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June 22, 2018

Administrator Seema Verma
U.S. Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Ms. Verma,

On September 30, 2013, CMS approved Delaware's request to extend the 1115 Demonstration Waiver project entitled Diamond State Health Plan (DSHP), project number 11-W-00036/4. The Demonstration was authorized beginning September 30, 2013 through December 31, 2018.

On May 15, 2014, CMS approved Delaware's request to amend its section 1115 Medicaid Demonstration Waiver project, DSHP, to move its annual open enrollment period from May to October. Approval of this amendment to the demonstration was effective through December 31, 2018.

On December 19, 2014, CMS approved Delaware's request to amend its section 1115 Medicaid Demonstration Waiver project, DSHP, to help Medicaid beneficiaries with behavioral health needs and functional needs by creating the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) program. Approval of this amendment to the demonstration was effective through December 31, 2018.

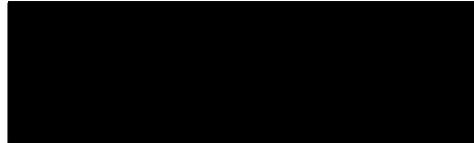
On December 20, 2017, CMS approved Delaware's request to amend its section 1115 Medicaid Demonstration Waiver project, DSHP, to add coverage for certain former foster care youth. Approval of this amendment to the demonstration was effective through December 31, 2018.

Pursuant to Section 1115(a) of the Social Security Act and in accordance with the Special Terms and Conditions of the current Demonstration, the Delaware Department of Health and Social Services/Division of Medicaid and Medical Assistance (DMMA) is requesting a five-year extension of the current DSHP demonstration. DMMA is not requesting any changes to the demonstration for the extension period at this time, but is in the process of planning for initiatives that reflect our vision for Medicaid and CHIP. Delaware does intend to pursue an 1115 demonstration amendment in 2018 to incorporate strategies to address substance use disorders.

Glyne Williams, Chief Administrator of Policy, is our lead person for this Waiver extension. Mr. Williams can be reached at glyne.Williams@state.de.us or by calling (302) 255-9628.

Thank you for your consideration of our request. We look forward to continuing our work with CMS in administering this Demonstration.

Sincerely,



 John C. Carney
Governor



Delaware Health and Social Services

**Delaware Diamond State Health Plan
Section 1115 Demonstration Waiver
Extension Application Request**

to

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

State of Delaware

**Stephen Groff, Director
Division of Medicaid & Medical Assistance (DMMA)**

June 2018

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Section I – Introduction

The current Diamond State Health Plan (DSHP) 1115 Demonstration waiver expires on, December 31, 2018. Pursuant to Section 1115(a) of the Social Security Act, the Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DMMA) is requesting a five-year extension of the current DSHP demonstration. DMMA is also submitting a separate waiver amendment request for substance use disorder (SUD) treatment services that, once approved, is requested to be incorporated into this waiver extension. DMMA is not requesting any other changes to the demonstration for the extension period at this time, but is in the process of planning for initiatives that reflect our vision for Medicaid and CHIP. These initiatives may necessitate future waiver amendments.

Section II – DSHP 1115 Waiver Program Background, Description, Goals and Objectives

Delaware's DSHP 1115 Demonstration Waiver was initially approved in 1995, and implemented on January 1, 1996. The original goal of DSHP 1115 Demonstration was to improve the health status of low-income Delawareans by expanding access to healthcare to more individuals throughout the State; creating and maintaining a managed care delivery system with an emphasis on primary care; and controlling the growth of healthcare expenditures for the Medicaid population.

Delaware has been successful in achieving these early objectives. The DSHP 1115 Demonstration was designed to mandatorily enroll eligible Medicaid recipients into managed care organizations (MCOs) and create cost efficiencies in the Medicaid program that could be used to expand coverage. Delaware achieved its objective of implementation of mandatory managed care focused on primary care in 1996 and invested the resulting waiver savings in Delaware's Medicaid eligibility coverage expansion to uninsured adults up to 100% of the federal poverty level. Long before Medicaid expansion under the Affordable Care Act, Delaware was a pioneer in coverage expansion for individuals who would otherwise not be eligible for Medicaid. Delaware built upon this success with the eventual expansion of coverage for family planning services, leading up to Medicaid expansion under the Affordable Care Act in 2014. The demonstration was previously renewed on June 29, 2000, December 12, 2003, December 21, 2006, and January 31, 2011 and has remained budget neutral to the federal government. Over the last 21 years, Delaware has demonstrated that the DSHP can provide quality physical health, behavioral health, and long-term services and supports through a private and public sector cooperation to a greater number of uninsured or underinsured individuals, and at a lesser or comparable cost than the projected fee-for-service program costs for the Medicaid eligible population. For additional detail on Delaware's success in meeting its goals and objectives, please see the Interim Evaluation summary results in Attachment B.

Through an amendment approved by CMS in 2012, the State was authorized to expand the demonstration to create the Diamond State Health Plan Plus (DSHP-Plus), Delaware's managed long-term services and supports (MLTSS) program, and mandate care through MCOs for additional state plan populations, including (1) individuals receiving care at nursing facilities (NF) other than intermediate care facilities for the mentally retarded (ICF/MR); (2) children in pediatric nursing facilities; (3) individuals who receive benefits from both Medicaid and Medicare (dual eligibles); and (4)

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workers with disabilities who buy-in for coverage. This amendment also added eligibility for the following new demonstration populations: (1) individuals who would previously have been enrolled through the 1915(c) home and community based services (HCBS) waiver program for the Elderly and Disabled – including those receiving services under the Money Follows the Person demonstration; (2) individuals who would previously have been enrolled through the 1915(c) HCBS waiver for Individuals with Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS) Related Diseases; (3) individuals residing in NF who no longer meet the current medical necessity criteria for NF services; and (4) adults and children with incomes below 250 percent of the Supplemental Security Income Federal Benefit Rate who are at risk for institutionalization. Additionally, this amendment expanded HCBS to include: (1) cost- effective and medically necessary home modifications; (2) chore services; and (3) home delivered meals. As noted in the Interim Evaluation summary results, Delaware has been successful in increasing access to HCBS through the implementation of DSHP Plus in 2012.

In 2013, the Demonstration was renewed and amended to provide authority to extend the low income adult demonstration population to individuals with incomes up to 100 percent of the FPL until December 31, 2013. After that date, the demonstration population was not necessary because it was included under the approved state plan as the new adult eligibility group authorized under the Affordable Care Act (ACA). The new adult group, for individuals with incomes up to 133 percent of the FPL, receive medical assistance through enrollment in MCOs pursuant to this Demonstration.

The Demonstration was later amended at the end of 2014 to add coverage in 2015 for enhanced behavioral health services and supports for targeted Medicaid beneficiaries through a voluntary program called Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE). PROMISE enrollees include Medicaid beneficiaries who have a severe and persistent mental illness (SPMI) and/or a substance use disorder (SUD) and require HCBS to live and work in integrated settings. As noted in the Interim Evaluation summary results, creation of PROMISE has begun expanding access to behavioral health HCBS, but is still in early stages and has not yet achieved the program's full potential.

A waiver amendment was approved in December 2017 to add coverage for out-of-state former foster care youth.

Delaware's goal today in operating the DSHP 1115 Demonstration waiver is to improve the health status of low-income Delawareans by:

- Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to home and community-based services (HCBS);
- Rebalancing Delaware's LTC system in favor of HCBS;
- Promoting early intervention for individuals with, or at-risk, for having, LTC needs;
- Increasing coordination of care and supports;
- Expanding consumer choices;
- Improving the quality of health services, including LTC services, delivered to all Delawareans;
- Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTSS services where appropriate;

- Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles;
- Expanding coverage to additional low-income Delawareans; and
- Improving overall health status and quality of life of individuals enrolled in PROMISE.
- Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population.

Delaware has completed an interim evaluation of the DSHP 1115 Waiver. The interim evaluation assesses Delaware's progress in meeting ten of the eleven goals in place during the most recent waiver period. (The eleventh goal related to foster-care youth is too new to evaluate.) Overall, this interim evaluation concludes that Delaware has been successful in meeting the DSHP Waiver's goals, but additional efforts may be needed with respect to PROMISE behavioral health services and improving coordination for full-benefit dual eligibles. A summary of this interim evaluation is included Attachment B and the full evaluation report will be submitted with the application. Delaware will continue working towards the goal to improve the health status of low-income Delawareans during the DSHP 1115 Demonstration extension.

Section III – Summary of the Current DSHP 1115 Demonstration

Eligibility – Most eligibility groups in the DSHP 1115 Demonstration are approved in the Medicaid and CHIP State Plan. The 1115 Demonstration extends eligibility to additional groups as necessary for their receipt of LTSS through DSHP-Plus and behavioral health services through PROMISE. These groups are described in detail as “Demonstration Population Expenditures” in the current approved 1115 Demonstration. A waiver amendment was approved in December 2017 to add coverage for out-of-state former foster care youth.

Benefits – Individuals enrolled in the DSHP 1115 Demonstration receive most Medicaid and CHIP State Plan benefits through the DSHP 1115 Demonstration delivery system. Individuals eligible for DSHP-Plus receive comprehensive, integrated LTSS and individuals eligible for PROMISE services receive an enhanced package of behavioral health services.

Delivery System – DSHP and DSHP-Plus benefits are delivered through mandatory enrollment in MCOs. A limited number of benefits, such as children's dental and non-emergency transportation, are delivered through fee-for-service (FFS). PROMISE benefits will continue to be delivered through the FFS PROMISE program administered through the Division of Substance Abuse and Mental Health (DSAMH). In 2017, CMS approved an amendment to include certain DDDS Lifespan Waiver enrollees in MCOs.

Cost Sharing – Cost-sharing does not differ from the approved Medicaid and CHIP State Plans.

Hypotheses and Evaluation – Delaware's proposed hypotheses and draft Evaluation Plan are pending before CMS. Delaware has proposed various methodologies to evaluate the impact of the 1115 Demonstration on access to care, quality of care, cost-containment/cost-effectiveness, and the impact of rebalancing long-term care in favor of HCBS services. For example, Delaware has proposed to evaluate the following questions:

Access to Care

- Is access to primary care providers sufficient?
- Has access to specialists increased under the 1115 Waiver?
- Is access to HCBS providers sufficient in the community?
- Are the members satisfied with the services received under DSHP-Plus?
- Has there been a shift in where services are being received from Nursing Home to community based care?
- What is the Nursing Home admission rate in the DSHP-Plus population?
- What is the Nursing Home discharge rate (other than death) in the DSHP-Plus population?

Quality of Care

- Has the health status of waiver enrollees improved?
- Has the quality of care improved for select performance measures?
- What is the level of enrollee satisfaction with MCOs?

Cost Containment/Cost Effectiveness

- Are actual expenditures less than the per member per month projections for the 1115 waiver?
- Did emergency room care utilization and expenditures decrease for select populations?
- Is there a decrease in nursing home utilization?

The proposed evaluation will use data from a variety of sources as follows:

- Provider Satisfaction Surveys
- Member Satisfaction Survey
- MCO member surveys
- External Quality Review Reports
- Enrollment files and reports
- FFS claims and encounter data as applicable
- Data submitted to the State for review such as contracts, quality management plans; select utilization reports

Delaware has conducted an interim evaluation of the DSHP waiver's goals and a summary of these results is included in Attachment B. The full interim evaluation report will be posted to Delaware's website and submitted to CMS. Delaware looks forward to partnering with CMS to develop an updated demonstration evaluation plan consistent with new CMS direction for 1115 demonstrations in areas such as MLTSS.

Section IV – Changes Under the Demonstration Extension

Delaware is not proposing any changes to the current DSHP 1115 program design for the extension period. Delaware is also submitting a separate waiver amendment request for substance use disorder (SUD) treatment services that, once approved, is requested to be incorporated into this waiver extension.

Section V – Waiver and Expenditure Authorities

Expenditure authority for the proposed SUD amendment, if approved, is the only change proposed for the extension period:

SUD Expenditure authority requested for the amendment and extension periods:

Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an IMD.

No other changes to the DSHP 1115 waiver and expenditure authorities are proposed for the extension period. Delaware is requesting the same waiver and expenditure authorities as those approved in the current DSHP 1115 demonstration.

Section VI – Compliance with Special Terms and Conditions

Delaware is substantially compliant with the DSHP Special Terms and Conditions (STCs). As noted below, Delaware’s draft hypotheses and evaluation plan are pending with CMS and we expect to work with CMS in the development of hypotheses and an evaluation design that reflects our joint commitment to evaluation and outcomes in the DSHP Demonstration. Delaware has completed an interim evaluation of the DSHP 1115 waiver. During the most recent demonstration period, Delaware has invested significant resources and implemented numerous changes to comply with the Affordable Care Act, the Home and Community Based Settings Final Rule, the Mental Health Parity and Addiction Equity Act, and the Medicaid and CHIP Managed Care Final Rule, as required by the Demonstration STCs. Much of this activity occurred in 2016 and 2017 and was reflected in the 2017 annual report to CMS.

A summary of Delaware’s compliance with the STCs is provided below:

Demonstration Eligibility – Medicaid eligibility in Delaware is provided consistent with the Medicaid and CHIP State Plans and STCs #18-22, including the ACA expansion population added to the Demonstration in 2014, the use of modified adjusted gross income (MAGI), and the expanded eligibility under the Demonstration to individuals enrolled in DSHP-Plus and individuals receiving PROMISE behavioral health benefits.

Demonstration Benefits and Cost-Sharing – Medicaid and CHIP benefits are provided consistent with STCs #23-32. During the most recent Demonstration term, Delaware has added LTSS, expanded behavioral health benefits (PROMISE), and benefits under an approved Alternative Benefit Plan to the Demonstration. The Demonstration does not impact cost-sharing.

Demonstration Enrollment, Delivery System – Enrollment in MCOs is mandatory for all Demonstration enrollees, although some benefits remain provided through FFS. Many of the demonstration STCs (#34-46) have since been duplicated by the Medicaid and CHIP Managed Care Final Rule. Delaware has performed an extensive assessment of compliance with the Managed Care Final Rule, communicated challenges and issues to CMS, and revised 2018 MCO contracts to comply with the new rules. In addition, Delaware has demonstrated compliance with these STCs and managed care rules to CMS through readiness review activities that have included CMS attendees, through external quality review and through approved MCO contracts.

MCOs are also coordinating the provision of behavioral health benefits with the new PROMISE program and Delaware submitted a description of how all services will be coordinated (STC #53).

Quality, External Quality Review and Encounter Data – As addressed in STCs #47-52, Delaware has an approved Quality Management Strategy, contracts with a qualified external quality review organization (EQRO) and submits annual EQRO reports to CMS, is compliant with MSIS and T-MSIS reporting, and is compliant with Medicaid managed care requirements for collection and submission of MCO encounter data. A summary of these reports is included in Section VII.

HCBS Delivery System and Reporting Requirements – HCBS services delivered through DSHP-Plus and PROMISE are consistent with STCs #54-59. Notably, HCBS requirements described in the STCs have been incorporated into MCO contracts, are included as part of external quality review, and Delaware's HCBS Statewide Transition Plan has been approved by CMS (STC #54).

Compliance with Managed Care Rule, General Financial Requirements and Budget Neutrality Reporting (STCs #60-87) – As described earlier in the document, Delaware has spent considerable time addressing compliance with the final managed care rule and continues to evaluate compliance with sections of the final rule as they become effective. Delaware participates in monthly monitoring calls and is working to submit all quarterly and annual reports as described in the STCs. Delaware is budget neutral according to evaluation of expenditures and is projected to remain budget neutral to the federal government.

Demonstration of budget neutrality is included in Section VIII. Budget neutrality projections for the requested extension period is also included in Section VIII.

Demonstration Waiver Evaluation – Delaware has submitted a draft Evaluation Plan to CMS for feedback and approval.

1115 Demonstration Reporting – The last quarterly report submitted to CMS was for the fourth quarter of 2017 and the most recent annual report is 2017.

Interim Evaluation Report – A summary of the results from this report has been included in Attachment B. The full report will be posted to Delaware's website and submitted to CMS with the extension application.

Section VII – Summaries of Quality and Monitoring Reports

A summary of Delaware’s quality and monitoring reporting activities is included in Attachment A.

Section VIII – Financial Data and Budget Neutrality

DMMA, working with its actuary, Mercer, developed the budget neutrality models for both the current waiver period (2014-2018) and the extension period (2019-2023). The special terms and conditions define the Medicaid eligibility groups (MEGs) under which waiver enrollment and expenditures will be monitored to demonstrate budget neutrality. The MEGs are defined in two groupings: DSHP state plan and DSHP hypothetical groups. Budget neutrality savings can only be earned on the DSHP state plan group. The following PMPMs and trend rates are defined in the STCs for the DSHP state plan and hypothetical MEGs to develop the without waiver (WOW) budget ceiling.

