



Delaware Health and Social Services

Division of Medicaid & Medical Assistance

DIAMOND STATE HEALTH PLAN

Section 1115 2016 Annual Report

Demonstration/Quarter Reporting Period Demonstration

Year: 21 (1/1/2016 – 12/31/2016)

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Introduction

The Diamond State Health Plan (DSHP) is a mandatory Medicaid managed care program operating under an 1115 waiver from CMS. Diamond State Health Plan covers approximately ninety percent (90%) of Delaware's Medicaid population.

The delivery system for DSHP is mandatory enrollment in MCOs. Individuals eligible for DSHP-Plus receive comprehensive, integrated LTSS and individuals eligible for PROMISE services receive an enhanced package of behavioral health services. A limited number of benefits, such as children's dental and non-emergency transportation, are delivered through fee-for-service. PROMISE benefits are delivered through the fee-for-service PROMISE program administered through the Division of Substance Abuse and Mental Health (DSAMH).

The State of Delaware is utilizing a Health Benefits Manager (HBM), enrollment broker, to provide outreach, education and enrollment for the Medicaid clients. The Managed Care Entities are not allowed to direct market to the Medicaid population, but may hold or attend health fairs, special events or school programs.

History of MCO Contracts:

From July 1, 2002 to June 30, 2004 Diamond State Health Plan had contracted with one Managed Care Entity (First State Health Plan) and Diamond State Partners a Medicaid only, managed fee for service program, developed and implemented by the Division of Medicaid and Medical Assistance.

On July 1, 2004 Delaware Physicians Care Inc., a subsidiary of Schaller Anderson, became the State's managed care option. This contract was renewed for the SFY 2006, beginning July 2005 and again July 1, 2006 (SFY 07).

On July 1, 2007 Diamond State Health Plan expanded the program by offering a second commercial managed care option. In addition to Delaware Physicians Care Inc. (DPCI) and Diamond State Partners, the Medicaid only, managed fee for service program, enrollees may also choose United Healthcare Community Plan (formerly Unison Health Plan of Delaware). The contracts between the state and these two managed care plans have been extended from July 1, 2011 to June 30, 2013, with additional option years.

On April 1, 2012, Diamond State Health Plan expanded to include dual eligibles and managed long term services and support under DSHP Plus through the existing MCOs.

On January 1, 2015 Diamond State Health Plan completed a successful RFP process and awarded two contracts; one incumbent MCO, United Healthcare Community Plan and one new MCO Highmark BCBS Health Options. Effective December 31, 2014 Diamond State Partners ended.

Enrollment Information

Demonstration Populations	Ever Enrolled
Population 1: TANF Children less than 21	104,252
Population 2: TANF Adults aged 21 and over	36,936
Population 3: Disabled Children less than 21	5,718
Population 4: Aged and Disabled Adults 21 and older	6,911
Population 5: Infants less than one year of age with income levels above 185 percent FPL through 200 percent FPL; optional targeted low income children	N/A Charged to Title XXI
Population 6: Uninsured Adults up to 100% FPL	70,437
Population 7: Family Planning Expansion	N/A Terminated in 2013
Population 8: DSHP-Plus State Plan	10,538
Population 9: DSHP-Plus HCBS	4,258
Population 10: DSHP TEFRA-Like	N/A
Population 11: ACA Adults at 101-133% FPL	16,680
Total	255,730

Definition: For most groups above, the 1115 enrollment is an annual unduplicated count of clients in the MCO for at least one day in January 2016 through December 2016 based on Medicaid MCO paid capitation claims. In addition to MCO enrollees, the counts of Uninsured Adults below 133% FPL (Population 6 and 11 below, also referred to as VIII group Newly and Not Newly Eligible Adults) include clients who were Medicaid eligible in 2016 but not enrolled in MCOs (they were awaiting managed care enrollment or were inmates with hospital stays.) DMMA is including all costs (not rebate) for these adults in 1115 Waiver reporting per CMS' instructions.

