

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: *States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.*

- 9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))
- 1) to decrease the number of uninsured children and thereby improve their health and chances for life success;
 - 2) to mainstream uninsured children in the health care industry so they receive the same quality of care as insured children; and
 - 3) to go from a clinical based system (fee-for-service/sick care) to a community-based system (managed care/preventive care) which provides genuine access to high quality care.

Guidance: *Goals should be measurable, quantifiable and convey a target the State is working towards.*

- 9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))
- 1) show-rate of uninsured children;
 - 2) percentage increase in wellness visits; and
 - 3) percentage decline in unnecessary emergency room visits.

Guidance: *The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.*

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

- 9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

The State will use the first year of the DHCP to develop base line information to monitor future years of the program. In addition, the State will expect the same utilization reporting for the DHCP that we currently receive for the DSHP. We will also monitor the experience

of the DHCP against the experience for the same age cohorts under the DSHP to look for possible outliers.

The State will require encounter data submission for the DHCP. The State can also identify specific reporting categories and require the MCOs to report that information from their database. The State will be able to report all of the CMS required information identified in section 9.3.

Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
 - 9.3.7.1. Immunizations
 - 9.3.7.2. Well childcare
 - 9.3.7.3. Adolescent well visits
 - 9.3.7.4. Satisfaction with care
 - 9.3.7.5. Mental health
 - 9.3.7.6. Dental care
 - 9.3.7.7. Other, list: [ER Visits](#)
- 9.3.8. Performance measures for special targeted populations.
- 9.4. The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

Guidance: *The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.*

- 9.5. The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)
- 9.6. The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review or audit. (Section 2107(b)(3)) (42CFR 457.720)

Guidance: *The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS.*

the states, advocates, and other interested parties.

- 9.7. The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))
- 9.8. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.135)
- 9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment) - State general funds for mental health services covered under the SCHIP State Plan are appropriated annually to the Delaware Department of Services for Children, Youth and Their Families (DSCYF). Claims for covered behavioral health services are submitted to DMMA by DSCYF during the year as services are provided, and as the claims are processed and paid by DMMA. The State draws down the appropriate federal share and provides it to DSCYF.
- 9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

- 9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))
- A Legislative hearing was held on 3/18/98 related to Senate Bill 246, which would authorize the DHCP for Delaware. There were thirty (30) advocates present with testimony from eleven (11) and written testimony from three (3).
- The Delaware Health Care Commission (DHCC) hosted public hearings to obtain input on the Title XXI Plan in Kent County (Milford Library) on 3/31/98 and New Castle County (Stanton Middle School) on April 1, 1998.
- The major issues raised at all hearings were the imposition of premiums, the six-month waiting period after loss of other insurance, the proposed \$25 copay on ER services, and the exclusion of dental benefits for these children. In addition, advocates expressed concern that the State was not pursuing presumptive eligibility.
- The DHCC, after deliberating the testimony, supported the Plan as written with modifications/exceptions to the six-month waiting period and the \$25 copay on ER services. The recommended changes are reflected in this submission.
- Delaware will publish, concurrent with this Plan submission, notice in the State's Register of Regulations under the requirements of the Administrative Procedures Act (APA). Any changes proposed after the Plan is implemented will be published in accordance with the APA with appropriate periods for comment and review/consideration of comments.
- 9.9.1. Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures

required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))

Delaware has no federally or State-recognized Indian tribes. Any Delaware resident, including those who are American Indians or Alaska natives, may participate in the review of amendments to State law or regulation and may offer comments on all Program policies, including those relating to provision of child health assistance to American Indian or Alaska native children. The process for review and comment is outlined in 9.9.2 below.

- 9.9.2.** For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

Delaware will publish, concurrent with Plan submission, notice in the State's Register of Regulations under the requirements of the Administrative Procedures Act (APA). Any changes proposed after the Plan is implemented will be published in accordance with the APA with appropriate periods for comment and review/consideration of comments.

- 9.9.3.** Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

- 9.10.** Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
 - Projected amount to be spent on health services;
 - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
 - Assumptions on which the budget is based, including cost per child and expected enrollment.
 - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
 - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered

under the state plan using the attached form. Additionally, provide the following:

- Total 1-year cost of adding prenatal coverage
- Estimate of unborn children covered in year 1

CHIP Budget

STATE: Delaware	CHIP Health Service Initiative	Cost Projection of Approved CHIP Plan	Total
Federal Fiscal Year	FFY 2019	FFY 2019	FFY 2019
State's enhanced FMAP rate	93.29%	93.29%	93.29%
Benefit Cost			
Insurance Payments			
Managed care		\$29,781,503	\$29,781,503
per member/per month rate		8,732 / \$284.22	
Fee for Service		\$6,763,666	\$6,763,666
Total Benefit Costs		\$36,545,169	\$36,545,169
(Offsetting beneficiary cost sharing payments)		(\$900,000)	(\$900,000)
Net Benefit Costs		\$35,645,169	\$35,645,169
Cost of Proposed SPA Changes - Benefit	\$49,500	\$49,500	\$49,500
Administrative Costs			
Personnel		\$100,000	\$100,000
General Administration		\$369,298	\$369,298
Contractors/Brokers		\$267,115	\$267,115
Claims Processing		\$756,508	\$756,508
Outreach/marketing costs			
Health Services Initiatives		\$98,880	\$98,880
Other			
Total Administrative Costs		\$1,591,801	\$1,591,801
10% Administrative Cap		\$3,723,697	\$3,723,697
Cost of Proposed SPA Changes	\$49,500	\$49,500	\$49,500
Federal Share	\$46,179	\$34,738,369	\$34,738,369
State Share	\$3,321	\$2,498,601	\$2,498,601
Total Program Costs	\$49,500	\$37,236,970	\$37,236,970

Budget Assumptions

- Rate of Client growth will increase an average of 2% in FY 2019;
- Capitation rates paid to commercial managed care organizations will increase an average of 8.3% based on new contracts;
- Enhanced Federal FMAP will be 93.29% effective October 1, 2018

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: Sources of non-federal funds are General Funds, transfers from the Dept. of Children, Youth & Families and client premiums.