



State of Delaware
Delaware Health and Social Services (DHSS)



Division of Medicaid and Medical Assistance

Diamond State Health Plan
Diamond State Health Plan PLUS
Children's Health Insurance Program

QUALITY STRATEGY
2018



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Quality Strategy overview

The Delaware Quality Strategy (QS) is a comprehensive plan incorporating quality assurance (QA) monitoring and ongoing quality improvement (QI) processes to coordinate, assess and continually improve the delivery of quality care. This includes services to members in Medicaid and Medicaid managed care; the Children's Health Insurance Program (CHIP); Medicaid Long Term Care (LTC), including nursing facilities, home- and community-based (HCBS) services; assisted living; and dually certified Medicare/Medicaid funded programs. The QS provides a framework to communicate the State's vision, objectives and monitoring strategies addressing issues of health care cost, quality and timely access. It encompasses an interdisciplinary, collaborative approach through partnerships with members, stakeholders, governmental departments and divisions, contractors, managed care organizations (MCOs), community groups and legislators. The QS supports the missions of the Delaware Department of Health and Social Services (DHSS) and the following divisions to:

- *"Improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations." - DHSS*
- *"Improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost effective manner." - DMMA*
- *"Improve or maintain the quality of life for Delawareans who are at least 18 years of age with physical disabilities or who are elderly. The Division is committed to the development and delivery of consumer-driven services which maximize independence through individual choice, enable individuals to continue living active and productive lives and protect those who may be vulnerable and at risk" - DSAAPD*
- *"Improve the quality of life for adults having mental illness, alcoholism, drug addiction, or gambling addiction by promoting their health and well-being, fostering their self-sufficiency and protecting those who are at risk" - DSAMH*
- *"To develop and support a family-driven, youth-guided, trauma-informed prevention and behavioral health system of care. --DPBHS*
- *"Protect residents in Delaware long term care facilities through promotion of quality of care, quality of life, safety and security, and enforcement of compliance with State and Federal laws and regulations." - DLTCRP*
- *"Provide leadership for a service system that is responsive to the needs of the people we support by creating opportunities and promoting possibilities for meeting those needs." - DDDS*
- *"To protect and enhance the health of the people of Delaware by*
 - *Working together with others*
 - *Addressing issues that affect the health of Delawareans*
 - *Keeping track of the State's health*
 - *Promoting positive lifestyles*



- *Responding to critical health issues and disasters*
- *Promoting the availability of health services" – DPH*

To accomplish these missions, the QS seeks to:

- assure Medicaid and CHIP members receive the care and services identified in waivers and Medicaid and CHIP-funded programs by providing ongoing tracking and monitoring of quality plans, improvement activities and assurances;
- provide ongoing tracking and monitoring of Medicaid and CHIP-funded program quality plans to achieve the Centers for Medicare & Medicaid Services (CMS) requirements of "achieving ongoing compliance with the waiver assurances" and other Federal requirements and;
- assure that the State maintains administrative authority and implements DSHP-Plus in such a way that the waiver assurances and other program requirements currently part of the 1915 (c) waiver programs are met, either by the State or by the MCO through specific contract provisions, including: level of care; person-centered planning and individual service plans; qualified providers; health and welfare of enrollees; and fair hearings.

The Medicaid managed care program, known as the Diamond State Health Plan (DSHP), the Long Term Care Medicaid managed care program, known as Diamond State Health Plan Plus (DSHP Plus), and Title XXI, known as the Delaware Healthy Children Program (DHCP) or CHIP, are focused on providing quality care to the Medicaid and the CHIP populations in the State through increased access, and appropriate and timely utilization of health care services. We believe this will be achieved through a systematic and integrated QS that is consistent with current scientific evidence-based principles and coordinated with quality initiatives across all DSHP, DSHP Plus and CHIP-funded programs.

Goals, Values and Guiding Principles

The DSHP, DSHP Plus and CHIP programs are focused on providing quality care to the majority of the DSHP, DSHP Plus and CHIP populations in the State through increased access and appropriate and timely utilization of health care services. Goals and objectives provide a lasting reminder of program direction and scope. As identified in the 1115 waiver, the goals that play a significant role in the development of the quality strategy are:

Goal 1: *To improve timely access to appropriate care and services for adults and children with an emphasis on primary and preventive, and behavioral healthcare, and to remain in a safe and least-restrictive environment.*

Goal 2: *To improve quality of care and services provided to Medicaid and CHIP enrollees.*

Goal 3: *To control the growth of health care expenditures.*



Goal 4: *To assure member satisfaction with services.*

Guiding Values or Principles

The Division of Medicaid & Medical Assistance (DMMA) seeks to achieve excellence through ongoing QI activities.

- The QS employs a multi-disciplinary, collaborative approach through DHSS and its divisions to identify, assess, measure, and evaluate the access, timeliness, availability, level of care, and clinical effectiveness of care and services being provided to Medicaid and CHIP members
- DSHP, DSHP Plus and CHIP populations will receive care and services congruent with the six aims for health care systems identified by the Institute of Medicine. Care provided to Delaware Medicaid and CHIP members will be *"Safe, effective, patient-centered, timely, efficient and equitable."*¹
- Members are supported in taking responsibility for their own health and health care through use of preventive care and education.
- Institutionalized members are safely transitioned to a community setting with community supports.
- Providers of care and services are accountable for delivering quality services and programs in compliance with Federal and State regulations, as well as State QS requirements.
- Collaboration between community partners, the Medical Society of Delaware, professional organizations, individual providers, advocacy groups, State agencies and DMMA programs creates opportunities to identify and initiate valuable QI activities across MCOs, DSHP, DSHP Plus, CHIP-funded and Medicaid PROMISE programs.
- Access to care and services should be equitable.
- Cultural sensitivity to variation in the health care needs of a diverse population is an essential element in providing quality services and decreasing disparities.
- Forums for communication, which enhance an open exchange of ideas while maintaining privacy guidelines, are valued for identification of issues and to conduct QI activities.

Quality Strategy development

Delaware Medicaid and Medical Assistance's (DMMA) and Medical Management and Delegated Services (MMDS) Leadership Team, through an iterative process that includes participation by the multi-disciplinary statewide Quality Improvement Initiative (QII) Task Force, initiates development of the QS. Input is incorporated from governmental agencies, providers, members and advocates assisting in identifying quality activities and metrics of importance to the DSHP, DSHP Plus, and PROMISE Medicaid and CHIP populations. Results of the annual review of the effectiveness of the prior year's quality plan and external quality review (EQR) technical report provide additional data to further focus strategy development.

External Quality Review report

The EQR technical report provides: detailed information regarding the regulatory and

¹ Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st. Century.* 2001



contractual compliance of the DSHP, DSHP Plus and CHIP MCOs; as well as results of performance improvement projects (PIPs); and performance measures (PMs). Report results include information regarding the effectiveness of the MCOs' program; strengths, weaknesses, and opportunities for improvement. This information is utilized for input into the QS and for initiating and developing QI projects and PIPs.

Participant input

Input from DSHP, DSHP Plus, Medicaid and CHIP members into the development of the QS is accessed through a variety of methods. One approach is the use of member satisfaction surveys that may include Consumer Assessment of Healthcare Providers and Systems (CAHPS), and surveys administered through the Health Benefits Manager (HBM) and other DSHP, DSHP Plus and CHIP-funded programs. Additional sources of recipient input include member grievances and appeals, as well as public forums such as the State Council for Persons with Disabilities and MCO Member Advisory Committees which include DSHP, DSHP-Plus and CHIP populations as well as members residing in long-term care facilities and members residing in the community.

The Medical Advisory Committee or MCAC is a group appointed by the Secretary of the Delaware, DHSS, composed of representatives from the medical community, consumers, consumer and/or advocate groups and other fields concerned with health, as the Secretary may deem appropriate, to advise DMMA about health and medical care services.

Public input

QII Task Force goals and activities are drafted and integrated into the quality strategy and forwarded to the MCAC and QII for feedback by key stakeholders. The QS is submitted for public comment every three years or when significant changes are made to the document. A notification of public interest is released in the Delaware Register of Regulations, a monthly publication, allowing a 30-day period for public input. Once public input has been received and incorporated into the document, the process proceeds as described above, and the final strategy document is prepared and approved by DMMA.

Quality Strategy implementation

DMMA has delegated its quality oversight responsibilities for DSHP, DSHP Plus, CHIP-funded programs, including waivers and managed care programs, to the MMDS Leadership Team. DMMA has delegated its direct quality oversight for the Medicaid PROMISE program to DSAMH. DMMA will assure that it maintains administrative authority and implements DSHP-Plus and the Medicaid portion of the PROMISE program in such a way that the waiver assurances and other program requirements currently part of the 1915 (c) waiver and 1115 demonstration programs are met, either by the State, DSAMH or by the MCOs through specific contract provisions, including:

Level of Care (LOC) Determinations

- i. An evaluation for level of care must be given to all applicants for whom there is reasonable indication that services may be needed in the future, either by the State, or as a contractual requirement, by the MCO.
- ii. All DSHP-Plus enrollees must be re-evaluated at least annually or as otherwise specified either by the State, or as a contractual requirement, by the MCO.



iii. The LOC process and instruments will be implemented as specified by the State, either through the State's own processes, or as a contractual requirement, by the MCO.

a. Person-Centered Planning and Individual Service Plans

i. The MCO contract shall require the use of a person-centered and directed planning process intended to identify the strengths, capacities, and preferences of the enrollee as well as to identify an enrollee's long term care needs and the resources available to meet these needs, and to provide access to additional care options as specified by the contract. The person-centered plan is developed by the participant with the assistance of the team and those individuals the participant chooses to include. The plan includes the services and supports that the participant needs to live in the community.

ii. The MCO contract shall require that service plans must address all enrollees assessed needs (including health and safety risk factors) and personal goals.

iii. The MCO contract shall require that a process is in place that permits participants to request a change to the person-centered plan if the participant's circumstances necessitate a change. The MCO contract shall require that all service plans are updated and/or revised at least annually or when warranted by changes in the enrollees' needs.

iv. The MCO contract shall require development of a back-up plan to ensure that needed assistance will be provided in the event that the regular services and supports identified in the individual service plan are temporarily unavailable. The back-up plan may include other individual assistants or services.

v. The MCO contract shall require that services be delivered in accordance with the service plan, including the type, scope, amount, and frequency.

vi. The MCO contract shall require that enrollees receiving HCBS services have a choice of providers within the MCO's network.

vii. The MCO contract shall require policies and procedures for the MCO to monitor appropriate implementation of the individual service plans.

viii. The MCO contract shall utilize the State established minimum guidelines as outlined in the approved MCO contracts regarding:

- The individuals who develop the person-centered service plan (and their requisite qualifications);
- The individuals who are expected to participate in the plan development process;
- Types of assessments that are conducted as part of the service plan development process;
- How participants are informed of the services available to them.

b. Qualified Providers

i. The MCO provider credentialing requirement in 42 CFR 438.214 shall apply to all HCBS providers. If the State wishes to change provider qualification standards from those that exist under waivers # 0136 and #4159, the State must reach agreement with CMS to do so and ensure that the new standards preserve health and welfare. The State is required to report any changes in provider qualification standards as part of the quarterly monitoring calls and quarterly reports.

ii. To the extent that the MCO's credentialing policies and procedures do not address non-licensed non-certified providers, the MCO shall create alternative mechanisms to



ensure the health and safety of enrollees.

c. Health and Welfare of Enrollees. The MCO contract shall require the MCO to, on a continuous basis, identify, address, and seek to prevent instances of abuse, neglect, exploitation, and fraud.

d. Fair Hearings

i. All enrollees must have access to the State fair hearing process as required by 42 CFR 431 Subpart E. In addition, the requirements governing MCO appeals and grievances in 42 CFR 438 Subpart F shall apply.

ii. The MCO shall specify whether enrollees must exhaust the MCO's internal appeals process before exercising their right to a State fair hearing.

iii. The MCO contract shall require the MCO to make whatever reasonable accommodations are necessary to ensure that enrollees have a meaningful opportunity to exercise their appeal and grievance rights.

Responsibilities

DMMA has delegated responsibilities to the MMDS Unit. Responsibilities include oversight and monitoring of quality plans and improvement activities. Through the efforts of the MMDS, the QS has developed a structure and process that supports and encourages achievement of sustainable improvements in the quality of care and services provided to all DSHP, DSHP Plus and PROMISE Medicaid and CHIP members. The Quality Strategy promotes integration and collaboration, both horizontally and vertically, across State agencies and externally with key stakeholders, including advocacy groups, providers, members, MCOs and CMS.

The MMDS uses the QII Task Force as one of the various mechanisms to accomplish oversight responsibilities and solicit input for improvements. Members of the QII Task Force include representatives from all DSHP, DSHP Plus and PROMISE Medicaid and CHIP-funded programs and waivers, MCOs, the HBM, the Pharmacy Benefits Manager (PBM), the External Quality Review Organization (EQRO), the Aging and Disability Resource Center (ADRC), State agencies receiving DSHP, DSHP Plus and PROMISE Medicaid and CHIP funding, and the MMDS. These stakeholders appoint representatives from their organization to serve on the QII Task Force. Appointees are provided with an outline of the expected roles and responsibilities of membership on the QII Task Force. The chairperson of the QII Task Force is appointed by DMMA from their Leadership Team.

Each organization or governmental agency represented on the QII Task Force has their own quality framework and/or quality committee structure that is accountable for all phases of the quality management (QM) process. QII Task Force representatives link these quality committees to a unifying point. The QII Task Force is the central forum for communication and collaboration for quality strategies, plans and activities, and provides the opportunity to develop systematic and integrated approaches to quality activities. The QS employs a deliberate process of ongoing, continuous feedback mechanisms that affect changes and improves quality of care to recipients. The MMDS and the QII Task Force use data and information at each stage of the QI process to analyze and identify trends, as well as sentinel events. Task Force members discuss findings to identify issues and recommend opportunities for strategically developing an overall QI work plan to ensure appropriate integration of QI activities such as PIPs and PMs. Within this process, opportunities are



sought to develop collaborative quality activities that span across the DSHP, DSHP Plus and PROMISE Medicaid and CHIP programs.

Members of the QII Task Force participate in a scheduled rotation of reporting quality activities that are formal processes focusing on critical, high-impact issues to determine compliance in meeting their established goals. A consistent format is used to assure that key components of the quality process are included within all phases of quality activities and reporting. QII reporting may include statistical analysis, root cause analysis, analysis of barriers and recommended improvement interventions. These presentations allow an opportunity for dialogue, exchange of information and identification of best practices.