MCO Outreach/Innovative Activities

The MCOs continued to be very active in the community and their members. Some activities include:

- Sixteen Annual Diabetes Wellness Expo
- CHEER Trap Pond Fall Festival
- Delaware Hispanic Commission - Connecting through Civic Engagement
- Henrietta Johnson Medical Center Annual Eye Screening
- 2016 Diabetes Expo
- Annual Breast Cancer Awareness events
- School health and teen health fairs
- Community health fairs

The State's Health Benefits Manager (HBM)

HBM Ongoing Activities & Objectives

- Continue to educate clients about the two health plan options
- Conduct annual open enrollment
- Continue to provide ongoing caseworker training about DSHP, DSHP Plus and DHCP
- Continue to assist clients with complaints or issues concerning their managed care
- Continue tracking caseworker assistance performed by Outreach representatives
- Continue the process by which Outreach representatives consistently follow-up with caseworkers who need education, based on telephone calls from clients and caseworkers
- Continue to offer translation services for Spanish-speaking clients at selected State Service Centers statewide, for both oral and written translations
- Continue to supply representatives for oral translations by phone, for caseworkers and clients
- Continue to deliver the HBM monthly newsletter and distribute it to all caseworkers

For more detailed information regarding all our activities this quarter please see **Attachment-A** the HBM Annual report and **Attachment B** the HBM Monthly Newsletters.

Special Interest Meeting/Conference

Delawareans with Special Health Care Needs

DE Medicaid continues to support the Delawareans with Special Health Care Needs (DSHCN). The DSHCN host the bi-monthly MCO telephone panel discussion which includes an hour devoted to individuals under Delaware's Diamond State Health Plan Plus program. In addition, they host a bi-monthly MCO telephone panel discussion specifically focusing on child/adolescent behavioral health issues. DE Medicaid provides liaisons from both the policy unit and medical management unit to DSHCN who attend each of these bi-monthly MCO panel discussions and follow up with any topics discussed which require additional action.

Delaware Family Voices

DE Medicaid continues to support Delaware Family Voices. DE Medicaid provides liaisons to Delaware Family Voices who serve on their Family Leadership Advisory Council (FLAC). FLAC is the body of representatives of stakeholders, partner agencies, and interested community members that make suggestions for the direction and future goals for Delaware Family Voices. These liaisons participated in calls with DMMA, including two calls in the 4th quarter of CY 2016. DMMA stays in contact with this organization to provide assistance to any family in need.

Operational/Policy Developments/Issues

Regulations

During 2016, DMMA focused on assessing the impact of the Medicaid managed care final rule and planning for policy, contractual and operational compliance with the rule. DMMA also focused on compliance with the HCBS settings final rule, as required by the DSHP 1115 special terms and conditions.

MCO Procurement

None

Delaware Medicaid Enterprise System (DMES)

In 2016, DMMA focused on implementation of our new DMES system. The Go Live date for this system was December 29, 2016. DMMA met weekly with our trading partners Highmark Health Options and United Healthcare Community plans assuring they are prepared to send and receive member files in order to serve our Medicaid clients on January 1, 2017. Both MCOs were able to receive their member roster files and serve our Medicaid clients without interruption. We continued to meet with both MCOs to make sure the sharing of file information is working properly.

