Mercer

Government Human Services Consulting

Delaware External Quality Review

2021 Technical Summary Report

State of Delaware
Division of Medicaid and Medical Assistance

April 22, 2022

welcome to brighter

A business of Marsh McLennan

Contents

Section 1
Introduction

The State of Delaware (Delaware or State) Division of Medicaid and Medical Assistance (DMMA), within the Department of Health and Social Services (DHSS), has provided health care services to its Medicaid population, including individuals with disabilities, through the Diamond State Health Plan (DSHP), the Delaware Healthy Children's Program (DHCP), and the State's Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act since 1996, operating under an 1115 Managed Care Waiver.

In April 2012, DMMA, working with its Managed Care Organizations (MCOs), the Centers for Medicare & Medicaid Services (CMS), sister agencies, such as the Division of Services for Aging and Adults with Physical Disabilities, providers, such as nursing facilities (NFs) and Home- and Community-Based Services (HCBS) providers, and community stakeholders, including NFs, patient advocates, members, and others, amended their Section 1115 waiver to include a Managed Long-Term Services and Support (MLTSS) program. The program serves individuals eligible for MLTSS (institutional and HCBS) and individuals living in the community who are dually eligible for Medicaid and Medicare; this program is referred to as DSHP Plus. DSHP Plus does not include individuals with developmental disabilities receiving institutional or community-based Long-Term Services and Supports (LTSS).

On January 1, 2015, the DSHP Plus Medicaid Managed Long-Term Care program was launched. In 2015, the DSHP program continued to evolve and, in addition to integration of acute and LTSS services, the pharmacy benefit was "carved in" and DMMA integrated a new MCO, Highmark Health Options (HHO), into the Delaware market. In response to these changes, DMMA, with CMS approval, took an innovative approach to its quality review activities in 2015. This included an MCO implementation action plan review, technical assistance for the MCOs focused on MLTSS Case Management (CM) and Care Coordination (CC), development of Performance Improvement Project (PIP) topics, continued activities supporting compliance with the HCBS final rule, and an analysis of each MCOs compliance with existing network adequacy standards.

In 2017, DMMA issued a Request for Qualification (RFQ) to solicit innovative approaches to drive improvements in the delivery system and quality of services offered to DSHP and DSHP Plus members. DMMA provided formal notification to United Healthcare Community Plan of Delaware (UHCP), one of its incumbent MCOs, of its intent to not exercise the 2018 contract option year. DMMA opted to contract with AmeriHealth Caritas Delaware (ACDE) with a planned go-live date of January 1, 2018. Transition and continuity of care activities with UHCP occurred through December of 2017 while readiness review activities for ACDE commenced in October of 2017.

In 2021, Mercer Government Human Services Consulting (Mercer) completed a comprehensive compliance review of ACDE and HHO that encompassed the three mandatory activities, compliance review, validation of Performance Measures (PMs), and validation

of PIPs for both MCOs; Mercer also completed a comprehensive Information Systems Capabilities Assessment (ISCA). In addition to completion of mandatory activities, the External Quality Review Organization (EQRO) conducted the following activities, detailed throughout the report:

- Maternal health focused study.
- Technical assistance with CM and CC PM reporting.

Section 2

External Quality Review Overview

External Quality Review Objectives

Mercer's objective for the 2021 External Quality Review (EQR) was to assess Delaware MCO performance toward achieving the Delaware Quality Strategy goals, which are:

1. To improve timely access to appropriate care and services for adults and children with an emphasis on primary and preventive, and behavioral health (BH) care, and to remain in a safe and least-restrictive environment.
2. To improve quality of care (QOC) and services provided to Medicaid and CHIP enrollees.
3. To control the growth of health care expenditures.
4. To assure member satisfaction with services.

To achieve this objective, Mercer performed the mandatory EQR activities and conducted a comprehensive compliance review and this report presents the results as required by 42 CFR 438.364. The objectives of this review included:

- Assessing implementation of corrective action plan (CAP) activities by the MCOs for those items that scored less than "Met" in 2020.
- Assessing the quality of services provided, the timeliness of services provided, and access to care and recommendations to the MCOs and DMMA for continued improvement.
- Comparison of MCO PM results with national benchmarks.
- Evaluation of PIPs.

Technical Methods for Data Collection and Analysis

As a consulting firm, Mercer has access to individuals with expertise in a variety of fields. For this EQR process, Mercer chose a specifically designated team with a variety of specialties and talents that could meet the requirements of the EQR process.

The methodology used by Mercer, during this review process, was organized into five critical phases presented in the following diagram.

Standards Reviewed in the Current Reporting Cycle	
§438.206 Availability of Services	§438.230 Subcontractual Relationships and Delegation
§438.207 Assurances of Adequate Capacity of Services	§438.228 Grievance and Appeal Systems
§438.208 Coordination and Continuity of Care	§438.236 Practice Guidelines
§438.210 Coverage and Authorization of Services	§438.242 Health Information Systems
§438.214 Provider Selection	§438.330 Quality Assurance and Performance Improvement (QAPI)
§438.224 Confidentiality	

Request for Information

Mercer used the MCO request for information (RFI), based on CMS protocol and modified by Mercer to meet the needs of DMMA, to acquire information specific for all areas of the review. Mercer received information electronically and reviewed all documents submitted over a series of weeks. The information was organized on the SharePoint site into folders and subfolders, coordinating with the data request format. During the virtual onsite review phase, additional information was collected; a small number of outstanding data needs remained. At the close of the virtual onsite review process, Mercer summarized the outstanding information needs and the MCOs submitted additional information for further review and consideration following the virtual onsite visit.

Review Tool

Mercer utilized a comprehensive EQR compliance review tool (tool) adapted from CMS protocols for the compliance section of the review. The tool design included State standards reflecting key issues and priorities of DMMA. The tool assisted the reviewers in coordinating the review process in a logical manner, consistent with the flow of the Balanced Budget Act of 1997 (BBA) regulations. Mercer's desk review results helped to focus observations and interviews to gather additional information during the virtual onsite review.

File Review Protocol

Mercer developed a file request Excel template containing the specific date range and data fields required for each of the file review areas. Additionally, Mercer provided the detail file formats and content expected for each file review type. After receiving the universe file listing for the specified time period, Mercer selected a targeted random sample of 30 files for review. The final file selection was distributed to the MCO via the SharePoint site, and the MCO was provided three weeks to upload the file contents to the SharePoint site.

Mercer utilized the National Committee for Quality Assurance's (NCQA's) "8/30" rule for evaluation of health care organization file reviews. The rule states that of a sample of 30 files, if the initial eight pass the review, the entire sample of 30 is cleared. The additional 22 files undergo review if and only if the reviewers discover issues in the first eight. The NCQA has evaluated this method to be "a cost effective and statistically appropriate method of gathering data about the overall performance" of a health care organization. After discussion with DMMA for the purpose of all file reviews, Mercer employed a variant of the "8/30" rule, and chose to review 10 files selected from a sample of 30. For file reviews in which there was not enough volume to reach the 10 or 30 file denominator, Mercer reviewed all files for that category. Mercer reviewed the files and posted the preliminary file findings prior to the virtual onsite review to allow the MCO an opportunity to collect additional information to address file findings. Outstanding file findings were discussed during the virtual onsite review, additional supporting documentation was requested and provided as available.

For scoring the file review, Mercer has retained a three-tiered system. This approach for quantitative scoring was determined as more appropriate than the five-tiered system used for regulatory and contractual compliance activities due to predictive constraints of the denominator size.

File Review Compliance Level Definitions	
Met	For file reviews, the MCO must have achieved 90% compliance or greater.
Partially Met	For file reviews that scored between 75% and 89% compliance.
Not Met	For file reviews that scored less than 75% compliance.

Analysis and Reporting

Information from all phases of the review process was gathered, and a comprehensive analysis was completed. The MCO-specific report sections present the topics reviewed, the MCO team members who participated in the review, as well as the metrics requiring a CAP as a result of the 2021 review (i.e., substantially met, partially met, minimally met, not met). Summary results of the analysis make up this report. The table below outlines the five-tiered system utilized to determine compliance findings.

Compliance Level Definitions	
Met	All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.
Substantially Met	After review of the documentation and discussion with MCO staff, it is determined that the MCO has met most of the requirements as required for the Met category.
Partially Met	MCO staff describes and verifies the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice.
Minimally Met	After review of the documentation and discussion with MCO staff, it is determined that although some requirements have been met, the MCO has not met most of the requirements.
Not Met	No documentation is present and MCO staff have little to no knowledge of processes or issues that comply with regulatory or contractual provisions.

Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures the MCOs reported were compiled and comparative results between MCOs and relative to national benchmarks are included. The following rating scale is used to present these results:

			
HEDIS rating met or exceeded the national benchmark for the 90th percentile	HEDIS rating fell between the national benchmarks for the 75th and the 90th percentile	HEDIS rating fell between the national benchmarks for 50th and the 75th percentile	HEDIS ratings fell below the national benchmark for the 50th percentile

Description of the Data Obtained

The data obtained for the annual review included, but was not limited to:

- Policies and procedures (P&Ps), quality, utilization management (UM), and CM program descriptions
- CC, CM, pharmacy prior authorization (PA), grievance, appeal, credentialing, and recredentialing files
- Enrollee and provider documents
- Meeting minutes and data to support validation of PIPs and PMs
- Quality and Care Management Measurement Report (QCMMR) reports
- HEDIS results
- CAHPS results
- Provider satisfaction survey results

In addition to the documentation and files reviewed, Mercer conducted interviews with MCO staff to assess consistency of responses across operational areas and documentation the MCO provided.[1]

Conclusions Based on the Data Analysis

Compliance review results are presented in Section 3 of the report and were assigned a domain of quality, timeliness, and/or access to care. MCOs were given a rating of Met, Substantially Met, Partially Met, Minimally Met, or Not Met for each standard (see Analysis and Reporting above for full definitions). Comparative summary results reveal that ACDE was fully compliant or "Met" all expectations in four of the 11 Subpart D and QAPI standards (provider selection, confidentiality, subcontractual relationships and delegation, and grievance and appeal system). The scores for the seven standards that were not fully compliant for ACDE ranged from 70.0% to 98.5%. HHO was fully compliant in two areas (confidentiality and practice guidelines). However, the number of items within the standards needing a CAP, that is scoring less than "Met," was higher for ACDE (65) than HHO (48).

[1] Due to the COVID-19 Public Health Emergency (PHE), the onsite portion of the annual compliance review was conducted virtually. The virtual onsite review took place over a three-day period, utilizing web-based video and telephonic technology to link EQRO, DMMA, and MCO participants. The virtual onsite review began with an introductory session with Mercer, DMMA representatives, and appropriate MCO staff in attendance.

The areas of greatest opportunity for ACDE identified in the compliance review were related to CC and UM (33 and 18 items, respectively, requiring a CAP). By contrast, the areas of greatest opportunity for HHO were related to provider network and quality (each requiring a CAP for 13 items).

Based upon the ISCA review, ACDE continues to demonstrate effective partnership and collaboration between the local health plan and the enterprise ACFC teams, operations and systems and, as such, continues to perform well in supporting the systems-related requirements of Delaware's managed Medicaid program. The insights gained from ACDE's ISCA desk review and virtual discussions confirmed a strong infrastructure, claims and encounters subject matter expertise, and teamwork and commitment to Delaware. The desk and onsite reviews of the 2021 ISCA items resulted in 91 of the 99 desk review items (91.9%) receiving a review score of Met

HHO demonstrated their continued efforts to improve their claims processing operations to effectively support Delaware's Medicaid managed care program. In the latter part of 2019, HHO brought the claims operations in-house from the delegate, Gateway Health, but continued to process claims on the same claims platform, Optimal System for Claims and Reimbursement (OSCAR). HHO has made substantial progress in claims remediation activities, as well as identifying and implementing process improvements that improve claims processing outcomes overall. The insights gained from HHO's ISCA desk review and virtual discussions confirmed HHO's efforts to improve the claims operations and underlying infrastructure to ensure accurate claims processing. The desk and onsite reviews of the 2020 ISCA items resulted in 89 of the 99 desk review items (89.9%) receiving a review score of Met.

Both ACDE's and HHO's ongoing collaboration with DMMA and Gainwell on identifying and remediating encounter data submission issues has been beneficial to stakeholders.

Both MCOs have processes in place to generate standardized PMs (e.g., HEDIS and CAHPS) to fulfill contractual obligations. However, the validation of PM results indicate room for improvement for both MCOs in State-specific reporting. The EQRO reported low confidence in two State-specific measures for HHO and one State-specific measure for ACDE. A full description of the validation of PM results is in Section 4 of the report.

There is significant opportunity for improvement in HEDIS results for both MCOs. Of the 36 reported measures for ACDE, one measure, inpatient utilization — surgery average length of stay (ALOS), was at or above the 90th percentile. Seven measures, postpartum care, appropriate treatment for children with upper respiratory infection, inpatient utilization (surgery days/1,000, total inpatient days/1,000), total inpatient ALOS, and mental health (MH) utilization (inpatient services and intensive outpatient and partial hospitalization), were at or above the 75th percentile. Sixteen of ACDE's HEDIS results for these 36 measures (44%) were below the 50th percentile. Of the 36 reported measures for HHO, two measures, timeliness of prenatal care and inpatient utilization — total inpatient ALOS, were at or above the 90th percentile. Ten measures, well-child visits in the first 30 months of life (15–30 months), inpatient utilization (maternity and surgery ALOS), medicine, surgery and total days/1,000, medicine, surgery and total

discharges/1,000, and MH utilization (any services), were at or above the 75th percentile. Fifteen of HHO's HEDIS results for these 36 measures (42%) were below the 50th percentile.

Through ongoing waiver and grant projects, as well as engagement with the provider community, DMMA supports the efforts of the MCOs to ensure that care is coordinated and managed appropriately with timely access to a stable and robust provider network that is providing high quality care. However, the compliance and HEDIS results represent opportunities for continued collaborative work with the MCOs to achieve Goal 1 (to improve timely access to appropriate care and services for adults and children), and Goal 2 (to improve QOC and services provided to Medicaid and CHIP enrollees) detailed in the Quality Strategy.

Both ACDE and HHO improved CAHPS results from 2020 to 2021. ACDE's members gave the highest scoring for the measure All Health Care, which was above the 90th percentile on both the adult and child CAHPS surveys. However, both the adult and child CAHPS surveys highlight a significant opportunity for improvement across Getting Needed Care and Getting Care Quickly measures with ratings falling below the 50th percentile in both categories. HHO's members gave the highest scoring to the Rating of Health Plan measure which was above the 90th percentile on both the adult and child CAHPS surveys. Additionally, adult CAHPS survey respondents gave the highest rating to the Getting Care Quickly measure; and for the child CAHPS survey, respondents gave the highest rating to Rating of Personal Doctor measure. All seven measures for the HHO adult CAHPS survey and four measures for the HHO child CAHPS survey were above the 50th percentile. The child CAHPS survey highlight a significant opportunity for improvement across Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate. These results identify an opportunity for the MCOs and DMMA to work collaboratively toward improving results for Goal 4: To ensure member satisfaction with services, particularly related to getting needed care and getting care quickly.

A full description of the validation of PIP results can be found in Section 5 of the report. In the current Quality Strategy, DMMA has mandated that each MCO conduct a minimum of five PIPs covering specific topics. The HHO Quality department has faced challenges in leadership and staffing over the past several years, as evidenced by the lack of quantifiable measure results and the low confidence in reported results for two PIPs and moderate confidence in one PIP. The majority of interventions HHO implemented have been passive in nature (e.g., newsletter articles, mailings, etc.), which have not resulted in the quantifiable and sustainable improvement intended with PIPs. ACDE did have a sufficient number of PIPs in place with notable improvement; however, the MCO did not have a service related PIP in process and were required to submit a CAP to address this finding. DMMA has implemented process improvements and interim reporting requirements to improve oversight and monitoring of PIPs; however, several of the PIPs continue to languish and evidence limited statistical or qualitative improvement in the health outcomes for members.

Section 3

Review of Compliance with Medicaid and CHIP Managed Care Regulations and Contract Standards

At the request of the State, Mercer, DMMA's EQRO, conducted a comprehensive review of Delaware's MCOs, ACDE and HHO, assessing compliance with federal regulations. Below is a crosswalk of the standards reviewed by the EQRO to the Subpart D and QAPI Standards, MCO scores, as well as the timeframe for the review.

Standard Reviewed by the EQRO	Subpart D and QAPI Standard	ACDE	HHO	Last Reviewed
Access and Availability	§438.206 Availability of Services	97.1%	96.2%	Review Cycle 2021
	§438.207 Assurances of Adequate Capacity of Services	92.0%	92.0%	Review Cycle 2021
Care Management	§438.208 Coordination and Continuity of Care	70.0%	97.0%	Review Cycle 2021
Utilization Management	§438.210 Coverage and Authorization of Services	87.9%	98.0%	Review Cycle 2021
Provider Network	§438.214 Provider Selection	100.0%	92.8%	Review Cycle 2021
	§438.224 Confidentiality	100.0%	100.0%	Review Cycle 2021
	§438.230 Subcontractual Relationships and Delegation	100.0%	90.0%	Review Cycle 2021
Grievance and Appeals	§438.228 Grievance and Appeal Systems	100.0%	95.8%	Review Cycle 2021
Quality Improvement and Assessment	§438.236 Practice Guidelines	84.0%	100.0%	Review Cycle 2021
	§438.242 Health Information Systems	97.4%	97.4%	Review Cycle 2021
	§438.330 QAPI	98.5%	87.8%	Review Cycle 2021

Mercer completed this review as part of the mandatory EQR required by federal law using applicable CMS' EQR protocols, version 2, released in 2012. Areas included in the assessments were:

- Review of MCO compliance with Federal Regulations for Medicaid Managed Care (FRMMC), with the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), and State standards.
- Review of compliance with contract standards for:
  - DSHP and DSHP Plus CM.
  - DSHP All Member Level Coordination, Level 1 Resource Coordination, and Level 2 Clinical Care Coordination (CCC).
- PIP validation.
- PM validation.

