



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 MANAGEMENT STRATEGY
2015



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Quality Management Strategy overview

The Delaware Quality Management Strategy (QMS) 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 QMS 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 QMS 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 QMS 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; and
- 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.
- 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 QMS 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 persistent 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, 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 QMS 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 of 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 QMS 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 Management Strategy development

DMMA's 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 QMS. 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 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

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



regarding the effectiveness of the MCOs' program, strengths and weaknesses identified and potential problems or opportunities for improvement. This information is utilized for input into the QMS and for initiating and developing QI projects.

Participant input

Input from DSHP, DSHP Plus, Medicaid and CHIP members into the development of the QMS is accessed through a variety of methods. One method 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 DHCP populations.

The 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 QMS 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 Management 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 programs 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:

- a. 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 reevaluated 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.
- b. 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;

c. 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.

d. 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, and exploitation.

e. 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 QMS has developed a structure and processes that support and encourage 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 QMS employs a deliberate process of ongoing, continuous feedback mechanisms that affects change 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 and adverse 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 resulting or 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 QMS activities and 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/dmmaldshpplus.html> and set up an e-mail box for questions and comments.



The following table illustrates the Delaware Quality management (QM) integrated model.

Table 1: QM integrated model: Roles and responsibilities

QM Integrated Model		
Entities	Membership	Review of QMS 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 QMS development, implementation and evaluation •Reporting QII Task Force and QMS 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 QMS •Supports integration of the DSHP, DSHP Plus and PROMISE Medicaid and CHIP QMS 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 QM 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 Assistant 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:

1. 1902 (a) (10) (B) Amount, Duration and Scope
2. 1902 (a) (1) State-wideness
3. 1902 (a) (10) and 1902 (a) (13) (E) Payment of Federally Qualified Health Centers and Rural Health Centers
4. 1902 (a) (23) Freedom of Choice
5. 1902 (a) (34) Retroactive Eligibility
6. 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.

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. 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 (BR) 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, 1996, 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 disenroll 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." During the 2008 legislative session, Delaware House Bill 286 was passed and requires DHSS to collaborate with the school districts to share free and reduced lunch data for the purpose of identifying potentially eligible SCHIP children. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA or Public Law 111-3) reauthorized the CHIP. CHIPRA finances CHIP through federal FY 2013. The intent of this legislation was to preserve coverage for the millions of children who rely on CHIP and provide the resources for states to reach millions of additional uninsured children.



Additionally, 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 contacted 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, 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

Assurance: 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.

(See Appendix XXX for Sub-Assurances)

2. Person-Centered Planning

Assurance: 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.

(See Appendix XXX for Sub-Assurances)

3. Provider Qualifications

Assurance: 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.

(See Appendix XXX for Sub-Assurances)

4. HCBS Setting

Assurance: 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.

(See Appendix XXX for Sub-Assurances)

5. Operational Oversight

Assurance: 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

Assurance: 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. (See Appendix xxx for Sub-Assurances).

7. Health and Welfare

Assurance: 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. (See Appendix xx for Sub-Assurances)

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, 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 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 will



voluntarily phase in over a three-year period starting in 2011, with annual reporting 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 will be 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, and to remain in a safe and least-restrictive environment.*

MCO CONTRACTORS 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.

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.



Progress toward goal 1 achievement: -

- An ongoing focus has been adequate access to prenatal and postpartum care. While both MCOs remain below the 75th percentile for this benchmark in 2008 and 2009, progress has been either stable or trending in the right direction. UHPDE's baseline for prenatal visits was 80.33% in 2008 and increased to 84.66% in 2009. DPCI remained stable during this period at 88.20%. For postpartum visits, UHPDE showed a four percentage point improvement from 2008 to 2009. Both MCOs will focus on improving screening results for this important measure.
- The percentage of children and adolescents with access to a PCP improved for both MCOs for age groups 25 months-6 years, and 7-11 years of age. For both of these age groups, DPCI and UHPDE exceeded the 75th percentile for 2008 and 2009.
- The percentage of adults with access to a PCP was close to meeting or exceeding the identified benchmark for both MCOs. DPCI exceeded the 75th percentile for adults aged 20-44 years and 45-64 years. UHPDE improved from 2008 to 2009 in both age groups, but slightly under the benchmark. Both MCOs will focus on improving access to PCPs in all age bands.
- Future opportunities revolve around ensuring MCOs meet the 75th percentile in areas of prenatal and postpartum care. The State mandates a PIP in this area and results will continue to be monitored for sustained improvement.

Establish baseline for offered choice between institutional services and HCBS.

- Establish baseline for HCBS members living in their own home who implement an emergency back-up service plan.

Goal 1 Performance Measure matrix

Measure	Required Service/ Data Source	REQUIRED DOCUMENTATION/ ACCEPTABLE CPT-4/ICD-9 CODES*	FREQUENCY/ MCO VENDOR
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: •First year—Total incidents reported (HCBS and Institutional) •Second & Third years--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
<u>DSAMH VENDOR REPORTING</u>			
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	Monthly
Critical Incident reporting: First year—Total incidents reported in accordance with timeframes.	Tracked and reported based on the 42 CFR440.	PROMISE Incident reporting templates	Monthly
Provider Qualifications: First Year- 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	Monthly

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

MCO CONTRACTOR 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 (lips screening, retinal eye exams and HbA1C testing): HEDIS specifications
- ⇒Average number of medicines by member
- ⇒Use of High Risk Medications by age band (18-65 and 66 and older): Modified HEDIS specifications
- ⇒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.

Progress toward goal 2 achievement: -

- Based on the objectives of the last QMS, DMMA has added three new measures to this area: Lead screening for children, appropriate treatment of children with upper respiratory infection and anti-depressant medication management. The following bullets outline the progress towards goal for these new measures.
 - While under the benchmark for Lead Screening in children for 2008 and 2009, both MCOs showed incremental improvement, with UHPDE improving from 55.15% in 2008 to 64.23% in 2009. This significant jump is a result of the inclusion of Delaware Lead Registry data, as well as the change to HEDIS hybrid data collection methodology. DMMA will hold both MCOs accountable to bring this measure up to compliance.
 - Both MCOs made incremental progress toward the benchmark for appropriate treatment for children with upper respiratory infection in 2008 and 2009. As a key measure for Delaware, DMMA will have both MCOs focus on continued improvement with this benchmark.
 - The benchmark for antidepressant medication management has not been met for either MCO. DPCI showed a decrease in compliance with effective acute phase treatment from 2008 (46.92%) to 2009 (45.58%). UHCDE, on the other hand, made some progress toward the benchmark with an increase from 2008 (41.84%) to 47.64% in 2009. Effective continuation phase treatment showed a slight decline for DPCI from 31.51% in 2008 to 28.05% in 2009, while UHPDE stayed steady at 27.55% in 2008 and 27.95% in 2009.
 - Establish baseline for planning, assessment, and screening of Care for Older Adults
- Another high priority for the State was breast and cervical cancer screenings with the intent to focus on prevention by increasing screening rates for these measures. These programs are coordinated with the DPH and supported in part by tobacco funding. Breast cancer screening rates for DPCI increased from 53.22% (2008) to 55.30% (2009) while UHPDE's baseline achievement was 52.63% for 2009. DPCI continues to show incremental improvement year over year in this measure, although both MCOs remain below the stated benchmark. Cervical



cancer screening rates remain slightly below the benchmark in 2008 and 2009 for both MCOs. UHPDE improved from 49.25% in 2008 to 64.32% for cervical cancer screening in 2009. This significant increase may be due to the change in methodology, moving from administrative to hybrid data collection. DMMA will continue to work with plans to ensure year over year improvements in these measures.

Delaware has a high volume of DSHP, DSHP Plus and CHIP members with a diagnosis of diabetes, many of which are children. Interest throughout the State continues to focus on improving the quality of diabetic care. Three measures related to diabetic care, 1{HbA1c, retinal examinations and lipid screenings, continue to show improvement toward the 75th percentile benchmark. DPCI results for HbA1 c screenings are steady year over year, while UHPDE demonstrated a decline from 73.66% in 2008 to 70.80% in 2009. Retinal examination screening rates are holding steady for DPCI and have shown statistically significant improvement at UHPDE. This again is most likely due to the switch to hybrid data collection methodology. DMMA will continue to work with the MCOs to ensure year over year improvements to reach the benchmark are a priority.

- A large portion of DSHP's population is found to have a diagnosis of hyperlipidemia and, therefore, it is important to measure rates of lipid screening within the population diagnosed with this condition. Current rates for lipid screening for members diagnosed with hyperlipidemia are identified in the above chart. While under the 75th percentile, both MCOs have either remained stable or shown incremental improvement from year to year. DPCI has been moving toward improving the rate for lipid screening from 72.45% in 2008 to 75.91% in 2009. UHPDE has been stable at 66.67% for both 2008 and 2009. While under the 75th percentile, both MCOs will be accountable for improving compliance with this benchmark which has been identified at 79.52%.
- Establish baseline for HI V/AIDS testing, treatment and management. Establish baseline for Plan of Care review/update at least annually.

Future opportunities

While each MCO maintains their own HEDIS workgroups in efforts to improve HEDIS PMs, DMMA will provide feedback to each MCO on areas of interest, and possible areas for interventions and improvement based on the results of annual performance measurement.

Goal 2 Performance Measure matrix			
Measure	Required Service/ Data Source	REQUIRED DOCUMENTATION/ ACCEPTABLE CPT-4/ICD-9 CODES*	FRE-QUENCY/ MCO 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
Use of High Risk Medications by age band (18-65 and 66 and older)	Pharmacy data	Modified HEDIS specifications	Annually
HIV/AIDS Comprehensive Care Measure (HCC)	<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 	<u>Engaged in Care</u> ICD-9 codes: V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 <u>Viral Load Monitoring</u> CPT-4: 87534-87536 <u>Syphilis Screening</u> CPT-4: 86592-86593; 86780 <u>Cervical Cancer Screening</u> CPT-4: 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175 ICD-9 codes: V72.32, V76.2	Annually
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	Plan of care	Case management file	Semi-Annual
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.	Case manager documentation and/or provider note	Case Management file	Semi-Annual



DSAMH PROMISE VENDOR REPORTING			
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.	Recovery Plan	Care management file	Monthly
100% of case management files audited demonstrate a beneficiary has had an annual physical exam	Recovery Plan	Care management file	Monthly

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

MCO CONTRACTOR 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.

Progress toward goal 3 achievement: -

- Utilization measures have been calculated and performance is tracked and monitored. Now that benchmarks have been identified, DMMA will use these as opportunities to control the growth of health care expenditures. Both MCOs were above the maternity ALOS for 2009 and demonstrate a steady if not increasing utilization trend year over year; these changes are not statistically significant. For the medicine and surgery ALOS, each MCO is above the benchmark utilization goal. However, the medicine ALOS is trending downward, with a decrease from 4.93 days in 2008 to 3.94 days in 2009 for DPCI, and from 4.93 days in 2008 to 4.35 days in 2009 for UHCP. Surgery ALOS for DPCI shows an increasing trend by



almost a full day and a half between 2008 and 2009, while UHCP shows a steady ALOS. While overall inpatient ALOS has remained steady year over year, the driver of the overall ALOS appears to be in the surgical category. This is an area of focus that DMMA will address with each of the MCOs.