MEGs/DY	Trend Rate	CY 14 DY 19	CY 15 DY 20	CY 16 DY 21	CY 17 DY 22	CY 18 DY 23
<i>State Plan Groups</i>						
DSHP TANF Child	5.0%	\$413.82	\$434.51	\$456.24	\$479.05	\$503.00
DSHP TANF Adult	5.16%	\$685.11	\$685.11	\$757.64	\$796.73	\$837.84
DSHP SSI Child	5.0%	\$2,360.45	\$2,478.47	\$2,602.40	\$2,732.52	\$2,869.14
DSHP SSI Adult	4.5%	\$2,404.12	\$2,512.31	\$2,625.36	\$2,743.50	\$2,866.96
DSHP State Plan Plus	2.76%	\$2,528.14	\$2,597.92	\$2,669.62	\$2,743.30	\$2,819.02
<i>Hypothetical Groups</i>						
DSHP Adult Group (new)	5.1%	\$463.14	\$486.76	\$511.58	\$537.68	\$565.10
DSHP Adult Group (not new)	5.1%	\$463.14	\$486.76	\$511.58	\$537.68	\$565.10
DSHP TEFRA-like	5.1%	\$2,360.45	\$2,478.47	\$2,602.40	\$2,732.52	\$,869.14
Promise	5.1%	NA	\$1,233.54	\$1,296.45	\$1,362.57	\$1,432.06

The per member per month (PMPM) limit for the DSHP Adult Group was subject to adjustment based on actual experience as described in STC 83.b and such an adjustment was not subject to the amendment process. Delaware experienced significantly different expenditures for this group in CY 2014-2016 and the State submitted a request for a new blended rate in December 2016. CMS requested additional data to support the new blended rate. While the process of adjusting the rate has not been finalized, Delaware has included a proposed adjusted rate in the budget neutrality model.

Using actual experience in CY 2016, Mercer developed a new blended rate. The CY 2016 was used because it represented expenditures once enrollment and experience allowed for the development of a stable, representative PMPM. The blended rate was weighted to accurately represent the member months and actual expenditures for the two segments of the DSHP adult group – adult group members at or below 100% FPL (not new) and adult group member between 101% and 138% FPL (new). Mercer deflated the CY 2016 PMPM by the CMS trend rate for the group, 5.1%, to account for CY 2014 and CY

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2015. Delaware is proposing that the following table should be the applicable PMPMs for the DSHP Adult MEG.

	Trend	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018
DSHP Adult Group	5.1%	\$686.54	\$721.55	\$758.35	\$797.02	\$837.67

The following is a description of the methodology and assumptions used to develop PMPM enrollment trends for each MEG as well as the expenditures for the waiver period.

Member Months and Expenditures – Current Waiver

Member months and expenditures for all waiver MEGs for 2014 through 2016 are based on financial and enrollment information pulled from the State’s information system. Expenditures include FFS payments that constitute wrap-around payments for managed care enrollees subject to budget neutrality. Additionally, the DSHP adult hypothetical MEGs, unlike other MEGs, include expenditures for eligible member months incurred between the time of eligibility and the time of enrollment in an MCO.

Delaware implemented a new payment system called DMES starting in CY 2017 and there may be some claims for CY 2016 that were not paid under the old payment system. As such, there was some claim lag and wrap payments that may need to be added to CY 2016 from the old system. Data for CY 2017 was also determined to be incomplete as the year is not complete. Completion factors for both years were applied to create an estimate of total actual CY 2016 and CY 2017 expenditures. Delaware worked with its actuary, Mercer, to develop these completion factors as well as estimates for CY 2018 expenditures. Mercer used data provided by the State to develop historical payment lags for CYs 2014 and 2015.

Estimates for 2018 expenditures and enrollment are based on data and assumptions used to develop the CMS approved contract rates used in the negotiations with AmeriHealth and Highmark. Adjustments for FFS wrap-around payments were based on historical experience in 2014-2015. Finally, the TEFRA-like MEG in the hypothetical group was added in the current waiver period and is described in the STCs as:

“§1902(e)(3) Children, ages 18 or younger, who are disabled as described in section 1614(a) of the Social Security Act, who do not meet the NF LOC, but who in the absence of receiving care are “at-risk” of institutionalization and meet an “at-risk of NF” LOC. Use financial institutional eligibility rules for individuals who would not be eligible in the community because of community deeming rules.”

The Delaware eligibility system was not able to differentiate between this group and the DSHP SSI Child MEG based on determination of ADLs. The without waiver PMPMs are exactly the same for each group and both have the same trend rate. Member months and expenditures for the TEFRA-like MEG are embedded within the DSHP SSI Child MEG.

Budget Neutrality – CY 2014 – CY 2018

The following table shows the WOW budget neutrality ceiling and the with waiver expenditures. Delaware has shown total waiver savings generated on state plan MEG groups of \$122,638,393. There was a projected potential CY 2018 loss of \$3,138,382 on the hypothetical DSHP Adult Group MEG. The net budget savings for the waiver periods of CY 2014-2018 is projected to be \$119,500,011.

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Table 1					
WOW BN Ceiling for DY 19 - DY 23					
Waiver Year PMPM Limits	DY 19 CY 2014	DY 20 CY 2015	DY 21 CY 2016	DY 22 CY 2017	DY 23 CY 2018
<i>State Plan Groups</i>					
DSHP TANF Child	\$ 413.82	\$ 434.51	\$ 456.24	\$ 479.05	\$ 503.00
DSHP TANF Adult	\$ 685.11	\$ 720.46	\$ 757.64	\$ 796.73	\$ 837.84
DSHP SSI Child	\$ 2,360.45	\$ 2,478.47	\$ 2,602.40	\$ 2,732.52	\$ 2,869.14
DSSHP SSI Adult	\$ 2,404.12	\$ 2,512.31	\$ 2,625.36	\$ 2,743.50	\$ 2,866.96
DSHP-Plus State Plan	\$ 2,528.14	\$ 2,597.92	\$ 2,669.62	\$ 2,743.30	\$ 2,819.02
<i>Hypothetical Groups</i>					
DSHP Adult Group (new)	\$ 686.54	\$ 721.55	\$ 758.35	\$ 797.02	\$ 837.67
DSHP Adult Group (not new)	\$ 686.54	\$ 721.55	\$ 758.35	\$ 797.02	\$ 837.67
DSHP TEFRA like	\$ 2,360.45	\$ 2,478.47	\$ 2,602.40	\$ 2,732.52	\$ 2,869.14
PROMISE		\$ 1,233.54	\$ 1,296.45	\$ 1,362.57	\$ 1,432.06
With Waiver Expenditures for DY 19 - DY 23					
Waiver Year PMPM Limits	DY 19 CY 2014	DY 20 CY 2015	DY 21 CY 2016	DY 22 CY 2017	DY 23 CY 2018
<i>State Plan Groups</i>					
DSHP TANF Child	\$ 304.18	\$ 327.97	\$ 347.24	\$ 368.69	\$ 391.47
DSHP TANF Adult	\$ 520.05	\$ 539.13	\$ 573.77	\$ 598.14	\$ 623.55
DSHP SSI Child	\$ 1,474.36	\$ 1,722.19	\$ 1,670.13	\$ 1,774.32	\$ 1,885.01
DSSHP SSI Adult	\$ 1,515.53	\$ 1,580.44	\$ 1,567.86	\$ 1,628.67	\$ 1,691.83
DSHP-Plus State Plan	\$ 1,944.86	\$ 1,871.23	\$ 1,838.15	\$ 1,869.25	\$ 1,900.88
<i>Hypothetical Groups</i>					
DSHP Adult Group (new)	\$ 437.66	\$ 474.86	\$ 523.41	\$ 557.62	\$ 594.07
DSHP Adult Group (not new)	\$ 659.76	\$ 655.43	\$ 808.83	\$ 853.56	\$ 900.77
DSHP TEFRA like					
PROMISE		\$ 226.33	\$ 227.74	\$ 241.95	\$ 257.05
DSHP HCBS PLUS	\$ 6,476.20	\$ 6,408.80	\$ 6,639.55	\$ 6,751.89	\$ 6,866.14
BUDGET NEUTRALITY	\$ 145,697,305	\$ 134,402,570	\$ 111,880,232	\$ 116,939,993	\$ 122,638,393
HYPOTHETICAL BN	\$ 35,830,729	\$ 69,914,108	\$ 1,343,364	\$ 29,658	\$ (3,138,382)
Combined	\$ 145,697,305	\$ 134,402,570	\$ 111,880,232	\$ 116,939,993	\$ 119,500,011

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Trend Rates – Extension Period

The trend rates used to develop the PMPM rates were developed from state historical expenditures. Enrollment trends were based on estimates from Delaware. The resulting trend rates reflect a weighted average growth rate from the current waiver period. The only exceptions are the DSHP-Plus state plan group growth rate and the PROMISE group growth rate. The growth rate for the DSHP-Plus state plan group was negative and was deemed not reflective of the extension period. A conservative positive growth rate equal to the experience in the DSHP-Plus state plan group was used for the MEG. In addition, due to a lack of information and relative newness of the PROMISE group, cost trends have been set equal to SSI Child MEG.

Without Waiver Budget Neutrality Trends		
Waiver Year PMPM Limits	D19 - D23 CY 2014 - 2018	D24 - D28 CY 2019 - 2023
<i>State Plan Groups</i>		
DSHP TANF Child	5.00%	6.51%
DSHP TANF Adult	5.16%	4.64%
DSHP SSI Child	5.00%	6.34%
DSHP SSI Adult	4.50%	3.88%
DSHP-Plus State Plan	2.76%	1.69%
<i>Hypothetical Groups</i>		
DSHP Adult Group (new)	5.10%	7.94%
DSHP Adult Group (not new)	5.10%	8.10%
DSHP TEFRALike	NA	NA
PROMISE	5.10%	6.24%

Member Months

Member months were trended forward using State forecasts. The following table describes the trends for each MEG and the projected member months for the extension period.

MEGs	Trend	CY 2019 DY 24	CY 2020 DY 25	CY 2021 DY 26	DY 2022 DY 27	DY 2023 DY 28
DSHP TANF Child	2.1%	1,068,358	1,090,793	1,113,700	1,137,088	1,160,966
DSHP TANF Adult	2.0%	355,422	362,530	369,781	377,177	384,172
DSHP SSI Child	2.0%	67,184	68,528	69,899	71,297	72,723
DSHP SSI Adult	1.0%	78,904	79,693	80,489	81,294	82,107
DSHP State Plan Plus	3.0%	115,413	118,875	122,441	126,115	129,898
DSHP Adult Group (new)	3.65%	144,701	149,983	155,457	161,131	167,013
DSHP Adult Group (not new)	1.0%	625,918	632,177	638,499	644,884	651,333
Promise	15%	1,912	2,199	2,528	2,908	3,344
DSHP-Plus HCBS	5.1%	50,244	52,807	55,500	58,330	61,305

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Budget Neutrality – DY 24-28

WOW BN Ceiling for DY 24 - DY 28					
Waiver Year PMPM Limits	DY 24 CY 2019	DY 25 CY 2020	DY 26 CY 2021	DY 27 CY 2022	DY 28 CY 2023
<i>State Plan Groups</i>					
DSHP TANF Child	\$ 535.75	\$ 570.63	\$ 607.78	\$ 647.35	\$ 689.49
DSHP TANF Adult	\$ 876.74	\$ 917.44	\$ 960.03	\$ 1,004.60	\$ 1,051.23
DSHP SSI Child	\$ 3,050.91	\$ 3,244.19	\$ 3,449.71	\$ 3,668.26	\$ 3,900.65
DSHP SSI Adult	\$ 2,978.14	\$ 3,093.64	\$ 3,213.62	\$ 3,338.25	\$ 3,467.71
DSHP-Plus State Plan	\$ 2,866.72	\$ 2,915.22	\$ 2,964.55	\$ 3,014.71	\$ 3,065.72
<i>Hypothetical Groups</i>					
DSHP Adult Group (new)	\$ 905.25	\$ 978.28	\$ 1,057.21	\$ 1,142.50	\$ 1,234.67
DSHP Adult Group (not new)	\$ 905.25	\$ 978.28	\$ 1,057.21	\$ 1,142.50	\$ 1,234.67
PROMISE	\$ 1,521.40	\$ 1,616.30	\$ 1,717.13	\$ 1,824.25	\$ 1,938.05
With Waiver Expenditures for DY 24 - DY 28					
Waiver Year PMPM Limits	DY 24 CY 2019	DY 25 CY 2020	DY 26 CY 2021	DY 27 CY 2022	DY 28 CY 2023
<i>State Plan Groups</i>					
DSHP TANF Child	\$ 415.65	\$ 441.33	\$ 468.59	\$ 497.53	\$ 528.27
DSHP TANF Adult	\$ 650.04	\$ 677.65	\$ 706.44	\$ 736.45	\$ 767.73
DSHP SSI Child	\$ 2,002.60	\$ 2,127.52	\$ 2,260.24	\$ 2,401.24	\$ 2,551.04
DSHP SSI Adult	\$ 1,757.44	\$ 1,825.60	\$ 1,896.40	\$ 1,969.94	\$ 2,046.34
DSHP-Plus State Plan	\$ 1,933.04	\$ 1,965.75	\$ 1,999.01	\$ 2,032.84	\$ 2,067.24
<i>Hypothetical Groups</i>					
DSHP Adult Group (new)	\$ 632.90	\$ 674.26	\$ 718.33	\$ 765.29	\$ 815.31
DSHP Adult Group (not new)	\$ 950.58	\$ 1,003.16	\$ 1,058.64	\$ 1,117.18	\$ 1,178.97
PROMISE	\$ 273.08	\$ 290.12	\$ 308.21	\$ 327.44	\$ 347.87
DSHP HCBS PLUS	\$ 6,982.32	\$ 7,100.47	\$ 7,220.61	\$ 7,342.79	\$ 7,467.03
BUDGET					
NEUTRALITY	\$ 132,566,889	\$ 143,465,479	\$ 155,433,989	\$ 168,582,432	\$ 183,032,024
HYPOTHETICAL BN	\$ 13,422,957	\$ 32,789,733	\$ 55,329,961	\$ 81,456,792	\$ 111,634,091
Combined	\$ 132,566,889	\$ 143,465,479	\$ 155,433,989	\$ 168,582,432	\$ 183,032,024

Section IX – 1115 Transparency Requirements, Public Notice and Post-Award Forum

1. Delaware provided an open comment period from May 1 through May 30, 2018 on the draft extension application.
2. Public Notice of the Section 1115 Demonstration Waiver extension application (consistent with 42 CFR 431.408) was posted on the Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) website on May 1, 2018. A copy of this notice is available at: <http://dhss.delaware.gov/dhss/dmma/medicaid.html>.
3. Delaware published a Notice of Public Comment in the Delaware News Journal and the Delaware State News on April 24, 2018 2018. A copy of these notices can be found in Attachment C.
4. Delaware published a Notice of Public Comment in the Delaware Register of Regulations on May 1, 2018. The publication in the Delaware Register can be found in Attachment C and at: <http://regulations.delaware.gov/register/may2018/>
5. A draft of this Section 1115 Demonstration Waiver extension application was posted on the Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) website on May 1, 2018 at: <http://dhss.delaware.gov/dhss/dmma/medicaid.html>
6. Delaware presented to the Medical Care Advisory Committee on May 23, 2018.
7. Delaware conducted three public hearings on this Section 1115 Demonstration Waiver. Individuals were also invited to attend via teleconference. The information for these hearings is as follows:

a. SUSSEX COUNTY

Date: May 9, 2018
Time: 10:00 AM – 11:00 AM
Location: Thurman Adams State Svc Center
546 S. Bedford St.
Georgetown, DE 19947

b. KENT COUNTY

Date: May 9, 2018
Time: 1:30 PM – 2:30 PM
Location: Thomas Collins Building
540 S. DuPont Hwy
Dover, DE 19901

c. NEW CASTLE COUNTY

Date: May 11, 2018
Time: 3:00 PM – 4:00 PM
Location: DDDS Fox Run Center

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2540 Wrangle Hill Road
Suite 200, Bear, DE 19701

8. Delaware certifies that it used an electronic mailing list to notify the public.
9. Hardcopies of the public notice and draft waiver amendment were available by contacting Nicole Cunningham at the address below. Comments and input were also to be submitted in the following ways:

By email: Nicole.M.Cunningham@state.de.us
By fax: 302-255-4413 to the attention of Nicole Cunningham
By mail: Nicole Cunningham
Division of Medicaid and Medical Assistance
Planning, Policy & Quality Unit
1901 North DuPont Highway
P.O. Box 906
New Castle, Delaware 19720-0906

10. The following is a summary of comments received and associated responses that pertain to the 1115 Demonstration submission:

Delaware received two comments on the draft application. Both commenters recommended that DMMA increase the current coverage thresholds for certain long-term services and supports covered in the DSHP Plus program to reflect increased coverage costs. These commenters also recommended the coverage of stair lifts and elevators in certain circumstances. In response, DMMA is exploring the flexibility afforded under current waiver terms and conditions but is not proposing additional changes to the DSHP Waiver at this time.

