post discharge office visit rate;
- The number of 30 post discharge ED visits per member;
- The average length of stay for member.

Positive Outcomes were shown in that the visit rate increased from 24% to 31% after the program intervention. The average length of stay for members decreased to 5.8 from 6.3 and the 30-day post discharge ED visits decreased from 0.8 to 0.7.

Readmission rate has declined in the measurement year 7/2017-6/30/2018. 19.2%.

Another reduction has been excessive emergency department use.

LTSS Visits/1000 has decline 22.6% in the measurement year 7/1/2017 – 6/30/2018.

QII participants also focused on efforts to control costs through member engagement and efforts to identify social determinants of health, including barriers for members in accessing and engaging in care.

Other programs presented were Reducing Readmissions and Low-Acuity Non-Emergent ER Utilization. The ER diversion survey was also utilized. This survey helps to identify barriers that led the member to the ER for care and assist in preventing the member from using the ER for non-emergent services. Barriers identified include the availability of real-time data, direct information from ER providers, and the inability to contact members.

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; and one for which the topic is prescriptive, but the MCOs develop their own the operations of the PIP. This PIP 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.

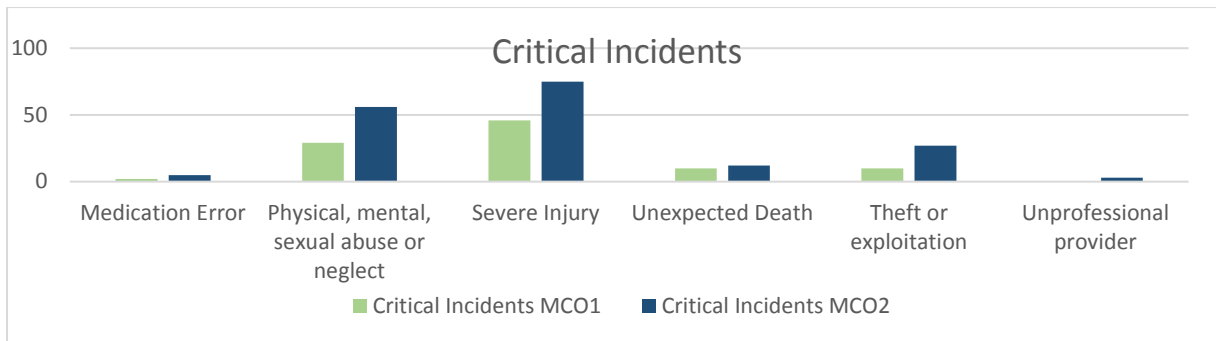
DMMA continues to use a reporting template and instructions for reporting of PIPs. The MCOs are provided feedback on the compliance of their submissions of the PIPs. DMMA has provided technical assistance to help develop the PIPs and further assistance to help develop Rapid Cycle Analysis. Over the past reporting cycle, it has been observed that the MCOs and their teams are requesting assistance with the Performance Improvement rapid cycle processes.

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, however, attaining appropriate data sources to provide rapid cycle processes continue to be a concern for the MCOs.

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. 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.

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 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.



Pathways to Employment Interdivisional Quality Team (IQT)

Pathways to Employment provides the following: Employment Navigator, Financial Coaching Plus, Benefits Counseling, Non-Medical Transportation, Orientation, Mobility and Assistive Technology, Career exploration and Assessment, Small Group Supported Employment, Individual Supported Employment, and Personal Care (including option for self-direction). These services are provided to those individuals with intellectual disabilities, autism spectrum disorders, visual impairments, or physical disabilities who meet specified functional criteria to attain and sustain employment in jobs in a competitive field.

The Pathways IQT met quarterly to review the completed excel spreadsheet used for quality data reporting. New program data is added as it becomes available to the PTE program Data Report to capture.

CHIP Annual Report Template System (CARTS)

CARTS was successfully completed for FFY 2018 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

28 Adult Core Measurements were entered successfully into MACPro for FFY 2018.

23 Child Core Measurements were entered successfully into MaCPro for FFY 2018.

These represent one contracted MCO as only one eligible MCO to report this measurement year.