- Emergency department (ED) visits per 1,000 members have increased from 2008 to 2009 across both MCOs. Some variability in this measure may be due to effects of the H1N1 pandemic that was experienced over the recent measurement year. However, ED *utilization continues to be an ongoing topic of concern for all health care constituents*. DMMA has mandated a PIP around this particular measure and continues to monitor MCO interventions to decrease ED utilization. Additionally, discussions regarding levels of ED usage have occurred at the QII Task Force meetings throughout 2008 and 2009. In 2010, the QII Task Force formed a sub-committee to explore quality initiatives related to access to care issues, quality of care issues regarding follow up and medication adherence, lack of referrals to appropriate sources/programs (CM/DM, BH, etc.), and lack of coordination of care with PCPs that could be affecting ED utilization rates.

- Outpatient visits per 1,000 showed an increase between 2008 and 2009 for both MCOs. DPCI went from 443.72 to 463.81 while UHCP went from 399.10 to 428.76. These results are significantly higher than the established benchmark of 301.16 visits and will be a focus going forward.

- Establish baseline for HCBS members who have transitioned from institutional-based LTC services to HCBS.

Future opportunities

DMMA will continue to work with the MCOs to identify plan- and/or population-specific drivers that could be affecting surgical ALOS, ED utilization and outpatient visits.



Goal 3 Performance Measure matrix			
Measure	Required Service/ Data Source	REQUIRED DOCUMENTATION/ ACCEPTABLE CPT-4/ICD-9 CODES*	FRE-QUENCY/MCO 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 individuals who are receiving HCBS versus Institutional services	Enrollment data Claims data	Delaware specifications	Annual
DSAMH PROMISE VENDOR REPORTING			
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 CONTRACTOR 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.

Progress towards goal 4 achievement: -

- Track and report CAHPS adult and pediatric survey results on an annual basis.)
- Establish a baseline for DSHP Plus member satisfaction/experience of care. (PROMISE)

<i>Goal 4 Performance Measure matrix</i>			
Measure	Required Service/ Data Source	REQUIRED DOCUMENTATION/ ACCEPTABLE CPT-4/ICD-9 CODES*	FRE-QUENCY 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 themselves. 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 Medicaid Management Information System (MMIS). 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. The MCO will use information on race/ethnicity and language to provide interpretive services, develop educational materials for employee training and facilitate member needs in the context of their cultural and language requirements. The race/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/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

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 Aids/HIV 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 Aids/HIV populations. MCO 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. 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. MCO will report monthly on the number of clients who completed HRA 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 MCO is 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, the 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 is 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 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
- AIDS/HIV
- 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 in accordance with 42 CFR 438.3 10 and 42 CFR 438.310(b) by an independent **EQRO**, including a review of the services covered under each MCO contract for: a) timeliness, b) outcomes, and c) accessibility 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 mentioned 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
- d) Conclusions drawn from the data
- e) Recommendations for improving the quality of health care services furnished by MCO
- f) Assessment of the degree to which the MCO effectively addresses previous EQRO review recommendations

The State and the EQRO shall monitor and annually evaluate the MCO performance on specific new 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 enrollee'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 enrollees--to ensure that the MCOs, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect, and exploitation.

The State's EQRO 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 EQR 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. DMMA has adopted the CHIPRA Pediatric Core Quality Measurement set and will phase in the measurement process over a three-year period starting in 2011.

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. 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
	Provider Satisfaction Survey	All	Includes HCBS providers
	HEDIS	All	Refer to Appendix C for full set of performance
Bi-Annual	Geo Access	All	
Quarterly	Grievances	DSHP, DSHP Plus, CHIPS	
	Appeals	DSHP, DSHP Plus, CHIPS	
	EPSDT outreach efforts		
	Eligibility, enrollment, disenrollment reports	DSHP Plus	
	Choice between institutional and HCBS services	DSHP Plus	
Monthly	HRAs	All, except those meeting NH level of care	
	Case management/Disease management	All	See Appendix D for full set of case management reports
	Network availability/Appointment timeliness	All	
	Call center/Customer service	All	
	Utilization Management	All	
	Education and outreach	All	Chapter II of Contract
	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

PIPs are required by CMS as an essential component of a MCO's quality program and are used to identify, assess and monitor improvement in processes or outcomes of care. DMMA has mandated that each MCO conduct five PIPs. The State may select any of the topics, to include both clinical- and service-oriented issues. Currently, the State requires two mandated clinical topics: Prenatal/Postpartum Care and Inappropriate Emergency Department Utilization. Additionally, one of the five PIPs must be specific to the pediatric population, and two PIPs should be related to the DSHP Plus population and encompass both clinical and service topics.

Intermediate Sanctions

The premise behind the QMS process is one of continuous 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 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 Chapter II of the RFP. The MCO shall meet these performance standards in full or be subject to sanctions by the State, including but not limited to, monetary- or enrollment-related penalties.

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 oOf the Act and any implementing regulation

Where these violations are documented, the State 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
- 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
- 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 Chapter II of the RFP. The MCO shall be liable for up to \$1,000 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 Chapter IV.

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

The State may identify contract compliance issues resulting from the MCO's performance of its responsibilities through routine contract monitoring activities. If this occurs, the Project Manager or designee will notify the MCO in writing of the nature of the performance issue. The State will also designate a period of time, not to be less than 10 business days, in which the MCO must provide a written response to the notification and implement that plan within 30 days from the initial notification.

If the non-compliance is not corrected by the specified date, the State may assess sanctions up to the amount of \$1,000 per business day after the due date until the non-compliance is corrected.

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 Access 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 QMS 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.

The following performance standards apply to DSHP, DSHP Plus and CHIP populations:

Table 4: 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			

Performance Standards



Delivery Network

Contracted network of appropriate Providers (42 CFR 438.206(b)(1)) Each

MCO must meet the following requirements.

Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each MCO must consider the anticipated Medicaid enrollment, the expected utilization of services, and take into consideration the characteristics and health care needs of specific Medicaid populations enrolled with the Contractor. The MCO must also consider the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services, the numbers of network providers who are not accepting new Medicaid patients, and the geographic location of providers and Medicaid members. Distance, travel time, the means of transportation ordinarily used by Medicaid members, will be considered, and whether the location provides physical access for Medicaid members with disabilities.

The networks must be comprised of hospitals, physicians, behavioral health providers, long term care providers (institutional and HCBS), and other specialists in sufficient numbers to make available all covered services in a timely manner.

Contractors must ensure that their networks include providers who specialize in the care of HIV/AIDS members.

Contractors will coordinate services with the State Public Health Laboratory supported by documented evidence of agreement.

The primary care network must have at least 1 full time equivalent PCP for every two thousand patients. The State must approve all capacity changes that exceed two thousand five hundred patients.

Direct Access to Women's Health Specialist (42 CFR 438.206(b)(2))

- Provides female members with direct access to a women's health specialist within the framework for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.
- Contractors must ensure that the network procedures for accessing family planning services are convenient and easily comprehensible to members.
- Pap smear is included as a family planning service if performed according to the United States Preventative Services Task Force Guidelines which specifies cervical cancer screening every one (1) to three (3) years based on the presence of risk factors (early onset of sexual intercourse, multiple sexual partners); however, Pap smear annual frequency may be reduced if three (3) or more annual smears are normal.
- A women's health specialist may serve as a primary care provider.
- The Smart Start Program must be offered to all pregnant women who have at least one risk factor. And providers of obstetrical care must show evidence of screening for Smart Start in patient charts

Adequate and Timely Second Opinion (42 CFR 438.206(b)(3))

- Provides for a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member.

Adequate and Timely Out-of-Network Providers (42 CFR 438.206(b)(4) & (b)(5))



- If the network is unable to provide necessary services, covered under the contract, the MCO must adequately and timely cover these services out of network for the member, for as long as the MCO is unable to provide them.
- Requires out-of-network providers to coordinate with the MCO with respect to payment and ensures that cost to the member is no greater than it would be if the services were furnished within the network.
- The MCO is responsible for making timely payment to out-of-network providers for medically necessary, covered services, up to their fee maximum for contracting providers.
- All MCOs must reimburse out-of-network providers for family planning services rendered to members.

Provider Credentialing as required in regulation (42 CFR 438.206(b)(6))

- Demonstrates that its providers are credentialed and compliant with 438.214.

Timely Access (42 CFR 438.206(c)(1)(i-vi))

Each MCO must meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. Standards for access and timeliness are identified in the chart at the beginning of the standards section.

Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members.

Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.

Establish mechanisms to ensure compliance by providers, monitor providers regularly to determine compliance, and take corrective action if there is a failure to comply.

The MCO must agree to make available to every member a PCP whose office is located within thirty 30 minutes driving time or thirty (30) miles from the member's place of residence.

Cultural Considerations (42 CFR 438.206(c)(2))

- Each MCO will participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds by:
 - The MCO is required to have available interpretive services and to provide Spanish interpretive services at all times and for all other languages upon request.
 - The MCO will encourage and foster cultural competency in its employees.

Assurances of Adequate Capacity 438.207

Documentation and Assurances of Adequate Capacity and Services (42 CFR 438.207 (b), (c))

Each MCO must give assurances to the State and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for



access to care.

- Nature of supporting documentation. Each MCO must submit documentation to the State, in a format specified by the State to demonstrate that it complies with the requirements below.
- Offers an appropriate range of preventive, primary care, and specialty services that are adequate for the anticipated number of members for the service area.
- Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.
- Timing of documentation. Each MCO must submit the required documentation, no less frequently than:
 - at the time it enters into a contract with the State or at any time there has been a significant change (as defined by the State) in the MCOs operations that would affect adequate capacity and services, including changes in Contractor services, benefits, geographic service area, payments or enrollment of a new population with the MCO.

Coordination and Continuity of Care 438.208

Primary Care and Coordination of health Care Services for all MCOs. (42 CFR 438.208 (a)(b)(1)(b)(4))

The MCO will comply with all State standards identified in the QMS.

Each MCO *must* implement procedures to *deliver* primary care to and coordinate health care service for all MCO members ensuring that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member.

MCO must implement procedures for transition of new members; transition of members receiving long term care services at the time of DSHP Plus implementation; transition of care; MCO case management; care coordination of DSHIP Plus members; consumer direction of HCBS; coordination and collaboration for member with behavioral health needs; coordination and collaboration of behavioral health providers

The MCO must have written policies and procedures for assigning each of its members to a primary care provider.

The MCO must contact the member within five (5) business days of his or her enrollment and provide information on options for selecting a primary care provider or confirmation that the member has been assigned to the PCP of choice.