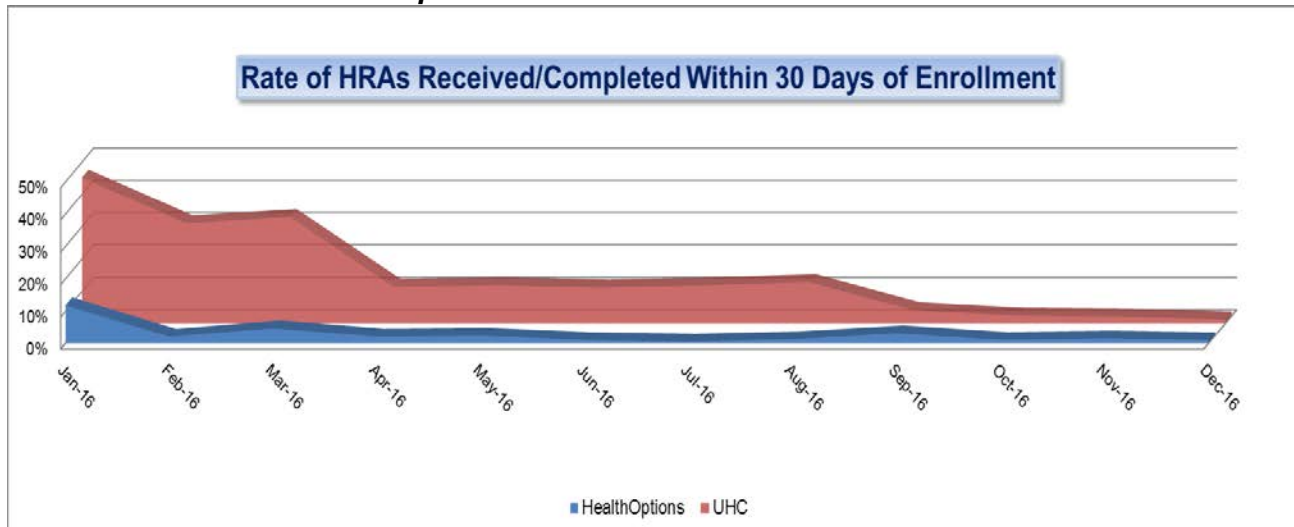
QCMMR and QCMMR Plus Reporting

The Medical Management Managed Care Team has developed and refined our **Quality and Care Management Measurement Reporting Templates (QCMMR) and QCMMR Plus**. The QCMMR reports on the DHSP and CHIP Medicaid Populations while the QCMMR Plus reports on the DSHP Plus population. The Managed Care Operations Team worked in conjunction with Mercer, our EQRO contractor, and the MCOs in developing the guidelines and reporting templates. The QCMMR and QCMMR Plus was developed as a method to specify the metrics to be reported monthly, compare metrics for the two commercial health plans, monitor the results at the State level, and roll up the results quarterly and annually for executive level reporting on the managed care program. The metrics or measures flow from contractual requirements or federal or state regulations contained in the Managed Care program contract.

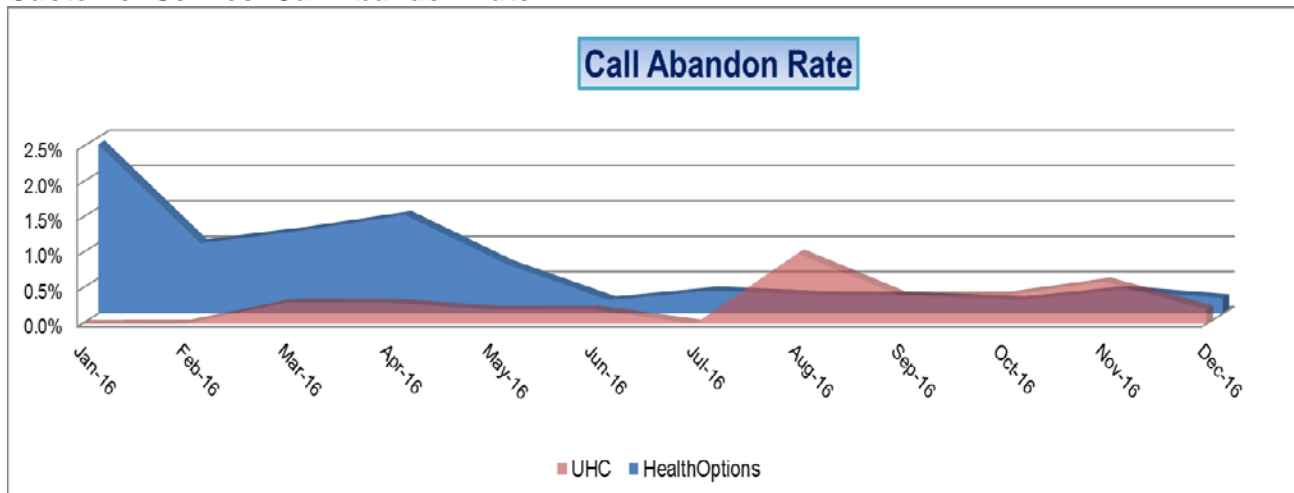
DMMA Managed Care Operations unit developed the full circle approach to the QCMMR and QCMMR Plus reporting. The reports are reviewed by the Managed Care Operations team and an agenda is developed for our monthly meeting with each MCO to discuss the findings from the reports. Managed Care Operation's goal is to establish a partnership with the MCOs to improve quality of care for our Medicaid population.