Report results are documented in QII Task Force meeting minutes and communicated to the larger stakeholder group and the MCAC. The MCAC and stakeholder group review QS activities, provide feedback and support for quality-related issues. These ongoing communications create a continuous feedback loop that impacts quality of care improvements for DSHP, DSHP Plus and PROMISE Medicaid and CHIP members. Quality results are also reported through the various public forums. DMMA is currently exploring a web-based solution for information dissemination for broader public consumption. During the planning phase of the managed LTC implementation, DMMA posted information to web-site <http://dhss.delaware.gov/dhss/dmma/> and set up an e-mail box for questions and comments.



Table 1: QM integrated model: Roles and responsibilities

QM Integrated Model		
Entities	Membership	Review of QS efforts
MCAC	<ul style="list-style-type: none"> •CMS •Providers •Advocacy Groups •Members •DSHP, DSHP Plus and PROMISE Medicaid and CHIP leadership 	<ul style="list-style-type: none"> •Forum for input from key stakeholders into quality efforts and key health care management concerns •Forum for input on State policy for health care delivery to DSHP, DSHP Plus and PROMISE Medicaid and CHIP members
MMDS Leadership Teams	DMMA DSHP, DSHP Plus and PROMISE Medicaid and CHIP leadership	<ul style="list-style-type: none"> •Oversight of QII Task Force •Approval and oversight of QS development, implementation and evaluation •Reporting QII Task Force and QS efforts and outcomes to MCAC to solicit feedback •Communication and support of stakeholder advisory groups
QII Task Force	<ul style="list-style-type: none"> •MMDS Leadership Team •Representatives from all DSHP, DSHP Plus and PROMISE Medicaid and CHIP-funded programs •MCOs •Representatives from agencies responsible for waiver programs •HBM •DDDS •DSAAPD •DSAMH •PBM •EQRO •DPH •DLTCRP •DPBHS 	<ul style="list-style-type: none"> •Supports development and implementation of the DSHP, DSHP Plus and PROMISE Medicaid and CHIP QS •Supports integration of the DSHP, DSHP Plus and PROMISE Medicaid and CHIP QS with managed care and waiver quality strategies •Provides forum for best-practice sharing •Provides support and feedback to waiver programs for the: <ul style="list-style-type: none"> - Establishment of priorities - Identification, design and implementation of quality reporting and monitoring - Development of remediation strategies •Identification and implementation of QI strategies •Provides feedback on quality measurement and improvement strategies to participating agencies and program staff. •Reporting to MMDS
DSAMH Performance Improvement Committee	•DSAMH leadership from all functional areas and DMMA representative meet quarterly	•Quarterly program reporting and monitoring related to PROMISE program



Quality Management Structure

The following diagram visually represents members of the QS structure, demonstrating levels of oversight, accountability and communication flows of quality activities. The structure is developed to maximize integration, seek opportunities for collaboration and assure a rigorous QMS in place.



- The Division of Medicaid and Medical Assistance Medical Management unit has overall oversight of all programs including PROMISE
- External Quality Review Organization (EQRO). MCO program validations and evaluation
- Medical Advisory Committee (MCAC). A public forum.

This results in a structured reporting responsibility by the MCOS and DSAMH and an overall collaborative relationship through the Quality Improvement Initiative Task Force.

History of managed care in Delaware

Medicaid

In 1994, the Delaware Health Care Commission recommended conversion of numerous aspects of the Medicaid program to a managed care model. The reasoning was that savings would be achieved from the use of a managed care model and those savings, along with some additional State funding, would be used to expand health coverage to all uninsured Delawareans at or below 100% of the Federal Poverty Limit (FPL). After applying to the Health Care Financing Administration (HCFA) (now CMS), DHSS received approval for waivers under 1115 of the Social Security Act, including:



- a) 1902 (a) (10) (B) Amount, Duration and Scope
- b) 1902 (a) (1) State-wideness
- c) 1902 (a) (10) and 1902 (a) (13) (E) Payment of Federally Qualified Health Centers and Rural Health Centers
- d) 1902 (a) (23) Freedom of Choice
- e) 1902 (a) (34) Retroactive Eligibility
- f) 1902 (a) (30) (A) as implemented in the Code of Federal Regulations (CFR) at 42 CFR 447.361 and 447.362 Upper Payment Limits for Capitation Contract Requirements

The waiver covers Medicaid services as defined by the Medicaid program and communicated in the contract. Within the waiver process, the State identified three goals to achieve in implementing a managed care model to provide care and services to the Medicaid population:

- Improve access to care and services for adults and children
- improve quality of care and services provided to Delaware Medicaid members
- Control the growth of health care expenditures for the Medicaid population

The Delaware Medicaid managed care program, DSHP, was implemented in 1996 upon receiving waiver approval. DSHP began with four MCOs participating in the Medicaid managed care program. Of the four MCOs, two provided services statewide, one MCO provided services in New Castle County only, and the remaining MCO provided services only in Kent and Sussex counties. In 1997, one contracted MCO withdrew from participation in DSHP, and by 1998, the MCO serving only two of three counties became a statewide provider. In July 2000, one MCO withdrew from participation in DSHP, leaving two remaining choices for eligible members, both of which provided statewide services. In 2002, DHSS selected one contractor to provide Medicaid managed care services. The DHSS then elected to create a State-operated program of managed medical care, using internal case management (CM) with quality measures as an alternative choice for DSHP members. Diamond State Partners (DSP) was approved by CMS as an enhanced fee-for-service (FFS) program. DSP and the commercial plan currently provide the network of care and services for the Delaware Medicaid managed care population. In 2004, the MCO contract was re-bid and in July was awarded to the current contractor, Delaware Physicians Care Inc. (DPC1), a subsidiary of Schaller Anderson. In 2006, DMMA released a Request for Proposal (RFP) for a new managed care contract. In 2007, DPCI was purchased by Aetna. On July 1, 2007, DSHP expanded the program by offering a second commercial managed care option. In addition to DPCI and DSP, the Medicaid-only managed FFS program, members could also choose Unison Health Plan of Delaware (UHPDE). In 2010 UHPDE was acquired by United Healthcare and in 2011 was renamed United Healthcare Community Plan (UHCP). The contracts between the State and these two managed care plans are for a two-year period, from July 1, 2007, through June 30, 2009 (State fiscal year [FY] 2008, and 2009), with three additional option years until June 30, 2012. In 2014, a Request for Proposal was again released by DMMA. Bids were received and after extensive Technical Evaluation and Financial negotiations two managed care organizations were awarded 5 year contracts; United Health Care Community Plan of Delaware and Health Option, Highmark Blue Cross and Blue Shield of DE. As of 2018, the State contracts with two MCOs: Amerihealth Caritas Delaware and Highmark Blue Cross Blue Shield of DE.



DSHP has used the services of a HBM throughout the history of the waiver to:

- Manage MCO enrollment
- Provide managed care education
- Ensure bilingual client outreach at State service centers
- Perform health risk assessments (HRAs) for DPCI and DSP

Since the last renewal in 2004, DHSS has reorganized to create a new DMMA which has primary responsibility for DSHP. DMMA continues to work in tandem with the Division of Health and Social Services in managing eligibility.

An effective and comprehensive approach to quality was understood to be an essential component in achieving the goals and objectives established within the 1115 waiver. Since the beginning of the demonstration project, a QA system has been in place to direct, develop and manage quality processes and to monitor Medicaid program compliance. In 2003, the State became compliant with the Balanced Budget Act of 1997 (BBA) regulations and the QM Unit redesigned the quality strategy, updating standards and incorporating BBA-revised regulations. Expectations of compliance with BBA regulations were communicated through updated contracts. In 2004, the EQRO evaluated the MCO in accordance with BBA regulations. The Medicare Sustainable Growth Rate (SGR) was a method used by the CMS to control spending by Medicare on physician services. President Barack Obama signed a bill into law on April 16, 2015, the Medicare Access and CHIP Reauthorization Act of 2015, which ended use of the SGR. The measure went into effect in July 2015. On March 1 of each year, the physician fee schedule was updated accordingly. The implementation of the physician fee schedule update to meet the target SGR could be suspended or adjusted by Congress, as was done regularly (this was referred to as a doc fix). The repeated task of implementing a "doc fix" led to the permanent repeal of the SGR, or "permanent doc fix," in 2015. Thereafter, the EQRO conducted annual compliance reviews of the MCO processes as per CMS requirements and protocols. Throughout the history of the waiver, Delaware has demonstrated that DSHP can provide quality physical and behavioral health (BH) care services through a private and public sector cooperation to a greater number of uninsured or underinsured individuals than would have been served through the State Plan.

Children's Health Insurance Program

Section 4901 of the BBA (Public Law 105-33) amended the Social Security Act by adding a new Title XXI, the State Children's Health Insurance Program (SCHIP). SCHIP regulations are found at 42 CFR Part 457. The Delaware SCHIP is known as the Delaware Healthy Children's Program (DHCP) and was approved by CMS on October 1, 1998, with a program implementation date of January 1, 1999.

Under Title XXI, states are provided federal matching funds to offer one of three program options: 1) a separate child health program; 2) a Medicaid expansion; or 3) a combination of both. Delaware has implemented a combination program, with infants (under age one) under 200% of the FPL covered through a Medicaid expansion program, and uninsured children ages one to 19 covered through a separate child health program, DHCP. Under the federal financial participation formula for SCHIP, Delaware is funded 65% with federal funds and 35% with State funds. With minor variations, Medicaid in contrast is funded at 50% federal and 50% State funds. Unlike Medicaid, which is an open-ended entitlement, SCHIP federal



funds are capped and allocated to states based on a formula specified in the enabling legislation.

Title XXI provides funds to states for the purpose of covering uninsured, low-income children who are not eligible for Medicaid. SCHIP children are not eligible for Medicaid because their family income exceeds that allowed under Medicaid (Title XIX).

The DHCP is targeted to uninsured children under age 19 with income at or below 200% of the FPL. Countable income, excluding certain deductions for earnings, child care costs and child support is compared to 200% of the FPL (based on family size) to determine eligibility. With some exceptions, children must have been uninsured for at least six months prior to their application for DHCP. Children who are eligible for Medicaid may not choose DHCP as an alternative to Medicaid. Children applying for DHCP must be screened for Medicaid eligibility before they can be evaluated for DHCP. Children of parents who work for public agencies and who have access to State employees' medical insurance are not eligible for DHCP, even if they do not opt to purchase coverage.

The child must be a current Delaware resident with intent to remain and the child must be a citizen of the US or must have legally resided in the US for at least five years if his/her date of entrance into the US is August 22, 2012, or must meet the Personal Responsibility and Work Opportunity Reconciliation Act of 1997 definition of "qualified alien", and must be ineligible for enrollment in any public group health plan (as stated above). Proof of citizenship and identity are not federally mandated under SCHIP although both are federal requirements in the Medicaid program. Still, the State does require that all applicants for SCHIP and Medicaid provide proof of citizenship and identity since all applications cascade through the same DCIS eligibility modules and since children must be made eligible for Medicaid if they qualify.

Children covered under a separate SCHIP program are not "entitled" to coverage, even if they meet eligibility requirements, and are not entitled to a defined set of benefits. Under DHCP, services are provided by MCOs. DMMA contracts with the same MCOs to provide services for both the Medicaid and SCHIP populations. All DHCP beneficiaries must enroll with a MCO in order to obtain services.

Children are assigned a MCO if the families fail to make a selection. Families must also select a primary care practitioner (PCP) who will serve as the children's "medical home." If a PCP is not selected for the children, one will be assigned.

The DHCP was implemented on January 1, 1999. Because of slow uptake in enrollment, premiums were waived during the second half of the year to encourage enrollment; then reinstated in 2000. By the end of the first year, 2,448 children were enrolled. By October 2008, there were 5,652 children enrolled in DHCP. Over the course of a typical calendar year, approximately 11,000 individual children are enrolled in DHCP. Members drop on and off the program during the course of a year. Some reasons include income reductions that make children eligible for Medicaid, income increases that make children ineligible for DHCP, gaining a parent's employer-related health coverage, moving out of state, and because families may enroll children when they are sick and transfer children when they are well to avoid paying monthly premiums.

There are various outreach activities occurring in the State to find and enroll these children -



activities such as the "Covering Kids & Families" program and Astra Zeneca's "Healthy Delawareans Today and Tomorrow."

On June 1, 2010, Delaware's legislature adopted the final ruling, 13 DE Reg. 1540, amending the five-year waiting period required for provision of medical assistance coverage to certain immigrants who are lawfully residing in the United States and are otherwise eligible for assistance, as described under CHIPRA. This population was previously required to complete a five-year waiting period to be eligible for federal medical assistance. Delaware now provides coverage to noncitizen children regardless of their date of entry into the United States.

In 2010, in accordance with CHIPRA, Delaware's EQRO began incorporating the CHIP population into the annual MCO compliance reviews, including PIP and PM validations.

Diamond State Health Plan Plus

Early in 2012, CMS approved an amendment to the 1115 waiver to incorporate individuals meeting an institutional level of care, as well as full benefit, non-long term care dual eligibles and Medicaid Workers with Disabilities populations into the managed Medicaid model. This change allowed MCOs to coordinate the majority of the care and services DSHP members required along a continuum inclusive of: medical, behavioral and long-term care services and supports. The DSHP Plus utilized the existing Medicaid MCOs to provide DSHP Plus members meeting the appropriate level of care with a choice between nursing facility and HCBS services. The DSHP Plus program was implemented April 1, 2012.

Through the movement of the majority of the State's Medicaid recipients into the managed care environment, DMMA became a more active purchaser and partner with the MCOs.

The goals of DSHP with the addition of DSHP Plus population are:

- Improving access to health care for the Medicaid population, including increasing options for those who need 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
- Promoting a structure that allows resources to shift from institutions to community-based services
- Improving the coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles
- Expanding coverage to additional low-income Delawareans



Rationale for managed care

Fundamental to implementation of a managed care model is the belief that the use of a managed care system will improve the quality of care delivered to all qualified recipients by consistent application of managed care principles, a strong QA program, partnerships with providers, and review and evaluation by an EQRO. Applying these techniques will serve to maintain or improve health outcomes for members by promoting consistent access to care, improving the quality of health care services through application of health home principles and achieving cost-effective service delivery to all DSHP, DSHP Plus and CHIP program members.

