



## Delaware Health and Social Services

Division of Medicaid & Medical Assistance

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### DIAMOND STATE HEALTH PLAN

#### Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period

Demonstration Year: 20 (1/1/2017 – 12/31/2017)

Federal Fiscal Quarter: 4/2017 (10/1/2017 –12/31/2017)

#### To **Robin P. Magwood**

Division of State Demonstrations & Waivers (DSDW)

State Demonstrations Group

Centers for Medicare & Medicaid Services

7500 Security Blvd., M/S S2-01-16

Baltimore, MD 21244-1850

(410) 786-0130 Office phone (410) 786-5882 FAX

Email: [Robin.Magwood1@cms.hhs.gov](mailto:Robin.Magwood1@cms.hhs.gov)

#### From: Glyne Williams

Social Service Chief Administrator

Policy, Planning & Quality

Division of Medicaid and Medical Assistance

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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 (90%) 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.

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; 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**

<b>Demonstration Populations</b>	<b>Ever Enrolled</b>
Population 1: Tanf Children less than 21	89,838
Population 2: Tanf Adults aged 21 and over	32,381
Population 3: Disabled Children less than 21	5,369
Population 4: Aged and Disabled Adults 21 and older	6,295
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	55,494
Population 7: Family Planning Expansion	None; program terminated in 2013
Population 8: DSHP-Plus State Plan	9,202

Population 9: DSHP-Plus HCBS	4,378
Population 10: DSHP TEFRA-Like	0
Population 11: ACA Adults at 101-133% FPL	11,562
Total	214,519

Definition: "Ever enrolled" in MCO/PCCM is an unduplicated count of clients in the MCO for at least one day in the October 1, 2017 to December 31, 2017 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)**

United Healthcare Community Plan participated in several community events during the fourth quarter:

Bay Health Go Pink Health Fair, Annual Breast Cancer Awareness event.

Dover High School Health Fair, targeting families with health literature and awareness of the importance of healthy eating.

Fifth Annual Empowering Teens Health Fair in all three counties in our state.

Sixteenth Annual Diabetes Wellness Expo

### **Highmark Health Options**

Highmark Health Options participated in several community events during the fourth quarter;

The Gumboro Community Association hosted a free health fair for the betterment of the citizens in the surrounding communities. Beebe healthcare was in attendance providing free health screenings as well as flu shots.

Beebe Healthcare hosted their Sussex County Health Fair in Frankford, DE. Free health screening and flu shots were available at the event.

Christiana Care Women's Health Navigator hosted their annual "Every Women Counts" health screening event.

Annual Breast Cancer Health Fair event hosted by Bayhealth of Dover; free mammograms screening were available.

### **The State's Health Benefits Manager (HBM)**

#### **Ongoing Activities**

- Continue to educate members about the two health plan options
- Continue to provide ongoing caseworker training about DSHP, DSHP Plus and DHCP
- Continue to assist members 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 members and caseworkers
- Continue to offer translation services for Spanish-speaking members at selected State Service Centers
- statewide, for both oral and written translations
- Continue to supply representatives for oral translations by phone, for caseworkers and members
- Continue to deliver the HBM monthly newsletter and distribute it to all caseworkers

For more detailed information regarding all our activities during this quarter please see

**Attachment-A** the HBM fourth quarter 2017 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. 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, Highmark Health Options and United Healthcare Community Plan participate in these monthly calls assisting families to navigate the complex healthcare field. There were three monthly calls this quarter: October 10<sup>th</sup>, November 14<sup>th</sup> and December 12<sup>th</sup>. DMMA stays in contact outside of scheduled calls to provide assistance to any Medicaid family in need.

#### **Operational/Policy Developments/Issues**

The Department of Health and Social Services (DHSS) announced September 29, 2017 it has selected two companies to operate its Medicaid Managed Care Program effective January 1, 2018. DHSS' Division of Medicaid and Medical Assistance (DMMA) has announced its intent to enter into a new contract to continue its Managed Care Organization (MCO) partnership with Highmark Health Option Blue Cross Blue Shield, which began in 2015. In addition, DHSS announced its intent to contract with AmeriHealth Caritas to join the Medicaid program on January 1, 2018. AmeriHealth Caritas has managed care for Medicaid members in Pennsylvania since 1983.

DMMA's MCO contract with United Healthcare will end on December 31, 2017.