DMMA continues to evaluate the QCMMR reports for both DSHP and DSHP Plus populations. DMMA has been working in conjunction with the MCOs to redefine and modify the reporting template to assure both MCOs are pulling and reporting the same data.

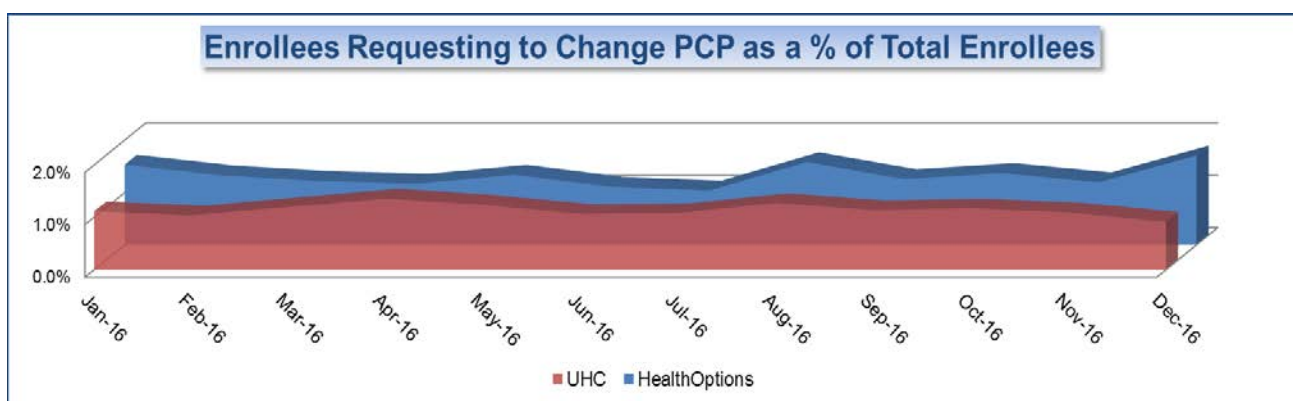
Health Risk Assessment Completion Rate



Customer Service: Call Abandon Rate



Percent of Enrollees Requesting a Change in Primary-Care Provider



Quality Assurance and Monitoring Activity

Quality Management Strategy (QMS)

During 2016, the QMS was reviewed and a plan has been put in place to revise it, which will include the new managed care rule requirements. Input will be requested from both MCOs as well as internal and sister agency supportive comments which will be incorporated.

Quality Improvement Initiative Task Force (QII)

The QII is guided by the Quality Management Strategy. The QII is meant to be a way to improve health outcomes for all Medicaid recipients.

During the first quarter of 2016, Goal 1 of the Quality Management Strategy was reviewed. This forum was used to report on a variety of ways to improve timely access to appropriate care and services for adults and children with an emphasis on primary, preventive, and behavioral health care, and to remain in a safe and least-restrictive environment for DSHP, DSHP Plus, and CHIP members.

The Medical Case Management Unit/DMMA has continued with Case Management oversight of the DSHP Plus population and oversight of DSHP members identified by the MCO's thru Risk Stratification as requiring Care Coordination Services. This oversight is accomplished through on site reviews at the MCO's and joint State/MCO visits with members of the DSHP Plus and DSHP population. We continue to review and monitor the required Case Management and Care Coordination reporting from the MCO's. Including, but not limited to the Care Coordination Reports, Case Management for DSHP Plus LTSS, Service Coordination reports, Self-Directed Attendant Care service and Utilization Management reports. DMMA continues with monthly meetings with each MCO, this provides a forum to discuss any case management issues in a collaborative manner, identify issues and plan resolutions. Our Medical Case Management Unit also meets bi-monthly with our MCO's and our DMMA LTC units to discuss any LTC issues, again in a collaborative manner to identify issues and plan resolutions.