If a member does not select a primary care provider within thirty business days of enrollment, the MCO *must* make an automatic assignment, taking into consideration such know factors as current provider relationships, language needs and area of residence

The primary care provider serves as the member's initial and most important contact and maintains the continuity of a member's health care.

Coordinate the services the MCO furnishes to the member with the services the member receives from any other MCO or behavioral health provider.

Share with other MCOs serving the member with special health care needs the results of its identification and assessment of that member's needs to prevent duplication of those activities.

Ensure that in the process of coordinating care, each member's privacy is protected in accordance with privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.



The MCO must have written policies and procedures for maintaining the confidentiality of data, including medical records/member information and adolescent/STD appointment records.

The MCO must maintain a case management program. The MCO will assure case managers initiate and maintain a member care/treatment plan that includes:

- a thorough initial assessment including all domains of care with periodic updates, including member strengths and barriers to care
- short and long term goals that are developed in collaboration with the member
- periodic assessment of goal achievement and development of new goals
- identification and documentation of coordination of care opportunities with all providers involved in the members care

Additional Services for Children with Special Health Care Needs

The MCO must demonstrate that they have in place all of the following to meet the needs of Children with Special Health Care Needs (CSHCNs):

- Satisfactory methods for ensuring their providers are in compliance with Title II and III of the Americans with Disabilities Act.
- Members with disabling conditions or chronic illnesses may request that their primary care physicians be specialists.
- Satisfactory care coordination and case management systems for coordinating service delivery with out-of-network providers, including behavioral health providers and ongoing service providers.
- Policies and procedures to allow for the continuation of existing relationships with out-of network providers, when considered to be in the best interest of the member.
- Demonstrate satisfactory methods for care coordination with the Department of Education, school districts, the Division of Family Services, early intervention programs and other agencies for the purpose of coordinating and assuring appropriate service delivery.
- Care Coordination with the Delaware school-based Wellness Centers.
- Contractors must coordinate and link with Division of Public Health (DPH) Immunization Registry in order to track immunizations provided to their covered population. Contractors must assure all childhood immunizations are obtained and should report immunization levels as required under the DMMA data and reporting requirements.
- Include an adequate network of pediatric providers and sub-specialists, and contractual relationships with tertiary institutions, to meet members' medical needs.
- Satisfactory methods for assuring that children with serious, chronic, and rare disorders receive appropriate diagnostic workups on a timely basis
- A satisfactory approach for assuring access to allied health professionals (Physical Therapists, Occupational Therapists, Speech Therapists) experienced in dealing with children and their families.

Additional Services for DSHP-Plus (Elderly and disabled) Members with Special Health Care Needs (SHCN):

The MCO must demonstrate that they have in place all of the following to meet the needs of the DSHP-Plus members with Special Health Care Needs:

- Nursing facility services. The service plan must indicate the level of care based on the Pre-admission evaluation or for any specialty that may have been negotiated between the Nursing



Facility and Contractor.

- Hospital admissions (acute and psychiatric)
- Bed hold or therapeutic leave days
- DME not included under the institutional facility per diem
- Hospice services
- Therapies (occupational, physical and speech)
- Medically necessary non-emergency transportation
- Behavioral health services
- Title XIX covered services as noted above if provided by other funding sources, for example, Medicare and other insurance sources.

Service plans for members residing in an **HCBS setting** must include the following types of services (also including services under CONTRACTOR contract Chapter II section 3.2 DSHP Plus Contractor Benefit Package), as appropriate, based on the member's needs:

- Adult day services or day habilitation
- Hospital admissions (acute and psychiatric)
- Personal care/attendant care Services (including participant directed services) service code modifiers for encounter submissions may be developed during Implementation Team Meetings to be used to distinguish the type of Attendant Care when and if provided:
 - i. by family living with the member
 - ii. by family not living with the member and/or
 - iii. as self-directed personal care/Attendant Care
- DME not included in the institutional facility per diem
- Emergency alert systems
- Habilitation
- Home delivered meals
- Home health aide
- Transition services type that will be authorized in order to transition the NF member to HCBS. This service may be authorized while the member is still in an institutional placement. The case manager must document the date of case review and initiation of transition type (Money Follows the Person MFP) services for reporting to DMMA. This format and schedule of submission of this report will be determined during Implementation Team Meetings. (See CONTRACTOR contract Chapter II section 7.5 DSHP Plus Benefit Package.)
- Hospice
- Respite care, including nursing facility respite
- Therapies (occupational, physical, speech, and/or respiratory)
- Behavioral health services
- Medically necessary non-emergency transportation that is regularly scheduled
- (e.g., dialysis three times per week – this is a benefit through the DMMA Transportation Broker contract)
- Home modifications
- Assisted Living Facility services
- Nutritional supplements for individuals diagnosed with AIDS that are not covered under the State Plan. This service is not available to persons residing in Assisted Living and Nursing Facilities.
- Title XIX covered services as noted above, if provided by other funding sources, for example, Medicare, other insurance sources or DSAMH.



•Cognitive Services

Refer to CONTRACTOR Contract Chapter II Section 3.2 DSHP Plus Contractor Benefits for descriptions of the amount, duration and scope of DSHP Plus services and settings, including information about restrictions on the combination of services.

Identification and Assessment (42 CFR 438.208(c)(1)(2))

Each MCO must implement mechanisms to assess each Medicaid member identified by the State, or its Health Benefits Manager, and identified to the MCO and by the State as having special health care needs. This is done to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

Mechanisms for Members with Special Health Care Needs: Development of Service Plans (42 CFR 438.208(c)(3))

- MCOs will produce a service plan for members with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring.
- For the DSHP-Plus population, the MCOs will develop a plan of care and produce a Service Plan through an assessment used to determine a plan of service or regular care monitoring.
- The service plan must be:
 - Developed by the member's primary care provider with member participation and in consultation with any specialists caring for the member in a timely manner, if this approval is required by the MCO
 - In accordance with any applicable State quality assurance and utilization review standards.

Mechanisms for Members with Special Health Care Needs: Direct Access to Specialists (42 CFR 438.208(c)(4))

- For members with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, each MCO must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for members condition and identified needs.
- The MCOs will have documented policies and procedures for members with special health care needs to achieve direct access to Specialist services as appropriate for member's condition and identified needs.

Coverage and Authorization of Services 438.210

Amount, Scope and Duration of Service Coverage (42 CFR 438.210(a)(1-4))

- MCOs are required to provide for all medically necessary and appropriate Medicaid covered services, consistent with FFS Medicaid, in sufficient amount, scope, and duration to achieve the purpose of the service(s) and, may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.
- The MCO may place appropriate limits on a service based criteria applied under the State plan, such as medical necessity or for the purpose of utilization control, provided the services furnished can reasonably be



expected to achieve their purpose. And specify what constitutes "medically necessary services" in a manner that:

- is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and
 - addresses the extent to which the MCO is responsible for covering services related to the following:
 - (A) the prevention, diagnosis, and treatment of health impairments,
 - (B) the ability to achieve age-appropriate growth and development, and
 - (C) the ability to attain, maintain, or regain functional capacity
- The MCO UR/UM staff must be fully aware of the Medicaid medical necessity definition and covered benefits, including authorization of long term care services, and transition of members receiving long term care services at the time of DSHP Plus implementation.

Policies and Procedures for Authorization of Services (42 CFR 438.210(b)(1), (2), and (3))

- For processing of initial and continuing authorization of services, the MCO and its subcontractors must have in place, and follow, written policies and procedures addressing denial of services, prior approval, and hospital discharge planning.
- The MCO must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and procedures to consult with the requesting provider when appropriate.
- That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

Notice of Adverse Action (42 CFR 438.210(c))

- The MCO must have and follow policies and procedures defining requirements for notifying the requesting provider, and providing the member written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested, except the MCO's notice must meet the requirements of §438.404 except the notice to the provider need not be in writing.

Timeframe for decisions (42 CFR 438.210(d))(1), (2)&(e)

The MCO must provide the following decisions and notices meeting the following requirements:

- *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the member's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service,
 - with a possible extension of up to 14 additional calendar days, if-
 - The member, or the provider, requests extension; or
 - The MCO justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest.
- *Expedited authorization decisions.* For cases in which a provider indicates, or the MCO, determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 3 working days after the receipt of the request for service.
- The MCO may extend the 3 working days time period by up to 14 calendar days if the member requests an extension, or if the MCO, prepaid inpatient health plans (PIHP), or prepaid ambulatory health plans (PAHP) justifies (to the State agency upon request) a need for additional information and how the



extension is in the member's interest.

- Compensation for utilization management activities: Compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

Compensation for UM activities (42 CFR 438.210(e))

The MCOs compensation structure shall not have incentives based on approvals, limitations, or denials of medically necessary services for members

Emergency and Post—Stabilization Care Service (42 CFR 438.114) The

MCO will comply with the following definitions:

- Emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
 - 1) Placing the health of the individual or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
 - 2) Serious impairment to bodily functions; or
 - 3) Serious dysfunction of any bodily organ or part.
- Emergency service means covered inpatient or outpatient services that are:
 - 1) Furnished by a provider who is qualified to furnish these services under this title; or
 - 2) Needed to evaluate or stabilize an emergency medical condition.
- Post-stabilization care services are defined as covered services, related to an emergency medical condition that are provided after an member is stabilized in order to maintain the stabilized condition or to improve or resolve the members condition.
- The MCO must cover Post Stabilization services without requiring authorization, and regardless of whether the member obtains the services within or outside the Contractor's provider network if any of the following circumstances exist:
 1. The Post stabilization Services were pre-approved by the Contractor;
 2. The Post Stabilization Services were not pre-approved by the Contractor because the Contractor did not respond to the Provider's request for these Post stabilization services within one (1) hour of the request;
 3. The Post stabilization services were not pre-approved by the Contractor because the Contractor could not be reached by the provider to request pre-approval for these post stabilization services; or
 4. The Contractors representative and the treating physician cannot reach an agreement concerning the member's care and a Contracting physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician and treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR 422.113 (C)(3) is met.



The MCOs may not deny payment for treatment if member had an emergency medical condition, or if representative of the MCO instructs the member to seek emergency services.

The MCOs may not limit what constitutes an emergency medical condition on the basis of lists of diagnosis or symptoms.

The MCO may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider's MCO or applicable State entity of the member's screening and treatment within 10 calendar days of presentation for emergency services.

The MCO must assure that a member who has an emergency not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

The MCO must assure that the attending emergency physician or the treating provider is responsible for binding determination of member stabilization for transfer or discharge based upon the general rule for coverage and payment.

