



Delaware Health and Social Services

DRAFT

**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

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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 just 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)

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 is in the process of completing an interim evaluation report to be submitted to CMS. 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. 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). A waiver amendment is pending before CMS to include 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.

Section V – Waiver and Expenditure Authorities

Expenditure authority for the proposed SUD amendment 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 is also finalizing an interim evaluation of the DSHP 1115 waiver to be submitted to CMS in support of the extension request. 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 Delaware has not yet completed the 2016 annual report, but has submitted the 2017 annual report.

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 in August 2017 for the first quarter CY 2017 and the most recent annual report is 2015. Delaware is in the process of preparing the 2016 annual report and second quarter CY 2017 report.

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 in support of 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 – 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 waiver 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. Updated budget neutrality spreadsheets and narrative will be submitted with the final application to CMS.

	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

Section IX – 1115 Transparency Requirements, Public Notice and Post-Award Forum
(To be completed after Public Notice period ends)

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 Register of Regulations on May 1, 2018, and in the Delaware News Journal and the Delaware State News on April 24, 2018. The publication in the Delaware Register can be found at: <http://regulations.delaware.gov/default.shtml>
4. 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>
5. Delaware presented to the Medical Care Advisory Committee on May 23, 2018.
6. 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
2540 Wrangle Hill Road
Suite 200, Bear, DE 19701

7. Delaware certifies that it used an electronic mailing list to notify the public.
8. 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

9. The following is a list of comments received and associated responses that pertain to the 1115 Demonstration submission: *(TBD after public comment period ends.)*
10. 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
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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

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.

DRAFT

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 and is in the process of finalizing the complete report to be submitted to CMS in support of the extension request. 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.

- 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

(Documentation section to be finalized after public comment period ends.)

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.
3. Documentation of newspaper publication.

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