DMMA was very busy during the fourth quarter bringing up a brand new Managed Care Organization, AmeriHealth Caritas DE on January 1, 2018. DMMA contracted with Mercer Government Services to assure a smooth and compliant transition. Mercer performed the onsite Readiness Review at AmeriHealth Caritas Philadelphia PA offices on November 28<sup>th</sup> and 29<sup>th</sup>. The Readiness Review went very well, AmeriHealth Caritas was very prepared and capable of adding seasoned staff from other markets to assure a smooth transition for our clients. The provider network

was very robust. AmeriHealth Caritas offers a Rapid Response Team 24/7 ready to assist our clients with all their medical needs.

### **Delaware Medicaid Enterprise System (DMES)**

**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 worked to gather artifacts and document CMS checklist items to certify our new Delaware Medicaid Enterprise System (DMES). CMS will be onsite in Delaware for certification in December 2017.

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 was able to provide DMES system demonstrations on a variety of functional areas.

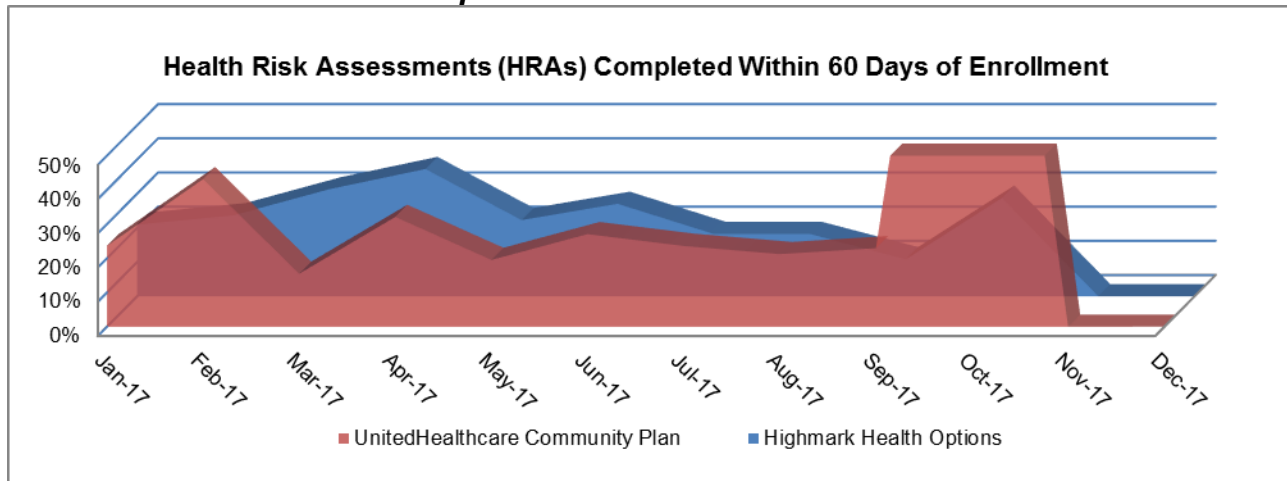
### **QCMMR and QCMMR Plus Reporting**

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.

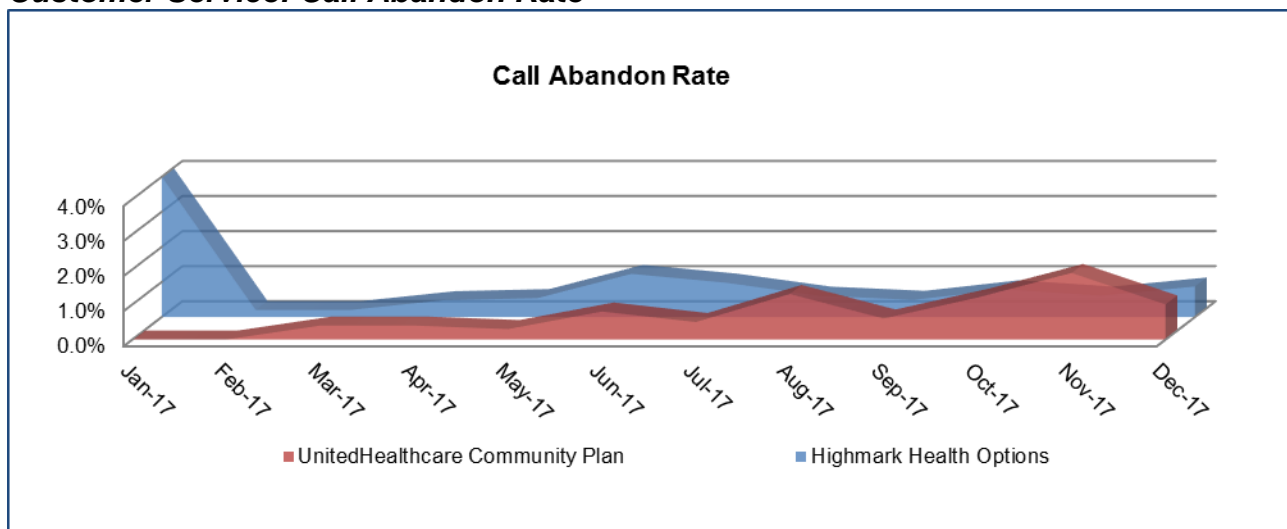
DMMA Managed Care Operations unit developed the full circle approach to the QCMMR and QCMMR Plus reporting. The reports are reviewed by the Managed Care Operations team and an agenda is developed for our monthly meeting with each MCO to discuss the findings from the reports. Manage Care Operation's goal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