Structure and operations

The following structure and operations performance standards apply to DSHP, DSHP Plus and CHIP populations:

Structure and Operations Performance Standards

Provider Selection

Selection and Retention (42 CFR (a), (b)(2))

- The MCO must have written credentialing and re-credentialing policies and procedures for determining and assuring that all providers under contract to the plan are licensed by the State and qualified to perform their services according to DMMA Quality Management.
- A documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements with the MCO and how the MCO will follow those processes.
- Verification of provider qualifications will include but is not limited to:
 - Current valid license to practice
 - Clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility
 - Valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate
 - Education and training including evidence of graduation from the appropriate professional school and completion of a residency or specialty training
 - Board certification of the practitioner states s/he is board certified on the application, - Current, adequate malpractice insurance meeting the MCOs requirements
 - History of professional liability claims that resulted in settlements or judgments by or on behalf of the practitioner (May be obtained by the National Practitioner Data Bank)
 - Information about sanctions or limitations on licensure from the applicable state licensing agency or board

Nondiscrimination (42 CFR 438.214(c)) (42 CFR 438.12(a))

- Policies and procedures and documented practice within the MCO must be free of any indication of discrimination related to the population served or the cost of covered treatment. If the MCO declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.



- Contractors must also have a written appeals process providers will use to challenge any denial of credentialing resulting from this process.

(42 CFR 438.12 (b)(1))

- The MCOs will not be required to contract with providers beyond the number necessary to meet the needs of the members.
- The MCOs will be required to contract with all existing nursing facilities that have contracts with the Medicaid FFS program.

(42 CFR 438.12(b)(2))

- The MCOs may use different reimbursement amounts for different specialties or for different practitioners in the same specialty.

(42 CFR 438.12(b)(3))

- The MCO is not precluded from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

Excluded Providers (42 CFR 438.214(d))

- The MCO must be consistent with policy, procedure, and regulatory requirements and may not employ or contract with providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Act.

State Requirements (42 CFR 438.214(e))

- The MCO will have written policies and procedures for monitoring its providers and for disciplining providers who are found to be out-of-compliance with the Contractors medical management standards.
- The MCO will monitor appeals and grievance logs on a monthly basis to assess for network or provider related problems.

Confidentiality 438.224

Confidentiality requirements consistent with (42 CFR 438.224), (45 CFR parts 160 and 164)

- The MCO, including all providers, physicians' practitioners, suppliers, etc., shall have in place policies and procedures to maintain the confidentiality of all-medical records and assure that all records and their use meet all HIPPA requirements.
- The State is not required to obtain written approval from a member before requesting the member's record from the primary care provider or any other provider and shall be afforded access within thirty 30 calendar days to all members' medical records whether electronic or paper.
- The Contractor shall upon the written request of the member, guardian or legally authorized representative of a member, furnish a copy of the medical records of the member's health history and treatment rendered. Such record shall be furnished within a reasonable time of the receipt of the written request.
- When a member changes primary care providers, his or her medical records or copies of medical records must be forwarded to the new primary care provider within ten (10) business days from receipt of request.



- The MCO must have written policies and procedures for maintaining the confidentiality of data, including medical records/member information and adolescent/STD appointment records.
- Access to all individually identifiable information relating to Medicaid members that is obtained by the MCO shall be limited by the MCO to persons or agencies that require the information in order to perform their duties in accordance with this contract, and to such others as may be authorized by the State in accordance with applicable law.
- The MCO must provide safeguards that restrict the use or disclosure of information concerning members to purposes directly connected with the administration of the contract.

Enrollment and Disenrollment 438.226

Enrollment and Disenrollment (42 CFR 438.226)

- The State does not allow for disenrollment and prefers to apply the term transfer to the following MCO expectations.
- The MCOs must ensure compliance with the enrollment and transfer requirements and limitations set forth in 438.56.

Transfer: Requirements and Limitations (42 CFR 438.56)

- The MCOs must have written policies that specify the reasons for which the MCO may request a transfer of an member and reasons a transfer may not be requested. The MCO may not initiate transfers because of a medical diagnosis or health status of a member, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (unless member's continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this member or other members), or non-compliance related to diagnosis, a member's attempt to exercise his or her rights under the grievance system, or based on the demands of a member to seek referrals to specialists or for information regarding their medical condition system.
- The MCO will identify methods to assure the State that it does not request transfer for reasons not covered by contract.

Transfer requested by the member

- The MCO must provide that a recipient may request to transfer for cause at any time and without cause, at the following times:
 - During the 90 days following member's initial enrollment date or State notice of enrollment date, whichever is later
 - At least once every 12 months thereafter
 - Upon automatic reenrollment per paragraph (g) of this Section
 - Upon State imposed sanctions per 438.702(a) (3)

Procedures for Transfer

- The MCO may initiate transfers for valid reasons including:
 - Persistent and documented refusals of the member to follow prescribed treatments or comply with contractor requirements that are consistent with State and Federal laws and regulations
 - Misuse of the system, abuse or threatening conduct by the member
 - Deliberate falsification of application or enrollment materials by the member
- The MCO must have attempted through education and case management to resolve any difficulty leading to



a request for transfer at least three (3) times over a period of ninety 90 consecutive, calendar days before requesting transfers, unless the member has demonstrated abusive or threatening behavior.

- Contact attempts must occur at least at thirty days intervals of the 90-day period.
- Prior to transfer, the case will be referred to the HBM, who must make at least one (1) attempt to resolve the matter.

- In cases involving abusive or threatening behavior, only one (1) attempt is required.

- The Contractor must cite at least one (1) example of an appropriate reason to require transfer and give written notice of the request of transfer to both the member and the State.
- All notifications regarding requests for transfer must inform the member of appeal rights and be documented.

Structure and Operations Performance Standards

Grievance Systems 438.228

Grievance Systems (42 CFR 438.228(a))

- The MCOs must have a grievance system in place that meets the requirements of subpart F of this Section.

Statutory Basis and Definitions 438.400

- The MCO is required to establish and maintain internal grievance system procedures under which Medicaid members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.
- An "action" shall be defined as:
 - Denial or limited authorization of a requested service, including the type or level of service;
 - Reduction, suspension, or termination of a previously authorized service;
 - Denial, in whole or in part, of payment for a service;
 - Failure to provide services in a timely manner, as defined by the State or act within the timeframes of 438.208;
 - For a resident of a rural area with only one Contractor, the denial of a Medicaid members request to exercise his or her right to obtain services out of network.
- *Appeal* means a request for review of an action as defined in this section.
- *Grievance* means an expression of dissatisfaction about any matter other than an action, as "action" is defined in the section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO level and access to the State fair hearing process.

General Requirements 438.402

The Grievance System (42 CFR 438.402 (a))

- Each MCO must have a system in place for members that include a grievance process, an appeal process, and access to the State's fair hearing system.

Authority to File (42 CFR 438.402(b))

- A member may file a grievance or a MCO level appeal and may request a State Fair Hearing. A provider or the member's legal representative acting on behalf of the member and with the member's written consent, may



file an appeal. A provider may file a grievance or request a State fair hearing on behalf of a member.

Structure and Operations Performance Standards

Timing (42 CFR 438.402(b)(2))

- A member may file a grievance either orally or in writing. A provider may file a grievance as the State permits the provider to act as the member's authorized representative.
- A member or the provider may file an appeal; and request a Fair Hearing within a timeframe that may not exceed 90 days from the date on the Contractors notice of action.

Procedure (42 CFR 438.402(b)(3))

- A member may file a grievance orally or in writing and, either with the State or with ti MCO. And unless he or she requests expedited resolution must follow an oral filing with written, signed, appeal.

Notice Of Action 438.404, 438.200, 438.228, 438.206

42 CFR 438.228, 431.206(b) and 431.210:

The MCO has delegated responsibility for State Fair Hearing notices. **MCO**

Notification of State Procedures (42 CFR 438.200(b))

- The MCO is required to provide information on State Fair Hearing procedures including, but not limited to the member's right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing. Additionally, the State fair hearing description must be included in member and provider information.
- The MCO must give the member written notice of any action to include but not limited to, service authorizations, within the timeframes for each type of action.
- MCOs are responsible to ensure timely notification of members of his/her right to use the State administrative grievance process.

Language and Format (42 CFR 438.404(a), 42 CFR 438.10(c) and (d)) Language:

- The MCO is required to make written information available in prevalent non-English languages in its particular service areas. In Delaware, Spanish is currently the prevalent non-English language.
- Inform the member about rights as a member of MCO services; this will include informing the member both orally and in a clearly written format in the member's own language about both the MCO and State grievance and appeal procedures; if the member has an auditory and/or visual impairment, reasonable accommodations must be made to assure that the member is informed and understands his/her rights
- **Format:**
- The MCO must produce written materials including notice of actions and must meet the language and format requirements to ensure ease of understanding. Information must be available in alternative formats, must be available and in an appropriate manner.
- The MCO is required to notify all members and potential members that information is available in alternative formats and how to access those formats.



Structure and Operations Performance Standards

Notice of Adverse Action Content (42 CFR 438.404(b)) (42 CFR 431.206(b) and 431.210)

The notice must explain the action the MCO or its sub-contractor has taken or intends to take. The reason for the action and the member's or provider's right to file an appeal with the MCO or to request a state fair hearing. Procedures for exercising the member's right to appeal or grieve. Circumstances under which an expedited resolution is available and how to request it, and the member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services.

The MCO will also inform members that:

- 1)the member may represent himself or use legal counsel, a relative, a friend, or other spokesman
- 2)the specific regulations that support, or the change in Federal or State law that requires, the action
- 3)an explanation of the members right to request an evidentiary hearing if one is available or a state agency hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted.)

Timeframes for Notice of Action: (42 CFR 438.404(c)(1))

Termination, Suspension, or Reduction of Services

The MCO is required to give at least 10 days notice before the date of action when the action is termination, suspension, or reduction of previously authorized Medicaid-covered services except if probable member fraud has been verified, then notice is reduced to 5 days

These notices will be given to the member by the date of the action for:

- the death of a member
- a signed written member statement requesting service termination or giving information requiring termination or reduction of services
- the member's admission to an institution where he is no longer eligible for services
- the member's address is unknown and the mail directed to him has no forwarding address
- the member has accepted Medicaid services by another local jurisdiction
- the member's physician prescribes a change in level of medical care
- an adverse determination made with regard to the pre-admission screening requirements for nursing facility admissions on or after January 1, 1989
- the safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a member has not resided in the NF for 30 days.

Structure and Operations Performance Standards

Timeframes of Notice of Action (42 CFR 438.404(c)(2), (3), (4), (5)&(6)) Untimely Service

Authorization Decisions

- The MCO is required to give notice on the date that timeframes expire if service authorization decisions are not reached for either standard or expedited service requests. Untimely service authorizations constitute



a denial and are considered adverse actions. For denial of payment, the MCO is required to give notice at the time of any action affecting the claim.