Delaware received support for the waiver extension at the May 23rd Medical Care Advisory Committee meeting.

11. Delaware conducted the post-award forums required by 42 CFR 431.420(c) through the Delaware Medical Care Advisory Committee meetings. The initial post-award forum was held on February 19, 2014 and no comments on the waiver progress were received. DSHP is a standing agenda item for each quarterly MCAC meeting and these meetings also serve as the annual post-award forums. Frequent areas for updates and comments on progress include: MCO contracting; managed care enrollment; and special initiatives (e.g., HCBS transition plan, PROMISE, Pathways).

Section X – Demonstration Administration

Name and Title: Glyne Williams, Chief of Policy, Planning, and Quality, DMMA

Telephone Number: (302) 255-9628

Email Address: Glyne.Williams@state.de.us

Attachment A – Performance Monitoring and Quality Reporting

Below is a summary of the most recent activities and information from Delaware’s EQRO reports, focused studies and monitoring.

I. Summary of 2016 External Quality Review Results

Delaware contracts with Mercer Government Human Services Consulting (Mercer) as its EQRO. The EQRO is responsible for performance of all mandatory EQRO activities and, in 2016 (the most recent year available), the following optional activities:

- Assessment of network adequacy to existing contract standards
- Technical assistance in selecting a standardized MLTSS comprehensive assessment tool
- Continued work on ensuring compliance with HCBS settings requirements
- Technical assistance to the MCOs on the Quality Care Management Monitoring Report (QCMMR)
- Participating in State planning efforts related to EQRO support of the new managed care final rule

In 2016, Mercer conducted an external quality review (EQR) of the two MCOs under contract in that year, Highmark Health Options (HHO) and United Healthcare Community Plan (UHCP). The EQRO’s report aimed to assess MCO performance in accordance with the goals identified in DMMA’s current Quality Management Strategy (QMS).

- Goal 1: Improve timely access to appropriate care and services for adults and children with an emphasis on primary and preventive care, and to remain in a safe and least-restrictive environment.
- Goal 2: Improve quality of care and services provided to Diamond State Health Plan (DSHP), DSHP-Plus and Children's Health Insurance Program (CHIP) members.
- Goal 3: Control the growth of health care expenditures.
- Goal 4: Assure member satisfaction with services.

In addition to evaluating MCO performance with respect to DMMA’s QMS goals, the EQR report offers a summary of the comprehensive compliance review based on CMS EQR requirements under 42 CFR 438.358. Based on findings of the descriptive and comparative analyses, Mercer identified MCO strengths and opportunities for improved performance in the delivery of health care services for enrollees in Delaware’s managed Medicaid programs.

A summary of these results is described below:

Overall Member Experience with Care (based on CAHPS survey results)

Member ratings of the entire care delivery experience for children were strong at MCO A and moderate at MCO B. Both MCO A and B had moderate results when members rated their health plans — a key indicator of a member’s experience with the MCO.

Comparing MCO A to MCO B suggests significant opportunities for improvement at both MCOs. Primary concerns for MCO A included the rating of adult personal doctors, adult specialists and all health care delivered to adults. Primary concerns for MCO B include the adult composite score for rating of specialist and the pediatric composite score for getting needed care.

Overall Access Performance (based on HEDIS results)

The comparisons of reportable-HEDIS data between MCOs and against the national benchmarks indicated both MCOs need to focus on quality improvement strategies for accessing preventive and maternity care.

Overall Quality Performance (based on HEDIS results)

Both MCOs have operated at or above the 50th percentile for each of the child/adolescent quality of care measures reported. These services to the young and vulnerable population are key to improving the health outcomes of the Delaware Medicaid populations.

Both MCOs scored low to moderate for overall performance on measures pertaining to quality of care. Both MCOs have opportunities for significant improvement with early detection and service intervention as well as with diabetes management. This topic has been an ongoing theme targeted by DMMA’s Quality Improvement Initiative task force and MCO quality committees.

Compliance Review

The EQRO completed a comprehensive compliance review using the CMS protocol “Assessment of Compliance with Medicaid Managed Care Regulations.” The review addressed the following four areas:

- Enrollee rights and protections
- Quality assessment and performance improvement
- Grievances and appeals
- Certifications and program integrity

Both of Delaware’s Medicaid MCOs performed well overall in 2016, scoring in the highest compliance-rating tier. While MCO A attained greater than 90 percent of possible points in all four areas, MCO B earned greater than 90 percent of the points possible in two areas: Grievances and Appeals and Certifications and Program Integrity. MCO B also obtained a third rating, for Enrollee Rights and Protections, less than one percent below this threshold. These results indicate that both MCOs are compliant with the majority of federal regulations and state contract expectations.

Findings of the compliance review indicate room for improvement at MCO B for Quality Assessment and Performance Improvement metrics.

Validation of Performance Measures (PMs)

The measures reviewed for 2016 included: (1) Antidepressant medication management; (2) Childhood and adolescent immunization rate(s); (3) Live births weighing less than 2,500 grams; (4) Health risk assessments; (5) Number of HCBS critical incidents; and (6) Percent of DSHP-Plus members receiving behavioral health services.

The validation process revealed that MCO A's reported performance measurement was fully compliant for all but one performance measure: the number of HCBS critical incidents. The PM validation review also indicated MCO B as fully compliant in all but two scores: live births weighing less than 2,500 grams and health risk assessment services.

Validation of Performance Improvement Projects (PIPs)

In 2016, the EQRO validated three PIPs by each MCO: one a DMMA-mandated study question, one a DMMA-mandated study topic and one a topic selected by the MCO. The evaluation found a high degree of confidence in the baseline development of the PIPs at MCO A. However, despite significant DMMA investment in 2015 in technical assistance for MCO B, PIP-related data and report submissions did not demonstrate implementation of aspects covered by the technical assistance provided.

Results from the 2017 EQR activities will be available in the second quarter of 2018.

II. Ongoing Quality Assurance and Monitoring Activity

As reported in the most recent quarterly report submitted to CMS (Q1 CY2017), 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 programs based upon the goals identified in the QMS. The QMS goals are monitored through the QII Task Force.

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 first quarter of 2017, Goal 1 of the Quality Management Strategy was reviewed. The QII 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 healthcare. The QII forum also focused on ways to remain in a safe and least-restrictive environment for DSHP, DSHP-Plus, and CHIP members through reports on PIPs and other Performance Management strategies.

For example, the Managed Care Final Rule was discussed as it pertains to access and availability. Improving discharge planning coordination goals was also discussed. A process was put in place to communicate and coordinate all authorization requests. This helps make prescription drugs 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 are addressed. EPSDT members receive outreach from resource coordinators who facilitate attendance at health care appointments; receipt of immunizations; and help address barriers or concerns. Future initiatives will include partnerships with DHSS, Providers, and Wellness Centers.

Quality and Care Management Monitoring Report (QCMMR) Activity

The monthly QCMMR serves as a vital early warning system to identify any areas related to quality, access and/or timeliness (QAT) of services as well as, monitor activities that support enrollee health safety through care coordination and case management. There are 2 QCMMR templates and 2 separate reporting guides (technical specifications). One is for DSHP and DHCP (CHIP) and the other is for DSHP Plus. These are reviewed monthly and a brief summary of items for additional discussion is developed and shared with the MCOs. The MCOs then respond to the inquiry. Through this iterative process DMMA has been able to work to improve the quality and consistency of reporting from the MCOs on key QAT metrics. DMMA also monitors the EQRO CAP items after initial CAP approval by the EQRO.

Case Management Oversight

The Medical Case Management Unit of DMMA has continued with Case Management oversight of the 1115 waiver populations. This oversight is accomplished through on site reviews at the MCOs and joint State/MCO visits with members of the DSHP-Plus and DSHP population. We continue to review and monitor the required Case Management and Care Coordination reporting from the MCOs, including but not limited to the Care Coordination Reports, Case Management for DSHP-Plus LTSS, Service Coordination reports, Self-Directed Attendant Care service and Utilization Management reports. DMMA continues with monthly meetings with each MCO and 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 MCOs and our DMMA Long Term Care (LTC) units to

discuss any LTC issues. During the first quarter of 2017, our Medical Case Management Team planned for our annual onsite EQR at our MCOs.

Our team is worked to coordinate services with our other State Divisions, such as Division of Developmental Disabilities Services, DDDS and Division of Substance Abuse and Mental Health, DSAMH to meet the special needs of our members and maintain them safely in the community. We continued with State/MCO visits for members in our DSHP-Plus and DSHP members as part of our oversight activities.

Managed Care Meetings

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 identify potential Quality Improvement Activities. DMMA held two bi-monthly MCO meetings during the first quarter, January 17th and March 21, 2017.

III. 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.

IV. Program Integrity

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 MCOs 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

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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.

Attachment B – Summary of Waiver Interim Evaluation

DSHP Interim Evaluation Report – Summary

In compliance with the DSHP 1115 Waiver Special Terms and Conditions #90, Delaware has completed an interim evaluation of the DSHP Waiver. Overall, this interim evaluation concludes that Delaware has been successful in meeting the DSHP Waiver’s goals, but additional efforts may be needed with respect to PROMISE behavioral health services and improving coordination for full-benefit dual eligibles. The following is a summary of the interim evaluation results.

This Interim Evaluation summary reports Delaware’s progress towards meeting the following program goals:

1. Improving access to health care for the Medicaid population, including increasing options for those who need long-term care by expanding access to HCBS.
2. Rebalancing Delaware’s long-term care (LTC) system in favor of HCBS.
3. Promoting early intervention for individuals with, or at-risk, for having, LTC needs.
4. Increasing coordination of care and supports.
5. Expanding consumer choices.
6. Improving the quality of health services, including LTC services, delivered to all Delawareans.
7. Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTC services where appropriate.
8. Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles.
9. Expanding coverage to additional low-income Delawareans.
10. Improving overall health status and quality of life of the individuals enrolled in the PROMISE program.

The following resources were used to develop this Summary:

- 2018 Medicaid MCO contracts
- 2015-2017 External Quality Review Organization (EQRO) Reports
- Medicaid MCOs’ Quality Improvement Program Evaluations
- 2015-2016 National Core Indicators Aging and Disability (NCI-AD) Adult Consumer Survey
- 2012-2017 Medicaid Enrollment Data
- 2015-2017 Encounter Data
- 2017 EQRO plan-specific reports
- 2016 and 2017 HEDIS Outcomes
- 2015 MLTSS Focused Study
- 2018 Delaware Behavioral Health Environmental Landscape Report
- 2017 Delaware Pharmacy Focused Study

- 2015-2017 Health Benefit Manager reports

Goal 1: Improving access to health care for the Medicaid population, including increasing options for those who need long-term care by expanding access to HCBS

A fundamental objective in expanding the DSHP program is to provide needed services to covered populations. The following are indicators of Delaware's success and challenges in accomplishing this goal.

- The managed care regulations require MCOs to maintain provider networks that allow members adequate and timely access to care. For PCPs, MCOs must ensure that at least two PCPs are available within 30 miles for urban residents and at least two PCPs are available within 60 miles for rural residents. The DSHP MCOs have consistently met the access standards for PCPs. However, opportunities for improvement exist for improving access to some specialists and strengthening the pediatric subspecialty network.
- Overall findings from the 2017 Pharmacy Focused Study indicate that both DSHP MCOs have higher rates of initiation of alcohol and other dependence treatments for members prescribed buprenorphine relative to national benchmarks.
- Implementation of DSHP Plus in 2012 has increased access to HCBS, including the addition of three new home and community-based services (HCBS) (home modifications, chore services, and home delivered meals).
 - A focused review of managed long-term services and supports (MLTSS) utilization, using 2013 calendar year encounter data, revealed high rates of utilization of several HCBS (home delivered meals, homemaker services, emergency response and centered-based day care services) one year following DSHP Plus implementation.
 - Monthly claim counts for the nursing facility (NF) and HCBS populations between January 2017 and December 2016 demonstrates an increase in HCBS claim counts by almost 11%, while NF claim counts have barely increased.
- Creation of the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) program in 2015 has begun expanding access to behavioral health HCBS. Under PROMISE, enhanced behavioral health services and supports are available for Medicaid beneficiaries who have a severe and persistent mental illness (SPMI) and/or a substance use disorder (SUD) and require HCBS to live and work in integrated settings. As noted later in this evaluation, expanded access under PROMISE has not yet achieved the program's full potential.

Goal 2: Rebalancing Delaware’s LTC system in favor of HCBS

States have long struggled with shifting LTC away from costly, institutional care to supports that enable individuals to remain in the comfort of their local communities. Delaware is no different, but has made tremendous strides in obtaining this objective, as measured by the following indicators.

- In 2012 Delaware changed the LTC level of care (LOC) evaluation criteria so that individuals newly entering the system had to meet a higher LOC for institutional services as compared to HCBS. Individuals require two activities of daily living (ADLs) for institutional stay in comparison to one ADL for HCBS community supports (those currently in the system were grandfathered-in). This change permitted individuals “at risk” of needing institutional services to receive HCBS and potentially delay or avoid the need for institutional care.
- Delaware also added three new HCBS when the DSHP Plus benefit package was created and added expanded case management functions for PLUS LTSS members in the MCO contracts.
- Between January 2013 and April 2017, monthly member counts of NF residents and members receiving HCBS reveal that the HCBS population has grown upwards of 13% on average, while the NF population has only grown around 2%.

Goal 3: Promoting early intervention for individuals with, or at-risk, for having long-term care (LTC) needs

There are several indicators that demonstrate the impact of Delaware’s early intervention efforts.

- With the implementation of DSHP Plus, Delaware created a pathway for individuals at-risk of requiring institutional long-term services and supports (LTSS) to begin receiving HCBS to delay or avoid the need for additional LTSS.
- Delaware also opted to include all Medicare/Medicaid dual eligibles in DSHP Plus, including dual eligibles that do not meet a LTC LOC. These members receive a Health Risk Assessment (HRA).
- Results from the 2015-2016 NCI-AD Survey revealed the following performance on preventive care measures: 81% of DSHP Plus surveyed participants indicated they have had a physical exam or wellness exam in the past year, 56% had a vision exam in the past year, 68% had a flu shot within the past year and 87% had a cholesterol screen with the past year.
- The 2017 EQRO review found that both DSHP MCOs met the following performance measures specifically targeted to the DSHP Plus population: 1) timely completion of a HRA within 60 days of enrollment and 2) percentage of DSHP Plus members receiving one of the following behavioral health services:
 - Inpatient psychiatric services
 - Partial hospitalization services
 - Intensive outpatient services
 - Outpatient psychiatric services

- Inpatient substance abuse services
- Outpatient substance abuse services.

Goal 4: Increasing coordination of care and supports

Delaware strives to provide coordinated care and supports to all members, with particular focus on special populations such as members participating in the PROMISE program and DSHP Plus members. The 1115 waiver has succeeded in increasing coordination of care and supports, as measured in the following areas.

- In 2015, Delaware strengthened the requirements for care coordination in its Medicaid MCO contracts. Medicaid MCOs are also required to provide person-centered case management for DSHP Plus LTSS members. EQRO assessments of the MCOs' care coordination and case management activities show compliance with contractual requirements with areas of strengths and opportunities for improvement.
- The results of the 2015-2016 NCI-AD Survey revealed that, of those DSHP Plus members surveyed, 91% reported they know how to manage their chronic condition, and 83% reported feeling comfortable and supported enough to go home after being discharged from a hospital or rehabilitation facility
- Delaware established expectations for care coordination and supports for PROMISE members when the program began. As PROMISE has gained more operational experience, Delaware has begun assessing additional opportunities to improve coordination of care for PROMISE members between the member's MCO case manager and the member's Division of Substance Abuse and Mental Health (DSAMH) care manager, who coordinates the enhanced behavioral health services.