The purpose of this independent review was to assess the following:

- The ability of the MCO and its programs to achieve quality outcomes and timely access to health care services for Medicaid, CHIP, and DSHP Plus members.
- Compliance with all regulations and requirements related to the FRMMC State-defined standards.
- The consistency of the MCO's internal policies, procedures, and processes, and to evaluate maintenance of effort for all previous corrective actions.

To kick off the EQR, Mercer developed a timeline that chronologically summarized the EQR deliverables and their due dates for 2021 and distributed it to MCO staff. The 2021 comprehensive compliance review encompassed the MCO's calendar year 2021 operations and specifically focused the file review on the period of July 1, 2020 through December 31, 2020. The 2021 EQR process began on May 17, 2021, when Mercer delivered the RFI to both MCOs. Mercer used a Health Insurance Portability & Accountability Act (HIPAA) compliant secure file transfer protocol site, SharePoint, to allow a secure exchange of information among Mercer, DMMA, and the MCO. MCO materials were uploaded to the SharePoint site by June 7, 2021. The desk review was a comprehensive analysis of P&Ps and supporting documents related to FRMMC, CHIPRA, and State contract standards. In addition, Mercer reviewed the CC, CM, provider and organizational provider credentialing/recredentialing, provider termination, pharmacy PA, and grievance and appeal files and submitted preliminary findings to both MCOs to prepare for the onsite review.

Due to the public health emergency (PHE) declared January 31, 2020 (i.e., the Novel Coronavirus Disease [COVID-19]) the onsite portion of the annual compliance review was conducted virtually via video conference and teleconference. The annual virtual onsite review was conducted by Mercer, with DMMA staff in attendance, on August 3, 2021–August 5, 2021 for ACDE and August 10, 2021–August 12, 2021 for HHO. The documentation reviews and staff interviews were conducted to gain a more complete

and accurate understanding of the operations of the MCO and how those operations contribute to its compliance with federal and State regulations and requirements, consistency with internal P&Ps and processes, and adherence to contractual standards in the provision of health care services to its enrollees

Compliance Review

This review was conducted based on information submitted by ACDE and HHO through the RFI and through virtual onsite meetings. The table below provides a sense of the MCO's progress toward full compliance with expectations by review area.

MCO Comprehensive Review				
EQRO Review Sections	ACDE		HHO	
	Number of items reviewed in 2021	Number of items needing CAP from 2021 EQR	Number of items reviewed in 2021	Number of items needing CAP from 2021 EQR
Administration & Organization	59	0	59	3
Care Coordination	54	33	54	6
Dental	28	2	28	0
Grievances & Appeals	33	0	33	3
LTSS Case Management	73	4	74	4
Pharmacy	18	1	18	2
Provider Network	61	4	61	13
Quality	49	3	49	13
Utilization Management	67	18	66	4
Total	**442**	**65**	**442**	**48**

2021 Findings and Recommendations for the State's Quality Strategy

Delaware's Medicaid managed care program focuses on providing quality care to the majority of DSHP (Medicaid and CHIP) and DSHP Plus eligible individuals in the State through increased access to and appropriate, timely utilization of health care services. Goals and objectives of the Quality Strategy provide a persistent reminder of program direction and scope. The following four goals equate to areas of focus for clinical quality improvement in Delaware as listed in the State's Quality Strategy:

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

Goal 2: To improve QOC and services provided to Medicaid and CHIP enrollees

Goal 3: To control the growth of health care expenditures

Goal 4: To ensure member satisfaction with services

Below are tables with the EQRO's 2021 findings and recommendations for DMMA's Quality Strategy broken out by goal.

Information from the 2018 Quality Strategy **Goal: 1. To improve timely access to appropriate care and services for adults and children with an emphasis on primary and preventive, and BH care, and to remain in a safe and least-restrictive environment**		
Quality Strategy Expectation	**EQRO Finding or HEDIS Rates**	**EQRO Suggestions for the State**
Availability of services — cultural considerations, delivery network, provider selection, and timely access	Network development plans may be enhanced by adding more data elements related to BH and LTSS services as mechanisms for ensuring adequate capacity to serve the managed care population.	Continue to monitor service wait times and missed and late visit report data from the MCOs to ensure timely access to appropriate care and services for the DSHP Plus LTSS population and members with BH needs.
	There were no overarching Delaware specific approaches to provider recruitment, retention, and termination activities to support ongoing network management.	Consider additional approaches to provider recruitment, retention, and termination activities to support ongoing network management by MCOs.
	Secret shopper calls found the LTSS directory to contain multiple issues such as provider telephone and address mismatches and listing providers under services they do not provide.	Implement action steps to correct the process by which the Provider Directory accuracy is assessed based on identified findings.
DSHP Plus CM File Compliance	The sample of files reviewed identified the following areas for improvement: • Timely assignment of a case manager. • Follow up after emergency department (ED) visit or hospital admission. • Appropriate and consistent preventive care.	Continue monitoring DSHP Plus CM files through ongoing case file review to ensure all contractual requirements are met and members are receiving appropriate care in a safe and least restrictive environment.

Information from the 2018 Quality Strategy Goal: 1. To improve timely access to appropriate care and services for adults and children with an emphasis on primary and preventive, and BH care, and to remain in a safe and least-restrictive environment			
Adult Access to Primary and Preventive Care Services*	**ACDE:** Ages 20–44: 68.70% Ages 45–64: 79.58% Ages 65+: 83.62% **Total: 72.68%**	**HHO:** Ages 20–44: 74.72% Ages 45–64: 83.63% Ages 65+: 85.48% **Total: 78.30%**	Identify initiatives, including network development for access and availability of services, to drive improved rates of utilization of primary and preventive care services.

**NCQA HEDIS Specifications*

Information from the 2018 Quality Strategy Goal: 2. To improve QOC and services provided to Medicaid and CHIP enrollees		
Quality Strategy Expectation	**EQRO Finding or HEDIS Rates**	**EQRO Suggestions for the State**
DSHP Plus CM File Compliance	The sample of files reviewed identified the following areas for improvement: • Timely completion of updated plans of care within 30 days of all annual review. • Coordination of care for members with BH diagnosis.	Continue monitoring DSHP Plus CM files through ongoing case file review to ensure QOC provided and all contractual requirements are met.
Peer review and critical incident (CI) management	The peer review committee lacked ongoing provider practice review based on practice analysis as part of the recurring committee meetings. The process for developing interventions and enhancements to prevent, detect, and remediate CIs was mapped, but not fully implemented.	Ensure MCO Quality department activities are meeting all expectations related to ongoing provider practice analysis and mitigation of CIs.

Information from the 2018 Quality Strategy Goal: 2. To improve QOC and services provided to Medicaid and CHIP enrollees			
Inpatient days/1000 MM*	**ACDE:** Maternity: 7.66 Medicine: 13.73 Surgery: 15.61 **Total Inpatient: 35.24**	**HHO:** Maternity: 6.15 Medicine: 18.25 Surgery: 17.71 **Total Inpatient: 40.20**	Continue to monitor MCO UM reports and work to identify areas of opportunity for alternative service settings.
ALOS*	**ACDE:** Maternity: 2.62 Medicine: 4.71 Surgery: 10.30 **Total Inpatient: 5.27**	**HHO:** Maternity: 2.83 Medicine: 4.95 Surgery: 9.97 **Total Inpatient: 5.77**	Continue to monitor UM reports to ensure appropriate lengths of stay and management of care by the MCOs.
Comprehensive diabetes care*	**ACDE:** Blood Pressure Control (<140/90): 47.93% Eye Exams: 45.50% HbA1c Control (<8%): 44.28% HbA1c Testing: 78.10% Poor HbA1c Control: 47.93%	**HHO:** Blood Pressure Control (<140/90): 53.77% Eye Exams: 42.58% HbA1c Control (<8%): 53.28% HbA1c Testing: 81.02% Poor HbA1c Control: 38.44%	Ensure MCOs are engaging in best practices and with community partners to drive improved quality of comprehensive diabetes care.

Information from the 2018 Quality Strategy Goal: 3. To control the growth of health care expenditures			
Quality Strategy Expectation	**EQRO Finding or HEDIS Rates**		**EQRO Suggestions for the State**
Emergency department utilization per 1000 MM*	**ACDE**: 47.92	**HHO**: 41.91	Continue to identify areas of opportunity for alternative (non-ED) service settings.
Non-elective inpatient discharges per 1000 MM*	**ACDE**: 6.69	**HHO**: 6.97	Continue to monitor UM reports to ensure appropriate management of care by the MCOs.
Plan all cause readmission observed/expected ratio*	**ACDE**: 1.2025	**HHO**: 1.1160	Continue to monitor UM reports to ensure appropriate management of care by the MCOs.