DMMA concentrated its efforts on expanding our case management oversight and improving and our assessment tools. Currently DMMA has completed over 150 joint State/MCO visits with members in our DSHP Plus and DSHP members, our Joint Visit tools have been updated and are completed in real time. A Case File review, Level of Care Redetermination and Critical Incident review have been completed. All findings were reviewed with the MCO's to identify areas for improvement and plan resolution. DMMA's ongoing case management oversight activities ensure all the populations served are receiving the highest quality and comprehensive medical services in the most cost effective manner.

During the second quarter of 2016, Goal 2 of the Quality Management Strategy was reviewed. The QII forum was used to report on an assortment of ways to improve the quality of care and services to DSHP, DSHP PLUS, and CHIP members. Some of the ways the MCOs reported successes are described below.

The Medical Case Management Unit/DMMA has continued with Case Management oversight of the DSHP Plus population and oversight of DSHP members identified by the MCO's thru Risk Stratification as requiring Care Coordination Services. This oversight is accomplished through on site reviews at the MCO's and joint State/MCO visits with members of the DSHP Plus and DSHP population. We continue to review and monitor the required Case Management and Care Coordination reporting from the MCO's. Including, but not limited to the Care Coordination Reports, Case Management for DSHP Plus LTSS, Service Coordination reports, Self-Directed Attendant Care service and Utilization Management reports. DMMA continues with monthly meetings with each MCO, this provides a forum to discuss any case management issues in a collaborative manner, identify issues and plan resolutions. Our Medical Case Management Unit also meets bi-monthly with our MCO's and our DMMA LTC units to discuss any LTC issues, again in a collaborative manner to identify issues and plan resolutions.

Our Medical Case Management unit has finalized and implemented our updated DMMA/MCO Care Coordination Joint Visit Tool. Our Nurses are completing an average of 20 joint visits per week, statewide. Our updated MCO Care Coordination on site Case File review tool has been finalized and will be utilized for our third quarter review. We continue to work with our Applied Behavior Analysis (ABA) providers to facilitate the authorization/billing process.

During the third quarter of 2016, Goal 3 of the Quality Management Strategy was reviewed. The QII forum was used to report on a variety of ways to control the growth of health care expenditures.

The Medical Case Management Unit/DMMA has continued with Case Management oversight of the DSHP Plus population and oversight of DSHP members identified by the MCO's thru Risk Stratification as requiring Care Coordination Services. This oversight is accomplished through on site reviews at the MCO's and joint State/MCO visits with members of the DSHP Plus and DSHP population. We continue to review and monitor the required Case Management and Care Coordination reporting from the MCO's. Including, but not limited to the Care Coordination Reports, Case Management for DSHP Plus LTSS, Service Coordination reports, Self-Directed Attendant Care service and Utilization Management reports. DMMA continues with monthly meetings with each MCO, this provides a forum to discuss any case management issues in a collaborative manner, identify issues and plan resolutions. Our Medical Case Management Unit also meets bi-monthly with our MCO's and our DMMA LTC units to discuss any LTC issues, again in a collaborative manner to identify issues and plan resolutions.

Our Medical Case Management team has been responding to member concerns and assisting in Care Coordination with their MCO's, providers and other community supports. We continue to provide Case Management oversight to our MCO's, our staff participates in Care Coordination meetings for some of our members with complex needs and facilitate the communication between our MCO's and our other state agencies. Our team has just completed our Third Quarter MCO site reviews and submitted our findings to the MCO's. This is a collaborative process with the MCOs which has enhanced care coordination for our members.

During the fourth quarter of 2016, goal four of the Quality Management Strategy was reviewed. The QII forum was used to report on an assortment of ways to assure membership satisfaction with services.