Goal 5: Expanding Consumer Choice

Consumer choice is defined broadly to include greater availability of services, more freedom regarding personal choices and greater decision making authority. Delaware has expanded consumer choice, as measured by the following indicators:

- Delaware has been able to maintain a choice of two Medicaid MCOs in DSHP, as required by the 1115 waiver.
- Between 2015 and 2017, more DSHP members made an active decision to enroll in a MCO than those who were enrolled by default.
- Implementation of DSHP Plus in 2012 added three new services to the menu of available LTSS (home modifications, chore services, and home delivered meals).
 - Also as a result of DSHP Plus implementation, more individuals have the ability to choose to self-direct personal care services.

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- From the 2015-2016 NCI-AD Survey, DSHP Plus respondents indicated choice in the following areas: 1) 92% of respondents indicated that they can get up and go to bed when they want; 2) 92% indicated they can eat their meals when they want; and 3) 74% say they are able to decorate their room the way they want (group settings).
- Also from the from the 2015-2016 NCI-AD Survey, 79% of DSHP Plus respondents indicated that their paid support staff (personal care services) do things the way they want them done.

Goal 6: Improving the quality of health services, including LTC services, delivered to all Delawareans

The State demonstrates achievement and ongoing improvement of this goal in the following ways:

- Quality improvement initiatives focused on improving timely access to appropriate care and services for adults and children and remaining in a safe and least-restrictive environment for DSHP, DSHP Plus, and CHIP members, which revealed the following outcomes: 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 rate, and unmet needs were addressed.
- Treatment outcomes and prescribing patterns among Delaware Medicaid managed care plans for members prescribed buprenorphine indicate that MCOs have higher rates of initiation and engagement of alcohol and other dependence treatments relative to the national benchmarks.
- The State is continuing to expand its data-informed approach to measure changes in readmissions and calculated baseline readmission totals for the DSHP Plus rate cells split by NF and HCBS populations using 2015 encounter information. The State will continuously monitor future changes against the 2015 baseline.

Goal 7: Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTC services where appropriate

Delaware DSHP Plus MCO capitation rates are developed to incentivize the use of community-based LTC services and gradually shift to more community-based LTC services as described below.

- MCOs receive payments based on a blended HCBS/LTC institution rate and may experience losses if more resources are used for nursing facility LTC services.
- Before implementation of DSHP Plus, Delaware's experience was that more than 60% of nursing facility level of care members resided in a skilled nursing home instead of residing in the community.
- By 2013, the overall split was reduced to 55% of members with a NF LOC residing in a NF.
- The 2018 rate assumption reflects a split of 45.2% skilled NF LOC and 54.8% HCBS. For non-duals, the 2018 rate assumption is 17.7% NF and 82.3% HCBS.

Goal 8: Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles

Delaware has processes in place to coordinate and integrate care for full-benefit dual eligibles from both a care delivery and financial/program integrity perspective. The State is exploring new potential opportunities to increase coordination.

- Full-benefit dual eligibles are enrolled in DSHP Plus and provided care coordination. If the individual requires LTSS, they are also provided with case management services.
- DMMA is enrolled with CMS as a Trading Partner under a Coordination of Benefits Agreement (COBA) which facilitates the exchange of Medicare data. The Medicaid MCOs must accept Medicare data and load the data into their system for use by, at a minimum, case management, care coordination, member services, claims processing, and utilization management staff. Delaware's Medicaid MCOs are responsible for coordinating with Medicare payers, Medicare Advantage plans and Medicare providers as appropriate to coordinate the care of dual eligible members.
- Moving forward, the State will continue exploring opportunities to enhance coordination for full-benefit dual eligibles. For example, the State is considering exploring potential efficiencies related to coordination of prescription drug coverage with Medicare.

Goal 9: Expanding coverage to additional low-income Delawareans

Delaware has expanded healthcare coverage over the life of the 1115 waiver by extending Medicaid eligibility to additional populations and adding new services to the Medicaid benefit package. The 1115 waiver has succeeded in expanding healthcare coverage for low-income Delawareans in the following ways:

- Using savings achieved under managed care in the 1115 waiver, Delaware initially expanded Medicaid health coverage to uninsured Delawareans with incomes up to 100% of the federal poverty level (FPL) and provided family planning coverage to women losing Medicaid pregnancy coverage at the end of 60 days postpartum or losing DSHP comprehensive benefits and have a family income at or below 200% of the FPL.
- Delaware later expanded Medicaid to individuals with incomes up to 133% FPL under the Affordable Care Act in 2014 and uses the 1115 waiver delivery system to provide most Medicaid services to the expansion population.
- In 2012, Delaware launched DSHP-Plus which created new HCBS benefits and expanded access to community-based long-term care services for the elderly and persons with physical disabilities.
- Beginning January 1, 2015, Delaware implemented PROMISE, which expanded access to HCBS for adults who have an SPMI and/or SUD.

- Between the first quarter of 2012 and the third quarter of 2017, total Medicaid enrollment across all rate cells has increased from 573,144 to 659,968 member months.

Goal 10: Improving overall health status and quality of life of the individuals enrolled in the PROMISE program

Delaware implemented PROMISE in 2015. Toward the end of 2017, DMMA commissioned an assessment of Medicaid behavioral health services, including PROMISE services, to understand how services are accessed and to discuss system strengths and gaps. As is often the case when complex systems implement new programs, Delaware has not yet seen PROMISE realize the program's full potential. Below is a summary of the key PROMISE observations and activities:

- Stakeholder commitment to system improvements is strong. State staff, MCOs and providers across the behavioral health landscape are invested in system improvements and are willing to contribute to ongoing planning processes.
- There are several opportunities for improvement in the areas of: operationalizing the benefit design, navigating service eligibility and access, care coordination and care transitions, provider network and evidence-based practices, quality and outcomes measurement. These areas are currently under review by DHSS.
- Delaware is modifying the QCMMR reporting to enable a focus on the receipt of PROMISE services.
- Through implementation of a performance improvement project (PIP) related to achieving primary care visits and medication adherence for PROMISE members with a diagnosis of hypertension, and a significant investment by the State in technical assistance for the MCOs in this area, DMMA identified challenges related to the care coordination system. The State is using this finding to develop a corrective action plan for improving data collection and documenting and assessing the effectiveness of interventions.

Attachment C – Additional Documentation for Transparency Requirements

1. Full Public Notice of the Section 1115 Demonstration Waiver extension application and a copy of the draft extension application (consistent with 42 CFR 431.408) were posted on the Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) website on May 1, 2018.

A copy of this notice and the draft extension application are available at:
<http://dhss.delaware.gov/dhss/dmma/medicaid.html>

2. Notice of intent to file an extension application to CMS in the Delaware Register of Regulations on May 1, 2018.



DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID AND MEDICAL ASSISTANCE
Statutory Authority: 31 Delaware Code, Section 512 (31 Del.C. §512)

GENERAL NOTICE

Delaware Diamond State Health Plan 1115 Demonstration Waiver Amendment and Extension Requests

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code) and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) intends to submit a request to the Centers for Medicare and Medicaid Services (CMS) to immediately amend Delaware's Section 1115 Diamond State Health Plan (DSHP) Demonstration Waiver to address Medicaid coverage of substance use disorder (SUD) treatment services when provided in a setting that qualifies as an institution for mental diseases (IMD).

In compliance with federal public notice requirements of 42 U.S.C. §1315(d) and 42 CFR Part 431, Subpart G, as well as the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code), and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, DHSS / DMMA also gives notice of its intent to file an application with CMS to request a five year extension of the DSHP 1115 Demonstration Waiver, which is currently approved through December 31, 2018. The requested extension period is from January 1, 2019 through December 31, 2023. DHSS/DMMA is not currently requesting any changes to the DSHP 1115 Demonstration Waiver for the extension period, with the exception of the amendment described below.

Purpose

The purpose of this posting is to: (1) provide public notice and receive input for consideration regarding Delaware's DSHP Waiver amendment for SUD treatment services; and (2) provide public notice and receive public input for consideration regarding Delaware's DSHP 1115 Waiver five-year extension request. Delaware is proposing an amendment and an extension that will be submitted to CMS at the same time.

Proposed Amendment: Overview and Summary of Proposed 1115 DSHP Waiver Amendment for SUD Services in IMDs

Federal Medicaid rules generally prohibit Medicaid coverage of services for individuals ages 21-64 provided in settings that qualify as IMDs. However, Delaware's Medicaid managed care program has had a long-standing exception to these rules due to separate policies that govern Medicaid managed care contracts and payment rates, known as Medicaid "in lieu of" services. These policies allowed Delaware to provide coverage in settings that qualify as IMDs if an IMD is a cost-effective alternative setting to an allowable Medicaid state plan setting. In 2016, CMS revised the managed care regulations to limit such IMD stays to no more than 15 days in a month. In recognition of the national opioid/ SUD epidemic and the need for potentially longer, medically necessary residential treatment stays as part of a comprehensive continuum of care for SUD, CMS is now offering states the opportunity to apply for and receive 1115 waiver authority to include IMD settings as Medicaid-covered settings for SUD treatment.

If Delaware does not amend the 1115 waiver, Medicaid funding will no longer be available for SUD services provided in settings that qualify as IMDs. This amendment is needed to avoid unnecessarily disrupting Delaware's substance use continuum of care during the addiction epidemic in Delaware. This amendment will also remove federal Medicaid payment barriers for SUD treatment in IMD settings, regardless of whether the SUD treatment services are delivered through managed care or fee-for-service.

Proposed Extension: Overview and Summary of Proposed DSHP 1115 Waiver Extension DSHP 1115 Waiver Program Description, Goals and Objectives

Delaware's DSHP 1115 Demonstration Waiver was initially approved in 1995, and implemented on January 1, 1996. The original goal of DSHP 1115 Waiver was to improve the health status of low-income Delawareans by expanding access to healthcare to more individuals throughout the state; creating and maintaining a managed care delivery system with an emphasis on primary care; and controlling the growth of healthcare expenditures for the Medicaid population.

In order to achieve this goal, the DSHP 1115 Waiver was designed to mandatorily enroll eligible Medicaid recipients into managed care organizations (MCOs) and create efficiencies in the Medicaid program. Initial savings achieved under managed care enabled the expansion of coverage to certain individuals who would otherwise not be eligible for Medicaid, leading up to Medicaid expansion under the Affordable Care Act in 2014. Since 2012, the DSHP 1115 Waiver provides long-term services and supports (LTSS) to eligible individuals through DSHP Plus, as well as enhanced behavioral health services and supports for targeted Medicaid beneficiaries through a voluntary program begun in 2015 called Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE).

June 2018 DSHP 1115 Waiver Extension Application

A complete description of the current DSHP 1115 Waiver is available at:

<http://dhss.delaware.gov/dhss/dmma/medicaid.html>

Delaware's goal today in operating the DSHP 1115 Waiver demonstration is to improve the health status of low-income Delawareans by:

- Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to home and community based services (HCBS);
- Rebalancing Delaware's LTC system in favor of HCBS;
- Promoting early intervention for individuals with, or at-risk, for having, LTC needs;
- Increasing coordination of care and supports;
- Expanding consumer choices;
- Improving the quality of health services, including LTC services, delivered to all Delawareans;
- Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTSS services where appropriate;
- Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles;
- Expanding coverage to additional low-income Delawareans;
- Improving overall health status and quality of life of individuals enrolled in PROMISE; and
- Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population.

Delaware will continue working to improve the health status of low-income Delawareans during the DSHP 1115 Waiver extension. During the extension, DHSS/DMMA continues to plan and prepare for the future of healthcare in Delaware, including the roles of Medicaid and the Children's Health Insurance Program (CHIP).

DSHP 1115 Waiver Eligibility

No changes to the DSHP 1115 Waiver eligibility are proposed for the extension period. Most eligibility groups in the DSHP 1115 Waiver are approved in the Medicaid and CHIP State Plan. The 1115 Waiver extends eligibility to additional groups as necessary for their receipt of LTSS through DSHP Plus and behavioral health services through PROMISE. These groups are described in detail as "Demonstration Population Expenditures" in the current approved 1115 Waiver. A waiver amendment was recently approved to add coverage for out-of-state former foster care youth.

DSHP 1115 Waiver Benefits

No changes are proposed to the DSHP 1115 Waiver benefits for the extension period. Individuals enrolled in the DSHP 1115 Waiver receive most Medicaid and CHIP State Plan benefits through the DSHP 1115 Waiver delivery system (described below). Individuals eligible for DSHP Plus receive comprehensive, integrated LTSS and individuals eligible for PROMISE services receive an enhanced package of behavioral health services.

DSHP 1115 Waiver Delivery System

No changes are currently proposed to the DSHP 1115 waiver delivery system for the extension period. The delivery system for DSHP and DSHP-Plus benefits during the extension period will continue to be mandatory enrollment in MCOs. A limited number of benefits, such as children's dental and non-emergency transportation, are delivered through fee-for-service. PROMISE benefits will continue to be delivered through the fee-for-service PROMISE program administered through the Division of Substance Abuse and Mental Health (DSAMH). A waiver amendment was recently approved to include DDDS Lifespan Waiver enrollees in MCOs. The SUD amendment proposes to include IMDs as allowable settings for SUD treatment in managed care and fee-for-service.

DSHP Cost Sharing

No changes to cost sharing are proposed for the extension period. Cost-sharing will not differ from the approved Medicaid and CHIP State Plans.

DSHP Waiver Hypotheses and Evaluation

Once the SUD amendment has been approved by CMS, those hypotheses and evaluation plans will be incorporated into the extension period. The SUD amendment proposes to test whether Delaware can enhance the effectiveness of the SUD treatment system in Medicaid by maintenance and expansion of SUD residential services as part of a coordinated, full continuum of care, resulting in increased access and improved health outcomes for individuals with SUD. Delaware expects to evaluate whether the SUD amendment:

- Increases enrollee access to and utilization of appropriate SUD treatment services based on the American Society of Addiction Medicine (ASAM) Criteria;
- Decreases the use of medically inappropriate and avoidable high-cost emergency department and hospital services by enrollees with SUD;

June 2018 DSHP 1115 Waiver Extension Application

- Increases initiation of follow-up after discharge from emergency department for alcohol or other drug dependence; and
- Reduces readmission rates for SUD treatment.

Details on the SUD amendment can be found in the draft application for public comment.

No other changes to the DSHP 1115 waiver proposed hypotheses and evaluation parameters are planned for the extension period. Delaware's proposed hypotheses and evaluation approach is in its draft Waiver Evaluation Plan pending before CMS. Delaware has proposed various methodologies to evaluate the impact of the 1115 Waiver on access to care, quality of care, cost-containment/cost-effectiveness, and the impact of rebalancing LTC in favor of HCBS. For example, Delaware has proposed to evaluate the following questions:

Access to Care

- Is access to primary care providers sufficient?
- Has access to specialists increased under the 1115 Waiver?
- Is access to HCBS providers sufficient in the community?
- Are the members satisfied with the services received under DSHP Plus?
- Has there been a shift in where services are being received from Nursing Home to community based care?
- What is the Nursing Home admission rate in the DSHP Plus population?
- What is the Nursing Home discharge rate (other than death) in the DSHP Plus population?

Quality of Care

- Has the health status of waiver enrollees improved?
- Has the quality of care improved for select performance measures?
- What is the level of enrollee satisfaction with MCOs?

Cost Containment/Cost Effectiveness

- Are actual expenditures less than the per member per month projections for the 1115 waiver?
- Did emergency room care utilization and expenditures decrease for select populations?
- Is there a decrease in nursing home utilization?

The proposed evaluation will use data from a variety of sources as follows:

- Provider Satisfaction Surveys
- Member Satisfaction Survey
- MCO member surveys
- External Quality Review Reports
- Enrollment files and reports.
- Fee-for-service claims and encounter data as applicable.
- Data submitted to the State for review such as contracts, quality management plans; select utilization reports.

An interim evaluation report will be submitted to CMS on ten of the eleven goals in place during the most recent waiver period. (The eleventh goal related to foster-care youth is too new to evaluate.) Overall, this interim evaluation concludes that Delaware has been successful in meeting the DSHP Waiver's goals, but additional efforts may be needed with respect to PROMISE behavioral health services and improving coordination for full-benefit dual eligibles. A summary of this interim evaluation is included in the draft application for public comment.