Information from the 2018 Quality Strategy Goal: 4. To assure member satisfaction with services			
Quality Strategy Expectation	**EQRO Finding or HEDIS Rates**		**EQRO Suggestions for the State**
CAHPS Getting Needed Care Composite	**ACDE:** Adult: 82.80% Child: 84.50%	**HHO:** Adult: 88.40% Child: 82.60%	Monitor grievance reports to identify opportunities for improved member satisfaction with timely access to high quality care.
CAHPS Getting Care Quickly Composite	**ACDE:** Adult: 80.10% Child: 88.10%	**HHO:** Adult: 88.60% Child: 87.50%	Monitor grievance reports to identify opportunities for improved member satisfaction with timely access to high quality care.
CAHPS How Well Doctors Communicate Composite	**ACDE:** Adult: 94.40% Child: 92.30%	**HHO:** Adult: 94.30% Child: 94.50%	Monitor grievance reports to identify opportunities to ensure a continued level of high member satisfaction with care by providers.

2021 Quality, Timeliness, and Access to Care Strengths and Weaknesses

Plan	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
PIP validation			
ACDE	The EQRO has high confidence in ACDE's Benzodiazepines and opioids concomitant use PIP as well as ACDE's Attention-Deficit/Hyperactivity Disorder (ADHD) clinical practice guidelines, medication, and therapy PIP.	DMMA has mandated that each MCO conduct a minimum of five PIPs covering specific topics. ACDE did have a sufficient number of PIPs in place; however, the MCO did not have a service related PIP in process.	Quality, Access, Timeliness
HHO	The EQRO has moderate confidence in HHO's Health Risk Assessment (HRA) PIP.	The EQRO has low confidence in both HHO's Oral Health for DSHP Plus LTSS members PIP and physical health (PH) and BH CC PIP.	Quality, Access, Timeliness

Plan	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
PM validation			
ACDE	The EQRO has a high level of confidence in the validity of the PMs generated using NCQA certified HEDIS software and nationally recognized specifications.	The EQRO has moderate confidence in the QCMMR measure Adult primary care providers (PCPs) with Closed Panels.	Quality, Timeliness, Access
HHO	The EQRO has a high level of confidence in the validity of the PMs generated using NCQA certified HEDIS software and nationally recognized specifications.	None identified.	Quality, Timeliness, Access

Plan	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance review			
ACDE	Appropriate P&Ps are in place to ensure adherence to federal and State contract requirements. There is evidence of integration of quality throughout the organization as evidenced by QAPI meeting minutes and team involvement in the development, implementation, and progress in PIPs.	The Provider Network and Development Plan (PNDP) has not incorporated all elements, such as member demographics in the evaluation of network adequacy and capacity. The PNDP also has not incorporated additional information Network on BH, LTSS provider monitoring, and oversight activities. The MCO will need to develop a process for routine peer reviews of participating provider practice methods and patterns, including quality outcomes, prescribing patterns, morbidity/mortality rates, and QOC/quality of service grievances.	Quality, Timeliness, Access
	The MCO stood up a new adult dental program quickly and effectively and demonstrated strong oversight of the dental benefit manager as evidenced through audit results. The opioid drug utilization review programs have expanded to include proactive outreach for concurrent use with additional interacting drugs. Case files are reviewed for all members with two or more Narcan® fills expanded to include referrals to Rapid Response and CCC teams for member outreach as needed.	None identified.	Quality, Access

Plan	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
	ACDE's systems are strategically designed to ensure seamless operations including provider data management, management of claims, encounter systems and data. The data security systems, standards, personnel, and policies lead the industry; this includes ACDE's approach to ensuring their subcontractor data security for DMMA's data. ACDE is employing a forward thinking approach to establish the enterprise-wide data analytics platform to meet DMMA's reporting requirements and the federal interoperability regulations. ACDE has strong implementation plans for the data lake that include the incorporation of external data sources, such as the Delaware Health Information Network (DHIN) and public health data, to gain improved and timely insights into ACDE's members. ACDE's encounter data reporting dashboards with drill down capability are very beneficial for monitoring encounter data submissions and trends.	The Master Services Agreement (MSA) with DMMA requires that contractual expectations and standards flow down to delegates and subcontractors for any services they provide. Oversight and management of delegates and subcontractors remains an area with a number of opportunities for improvement by ACDE. The CC program has opportunities to adopt and implement nationally recognized standards that address core competencies for care coordinators and evidence-based disease management standards for CC of members with PH and BH conditions, and substance use disorders (SUDs). The CC files reviewed did not demonstrate that supports meet the needs of members with health-related social needs (HRSNs). Training throughout the organization should be enhanced to ensure all staff identify and report QOC and quality of service issues so they can be tracked and trended for continuous quality improvement (QI) efforts.	Quality

Plan	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
HHO	HHO exhibited strong oversight and auditing processes and utilized case file findings to address individual and systemic issues throughout the CC and CM programs. The innovative Opioid pod program continues to improve by engaging in weekly provider training; including reporting on provider specific prescribing patterns. HHO also implemented a Point of Sale edit to alert dispensing pharmacies to recommend Narcan for members that are on high-dose opioids.	The MCO needs to continue its efforts to audit member files to ensure care coordinators are consistently utilizing disease management standards and to ensure member case files reflect appropriate assessment, care planning, follow-up to identified member needs, and documentation standards. The PNDP has not incorporated all elements, such as member demographics in the evaluation of network adequacy and capacity. The provider team also must develop an overarching, end-to-end policy that addresses provider terminations, inclusive of the role that delegate provider roster exchanges play in the process, addressing the role and responsibility of each entity and business unit, and the process used to ensure ongoing compliance and quality assurance. Vendor management oversight policies outlining delegation oversight were submitted, but some documents were still marked draft and HHO did not consistently identify what services were delegated to a specific vendor. The MCO does not have a tool or process to evaluate the compliance of its delegates responsible for adjudication of a grievance and/or appeals. The MCO needs to develop a process and tools for structured oversight of delegated grievance and appeals activities.	Quality, Timeliness, Access
	The MCO stood up a new adult dental program quickly and effectively and demonstrated strong oversight of the dental benefit manager as evidenced through audit results.	None identified.	Quality, Access

Plan	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
	HHO's continued, diligent work resulted in improvements to the workflows and processes applied during claims processing. HHO has evidenced the organization's ability to develop and implement comprehensive enhancements and an operations transformation plan. HHO's approach to developing the transformation plan helped to ensure the outcomes would bring the highest benefit. HHO is employing a forward thinking approach to establishing the enterprise-wide data analytics platform to meet DMMA's reporting requirements and the federal interoperability regulations. HHO's encounter data management team has been instrumental to driving resolution to the historical encounter submission challenges. HHO's ongoing contributions are key to improving the overall quality of DMMA's encounters.	The MSA with DMMA requires that contractual expectations and standards flow down to delegates and subcontractors for any services they provide. Oversight and management of delegates and subcontractors remains an area with a number of opportunities for improvement by HHO. The volume of manually entered claims continue to pose a risk that could be mitigated with additional audits (e.g., claims outliers, etc.) leveraging the data analytics. While there has been some preliminary evidence of improvement throughout 2020, a number of opportunities exist. Participation by departmental leads was lacking for most of 2020 in the QI/UM committee. The committee meeting notes indicate a significant number of committee members, many of whom did not participate in the meetings in over one year. In addition to participation in the committee, there should be robust engagement of departmental leads within PIPs and other QI initiatives. The majority of PIP interventions implemented over the past several years, including 2020, have been passive in nature (e.g., newsletter articles, mailings, etc.), which have not resulted in the improvement intended with PIPs. Preventing, detecting, and remediating CIs to ensure the safety and well-being of HHO members is vital. Throughout 2020, the MCO was in the process of developing interventions and enhancements; however, the interventions and enhancements were focused almost exclusively on the role of the care coordinator/case manager. HHO should update and refine the workflow for	Quality

Plan	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
		management of CIs to indicate identification of a CI may occur by anyone, not exclusively a care coordinator/case manager. The quality program evaluation included tracking/trending analysis of CIs, but the policy for quarterly and annual evaluation does not include CIs. Quarterly tracking/trending of CIs would serve as an early warning for HHO.	

Information Requirements, Benefit Information, Marketing, and Emergency and Post-Stabilization Services

ACDE 2021 Findings and Recommendations

Member Rights, Responsibilities, and Member Communication Requirements

Enrollee rights are published in the Member Handbook, Provider Manual, and ACFC's Notice of Privacy Practices (NPP). Members are advised of their rights and responsibilities (R&R) upon enrollment and annually. Upon enrollment, the member is mailed a new member enrollment packet which includes documents that instruct the member to access the Member Handbook as well as the R&R and NPP online via ACDE's website. These documents include information on how a member can receive a copy of the Handbook via mail at no charge by calling the toll-free Member Services number. Staff members are educated about enrollee rights as part of new hire orientation; training emphasizes the requirements found in Section 1557 of the Patient Protection and Affordable Care Act, which outlines the nondiscrimination provisions prohibiting discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Corporate P&Ps globally address Member R&Rs and specifically address member requests for access to health records and the right to change information including instances where access to and the right to change are denied along with due process and grievance pathways. Delegates, through contract, are required to follow all Delaware contract requirements; when necessary and appropriate ACDE/Corporate works with its delegates to provide training on key topics pertinent to the Delaware contract.