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. One MCO will not begin reporting HEDIS measures until next measurement year as the MCO was contracted with DMMA for this

measurement year. The HEDIS data for each MCO for each measure will be available when the 2018 External Quality Review Report is finalized and published in April 2019.

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. Only one MCO performed a CAHPS survey this measurement year as one MCO was not contracted for the entire measurement year. The results were reported and discussed in the Quality Improvement Initiatives Task Force with ways to improve results as well as how positive results were attained.

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 and in 2018, DMMA and DSAMH continued to work toward improvements in the areas addressed in the assessment. 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.

Pharmacy Focus Study

In 2018, Delaware's EQRO conducted a pharmacy focused study to identify treatment engagement differences and best practices among Delaware Medicaid members. The purpose of the pharmacy focus study was to identify differences in treatment engagement levels for Medicaid members prescribed buprenorphine for an opioid use disorder (OUD) and potential, underlying reasons for any noted differences. Buprenorphine is a prescription drug used to treat OUDs. While medication is an important part of successfully treating certain addictions, including OUD, research has shown Medicated Assisted Treatment (MAT) is most beneficial when used in combination with counseling, other behavioral therapies, peer support, and/or self-help groups. The results of this study will be made available as part of the 2018 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)

Expenditure Containment Initiatives

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

Financial/Budget Neutrality Development/Issues

DMMA has updated budget neutrality and submitted to CMS as part of the negotiations on the DSHP 1115 extension.

Member Month Reporting

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

Program Integrity (2018)

Delaware Medicaid has commenced with in-depth policy reform. Bi-weekly meeting discussions led by Fraud, Waste, and Abuse (FWA) contractor Qlarant have risen to include stakeholders and other subject matter experts. Policy draft changes are continuing to be suggested, evaluated and shared with stakeholders. Policy areas that are currently being vetted include but are not limited to Attendant and Respite Care Services, Durable Medical Equipment (DME), Inpatient Services, Recipient Eligibility, Appeal Process and Ambulance Services.

The introduction of overpayment extrapolation to the Delaware provider community is encountering no resistance as overpayments continuing to be Identified and successfully collected. Audit Plans for fraud-prone areas such as Private Duty Nursing Services, Personal Care Services and Chiropractic Services are underway and in the final phases of completion. Audit plan criteria include reviewing all claims paid by the two Managed Care Organizations (MCOs) that service Delaware Medicaid, as well as Fee-for-service claims. New Analytical and Algorithm development for combatting FWA is progressing and ongoing. Thus far, analytic

efforts have produced several new edits that are ready for system deployment and collection of claim samples for utilization review.

A thorough assessment of essential training needs is being conducted and the focus is keeping relevant with nationwide FWA trends and the educational training needs for Delaware Medicaid Nurse Reviewers. With the assistance of Qlarant staff, Delaware Medicaid is developing a comprehensive Training Manual to be utilized for the training of newly hired Nurse Reviewers.

Collaborative fraud detection efforts with other investigative agencies are continuing to identify improperly paid Medicaid taxpayer dollars. Steadfast investigations continue to become a deterrent to aberrant Medicaid providers and members by producing successful prosecutions. The return of Medicaid monies continues to flow back into the Delaware Medical Assistance Program through restitution payments.

Lastly, the collaborative partnership with the Unified Program Integrity Contractor (UPIC) SafeGuard Services (SGS) has progressed. Audit Work Plans for Pharmacy compliance, opioid overprescribing, overlapping payments between MCO and FFS, as well as duplication of payments have been discussed and are currently near completion.

Program Integrity Reviews of both contracted MCOs were completed by the State's External Quality Review Organization (EQRO) in December 2018. Part of this review process was verifying that the plans were conforming to the Corrective Action Plans established during the previous year's review.

Family Planning Expansion Program

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

Demonstration Evaluation

DMMA submitted an interim evaluation to CMS in June 2018.

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