- For standard service authorization decisions, (42 CFR 438.210 (d) (1)), that deny or limit services, notification occurs within the timeframe specified in Coverage and Authorization of Services.
- If the MCO is granted an extension, the member must be given written notice of the extension, and be offered the opportunity to file a grievance if they disagree with the decision. The MCO must carry out the decision as expeditiously as the member's health condition requires and no later than the date the extension expires.
- For service authorization decisions not reached within the timeframes (which constitutes a denial and is thus an adverse action), notification occurs on the date that the timeframes expire.
- For expedited service authorization decisions, notification occurs within the timeframe specified in Coverage and Authorization of Services.

Handling of Grievances and Appeals 438.406

General Requirements (42 CFR 438.406(a))

- The MCOs grievance and appeals process must be approved by the State. The appeals process shall consist of an informal internal review by the MCO (Stage 1 appeal) and a formal internal review by the MCO (Stage 2 appeal). The member always has the right to appeal to the DMMA, whether or not they have filed an appeal with the MCO.
- The MCO will provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- The MCO will acknowledge the receipt of each grievance and appeal within 5 days of receipt.
- Ensure that individuals who make decisions on Grievances and Appeals are individuals who were not involved in any previous level of review or decision-making. And who if deciding an appeal of a denial that is based upon lack of medical necessity or grievance resolution regarding denial of expedited resolution of an appeal or a grievance or appeal that involves clinical issues are health care professionals who have the appropriate clinical expertise as determined by the State, in treating the members condition or disease.

Special Procedures - The Process for Appeals (42 CFR 438.406(b))

- The member or provider may file an appeal either orally or in writing and must follow the oral filing with a written, signed appeal.



Structure and Operations Performance Standards

The MCO must:

- Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the member or provider requests expedited resolution;
- Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing and inform the member of the limited time for this in the case of an expedited resolution;
- Allow the member and representative the opportunity, before and during the appeals process to examine the member's case file, including medical records, and any other documents and records
- Consider the member representative, or estate representative of a deceased member as parties to the appeal

Resolution and Notification: Appeals. 438.408

Resolution and Notification (42 CFR 438.408(a), (b), (c))

- The MCO must resolve each appeal and provide notice as expeditiously as the member's health condition requires but within the State established timeframes not to exceed 90 cal days from the day the MCO receives the appeal.
- for standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day the MCO receives the appeal and for expedited resolution of an appeal and notice to affected parties, the timeframe is no longer than 3 working days after the MCO receives the appeal.

the MCO may extend the timeframes by up to 14 days if the member requests an extension, or the MCO shows there is need for additional information and that the delay is in the members interest. For an extension not at the member's request, the MCO must give the member written notice of the reason for the delay. If the MCO extends the timeframes, it must for any extension not requested by the member, give the member written notice of the reason for the delay.

Format and Content of Resolution Notice (42 CFR 438.408(d)(e))

- The MCO must follow State defined requirements for notification of a member of the disposition of an appeal.
- The MCO will provide written notice of disposition of grievances and appeals and for expedited resolution; the MCO must also make reasonable efforts to provide oral notice.
- The MCO must provide written notice of disposition, which must include the results date of appeal resolution. And for decisions not wholly in the members favor:
 - The right to request a State fair hearing
 - How to request a State fair hearing
 - The right to continue to receive benefits pending a hearing - How to request the continuation of benefitsIf the MCO action is upheld in a hearing, the member maybe liable for the cost of any continued benefits.



Structure and Operations Performance Standards

Requirements for State Fair Hearings (42 CFR 438.408(f))

- Ensure that the MCOs appeal system cannot be prerequisite to, nor a replacement for, the *member's* right to appeal to the DMMA and request a *fair* hearing *in* accordance with 42CFR 431, Subpart E. The member always has the right to appeal to the Division of Social Services or DMMA, whether or not they have filed for an appeal with the MCO.
- The entire Appeal/Fair Hearing process must be accomplished within the specified 90-day period from notice of "action". The parties to the State fair hearing include the MCO as well as the member and his or her representative of a deceased member's estate.
- The parties to the State fair hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate

Expedited Appeals Process: 438.410

General (42 CFR 438.410(a))

- The MCO must establish and maintain an expedited appeal process. The expedited review process is necessary when the MCO determines, or the provider indicates, that the time required for a standards resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

Punitive Action (42 CFR 438.410(b))

- The MCO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a member's appeal.

Action following a denial of a Request for Expedited Resolution (42 CFR 438.410(c)) If

an MCO denies a request for an expedited resolution of an appeal, it must:

- transfer the appeal to the standard timeframe of no longer than 45 calendar days from the day the MCO received the appeal, with a possible 14-day extension.
- give the member prompt oral notice of the denial then written notice within two calendar days. This decision does not constitute an action therefore can be grieved but not appealed.



Structure and Operations Performance Standards

Information about the grievance system to providers and subcontractors. 438.414

Information (42 CFR 438.414) (438.10 (g))

- The MCO must provide procedures and timeframes related to grievance, appeal, and fair hearings to all providers and subcontractors at the time they enter into a contract.
- Information must include the right to a State fair hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing.
- The right to file grievances and appeals with requirements and timeframes for filing a grievance or appeal.
- The availability of assistance in the filing process including the toll-free numbers that the member can use to file a grievance or an appeal by phone.
- The fact that, when requested by the member, benefits will continue if the member files an appeal or a request for State fair hearing within the timeframes specified for filing. The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.
- Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.

Record keeping and Reporting Requirements. 438.416

- The MCO is required to maintain records of grievances and appeals. Those records will include, at a minimum a log of all grievances/appeals whether verbal or written. The log should include Member identifying information, a statement of the appeal and resolution, if affected. Log data should be analyzed monthly to identify trends and/or patterns for administrative use and review
- Logs must always be available for State and CMS review.

Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending. 438.420

Terminology, Timely Filing and Continuation of Benefits (42 CFR 438.420(a), (b))

- Timely filing means that the appeal is filed on or before the later of the following:
 - Within 10 days of the MCO mailing the notice of action, or
 - The intended effective date of the MCO proposed action;
- The MCO must continue the member's benefits if the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- An authorized provider ordered the services and the authorization period has not expired.
- The member requests extension of benefits.



Structure and Operations Performance Standards

Duration of Continued or Reinstated Benefits (42 CFR 438.420(c))

- If the MCO continues or reinstates benefits, they will be continued until the member withdraws the appeal or does not request a fair hearing within 10 days from when the MCO mails an adverse MCO decision. Benefits will also continue until a State fair hearing decision adverse to the member is made or the authorization expires or authorization service limits are met.
- Information regarding continuance of benefits must be included in the "Notice of Action" letters to the member or the member's representative.

Member Responsibility for Services Furnished (42 CFR 438.420(d))

- The MCO may recover the cost of the continuation of services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with (43 1.230 (b)), if the final resolution of the appeal upholds the MCOs action.

Effectuation of Reversed Appeal Resolutions. 438.424

Effectuation when Services were not Furnished (42 CFR 438.424(a))

- The MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires if the MCO or State fair hearing officer reverses the decision to deny, limit, or delay services

Effectuation when Services were Furnished (42 CFR 438.424(b))

- The MCO or the State must pay for disputed services in accordance with State policy and regulation if the MCO or State fair hearing officer reverses the decision to deny authorized services and the member received the disputed services while the appeal was pending.

Sub contractual Relationships and Delegation 438.230

Written Agreement (42 CFR 438.230 (a), (b))

- The MCO is accountable for any functions and responsibilities that it delegates to any subcontractor as well as any payments to a subcontractor for services related to the contract.
- The MCO shall give the State immediate notice in writing, by certified mail, of any action or suit filed and of any claim made against the MCO or subcontractor(s) that, in the opinion of the MCO, may result in litigation related in any way to the contract with the State.
- MCOs are responsible to maintain a written agreement between the entity and subcontractor that specifies the delegated scope of work, and report responsibilities including revocation of agreement.
- Before any delegation, each Contractor must evaluate the prospective subcontractor's ability to perform the activities to be delegated.

Periodic Performance Review (42 CFR 438.230(b))

- MCOs are responsible for periodic evaluation of subcontractor performance consistent with established state schedule, industry standards or state MCO laws and regulations.

Corrective Action Plan (42 CFR 438.230(b))

- MCOs must ensure that identified deficiencies or areas for improvement are subject to corrective action.



Quality Assessment and Performance Improvement

Measurement and Improvement Performance Standards

Practice Guidelines

Dissemination (42 CFR 438.236(c))

- MCOs will disseminate the guidelines and new technologies to all affected providers, and upon request to members, potential members, consumer advocates.

Application (42 CFR 438.236(d))

- MCOs will assure that decisions regarding utilization management, member education, coverage of services and other areas to which the guidelines apply are consistent with the guidelines.

Quality Assessment and Performance Improvement

Program Requirements (42 CFR 438.240(b))

- MCOs are required to have an ongoing quality assessment and performance improvement program consistent with contractual obligations, State and Federal requirements and accreditation guidelines and should address physical health, behavioral health, and long term care.
- Contractors must survey their members on at least an annual basis to determine satisfaction with Contractor's services.
- The MCO must also have a quality management plan for the upcoming year that is consistent with the State Quality Plan. This plan must describe the program's scope; objectives and all planned projects, activities, and focused studies for the upcoming *year*. The plan must also describe monitoring of previously identified issues including tracking of issues over time. A timetable must be included, which clearly identifies target dates for implementation and completion of all phases of activities. This plan must be approved by DMMA prior to implementation.
- The Program at a minimum must outline the administrative and organizational structures and design of the quality management program.
- Describe methodologies and mechanisms for objective and systematic monitoring of access to care and services provided to members.
- Describe mechanisms to ensure that findings, conclusions, recommendations, actions taken, and results of actions taken are documented and reported to individuals within the organization for use in conjunction with other related activities.
- Describe methodologies and mechanisms for tracking issues over time with an emphasis on improving health outcomes; such mechanisms should be developed in accordance with the *guidelines of the Guide to Clinical Preventive Services (Report of the U.S. Preventive Services Task Force)*, the EPSDT guidelines, or other criteria based on scientifically or clinically validated analysis.



Measurement and Improvement Performance Standards

Performance Measures &/or Performance Improvement Projects (42 CFR 438.240) (b))

- The State and CMS may specify performance measures and topics for required MCO performance improvement projects which must be achieved through ongoing measurements and intervention, significant improvement, sustained over time, clinically and non clinically, with favorable effect on health outcomes and member satisfaction.

Under-utilization and Over-utilization (42 CFR 438.240(b)(3))

- MCOs are required to implement mechanisms to detect over- and under-utilization of services.
- The MCO will develop a Utilization Management Plan and annual work plan.
- Describe methodologies and mechanisms for monitoring and auditing provider performance, identifying deficiencies, addressing deficiencies with corrective action, monitoring of corrective actions for intended results, and communication of all findings to providers.

Quality and Appropriateness of Care (42 CFR 438.240(b)(4))

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 special health care needs

Performance Measurement Requirements (42 CFR 438.240(b)(2) and 42 CFR 438.240(c)) The MCOs are responsible to provide:

- A full description of how they will address the clinical program initiatives as specified by the State for the Medicaid population.
- Ongoing reports quarterly, semi-annually, and annually as specified in the reporting section. Additional reports as determined necessary by the State for quality assurance and improvement activities.