Information regarding enrollee rights and protections, available benefits, and how to access emergency versus urgent care are all contained within the Member Handbook, which is made available in English and Spanish. Alternative formats of the member

handbook, including braille, audio tapes, TTY, and language translation services (including American Sign Language) are available to members at no cost. Members are advised, via the Member Handbook and ACDE website, to contact Member Services via ACDE's toll-free number to request translation assistance. ACDE indicated the Member Advocate can also provide assistance to the member in accessing these services or in accompanying the member to the provider's office.

A full list of covered benefits, including those not covered by ACDE, are available within the Member Handbook, which is accessible online via ACDE's website. Information on the types of conditions that constitute an emergency and how to access emergency services versus when to use urgent or primary care is shared via the Member Handbook and posted online. The Handbook addresses all contractually required elements. ACDE provided the new member enrollment packet, which included information about available benefits, urgent care facilities, how to contact Member Services, and how to file a grievance or appeal and State fair hearing, HRA incentive as well as member portal information. All P&Ps are consistent with federal regulations and contractual requirements.

Member call center operations continue to be handled out of the Philadelphia, Pennsylvania contact center and real-time monitoring of member calls is available from the Delaware office location. Over-flow calls can be load balanced with the ACFC call center in Florida where back-up staff have been trained on the Delaware line of business. During the virtual onsite review, Mercer and DMMA staff listened in to three member calls. Member services operations were smooth and evidenced happy, customer-centric staff dedicated to assisting members to the best of their ability. Of particular note, was the ability of the Member Services Representative to quickly identify any outstanding preventive screenings that the member had missed. ACDE stated that the Member Services system includes radio buttons, which enable red prompts to show on the screen to indicate any missing preventive services screenings for the member. This gives the Member Services Representative the ability to remind and assist the member in making preventive services appointments during the time of the call.

Emergency and Post-Stabilization Services

ACDE offers definitions of emergency and post-stabilization services, which are consistent with federal rules and State contract requirements and does not limit an emergency condition by diagnosis or symptom. These definitions are found within P&Ps, as well as in the Member Handbook. Education about what constitutes an emergency versus an urgent care need are defined in member materials. Policies authorizing payment for post-stabilization services reflect federal definitions and cover care provided in- and out-of-network (OON), and respects that it is the treating physician who determines whether the member is stable for transfer to in-network providers.

Marketing

ACDE maintains a Delaware-specific policy governing the development of marketing materials for members, which meets federal requirements pertaining to member communications. Additionally, ACDE creates an annual Marketing Plan, in accordance with its contract requirements with the State. The annual plan is submitted to DMMA for review and approval at the beginning of each year, as are all member facing wellness and marketing materials. When open and operating, ACDE submits a calendar of events on a weekly basis to DMMA outlining activities hosted at its Wellness Center.

ACDE's approach to development and distribution of marketing materials includes methods to ensure quality control as well as, ensure material is accurate, does not mislead, confuse, or defraud a member or the State. The State requires that the MCO disclose events and activities ACDE plans to sponsor and/or participate in during the year; the annual budget for sponsorship cannot exceed a pre-determined threshold set by the State. ACDE continued to expand its digital footprint beyond Facebook and Instagram to incorporating a strategy to include Twitter in the dissemination of DMMA approved health plan information and wellness messages, as well as information regarding ACDE and community events and resources.

All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

HHO 2021 Findings and Recommendations

Member Rights, Responsibilities, and Member Communication Requirements

Enrollee rights are published in the Member Handbook, Provider Manual, and on HHO's member portal. Members are advised of their R&Rs upon enrollment and annually. Upon enrollment, the member is mailed a new member welcome letter, which details instructions on accessing the member portal as well as the Member Handbook, both of which house the member's R&Rs. The welcome letter includes information on how a member can receive a copy of the handbook via mail or request an alternate version of the handbook at no charge by contacting Member Services at their toll-free number. Staff members are educated about enrollee rights as part of new hire orientation; training emphasizes the requirements found in Section 1557 of the Patient Protection and Affordable Care Act, which outlines the nondiscrimination provisions prohibiting discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Corporate P&Ps globally address member R&Rs and specifically address member requests for access to health records and the right to change information including instances where access to and the right to change are denied along with due process and grievance pathways. Delegates, through contract, are required to follow all Delaware contract requirements; when necessary and appropriate HHO/Corporate works with its delegates to provide training on key topics pertinent to the Delaware contract.

Information regarding enrollee rights and protections, available benefits, telemedicine, and how to access emergency care are all contained within the Member Handbook, which is made available in English and Spanish for both the DSHP/DHCP and DSHP Plus populations. Alternative formats of the Member Handbook, including braille, audio CD, TTY, and language translation services (including American Sign Language) are available to members at no cost. Members are advised, via the Member Handbook and HHO website, to contact Member Services via HHO's toll-free number to request translation assistance. HHO indicated the Member Advocate can also provide assistance to the member in accessing these services or in accompanying the member to the provider's office.

A full list of covered benefits, including those not covered by HHO, are available within the Member Handbook, which is accessible online via HHO's website. Information on the types of conditions that constitute an emergency and how to access emergency services versus when to use urgent or primary care is shared via the Member Handbook and is also posted online. The Handbook addresses all contractually required elements. All P&Ps are consistent with federal regulations and contractual requirements.

Member call center operations continue to be handled out of the Pittsburgh, Pennsylvania contact center and real-time monitoring of member calls is available from the Delaware office location. During the virtual onsite review, Mercer and DMMA staff listened in to four member calls. Member services operations were smooth and evidenced happy, customer-centric staff dedicated to assisting members to the best of their ability. While call center staff demonstrated exemplary customer service skills, there were opportunities for HHO to provide training and tools to call center staff to help them be more efficient and effective in call resolution.

Emergency and Post-Stabilization Services

HHO offers definitions of emergency and post-stabilization services, which are consistent with federal rules and State contract requirements and does not limit an emergency condition by diagnosis or symptom. These definitions are found within P&Ps, as well as in the Member Handbook. Education about what constitutes an emergency versus an urgent care need are defined in member materials. Policies authorizing payment for post-stabilization services reflect federal definitions and cover care provided in-network and OON, and respects that it is the treating physician who determines whether the member is stable for transfer to in-network providers.

All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

Marketing

HHO maintains a Delaware-specific policy governing the development, production, and distribution of marketing materials for members, which, meets federal requirements pertaining to member communications including the availability of materials in

alternative formats including braille. Additionally, HHO creates an annual marketing plan, in accordance with its contract requirements with the State. The annual plan is submitted to DMMA for review and approval at the beginning of each year, as are all member facing wellness and marketing materials. Given the PHE that dominated most of 2020, HHO focused its attention on marketing on the run up to the open enrollment period that occurs later in the year. Billboards, bus stop advertisements, and social media marketing campaigns focused on attracting new members, as well as encouraging existing members to stay with HHO.

HHO's approach to development and distribution of marketing materials includes methods to ensure quality control, as well as ensure material is accurate, does not mislead, confuse, or defraud a member or the State. The State requires that the MCO disclose events and activities HHO plans to sponsor and/or participate in during the year; the annual budget for sponsorship cannot exceed a pre-determined threshold set by the State. HHO continued to expand its digital footprint beyond Facebook and Instagram to incorporating a strategy to include Twitter in the dissemination of DMMA approved health plan information and wellness messages, as well as information regarding HHO and community events and resources.

All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

Metric Description	2021Score
The call center: • Has the capacity to monitor calls remotely. (3.14.2.3.3) • Can receive calls from limited English proficiency and hearing impaired callers. (3.14.2.3.4) • Has bilingual Spanish (and other prevalent language) representatives. (3.14.2.3.5) • Must allow members to first choose their preferred language on the phone line. (3.14.2.3.6) • Is staffed at least Monday through Friday, 8:00 am to 7:00 pm eastern, except for holidays, and has an automatic system to handle calls outside of business hours. (3.14.2.3.7 and 3.14.2.3.13) • Staff must be trained to respond to member questions on DSHP and DSHP Plus as described in 3.14.2.3.8. • Has procedures to transfer calls appropriately and warm transfer when required. (3.14.2.3.10, 3.14.2.3.11) • Has access to electronic documentation from previous calls from the member services line, nurse triage/advice line, pharmacy service information line, CC and CM. (3.14.2.3.14) • Has the ability to access the wellness registry to help link members to covered and non-covered services. (3.6.2.9.4.1.2)	Substantially Met

Advance Directives

ACDE 2021 Findings and Recommendations

ACDE meets the federal regulations and contract requirements for notification to adult members regarding their rights under State law relative to Advanced Directives (ADs). ACDE's website provides the appropriate link to the Delaware approved AD form, retrievable from the Division of Services for Aging and Adults with Physical Disabilities website. The Handbook encourages members who are interested in or who need assistance with completing AD paperwork to contact the Member Services call center for further assistance; call center representatives have been trained to access the online help, which contains standard instructions on how to work with members who may call inquiring about ADs. Member Advocates are available and have been trained to provide assistance to members and/or families and caregivers who have questions about ADs. Care coordinators and/or case managers receive training upon hire and annually thereafter about the importance of speaking with members about ADs. These care coordinators and/or case managers work directly with members, their families, and caregivers to provide education on this topic as well as collect completed ADs.