The Medical Case Management Unit/DMMA continues to provide Case Management Oversight of the DSHP Plus population and DSHP members identified by the MCO's thru Risk Stratification as requiring Care Coordination and Resource Coordination Services. This oversight is accomplished through on site reviews at the MCO's and joint State/MCO visits with members of the DSHP Plus and DSHP population. We continue to review and monitor the required Case Management and Care Coordination reporting from the MCO's. Including, but not limited to the Care Coordination Reports, Case Management for DSHP Plus LTSS, Service Coordination reports, Self-Directed Attendant Care service and Utilization Management reports. Our Medical Case Management Unit is finalizing our review of the 2016 EQRO Compliance Report and has requested additional verifications and supportive documentation from our MCO's to ensure contractual requirements and safeguard membership. We are reviewing the final responses from our MCO's to the HCBS Compliance Plan for the Home and Community-Based Services final rule. DMMA continues with monthly meetings with each MCO, utilizing this forum to discuss any case management issues in a collaborative manner, identify issues and plan resolutions.

Performance Improvement Projects (PIPs)

The Quality Department oversees the development and improvement of PIPs for the Managed Care Organizations. Currently, five PIPs are required of the MCOs. There are two mandatory PIPs: one prescriptive, which is oral health; one which the topic is prescriptive, however, the MCOs develop on their own the operations of the PIP, which is physical and behavioral health integration. Of the three other PIPs: one must be in the field of pediatrics; one must be a service oriented PIP (non-clinical); and one has to do with the LTSS/HCBS community.

DMMA has provided technical assistance to help develop the PIPs and further assistance to help develop Rapid Cycle Analysis. DMMA provides some constructive criticism on the PIPs quarterly.

In the Member Service Standards PIP, the MCO is increasing member service staffing to see if this will increase performance standards as far as having a 5% call abandonment rate, and 80% of calls answered by a live voice within 30 seconds and average wait time not to exceed 30 seconds. In this quarter their average speed to answers calls was 24 seconds, 85.1% of calls were answered within 30 seconds, and call abandonment rate was 1.2%. This supports their original question that increasing staff will increase performance standards.

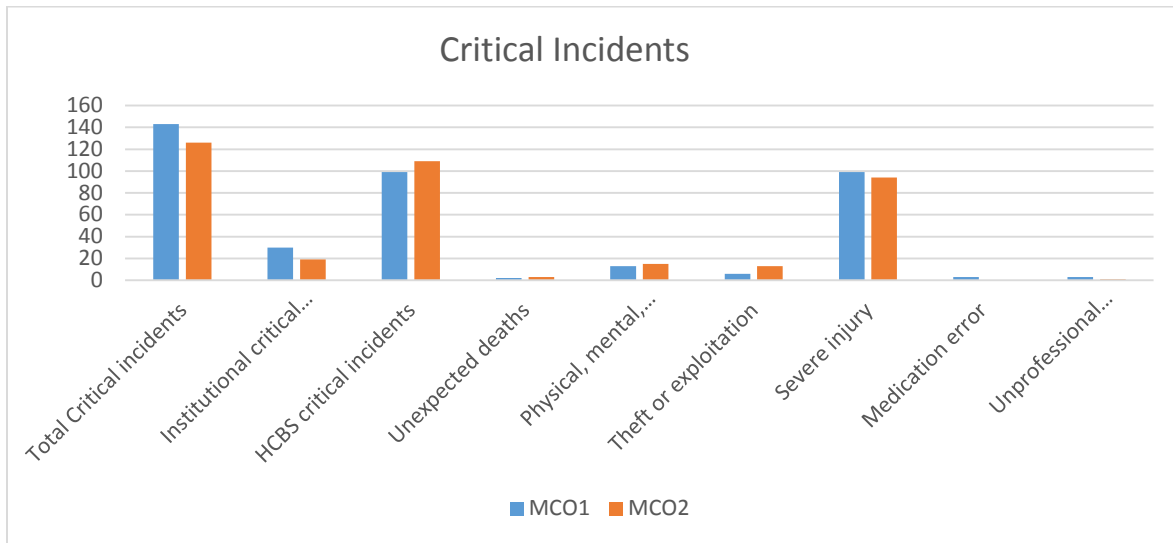
In the PROMISE Hypertension PIP the question addressed whether face to face or telephonic education improve the likelihood of completing a primary care visit and or adhering to hypertension medication for PROMISE program members with a diagnosis of hypertension. Moderate amounts of education occurred re: primary care visits, 61%. A great deal of education occurred regarding using anti-hypertensives, 90.1%. But there was little impact on the members: 21.2% had a primary care visit; and 32.6% achieved or maintained a medication possession ratio of .80 or greater. Claims data as a measurement was discussed along with possible barrier identification.