Requirements (42 CFR 438.240(b)(1) and 42 CFR 438.240(d)(1))

- The MCOs are responsible to conduct performance improvement projects, approved by the State that will achieve demonstrable and sustained improvement over time incorporating performance improvement standards of measurement, including objective quality indicators, implementation, and evaluation and planning.

Performance Measurement (42 CFR 438.204(c))

- The MCOs must measure and report to the State its performance using standard measures required by the State including those developed in consultation with States and other relevant stakeholders. (42 CFR 438.3204c and 438.240(a)(2). The MCO must submit data specified by the State to enable the State to measure the MCOs performance.

Reporting and Outcome (42 CFR 438.240(d)(2))



- MCOs are required to report the status and results of each project to the State upon request and annually as requested for the EQR process and must produce new information on quality of care every year.

Measurement and Improvement Performance Standards

State Review (42 CFR 438.240(e)(2))

MCOs will be subject to annual review of the impact and effectiveness of their quality assessment and performance improvement program, including:

- Performance on the required standard measures.
- Results of Performance Improvement Projects.

Information Requirements

Member Information as required by 42 CFR 438.10 (42 CFR 438.218) The State assumes the following responsibilities:

- **438.10(a)** The State defines the following terms compliant with the 438.10(a), "member" means a Medicaid recipient who is currently enrolled in an MCO in a given managed care program. A "potential member" means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an member of a specific MCO.
- **43 8. 1 0(b)(1)(d)(1)(i)** The State, assures the MCO, that the HBM will provide all enrollment-related notices, informational materials, and instructional materials to members/potential members in a manner and format that may be easily understood.
- **Choice Counseling - Mechanism.** The state has delegated to the HBM the responsibility to help members and potential members understand the State's managed care program.
- **42 CFR 438.10(c)(3)&(4)&(5)** The State assures that the HBM makes its written information available in the prevalent non-English languages in its particular service area, as specified by the State in the contract. The State assures that the HBM makes oral interpretation services available free of charge to each potential member and member. The HBM must notify its members:
 - that oral interpretation is available for any language
 - that written information is available in prevalent languages
 - how to access the interpretation services and written information
- **42 CFR 438.10(d)(1)(ii)&(d)(2)**Information - Alternative formats. The State is responsible to assure written material is available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All members and potential members must be informed that information is available in alternative formats and how to access those formats.
- **42 CFR 438.10 (e)(f)** Information - Potential Members and Members non-covered services. The State assures through its contract with the HBM that each managed care member is informed of any services available under the State plan and not covered by the capitated or FFS contractor. That the HBM shall make available to potential members and new members, information in a written and prominent manner of any benefits to which the member may be entitled but which are not made available to the member by the entity. Such information shall include information on where and how such member may access benefits not made available to the member through the MCO.



Measurement and Improvement Performance Standards

42 CFR 438.10(e)(1) & (e)(2) 42 CFR 438.102(c)

Information Potential Members. The State delegates through the *contract* to the HBM who must provide the information of this Section to each potential member as follows:

- At the time the potential member first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program.
- Within a timeframe that enables the potential member to use the information in choosing among available MCOs, PIHP, PAUPs, or PCCMs.

The information for potential members must include the following:

- General information about:
 - the basic features of managed care
 - which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program
 - MCO, PIHP, PAHP, and PCCM responsibilities for coordination of member care.
- Information specific to each MCO, PIHP, PAHP, or PCCM program operating in potential member's service area. A summary of the following information is sufficient, but the State must provide more detailed information upon request:
 - benefits covered
 - cost sharing, if any
 - service area
 - names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients. For MCOs, PIHP, and PAHPs, this *includes* at minimum information on primary care physicians, specialists, hospitals, nursing facilities, and HCBS providers.
- The State will provide through the HBM information to members indicating benefits that are available under the State plan but are not covered under the contract, including how and where the member may obtain those benefits, any cost sharing, and how transportation is provided. This includes counseling or referral services that the MCO does not cover because of moral or religious objections.
- 42 CFR 438.10(3) Information - Members. The State assures the enrollment broker, provides information to each member as follows:
 - > Notify all members of their disenrollment rights, at a minimum, annually. For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 days before the start of each enrollment period.
 - Notify all members, at the time of enrollment, of the member's rights to change providers or disenroll enrollment for cause.

Notify all members of their right to request and obtain information at least once a year.

MCO Requirements

Information Requirements (42 CFR 438.10 (a), (b))

438.10(a) the MCO will be compliant with how the State defines the following terms compliant with **438.10(a)**, "member" means a Medicaid recipient who is currently enrolled in a MCO in a given managed care program. A "potential member" means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet a member of a specific MCO.



Measurement and Improvement Performance Standards

The MCO is required to meet the following State standards regarding information:

(b) The MCO must provide all informational materials, and instructional materials relating to members and potential members in a manner and format that may be easily understood.

(3) The MCO will have in place a mechanism to help members and potential members understand the requirements and benefits of the plan.

(c) (1) *Language.* The MCO must comply with the States definition of prevalent non-English languages spoken by members and potential members throughout the State.

(c) (3) The MCO will make available written information in each prevalent non-English language in its service area.

(c), (4) The MCO will make oral interpretation services available and free of charge to each potential member and member in its service area for Spanish at all times and for all languages not just those identified by the State as prevalent upon request.

(c)(5) (i)&(ii) The MCO will notify its members that:

- that oral interpretation is available for any language and written information is available in prevalent languages
- how to access those services

(d) *Format.* (1),(i)&(ii) The State expects the MCO will assure that written material uses:

- (i) easily understood language and format at a sixth grade level
- (ii) written materials are available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
- (2) The MCO will inform all members and potential members that information is available in alternative formats and how to access those formats.

(f)(4)The MCO will provide members with written notice of any change (that the State defines as "significant") in the information specified in paragraphs (f) (6) of the Section and if applicable, paragraphs (g) and (h) of this Section, at least 14 days before the intended effective date of the change.

(f)(5) The MCO, PIHP, and, when appropriate, the PAHP or PCCM, must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each member who received his or her primary care from the provider.



Measurement and Improvement Performance Standards

- 438.10(f)(6)(i) The MCO will provide the following information to members:
 - Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the member's service area, include identification of providers that are not accepting new patients. For MCOs, this includes, at a minimum, information on primary care physicians, specialists, hospitals, nursing facilities and HCBS providers.
- 438.10(f)(6)(ii) restrictions on the member's freedom of choice among network provider
- 438.10(f)(6)(iii) member rights consistent with 438.100.
- 438.10(f)(6)(iv) information on grievance and fair hearing procedures, and for MCO and PIHP members, the information specified in §438.10(g)(1), and for PAHP members, the information specified in §438.10(h)(1).
- 438.10(f)(6)(v) describing the amount, duration, and scope of benefits, and in sufficient detail to assure the member understand entitled benefits.
- 438.10(f)(6)(vi) the procedures for obtaining benefits and authorizations for services.
- 438.10(f)(6)(vii) the extent and how members may obtain benefits, including family planning services from out of network providers, and
- 438.10(f)(6)(viii) the extent of and how after hour emergency services are provided including:
 - 438.10(f)(6)(viii), (a) what constitutes and emergency providing definitions consistent with 438.114
 - 438.10(viii)(b) a prior authorization is not required for Emergency Services
 - 438.10(viii)(c) the process and procedures for obtaining emergency services, including use of the 911- telephone system
 - 438.10(viii)(d) locations of emergency setting and locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract
- 438.10(viii)(e) informing members that they have a right to access the nearest emergency facility without regard to contracting status
- 438.10(6) (ix) The MCO will provide information to members congruent with 422.113;
- 438.10 (6)(x) policy on referral for specialty care and other benefits not furnished by the members primary care provider



Measurement and Improvement Performance Standards

Information to Members 42 CFR 438.10 G

The MCO will provide members with information about State fair hearing, the right to a hearing the method for obtaining a hearing. Information to members will include:

- the rules that govern representation at the hearing
- the right to file grievances and appeals, requirements and timeframes for filing a grievance or appeal and the *availability* of assistance in the filing process
- the toll-free numbers that the member can use to file a grievance or an appeal by phone
- the fact that, when requested by the member, benefits will continue if the member files an appeal or a request for State fair hearing within the timeframes specified for filing; and the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member
- any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service
- advance directives, as set forth in §438.6(i) (2)

Additional information that is available upon request, including the following:

- Information on the structure and operation of the MCO or PIHP
- Physician incentive plans as set forth in §438.6(h) of this chapter.



Monitoring mechanisms - State monitoring and evaluation

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 QMS, 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 does not require NCQA accreditation. DMMA recognizes that its MCOs would need to be accredited by NCQA or another accrediting body in order to require that the EQRO use information from the accreditation report to determine compliance with standards regarding access to care, structure and operations, and quality measurement and improvement pursuant to 42 CFR 43 8.360. Furthermore, DMMA recognizes that it would need to consider, in the future, developing a crosswalk outlining between NCQA or other accrediting body standards and the BBA requirements and how these would be used to determine compliance for the MCOs.

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



- credentialed, 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: Annually, following EQRO validation of results
- Monitors: Quality assessment and performance improvement program and PIPs
- Monitored by: MMDS 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, 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 MMIS is used to monitor the encounter data submitted by MCOs. The MMIS 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 MMIS 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

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 intended to improve the care, services or member outcomes in a focused area of study. The State may opt to mandate additional PIPs based on results of sub-optimal PMs or identified needs in the population. Discretionary PIP topics must be presented to the MMDS Leadership Team for review and approval. Additionally, the MCO shall present this 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 PIN at the QIT 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.