All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

HHO 2021 Findings and Recommendations

HHO meets the federal regulations and contract requirements for notification to adult members regarding their rights under State law relative to ADs. In addition to new member orientation, newsletter articles, and the Member Handbook, HHO's website provides the appropriate link to the Delaware approved AD form, retrievable from the Division of Services for Aging and Adults with Physical Disabilities website. HHO encourages members to contact Member Services for AD forms. Case managers and care coordinators have been trained to provide assistance to members and/or families and caregivers who have questions about ADs. Training on ADs for HHOs care coordinators and/or case managers occurs upon hire and annually thereafter, emphasizing the importance of speaking with members about ADs. These care coordinators and/or case managers work directly with members, their families, and caregivers to provide education on this topic as well as collect completed ADs.

All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

Availability of Services — Cultural Considerations, Delivery Network, Provider Selection, and Timely Access

ACDE 2021 Findings and Recommendations

In Delaware, by contract, ACDE is required to develop and maintain a Provider Network Development and Management Plan (PNDMP). The PNDMP acts as the Network Management program description outlining the different populations served, goals, objectives, outcomes, and action steps taken to develop, monitor, and maintain ACDE's network of providers. While the expectation is that ACDE use the PNDMP as a living document, updating it as the year unfolds, annually the State requires an evaluation of the effectiveness of the PNDMP; the results to be used as the basis for the next year's plan. ACDE has robust reporting capabilities and utilizes geo-spatial analytics, grievance, and CI data, as well as member and provider experience information to evaluate the effectiveness of its PNDMP. Account Executives (AEs) are assigned to providers and are available to conduct office visits or virtual visits during the PHE. AEs play a critical role in communicating ACDE policy, conducting training on new business processes, and providing technical assistance to their assigned provider community. Various provider forums are conducted at different locations and times throughout the year. The year 2020, saw these face-to-face meetings move to a virtual environment. Annual provider satisfaction and member experience surveys are conducted and results are used to inform network management and oversight activities.

Delegation of network development and management activities does occur using both nationally (Avēsis and SKYGEN) and locally (Christiana Care Health System [CCHS], Delaware Chiropractic Services Network [DCSN], and Nemours) contracted vendors. More information on Delegation Oversight can be found in the Sub-Contractual Relationships and Delegation section of this report. ACDE's Network Management team has partnered with delegates to ensure a clear understanding of Delaware Medicaid contract requirements, and participates in ongoing monitoring and oversight to ensure compliance with key indicators and service level agreements. ACDE has also contracted with recognized Medicaid Accountable Care Organizations (ACOs) and is actively engaged in the development and proliferation of alternative payment models and value-based contract relationships.

ACDE maintains a large network of providers and offers a Wellness Registry, powered by Aunt Bertha™ that lists community-based support and service organizations; access to it is made available to members and providers. An overview of the ACDE network is as follows:

Provider Type	Number of Providers	Provider Type	Number of Providers
PCP	932	Home Modifications	5
Specialty Care Provider (SCP)	1256	Home Delivered Meals	5
BH	1193	Home Health	35
Hospital	9	Adult Day Services	10
Urgent Care	20	Respite Care	60
NF	55	Personal Assistance Service Agencies	40
Assisted Living Facility	11	Personal Emergency Response System	12
Durable Medical Equipment (DME)	73	Consumer Directed Fiscal Intermediaries	2

ACDE operates a provider website and contracts with NaviNet for its online provider portal. The NaviNet portal allows for claims status check, eligibility verification, and PA submission and response as well as provider complaint submission. The provider contract templates meet all contract requirements. Submitted P&Ps demonstrate compliance with providing women with direct access to a women's health practitioner in addition to their PCP of record, allow for a second opinion, and demonstrate the use of single case agreements and OON authorizations to ensure members received medically necessary care when such care or specialty is not available in-network. However, ACDE must update its P&P for utilizing specialists as PCP to incorporate the State required language allowing an individual undergoing dialysis to use their nephrologist as a PCP.

Providers have access to training and education materials through the NaviNet portal and receive new provider orientation when entering the network. Annual provider forums were hosted in the last half of 2020 and quarterly newsletter and monthly provider bulletins were disseminated. The Provider Manual is a critical resource document for providers and their office staff; it is made available electronically. ACDE will need to update the Provider Manual to include language around the 45-day period to file a non-claim related complaint.

ACDE maintains a provider directory, which contains all contractually required elements. On a quarterly basis, ACDE conducts verification on a statistically valid sample of the provider types contained within the directory. Verification of provider data can occur through many different mechanisms but pertinent information such as a provider's race, ethnicity, language (REL), and completion of cultural competency training is captured and evaluated, along with address, phone, hospital affiliation, etc. A spreadsheet of provider REL information is maintained in the Member Contact Center and is available to customer service representatives to respond to member requests. Access and accommodation for individuals with physical or mental disabilities is reviewed and information on handicap access and accommodation for vision and hearing impairment are assessed by the Provider Account Representatives and included in the directory. Translation services, including American Sign Language, is available with advanced notice to the MCO.

Network monitoring activities are outlined in the PNDMP and include geo-spatial analysis of the time/distance and provider ratio requirements outlined in the contract. Appointment availability monitoring is conducted quarterly and is a shared responsibility between the Medicaid MCOs. Network changes (additions and terminations) are monitored. Grievance and CI information is reviewed and when necessary providers are brought to the Peer Review committee for further evaluation and continued participation in the network. Provider satisfaction is monitored through annual surveys and through review of trends related to provider complaints. There was evidence of linkages to Program Integrity, Quality, and other health plan operation areas as a routine part of day-to-day network management. Evidence of network opportunities by specialty and geography were identified by ACDE and plans to remediate the gaps were outlined in the PNDMP and progress discussed during the interviews. However, one area of opportunity for ACDE is related to the incorporation of additional information into the PNDMP to more fully evaluate network adequacy and capacity. An overview of membership demographics as well as, incorporating BH and LTSS provider monitoring and oversight activities should be added to the PNDMP.

Provider Selection and the Credentialing File Review Process

Credentialing support is provided by the ACFC and is conducted in accordance with NCQA standards and modified as necessary for Delaware specific requirements. ACDE maintains written P&Ps outlining its provider selection activities, which comport with federal and State specific requirements. ACDE's internal policy for provider selection includes nondiscrimination language and providers are also required to practice nondiscrimination in their approach to patient selection and treatment planning. Recredentialing follows a three-year cycle except for LTSS provider types who are recredentialed annually. Peer review activities and the Credentialing committee are operated at the local level by the Chief Medical Officer (CMO) or designee and follow all confidentiality protections, including a code of conduct for non-employee committee participants.

ACDE currently delegates credentialing and recredentialing of practitioners, in the local market, to CCHS, DCSN, and Nemours. Delegation oversight of these credentialing entities includes review of standards and review of (re)credentialing files. In 2020, both CCHS and DCSN were under CAPs as a result of the annual oversight audit. ACDE monitored CAP implementation, which focused on consistent checking of sanction and debarment information as well as, adding Delaware specificity to policies (e.g., processing a complete credentialing application and sending to ACDE for loading in a 45-day turnaround time). All three entities were approved for continued delegation and as of the time of the review, all CAPs had been closed.

ACFC and ACDE delegate credentialing to national partners Avēsis and SKYGEN and are overseen by the Vendor Management team. The 2020 annual oversight audit for Avēsis resulted in a CAP for both the NCQA and Delaware specific State standards. The CAP was closed in March 2021 after submission of additional material satisfying the CAP.

The credentialing file review was performed using the File Review Protocol methodology outlined in Section 3. File review encompassed initial and recredentialing activities for organizational providers and independent practitioners. A sample of 30

credentialing files (15 initial and 15 recredential) were selected, including LTSS provider types. In total, 10 practitioner and 10 institutional files were selected for initial review, with files split between initial and recredentialing. While no CAP is required as a result of the file review, there are two opportunities (detailed below) for ACDE to consider addressing in advance of the 2022 EQR. The files were assessed for compliance with Final Rule regulations, State contract requirements, and ACDE internal policy standards.

As noted above, there are opportunities for ACDE. Issues with creation of the Universe file, the listing Mercer uses to select its file review random sample, persist from last year's review to current for practitioners who are credentialed through one of the three delegated credentialing entities and who also hold a contract(s) directly with ACDE. ACDE's continued difficulty in being able to accurately report the credentialing cycle data for these shared delegated practitioners/practices represents an opportunity for the 2022 EQR cycle. Should these issues persist a CAP may be required.

Overall, the practitioner and institutional files reviewed demonstrated compliance with DMMA's required 45-day turnaround time for all initial applications. Recredentialing activities occurred within the one-year cycle for LTSS providers and three-years for all other practitioners and institutions. Evidence of sanction and debarment checks, Social Security Death Master File (SSA DMF) review, collection of Clinical Laboratory Improvement Amentments waivers, and provider disclosure forms were all evidenced in the file review or supported by P&P. Interview sessions dedicated to file review demonstrated consistency with ACDE's submitted written response. Overall, the files reviewed were found to have greater than 90% compliance in the required elements.