DSAMH PROMISE Program

On December 19, 2014 the Centers for Medicare and Medicaid (CMS) approved the request to amend the Diamond State Health Plan (DSHP), Medicaid section 1115 demonstration (No. 11-W-00036/4). This approval allowed the state of Delaware to help Medicaid beneficiaries with their behavioral health and functional needs by creating the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) program which began January 1, 2015. This request was approved by CMS under the authority of section 1115(a) of the Social Security Act (The Act).

The PROMISE program will identify individuals with behavioral health needs and functional limitations in a manner similar to a Home and Community-Based Services plan. The HCBS-like plan was sought under a 1115 amendment to ensure coordination with the Diamond State Health Plan (DSHP) Plus program, to allow the State to include State Plan Behavioral Health services in the managed care organization (MCO) benefit package, and to allow the State to competitively procure professional staff vendors under its new PROMISE program.

The goals of the two delivery system models, PROMISE and State Plan/MCO, are to improve clinical and recovery outcomes for individuals through cost-effective behavioral health community care while assuring a reduction in unnecessary institutional care through care coordination. Through this initiative, network capacity shall increase to deliver community-based recovery-oriented services and supports.

The overall objective is to improve the delivery of mental health and substance use services in Delaware to better meet the needs of those currently Medicaid eligible, but also to build the foundation to ensure that there is a robust continuum of supports and evidenced-based options available in the future.

Adult populations meeting the severe and persistent mentally ill (SPMI) and substance use disorders (SUD) eligibility criteria for PROMISE services will have the choice to receive specialty behavioral health care services throughout the State. The services are on a fee-for-service basis with DSAMH care managers participating in person-centered planning with beneficiaries to fully integrate physical health needs with behavioral health needs in collaboration with the State's contracted MCO vendors. The PROMISE program strives to address the special needs issues arising from populations with SPMI and/or SUD through a comprehensive, interconnected approach to providing services to all individuals with behavioral health needs in Delaware, while ensuring that the individuals served, are receiving the most appropriate services to meet their needs in the most integrated settings possible.



PROMISE Eligibility Requirements

Those persons meeting the presumptive eligibility due to SPMI or SUD and desire to apply for services must be screened by DSAMH using a standardized clinical and functional assessment developed for Delaware and based on national standards. A Delaware-specific American Society for Addiction Medicine (ASAM) tool integrates the assessment and evaluation of both mental health and SUD conditions into a single document with an algorithm that can be used to determine functional eligibility and is designed to ensure appropriate treatment of individuals based on their medical and functional needs. State Medicaid eligibility staff will review financial criteria to ensure that applicants meet the community financial eligibility criteria. .

PROMISE Quality and Assurances

Critical incidents are a vital component of assuring the health and welfare of the waiver beneficiaries. The quarterly reporting of system-wide information includes the numbers types of incidents, participant characteristics, provider issues, and timeliness of investigations and outcomes of investigations.

PROMISE Performance Improvement in collaboration with care management staff, quality assurance staff and provider relations staff produce data associated with all assurances through discovery and remediation activities. Data is gathered using various instruments, tools and checklists. Data is collected monthly and analyzed on a quarterly basis using discovery and remediation. However, level of care and health and welfare non-compliance issues are remediated immediately upon learning of the situation, but the data analysis is reported on a quarterly basis. Remediation plans are tracked by Performance Improvement for timeliness of compliance. If DSAMH determined that provider staff were not adhering to the agreed upon compliance plan, DSAMH would move to terminate the providers contract.

Recognizing DMMA as the administrative authority, the PROMISE program assurances will be met in the following areas:

1. Needs-Based Criteria

The State demonstrates that it implements the processes and instruments specified in its approved waiver for evaluating/reevaluating a participant's level of need, consistent with the needs-based criteria in the demonstration amendment. The processes and instruments described in the approved PROMISE 1115 amendment are applied appropriately and according to the approved description to determine if the needs-based criteria were met.

The Eligibility and Enrollment Unit (EEU) gives the quarterly PI Committee reports on the screening of confirmed eligibility evaluations and the disenrollment request reasons. The PI Committee tracks and trends the rates over time and determines if there are ways to improve screening and eligibility evaluations, maintain provider continuity, and keep beneficiaries engaged in PROMISE. The team also reviews disenrollment requests to determine if there are quality of care concerns with particular providers or if there is an access to care issue that requires corrective action. The analysis is part of the state quality work plan and is reported to the QII Committee. The committee members discuss the findings to identify opportunities for improvement. If deficiencies are noted, the EEU and care managers must perform corrective action until compliance is met.



2. Person-Centered Planning

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of recovery plans for waiver beneficiaries. Recovery plans address assessed needs of 1915(i) beneficiaries, are updated annually, and document choice of services and providers.

A person-centered focus is a fundamental component of the PROMISE program. Recovery planning is developed in a person-centered manner with the active participation of the beneficiary, family, and providers and should be based on the beneficiary's condition, personal goals, and the standards of practice for the provision of the specific rehabilitative services. The information gathered by the EEU during the review of recovery plans is used as the evidence of CMS compliance related to the person-centered planning process.

3. Provider Qualifications

The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. Providers meet required qualifications. Sub-assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

Delaware understands it shall maintain a network of qualified providers that initially and continually meet required standards for furnishing services under an HCBS authority, such as PROMISE, including licensure and certification standards. PROMISE service providers will submit evidence of the licensure or certification requirements for their provider type, as well as additional documentation supporting their qualifications to provide PROMISE services, both during the initial enrollment process and on a regular basis thereafter. Provider qualifications are important safeguards for beneficiaries enrolled in PROMISE to ensure that providers possess the requisite skills and competencies to meet the needs of the PROMISE population.

4. HCBS Setting

Settings meet the home and community-based setting requirements.

Beneficiaries receiving HCBS services should live, work, and enjoy fully integrated lives in the community. Community-based residential settings (excluding assisted living) offer a cost-effective, community-based alternative to nursing facility care for persons with behavioral health needs. Characteristics of these settings include a) full access to the greater community; b) choice from among available service setting options that are appropriate for the individual; c) protection of the rights of privacy, dignity, respect, and freedom from coercion and restraint; d) optimization of autonomy and independence in making choices; and e) facilitation of choice regarding services and who provides them. Care manager monitoring data will be aggregated and analyzed to ensure CMS requirements regarding HCBS settings are met.

5. Operational Oversight

The Medicaid Agency retains ultimate administrative authority and responsibility for the



operation of the waiver program by exercising oversight of the performance of waiver functions by other state agencies and contracted entities.

6. Fiscal Accountability

The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to PROMISE participants by qualified providers.

As part of the provider billing, the Fiscal Unit ensures that processes are in place to prevent duplicate payment and that payment to providers is consistent with approved recovery plans, paid using rates consistent with the approved rate-setting methodology. Additional payments to providers outside of the Medicaid reimbursement may not subsidize Medicaid providers for Medicaid covered services to Medicaid beneficiaries.

Utilization review reports from providers are analyzed quarterly. Data on beneficiary utilization is reviewed annually. If the utilization review process identifies issues with program integrity, the Fiscal Unit shall follow up with providers, use corrective action plans when indicated, recoup overpayments, or report abusive or fraudulent claiming to the Medicaid Fraud Unit via the SMA.

The analysis is part of the state quality work plan and is reported to the state QA Committee. The committee members discuss the findings to identify opportunities for improvement. If deficiencies are noted, the contractor must perform corrective action until compliance is met.

7. Health and Welfare

The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

The State is responsible for assuring the health and welfare of each beneficiary in the PROMISE program. The QA Unit, within DSAMH is integrally involved in the tracking of health and welfare issues and addressing those issues through remediation efforts.

The Consumer Affairs Office, QA Unit, and EEU are required to track grievances and the appeals system. Grievance and appeal data are included in quarterly quality improvement reporting and are reviewed at least annually by the State QA Committee. Data are also included in quality improvement annual reports. Data are gathered and reported quarterly with quarterly review and annually, at a minimum.

This data is integrated into the PMs as part of the overall State performance improvement plan. The data is analyzed to identify trends, and general and critical incidents. The findings are reported to the State QA Committee. The committee members discuss the findings to identify opportunities for improvement. In addition, this information is used to assess the effectiveness of quality initiatives or projects. PMs are implemented when indicated by findings.

The MCO will provide encounter data to DMMA that includes primary care physical health service claims data for all PROMISE members, which can be aggregated by DSAMH.

All DSAMH Medicaid claims are paid fee-for-service, so DSAMH will have the data available to create reports needed.



Goals and Objectives

The Medicaid managed care programs, which are known as DSHP, DSHP Plus, PROMISE, and CHIP are focused on providing: quality care to members in the State through increased access; support to obtain competitive employment; support to remain in the community rather than in an institution; and appropriate and timely utilization of health care services. Goals and objectives provide a persistent reminder of program direction and scope. DMMA endeavors to utilize nationally recognized and accepted performance measures (PMs) and benchmarks whenever possible. To align with this strategy, in 2008 DMMA changed from "Healthcare Effectiveness Data and Information Set- "HEDIS-like" to full HEDIS technical specifications for annual MCO PM reporting for the DSHP and CHIP populations. In early 2011, CMS provided the final CHIPRA Pediatric Core Measurement Set, which DMMA phased in over a three-year period starting in 2011, and annual reported to CMS. DMMA has also phased in the Adult and Child Core Measures which are both HEDIS and NCQA measures. This is done annually using data from both MCOs combined to give a state Medicaid and CHIP population view of these measures to CMS. With the addition of the DSHP Plus population in 2012, incorporating performance measures specific to this population into the overall goals and objectives of the waiver have been refined over time based on the needs of the population. As identified in the 1115 waiver, the goals that play a significant role in the development of the quality strategy are:

Goal 1: *To improve timely access to appropriate care and services for adults and children with an emphasis on primary and preventive care, behavioral health and to remain in a safe and least-restrictive environment.*

MCO VENDOR REPORTING

- ⇒ Adult Access to Primary and Preventive Care Services: HEDIS specifications
- ⇒ 100% of case management files audited demonstrate that a member was offered choice between Institutional and HCBS services.
- ⇒ 100% of case management files audited demonstrate that members receiving HCBS services have a back-up plan created or updated within the past year.
- ⇒ Number and percent of member's receiving HCBS services who have not had a service in the past 30 days.
- ⇒ Grievances broken down by Quality of Care (QOC) and Quality of Service (QOS) per 1000 members
- ⇒ Appeals both pre-service and post-service per 1000 members
- ⇒ Critical Incident reporting per 1000 enrollees total and by population (HCBS and Institutional).
- ⇒ Number and percent of members receiving at least 90% of services identified in the plan of care during the past 90 days.
- ⇒ 100% of case management files audited demonstrate that member's using HCBS participated in the service planning process.
- ⇒ 100% of case management files audited of new enrollees demonstrate that the assigned case manager or designee has initiated contact with the member or member represented within seven (7) business days.



- ⇒ 100 % of case management files audited of new enrollees demonstrate that an on-site visit/face-to-face visit to initiate service planning is completed within 10 business days of member’s enrollment.
- ⇒ 100 % of case management files audited demonstrate a documented level of care review, and updated service plan addressing mental health and welfare.
- ⇒ Quarterly reporting on Performance Improvement Projects (PIPs)
- ⇒ Annual Reporting on Adult and Child Core Measurements

DSAMH PROMISE VENDOR

- ⇒ 100% of PROMISE care managers’ assessments audited to determine level of need, choice and risk profile completed.
- ⇒ 100% PROMISE Incident reports submitted on timely basis and remediation plans within appropriate time frames.
 100% provider files demonstrate they are qualified prior to providing services.

Goal 1 Performance Measure matrix			
Measure	Required Service/ Data Source	REQUIRED DOCUMENTATION/ ACCEPTABLE CPT-4/ICD-9 CODES*	FRE-QUENCY/M CO VENDOR REPORTIN
Adult Access to Primary and Preventive Care Services	Claims data	HEDIS specifications	Annually
100% of case management files audited demonstrate that a member was offered choice between Institutional and HCBS services	Presence of choice form within member’s chart, signed and dated by the member.	Choice form from the member’s case management record	Semi-Annual
100% of case management files audited demonstrate that members receiving HCBS services have a back-up plan created or updated within the past year	Presence of an established back-up plan signed and dated by the member.	Back-up Plan Form from the member’s case management record.	Semi-Annual
New Clients: Number and percent of member’s receiving HCBS services who have not had a service in the past 30 days	Tracked and reported based on submission of the Unable to Reach Form and workflow.	Unable to Reach Form	Monthly
Grievances broken down by Quality of Care (QOC) and Quality of Service (QOS) per 1000 members	Tracked and reported based on the Quality and Care Management Measurement Reporting (QCMMR) guide.	QCMMR reporting template and on the QCMMR Plus reporting template for DSHP Plus population	Monthly



Critical Incident reporting: •Total incidents reported (HCBS and Institutional) •Per 1000 enrollees total and by population (HCBS and Institutional)	Tracked and reported based on the Quality and Care Management Measurement Reporting (QCMMR) guide.	QCMMR reporting template and on the QCMMR Plus reporting template for DSHP Plus population	Monthly
•Baseline HCBS living in home who implement emergency backup service plan	Presence of an established backup service plan	Back up Plan from the member’s case management record	Annual

DSAMH VENDOR REPORTING

100% of PROMISE care managers assessments audited to determine level of need, choice and risk profile completed	Tracked and reported based on the HCBS Guidance Manual and 42 CFR 441	PROMISE reporting template	Quarterly
Critical Incident reporting: Total incidents reported in accordance with timeframes.	Tracked and reported based on the 42 CFR440.	PROMISE Incident reporting templates	Quarterly
Provider Qualifications: 100% of PROMISE providers are determined to be qualified prior to their first PROMISE beneficiary service	Tracked and reported based on the 42 CFR440.	PROMISE Incident reporting templates	Quarterly

Goal 2: To improve quality of care and services provided to DSHP, DSHP Plus and CHIP members.

MCO VENDOR REPORTING

- ⇒Flu Shots for Adults by age band (aged 50 – 64 and 65 and older): HEDIS specifications
- ⇒Pneumonia Vaccination Status for Older Adults: HEDIS specifications
- ⇒Inpatient days/1000 by population (HCBS and Institutional)
- ⇒Average length of stay (ALOS) by population (HCBS and Institutional)
- ⇒Care for Older Adults: HEDIS specifications
- ⇒Comprehensive Diabetes Care (lipid screening, retinal eye exams and HbA1C testing): HEDIS specifications
- ⇒Average number of medicines by member
- ⇒HIV/AIDS Comprehensive Care (engaged in care, viral load monitoring, syphilis screening and cervical cancer screening): DE specific measure
- ⇒100% of case management files audited demonstrate that a member’s plan of care is reviewed and updated within 30 days (pre/post) the member’s annual review date.
- ⇒100% of case management files audited demonstrate that member’s with a behavioral health diagnosis demonstrate the MCO care manager’s semi-annual discussion and coordination of the member’s needs with the member’s behavioral health provider.
- ⇒90% or more of those using HCBS report they are satisfied with their HCBS.