Waiver and Expenditure Authorities

Expenditure authority for the proposed SUD amendment is the only change proposed for the extension period. No other changes to the DSHP 1115 waiver and expenditure authorities are proposed for the extension period. DHSS/DMMA is requesting the same waiver and expenditure authorities as approved in the current DSHP 1115 Waiver. These include:

Waiver authorities:

1. Amount, duration and scope of services (Section 1902(a)(10)(B) and 1902(a)(17))-To permit benefit packages for DSHP and DSHP Plus enrollees that vary from the State Plan and permit the provision of additional benefits under DSHP Plus and PROMISE.
2. Provision of Medical Assistance Section 1902(a)(8) and 1902(a)(10)-To the extent necessary to enable Delaware to limit the provision of medical assistance (and treatment as eligible) for individuals described in the eligibility group under section 1902(a)(10)(A)(ii)(XX) of the Act and the Medicaid state plan to only former foster care youth who are under 26 years of age, were in foster care under the responsibility of another state or tribe on the date of attaining 18 years of age (or such higher age as the state has elected), were enrolled in Medicaid on that date, and are now residents in Delaware applying for Medicaid.

June 2018 DSHP 1115 Waiver Extension Application

3. Freedom of Choice (Section 1902(a)(23)(A))-To permit mandatory enrollment in MCOs and selective contracting for certain HCBS and transportation providers.
4. Retroactive Eligibility Section 1902(a)(34)-To permit Delaware to not extend eligibility to DSHP and DSHP Plus participants prior to the date that an application for assistance is made, with the exception of institutionalized individuals in nursing facilities and workers with disabilities who buy-in for Medicaid coverage.

Current Expenditure authorities:

Expenditures for the following 1115 Demonstration Populations receiving LTSS or PROMISE services:

1. 217-Like Elderly and Disabled Home and Community Based Services (HCBS) Group
2. 217-Like HIV/AIDS HCBS Group
3. "At-risk" for Nursing Facility Group
4. TEFRA-Like Group
5. Continuing Receipt of Nursing Facility Care Group
6. Continuing Receipt of Home and Community-Based Services Group
7. Continuing Receipt of Medicaid State Plan Services Disabled Children Group.
8. PROMISE Services Group

SUD Expenditure authority requested for amendment and extension periods:

Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an IMD.

DSHP 1115 Waiver Estimate of Expected Increase/Decrease in Annual Enrollment and Annual Aggregate Expenditures

The expected increase in enrollment and expenditures through the extension period reflect the program as currently approved. The estimated enrollment and expenditures for 2018-2023 also reflect the proposed SUD amendment. The SUD amendment is not expected to have a material impact on Medicaid expenditures. No other changes are currently proposed for the extension period.

	Historical Data (Current Waiver Period)				
	2014	2015	2016	2017	2018* (estimated)
Enrollment	180,879	193,774	204,641	200,155	205,158
Expenditures	\$1,577,390,016	\$1,752,418,701	\$1,843,586,926	\$1,989,261,953	2,039,318,474

	Demonstration Extension Period				
	2019	2020	2021	2022	2023
Enrollment	208,974	212,861	216,820	220,853	224,961
Expenditures	\$2,209,320,592	\$2,362,914,413	\$2,527,612,873	\$2,704,251,065	\$2,893,729,626

Public Comment Submission Process

As required by 42 CFR Part 441.304, DHSS/DMMA must establish and use a public input process for any changes in the services or operation of the waiver. Per Del. Code, Title 29, Ch. 101 §10118 (a), The opportunity for public comment shall be held open for a minimum of 30 days after the proposal is published in the *Register of Regulations*, scheduled for May 1, 2018. The public is invited to review and comment on the proposed amendment for SUD treatment services. Comments must be received by 4:30 p.m. on May 31, 2018 and may be submitted as described below.

As required by 42 CFR Part 431, Subpart G, DHSS/DMMA must provide opportunity for public comment on the DSHP 1115 Waiver extension request. Per Del. Code, Title 29, Ch. 101 §10118(a), the opportunity for public comment shall be

June 2018 DSHP 1115 Waiver Extension Application

held open for a minimum of 30 days after the proposal is published in the *Register of Regulations*, scheduled for May 1, 2018.

The public is invited to review and comment on the proposed DSHP 1115 Waiver extension and amendment as of the date of publication of this public notice. Comments must be received by 4:30 p.m. on May 31, 2018.

Comments on the amendment and the extension may be submitted in the following ways:

This public notice and copies of the draft amendment and extension applications are posted on the DHSS/DMMA website at: <http://dhss.delaware.gov/dhss/dmma/medicaid.html>

Comments and input may be submitted in the following ways:

By email: Nicole.M.Cunningham@state.de.us
By fax: 302-255-4413 to the attention of Nicole Cunningham
By mail: Nicole Cunningham
Division of Medicaid and Medical Assistance
Planning, Policy & Quality Unit
1901 North DuPont Highway
P.O. Box 906
New Castle, Delaware 19720-0906

Hardcopies of the public notice may also be obtained by contacting Nicole Cunningham at the address above.

Any public feedback received will be summarized including any changes that will be made as a result of the public comment to the proposed 1115 DSHP Waiver amendment or extension that will be submitted to CMS.

Stephen M. Groff 4/15/2018
Director
Division of Medicaid and Medical Assistance

21 DE Reg. 917 (05/01/18) (Gen. Notice)

3. Documentation of newspaper publication.

INDEPENDENT NEWSMEDIA INC. USA

110 Galaxy Drive • Dover, DE • 19901 • 1-800-282-8586

State of Delaware:

County of Kent:

Before me, a Notary Public, for the County and State aforesaid, Edward Dulin, known to me to be such, who being sworn according to law deposes and says that he is President of Independent Newsmedia Inc. USA, the publisher of the **Delaware State News**, a daily newspaper published at Dover, County of Kent, and State of Delaware, and that the notice, a copy of which is hereto attached, as published in the **Delaware State News** in its issue of April 24, 2018.

[Redacted Signature]

President
Independent Newsmedia Inc. USA

OK To Pay
[Redacted Signature]

Sworn to and subscribed before me this 24th

Day of April A.D. 2018



[Redacted Signature]

Notary Public

June 2018 DSHP 1115 Waiver Extension Application

State Public -
Legal Notices



STATE OF DELAWARE PUBLIC NOTICE DELAWARE HEALTH AND SOCIAL SERVICES DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

DELAWARE DIAMOND STATE HEALTH PLAN 1115 DEMONSTRATION WAIVER AMENDMENT AND EXTENSION REQUESTS

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code) and under the authority of Title 31 of the Delaware Code, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) intends to submit a request to the Centers for Medicare and Medicaid to amend Delaware's Section 1115 Diamond State Health Plan (DSHP) Demonstration Waiver to address Medicaid coverage of substance use disorder (SUD) treatment in a setting that qualifies as an institution for mental diseases (IMD).

In compliance with federal public notice requirements of 42 U.S.C. §1315(d) and 42 CFR Part 431, Subpart G, as well as the State's Administrative Procedures Act (APA - Delaware Code), and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, DHSS / DMMA also gives notice of its intent to file an application with extension of the DSHP 1115 Demonstration Waiver, which is currently approved through December 31, 2018. The requested extension period is from January 1, 2019 through December 31, 2023. DHSS/DMMA is not currently requesting any changes to the DSHP 1115 Demonstration Waiver for the extension period, with the exception of the amendment described below.

Purpose

The purpose of this posting is to: (1) provide public notice and receive input for consideration regarding Delaware's DSHP Waiver amendment for SUD treatment services in a setting that qualifies as an institution for mental diseases (IMD) and (2) receive public input for consideration regarding Delaware's DSHP 1115 Waiver five-year extension request. Delaware is proposing an amendment and an extension of the DSHP 1115 Demonstration Waiver for the extension period, with the exception of the amendment described below.

Proposed Amendment: Overview and Summary of Proposed 1115 DSHP Waiver Amendment for SUD Services in IMDs

Federal Medicaid rules generally prohibit Medicaid coverage of services for individuals ages 21-64 provided in settings that qualify as IMDs. However, Delaware's Medicaid has had a long-standing exception to these rules due to separate policies that govern Medicaid managed care contracts and payment rates, known as Medicaid "in lieu of" care regulations to provide coverage in settings that qualify as IMDs if an IMD is a cost-effective alternative setting to an allowable Medicaid state plan setting. In 2016, care regulations to limit such IMD stays to no more than 15 days in a month. In recognition of the national opioid/ SUD epidemic and the need for potentially longer, more intensive treatment stays as part of a comprehensive continuum of care for SUD, CMS is now offering states the opportunity to apply for and receive 1115 waiver authority to include covered settings for SUD treatment.

If Delaware does not amend the 1115 waiver, Medicaid funding will no longer be available for SUD services provided in settings that qualify as IMDs. This amendment is necessary to ensure that Delaware's substance use continuum of care during the addiction epidemic in Delaware. This amendment will also remove federal Medicaid payment barriers to IMD settings, regardless of whether the SUD treatment services are delivered through managed care or fee-for-service.

Proposed Extension: Overview and Summary of Proposed DSHP 1115 Waiver Extension

DSHP 1115 Waiver Program Description, Goals and Objectives

Delaware's DSHP 1115 Demonstration Waiver was initially approved in 1995, and implemented on January 1, 1996. The original goal of the DSHP 1115 Waiver was to improve the health status of low-income Delawareans by expanding access to healthcare to more individuals throughout the state; creating and maintaining a managed care delivery system with an emphasis on controlling the growth of healthcare expenditures for the Medicaid population.

In order to achieve this goal, the DSHP 1115 Waiver was designed to mandatorily enroll eligible Medicaid recipients into managed care organizations (MCOs) and create a program. Initial savings achieved under managed care enabled the expansion of coverage to certain individuals who would otherwise not be eligible for Medicaid, leading to the Affordable Care Act in 2014. Since 2012, the DSHP 1115 Waiver provides long-term services and support (LTSS) to eligible individuals through DSHP-Plus, as well as health services and supports for targeted Medicaid beneficiaries through a voluntary program begun in 2015 called Promoting Optimal Mental Health for Individuals through Promise (PROMISE). Most individuals enrolled in Medicaid and CHIP are enrolled in the DSHP 1115 Waiver and in MCOs. A limited number of benefits, such as children's transportation, are delivered through fee-for-service. PROMISE benefits are delivered through the fee-for-service PROMISE program administered through the Division of Social Health (DSAMH). A complete description of the current DSHP 1115 Waiver is available at: <http://dhss.delaware.gov/dhss/dmma/medicaid.html>

Delaware's goal today in operating the DSHP 1115 Waiver demonstration is to improve the health status of low-income Delawareans by:

- Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS;
- Rebalancing Delaware's LTC system in favor of HCBS;
- Promoting early intervention for individuals with, or at-risk, for having, LTC needs;
- Increasing coordination of care and supports;
- Expanding consumer choices;
- Improving the quality of health services, including LTC services, delivered to all Delawareans;
- Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTSS services where appropriate;
- Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles;
- Expanding coverage to additional low-income Delawareans; and
- Improving overall health status and quality of life of individuals enrolled in PROMISE.

Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population.

Delaware will continue working towards this goal to improve the health status of low-income Delawareans during the DSHP 1115 Waiver extension. Delaware is not requesting any changes to the DSHP 1115 Demonstration Waiver for the extension period, with the exception of the amendment for SUD services. During the extension, DHSS/DMMA continues to plan for the health status of low-income Delawareans, including the roles of Medicaid and the Children's Health Insurance Program (CHIP).

Public Comment Submission Process

As required by 42 CFR Part 441.304, DHSS/DMMA must establish and use a public input process for any changes in the services or operation of the waiver. Per Del. Code Title 29, Chapter 101, § 101-201(a), the opportunity for public comment shall be held open for a minimum of 30 days after the proposal is published in the Register of Regulations, scheduled for May 1, 2018, to review and comment on the proposed amendment for SUD treatment services. Comments must be received by 4:30 p.m. on May 30, 2018 and may be submitted as follows:

As required by 42 CFR Part 431, Subpart G, DHSS/DMMA must provide opportunity for public comment on the DSHP 1115 Waiver extension request. Per Del. Code, Title 29, Chapter 101, § 101-201(a), the opportunity for public comment shall be held open for a minimum of 30 days after the proposal is published in the Register of Regulations, scheduled for May 1, 2018. The public is invited to review and comment on the proposed DSHP 1115 Waiver extension and amendment as of the date of publication of this public notice. Comment period is from May 1, 2018 to May 30, 2018.

Comments on the amendment and the extension may be submitted in the following ways:

This public notice and copies of the draft amendment and extension applications are posted on the DHSS/DMMA website at: <http://dhss.delaware.gov/dhss/dmma/mex>

Comments and input may be submitted in the following ways:
By email: Nicole.M.Cunningham@state.de.us

By fax: 302-255-4413 to the attention of Nicole Cunningham

By mail: Nicole Cunningham

Division of Medicaid and Medical Assistance Planning, Policy & Quality Unit
1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906

Hardcopies of the public notice may also be obtained by contacting Nicole Cunningham at the address above.

Public Hearings

DHSS/DMMA will hold three public hearings with opportunity for public comment, as listed below.

1. **NEW CASTLE COUNTY:** Date: May 11, 2018 TIME: 3:00 PM to 4:00 PM

LOCATION: **DDDS Fox Run Center**, Suite 200, 2540 Wrangle Hill Road, Bear, DE 19701

2. **KENT COUNTY:** Date: May 9, 2018 TIME: 1:30 PM to 2:30 PM

LOCATION: Thomas Collins Building, 540 S. DuPont HWY., Dover, DE 19901

SUSSEX COUNTY: Date: May 9, 2018 TIME: 10:00 AM to 11:00 AM

LOCATION: Thurman Adams State Svc Center, 546 S. Bedford St, Georgetown, DE 19947

If you are unable to attend the public hearing in person, you may participate by teleconference. To participate via teleconference, on the date and time of the public hearing, call the toll-free number 1-800-441-7995.

Any public feedback received will be summarized including any changes that will be made as a result of the public comment to the proposed 1115 DSHP Waiver Extension th

If you require special assistance or auxiliary aids and/or services to participate in the public hearing (e.g., sign language or wheelchair accessibility), please call the fo

(10) days prior to the hearing for arrangements:

Lauren Gunton at (302) 255-9561

The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations in advance.

Stephan M. Gruff, Director

Date: 4/16/2018



Street Address: (302) 324-2500
950 West Basin Road (800) 235-9100
New Castle, DE 19720

Mailing Address: Legal Desk:
P.O. Box 15505 (302) 324-2676
Wilmington, DE 19850 Legal Fax:
302 324-2249

DIVISION OF MEDICAID
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NEW CASTLE, DE 19720

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04/24/18 A.D 2018



Sworn and subscribed before me, this 24 day of April, 2018

Ad Number: 0002881662

Legal notification printed at larger size for affidavit.



OK To Post

June 2018 DSHP 1115 Waiver Extension Application

Ad Number: 0002881662

Run Dates: 04/24/18

STATE OF DELAWARE
PUBLIC NOTICE
DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

DELAWARE DIAMOND STATE HEALTH PLAN
1115 DEMONSTRATION WAIVER AMENDMENT AND
EXTENSION REQUESTS

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code) and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS)/ Division of Medicaid and Medical Assistance (DMMA) intends to submit a request to the Centers for Medicare and Medicaid Services (CMS) to immediately amend Delaware's Section 1115 Diamond State Health Plan (DSHP) Demonstration Waiver to address Medicaid coverage of substance use disorder (SUD) treatment services when provided in a setting that qualifies as an institution for mental diseases (IMD).

In compliance with federal public notice requirements of 42 U.S.C. §1915(d) and 42 CFR Part 431, Subpart G, as well as the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code), and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, DHSS/DMMA also gives notice of its intent to file an application with CMS to request a five-year extension of the DSHP 1115 Demonstration Waiver, which is currently approved through December 31, 2018. The requested extension period is from January 1, 2019 through December 31, 2023. DHSS/DMMA is not currently requesting any changes to the DSHP 1115 Demonstration Waiver for the extension period, with the exception of the amendment described below.

Purpose

The purpose of this posting is to: (1) provide public notice and receive input for consideration regarding Delaware's DSHP Waiver amendment for SUD treatment services; and (2) provide public notice and receive public input for consideration regarding Delaware's DSHP 1115 Waiver five-year extension request. Delaware is proposing an amendment and an extension that will be submitted to CMS at the same time.

Proposed Amendment: Overview and Summary of Proposed 1115 DSHP Waiver Amendment for SUD Services in IMDs

Federal Medicaid rules generally prohibit Medicaid coverage of services for individuals ages 21-64 provided in settings that qualify as IMDs. However, Delaware's Medicaid managed care program has had a long-standing exception to these rules due to separate policies that govern Medicaid managed care contracts and payment rates, known as Medicaid "in lieu of" services. These policies allowed Delaware to provide coverage in settings that qualify as IMDs if an IMD is a cost-effective alternative setting to an allowable Medicaid state plan setting. In 2016, CMS revised the managed care regulations to limit such IMD stays to no more than 15 days in a month. In recognition of the national opioid/ SUD epidemic and the need for potentially longer, medically necessary residential treatment stays as part of a comprehensive continuum of care for SUD, CMS is now offering states the opportunity to apply for and receive 1115 waiver authority to include IMD settings as Medicaid-covered settings for SUD treatment.