Provider Terminations and the Provider Termination File Review Process

When a provider is terminated from an MCO network, members who had an established relationship or who had an ongoing plan of care can experience disruption in access and availability. To decrease the impact to members, MCOs alert members to the impending provider termination and provide assistance to transfer medical records and/or locate a new provider. ACDE's provider termination P&Ps reflect the appropriate look-back periods to determine established relationships and consider any open service authorizations to limit disruption to members. Letters are sent to members and members are encouraged to call Member Services should they need assistance with locating a new provider. ACDE updates the system that feeds the Provider Directory to ensure that all known network changes are processed within the required 30-day window.

Avēsis is ACFC's national vendor for vision benefit services and is used in the Delaware market by ACDE to provide vision benefits to its membership. Avēsis is responsible for developing ACDE's Optometry and Vision Service Provider Network. As part of its network management functions Avēsis is required to operate a provider call center, subject to the call center requirements outlined in ACDE's MSA with the State, as well as implementing a provider complaint system and processing provider terminations from the network. ACDE's 2020 delegation oversight audit tools evidenced inclusion of State specific requirements relating to the Provider Complaint system and its ongoing monitoring ensured outstanding CAP items pertaining to provider call center metrics continued to be addressed and resolved.

The provider termination file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 provider termination files were selected for review; sampling included practitioners and institutional providers representing ACDE and delegated credentialing entities.

At Mercer's request, ACDE submitted a Universe file listing of all terminated providers in the last half of 2020 (July 1–December 31). A total of 96 terminated providers were identified. Termination reasons appeared primarily voluntary in nature from non-response for recredentialing to provider no longer at practice, or at the provider's request. ACDE demonstrated marked improvement in the audit trail associated with provider terminations, incorporating member informing notices and review of provider panel information for PCP terminations, and open authorizations or visit history in the past 12 months for specialists. No LTSS providers appear to have been terminated in the latter half of 2020.

There were some issues identified in the file review process, but none that rose to the level requiring corrective action. However, there is opportunity for ACDE to review its provider data quality as a result of a termination. For example, in one case the provider file should have been retro-terminated back to the provider's known date of death: such actions can work to decrease potential fraud and abuse. In other instances, it was noted that some larger provider groups and/or ACOs may be exchanging provider rosters to document provider practice changes, which may result in delays in notification of provider terminations. Such a delay could impact member access to the provider or disruption in execution of plan of care. While no CAP is required based on the results of the file review, Mercer would encourage ACDE to review both its provider data quality management (QM) practices associated with the term process and evaluate whether provider practice roster exchange activities can be further streamlined to avoid unnecessary delays. Overall, the files reviewed were found to have greater than 90% compliance in the required elements.

Metric Description	2021 Score
The MCO's P&P definition of a PCP include the following provider types: nurse practitioners, nurse midwives, family practice, general practice, geriatricians, pediatricians, and obstetrics and gynecology (OB/GYN) or internist and allows nephrologists for members on dialysis and outlines how the MCO seeks State approval on a case-by-case basis to allow specialists as the member's PCP. (3.9.8.2)	Substantially Met
The MCO's PNDMP includes the following components: (1) summary of participating providers, by type and geographic location in the State, (2) demonstration of monitoring activities to ensure that access standards are met and that members have timely access to services, (3) a summary of participating provider capacity issues by service and county, the contractor's remediation and QM/QI activities, and the targeted and actual completion dates for those activities, (4) network deficiencies by service and by county, and interventions to address the deficiencies, and (5) ongoing activities for provider network development and expansion, taking into consideration identified participating provider capacity, network deficiencies, service delivery issues, and future needs. (42 CFR 438.207 and 3.9.2.1)	Substantially Met
The MCO has adequate methods to verify compliance with State-determined network adequacy standards and produces quarterly geo-spatial analysis reports. Methods to detect network adequacy should include at a minimum geo-spatial reports, tracking PCP open/closed panels, appointment availability within defined State standards, and assessment of LTSS gaps in care. (3.9.2.3)	Substantially Met

Metric Description	2021 Score
The MCO's provider complaint system includes P&Ps, a designated staff person, and outlines the timeframes and notification processes required by the contract. • Allows providers 45 calendar days to file a written complaint for issues that are not about claims and no later than 12 months from the date of service, or 60 calendar days from payment, denial or recoupment for issues about claims, whichever is latest. • Notification within three business days of receipt of complaint and the expected date of resolution. • Resolves all complaints within 90 calendar days of receipt and provides written notice of the resolution and the basis for the resolution to the provider within three business days of resolution. • Documents why a complaint is unresolved after 30 calendar days of receipt and provides written notice of the status to the provider every 30 calendar days thereafter. (3.9.6.6)	Substantially Met

HHO 2021 Findings and Recommendations

In Delaware, by contract, HHO is required to develop and maintain a PNDMP. The PNDMP acts as the Network Management program description outlining the different populations served, goals, objectives, outcomes and action steps taken to develop, and monitor and maintain HHO's network of providers. While the expectation is that HHO use the PNDMP as a living document, updating it as the year unfolds, annually the State requires an evaluation of the effectiveness of the PNDMP; the results to be used as the basis for the next year's plan. HHO has embraced the concept of the PNDMP and demonstrates a CQI mindset in the enhancements and evolution of this document. HHO monitors its network adequacy monthly via cross-departmental meeting using its robust reporting capabilities to assess geo-spatial analytics, grievance, and CI data, as well as member and provider experience information to evaluate the effectiveness of its PNDMP. AEs are assigned to providers and are available to conduct office visits or virtual visits during the PHE; a total of 465 visits were conducted in 2020. AEs play a critical role in communicating HHO policy, conducting training on new business processes, and providing technical assistance to their assigned provider community. Visits follow a predefined agenda to ensure consistency of information. Various provider forums are conducted at different locations and times throughout the year. The year 2020 saw these face-to-face meetings move to a virtual environment with a total of four different forums held in June 2020 and November 2020. Annual provider satisfaction and member experience surveys are conducted and results are used to inform network management and oversight activities.

Delegation of network development and management activities occurs nationally with Davis Vision and United Concordia Dental (UCD) and locally with CCHS and Nemours as credentialing delegates. More information on Delegation Oversight can be found in the Sub-Contractual Relationships and Delegation section of this report. HHO's Network Management team has partnered with delegates to ensure a clear understanding of Delaware Medicaid contract requirements, and participates in ongoing monitoring and oversight to ensure compliance with key indicators and service level agreements. HHO has also contracted with recognized Medicaid ACOs and is actively engaged in the development and proliferation of alternative payment models and value-based contract relationships.

HHO's alternative payment program is geared towards primary care and incorporates the DMMA quality PMs and other quality indicators.

HHO maintains a large network of providers and offers a Wellness Registry, powered by Aunt Bertha that lists community-based support and service organizations; access is made available to providers via the HHO Community Resources page. An overview of the HHO network is as follows:

Provider Type	Number of Providers	Provider Type	Number of Providers
PCP	1212	Home Modifications	11
SCP	5816	Home Delivered Meals	7
BH	1144	Home Health	19
Hospital	12	Adult Day Services	9
Urgent Care	10	Respite Care	33
NF	42	Personal Assistance Service Agencies	49
Dental	21	Personal Emergency Response System	13
Vision	54	Consumer Directed Fiscal Intermediaries	2
Assisted Living Facility	13		

HHO operates a provider website and contracts with NaviNet for its online provider portal. The NaviNet portal allows for claims status check, eligibility verification, and PA submission and response, as well as provider appeals and claims disputes/complaint submission. HHO also posts provider reports and provides secure messaging features through its portal. The provider contract templates meet all contract requirements. Submitted P&Ps demonstrate compliance with providing women with direct access to a women's health practitioner in addition to their PCP of record, allow for a second opinion, and demonstrate the use of single case agreements and OON authorizations to ensure members receive medically necessary care when such care or specialty is not available in-network.

Providers have access to training and education materials through the NaviNet portal and receive new provider orientation when entering the network. Provider forums were hosted in June 2020 and November 2020, newsletters and provider bulletins are disseminated as necessary. The Provider Manual is a critical resource document for providers and their office staff; it is made available electronically. HHO's Provider Manual includes specificity around appointment availability standards but does not incorporate the MLTSS alternative service wait time standards nor does it capture missed or late visit reporting requirements for certain MLTSS provider types as required by contract.

HHO maintains a provider directory, which contains all contractually required elements. HHO has created separate directories for different provider types including one specific to HCBS providers. On a quarterly basis HHO relies on its vendor, Atlas Systems to conduct verification (fax and telephonic) on a statistically valid sample of the provider types contained within the directory. Verification of provider data can occur through many different mechanisms but pertinent information such languages spoken, wheelchair accessibility, and open panel status is captured and evaluated, along with address, phone, specialty, etc. It is unclear how HHO assesses accommodation for individuals with physical or mental disabilities, nor was there indication that HHO was gathering data on completion of cultural competence training.

In review of the submitted procedure CRD-001A Confidentiality of Provider Information, Nondiscriminatory Selection, and Directory Accuracy it was noted to lack the necessary Delaware specific requirements related to quarterly review of a statistically valid sample of providers, across all provider types included in the Provider Directory. Given the results of the secret shopper calls noted above, HHO must address the issues with the validity of information as it pertains to the LTSS Directory and update its P&Ps to reflect its methodology to select a statistically valid sample of all provider types within the directory.