- ⇒90% or more of those using HCBS report that they have sufficient services to be able to engage in community activities (including employment where applicable).
- ⇒100% of case management files audited demonstrate coordination of care with PCP.
- ⇒100% of case management files audited demonstrate the case manager has developed a written service plan that reflects services authorized appropriate to the level of care.
- ⇒100% of members enrolled in program receive initial assessments and annual assessments to determine their appropriate care and service needs.

DSAMH PROMISE VENDOR REPORTING

- ⇒100% of PROMISE care management files audited demonstrate the care manager has developed a written service plan that reflects services authorized appropriate to the level of care.
- ⇒100% of PROMISE care management files audited demonstrate that beneficiary has had a physical examination within one year.

Goal 2 Performance Measure matrix

Measure	Required Service/ Data Source	REQUIRED DOCUMENTATION/ ACCEPTABLE CPT-4/ ICD-9 CODES*	FRE- QUENCY/M CO VENDOR REPORTING
Flu Shots for Adults by age band (aged 50 – 64 and 65 and older)	Claims data/Hybrid data MCOs will collect data	HEDIS specifications	Annually
Pneumonia Vaccination Status for Older Adults	Claims data/Hybrid data MCOs will collect data	HEDIS specifications	Annually
Inpatient days/1000 by population (HCBS and Institutional)	Claims data/Hybrid data MCOs will collect data	HEDIS specifications	Quarterly
Average length of stay (ALOS) by populations (HCBS and Institutional)	Claims data MCOs will collect data	HEDIS specifications	Quarterly
Care for Older Adults residing in LTC Nursing Facility	Members 66 years of age and older should receive the following: <ul style="list-style-type: none"> • Advance care planning • Medication review • Functional status assessment • Pain screening 	Audit of Institutional records	Annually
Comprehensive Diabetes Care (lipid screening, retinal eye exam, and HbA1C testing)	Claims data MCOs will collect data	HEDIS specifications	Annually
Average number of medicines by member	Pharmacy data	Discreet count of specific medication with at least a 30 day supply	Annually
High dose opioid use in those who do not have cancer	Pharmacy data	HEDIS specifications	Annually
Use of High Risk Medications by age band (18-65 and 66 and older)	Pharmacy data	HEDIS specifications	Annually



<p>HIV/AIDS Comprehensive Care Measure (HCC)</p>	<ul style="list-style-type: none"> • Engaged in Care – two outpatient visits for physician services of primary care or HIV related care, one visit occurring on or between January 1 – June 30 and second visit occurring on or between July 1 – December 31 of the measurement year • Viral Load Monitoring – two viral load tests conducted on or between January 1 – June 30 and second test occurring on or between July 1 – December 31 of the measurement year • Syphilis Screening Rate – one syphilis screening test performed within the measurement year for members 19 years or older • Cervical Cancer Screening – one cervical cancer screen performed during the measurement year for female members ages 19-64 	<p><u>Engaged in Care</u> ICD-10 codes: B20 V34.0 969, 970, 974, 975, 976, 977</p> <p><u>Viral Load Monitoring</u> CM Z11.4, Z13.9</p> <p><u>Syphilis Screening</u> Z11.3</p> <p><u>Cervical Cancer Screening</u> Z11.51</p>	<p>Annually</p>
<p>100% of case management files audited demonstrate a member’s plan of care is reviewed and updated within 30 days (pre/post) the member’s annual review date</p>	<p>Plan of care</p>	<p>Case management file</p>	<p>Semi-Annual</p>
<p>100% of case management files audited demonstrate that member’s with a behavioral health diagnosis demonstrate the MCO care manager’s semi-annual discussion and coordination of the member’s needs with the member’s behavioral health provider.</p>	<p>Case manager documentation and/or provider note</p>	<p>Case Management file</p>	<p>Semi-Annual</p>
<p>DSAMH PROMISE VENDOR</p>			<p>DSAMH/ PROMISE VENDOR REPORTING</p>
<p>100% of care management files audited demonstrate the care manager has developed a written service plan that reflects services authorized appropriate to the level of care.</p>	<p>Recovery Plan</p>	<p>Care management file</p>	<p>Monthly</p>



100% of case management files audited demonstrate a beneficiary has had an annual physical exam	Recovery Plan	Care management file	Monthly
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Goal 3: To control the growth of health care expenditures.

MCO VENDOR REPORTING

- ⇒Emergency department utilization per 1000 members total and by population (HCBS and Institutional): HEDIS specifications
- ⇒Non-elective inpatient admissions per 1000 members total and by population (HCBS and Institutional): HEDIS specifications
- ⇒All cause re-admission rate per 1000 members total and by population (HCBS and Institutional): HEDIS specifications
- ⇒Number and percent of new members meeting Nursing Facility Level of Care criteria who opt for HCBS over Institutional placement
- ⇒Mix of services: number and percent of individuals who are receiving HCBS versus Institutional services.
- ⇒100% of Redeterminations are completed within the contracted timeline.
- ⇒100% of all members will have their needs assessed for discharge or placement potential for HCBS setting to determine cost effectiveness of services.

DSAMH PROMISE VENDOR REPORTING

- ⇒Number and percent of PROMISE beneficiaries in ACT teams Hospitalized in an IMD in the first year.

<i>Goal 3 Performance Measure matrix</i>			
Measure	Required Service/ Data Source	REQUIRED DOCUMENTATION/ ACCEPTABLE CPT- 4/ICD-9 CODES*	FRE- QUENCY/MC O VENDOR REPORTING
Emergency department utilization per 1000 members total and by population (HCBS and Institutional)	Claims data MCOs will collect data	HEDIS specifications	Annual
Non-elective inpatient admissions per 1000 members total and by population (HCBS and Institutional)	Claims data MCOs will collect data	HEDIS specifications	Annual
All cause re-admission rate per 1000 members total and by population (HCBS and Institutional)	Claims data MCOs will collect data	HEDIS specifications	Annual
Number and percent of new members meeting Nursing Facility Level of Care criteria who opt for HCBS over Institutional placement	Enrollment data Choice form	Delaware specifications	Monthly
Mix of services: number and percent of	Enrollment data	Delaware specifications	Annual



individuals who are receiving HCBS versus Institutional services	Claims data		
DSAMH PROMISE VENDOR REPORTING			DSAMH /PROMISE/VE NDOR
Number and percent of PROMISE beneficiaries in ACT teams hospitalized in IMDs	EEU data Claims data	EEU data Claims data	Annual

Goal 4: To assure member satisfaction with services

MCO VENDOR REPORTING

DMMA will utilize surveys to field both HCBS and Institutional enrollees to assess member satisfaction

- ⇒ At least 90% of HCBS and Institutional enrollees surveyed will rate their satisfaction with services as satisfied or very satisfied.
- ⇒ DMMA will use the benchmark of the CAHPS national Medicaid HMO 75th percentile
- ⇒ For those measures that have not reached the national 75th percentile, the goal is to improve the CAHPS rate by 5% per year until the benchmark is attained
- ⇒ For those measures that have attained and/or maintained the national 75th percentile, the goal is to strive towards an incremental annual increase to reach the national Medicaid HMO 90th percentile

DSAMH PROMISE VENDOR REPORTING

- ⇒ Develop baseline satisfaction survey results from PROMISE Care manager assessment tool.

Goal 4 Performance Measure matrix

Measure	Required Service/ Data Source	REQUIRED DOCUMENTATION/ ACCEPTABLE CPT-4/ICD-9 CODES*	FREQUENCY MCO VENDOR REPORTING
Number and percent of members who rate their experience of care as Good or Very Good	Member perception of care survey	Delaware survey	Annual

Assessment: Quality and Appropriateness of care

Procedures for race, ethnicity, primary language and data collection

The RFP, which is a part of the MCO contract, includes language requirements compliant with federal regulations.

•**Data collection:** Delaware updated its procedures for collecting racial and ethnic data consistent with the Office of Management and Budget revised standards via Administrative Notice (A-14-2003) on September 11, 2003. Delaware follows the guidance presented in the notice for obtaining information when individuals fail to self-identify. The two ethnic categories are: Hispanic or Latino and Non-Hispanic or Non-Latino. The five racial categories are American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White.



During the application process, the applicant identifies race, ethnicity and primary spoken language. The data collected for race and language is passed daily to the Delaware Medical Enterprise System (DMES). Ethnicity, race and language are currently communicated to the MCO in monthly enrollment files.

Communication with the MCO: The MCO is notified of client enrollment/disenrollment information via a monthly enrollment report in the form of a data file. The file is electronically transmitted on or before the first day of each enrollment month. It includes members who are newly enrolled, members who were enrolled last month and continue to be enrolled, members who transferred into the plan and members who are no longer enrolled with the plan. Starting in 2007, a daily file update of the client enrollment/disenrollment was created and transmitted to the MCOs. The MCO is responsible for payment of the benefit package for each enrolled client. To facilitate care delivery appropriate to client needs, the enrollment file also includes race, ethnicity, primary language spoken and selective health information, including disability status. The MCO will use information on race/ethnicity, language, and disability status to provide interpretive services, develop educational materials for employee training and facilitate member needs in the context of their culture, language, and ability requirements. The race and ethnicity information captured for DSHP, DSHP Plus and CHIP eligibility purposes is categorized in accordance with the Bureau of the Census and then forwarded from the eligibility file. Primary language spoken and predetermined health indicators are forwarded from the managed care system. Although neither method collects 100% of the required data, there are data for a significant portion of the population served. Until the Medicaid and CHIP eligibility process implements mandatory disclosure of race and ethnicity and primary language, the State relies on demographic updates to the enrollment file.

Mechanisms the State uses to identify persons with special health care needs (SHCN)

The SHCN population is defined as:

- Members who have or are suspected of having a serious or chronic physical, developmental, behavioral or emotional condition
- Children with vision or hearing impairments
- Foster or adoptive children
- Persons at risk of or having chronic diseases and disabilities
- Members diagnosed with HIV/AIDS
- Members who are elderly and/or physically disabled
- Members who are developmentally disabled
- Members who use English as a second language

New members entering the DSHP Plus program will continue to be assessed for Nursing Facility Level of Care, Home and Community Based Service Level of Care, and Acute Hospital Level of Care for the HIV/AIDS Population by State of Delaware Nurses. The State will retain the yearly Level of Care re-determination for the Nursing Facility population. The MCO will perform the yearly Level of Care re-determination on the HCBS and HIV/AIDS populations. The MCOs will provide the LOC documentation to the State for 100% review for all members who have changes in their level of care. DMMA will conduct quarterly monitoring of 5% of the total LOC documentation for clients with no change in their level of care.



New DSHP and CHIP members receive an outreach call, conducted within 30 days of enrollment, for the purposes of completing a Health Risk Assessment (HRA). New member outreach and administration of the HRA is performed by the MCO directly. DMMA must review and approve all MCO HRAs to ensure consistency of information captured. The MCOs will report monthly on the number of clients who completed HRAs to assure outreach success.

The State (DMMA) will conduct scheduled monitoring and oversight of the assessments of nursing facility levels of care in accordance to the Case Management Standards. The scheduled monitoring and oversight activities will include case file audits, quarterly reviews of the consistency of member assessments/service authorizations, and joint visits with the MCOs. The MCOs will conduct and compile reports quarterly and annually, conduct data analysis, identify quality improvement strategies, including lessons learned and identification of strategies for improvement to be submitted to DMMA. The State will review these reports for tracking and follow up as part of its monitoring and oversight activities. The EQR, on behalf of the State, will conduct a review of policies and procedures related to level of care assessments for members in the DSHP-Plus program during the compliance review. Additionally, the MCOs will review and update these policies and procedures as needed and communicate this to the State.

The MCOs are required to complete a service plan for all beneficiaries meeting the requirements of persons with SHCN as defined above. All service plans must comply with the regulations found in federal regulations at 42 CFR 43 8.208, including requirements for direct access to specialists. For members in the DSHP-Plus population, each MCO is required to complete a service plan in compliance with Case Management Requirements.

MCOs are required to have in place mechanisms to assess the quality and appropriateness of care furnished to all members, with particular emphasis on children with SHCN and those receiving HCBS or nursing facility (NF) services annually.

Clinical guidelines

The use of evidence-based Clinical Practice Guidelines are expected as their application has been demonstrated to decrease variation in treatment resulting in improved quality. The MCO is expected to adopt practice guidelines that are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate, in compliance with 42 C.F.R. Part 438, subpart D-438.236 (b). These Clinical Practice Guidelines must have been formally adopted through the MCO's Quality Management/Quality Improvement Committee or other clinical committee, in compliance with 42 CFR 438.236.

The MCO will utilize clinical practice guidelines, including but not limited to those addressing:

- Adult and child preventive care, including Early Periodic Screening, Diagnosis and Treatment (EPSDT) services
- Chronic conditions (i.e., diabetes and asthma)
- Behavioral health services
- Obstetrical care
- HIV/AIDS Palliative care



External Quality Review Organization (EQRO)

The State EQR process shall meet all of the requirements of 42 CFR438 Subpart E.

The Federal and State regulatory requirements and performance standards as they apply to MCOs will be evaluated annually for the State as provided in § 438.362, a qualified EQRO performs an annual EQR for each such contracting MCO (described in § 438.310(c) (2)), including a review of the services covered under each MCO contract for: a) quality, b) timeliness, and c) access using definitions contained in 42 CFR 438.320 and CHIPRA: Public Law 111-3.