Progress toward goal achievement

The table below represents State-selected, mandatory, HEDIS-specific reporting metrics for MCOs. Data contained within demonstrates each MCO's year-over-year performance in the specific domains related to use of services, access and availability of care, and effectiveness of care. As of 2008, enrollment for DSP was insufficient to make application of HEDIS measures statistically significant. Therefore, the table below reflects both MCOs which manage health care needs of over 90% of Delaware's Medicaid population. The associated national 75th percentiles provide benchmarks from which DMMA establishes ongoing performance targets. DMMA will utilize the HEDIS national Medicaid HMO 25th percentile for all utilization measures. The change in percentiles is due to the inverse nature of how HEDIS reports the data. With the release of the final CHIPRA Pediatric Core Measurement Set, performance measures have been broken out to reflect those pertinent to the adult population and those specific to the pediatric population. The State will phase in the full set of Pediatric Core measures over the next three years starting in 2011. Appendix B & C. Additional charts specific to DSHP Plus will be added as the program gets underway



Table 5: (Sample)

DSHP CHIP pediatric quality measures

HEDIS Access and Effectiveness of Care performance measures 2010 (calendar year 2009)					
Measure	DPCI 2008	DPCI 2009	UHPDE 2008	UHPDE 2009	2008 75 th percentile Medicaid HMO
Use of Services					
Well-Child Visits in the First 15 months of Life (W15)					
0 visits	0.25	0.73	1.57	0.49	3.15
1 visit	0.50	0.13	1.57	0.24	3.29
2 visits	2.00	1.95	2.76	1.22	4.85
3 visits	4.24	1.95	11.81	5.35	7.11
4 visits	13.72	9.25	20.87	11.19	12.44
5 visits	17.46	16.30	25.98	19.95	19.45
6 or more visits	61.85	69.10	35.43	61.56	67.39
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	79.27	76.70	67.92	73.22	75.86
Access/ Availability of Care					
Children and Adolescents' Access to PCPs (CAP)					
12 - 24 months	98.11	97.48	96.84	96.57	97.85
25 months -6 years	91.33	91.45	89.16	90.47	91.04
7-11 years	92.96	94.10	N/A ²	92.53	92.46
12-19 years	87.35	88.88	N/A ²	84.15	90.22
Childhood Immunization Status (CIS)					
Combination 2 (DTaP, IPV, MMR HiB, hepatitis B, VZV)	81.71	80.05	N/A ²	73.97	82.06
Lead Screening in Children (LSC)	61.46	64.48	55.15	64.23	79.32
Appropriate Treatment for Children with Upper Respiratory Infection (UR!)	85.47	85.52	86.40	88.21	91.23
DSHP adult quality measures					
HEDIS Access and Effectiveness of Care performance measures 2010 (calendar year 2009)					
Adults' Access to Preventive/Ambulatory Health Services (AAP)	DPCI 2008	DPCI 2009	UHPDE 2008	UHPDE 2009	2008 75 th percentile Medical HMO
20-44 years	88.14	89.05	83.88	85.14	85.58
45 -64 years	92.15	92.82	85.13	88.28	89.62

² 2008 Unison measures were not populated due to the required HEDIS two-year look back period. The Plan started operation in July of 2007.



**HEDIS Access and Effectiveness of Care performance measures 2010
 (calendar year 2009)**

65 plus years	84.19	87.77	83.08	82.35	89.37
Breast Cancer Screening (BCS) Total ³	53.22	55.30	N/A ²	52.63	57.36
Cervical Cancer Screening (CCS)	72.13	70.07	49.25	64.32	72.99
Comprehensive Diabetes Care (CDC)					
Lipid Screening	72.45	75.91	66.57	66.67	79.52
HbA1C Screening	78.47	78.10	73.66	70.80	86.24
Retinal eye examination screening	61.68	61.86	40.95	56.20	62.30
Cholesterol Management of Patients with Cardiovascular Conditions (CIVIC)					
LDL-C Screening	77.20	83.21	N/A ²	82.76	85.17
LDL -C Control (<100 mg/dl)	43.13	50.36	N/A ²	39.08	48.61
Controlling High Blood Pressure (CBP)	57.18	60.83	55.23	47.17	62.26
Antidepressant Medication Management (AMM)					
Effective acute phase treatment	46.92	45.58	41.84	47.64	52.63
Effective continuation phase treatment ⁴	31.51	28.05	27.55	27.95	35.64
Timeliness of Prenatal and Postpartum Care					
At least 1 prenatal visit	88.20	88.20	80.33	84.66	89.29
1 postpartum visit between 21 and 56 days after delivery	70.60	67.20	53.25	57.23	68.23

HEDIS Access and Effectiveness of Care performance measures 2010 (calendar year 2009)

Ambulatory Care (AM B)

**HEDIS Use of Services performance measures 2010
 (calendar year 2009)**

Measure	DPCI 2008	DPCI 2009	UHPDE 2008	UHPDE 2009	2008 25th Percentile Medicaid HM0 ⁵
Emergency Department Visits/1,000	66.00	69.98	70.21	76.81	48.46
Observation room stays/1,000	0.95	0.75	1.13	1.78	0.95
Outpatient Visits/1,000	443.72	463.81	399.10	428.76	301.16
Surgery Procedures/1,000	11.21	11.72	8.44	10.54	6.42



Inpatient Utilization					
Maternity Days/1,000	13.61	12.22	19.10	17.66	11.05
Maternity Discharges/1,000	4.60	4.09	6.84	5.89	4.03
Maternity ALOS	2.96	2.99	2.79	3.00	2.47
Medicine Days/1,000	14.53	12.95	14.00	14.31	8.74
Medicine Discharges/1,000	2.95	3.29	2.84	3.31	2.53
Medicine ALOS	4.93	3.94	4.93	4.35	3.14
Surgery Days/1,000	16.52	16.47	11.50	13.86	4.44
Surgery Discharges/1,000	2.57	2.04	1.48	1.80	0.83
Surgery ALOS	6.43	8.06	7.75	7.70	4.82
Non-acute care Days/1,000	2.90	2.67	6.51	4.57	0.53
Non-acute care Discharges/1,000	0.22	0.21	0.32	0.20	0.04
Non-acute care ALOS	13.23	12.96	20.43	23.32	11.33
Total IP Days/1,000	39.95	37.28	38.06	39.78	23.52
Total IP Discharges/1,000	8.52	7.96	8.82	8.98	6.56
Total IP ALOS	4.69	4.68	4.32	4.43	3.12
Mental Health (MH) Utilization					
Inpatient Services	2.65	2.83	1.42	1.39	0.54
Intensive OP and Partial Hospitalization	0.99	1.29	0.44	0.48	0.02
HEDIS Use of Services performance measures 2010 (calendar year 2009)					
Measure	DPCI 2008	DPCI 2009	UHPDE 2008	UHPDE 2009	2008 25th Percentile Medicaid HMO ^s
Outpatient and ED	13.20	13.82	8.99	10.76	4.21
Any Services	13.55	14.17	9.71	11.36	4.63
* Two-year continuous eligibility criteria not met					



DSHP adult and pediatric quality measures results

HEDIS Access and Effectiveness of Care performance measures 2010 (calendar year 2009)					
Use of Appropriate Medications for People with Asthma (ASM)	DPCI 2008	DPCI 2009	UHPDE 2008	UHPDE 2009	2008 75th percentile Medicaid HMO
5- 9 years of age	92.69	94.98	N/A ²	92.50	94.58
10 - 17 years of age					92.00
18-56 years of age	92.12	87.49	N/A ²	85.63	89.05
Combined Rate	91.08	90.63	N/A ²	88.57	91.12
New age band for the 2010 HEDIS specifications indicate that measures should be ages 5 – IT 12-55 and combined rate					

Strategy review and effectiveness

How the Quality Management Strategy is reviewed

The QMS 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 QMS 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 Management 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 QMS 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 QMS 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 QMS 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 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

- GeoAccess updates are due every six months. Reports will be due August 15 and February 15. Reports will include overall access to primary care, specialty care and subspecialties of cardiology, orthopedics, psychiatry and OB/gynecologist providers.
- Specific GeoAccess reports include but are not limited to:
 - Accessibility summary
 - City and county detail information
 - Thermo 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 reports lead screening rates. The specifications for reporting the lead screening rates are defined by Medicaid Lead Screening Guidelines Committee.
- DMMA developed two QMCCR reporting templates; one for the DHSP 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 QMS 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 QMS 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 **QMS** initiative results
- Best practices and lessons learned with resultant changes to the following year's strategy

Achievements and opportunities

Successes

The State of Delaware has endeavored to assure the provision of the highest quality medical services to our vulnerable populations by promoting health and well-being and fostering self-sufficiency in the most cost-effective manner. As of 2010, this population will include the CHIP population. As of 2012, this population will include the **DSHP** Plus members. All of this has been made possible through the 1115 Managed Care Demonstration waiver. Successes have been achieved, along with opportunities identified as a result of an effective **QMS** which outlines the framework upon which quality activities and quality initiatives are built.

The **QII** Task Force has served as the central forum for the implementation of the **QMS**. 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 or during the sub-committee meetings that originate from the **QII** Task Force. 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 concern 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.

Another major area of strength has been ongoing partnerships with community providers. Through information dissemination and reporting of quality initiatives to community providers via committee forums, we have received valuable input resulting in program and system improvements. **DMMA** has a history of partnering with external organizations



such as the Medical Society and others on quality activities. The partnership with the Medical Society on the sickle cell project led to the development of clinical guidelines which Delaware applied until their retirement in 2008. Since that time, **DMMA** references nationally approved clinical guidelines that have been researched and supported by nationally recognized clinical experts.

Discussions at the QII Task Force meetings have resulted in the formation of subgroups with representation from DSP and the MCOs. One benefit has been the development of a mandatory PIP on ED visits for DSP and both MCOs. Subsequent discussions have led the QII Task Force to form a sub-committee to further explore opportunities to reduce the inappropriate use of the ED. Other collaborative efforts take place between the QII Task Force members outside of the group meetings to resolve issues and improve services. Another sub-committee was formed to participate in a collaborative effort to update the QMS and develop annual goals and direction for the QII Task Force.

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.

2008 —2009 success updates

1. quality-focused study on Childhood Overweight

This focused study was launched in February 2008 during a meeting with community providers and key stakeholders.

DMMA asked Mercer, a part of Mercer Health & Benefits LLC, to conduct a Childhood Overweight focus study in 2008 as part of its EQR activities. The study was done to:

- Evaluate the current provider practice patterns for screening and intervention of overweight and obesity in Delaware Medicaid children and adolescents.
- Identify barriers to screening and treatment as recommended in national clinical practice guidelines.
- Compare results from an earlier study conducted in 2003 by a DMMA subcontractor whereby data was collected to evaluate screening and diagnosis activities for overweight and obesity completed by Medicaid providers.

Mercer and DMMA worked with representatives from key stakeholder groups in Delaware, which included experts and professionals currently providing services and working with children who were overweight within the Medicaid population. These representatives were sought to provide direction for the study.

The key findings from the study included:

- Despite the routine recording of height and weight during EPSDT visits, data showed an absence of identification of overweight children through the documentation of body mass index (BMI).
- Study members stated they were knowledgeable of the American Academy of Pediatrics recommendations and guidelines for screening and treatment of



overweight and obesity, including calculating BMI.

- Documentation of BMI by providers increased significantly between the 2003 (0%) and the 2008 study (13%).

Stakeholder workgroups were formed and tasked with addressing five critical areas identified by the study:

- Resource and access
- Provider education and tools
- Member and community outreach and tools
- Benefits and reimbursement
- Evaluation, reporting and metrics

The stakeholder workgroups conducted exhaustive review of the critical areas identified. A final meeting of the combined workgroups was held in August 2009 and resulted in a thorough review of the accomplishments of the workgroups. Additionally, the workgroups submitted recommendations which are now being reviewed for approval by the new Chief within DMMA.

