DELAWARE HEALTH AND SOCIAL SERVICES

Division of Medicaid & Medical Assistance

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

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

**State of Delaware**

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# Introduction

## Purpose of Evaluation

In compliance with the Special Terms and Conditions of the Diamond State Health Plan (DSHP) Section 1115 Demonstration, the State of Delaware (Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DMMA)) submits to the Centers for Medicare & Medicaid Services (CMS) this Interim Evaluation Report. This evaluation reviews Delaware's progress for the period of September 30, 2013 to December 31, 2017. The following ten[1] program goals are examined in this evaluation:

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

## Background on DSHP

Delaware's DSHP 1115 Demonstration was initially approved in 1995, and implemented on January 1, 1996. The original goal of the DSHP 1115 Demonstration was to improve the health status of low-income Delawareans by: 1) expanding access to healthcare to more individuals throughout the State, 2) creating and maintaining a managed care delivery system with an emphasis on primary care, and 3) controlling the growth of healthcare expenditures for the Medicaid population.
In order to achieve this goal, the DSHP 1115 Demonstration was designed to mandatorily enroll eligible Medicaid recipients into managed care organizations (MCOs) and create efficiencies in the Medicaid program. Initial savings achieved under managed care enabled the expansion of coverage to certain individuals who would otherwise not be eligible for Medicaid, leading up to Medicaid expansion under the Affordable Care Act (ACA) in 2014. The DSHP 1115 Demonstration was previously renewed on June 29, 2000, December 12, 2003, December 21, 2006, and January 31, 2011.

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

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


## Evaluation Contents and Methodology

In accordance with Special Term and Condition #90, Delaware prepared an interim evaluation of the DSHP 1115 Demonstration and its performance relative to the stated goals. The interim evaluation design addresses the five research questions/topics described in STC #90[2] and aligns with Delaware's 10 waiver program goals. This evaluation is organized according to the 10 waiver program goals. For each goal, a summary of goal accomplishments and a discussion of related data and initiatives are presented. This evaluation relies heavily on a review of the assessment and improvement activities implemented to ensure ongoing quality of the program and services provided. The following are the specific data sources used for the evaluation.

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

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

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

### Highlight

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

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

### Description, Data and Initiatives

#### *Availability of Timely Care*

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

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

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

### *Increasing Access to HCBS*

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

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

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

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

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

### *Increasing Access to Behavioral Health HCBS*

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

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

### Highlight

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

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

### Description, Data and Initiatives

#### *HCBS Utilization*

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

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

**Table 2: 2013 Calendar Year HCBS High Utilization**

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

#### *Growth of HCBS Population*

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

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

### Highlight

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

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

### Description, Data and Initiatives

#### *DSHP Plus*

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

#### *Early Intervention for Medicare-Medicaid Dual Eligibles*

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

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

#### *MCO Performance on Key Performance Measures*

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

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

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

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

### *2015 NCI-AD Adult Consumer Survey*

Additional support for this goal can be found by looking at the results of the data from the NCI-AD Adult Consumer Survey. The NCI-AD Adult Consumer Survey, coordinated by the National Association of States United for Aging and Disabilities (NASUAD) and Human Services Research Institute (HSRI), is a national survey that collects person-reported data about the impact that states' publicly funded LTSS programs have on the quality of life and outcomes of the older adults and adults with physical disabilities. The project officially launched in mid-2015 with 13 participating states[3], including Delaware. Data was collected between 2015-2016 lead by the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) with support provided by DMMA.

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

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

**Table 3: NCI-AD Adult Survey Preventive Services**

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

### *NCI-AD Initiative – Future Years*

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

## Goal 4. Increasing coordination of care and supports

### Highlight

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

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

### Description, Data and Initiatives

#### *Care Coordination Activities*

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

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

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

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

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

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

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

### *DSHP Plus LTSS Case Management Activities*

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

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

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

### *2015-2016 NCI-AD Survey Results*

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

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

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

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

### *Coordination of Care for PROMISE Members*

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

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

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

### *Standardized Assessment Instrument*

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

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

## Goal 5. Expanding consumer choices

### Highlight

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

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

### Description, Data and Initiatives

#### *Medicaid MCO Choice and Enrollment*

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

Delaware's health benefit manager (HBM) provides support and information to members (outreach, newsletters, etc.) to facilitate their ability to make informed decisions about their care and choose the appropriate MCO to best meet their needs. Members can either make an active decision to enroll in an MCO or, if a decision is not made within 30 calendar days of the postmark date of an enrollment letter, the member is automatically enrolled into an MCO. HBM reports indicate that for program years 2015, 2016, and 2017[4], more DSHP members made an active choice to enroll in an MCO than those who did not make a choice and were enrolled by default.

[4] 2017 through end of first quarter.

**Table 4: Active Enrollment Choice**

| Year | Percentage |
|---|---|
| 2015 | 67% |
| 2016 | 57% |
| 2017 | 58% |

### *Choice under DSHP Plus*

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

### *2015-2016 NCI-AD Survey*

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

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

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

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

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

### Highlight

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

- Ongoing quality improvement activities which identify areas for improvement and facilitate enhanced quality outcomes such as: improved quality of life, increased percentage of members who have made progress toward achieving priority goals, positive experience with case management/care coordination services, reduced readmission rate, and addressing unmet needs.
- Treatment outcomes and prescribing patterns among Delaware DSHP MCOs for members prescribed buprenorphine indicate that MCOs have higher rates of initiation and engagement of alcohol and other dependence treatments relative to the national benchmarks.
- The State is continuing to expand its data-informed approach to measure changes in readmissions and calculated baseline readmission totals for the DSHP Plus rate cells split by NF and HCBS populations using 2015 encounter information. The State will continuously monitor future changes against the 2015 baseline.