The EQR produces at a minimum the following information as required in 42 CFR 438.364(a) without disclosing the identity of any patient as required in 42 CFR438.364(c):

A detailed technical report describing data aggregation and analysis, and the conclusions (including an assessment of strengths and weaknesses) that were drawn as to the quality, timeliness and access to care furnished by the MCO. For each activity conducted, the report includes:

- a) Objectives
- b) Technical methods of data collection and analysis
- c) Description of data obtained, including validated performance measurement data for each activity conducted in accordance with § 438.358(b)(1)(i) and (ii);
- d) Conclusions drawn from the data
- e) An assessment of each MCO's (described in § 438.310(c) (2)) strengths and weaknesses for the quality, timeliness, and access to health care services furnished to DSHP, DSHP Plus, and CHIP members.
- f) Recommendations for improving the quality of health care services furnished by each MCO (described in § 438.310(c)(2)) including how the State can target goals and objectives in the Quality Strategy, under § 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to DSHP, DSHP Plus, and CHIP members.
- g) Methodologically appropriate, comparative information about all MCOs (described in § 438.310(c) (2)), consistent with guidance included in the EQR protocols issued in accordance with § 438.352(e).
- h) An assessment of the degree to which each MCO (described in § 438.310(c) (2)) has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

The State and the EQRO shall monitor and annually evaluate the MCOs' performance on specific requirements under DSHP-Plus. These include, but are not limited to, the following:

- a) Level of Care determinations - to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served LTSS (Long Term Support Services) have been assessed to meet the required level of care for those services.
- b) Service plans - to ensure that MCOs are appropriately creating and implementing service plans based on member's identified needs.
- c) MCO credentialing and/or verification policies - to ensure that HCBS services are provided by qualified providers.



- d) Health and welfare of members - to ensure that the MCOs, on an ongoing basis: identify, address, and seek to prevent instances of abuse, neglect, and exploitation.

The State's EQR process shall meet all the requirements of 42 C.F.R. 438 Subpart E.

The State provides copies of the information, upon request, to interested parties through print or electronic media, or alternative formats for persons with sensory impairments as mentioned in 42 C.F. R. 438.364(b).

EQR results and technical reports are submitted to the MMDS for review and feedback. Report results, including data and recommendations, are then analyzed and used to identify opportunities for process and system improvements, PMs or PIPs. Report results are also used to determine levels of MCO compliance with federal and State requirements and assist in identifying next steps.

If a MCO is deemed non-compliant during any aspect of the EQR process, development of a corrective action plan (CAP) is required to address areas of noncompliance, including a timeline for achieving compliance. MMDS may request the EQRO to provide technical assistance regarding compliance review report findings and effectiveness of CAPs. CAPs are submitted to MMDS for review and approval prior to implementation by the MCO. MMDS monitors progress of these corrective actions through several mechanisms which may include internal meetings with the MCO, review of monthly, quarterly and annual required PMs and EQRO reports. As per federal requirements, the EQRO reviews MCO CAPs for effectiveness as part of the annual compliance review.

Performance measures and performance improvement projects

CMS, in consultation with states and other stakeholders, may specify PMs and topics for PIPs to be required by states in their contracts with MCOs. As CMS has not yet identified a mandatory set of PMs or PIPs, the MMDS, in conjunction with input from the QII Task Force, MCAC and other stakeholders, has identified a set of PMs and focused topics for required PIPs. These State-mandated measures and projects address a range of priority issues for the DSHP, DSHP Plus and CHIP populations. These measures have been identified through a process of data analysis and evaluation of trends within these populations.

Final selection and approval of PIPs and PMs is the responsibility of the MMDS Leadership Team. State-specific PMs are reported by the MCO and results are reviewed quarterly by MMDS, with final HEDIS results reviewed annually. PIP results are reviewed quarterly by the Quality Management Team, validation results of the PIPs are reviewed by MMDS on an annual basis in conjunction with the EQRO compliance report results.

State-specific mandatory performance reporting

A goal of the State is to have accurate data that clearly reflects the performance of the MCOs in managing the delivery of health care to their DSHP, DSHP Plus and CHIP members. Currently, the State requires a number of performance metric results to be reported on an annual, bi-annual, quarterly and monthly basis. The measures are submitted



by the MCO in a State-mandated format using State-specific definitions, and have required time frames by which to calculate and report. Any deviances are to be noted as variances by the MCO and actions taken for improvement are to be described. The metrics that are mandated for each MCO to self-report are submitted electronically via an approved template titled, Quality and Care Management Measurement-Report, (QCMMR). DMMA developed two specific QCMMR reporting templates, QCMMR which the MCOs use to report DSHP and CHIP populations and QCMMR Plus for reporting DSHP Plus population.

Table 2: *Quality and Care Management Measurement Report (QCMMR)*

Quality and Care Management (QCM)			
Frequency	Report Item	Applicable Program	Notes
Annual	Member Satisfaction Survey	DSHP, DSHP Plus, CHIPS,PROMISE	CAHPS survey and DMMA-approved survey for LTC recipients, PROMISE participants
	Provider Satisfaction Survey	All	Includes HCBS providers
	HEDIS	All	Refer to Appendix F for full set of performance measures
	Adult and Child Core Measures	All	Refer to Appendices B and C for full set of performance measures.
Bi-Annual	Geo Access	All	
Quarterly	Grievances	DSHP, DSHP Plus,	
	Appeals	DSHP, DSHP Plus, CHIP	
	EPSDT outreach efforts		
	Eligibility, enrollment, disenrollment reports	DSHP Plus	
	Choice between institutional and HCBS services	DSHP Plus	
	PIPs	DSHP, DSHP Plus, CHIP	
	HRAs	All, except those meeting NH level of	
Monthly	Case management/Disease management	All	See Appendix G for full set of case management reports
	Network availability/Appointment timeliness	All	
	Call center/Customer service	All	
	Utilization Management	All	
	Education and outreach	All	
	Level of Care determinations	DSHP Plus	
	Plan of Care completion with back-up service plan	DSHP Plus	



The QCM reporting process has been in place since calendar year 2008. As necessary, the State and the EQRO provided technical assistance to each MCO to refine, correct and maintain the reporting templates to reflect the most current program changes include evidence-based best practices and ensure continued standardization of the reporting process.

Delaware performance improvement projects

The MCOs will conduct PIPs that shall be designed to achieve, through ongoing rapid cycle measurement and intervention, significant improvement, sustained over time, in clinical and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. These PIPs must incorporate the following: measurement of performance using objective quality indicators; implementation of system interventions to achieve improvement in quality; evaluation of the effectiveness of the interventions; and planning and initiation of activities for increasing or sustaining improvement. These PIPs must be reported quarterly – due within 18 days of the quarter. Currently, the State requires five PIPs, two mandated clinical topics; 1) Oral Health of the LTSS population which is prescriptive in nature and 2) behavioral and physical health integration. Of the other three PIPs, one must be specific to the pediatric population, one should be related to the LTSS population and one should be non-clinical or service-related. At any time, CMS may specify topics for PIPs to be included as well as the DMMA may specify PIPs to be conducted.

Intermediate Sanctions

The premise behind the QS process is one of continuous Quality Improvement (QI). Delaware strongly believes in working with its MCOs in a proactive manner to improve the quality of care received by Delaware DSHP, DSHP Plus, and CHIP beneficiaries. However, should the need arise, part of the Delaware Quality Management (QM) process is the existence of sanctions and conditions for contract termination that may be imposed should the continuous QI process not be effective. These sanctions meet the federal requirements of 43 CFR Subpart I, as well as Delaware State requirements for sanctions and terminations.

The performance standards for MCOs shall be defined as absolute and total compliance with the participation requirements specified in the MCO Contract. The MCO shall meet these performance standards in full or be subject to sanctions by the State, including but not limited to, monetary penalties- \$1,000 per report up to \$50,000 per month or enrollment-related penalties such as reducing the scope of work for a number of days.

Whenever the State determines that the MCO is failing to meet performance standards, it may suspend the MCO's right to enroll new members. The State, when exercising this option, shall notify the MCO in writing of its intent to suspend new enrollment. The suspension period may be for any length of time specified by the State or may be indefinite. The State also may notify members of MCO non-performance and permit these members to transfer to another MCO.



The State may impose sanctions against a MCO if the MCO:

Fails substantially to provide medically necessary items and services that are required (under law or under the contracting entity's contract with the State) to be provided to a member covered under the contract;

Imposes premiums or charges on members in excess of the premiums or charges permitted under the contract, if any:

Acts to discriminate among members on the basis of their health status or requirements for health care services, including any practice that would reasonably be expected to have the effect of denying or discouraging enrollment in the MCO by eligible members whose medical condition or history indicates a need for substantial future medical services;

Misrepresents or falsifies information that it furnishes to CMS or the State;

Misrepresents or falsifies information that it furnishes to a member, potential member or health care provider;

Fails to comply with the requirements for physician incentive plans as set forth (for Medicare) in 42 CFR 422.208 and 422.210;

Distributes, as determined by the State, directly or through any agent or Independent MCO, marketing materials in violation of the contract and that have not been approved by the State, or that contain false or materially misleading information (applies to MCO and primary care case management (PCCM); voluntary for prepaid inpatient health plans (PIHPs) and prepaid Ambulatory health plans (PAHPs));

Violates any of the other applicable requirements of Section 1903 (m) or 1932 of the Act and any implementing regulation.

Where these violations are documented, DMMA will require a CAP be developed, approved by the State and implemented within 10 days from notification of the violation. The State will monitor improvement via reports and/or on-site reviews, the content of which will be specific to the violation and defined by the State. Performance free of violation must occur for 60 days or until the State and CMS agree the violation has been corrected and is not likely to recur.

If the CAP is not successful, intermediate sanctions will be applied. Payments provided for under the contract will be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in 42 CFR 438.730.

The State may also choose to:

- Suspend payments for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur
- Appoint temporary management for the MCO as provided in 42 CFR 438.706
- Apply additional sanctions allowed under the State statute or regulation that addresses areas of noncompliance, and;
- Limit enrollment or terminate the contract with the MCO.



The State may not terminate a contract with a MCO unless the MCO is provided with a hearing prior to the termination. However, if the State determines that it is necessary to appoint emergency temporary management for optional or required sanctions upon the MCO, the temporary management of the MCO may be assumed by the Delaware Department of Insurance.

Temporary management will be imposed if the MCO has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the BBA. In this circumstance, members will have the right to terminate enrollment without cause and will be notified by the State.

Circumstances under which the sanction of temporary management may be imposed include:

- Failure to meet the performance requirements;
- Continued egregious behavior by the MCO, including but not limited to behavior that is described in 42 CFR 43 8.700 or that is contrary to any requirements of Sections 1903(m) and 1932 of the Act;
- Substantial risk to member's health and;
- Necessary to ensure the health of the MCO's members while improvements are made to remedy violations under 42 CFR 43 8.700, or until there is an orderly termination or reorganization of the MCO.

The State may not delay imposition of temporary management to provide a hearing before imposing this sanction. In addition, the State may not terminate temporary management until it determines that the MCO can ensure that the sanctioned behavior will not recur.

The MCO shall also pay to the State the actual damages according to the following subsections. Written notice of said failure to perform shall be provided to the MCO. The State may, at its discretion, refund to the MCO all or part of the damages assessed and collected following corrective actions on the part of the MCO. The use of discretion by the State does not waive the MCOs non-compliance in the event of termination of the contract.

The MCO shall ensure that performance standards as described are met in full. The size of the damages associated with failure to meet performance standards will vary depending on the nature of the deficiency. Therefore, in the event of any breach of the terms of the contract with respect to performance standards, unless otherwise specified, sanctions shall be assessed against the MCO in an amount equal to the costs incurred by the State to ensure adequate service delivery to the affected members. If the degree of non-compliance results in transfer of members to another MCO; the sanctions shall include the difference in the capitated rates paid to the non-compliant MCO and the rates paid to the replacement MCO. The MCO shall carry out the monthly member reconciliation tasks.

The MCO shall comply with the operational and financial data reporting requirements described in the MCO contract under the Monetary Sanctions Chart. The MCO shall be liable for those sanctions described within the Monetary Sanctions Chart for each business day that any report is delivered after the date when it is due, or includes less than the required information, or is not in the approved media or format. The State may also suspend capitation payments or enrollment for the period of time the MCO is not in compliance.



The objective of this standard is to provide the State with an administrative procedure to address general contract compliance issues which are not specifically defined as performance requirements, or for which damages due to non-compliance cannot be quantified in the manner described in the MCO contract.

Any MCO selected under this contract will be required to provide all member benefits, enrollment, and grievance and provider network information in a timely manner, determined by the State and in the required format determined by the State.

If the State determines that the Contractor is not in compliance with one or more requirements of the MCO contract resulting in compliance issues from the MCO's performance of its responsibilities through routine contract monitoring activities, the State may issue a Notice of Deficiency, identifying the deficiency(ies) and follow-up recommendations/requirements either in the form of a Corrective Action Plan(CAP) developed by the Contractor or a Directed Corrective Action Plan (DCAP) developed by the State. A Notice of Deficiency from the State requiring a CAP or DCAP will also serve as a notice for sanctions in the event the State determines that sanctions are also necessary. If this occurs, the Project Manager or designee will notify the MCO in writing of the nature of the performance issue. The Contractor shall provide CAPS responses to the State within 14 calendar days of receipt of a Notice of Deficiency from the State. CAPs are subject to review and approval by the State. If the State disapproves the Contractor's CAP, the Contractor shall submit a new CAP within 10 business days, or an expedited timeframe if required by the State, that addresses the concerns identified by the State. If the State imposes a DCAP on the Contractor, the Contractor will have 14 calendar days to respond to the State.

Amounts due the State as sanctions may be deducted by the State from any money payable to the MCO pursuant to the contract. The Project Manager shall notify the MCO in writing of any claim for sanctions at least 15 days prior to the date the State deducts such sums from money payable to the MCO.

The State may, at its sole discretion, return a portion or all of any sanctions collected as an incentive payment to the MCO for prompt and lasting correction of performance deficiencies.

The Project Manager, with the agreement of the Division Director, may exercise the following remedial actions should the Project Manager find the MCO substantially failed to satisfy the scope of work found in the contract. Substantial failure to satisfy the scope of work shall be defined to mean incorrect or improper activities or inaction by the MCO. Incorrect payments to the MCO due to omission, error and/or fraud shall be recovered from the MCO by deduction from subsequent payments under this contract. The State may:

- a) Withhold payment to the MCO until the necessary services or corrections in performance are satisfactorily completed
- b) Suspend enrollment in the MCO until the corrections are satisfactorily completed

State Standards

In an effort to provide adequate access to care for Delaware's DSHP, DSHP Plus and CHIP populations, all standards for access to care, structure and operations, and quality



measurement and improvement, listed in the chart below and throughout the QS document, are incorporated in the MCO contract/RFP which is in accordance with federal regulations. DSHP Plus has the same appointment standards as all other populations in SHCN.