The PIPs are turned in to the DMMA quarterly. Initial feedback provided to the MCOs concerning the PIP submissions was assuring appropriate, specific, measurable, attainable, relevant, and time bound lead and lag measures. As the PIPs mature the feedback changed to barrier analysis and

use of Ishikawa diagrams.

Critical Incidents

Incidents are tracked and trended quarterly for progressions and patterns and also compared between MCOs to see if there is a difference in processes or procedures that may make a difference in number or type of occurrences. They are also reviewed for opportunities for quality improvement. To maintain or insure quality care for members, cases are reviewed on an advanced quality level to determine necessary prevention and/or corrective measures so that these incidents do not recur.



Child and Adult Core Measures

Twenty-six combined Adult Core Measurements were entered successfully into MACPro for FFY 2016. Twenty-four combined Child Core Measurements were entered successfully into MACPro for FFY 2016. These represent two contracted MCOs with the state of Delaware.

CAHPS

This measure provides information on beneficiaries' experiences with their health care and gives a general indication of how well the health care meets the beneficiaries' expectations. Results summarize beneficiaries' experiences through ratings, composites, and question summary rates. Four global rating questions reflect overall satisfaction: rating of all health care; rating of health plan; rating of personal doctor and rating of specialist seen most often. Five composite scores summarize responses in key areas: customer service; getting care quickly; getting needed care; how well doctors communicate; and shared decision making.

Item-specific question summary rates are reported for the rating questions and each composite question, the "written materials/Internet provided needed information" question, and the "forms were easy to fill out" question. Question summary rates are also reported individually for two items summarizing the following concepts: health promotion and education; and coordination of care.

2016 Survey on Adult Medicaid enrollees' age 18-65 yrs. old experiences with care

	MCO 1	MCO 2
<i>Rating of All Health Care</i>	57%	43%
<i>Rating of Personal Doctor</i>	64%	55.7%
<i>Rating of Specialist Seen Most Often</i>	36.8%	64.2%
<i>Rating of Health Plan</i>	76.2%	25.7%
<i>Customer Service</i>	27.7%	34.1%
<i>Getting Care Quickly</i>	50.2%	33.8%
<i>Getting Needed Care</i>	51.7%	35.3%
<i>How Well Doctors Communicate</i>	60%	50.3%
<i>Shared Decision Making</i>	29.2%	28.9%
<i>Health Promotion and Education</i>	55%	57.4%
<i>Coordination of Care</i>	39%	23.8%

HEDIS Submissions

HEDIS data is submitted by the MCOs quarterly for those measures that have not met the 75th percentile within their organizations. The Quality team reviews those measurements and also reviews the MCOs interventions for improving the measurements. A comparison document was created to compare the two MCOs measurements. After review of the information and data submitted using these documents, a decision was made by DMMA leadership to have the MCOs report for next reporting year those measures that did not meet the 50th percentile quarterly as well as what PIPs and interventions have been put into practice to assist in improving these measurement reports.

Measure/Data Element	Rate MCO 1	Rate MCO 2
BMI Percentile	NA	69.34%
Counseling for Nutrition	NA	69.34%
Counseling for Physical Activity	NA	63.99%
Childhood Immunization Status (cis)		
DTaP	65.04%	81.12%
IPV	80.53%	90.99%
MMR	83.04%	92.70%
HiB	82.01%	90.56%
Hepatitis B	65.27%	88.41%
VZV	83.04%	93.13%
Pneumococcal Conjugate	67.63%	80.69%
Hepatitis A	80.31%	91.85%
Rotavirus	65.63%	74.25%
Influenza	46.9%	63.09%
Combination #2	50%	78.11%
Combination #3	NA	75.54%