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Proposed Extension: Overview and Summary of Proposed DSHP 1115 Waiver Extension

DSHP 1115 Waiver Program Description, Goals and Objectives

Delaware's DSHP 1115 Demonstration Waiver was initially approved in 1995, and implemented on January 1, 1996. The original goal of the DSHP 1115 Waiver was to improve the health status of low-income Delawareans by expanding access to healthcare to more individuals throughout the state; creating and maintaining a managed care delivery system with an emphasis on primary care; and controlling the growth of healthcare expenditures for the Medicaid population.

Answers for the insurance populations

In order to achieve this goal, the DSHP 1115 Waiver was designed to mandatorily enroll eligible Medicaid recipients into managed care organizations (MCOs) and create efficiencies in the Medicaid program. Initial savings achieved under managed care enabled the expansion of coverage to certain individuals who would otherwise not be eligible for Medicaid, leading up to Medicaid expansion under the Affordable Care Act in 2014. Since 2012, the DSHP 1115 Waiver provides long-term services and support (LTSS) to eligible individuals through DSHP-Plus, as well as enhanced behavioral health services and supports for targeted Medicaid beneficiaries through a voluntary program begun in 2015 called Promoting Optimal Mental Health for Individuals Through Supports and Empowerment (PROMISE). Most individuals enrolled Medicaid and CHIP are enrolled in the DSHP 1115 Waiver and in MCOs. 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). A complete description of the current DSHP 1115 Waiver is available at:

<http://dhss.delaware.gov/dhss/dmms/medicaid.html>

Delaware's goal today in operating the DSHP 1115 Waiver demonstration is to improve the health status of low-income Delawareans by:

- Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS;
- Rebalancing Delaware's LTC system in favor of HCBS;
- Promoting early intervention for individuals with, or at-risk, for having LTC needs;
- Increasing coordination of care and supports;
- Expanding consumer choices;
- Improving the quality of health services, including LTC services, delivered to all Delawareans;
- Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTSS services where appropriate;
- Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles;
- Expanding coverage to additional low-income Delawareans; and
- Improving overall health status and quality of life of individuals enrolled in PROMISE.
- Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population.

Delaware will continue working towards this goal to improve the health status of low-income Delawareans during the DSHP 1115 Waiver extension. Delaware is not requesting any changes to the DSHP 1115 Demonstration Waiver for the extension period, with the exception of the amendment for SUD services. During the extension, DHSS/DMMA continues to plan and prepare for the future of healthcare in Delaware, including the roles of Medicaid and the Children's Health Insurance Program (CHIP).

Public Comment Submission Process

As required by 42 CFR Part 441.304, DHSS/DMMA must establish and use a public input process for any changes in the services or operation of the waiver. Per Del. Code, Title 29, Ch. 101 §10118 (a), The opportunity for public comment shall be held open for a minimum of 30 days after the proposal is published in the Register of Regulations, scheduled for May 1, 2018. The public is invited to review and comment on the proposed amendment for SUD treatment services. Comments must be received by 4:30 p.m. on May 30, 2018 and may be submitted as described below.

As required by 42 CFR Part 431, Subpart G, DHSS/DMMA must provide opportunity for public comment on the DSHP 1115 Waiver extension request. Per Del. Code, Title 29, Ch. 101 §10118(a), the opportunity for public comment shall be held open for a minimum of 30 days after the proposal is published in the Register of Regulations, scheduled for May 1, 2018.

The public is invited to review and comment on the proposed DSHP 1115 Waiver extension and amendment as of the date of publication of this public notice. Comments must be received by 4:30 p.m. on May 30, 2018.

Comments on the amendment and the extension may be submitted in the following ways:

June 2018 DSHP 1115 Waiver Extension Application

This public notice and copies of the draft amendment and extension applications are posted on the DHSS/DMMA website at:

<http://dhss.delaware.gov/dhss/dmna/medicaid.html>

Comments and input may be submitted in the following ways:

By email: Nicole.M.Cunningham@state.de.us
By fax: 302-255-4413 to the attention of Nicole Cunningham
By mail: Nicole Cunningham
Division of Medicaid and Medical Assistance
Planning, Policy & Quality Unit
1901 North DuPont Highway
P.O. Box 906
New Castle, Delaware 19720-0906

Hardcopies of the public notice may also be obtained by contacting Nicole Cunningham at the address above.

Public Hearings

DHSS/DMMA will hold three public hearings with opportunity for public comment, as listed below.

1. NEW CASTLE COUNTY

Date: May 11, 2018
TIME: 3:00 PM to 4:00 PM
LOCATION: **DDDS Fox Run Center**
Suite 200
2540 Wrangle Hill Road
Bear, DE 19701

2. KENT COUNTY

Date: May 9, 2018
TIME: 1:30 PM to 2:30 PM
LOCATION: **Thomas Collins Building**
540 S. DuPont HWY.
Dover, DE 19901

SUSSEX COUNTY

Date: May 9, 2018
TIME: 10:00 AM to 11:00 AM
LOCATION: **Thurman Adams State Svc Center**
546 S. Bedford St.
Georgetown, DE 19947

If you are unable to attend the public hearing in person, you may participate by teleconference. To participate via teleconference, on the date and time of the public hearing, call 1-800-391-2548 and enter passcode 45150795.

Any public feedback received will be summarized including any changes that will be made as a result of the public comment to the proposed 1115 DSHP Waiver Extension that will be submitted to CMS.

If you require special assistance or auxiliary aids and/or services to participate in the public hearing (e.g., sign language or wheelchair accessibility), please call the following contact at least ten (10) days prior to the hearing for arrangements:

Lauren Gunton at (302) 255-9561

The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations in advance.

Stephen M. Grolf
Director
Division of Medicaid and Medical Assistance
4/24-NJ

4/16/2018
Date

CCCC661662-01



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Medicaid & Medical Assistance

**DELAWARE DIAMOND STATE HEALTH PLAN (DSHP)
1115 DEMONSTRATION INTERIM EVALUATION REPORT**

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

State of Delaware

**Stephen Groff, Director
Division of Medicaid & Medical Assistance (DMMA)**

June 2018

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Introduction

Purpose of Evaluation

In compliance with the Special Terms and Conditions of the Diamond State Health Plan (DSHP) Section 1115 Demonstration, the State of Delaware (Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DMMA)) submits to the Centers for Medicare & Medicaid Services (CMS) this Interim Evaluation Report. This evaluation reviews Delaware's progress for the period of September 30, 2013 to December 31, 2017. The following ten¹ program goals are examined in this evaluation:

1. Improving access to health care for the Medicaid population, including increasing options for those who need long-term care by expanding access to home and community-based services (HCBS).
2. Rebalancing Delaware's long-term care (LTC) system in favor of HCBS.
3. Promoting early intervention for individuals with, or at-risk, for having, LTC needs.
4. Increasing coordination of care and supports.
5. Expanding consumer choices.
6. Improving the quality of health services, including LTC services, delivered to all Delawareans.
7. Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTC services where appropriate.
8. Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles.
9. Expanding coverage to additional low-income Delawareans.
10. Improving overall health status and quality of life of the individuals enrolled in the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) program.

Background on DSHP

Delaware's DSHP 1115 Demonstration was initially approved in 1995, and implemented on January 1, 1996. The original goal of the DSHP 1115 Demonstration was to improve the health status of low-income Delawareans by: 1) expanding access to healthcare to more individuals throughout the State, 2) creating and maintaining a managed care delivery system with an emphasis on primary care, and 3) controlling the growth of healthcare expenditures for the Medicaid population.

In order to achieve this goal, the DSHP 1115 Demonstration was designed to mandatorily enroll eligible Medicaid recipients into managed care organizations (MCOs) and create efficiencies in the Medicaid program. Initial savings achieved under managed care enabled the expansion of coverage to certain individuals who would otherwise not be eligible for Medicaid, leading up to Medicaid expansion under the Affordable Care Act (ACA) in 2014. The DSHP 1115 Demonstration was previously renewed on June 29, 2000, December 12, 2003, December 21, 2006, and January 31, 2011.

To continue Delaware's commitment to expanding access to care, the State has amended the DSHP 1115 Demonstration several times during the current renewal period to add new populations and services, as noted in the chart below.

¹ An eleventh goal was added in December 2017 for coverage of the former foster care group; however, this goal was not evaluated as part of this Interim Evaluation report.

2012	2013	2014	2017
<ul style="list-style-type: none"> •Implemented DSHP Plus (MLTSS program) •Added eligibility for new demonstration populations •Added coverage of additional HCBS 	<ul style="list-style-type: none"> •Expanded Medicaid to add the new adult group and added this group to the DSHP managed care program under the 1115 	<ul style="list-style-type: none"> •Implemented Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE), enhanced behavioral health services and supports for targeted Medicaid beneficiaries 	<ul style="list-style-type: none"> •Added coverage for out-of-state former foster care youth

Evaluation Contents and Methodology

In accordance with Special Term and Condition #90, Delaware prepared an interim evaluation of the DSHP 1115 Demonstration and its performance relative to the stated goals. The interim evaluation design addresses the five research questions/topics described in STC #90² and aligns with Delaware’s 10 waiver program goals. This evaluation is organized according to the 10 waiver program goals. For each goal, a summary of goal accomplishments and a discussion of related data and initiatives are presented. This evaluation relies heavily on a review of the assessment and improvement activities implemented to ensure ongoing quality of the program and services provided. The following are the specific data sources used for the evaluation.

- Calendar year 2018 Medicaid MCO contracts and MCO rate-setting methodology
- 2015-2017 External Quality Review Organization (EQRO) Reports
- 2015-2016 National Core Indicators Aging and Disability (NCI-AD) Adult Consumer Survey
- 2012-2017 Medicaid Enrollment Data
- 2015-2017 Encounter Data
- 2015 MLTSS Focus Study
- 2018 Delaware Behavioral Health Environmental Landscape Report
- 2017 Delaware Pharmacy Focus Study
- 2015-2017 Health Benefit Manager reports

² The five questions/topics in STC #90 are: 1) The impact of rebalancing the LTC system in favor of HCBS; 2) The costs and benefits of providing early intervention for individuals with, or at-risk, for having LTC needs; 3) The cost-effectiveness and efficiency of DSHP-Plus in ensuring that appropriate health care services are provided in an effective and coordinated fashion; 4) Effectiveness of the coordination of the MCO and DSAMH case managers, as well as the services provided by the MCO with the enhanced behavioral health services provided by PROMISE; and 5) The extent to which the PROMISE services improve the overall health status and quality of life of the individuals enrolled in PROMISE.

Goal 1. Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS

Highlight

A key programmatic goal of DSHP expansion is to increase access to community-based services and supports in order to delay and/or prevent institutionalization of eligible populations. The following are indicators of Delaware's success and challenges in accomplishing this goal.

- The managed care regulations require MCOs to maintain provider networks that allow members adequate and timely access to care. For PCPs, MCOs must ensure that at least two PCPs are available within 30 miles for urban residents and at least two PCPs are available within 60 miles for rural residents. The DSHP MCOs have consistently met the access standards for PCPs. However, opportunities for improvement exist for improving access to some specialists and strengthening the pediatric subspecialty network.
- Implementation of DSHP Plus in 2012 has increased access to HCBS, including the addition of three new HCBS (home modifications, chore services, and home delivered meals).
- A Delaware focused study (calendar year 2013) revealed high utilization of the three HCBS added with the DSHP Plus amendment in 2012.
- Monthly claims between January 2015 and June 2017 indicate an increase in HCBS monthly claims counts in comparison to steady state for nursing facility (NF) care.
- Creation of the PROMISE program in 2015 has begun expanding access to behavioral health HCBS. Under PROMISE, enhanced behavioral health services and supports are available for Medicaid beneficiaries who have a severe and persistent mental illness (SPMI) and/or a substance use disorder (SUD) and require HCBS to live and work in integrated settings.

Description, Data and Initiatives

Availability of Timely Care

An important measure of access to care is members' ability to receive timely care. The Medicaid managed care regulations (42 CFR 438.206 and 42 CFR 438.207) require that states ensure participating MCOs have provider networks that meet access standards for time and distance. Between 2015 and early 2016, Delaware engaged its EQRO to conduct a multi-phased network adequacy study to evaluate the MCO provider networks and compliance with the updated MCO contract requirements. Particular attention was given to pediatric subspecialty networks. The results revealed that both MCOs consistently met the Pediatric and Adult PCP access standards:

- At least two PCPs are available within 30 miles for urban residents and
- At least two PCPs are available within 60 miles for rural residents.

Both MCOs fell short of meeting access standards for several pediatric subspecialty providers, including: Allergy and Immunology, Child/Adolescent Psychiatry, Dermatology, Surgery and Urology. The report noted an opportunity to strengthen the pediatric subspecialty network through expanding network contracts where there is a shortage of a specific specialty provider type in a geographical area. However, the report noted that existing gaps could possibly be closed through the existing out-of-network, single-case agreement process.

Increasing Access to HCBS

Prior to implementation of DSHP Plus in 2012, access to HCBS outside of the state plan for persons who did not have an intellectual or developmental disability (I/DD) diagnosis was limited to two approved fee-for-service (FFS) HCBS waivers (Elderly and Disabled and HIV Related Diseases). With the implementation of DSHP Plus, the use of waiver “slots” was eliminated for these two groups, HCBS were made available to individuals “at risk” of meeting an institutional level of care, and three new services were added to the menu of HCBS (home modifications, chore services and home delivered meals). These changes were intended to provide expanded access to HCBS.

Two data sources were reviewed to measure increased access to HCBS. In 2015, at the State’s request, Delaware’s EQRO conducted a focused study to review the HCBS utilization patterns of DSHP Plus members. The study used 2013 calendar year encounter data which represented the year following implementation of DSHP Plus. The study was the first in depth review of the MCOs’ HCBS assessment and service authorization processes. Participants who had a comprehensive needs assessment completed by May 31, 2013 and continuous enrollment between May 31, 2013 and December 31, 2013 were included in the study (N=1427). The results revealed high utilization of the three new services (home delivered meals, home modifications and homemaker services (including chore and attendant services)).

Table 1: 2013 Calendar Year HCBS High Utilization of Three HCBS

Service	Number of Users
Home Delivered Meals	489
Home Modifications	61
Homemaker Services (including chore and attendant services)	1,288

A review of more recent data shows continued high utilization of HCBS in comparison to NF services. Monthly claim counts for HCBS and NF between January 2015 and June 2017 demonstrate an increase in HCBS claims by almost 11% over this time. In comparison, NF claims only increased on average by .5% over the same period.

Increasing Access to Behavioral Health HCBS

Delaware is committed to improving the availability and delivery of behavioral health services. In 2014, Delaware amended the DSHP Demonstration to create the PROMISE program. PROMISE, which operates as a FFS program administered through the Division of Substance Abuse and Mental Health (DSAMH), provides needed supports to Medicaid beneficiaries who have an SPMI and/or a SUD and require HCBS to live and work in integrated settings. Through the waiver amendment, which implemented changes to the MCO benefit package for adults, PROMISE participants also began receiving access to a robust SUD continuum of care and behavioral health (BH) crisis services. Additionally, the amendment discontinued the previously imposed limits on BH services. See Goal 10 for an assessment of the impact of PROMISE on access to behavioral health HCBS.

Goal 2. Rebalancing Delaware’s LTC system in favor of HCBS

Highlight

States have long struggled with shifting LTC away from costly, institutional care to supports that enable individuals to remain in the comfort of their local communities. Delaware is no different, but has made tremendous strides in obtaining this objective, as measured by the following indicators.

- In 2012 Delaware changed the LTC level of care (LOC) evaluation criteria so that individuals newly entering the system had access to HCBS at a lower LOC (an “at risk” LOC) than required for institutional services. Under DSHP Plus, individuals require two activities of daily living (ADLs) for institutional stay in comparison to one ADL for HCBS community supports.
- Delaware also added three new HCBS when the DSHP Plus benefit package was created and added expanded case management functions for PLUS members in the MCO contracts.
- Between January 2013 and April 2017, monthly member counts of NF residents and members receiving HCBS reveal that the HCBS population has grown upwards of 13% on average, while the NF population has only grown around 2%.