Monitoring mechanisms - State monitoring and evaluation

Table 3: Summarizes State-defined access standards:

Appointment standard					
General	Specialty	Maternity	Behavioral Health	EPSDT	SHCN/ Foster Care
Emergency services •Available 24 hours a day, seven days a week	Emergency Services •Immediate	Emergency services •Immediate	Emergency services •Within 24 hours of request; immediate treatment for a potentially suicidal individual	EPSDT screening •Available no more than two weeks after the initial request	Division of Family Services (DFS) suspects physical and/or sexual abuse •Within 24 hours
Emergency PCP •Available same day	Urgent care PCP •Available within 48 hours of referral	Initial prenatal care •First trimester Within three weeks of first request	Routine care •Within seven calendar days of request	Initial visit for Newborns •Newborn physical examination	DFS All other Cases •Within five days of notification that the child was removed from home
Urgent care PCP •Available within two calendar days	Routine care - •Available within three weeks of member request	Initial prenatal care •Second trimester •Within seven calendar days of first request		Preventive pediatric visit - •According to the American Academy of Pediatricians periodicity schedule, up to age 21	DFS – Child access to screening tool •Within 30 days of notification the child was removed from home; whenever possible, should be completed within five days' time frame
Routine care •Available within three weeks of member request		Initial prenatal care •Third trimester •Within three calendar days of first request Initial prenatal care •High-risk pregnancies •Within three calendar days of identification of high risk			

The State has given the MMDS Leadership Team under DMMA the administrative authority to monitor and evaluate both MCOs compliance with the contract requirements specific to its members, including those specific to the DSHP-Plus program. The State will maintain administrative authority and manage DSHP-Plus in such a way that the waiver assurances and other program requirements currently part of its 1915 (c) waiver programs are met, either by the State or by the MCOs through specific contract provisions, as follows:

- Level of Care
- Person-Centered Planning and Individual Service Plans
- Qualified Providers
- Health and Welfare of enrollees
- Fair Hearing



The MMDS Leadership Team monitors compliance with reporting requirements and reviews selected *measures* and *metrics* to ensure that MCOs are operating in the *most* efficient and effective manner consistent with Federal and State requirements. The scope of this review includes seeking out evidence of ongoing improvement efforts and resulting outcomes. The MMDS will provide feedback to the MCO should results reflect general non-compliance or sub-standard performance. The MMDS evaluates and provides feedback regarding identified opportunities for improvement, including analysis of trends and barriers, brainstorming interventions for improvement, barrier removal or additional measurement. If interventions are suggested, re-measurement occurs in the appropriate period following implementation.

Mechanisms

As required by CFR 438.204(b) (3), Delaware regularly monitors and evaluates the MCO's compliance with the standards. DMMA engages in a variety of methods to assure that the MCO develops and implements a quality plan that meets the expectations communicated through the QS, the managed care contract and compliance requirements specified within BBA regulations and CHIPRA; the Case Management Requirements for the DSHP-Plus population. In addition to internal meetings and Joint Visits as part of the Case Management Quality Monitoring and Oversight for the DSHP-Plus population, other methods include:

Member and providers satisfaction survey

The MCO is also expected to administer an annual CAHPS survey to the DSHP and CHIP population, as well as a State-defined member satisfaction survey to the DSHP Plus population, the results of which are reviewed during the EQR process.

- A provider satisfaction survey is completed annually by each MCO and the results are reviewed by the State in addition to the EQRO during the compliance review.
 - Frequency: Annually
 - Monitors: Availability of services, timely access to care, primary care and coordination/continuity of services, and coverage and authorization of services. Monitored by the MMDS Leadership Team

EQR

Refer to previous EQR section.

- Frequency: Annually
- Monitors: Availability of services, delivery of network adequacy, timely access to care, cultural consideration, primary care and coordination/continuity of services, SHCN, coverage and authorization of services, emergency and post-stabilization services, provider selection/credentialing, enrollment and disenrollment, grievance systems, practice guidelines, quality assessment and performance improvement program, health information systems, PIN and PMs
- Monitored by: MMDS Leadership Team



National Committee for Quality Assurance (NCQA) Accreditation

DMMA currently requires the Managed Care Contractors and the Managed Care behavioral health subcontractors, if applicable, to be NCQA accredited in the State of Delaware within two years from the start date of operations. The Contractor shall be NCQA accredited as a Health Plan, and any behavioral health subcontractor shall be NCQA accredited as a Managed Behavioral Health Organization (MBHO).

Grievance/Appeals

The State will operate a grievance/appeal system that affords participants the opportunity to register grievances concerning the provision of services. All reports specific to grievances and appeals will display DSHP Plus, DSHP and CHIP data separately.

- State review of grievance and appeal data and information is also used to assess quality and utilization of care and services. Results from ongoing analysis are applied to evaluation of compliance with quality expectations.
 - Frequency: Quarterly
 - Monitors: Availability of services, delivery of network adequacy, timely access to care, cultural consideration, primary care and coordination/continuity of services, SHCN, coverage and authorization of services, emergency and post-stabilization services, enrollment and disenrollment, grievance systems, health information systems and any quality of care and/or service issues that have been defined by DMMA as being egregious
 - Monitored by: MMDS Leadership Team

Managed care organization reporting

- As previously described in the MCO reporting section, the State conducts monthly, quarterly, bi-annual and annual review of numerical data and narrative reports describing clinical and quality related information on health services and outcomes.
 - Frequency: Reference MCO reporting requirements section
 - Monitors: Availability of services, delivery of network adequacy, timely access to care, primary care and coordination/continuity of services, provider selection and credentialing, grievance systems, quality assessment and performance improvement program, PIN(?) and PMs
 - Monitored by: MMDS Leadership Team

Managed care organization performance measures

- Results are reported and validated via several channels. Validation of PMs selected by the State is performed by the EQRO during the compliance review. Additionally, State-specific PMs are monitored by the MMDS Leadership Team as previously described.
 - Frequency: Quarterly monitoring of State-mandated measures and annual validation by the EQRO of specific measures
 - Monitors: Availability of services, quality assessment and performance improvement program and performance measurement



- Monitored by: MMDS Leadership Team

MCO PIPS

- Results of the EQRO PIP validation process will be analyzed, compared to expected outcomes, and determinations to continue or adjust will be based upon results.
 - Frequency: Quarterly, following EQRO validation of results
 - Monitors: Quality assessment and performance improvement program and PIPs
 - Monitored by: Quality and DMMA Leadership Team

Health information technology

In accordance with 42 CFR 43 8.242, the MCO must operate a Management Information System (MIS) capable of maintaining, providing and documenting information. The MIS will be capable of collecting, analyzing, integrating and reporting data sufficient to document the MCO's compliance with contract requirements.

MCOs must collect and ensure accurate and complete data on members, providers and services through a data system as specified by the State. To ensure data accuracy, MCOs will cooperate with the State in carrying out data validation steps. DMMA has developed an operational data collection plan to monitor actual program performance with respect to service access and health status/outcomes. The components of the plan include: encounter reporting; summary utilization reports; quality information, including focused quality of care studies, member satisfaction surveys, financial reports and grievance and appeals reports, access to care and; medical outcomes and health status.

The State requires the MCO to make all collected data available to the State and upon request to CMS. All encounters must be submitted in electronic or magnetic format that meets all the Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards.

The State expects the MCOs to submit encounter reports that include all capitated data for all services rendered that fall within the basic benefit package, including BH data even when the MCO has a subcontracting BH program. Encounter reports must be submitted monthly, within 240 days of the date of service and no later than 75 calendar days after the end of the period in which the encounters were processed. All encounters must be submitted in electronic or magnetic format that meets all HIPAA standards.

DMMA gathers and monitors encounter data from the MCO to assess over- and under-utilization using formats consistent with the formats and coding conventions required under HIPAA. DMMA will assure compliance with reporting requirements and may withhold capitation payments until encounter data requirements are met to enforce compliance. Should the State determine that encounter data errors are not decreasing as expected, the State may require that the MCO bear the cost of processing all encounters that consistently exceed the error tolerance. The State may also choose to auto-assign only to those contracting entities that are providing complete, accurate encounter data.

As required by CFR 438.204(f), Delaware DMES is used to monitor the encounter data submitted by MCOs. The DMES system stores and utilizes client eligibility records, managed care enrollment records, premium collection records and provider eligibility records for:



- Claims processing
- Encounter record processing
- Enrollment processing
- Premium collection
- Per capita payments
- Related tracking and reporting

The Surveillance and Utilization Review (SUR) system within DMES produces reports based either on claims data or encounter data or both. Information identified in the SUR unit is forwarded to the MMDS for investigation.

Improvement and interventions

Interventions for improvement of quality activities is determined based upon review and *analysis of results* of each activity and ongoing assessment of a member's health care needs.

Performance measures

Performance Measures (PMs) provide information regarding directions and trends in the aspects of care being measured. This information is used to focus and identify future quality activities and direct interventions for existing quality activities. For measures progressing toward or meeting goals, ongoing measurement with barrier analysis may continue. Measures meeting goals for at least two consecutive cycles may continue to be measured to assure improvement is maintained or may be retired or placed on an alternating year re-measurement cycle. For measures demonstrating consistent lack of progress or goal achievement, CAPs may be required to assist the MCO in meeting measurement-expected results. The corrective action must demonstrate appropriate actions to positively impact measurement results.

The MMDS Leadership Team determines the PMs to be validated during the EQR process and when to alter the required reporting schedule as described above. MCOs are required to develop a corrective plan for areas of non-compliance. Sanctions may be implemented should other efforts of cooperation fail.

Performance improvement projects

As previously described, a PIP is designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical and non-clinical care areas, that are expected to have a favorable effect on health outcomes and member satisfaction. The State may opt to mandate additional PIPs based on results of sub-optimal PMs or identified needs in the population. In this event, the PIP topic would be presented to the MMDS Leadership Team for review and approval. Additionally, the MCO shall present PIP information to the QII Task Force, along with a request for input and suggestions. Quality reporting on the status of the PIPs will also be conducted at QII meetings in addition to reporting to MMDS. The content of the improvement process and status reporting has been developed within the QII Task Force and must include, but is not limited to, the following elements: problem analysis, interventions, results, barrier identification, outcomes, next steps and timelines.

PIPs will be validated during the EQR process and results are expected to demonstrate achievement or progress toward achievement of the State-identified goal. For areas of noncompliance, CAPs are required which will be monitored for improvement by MMDS.



Sanctions may be implemented should all other methods of cooperation fail to occur.

Input for cross-organizational opportunities

During presentation and discussion of performance measures and PIPs at the QII Task Force, opportunities are sought to implement cross-organizational or agency quality activities, interventions or changes and improvement in information system identification or processing of data, and identification of topics for focused quality study.

Strategy review and effectiveness

How the Quality Strategy is reviewed

The QS is reviewed by MMDS through an ongoing process that incorporates input from a multitude of sources. The effectiveness of the Quality Strategy is reviewed on an annual basis and revised based upon analysis of the results. The QS may be reviewed more frequently if significant changes occur that impact quality activities or threaten the potential effectiveness of the strategy. As a result of the annual analysis process, a quality plan for the upcoming year is developed congruent with the overall quality strategy. The development process begins with an assessment of the accomplishments of the prior year's quality plans and reports, including the MCO's annual Quality Plan and Evaluation, the EQR technical report, as well as incorporating input from committees and other established quality forums that include governmental agencies, providers, MCOs, consumers and advocates. These sources help the MMDS in determining areas of focus for quality activities such as *QI* measures, improvement projects and performance indicators.

The strategy is reviewed annually by the MMDS Leadership Team. As part of this review, the effectiveness of the QS will be evaluated to determine whether potential changes to the Quality Strategy may be needed. Should the Leadership Teams determine that the change is significant enough to require additional stakeholder input, the MCAC, QII Task Force, and/or additional sub-committees may be engaged to assist in this endeavor.

The QS is presented to the QII Task Force and MCAC for comment before being finalized. Once the strategy is approved in draft form by the MMDS, further public input may be sought by releasing a notification of public interest in the Delaware Register of Regulations, a monthly publication indicating a 30-day period for public input. Once public input has been received, the final QS document is prepared and, upon approval by MMDS, is distributed to key stakeholders.

Following approval by DMMA, any amendments or major revisions to the quality strategy will be shared with CMS and quarterly reports will be submitted.

Managed Care Organization reporting requirements

Quality Care Management and Monitoring Report – QCMMR and QCMMR Plus

DMMA has developed separate QCMMR reporting templates, one for the DSHP and CHIP population and one for the DSHP- Plus population. All applicable reports will specify the



DSHP-Plus population separately.

The time frames for the mandatory reports due to the State are:

- Monthly reports will be due to the State on the 18th day of the following month.
- Quarterly reports will be provided to the State on the 18th day of the month following the end of each quarter.
- Annual reports will be submitted to the State on the 30th day of the month following the end of the calendar year.
- Exceptions to this schedule will be identified with the applicable report
- Report formats will be provided at implementation.

Monthly Reports

The MCO will submit monthly reports with the following content:

HRAs – QCMMR and QCMMR Plus

- Number of new members.
- Number of HRAs received/completed for new members or returning members/90 days.
- Rate of HRAs received/completed within 30 days of enrollment and total.

CM and DM – QCMMR and CM – QCMMR Plus

- Number of new members referred via HRA to the CM program.
- Total number of new members referred to the CM or Disease Management (DM) program.
- Number of existing members referred to the CM or DM program.
- Total number of new and existing members referred to the CM or DM program.
- Total number of members active in the CM or DM program.

Timely access to provider appointments – QCMMR

- Rate members received a routine appointment with PCP within three weeks.
- Rate members received a routine care appointment with specialist within three weeks.
- Rate of maternity appointment received in the first trimester within three weeks.
- Rate of maternity appointment received in the second trimester within seven days.
- Rate of maternity appointment received in the third trimester within three days.
- Rate of maternity appointment received for a high-risk pregnancy within three days.
- Rate members received appointment with a BH provider within seven days.
- Rate members received appointment for EPSDT screening within two weeks.

EPSDT Access Reporting-QCMMR

- Total Number of EPSDT visits.
- Rate of EPSDT visits versus eligible.
- Total number of outreach calls for EPSDT visits for visits missed within 30 days.



- Total number of outreach calls for EPSDT visits for visits missed within 60 days.
- Total number of mailers sent to members for missed EPSDT visits.

Network availability – QCMMR

- Number of in-network PCPs.
- Number of PCPs with open panels.
- Percent of in-network PCPs with open panels.
- New providers added to the network in the reporting periods who are PCPs or specialists.
- Percent of new practitioners added to the network in the reporting periods who are PCPs or specialists.
- Providers terminated from the network in the reporting periods who are PCPs or specialists.
- Percent of practitioners terminated from the network in the reporting periods who are PCPs or specialists.