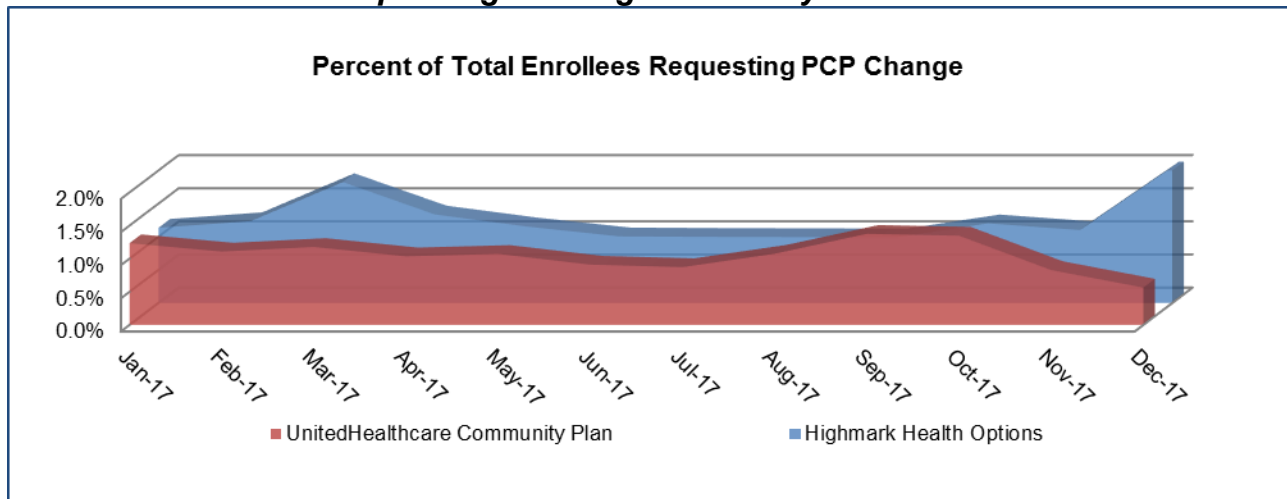
### Health Risk Assessment Completion Rate



### Customer Service: Call Abandon Rate



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



## **Quality Assurance and Monitoring Activity**

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, 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

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.

### **QII Activity**

During the fourth quarter of this monitoring period, goal four of the Quality Management Strategy; to assure member satisfaction with services, was reviewed. The QII forum was used to report on an assortment of ways to assure membership satisfaction with services through reports on Performance Improvement Projects and other Performance Management strategies.

One MCO reported 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%). Training needs to be reinforced to educate members re: importance of survey. There needs to be additional methods to obtain member feedback on the program.

The Key Member Indicator (KMI) Survey is a monthly survey that was described to the QII membership. The advantages of the survey are they: identify trends in member concerns as they arise; track performance and shows the MCO cares; provides an on-going "member voice"; and provides members with another means to resolve issues. The KMI survey asks the following loyalty questions: overall satisfaction; likelihood to recommend; likelihood to continue coverage; and is this

MCO coverage of choice. Using the Net Promoter Score System (NPS): extremely likely (9-10) or not likely at all (0-6). Key drivers and what it means to our members: access to care; plan features; easy to use; PCP/specialist care; and Prescription access/ Co Pay.

Long Term Care Surveys and HCBS surveys were discussed with the group. A goal is to align with National Surveys and the MCOs performing one survey and not individual surveys. The MCOs will await guidance going forward.

### **Case Management Oversight**

The Medical Case Management Unit/Division of Medicaid and Medical Assistance, 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, thru 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 exiting 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, MoveIt 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 thru MoveIt.

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 thru our secure site, MoveIt.

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 4<sup>th</sup> 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.

### **Managed Care Meeting**

The Bi-Monthly Managed Care meetings are 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 establish connections to our sister agencies for coordination of care. DMMA didn't hold any Managed Care meetings during this quarter as we were occupied with bringing on the new plan, AmeriHealth Caritas DE, January 1, 2018 and exiting United Healthcare Community Plan on December 31, 2017. DMMA was in constant contact with all three plans during this time.