Description, Data and Initiatives

HCBS Utilization

As mentioned previously, the addition of DSHP Plus in 2012 also expanded availability of HCBS. The addition of three new HCBS in DSHP Plus (home modifications, chore services and home delivered meals) increased the availability of community supports to promote individuals’ successful, long-term community living.

As discussed in Goal 1, the 2015 MLTSS Focused Study looked at utilization rates of key HCBS. The results revealed that of the 12 categories of HCBS reviewed, including the three services added as a result of the DSHP Plus amendment, more than half had high utilization (center-based day care services, emergency response, financial management services, home delivered meals, home modifications and homemaker services (including chore and attendant services)).

Table 2: 2013 Calendar Year HCBS High Utilization

Service	Number of Users
Centered-Based Day Care Services	206
Emergency Response	945
Financial Management Services	171
Home Delivered Meals	489
Home Modifications	61
Homemaker Services (including chore and attendant services)	1,288

Growth of HCBS Population

Monthly member enrollment counts show the impact of the changes in Delaware’s LTC system. Between January 2013 and April 2017, the HCBS population has grown upwards of 13% while the NF population has only grown around 2%. The counts for NF residents has increased and lowered over time. In comparison, the HCBS population has steadily increased. The most recent counts from April 2017 indicate that 2,690 members reside in NF vs. 3,886 members receiving HCBS.

Goal 3. Promoting early intervention for individuals with, or at-risk, for having, LTC needs

Highlight

There are several indicators that demonstrate the impact of Delaware's early intervention efforts.

- With the implementation of DSHP Plus, Delaware created a pathway for individuals at-risk of requiring institutional long-term services and supports (LTSS) to begin receiving HCBS to delay or avoid the need for additional LTSS.
- Delaware also opted to include all Medicare/Medicaid dual eligibles in DSHP Plus, including dual eligibles that do not meet a LTC LOC. These members receive care coordination and a Health Risk Assessment (HRA).
- The 2017 EQRO review found that both DSHP MCOs met the following performance measures specifically targeted to the DSHP Plus population: 1) timely completion of an HRA within 60 days of enrollment and 2) percentage of DSHP Plus members receiving a behavioral health service.
- Results from the 2015-2016 NCI-AD Survey revealed the following performance on preventive care measures: 81% of DSHP Plus surveyed participants indicated they have had a physical exam or wellness exam in the past year, 56% had a vision exam in the past year, 68% had a flu shot within the past year and 87% had a cholesterol screen within the past year. The rates for physical/wellness exam and cholesterol screen within the past year were higher than the NCI-AD state average.

Description, Data and Initiatives

DSHP Plus

The 2012 DSHP Plus amendment created programmatic and structural changes to facilitate early interventions for the LTSS population and persons at risk of requiring institutional care. Delinking LOC criteria for HCBS and institutional services created the ability to provide community supports to persons "at risk" of an institutional placement and potentially prolonging their stay in the community or reducing or avoiding the need for institutional placement.

Early Intervention for Medicare-Medicaid Dual Eligibles

Dual eligibles that meet the LOC criteria for LTSS receive case management supports through the DHSP MCOs. DSHP Plus members who are not eligible for LTSS receive care coordination and an HRA within 60 calendar days of their enrollment date. The HRA provides essential information regarding physical and behavioral health conditions with a special emphasis on identifying a member's need for resources, referrals, wellness programs and community supports; thereby enabling the MCO to identify and put in place needed supports early in the process.

Additional information regarding the coordination and integration of care for dual-eligibles can be found in Goal 8.

MCO Performance on Key Performance Measures

The 2017 EQRO report revealed that both MCOs met Delaware's performance measure for timely completion of HRAs for the non-LTSS dual population (50% of HRAs completed within 60 calendar days of the date of enrollment).

The second important measure to discuss from the 2017 EQRO report is the percentage of DSHP Plus members receiving BH services. This performance measure looks at MCO performance in assisting members in gaining access to critical BH services, defined as:

- Inpatient psychiatric services
- Partial hospitalization services
- Intensive outpatient services
- Outpatient psychiatric services
- Inpatient substance abuse services
- Outpatient substance abuse services

The measure is specifically to determine that of the DSHP Plus members who receive a BH service, the percentage that receives one or more of the specified services above. The 2017 EQRO report found that both MCOs met this performance measure.

2015 NCI-AD Adult Consumer Survey

Additional support for this goal can be found by looking at the results of the data from the NCI-AD Adult Consumer Survey. The NCI-AD Adult Consumer Survey, coordinated by the National Association of States United for Aging and Disabilities (NASUAD) and Human Services Research Institute (HSRI), is a national survey that collects person-reported data about the impact that states' publicly funded LTSS programs have on the quality of life and outcomes of the older adults and adults with physical disabilities. The project officially launched in mid-2015 with 13 participating states³, including Delaware. Data was collected between 2015-2016 lead by the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) with support provided by DMMA.

The survey results revealed that the majority of DSHP Plus respondents reported receiving several preventive services within the past year. Specifically, 81% of DSHP Plus surveyed participants indicated they had a physical exam or wellness exam in the past year, 56% had a vision exam in the past year, 68% had a flu shot within the past year and 87% had a cholesterol screen with the past year. The table below shows how the rates compare with the NCI-AD state average.

³ Colorado, Delaware, Georgia, Indiana, Kansas, Maine, Minnesota, Mississippi, New Jersey, North Carolina, Ohio, Tennessee, and Texas.

Table 3: NCI-AD Adult Survey Preventive Services

	Delaware	NCI-AD State Average
Physical Exam	81%	79%
Vision	56%	59%
Flu shot	68%	70%
Cholesterol	87%	85%

NCI-AD Initiative – Future Years

Delaware recognizes that there were challenges with the 2015-2016 NCI-AD survey. The DSHP Plus sample size was small (N=314) and therefore not optimal to serve as a representative sample of the comprehensive DHSP Plus population. DMMA was not involved at the beginning of the process and therefore was not able to help guide the survey process, educate members and MCOs about the process and the importance of member participation or help improve participation. Delaware is committed to continuing to implement and fund the survey in future years and to develop a survey process that helps to yield important, meaningful results. Data from future survey years will be used to support Delaware’s efforts to strengthen LTSS policy, inform quality assurance activities, and improve the quality of life of LTSS participants.

Goal 4. Increasing coordination of care and supports

Highlight

Delaware strives to provide coordinated care and supports to all members, with particular focus on special populations such as members participating in the PROMISE program and DSHP Plus members. The DSHP 1115 Demonstration has succeeded in increasing coordination of care and supports, as measured in the following areas.

- In 2015, Delaware strengthened the requirements for care coordination in its Medicaid MCO contracts. Medicaid MCOs are also required to provide person-centered case management for DSHP Plus LTSS members. EQRO assessments of the MCOs' care coordination and case management activities show compliance with contractual requirements with areas of strengths and opportunities for improvement.
- The results of the 2015-2016 NCI-AD Survey revealed that, of those DSHP Plus members surveyed, 91% reported they know how to manage their chronic condition, and 83% reported feeling comfortable and supported enough to go home after being discharged from a hospital or rehabilitation facility.
- Delaware established expectations for care coordination and supports for PROMISE members when the program began. As PROMISE has gained more operational experience, Delaware has begun assessing additional opportunities to improve coordination of care for PROMISE members.

Description, Data and Initiatives

Care Coordination Activities

For calendar year 2015, Delaware strengthened the care coordination requirements of the DSHP MCOs. As previously mentioned, the MCOs must assess members' needs through an HRA within 60 days of the member's enrollment. For all members, the MCOs must also provide appointment assistance, linkage to services and access to member wellness programs. The MCOs must use predictive modeling to stratify their member population into the following risk levels and provide the corresponding care coordination activities:

Level	Members	Activity
1	Members who are either pregnant, have one or more chronic conditions, have gaps in preventive care, have comorbid physical health and behavioral health conditions, have high inpatient hospital utilization, polypharmacy, overutilization of prescription drugs, or a high rate of low acuity, non-emergent visits to the emergency room.	Resource coordination
2	Members at the highest risk for adverse health outcomes.	Clinical care coordination

Prior to the start of the 2015 contract, the State's EQRO conducted a readiness review of the MCOs to assess their capacity for meeting contractual standards, including in the area of care coordination. The results of the readiness review indicated that the MCOs had sufficient capacity to begin operations. The State's EQRO also evaluates compliance with contract standards for care coordination as part of its annual review of the MCOs. The 2017 EQRO review encompassed the MCOs' calendar year 2016 operations. The review found strengths for both MCOs. Both MCOs had developed a "low-acuity, non-

emergent (LANE)” report to outreach to members with high LANE emergency room visits. One MCO had implemented activities to increase the completion rate of HRAs, and had initiated a new pilot stratification method to find more members whose care may be impacted through Level 2 clinical care coordination.

In terms of opportunities for improvement, one MCO faced challenges in terms of staffing levels and cohesiveness of care coordination functions to consistently identify and link a member to services. The other MCO was challenged by a staffing model that requires care coordinators to answer clinical queue calls in addition to their care coordination responsibilities.

The 2017 MCO procurement resulted in replacement of one of the DSHP MCOs. The EQRO performed a targeted readiness review of the new MCO which began providing managed acute and LTSS effective January 1, 2018. The targeted readiness review included an evaluation of care coordination capacity. The assessment showed that the MCO was ready to begin management of the DSHP and DSHP Plus populations, including the provision of care coordination.

Moving forward, the State’s EQRO will continue to evaluate the MCOs’ care coordination activities as part of its annual review.

DSHP Plus LTSS Case Management Activities

DSHP MCOs also provide case management for DSHP Plus LTSS members. Like care coordination, the requirements for DSHP Plus LTSS case management were strengthened in the 2015 contract. Case managers must work with members to conduct a needs assessment and develop a person-centered care plan. The case managers then facilitate placement and services based on the member’s choices, and discuss the option for the member to self-direct his/her attendant care services. Case managers provide ongoing monitoring of the care plan in order to assess the continued appropriateness of the services and placement in meeting the member’s needs, and to monitor the quality of the care delivered by the member’s providers.

Like with care coordination, the State’s EQRO evaluates the MCOs’ DSHP Plus LTSS case management activities as part of its annual review. The 2018 EQRO report showed that, as of the fourth quarter of 2017, there were approximately 7,100 members active in case management in the two MCOs. Case manager change requests were extremely low (four total requests). The EQRO identified areas of strength for both MCOs. For example, one MCO had successfully implemented training and tools to ensure the preadmission screening and resident review (PASRR) screening is completed for all nursing facility residents.

In terms of challenges, both MCOs were facing difficulty with case management staffing levels.

2015-2016 NCI-AD Survey Results

The 2015-2016 NCI-AD survey included five questions regarding care coordination. Of the DSHP Plus members surveyed, the following results were obtained:

- 43% had stayed overnight in a hospital or rehabilitation facility (and were discharged to go home) in the past year.
- 83% reported feeling comfortable and supported enough to go home after being discharged from a hospital or rehabilitation facility.

- 84% reported someone followed-up with them after discharge from a hospital or rehabilitation facility (if occurred in the past year).
- 86% reported have one or more chronic condition(s).
- 91% of those who reported having one or more chronic condition(s) reported they know how to manage their chronic condition.

As noted previously, Delaware recognized challenges with the 2015-2016 NCI-AD survey. To enable an evaluation of year-over-year results, Delaware plans to participate in the 2016-2017 NCI-AD survey. Delaware will assess the 2016-2017 survey results and take action as appropriate based on their assessment.

Coordination of Care for PROMISE Members

For PROMISE members, the DSHP MCOs are required to coordinate services provided by the MCO (primary, acute, and any state plan behavioral health services) with the member's assigned DSAMH care manager, who coordinates the enhanced behavioral health services provided FFS by the PROMISE program.

Recent assessments of the behavioral health system in Delaware revealed opportunities to improve the coordination of care for PROMISE members. The State is currently evaluating recommendations to improve care coordination, such as:

- Developing policies and practices that address cross-system longitudinal care management, care coordination and transitions of care.
- Establishing an interdepartmental/division planning process in collaboration with the MCOs to develop policies and procedures for transitions between Departments and the MCOs, and codifying arrangements in a Memorandum of Understanding.
- Inviting adult consumers and youth and their families to participate in the planning process and provide input on system needs and strengths.

Standardized Assessment Instrument

An issue identified through EQRO reviews is the fact that each MCO utilizes different instruments to assess the need for care and determine the type of service and the amount, scope and duration of each service to address identified needs. Delaware understands the limitations associated with continuing to operate in this manner and the inefficiencies presented with a bifurcated approach to assessing need. As such, Delaware has considered developing a standardized assessment instrument by which MCOs would assess the need for and authorize HCBS in a consistent manner. A standardized assessment instrument would provide a rich source of data that can be derived from a comprehensive assessment system.

The issue at hand for Delaware is how best to move forward regarding introducing a standardized assessment instrument into the State's LTSS system of care to create financial savings and administrative efficiencies for the State and MCOs and the associated next steps. Making the commitment to move to a standardize assessment instrument will require investment in staff resources and time and support from the broad community of stakeholders; therefore, thoughtful consideration needs to be given to timing.

Goal 5. Expanding consumer choices

Highlight

Consumer choice is defined broadly to include greater availability of services, more freedom regarding personal choices and greater decision making authority. Delaware has expanded consumer choice, as measured by the following indicators:

- Delaware has been able to maintain a choice of two Medicaid MCOs in DSHP, as required by the 1115 waiver.
- Between 2015 and 2017, more DSHP members made an active decision to enroll in a MCO than those who were enrolled by default.
- Implementation of DSHP Plus in 2012 added three new services to the menu of available LTSS (home modifications, chore services, and home delivered meals). As a result of DSHP Plus implementation, more individuals have the ability to choose to self-direct personal care services.
- From the 2015-2016 NCI-AD Survey, DSHP Plus respondents indicated high-levels of choice in independent living. Also from the 2015-2016 NCI-AD Survey, 79% of DSHP Plus respondents indicated that their paid support staff (personal care services) do things the way they want them done.

Description, Data and Initiatives

Medicaid MCO Choice and Enrollment

Information and choice are the hallmarks of a mandatory Medicaid managed care program. This choice starts with an individual's ability to choose the qualified MCO that will manage their services and provide additional supports. Since challenges in the early 2000's with maintaining multiple MCOs in a small Medicaid market, Delaware has successfully maintained a choice of two Medicaid MCOs for the DSHP program, has been able to expand the services offered by MCOs to include LTSS, and has been able to utilize MCOs to serve the Medicaid expansion population.

Delaware's health benefit manager (HBM) provides support and information to members (outreach, newsletters, etc.) to facilitate their ability to make informed decisions about their care and choose the appropriate MCO to best meet their needs. Members can either make an active decision to enroll in an MCO or, if a decision is not made within 30 calendar days of the postmark date of an enrollment letter, the member is automatically enrolled into an MCO. HBM reports indicate that for program years 2015, 2016, and 2017⁴, more DSHP members made an active choice to enroll in an MCO than those who did not make a choice and were enrolled by default.

⁴ 2017 through end of first quarter.

Table 4: Active Enrollment Choice

Year	Percentage
2015	67%
2016	57%
2017	58%

Choice under DSHP Plus

Once enrolled in an MCO, DSHP members meeting the Plus LOC requirements are eligible for DSHP Plus and have access to an expanded array of acute, behavioral health and physical health services, including LTSS. Also as a result of DSHP Plus, more people were given the opportunity to self-direct their care (have greater choice and control over how their personal care services are provided). This option was not previously available to all populations eligible for Plus including those at risk for institutionalization and persons previously receiving services in the AIDS waiver.

2015-2016 NCI-AD Survey

An additional measure of choice is the extent to which individuals believe they have control over their personal choices. In the NCI-AD 2015-2016 consumer survey, DSHP members self-reported high levels of choice in several key areas of daily activities. They also noted high level of satisfaction with their paid supports they choose. The table below notes these preferences and also compares the responses to the average of all 13 states participating in the 2015-2016 NCI-AD survey.

Table 5: NCI-AD Adult Survey Control Over Personal Choices

Survey Question	Delaware	NCI-AD State Average
Get up and go to bed when they want	92%	91%
Eat meals when they want	92%	87%
Paid support staff do things the way they want them done	79%	86%

As noted previously, Delaware recognized challenges with the 2015-2016 NCI-AD survey and will make adjustments to the survey process moving forward to ensure more meaningful data is captured to inform future program changes.