Customer service statistics – QCMMR and QCMMR Plus

- Average speed to answer a call by a live person reported in seconds.
- Percent of calls answered within 30 seconds.
- Call abandonment rate.
- Number of members requesting to change PCPs.

UM - Inpatient services – QCMRR and QCMMR Plus

- Medical: Admissions/1,000 members, ALOS, days/1,000 members, member average cost per day, per member per month (PMPM), number of inpatients with length of stay greater than 10 days, number of inpatients readmitted within 10 days with the same diagnosis.
- Surgical: Admissions/1,000 members, ALOS, days/1,000 members, member average cost per day, PMPM, number of inpatients with length of stay greater than 10 days, number of inpatients readmitted within 10 days with the same diagnosis, number of inpatients with unexpected transfer or return to operating room.
- Intensive Care Unit (ICU)/Cardiac Care Unit (CCU): Admissions/1,000 members, ALOS, days/1,000 members, member average cost per day, PMPM, number of patients with unexpected transfer or return to ICU/CCU.
- Maternity: Admissions/1,000 members, ALOS, days/1,000 members, member average cost per day, PMPM, number of cases of Intrauterine Fetal Demise.
- Neonatal ICU: Admissions/1,000 members, ALOS, days/1,000 members, member average cost per day, PMPM.
- Rehabilitation/Skilled Nursing Facility: Admissions/ 1,000 members, ALOS, days/1,000 members, member average cost per day, PMPM.
- Psychiatric/Detoxification: Admissions/ 1,000 members, ALOS, days/1,000 members, member average cost per day, PMPM, number of psychiatric patients readmitted within seven days.
- MM/Residential Rehabilitation: Admissions/ 1,000 members, ALOS, days/1,000 members, member average cost per day, PMPM.



UM— Outpatient services and physician visits – QCMMR and QCMMR Plus

- ED outpatient services: Visits/1,000 members, member average cost per visit, PMPM, percent of hospital admissions resulting in inpatient admissions.
- Maternity outpatient services: Visits/1,000 members, member average cost per visit, PMPM.
- BH outpatient services: Visits/1,000 members, member average cost per visit, PMPM
- Adult physical examinations/Well-baby physician visits: Visits/1,000 members, member average cost per visit, PMPM.
- Maternity physician visits: Visits/1,000 members, member average cost per visit, PMPM.
- BH physician visits: Visits/1,000 members, member average cost per visit, PMPM.

Education and Outreach – QCMMR

Description and number of educational and outreach activities conducted throughout the month, including EPSDT outreach activities.

Choice/Community Tenure – QCMMR Plus

Total number of current DSHP PLUS enrollees

Number of new DSHP PLUS enrollees

Number of new community-well dual enrollees

Number of new managed long term care (MLTC) enrollees

Number of new MLTC members who chose institutional care

Number of new MLTC members who chose HCBS

Access/Availability of HCBS – QCMMR Plus

Number of HCBS providers statewide

Number of HCBS providers by county

Number of Type 1 providers statewide and by county

Type 1: Home health providers (personal care, self-directed care, respite care etc.)

Number of Type 2 providers statewide and by county

Type 2: Day service providers (adult day care, day habilitation)

Number of Type 3 providers statewide and by county

Type 3: Behavioral health service providers

Number of Type 4 providers statewide and by county

Type 4: Atypical service providers (home delivered meals, home modifications, personal emergency response systems)

Number of Type 5 providers statewide and by county

Type 5: Durable medical equipment providers

Number receiving services from a behavioral health provider

Safety and Welfare

Critical Incidents

- Number of critical incidents
- Number of institutional critical incidents
- Number of home and community based services critical incidents
- Unexpected death
- Physical, mental, sexual abuse or neglect
- Theft or exploitation



- Severe injury
- Medication error
- Unprofessional provider

Gaps in care

Gaps in care by hours:

- The number of DSHP PLUS service hours delivered minus the number of service hours approved

Gaps in care by member:

- The number of DSHP PLUS members for whom there was a negative differential in the number of service hours delivered minus the number of service hours approved

Encounter data as defined by the State third-party liability information.

Quarterly reports – QCMMR and QCMMR Plus

Reporting regarding the grievance and appeals system within the MCO which includes:

- Total number of grievances received from members.
- Grievances per 1,000 members.
- Total number of medical grievances in the following categories:
 - Quality of care
 - Days to appointment
 - Transportation to medical doctor
 - Specialist referral
 - Request for interpreter
 - Denial of ED claim
 - Other
- Total number of non-medical grievances in the following categories:
 - Doctor's office staff
 - MCO office staff
 - Office waiting time
 - Other
- Total rate of medical and non-medical grievances by members.
- Total number of families or caregivers of enrolled children with SHCN where a written grievance was filed regarding access to care specified in the child's care plan.
- Total number of families or caregivers of enrolled children with SHCN where they filed a written grievance regarding quality of services specified in the child's care plan.
- Total number of member appeals.
- Total number of appeals denied.
- Percent of total denied appeals that were upheld or overturned by the MCO.
- Percent of appeals made where the MCO acknowledged receipt within five days.
- Percent of appeals made where the MCO resolved and notified member of resolution within 45 days.
- Percent of appeals made where the MCO resolved and notified member of resolution within 90 days.
- Number of requests for expedited review of appeals.
- Percent of expedited review requests denied.



- Percent of expedited review requests resolved and notified within three days.
- Number of requests for extensions of appeals.
Percent of extension request denials.

The minutes of the MCO QM Committee quarterly meeting are submitted to DMMA. Quarterly summary of monthly reports are listed above.

The MCO reports HEDIS PMs with quarterly status reports for each metric.

- Reporting PMs, the MCO uses criteria of the most recent specifications communicated by the State.

Bi-annual reports

- Geo-Access updates are due every six months. Reports will be due August 15 and February 15. Reports will include overall access to primary care, which includes: general practice; family care; internal medicine; and OB/GYN, specialty care and subspecialties of cardiology, orthopedics, psychiatry and OB/GYN providers.
- Specific Geo-Access reports include but are not limited to:
 - Accessibility summary – including time and mileage
 - City and county detail information
 - Thermal maps demonstrating access issues
 - Provider location maps
 - City access standard detail reports

Annual reports

- The MCO submits their QM plans annually. If DMMA recommends revisions to the plan, a revision will be submitted to the State within 30 days following notification.
- The MCO reports HEDIS PMs, applying State specifications and final results annually. Date to be determined by DMMA.
- The MCO will submit results of HEDIS measures annually as requested by the State. Specific measures may be identified. At a minimum, measures will include timely access to prenatal care, timely postpartum care and frequency of prenatal care visits. Date to be determined by DMMA.
- The MCO submits their Adult and Child Core Measures annually in December – exact date determined by DMMA per CMS.
- The MCO reports lead screening rates. The specifications for reporting the lead screening rates are defined by Medicaid Lead Screening Guidelines Committee.
- DMMA developed two QCMMR reporting templates; one for the DSHP and CHIP population and one for the DSHP Plus population. (See Attachment B and D)

Centers for Medicare & Medicaid reporting requirements

MMDS will prepare and submit quarterly reports summarizing progress toward QS results. Progress toward goal achievement will be included as available from data and results reporting. Discussion of barriers and trends will be addressed. Quarterly reports will be submitted 60 days after the close of the quarter. The annual report will provide a



more detailed overall analysis and assessment of the effectiveness of the QS strategy including, but not limited to, the following:

- Data and numeric analysis
- Discussion of variations from expected result
- Barriers and obstacles encountered
- Interventions planned to overcome barriers
- How participant and system changes were improved as a result of QS initiative results
- Best practices and lessons learned with resultant changes to the following year's strategy

Achievements and opportunities

Successes

The QII Task Force has served as the central forum for the implementation of the QS. The QII Task Force has evolved over the past few years from defining its purpose and refining the goals, to effectively focusing on quality activities and initiatives which are making a difference for our Medicaid population. Collaborative discussions continue to take place within the QII Task Force meetings. There continues to be an exchange of knowledge and concern for the health care needs of the vulnerable population we serve. These exchanges have served to enhance knowledge and appreciation of significance across programs, divisions and external organizations, and were evidenced through resultant quality initiatives.

During the QII Task Force meetings, ongoing quality updates and quality reporting are presented and form the basis of the Standing Agenda topics. Information is shared, discussed and disseminated to the MCAC oversight committee. The MCAC provides consistent feedback which has resulted in a demonstration of positive support for continued quality activities with a potential for improvement through the quality process.

Continued development of our QII Task Force has been evident through quality reporting and updates on quality strategies by the members; updates to the QII Task Force from the State Medicaid Medical Director and the managed care health plan Medical Directors; ongoing reports to the committee on quality program progress and activities; and the provision of a forum for active discussion of collaborative opportunities by members to improve care for our DSHP, DSHP Plus and CHIP population.



Appendix A: Definition of Medical Necessity

Medical necessity is defined as:

The essential need for medical care or services (all covered State DSHP, DSHP Plus and CHIP plan services, subject to age and eligibility restrictions and/or EPSDT requirements) which, when prescribed by the beneficiary's primary physician care manager and delivered by or through authorized qualified providers, will:

- Be directly related to the diagnosed medical condition or the effects of the condition of the beneficiary (the physical or mental functional deficits that characterize the beneficiary's condition), and be provided to the beneficiary only.
- Be appropriate and effective to the comprehensive profile (e.g., needs, aptitudes, abilities and environment) of the beneficiary and the beneficiary's family.
- Be primarily directed to treat the diagnosed medical condition or the effects of the condition of the beneficiary, in all settings for normal activities of daily living, but will not be solely for the convenience of the beneficiary, beneficiary's family or the beneficiary's provider.
- Be timely, considering the nature and current state of the beneficiary's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time.
- Be the least costly, appropriate, available health service alternative and will represent an effective and appropriate use of program funds.
- Be the most appropriate care or service that can be safely and effectively provided to the beneficiary, and will not duplicate other services provided to the beneficiary.
- Be sufficient in amount, scope and duration to reasonably achieve its purpose. Be recognized as either the treatment of choice (i.e., prevailing community or statewide standard) or common medical practice by the practitioner's peer group, or the functional equivalent of General Policy Provider Policy Manual's other care and services that are commonly provided.
- Be rendered in response to a life-threatening condition or pain, or to treat an injury, illness or other diagnosed condition, or to treat the effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation, including loss of physical or mental functionality or developmental delay.



And will be reasonably determined to:

- Diagnose, cure, correct or ameliorate defects and physical and mental illnesses and diagnosed conditions or the effects of such conditions; or
- Prevent the worsening of conditions or effects of conditions that endanger life or cause pain, or result in illness or infirmity, or have caused or threaten to cause a physical or mental dysfunction, impairment, disability or developmental delay; **or**
- Effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an institutional setting or other Medicaid program; **or**
- Restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury or other diagnosed condition or the effects of the illness, injury or condition; **or**
- Provide assistance in gaining access to needed medical, social, educational and other services required to diagnose, treat or support a diagnosed condition or the effects of the condition.

In order that:

- The beneficiary might attain or retain independence, self-care, dignity, self-determination, personal safety and integration into all natural family, community and facility environments and activities.



Appendix B

Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP				
(example only –may not be current reporting year)				
#	NQF#	Measure Steward	PM Abr.	Measure Name
1	0108	NCQA	ADD	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD)
2	NA	NCQA	AMB	Ambulatory Care – Emergency Department (ED) Visits
3	NA	AHRQ-CMS-CHIPRA NCINQ	APC	Use of Multiple Concurrent Antipsychotics in Children and Adolescents
4	NA	NCQA	AWC	Adolescent Well-Care Visit
5	NA	AMA-PCPI	BHRA	Behavioral Health Risk Assessment (for Pregnant Women)
6	NA	NCQA	CAP	Child and Adolescent Access to Primary Care Practitioners
7	0033	NCQA	CHL	Chlamydia Screening in Women
8	0038	NCQA	CIS	Childhood Immunization Status
9	NA	NCQA	CPC	Consumer Assessment of Healthcare Providers and Systems® CAHPS 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items)
10	1448	OHSU	DEV	Developmental Screening in the First Three Years of Life
11	NA	NCQA	FPC	Frequency of Ongoing Prenatal Care
12	0576	NCQA	FUH	Follow-up After Hospitalization for Mental Illness
13	1407	NCQA	IMA	Immunizations for Adolescents
14	1382	CDC	LBW	Live Births Weighing less than 2,500 Grams
15	NA	NCQA	MMA	Medication Management for People with Asthma
16	0471	TJC	PCO2	Cesarean Rate for Nulliparous Singleton Vertex
17	2902	OPA	CCP	Contraceptive Care – Postpartum Women Ages 15–20
18	NA	CMS	PDENT	Percentage of Eligibles That Received Preventive Dental Services
19	NA	NCQA	PPC	Timeliness of Prenatal Care
20	2508	DQA(ADA)	SEAL	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk
21	1365	AMA-PCPI	SRA	Child and Adolescent Major Depressive Disorder Suicide Risk Assessment
22	1392	NCQA	W15	Well-Child Visits in the First 15 Months of Life
23	1516	NCQA	W34	Well-Child Visits in the 3rd, 4th 5th, and 6th Years of Life
24	0024	NCQA	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents

AHRQ = Agency for Healthcare Research and Quality; AMA-PCPI = American Medical Association-Physician Consortium for Performance Improvement; CDC = Centers for Disease Control and Prevention; CHIP = Children’s Health Insurance Program; CHIPRA = Children’s Health Insurance Program Reauthorization Act; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); NA = Measure is not NQF endorsed; NCINQ = National Collaborative for Innovation in Quality Measurement; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs.