Combination #4	NA	73.82%
Combination #5	NA	63.95%
Combination #6	NA	51.93%
Combination #7	NA	63.52%
Combination #8	NA	51.07%
Combination #9	NA	44.64%
Combination #10	26.6%	44.21%
Comprehensive Diabetes Care (cdc)		
Hemoglobin A1c (HbA1c) Testing	75.7%	84.31%
HbA1c Poor Control (>9.0%)	71.2%	50.91%
HbA1c Control (<8.0%)	24.3%	41.42%
HbA1c Control (<7.0%)	18.1%	26.52%
Eye Exam (Retinal) Performed	34.8%	51.46%
Medical Attention for Nephropathy	86%	91.97%
Blood Pressure Control (<140/90 mm Hg)	0.06%	54.20%

Case Management Oversight

The Medical Case Management Unit/DMMA continued to provide Case Management Oversight of the DSHP Plus population and DSHP members identified by the MCO's through Risk Stratification as requiring Care Coordination and Resource Coordination Services. This oversight is accomplished through on site reviews at the MCOs and joint State/MCO visits with members of the DSHP Plus and DSHP population. We continue to review and monitor the required Case Management and Care Coordination reporting from the MCOs, including, but not limited to the Care Coordination Reports, Case Management for DSHP Plus LTSS, Service Coordination reports, Self-Directed Attendant Care service and Utilization Management reports. Our Medical Case Management Unit finalized our review of the 2016 EQRO Compliance Report and requested additional verifications and supportive documentation from our MCO's to ensure contractual requirements and safeguard membership. We reviewed the final responses from our MCOs to the HCBS Compliance Plan for the Home and Community-Based Services final rule. DMMA continues with monthly meetings with each MCO, utilizing this forum to discuss any case management issues in a collaborative manner, identify issues and plan resolutions.

Managed Care Meeting

Throughout the year, the State conducts Bi-Monthly Managed Care meetings, used to provide a forum to discuss issues in a collaborative manner. These meetings are used to collaborate on common practices, identify issues, plan resolutions and identify potential Quality Improvement Activities.

Medicaid Special Bulletin

This bulletin is given to our Medicaid Providers on a quarterly basis. Throughout the year, topics included (but were not limited to):

- DMES
- PASRR
- Delaware Cancer Treatment Program
- EHR incentive payments
- Newborn coverage policy
- PERM
- We have attached the entire Fourth Quarter 2016 Medicaid Special Bulletin:

Attachment C.

Expenditure Containment Initiatives

DMMA doesn't have any new cost containment initiatives to report for this quarter.

Financial/Budget Neutrality Development/Issues

Budget Neutrality Workbook – To be submitted under separate cover.

Member Month Reporting

A. For use in budget neutrality calculations – To be submitted under separate cover.

Eligibility Group

Program Integrity

DMMA staff attended a seminar at the National Advocacy Center designed for Medicaid Program Integrity staff and Medicaid Fraud Control Unit (MFCU) staff. The seminar focused on collaboration by giving attendees an opportunity to exchange ideas on building and maintaining effective relationships between Program Integrity units and MFCUs to combat fraud, waste, and abuse in Medicaid. This seminar addressed issues of common interest to both groups such as trends and issues, including: strategies for effective collaboration in fighting fraud, waste, and abuse; best practices in case file development; lessons learned and best practices in payment suspensions and credible allegations of fraud; discovery and e-discovery issues; and collaborating on managed care, home health, and personal care services. We have identified vulnerabilities and risk and are now working together to mitigate those areas in a collaborative effort.

DMMA continues to work closely with our MCOs on reporting fraud, waste and abuse. Program Integrity has quarterly meetings with both MCOs and other outside agencies.

Family Planning Expansion Program

Delaware's Family Planning waiver was discontinued per the 1115 Waiver on December 31, 2013.

Demonstration Evaluation

The DSHP Draft Evaluation Plan is pending review and feedback from CMS.

Enclosures/Attachments

Attachment A:

- Health Benefits Manager Annual Report 2016

Attachment B:

- 2016 HBM Monthly Newsletters for fourth quarter
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Attachment C:

- 2016 Fourth Quarter Medicaid Special Bulletin

State Contacts

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