### Description, Data and Initiatives

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

#### *Summary of Quality Improvement Initiatives*

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

**1. MCO Touch Point Meetings**

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

quality of life; increased percentage of members who have made progress toward achieving priority goals; positive experience with case management/care coordination services; reduced readmission rates; and unmet needs are addressed.

### 2. Quality Care Management and Measurement Reporting

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

#### *Summary of 2017 DSHP Plus QCMMR Findings*

***Access & Availability***

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

**Behavioral Health Services**

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

**Safety/Welfare**

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

**Table 6: Critical Incidents by Category for Q4 2017**

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

### 3. EQRO

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

#### *Initiation and Engagement of Alcohol and Other Dependence Treatment*

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

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

**Table 7: Initiation of Alcohol and Other Drug Dependence Treatment**

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

**Table 8: Engagement in Alcohol and Other Drug Dependence Treatment**

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

### *Hospital Readmission Counts for DSHP Plus in Calendar Year 2015*

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

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

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

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

### Highlight

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

### Description, Data and Initiatives

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

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

### Highlight

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

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

### Description, Data and Initiatives

#### *Coordination of Benefits*

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

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

#### *Future Coordination Opportunities*

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

## Goal 9. Expanding coverage to additional low-income Delawareans

### Highlight

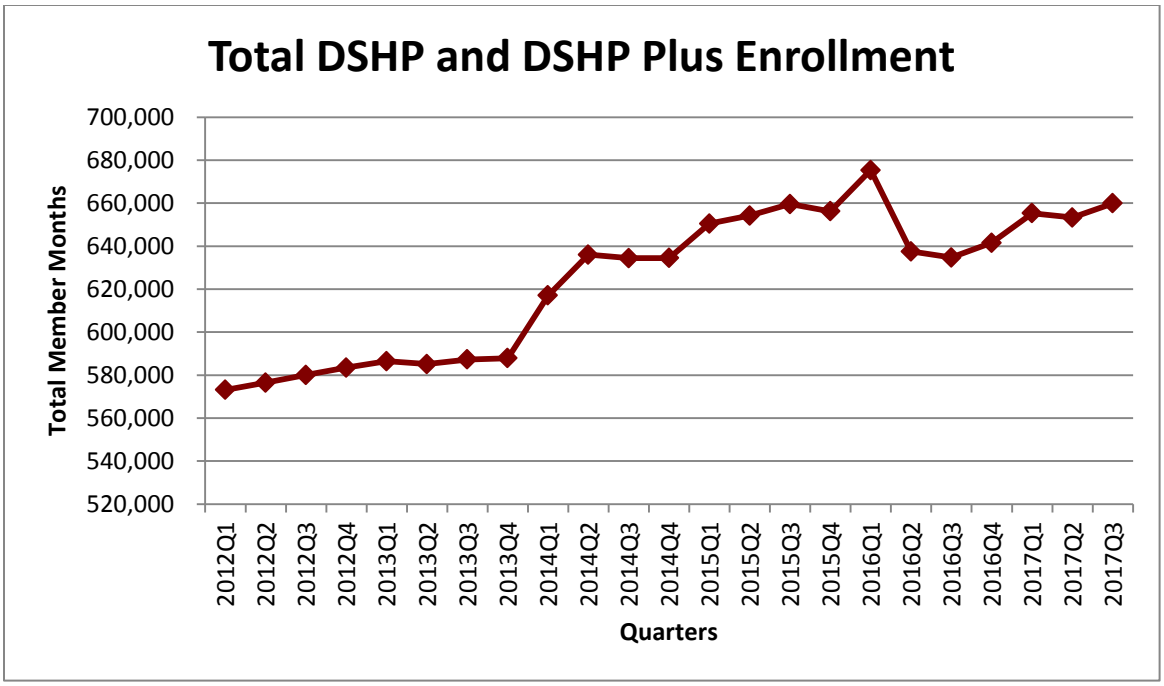
Delaware has expanded healthcare coverage over the life of the DSHP 1115 Demonstration by extending Medicaid eligibility to additional populations and adding new services to the Medicaid benefit package. The 1115 waiver has succeeded in expanding healthcare coverage for low-income Delawareans in the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

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

### Description, Data and Initiatives

#### *Impact of Initiatives to Expand Health Care Coverage*

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


Total DSHP and DSHP Plus Enrollment
Total Member Months
700,000
680,000
660,000
640,000
620,000
600,000
580,000
560,000
540,000
520,000
2012Q1
2012Q2
2012Q3
2012Q4
2013Q1
2013Q2
2013Q3
2013Q4
2014Q1
2014Q2
2014Q3
2014Q4
2015Q1
2015Q2
2015Q3
2015Q4
2016Q1
2016Q2
2016Q3
2016Q4
2017Q1
2017Q2
2017Q3
Quarters

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

### Highlight

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

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

### Description, Data and Initiatives

#### *Findings of the Behavioral Health Services Assessment*

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

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

#### *Opportunities for Improvement*

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

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

## Conclusion

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