Accomplishments and recommendations

- Compiled a manual of accumulated resources on Childhood Overweight and Obesity. The recommendation is that this information be made available in one place, possibly a website location. This recommendation will be referred to the statewide initiative on Childhood Overweight being led by DPH.
- Research was conducted on reimbursement codes, including obesity and overweight, as well as BH/MIH. This list has been submitted for further review to determine if there is benefit to opening the codes for providers treating members for overweight and obesity.
- Workgroups recommended DMMA adopt HEDIS measures for overweight/obesity and assign to the MCOs. This recommendation has now been referred for implementation.

Transition all workgroups to a collaborative partnership with DPH's community health initiative Healthy Eating and Living (HEAL). Several members of the DMMA workgroups have transitioned onto the teams established under the DE-HEAL program. The benefit of this transition from DMMA to DPH is that the DE-HEAL initiative is statewide and will be addressing all of the *critical* areas addressed by DMMA on a larger scale and with greater resources.

2. Assuring Better Child Health and Development (ABCD) grant update

Additionally, DMMA worked collaboratively with community providers and key stakeholders to look at developmental screening through the ABCD grant project. This ABCD grant project was a 15-month endeavor sponsored by the National Academy for State Health Policy (NASHP) to increase the use of developmental screening tools as part of the PCP services during well-child care. The goal was to identify developmental issues early rather than later during the child's developmental years. Delaware partnered with 18 other selected *states* to identify and implement policies and practices that move the use of standardized developmental screening tools as part of well-child care from a "best practice" to a "standard practice." NASHP provided technical assistance and an opportunity to exchange experience and expertise, as well as national recognition of our efforts.



The final ABCD grant report was submitted to the grantor, National Academy for State Health Policy, in July 2008. DMMA was a key member of the core team for this ABCD grant. The report highlighted a number of findings and activities related to the ABCD grant. These include:

A successful stakeholder's forum was held which featured Dr. Frances Glascoe, author of the Parents Evaluation of Developmental Status (PEDS) tool, who offered valuable information about the benefit of developmental screening using a validated tool. From the beginning of the project and following the stakeholder's forum, all 10 pediatric satellite offices committed to the use of developmental screening with the use of the PEDS tool. The 10 pediatric offices are located throughout Delaware and serve over 300,000 children in mostly medically-underserved communities. The use of the PEDS tool continues to spread statewide and has led Delaware in a positive direction, working with the pediatric community in implementing developmental screening with the use of a validated tool. Delaware was invited to and presented at the National Academy of State Health Policy's Annual Conference. The topic was Coordinating Services for Young Children, with a focus on Delaware's Part C early intervention program. The ABCD grant core team was instrumental in assisting the University of Delaware Center for Disabilities Study with writing the grant proposal to look at changing the way family/general practice physicians screen for developmental milestones and utilize early intervention and early childhood special education services. The work of the ABCD initiative was an integral part of the proposed plan for a statewide spread of the work begun by ABCD. Ultimately, the work of this grant will pave the way for DMMA and the State of Delaware to implement plans to ensure that all children begin kindergarten physically and emotionally healthy.

Through rigorous quality processes, Medicaid managed care has been successful in improving or maintaining quality results and improving care and services to DSHP, DSHP Plus, and CHIP members during times of MCO transition. We now have the added benefit of increased access and choice with the addition of another MCO as of July 2007.

Opportunities

Refined reporting processes and structures for the MCOs have been accomplished. This will lead to timely reporting and assessment of quality findings for identifying and implementing improvement measures. Additionally, this will be reflected in greater compliance with established performance benchmarks. However, as the program continues to mature, continuing attention will be paid to administrative efficiencies to enhance the value of the data being presented.

Ongoing opportunities exist to continue to expound upon the skills and abilities of the QII Task Force members through QII Task Force meetings/discussions, ad hoc groups and other activities as appropriate.

Better opportunities exist to reduce the inappropriate use of the ED, improve preventative screening rates and further identify cost-saving measures. DMMA will continue to seek innovative ways to assure the provision of quality services for the DSHP, DSHP Plus and CHIP populations served.



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

2015 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP			
#	NFQ#	Measure Steward	Measure Name
1	1959	NCQA	Human papillomavirus (HPV) Vaccine for Female Adolescents
2	0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents
3	NA	NCQA	Child and Adolescent Access to Primary Care Practitioners
4	0038	NCQA	Childhood Immunization Status
5	1391	NCQA	Frequency of Ongoing Prenatal Care
6	1517	NCQA	Timeliness of Prenatal Care
7	1382	CDC	Live Births Weighing less than 2,500 Grams
8	0471	CMQCC	Cesarean Rate for Nulliparous Singleton Vertex
9	NA	AMA-PCPI	Behavioral Health Risk Assessment (for Pregnant Women)
10	1448	OHSU	Developmental Screening in the First Three Years of Life
11	0060	NCQA	Annual Pediatric Hemoglobin A1C Testing
12	1392	NCQA	Well-Child Visits in the First 15 Months of Life
13	1516	NCQA	Well-Child Visits in the 3 rd , 4 th , 5 th , and 6 th Years of Life
14	NA	NCQA	Adolescent Well-Care Visit
15	0033	NCQA	Chlamydia Screening in Women
16	NA	CMS	Percentage of Eligibles That Received Preventive Dental Services
17	NA	CMS	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk
18	1799	NCQA	Medication Management for People with Asthma
19	0576	NCQA	Follow-up After Hospitalization for Mental Illness
20	0108	NCQA	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD)
21		CMS	Child and Adolescent Major Depressive Disorder Suicide Risk Assessment
22	0002	NCQA	Appropriate Testing for Children with Pharyngitis
23	1381	Alabama Medicaid	Annual Percentage of Asthma Patients 2 through 20 Years Old with One or More Asthma-Related Emergency Room Visit
25	NA	NCQA	Ambulatory Care – Emergency Department (ED) Visits
26	NA	NCQA	Consumer Assessment of Healthcare Providers and Systems® CAHPS 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items)

AMA-PCPI: American Medical Association-Physician Consortium for Performance Improvement; CMQCC: California maternal Quality Care Collaborative; CDC: Centers for Disease Control and Prevention; CMS: Centers for Medicare * Medicaid Services; NA Measure is not NQF endorse; NCQA: National Committee for Quality Assurance; NQF: national Quality Forum; OHSU: Oregon Health and Science University.



Appendix C

Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults			
#	NQF#	Measure Steward	Measure Name
1	0039	NCQA	Flu Shots for Adults Ages 50-64 (Collected as part of HEDIS CAHPS Supplemental Survey)
2	NA	NCQA	Adult BMI Assessment
3	0031	NCQA	Breast Cancer Screening
4	0032	NCQA	Cervical Cancer Screening
5	0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (Collected as part of HEDIS CAHPS Supplemental Survey)
6	0418	CMS	Screening for Clinical Depression and Follow-Up Plan
7	1768	NCQA	Plan All-Cause Readmission
8	0272	AHRQ	PQI 01: Diabetes, Short-term Complications Admission Rate
9	0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
10	0277	AHRQ	PQI 08: Congestive Heart Failure Admission Rate
11	0283	AHRQ	PQI 15: Adult Asthma Admission Rate
12	0033	NCQA	Chlamydia Screening in Women Ages 21-24
13	0576	NCQA	Follow-Up After Hospitalization for Mental Illness
14	0469	HCA/TJC	PC-01: Elective Delivery
15	0476	Prov/CWIS/NPIC/QAS/TJC	PC-03: Antenatal Steroids
16	0018	NCQA	Controlling High Blood Pressure
17	0066	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)
18	0403	NCQA	Annual HIV/AIDS Medical Visit
19	0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c Testing
20	0105	NCQA	Antidepressant Medication Management
21	NA	CMS-CMHAG	Adherence to Antipsychotics for Individuals with Schizophrenia
22	0021	NCQA	Annual Monitoring for Patients on Persistent Medications
23	0006 & 0007	AHRQ & NCQA	CAHPS@Health Plan Survey V 4.0--Adult Questionnaire with CAHPS@Health Plan Survey V 4.0H-NCQA Supplemental
24	648	AMA-PCPI	Care Transition-Transition Record Transmitted to Health Care Professional
25	0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
26	1517	NCQA	Prenatal and Postpartum Care: Postpartum Care Rate

AH RQ: Agency for Healthcare Research and Quality; AMA-PCPI: American Medical Association-Physician Consortium for Performance Improvement; CMS: Centers for Medicare & Medicaid Services; CMS-QMHAG: Centers for Medicare & Medicaid Services-Quality Measurement and Health Assessment Group; HCA/TJC: Hospital Corporation of America-Women's and Children's Clinical Services, The Joint Commission; NA: Measure is not NQF endorsed; NCQA: National Committee for Quality Assurance; NQF: National Quality Forum; Prov/CWIS/NPIC/QAS/TJC: Providence St. Vincent Medical Center/Council of Women/s and Infant's Specialty Hospitals/National Perinatal Information Center/Quality Analytic Services/The Joint Commission.



Appendix -D: Critical Incident Reporting

The Contractor shall develop and implement a critical incident reporting system for incidents that occur with its members related to the provision of DSHP and DSHP Plus covered services. Critical incidents shall include but not be limited to the following incidents when they occur:

- Unexpected death of a member;
- Suspected physical, mental or sexual abuse and/or neglect of a member;
- Theft or financial exploitation of a DSHP Plus member;
- Severe injury sustained by a member;
- Medication error involving a member; or
- Inappropriate/unprofessional conduct by a provider involving a member.

The Contractor shall regularly identify, track, review and immediately report (within 24 hours) to the State 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 twenty-four (24) hours may be submitted verbally, in which case the Contractor must submit a follow-up written report within forty-eight (48) hours.

The Contractor is required to immediately report suspected abuse, neglect, and exploitation of members who are adults to the State Adult Protective Services. The Contractor is required to immediately report suspected brutality, abuse or neglect of members who are children to the Child Protective Services hotline.

The Contractor shall require its providers involved in a critical incident to conduct an internal critical incident investigation and submit a report on the investigation within the timeframe specified by the Contractor. The timeframe for submitting the report shall be as soon as possible, may be based on the severity of the incident, and shall be no more than thirty (30) days after the date of the incident. The Contractor shall review the provider's report and follow-up with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.

The Contractor, its staff and contracted providers are required to cooperate with any investigation conducted by the State or state-designated agency.

The Contractor shall submit monthly reports to the State regarding all critical incidents.



Appendix E- 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—11years
 - 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 F 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



Smart Start

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

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 -G: -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



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:	Medical Management and Delegated Services
MIVIS:	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
QMS:	Quality Management 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 xx 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. Subassurance: 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. Subassurance: 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. Subassurance: 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. Subassurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
3. Subassurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.
4. Subassurance: 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. Subassurance: 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. Subassurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
3. Subassurance: 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. Subassurance: 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. Subassurance: 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. Subassurance: The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death.
2. Subassurance: 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. Subassurance: The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.
4. Subassurance: 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.