Goal 6. Improving the quality of health services, including LTC services, delivered to all Delawareans

Highlight

Delaware demonstrates achievement and ongoing improvement of this goal in the following ways:

- Ongoing quality improvement activities which identify areas for improvement and facilitate enhanced quality outcomes such as: 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 rate, and addressing unmet needs.
- Treatment outcomes and prescribing patterns among Delaware DSHP MCOs for members prescribed buprenorphine indicate that MCOs have higher rates of initiation and engagement of alcohol and other dependence treatments relative to the national benchmarks.
- The State is continuing to expand its data-informed approach to measure changes in readmissions and calculated baseline readmission totals for the DSHP Plus rate cells split by NF and HCBS populations using 2015 encounter information. The State will continuously monitor future changes against the 2015 baseline.

Description, Data and Initiatives

Delaware has continued to expand its scope of external quality review (EQR) activities over the years in order to gain a richer wealth of information regarding the quality of services provided. Most recently, the State's 2017 EQR activities were expanded to include the three (3) mandatory activities, compliance review, validation of performance measures, and validation of Performance Improvement Projects (PIPs), as well as a number of optional activities (e.g., Pharmacy Focus Study: Treatment Outcomes and Prescribing Patterns Among Delaware Medicaid Managed Care Plans for Members Prescribed Buprenorphine; Early Periodic Screening Diagnosis and Treatment Focused Study (EPSDT): Briefing document on teen suicide; HCBS statewide transition plan; and Quality Care Management and Measurement Reporting (QCMMR) template revisions and reporting).

Summary of Quality Improvement Initiatives

Delaware's quality improvement activities are multi-faceted. The following provides a highlight of the various quality improvement activities and examples of relevant outcomes.

1. MCO Touch Point Meetings

On a monthly basis, DMMA meets with each MCO to provide a forum to discuss any case management matters in a collaborative manner, identify issues, and plan resolutions. As determined appropriate, DMMA may use the meetings to address a specific programmatic area of focus. As an example, during the first quarter of 2017, Goal 1 of the Quality Management Strategy (i.e., improve timely access to appropriate care and services for adults and children with an emphasis on primary and preventive care, and to remain in a safe and least-restrictive environment) was reviewed. A forum in the subsequent quarter was used for MCOs to report on a variety of methods to improve timely access to appropriate care and services for adults and children with an emphasis on primary, preventive, and behavioral healthcare. The forum also focused on ways for DSHP, DSHP Plus, and CHIP members to remain in a safe and least-restrictive environment as well as other PIPs and performance management strategies. These efforts resulted in the following outcomes: 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 are addressed.

2. Quality Care Management and Measurement Reporting

QCMMR is one of the oversight and monitoring tools used by DMMA to monitor quality, access and timeliness of care management operations of MCOs. The report relies on self-reported monthly data from the MCOs. Highlights of 2017 QCMMR findings for the DSHP and DSHP Plus populations are found below.

Summary of 2017 DSHP Plus QCMMR Findings

Access & Availability

The number of providers for HCBS remained relatively consistent throughout 2017 for both MCOs. MCO 2 had roughly double the number of HCBS providers than MCO 1. At midyear, the Atypical Service Provider count at MCO 1 increased dramatically. This could be the result of recent reclassification to begin capturing more accurate data from an integrated reporting platform.

Behavioral Health Services

A large disparity continued to exist between MCOs regarding numbers of DSHP Plus members receiving services from a BH provider. The rate of DSHP Plus members receiving BH services was consistently twice as high for MCO 2 in comparison to MCO 1.

Safety/Welfare

Critical incidents (CIs) by category are reported for Q4 2017 in Table 6.

Table 6: Critical Incidents by Category for Q4 2017

Category	MCO 1	MCO 2
Unexpected deaths	0	2
Physical, mental, sexual abuse or neglect	6	2
Theft or exploitation	2	3
Severe injury	14	19
Medication error	0	0
Unprofessional provider	0	0

3. EQRO

Delaware’s EQRO is a key player in the State’s quality improvement strategy. The EQRO evaluates and monitors the access, and timeliness of health care services provided by DSHP MCOs. In addition, the EQRO also designs and executes focused clinical studies, the data from which are used to help pinpoint areas for improvement. Several of these studies have been identified in this report.

Initiation and Engagement of Alcohol and Other Dependence Treatment

A pharmacy focus study was completed in December 2017 to identify differences in treatment outcomes among the Delaware MCOs for members prescribed buprenorphine to treat opioid dependence. Buprenorphine is a prescription drug used in medication-assisted treatment (MAT) to treat opioid dependence and is included as a component of a complete treatment program that includes counseling and behavioral therapy.

The specific questions developed for this study were, “Do DMMA members who are receiving buprenorphine have better rates of initiation of Alcohol and Other Drug (AOD) treatment when comparing MCOs?” and “Do DMMA members who are receiving buprenorphine have better rates of engagement of AOD treatment when comparing MCOs?” The study was based on the comparable HEDIS measure which defines initiation as an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. Engagement is defined as an individual initiating treatment and having two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. Overall findings indicate that both MCOs have higher rates of initiation of alcohol and other dependence treatments relative to the national benchmarks. Findings also suggest that both MCOs’ members experience higher rates of engagement of alcohol and other dependence treatments relative to the national benchmarks.

Table 7: Initiation of Alcohol and Other Drug Dependence Treatment

Age	Benchmark	MCO 1	MCO 2
13-17 Years	42.3%	83.3%	40.0%
18+ Years	37.9%	58.9%	63.9%
Initiation Total	38.2%	59.2%	63.7%

Table 8: Engagement in Alcohol and Other Drug Dependence Treatment

Age	Benchmark	MCO 1	MCO 2
13-17 Years	15.4%	66.7%	40.0%
18+ Years	9.7%	28.6%	37.1%
Engagement Total	10.2%	29.1%	37.1%

Hospital Readmission Counts for DSHP Plus in Calendar Year 2015

The State calculated baseline hospital readmission rates among DSHP Plus populations (NF, HCBS, Community Well) using 2015 encounter information. Populations were further stratified as Duals and Non-Duals. As the State moves forward with efforts to reduce preventable readmissions, the data will enable the State to measure changes in readmissions resulting from those initiatives. The State will continuously monitor future changes against the 2015 baseline.

Table 9: Readmission Counts for DSHP Plus Rate Cells in CY 2015

Population	Rate Cell	Readmissions
NF	NF/HCBS Dual	12
NF	NF/HCBS Non-Dual	67
HCBS	NF/HCBS Dual	31
HCBS	NF/HCBS Non-Dual	140
CW	Community Well	117

Goal 7. Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTC services where appropriate

Highlight

Delaware DSHP Plus MCO capitation rates are developed to incentivize the use of community-based LTC services and gradually shift to more community-based LTC services.

Description, Data and Initiatives

MCOs currently receive payments based on a blended HCBS/LTC institution rate and may experience losses if more resources are used for NF LTC services. Before implementation of DSHP Plus, Delaware's experience was that more than 60% of NF LOC members resided in a skilled nursing facility instead of residing in the community. By 2013, the overall split was reduced to 55% of members with an NF LOC residing in an NF. The 2018 rate assumption reflects a split of 45.2% skilled NF LOC and 54.8% HCBS. For non-duals, the 2018 rate assumption is 17.7% NF and 82.3% HCBS.

Goal 8. Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles

Highlight

Delaware has processes in place to coordinate and integrate care for full-benefit dual eligibles from both a care delivery and financial/program integrity perspective. The State is exploring new potential opportunities to increase coordination.

- Full-benefit dual eligibles are enrolled in DSHP Plus and provided care coordination, even if an individual does not require LTC services.
- Delaware is enrolled with CMS as a Trading Partner under a Coordination of Benefits Agreement (COBA) which facilitates the exchange of Medicare data. The Medicaid MCOs must accept Medicare data and load the data into their system for use by, at a minimum, case management, care coordination, member services, claims processing, and utilization management staff. Delaware's Medicaid MCOs are responsible for coordinating with Medicare payers, Medicare Advantage plans and Medicare providers as appropriate to coordinate the care of dual eligible members.

Description, Data and Initiatives

Coordination of Benefits

Like all state Medicaid programs, Delaware is enrolled with CMS as a Trading Partner under a COBA which facilitates the exchange of Medicare data. DMMA's contract with the DSHP MCOs also requires the MCOs to work with DMMA to complete an attachment packet to the COBA to establish a new COBA ID for management of the MCOs' cross-over claims. The DSHP MCOs must accept Medicare data and load the data into their system for use by, at a minimum, case management, care coordination, member services, claims processing, and utilization management staff.

As of the third quarter of 2017, the number of dual-eligibles in DSHP totaled 17,845 member months. As part of the care coordination and case management services provided to DSHP Plus members who are dual-eligibles, Delaware's DSHP MCOs are responsible for coordinating with Medicare payers, Medicare Advantage plans and Medicare providers as appropriate. DMMA provides ongoing monitoring of the MCOs' care coordination activities.

Future Coordination Opportunities

Moving forward, the State will continue exploring opportunities to enhance coordination for full-benefit dual eligibles. Delaware is working to identify opportunities to improve integration of benefits for dual eligibles. For example, the State has recently identified opportunities related to prescription drug coverage. The State's actuary is exploring potential efficiencies in coordinating prescription drug coverage with Medicare. In 2018, claims data will be reviewed to determine whether the Medicaid MCOs paid for any National Drug Codes (NDCs) covered by Medicare Part B or Part D. Depending on the findings, an actuarial adjustment might be made to the MCO rates to promote better coordination with Medicare and prevent payment of Part B or Part D prescription drugs.

Goal 9. Expanding coverage to additional low-income Delawareans

Highlight

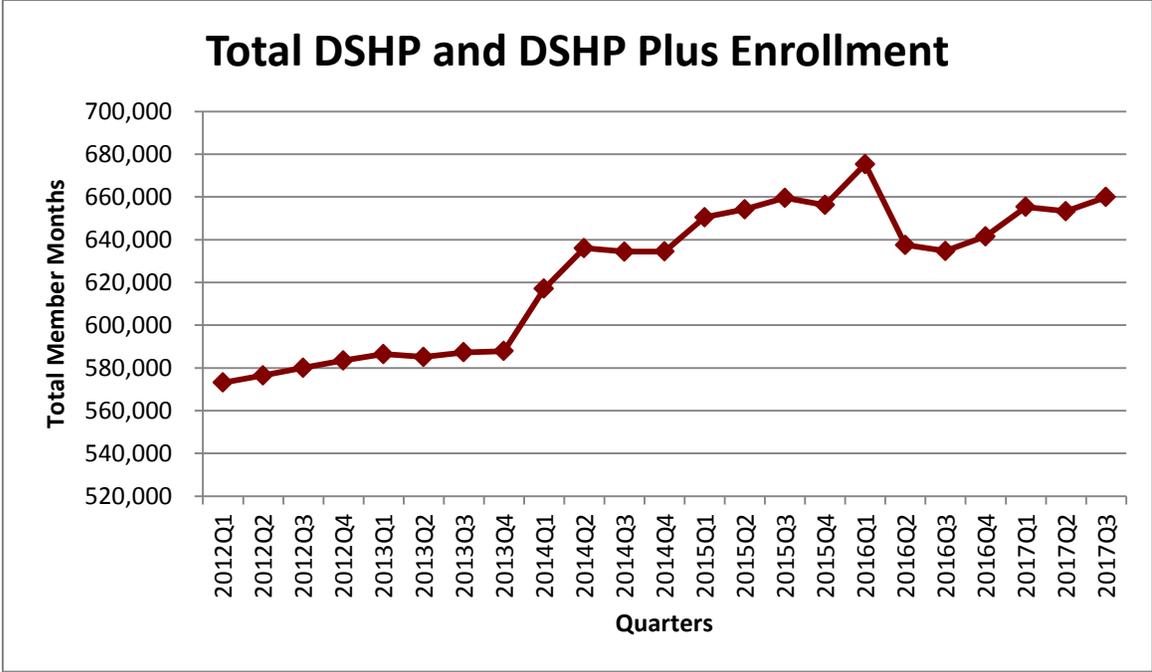
Delaware has expanded healthcare coverage over the life of the DSHP 1115 Demonstration by extending Medicaid eligibility to additional populations and adding new services to the Medicaid benefit package. The 1115 waiver has succeeded in expanding healthcare coverage for low-income Delawareans in the following ways:

- Using savings achieved under managed care in the DSHP 1115 Demonstration, Delaware initially expanded Medicaid health coverage to uninsured Delawareans with incomes up to 100% of the federal poverty level (FPL) and provided family planning coverage to women losing Medicaid pregnancy coverage at the end of 60 days postpartum or losing DSHP comprehensive benefits and have a family income at or below 200% of the FPL.
- Delaware later expanded Medicaid to individuals with incomes up to 133% FPL under the ACA in 2014 and uses the 1115 waiver delivery system to provide most Medicaid services to the expansion population.
- In 2012, Delaware launched DSHP Plus which created new HCBS benefits and expanded access to community-based long-term care services for the elderly and persons with physical disabilities.
- Beginning January 2015, Delaware implemented PROMISE, which expanded access to HCBS for adults who have an SPMI and/or SUD.
- Between the first quarter of 2012 and the third quarter of 2017, total Medicaid enrollment across all rate cells has increased from 573,144 to 659,968 member months.

Description, Data and Initiatives

Impact of Initiatives to Expand Health Care Coverage

As mentioned above, Delaware has implemented multiple initiatives throughout the course of the DSHP 1115 Demonstration to expand access to services. To assess how total Medicaid enrollment has changed over time, Medicaid eligibility data was compiled for calendar years 2012 through 2017. The eligibility data set was limited to individuals that were assigned to a rate cell, based on their aid category. The findings reveal that total Medicaid enrollment has increased by 15% between the first quarter of 2012 and the third quarter of 2017, from 573,144 to 659,968 total member months. The Waiver Expanded rate cell, which represents individuals with incomes less than or equal to 100% FPL, has grown at a higher rate than total program counts over the last five years. Furthermore, the percent of the total Medicaid program comprised of Waiver Expanded and ACA Expansion individuals (individuals with income between 100% and 133% FPL) has grown significantly over time.



Goal 10. Improving overall health status and quality of life of the individuals enrolled in the PROMISE program

Highlight

Delaware implemented PROMISE in 2015. Toward the end of 2017, Delaware commissioned an assessment of Medicaid BH services, including PROMISE services, to understand how services are accessed and to discuss system strengths and gaps. As is often the case when complex systems implement new programs, Delaware has not yet seen PROMISE realize the program's full potential. Below is a summary of the key PROMISE observations and activities:

- Stakeholder commitment to system improvements is strong.
- There are several opportunities for improvement in key areas that are currently under review by DHHS.
- Delaware is modifying the QCMR to enable a focus on the receipt of PROMISE services.
- PIPs are proving useful for development of technical assistance to improve care coordination.

Description, Data and Initiatives

Findings of the Behavioral Health Services Assessment

The purpose of the 2017 BH services assessment was to: (a) determine how adults and children in Medicaid and CHIP should ideally access mental health and SUD services in Delaware, and (b) identify the operational reality, including an inventory of challenges accessing services, by describing the system's strengths and gaps. A key focus area of the assessment was the PROMISE program.

The assessment revealed that State staff, MCOs and providers across the BH landscape are invested in system improvements and are willing to contribute to ongoing planning processes. While Delaware offers a comprehensive BH benefit, the assessment also found that operational improvements such as improving coordination of care are necessary to support delivery of a full range of covered services by providers, including the application and use of evidence based practices. The assessment noted particular opportunities to improve coordination and transitions of care across MCOs, DSAMH and the Department of Services for Children, Youth and Families/Division of Prevention and Behavioral Health Services, and between levels of care within systems.

Opportunities for Improvement

Opportunities exist to enhance the experience of PROMISE members and to better monitor their overall care experience. Participating stakeholders in the 2017 BH services assessment agreed to a series of additional discussions regarding the PROMISE program to identify potential areas for improvements. Discussions are continuing in 2018.

Recently, DMMA, DSAMH and the MCOs have made steps to improve coordination of care for PROMISE members. For example, the MCOs implemented a PIP related to achieving primary care visits and medication adherence for PROMISE members with a diagnosis of hypertension. DMMA provided technical assistance to the MCOs to support the PIP. As part of the PIP, the State is working with the MCOs to improve data collection and documenting and assessing the effectiveness of interventions.

Conclusion

Delaware continues to identify and refine methods for tracking outcomes associated with the comprehensive DSHP 1115 Demonstration. Current efforts have enabled the State to identify and prioritize areas for improvement, particularly where evaluation results have revealed less than desired achievement of performance goals. In the upcoming renewal, Delaware will ensure that key hypotheses are addressed and will include key outcome measures to assist in both State and federal decision-making about the efficacy of the demonstration.