Appendix C

Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (example – may not be current reporting year)				
#	NQF #	Measure Steward	PM Abbreviation	Measure Name
1	NA	NCQA	ABA	Adult BMI Assessment
2	0105	NCQA	AMM	Antidepressant Medication Management
3	2372	NCQA	BCS	Breast Cancer Screening
4	0018	NCQA	CBP	Controlling High Blood Pressure
5	2902		CCP	Contraceptive Care-Postpartum Women
6	0032	NCQA	CCS	Cervical Cancer Screening
7	0418	CMS	CDF	Screening for Clinical Depression and Follow-Up Plan
8	0033	NCQA	CHL	Chlamydia Screening in Women Ages 21-24
9	0006	AHRQ	CPA	CAHPS® Health Plan Survey V 5.0H--Adult Questionnaire with CAHPS® Health Plan Survey V 5.0H-NCQA Supplemental
10	0576	NCQA	FUH	Follow-Up After Hospitalization for Mental Illness
11	2605	NCQA	FUA	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
12	0039	NCQA	FVA	Flu Shots for Adults Ages 18-64
13	0057	NCQA	HA1c	Hemoglobin A1c Testing
14	0059	NCQA	HPC	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)
15	2607	NCQA	NEW	Diabetes Care for People with Serious Mental Illness: Hemoglobin (HbA1c) Poor Control (>9.0%)
16	2082	HRSA	HVL	HIV Viral Load Suppression
17	0004	NCQA	IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
18	2371	NCQA	MPM	Annual Monitoring for Patients on Persistent Medications
19	0027	NCQA	MSC	Medical Assistance with Smoking and Tobacco Use Cessation (Collected as part of HEDIS Survey)
20	NA	PQA	OHD	Use of Opioids at High Dosage
21	0469/ 2829	TJC	PC-01	Elective Delivery
22	0476	TJC	PC-03	Antenatal steroids
23	1768	NCQA	PCR	Plan All-Cause Readmission
24	1768	NCQA	PPC	Postpartum Care Rate
26	0272	AHRQ	PQI 01	Diabetes, Short-term Complications Admission Rate
27	0275	AHRQ	PQI 05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma Admission Rate
28	0277	AHRQ	PQI 08	Congestive Heart Failure Admission Rate
29	0283	AHRQ	PQI 15	Asthma in younger adults Admission Rate
30	1879	CMS	SAA	Adherence to Antipsychotics for Individuals with Schizophrenia
31	2607	NCQA	SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications

AHRQ = Agency for Healthcare Research and Quality; AMA-PCPI = American Medical Association-Physician Consortium for Performance Improvement; CDC = Centers for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CHIPRA = Children's Health Insurance Program Reauthorization Act; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); NA = Measure is not NQF endorsed; NCINQ = National Collaborative for Innovation in Quality Measurement; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs.



Appendix D: (Reference use only)

Common Scorecard Measurements

Category Measures

<u>Quality of Care</u>	<u>Measure Type</u> ¹
Diabetes: HbA1c control 2	Reporting
Diabetes: Medical attention for nephropathy	Accountable
Medication adherence in diabetes	Accountable
Medication adherence in high blood pressure: RASA	Accountable
Adherence to statin therapy for individuals with cardiovascular disease	Accountable
Medication management for people with asthma	Accountable
High risk medications in the elderly	Accountable
Colorectal cancer screening	Accountable
Cervical cancer screening	Accountable
Breast cancer screening	Accountable
BMI assessment	Reporting
Screening and follow-up for clinical depression	Reporting
Avoidance of antibiotic treatment in adults with 13 acute bronchitis	Accountable
Appropriate treatment for children with URI	Accountable
Childhood immunization status 3	Accountable
Developmental screening in the first three years of life	Reporting
Fluoride varnish application for pediatric patients	Reporting
HPV vaccination for female adolescents	Accountable
Adolescent well-care visits	Accountable
Well child care: 0-15 months	Accountable
Well child care: 3-6 years	Accountable
 <u>Utilization</u>	
Follow-up within 7 days after hospital discharge 4	Reporting
Plan all-cause readmissions	Accountable
Inpatient utilization	Accountable
Emergency department utilization	Accountable
 <u>Total Cost of Care</u>	
Total cost of care per patient	Accountable

¹Accountable measures are being promoted by DCHI for alignment with payers' outcomes-based payment programs. Reporting measures are currently intended to be for information only, though DCHI will continue to learn more about them to determine if they should be accountable measures in the future.

² Modified HEDIS definition: HbA1c ≤ 9%.

³ Combination 10 is used.

⁴ Conditions included in this measure: CHF, COPD, pneumonia and ischemic vascular disease.



Appendix E: Critical Incident Reporting

The Contractor shall operate a critical incident management system that complies with State law and policy, including the requirement to report, document, and investigate Critical Incidents that occur with its members and the provision of DSHP and DSHP Plus covered services. Critical incidents shall include but not be limited to the following incidents when they occur:

- Suspected physical, mental or sexual abuse and/or neglect of a member;
- Theft or financial exploitation of a DSHP Plus member;
- Inappropriate/unprofessional conduct by a provider involving a member.
- Physical abuse with injury(member to member);physical abuse(staff to resident)
- Sexual abuse: all staff to resident; non-consensual resident to resident; non-consensual other to resident
- Emotional Abuse: all staff to resident; all resident to resident; all other to resident
- Neglect
- Mistreatment
- Financial exploitation

The Contractor shall regularly identify, track, review and immediately report (within 8 hours) to the State and the appropriate investigative agency (see MCO contract) critical incidents. The Contractor shall review and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. The initial report of an incident within 8 hours may be submitted in writing using the Move IT file transfer system, to DMMA and the appropriate investigative agency. The Contractor shall provide a full written report to DMMA within 30 business days of identifying a Critical Incident that includes, at a minimum, information regarding the Critical Incident, the investigation conducted by the Contractor and/or investigative agency (if applicable) findings by the Contractor and the investigative agency (as applicable, and any corrective actions.

Critical Incidents are also tracked on the QCMMR reports quarterly. The Contractor must report to the State those initiatives that the Contractor is taking to prevent Critical Incidents from occurring on the QCMMR reports.



Appendix F: - Full set of Performance Measures

- Well-Child Visits in the First 15 months of Life (W15)
 - 0 visits
 - 1 visit
 - 2 visits
 - 3 visits
 - 4 visits
 - 5 visits
 - 6 or more visits
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Children and Adolescents' Access to PCPs (CAP)
 - 12-24months
 - 25 months -6 years
 - 7-11 years
 - 12-19years
- Childhood Immunization Status (CTS)
 - Combination 2 (DTap, WV, MMR HiB, hepatitis B, VZV)
- Lead Screening in Children (LSC)
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- Adults' Access to Preventive/Ambulatory Health Services (AAP)
 - 20-44 years
 - 45-64 years
 - 65 plus years
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Comprehensive Diabetes Care (CDC)
 - Lipid Screening
 - HbA1 C Screening
 - Retinal eye examination screening
- Cholesterol Management of Patients with Cardiovascular Conditions (CMC)
 - LDL-C Screening
 - LDL-C Control (<100 mg/dl)
- Controlling High Blood Pressure (CBP)
- Antidepressant Medication Management (AMM)
 - Effective acute phase treatment
 - Effective continuation phase treatment
- Prenatal and Postpartum Care (PPC)



- At least 1 prenatal visit
- 1 postpartum visit between 21 and 56 days after delivery
- Ambulatory Care (AMB)
 - Emergency Department Visits/1,000
 - Observation Room Stays/1,000
 - Outpatient Visits/1,000
 - Surgery Procedures/ 1,000
- **Inpatient Utilization (IPU)**
 - Maternity Days/1,000
 - Maternity Discharges/ 1,000
 - Maternity ALOS
 - Medicine Days/1,000
 - Medicine Discharges/ 1,000
 - Medicine ALOS
 - Surgery Days/1,000
 - Surgery Discharges/ 1,000
 - Surgery ALOS
 - Non-acute Care Days/1,000
 - Non-acute Care Discharges/1,000
 - Non-acute Care ALOS
 - Total IP Days/1,000
 - Total IP Discharges/ 1,000
 - Total IP ALOS
- Mental Health Utilization (MPT)
 - inpatient Services
 - Intensive OP and Partial Hospitalization
 - Outpatient and ED
 - Any Services
- Use of Appropriate Medications for People with Asthma (ASM)
 - 5-9 years of age
 - 10-17 years of age
 - 18-56 years of age
 - Combined Rate



Appendix G: Full set of Case Management reports

Pediatric

- Number of new pediatric Medicaid enrollees referred via the HRA to pediatric CM
- Number of new pediatric Medicaid enrollees referred to pediatric CM by mode other than HRA
- Number of existing pediatric Medicaid enrollees referred to pediatric CM
- Total number of pediatric Medicaid enrollees referred to pediatric CM
- Total number of pediatric Medicaid enrollees active in pediatric CM

Adult

- Number of new adult Medicaid enrollees referred via the HRA to adult CM
- Number of new adult Medicaid enrollees referred to adult CM by mode other than HRA
- Number of existing adult Medicaid enrollees referred to adult CM
- Total number of adult Medicaid enrollees referred to adult CM
- Total number of adult Medicaid enrollees active in adult CM

Behavioral Health

- Number of new Medicaid enrollees referred via the HRA to BH CM
- Number of new Medicaid enrollees referred to **BH** CM by mode other than **HRA**
- Number of existing Medicaid enrollees referred to BH CM
- Total number of Medicaid enrollees referred to BH CM
- Total number of Medicaid enrollees active in BH CM

Transplant

- Number of new Medicaid enrollees referred via the HRA to transplant CM
- Number of new Medicaid enrollees referred to transplant CM by mode other than HRA
- Number of existing Medicaid enrollees referred to transplant CM
- Total number of Medicaid enrollees referred to transplant CM
- Total number of Medicaid enrollees active in transplant CM

Pregnancy

- Number of new Medicaid enrollees referred via the HRA to the Pregnancy CM program
- Number of new Medicaid enrollees referred to the Pregnancy CM program by mode other than HRA
- *Number of existing* Medicaid enrollees referred to the Pregnancy CM program
- Total number of Medicaid enrollees referred to the Pregnancy CM program
- Total number of Medicaid enrollees active in the Pregnancy CM program



Long Term Care

- Timeliness of initial contact
- Timeliness of initial onsite for assessment
- Timeliness for onsite for reassessments
- Member specific goals
- Contingency plan for HCBS members



Appendix H: -Acronyms

ADRC:	Aging and Disabilities Resource Center
ALOS:	Average Length of Stay
BBA:	Balanced Budget Act of 1997
BH:	Behavioral Health
CAHPS:	Consumer Assessment of Healthcare Providers and Systems
CAP:	Corrective Action Plan
CCU:	Cardiac Care Unit
CDS:	Controlled Dangerous Substances
CFR:	Code of Federal Regulations
CHIP:	Children's Health insurance Program
CHJPRA:	<i>Children's</i> Health insurance Program Reauthorization Act
CM:	Case Management
CMS:	Centers for Medicare & Medicaid Services
CSHCN:	Children with Special Health Care Needs
DDDS:	Division of Developmental Disabilities Services
DEA:	Drug Enforcement Agency
DFS:	Division of Family Services
DHCP:	Delaware Healthy Children Program
DHSS:	Department of Health and Social Services
DLTCRP:	Department of Long Term Care Residents Protection
DM:	Disease Management
DMMA:	Division of Medicaid & Medical Assistance
DPBHS	Division of Prevention and Behavioral Health Services
DPCI:	Delaware Physicians Care Inc.
DPH:	Division of Public Health
DSAAPD:	Division of Services for Aging and Adults with Physical Disabilities
DSAMH:	Division of Substance Abuse & Mental Health
DSHP:	Diamond State Health Plan
DSHP Plus:	Diamond State Health Plan Plus
DSP:	Diamond State Partners
ED:	Emergency Department
EPSDT:	Early and Periodic Screening, Diagnosis and Treatment
EQR:	External Quality Review
EQRO:	External Quality Review Organization
FFS:	Fee-for-service



FPL:	Federal Poverty Limit
FY:	Fiscal Year
HBM:	Health Benefits Manager
HHO:	Highmark Health Options
HCBS:	Home- and Community-Based Services
HCFA:	Health Care Financing Administration
HEAL:	Healthy Eating and Living
HEDIS:	Healthcare Effectiveness Data and Information Set
HIPAA:	Health Insurance Portability and Accountability Act of 1996
HMO:	Health Maintenance Organization
HRA:	Health Risk Assessment
ICU:	Intensive Care Unit
LTC:	Long-Term Care
MCAC:	Medical Care Advisory Committee
MCOs:	Managed Care Organizations
MIS:	Management Information System
MMDS:	Managed Care Operations Team/DMMA Leadership
MIVIIS:	Medicaid Management Information System
NASHP:	National Academy for State Health Policy
PAHP:	Prepaid Ambulatory Health Plans
PBM:	Pharmacy Benefits Manager
PCCM:	Primary Care Case Management
PCP:	Primary Care Practitioner
PEDS:	Parents Evaluation of Developmental Status
PIHP:	Prepaid Inpatient Health Plans
PIPS:	Performance Improvement Projects
PMs:	Performance Measures
PMPM:	Per Member Per Month
QA:	Quality Assurance
QCM:	Quality and Care Management
QCMMR:	Quality and Care Management Measurement Report
QI:	Quality Improvement
QII:	Quality Improvement Initiative
QM:	Quality Management
QS:	Quality Strategy



SCHIP: State Children's Health Insurance Program

SHCN: Special Health Care Needs

SUR: Surveillance and Utilization Review

UHPDE: Unison Health Plan of Delaware

UHCP: United Healthcare Community Plan



Appendix I: PROMISE Sub-Assurances

Assurance 1: Needs-Based Criteria

The State demonstrates that it implements the processes and instruments specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of need, consistent with the needs-based criteria in the demonstration. The processes and instruments described in the approved PROMISE 1115 amendment are applied appropriately and according to the approved description to determine if the needs-based criteria were met.

1. Sub assurance: An evaluation for needs-based criteria is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
2. Sub assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial participant level of need.
3. CMS 1115 requirement: All PROMISE enrollees must be evaluated at least annually or as otherwise specified by the State.

Assurance 2: Person-Centered Planning

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of recovery plans for waiver participants. Recovery plans address assessed needs of PROMISE participants, are updated annually, and document choice of services and providers.

1. Sub assurance: Service plans address all members' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.
2. Sub assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
3. Sub assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.
4. Sub assurance: Participants are afforded choice among waiver services and providers.

Assurance 3: Provider Qualifications

The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. Providers meet required qualifications.

1. Sub assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
2. Sub assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.



3. Sub assurance: The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.

Assurance 4: Settings Meet the HCBS Setting Requirements

Assurance 5: State Medicaid Agency Oversight

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state agencies and contracted entities.

Assurance 6: Fiscal Accountability

The State Medicaid Agency (SMA) maintains financial accountability through payment of claims for services that are authorized and furnished to PROMISE participants by qualified providers.

1. Sub assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
2. Sub assurance: The State provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.

Assurance 7: Health and Welfare

The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

1. Sub assurance: The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death.
2. Sub assurance: The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.
3. Sub assurance: The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Sub assurance: The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.