### **Medicaid Provider Bulletin**

In the fourth quarter issue;

- New MCO – AmeriHealth Caritas DE joins Delaware Medicaid 2018
- How to Corner; Tips to Help you
- Manual and Form Updates
- PASSR News
- EHR News
- Reminders
- Delaware Cancer Treatment Program revised application
- Prevention
- Vaccines for Children – vaccine storage guidelines
- Program Integrity
- Pharmacy Corner
- Early Periodic Screening, Diagnosis & Treatment Corner
- PERM new payment error rate measurement cycle
- Dental News
- Need Assistance?

To read the entire Delaware Medical Assistance Program Provider 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>	<u>Month 1 October 2017</u>	<u>Month 2 November 2017</u>	<u>Month 3 December 2017</u>	<u>Total Quarter ending December 31, 2017</u>
DSHP TANF CHILDREN	86,019	85,623	85,453	257,095
DSHP TANF ADULT	30,591	30,478	30,380	91,449
DSHP SSI CHILDREN	5,245	5,246	5,268	15,759
DSHP SSI ADULTS	6,207	6,220	6,164	18,591
DSHP MCHP (Title XIX match)	0	0	0	0
Expansion Group <100% FPL	51,636	51,982	52,551	156,169
New ACA Adults 101 to 133% FPL	10,342	10,435	10,584	21,361
FP Expansion	0	0	0	0
DSHP-Plus State Plan	8,909	8,916	8,887	26,712
DSHP-Plus HCBS	4,157	4,218	4,293	12,668
DSHP TEFRA-Like	0	0	0	0
MCHIP Title XXI Chip Funds	0	0	0	0

### Consumer Issues

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

#### HBM Highlights from the HBM Fourth Quarter 2017 report

##### **Summary of Outreach Accomplishments**

- Provided 521 separate translation services for DMMA and DSS programs, for members and caseworkers
- Documented 303 instances of caseworker assistance

- Completed 37 enrollments in person
- Distributed the HBM newsletter each month, statewide, to caseworkers and supervisors
- Provided translation for the Audit Recovery Management Services unit at DSS and the Quality Control Unit

## **Program Integrity**

### **3<sup>rd</sup> 2017 Quarter Program Integrity Update**

Delaware Medicaid has reached the halfway mark of the second option year with our Fraud, Waste, and Abuse Contractor, Health Integrity. The tactical discussions has come to fruition. Provider training seminars have been successful and ongoing. Provider actions are being consistently reviewed. The auditing of claims has moved into a continuous process, and overpayments are be identified. The education of Delaware providers and other stakeholders on Medicaid program integrity matters is continuing. Health Integrity recently identified additional provider areas of risk in Delaware's encounter claim universes, and procedures to operationalize a work plan are being discussed. The current areas of interest focus on the continuation of capitation payments after the date of death, and capitation payments made for 0 to six-year-old children with no history of services received.

### **4<sup>th</sup> 2017 Quarter Program Integrity Update**

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. Collaborative efforts with Health Integrity has established a focus point towards strengthening policy and guidance for Delaware Medicaid and the provider community.

## **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 Report, Fourth Quarter 2017
- DSHP Enrollment Summary
- Telephone Summary
- Forms, Returned Mail & Mailings
- Client Complaints & Assisted Caseworker Calls Summary
- Outreach Report
- DHCP Report
- HBM Objectives

### **Attachment B –**

- 2017 HBM Monthly Newsletters – October, November and December

**Attachment C–** Delaware Medical Assistance Program Provider Bulletin

**Attachment D-** not at this time

### **State Contact(s)**

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**Kathleen Dougherty**  
**Social Service Chief Administrator**  
***DSHP/DSHP-Plus Operations***  
*Division of Medicaid and Medical Assistance*  
*Delaware Health and Social Services*  
*1901 N. DuPont Highway, Lewis Building*  
*New Castle, DE 19720*  
*Phone: 302-255-9937*  
*Fax: 302-255-4481*  
[Kathleen.dougherty@state.de.us](mailto:Kathleen.dougherty@state.de.us)

**Glyne Williams**  
**Social Service Chief Administrator**  
***Policy, Planning & Quality***  
*Division of Medicaid and Medical Assistance*  
*Delaware Health and Social Services*  
*1901 N. DuPont Highway, Lewis Building*  
*New Castle, DE 19720*  
*Phone: 302-255-9628*  
*Fax: 302-255-4481*  
[glyne.williams@state.de.us](mailto:glyne.williams@state.de.us)