Network monitoring activities are outlined in the PNDMP and include geo-spatial analysis of the time/distance, open/closed panels, and provider ratio requirements outlined in the contract. Appointment availability monitoring is conducted quarterly and is a shared responsibility between the Medicaid MCOs. Network changes (additions and terminations) are monitored monthly. Grievance and CI information is reviewed and, when necessary, providers are brought to the Peer Review committee for further evaluation and continued participation in the network. Provider satisfaction is monitored through annual surveys and through review of trends related to provider complaints. There was evidence of linkages to Program Integrity, Quality, and other health plan operation areas as a routine part of day-to-day network management. Evidence of network opportunities by specialty and geography were identified by HHO, and plans and progress to remediate the gaps were outlined in the PNDMP and discussed during the interviews. One area of opportunity for HHO is related to the incorporation of additional information into the PNDMP to more fully evaluate network adequacy and capacity. HHO should incorporate LTSS provider monitoring and oversight activities such as missed and late visit reports and alternative service wait times.

Provider Selection and the Credentialing File Review Process

Credentialing support is provided by Highmark Shared Services and is conducted in accordance with NCQA standards and modified as necessary for Delaware specific requirements. Highmark Shared Services is responsible for coordinating the National Credentialing committee while the HHO CMO is responsible for chairing the Peer Review committee. Findings and recommendations from the Peer Review committee are communicated to the National Credentialing committee. HHO maintains written P&Ps outlining its provider selection activities, which comport with federal and, at times, State specific requirements. HHO's internal guidance documents for provider selection include nondiscrimination language and providers are also required to practice nondiscrimination in their approach to patient selection and treatment planning. However, while the documents submitted meet general credentialing and

recredentialing requirements they often miss Delaware specificity. For example CRP-004 Ongoing Monitoring, Interventions and Reporting Policy, lacks specificity related to checking the SSA DMF, which should be monitored monthly. The MSA requires written P&Ps that demonstrate compliance with DMMA's provider selection requirements — many of the submitted documents lack specificity. Recredentialing follows a three-year cycle except for LTSS provider types, which are recredentialed annually. Peer review activities are operated at the local level by the CMO or designee and follow all confidentiality protections, including a code of conduct for non-employee committee participants.

Delegated Provider Network Development: Credentialing

HHO currently delegates credentialing and recredentialing of practitioners, in the local market, to CCHS and Nemours. Delegation oversight of these credentialing entities includes review of standards and review of (re)credentialing files. In 2020, CCHS was under CAP, focused on ensuring more rapid exchange of delegate rosters that will allow HHO to maintain its compliance with the State's requirement to turnaround a complete credentialing application and load the provider into the billing system in 45 days. Both CCHS and Nemours were approved for continued delegation and as of the time of the review all CAPs had been closed.

HHO's newly created CMO works with Functional Business Owner (FBO), Quality, and Compliance units to ensure oversight of delegated credentialing to national partners Davis Vision and UCD. The 2020 annual oversight audits were completed and each vendor was recommended for continued delegation.

The credentialing file review was performed using the File Review Protocol methodology outlined in Section 3. File review encompassed initial credentialing activities for organizational providers and independent practitioners. A sample of 30 credentialing files (15 initial and 15 recredential) were selected, including LTSS provider types. The files were assessed for compliance with BBA regulations, State contract requirements, and HHO internal policy standards.

Overall, the practitioner and institutional files reviewed demonstrated compliance with DMMA's required 45-day turnaround time for all initial applications. Recredentialing activities occurred within the one-year cycle for LTSS providers and three-years for all other practitioners and institutions. Evidence of sanction and debarment checks, SSA DMF review, collection of Clinical Laboratory Improvement Amendments waivers, and provider disclosure forms were all evidenced in the file review or supported by P&P. Interview sessions dedicated to file review demonstrated consistency with HHO's submitted written response. The files reviewed were found to have greater than 90% compliance in the required elements.

Provider Terminations and the Provider Termination File Review Process

When a provider is terminated from an MCO network, members who had an established relationship or who had an ongoing plan of care can experience disruption in access and availability. To decrease the impact to members, MCOs alert members to the impending provider termination and provide assistance to transfer medical records and/or locate a new provider. HHO's provider

termination P&Ps reflect the appropriate lookback periods to determine established relationships and consider any open service authorizations to limit disruption to members. Letters are sent to members and members are encouraged to call Member Services should they need assistance with locating a new provider. HHO updates the system that feeds the Provider Directory to ensure that all known network changes are processed within the required 30-day window.

Davis is Highmark's national vendor for vision benefit services and is used in the Delaware market by HHO to provide vision benefits to its membership. Davis is responsible for developing HHO's optometry and vision service provider network. As part of its network management functions Davis is required to operate a provider call center, subject to the call center requirements outlined in HHO's MSA with the State, as well as implementing a provider complaint system and processing provider terminations from the network to ensure HHO receives timely notification of network changes. Delegate oversight information demonstrates that HHO has been working with Davis to address identified compliance issues.

A provider termination file review was not performed due to HHO's extended implementation timeframe of its prior provider termination CAP, which remains under development as of this report. The EQRO encourages HHO to fully implement its CAP and to develop an overarching, end-to-end policy that addresses provider terminations, inclusive of the role that delegate provider roster exchanges play in the process, addressing the role and responsibility of each entity and business unit and the process used to ensure ongoing compliance and quality assurance.

Metric Description	2021 Score
The MCO's PNDMP includes the following components: • Summary of participating providers, by type and geographic location in the State. • Demonstration of monitoring activities to ensure that access standards are met and that members have timely access to services. • A summary of participating provider capacity issues by service and county, the contractor's remediation and QM/QI activities, and the targeted and actual completion dates for those activities. • Network deficiencies by service and by county, and interventions to address the deficiencies. • Ongoing activities for provider network development and expansion, taking into consideration identified participating provider capacity, network deficiencies, service delivery issues, and future needs. (42 CFR 438.207 and 3.9.2.1)	Substantially Met
The MCO has adequate methods to verify compliance with State-determined network adequacy standards and produces quarterly geo-spatial analysis reports. Methods to detect network adequacy should include at a minimum geo-spatial reports, tracking PCP open/closed panels, appointment availability within defined State standards, and assessment of LTSS gaps in care. (3.9.2.3)	Substantially Met

Metric Description	2021 Score
The MCO's provider recruitment P&Ps include effective strategies to ensure adequate access to all covered services in accordance with the State's access standards that includes the following: • Considers State standards for timely access, consistent with the needs of the member. • Ensures network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees. • Makes services in the contract available 24 hours a day, seven days a week, when medically necessary. • Established mechanism to ensure compliance by providers. • Regular process to monitor compliance. • Process to take corrective action when providers fail to comply. (42 CFR 438.206(c)(1) and 3.9.1.2.5)	Partially Met
The MCO has P&Ps in place for maintaining an appropriate network of providers taking into consideration membership, utilization, number and type of providers, providers with closed panels, and geographic location. (42 CFR 438.206 and 3.9.1.2.4)	Substantially Met
The MCO's provider recruitment P&Ps describe effective responses to a change in the network that affects access and the MCO's ability to deliver services in a timely manner. (3.9.1.2.5)	Partially Met
The MCO has P&Ps describing how the Provider Directory is updated, frequency of updates (quarterly), and validation of information in its Provider Directory, including the data elements listed in Section 3.14.1.6.1 (e.g., open/closed panel, languages, Americans with Disabilities Act [ADA] compliance, etc.). (3.14.1.6.6)	Substantially Met
The Provider Manual contains all 35 elements required by the contract. (3.9.6.3.5)	Substantially Met
The MCO has established P&Ps on provider recruitment, retention, and termination and describes how the MCO responds to changes in the network that affect access and availability of covered services. (3.9.1.2.5)	Partially Met
The MCO's credentialing and recredentialing P&Ps comply with 42 CFR 438.214 including: • Having written P&Ps. • Follow State guidelines for (re)credentialing — every three years for non-HCBS providers and annually for HCBS. • Nondiscrimination, consistent with (42 CFR 438.12). • Does not employ or contract with providers precluded from participation (MCO must have a process to check its own internal providers). (3.9.7.1 and 42 CFR 438.12) • As well as comply with NCQA standards for the credentialing and recredentialing of providers. (3.9.7.3)	Substantially Met
The MCO's P&Ps include that the MCO provides written notice to members no less than 30 calendar days prior to the effective date of the termination of a PCP and no more than 15 calendar days after receipt or issuance of the termination notice. (3.9.18.2.1.1)	Substantially Met
The MCO's P&Ps include that the MCO provides written notice to members no less than 30 calendar days prior to the effective date of the termination of a non-PCP provider (including but not limited to LTSS provider) and no more than 15 calendar days after receipt or issuance of the termination notice. (3.9.18.2.2.1, 3.9.18.2.3.1)	Substantially Met

Metric Description	2021 Score
The MCO's P&Ps include that hospital terminations are reported to the State no less than 30 calendar days prior to the effective date and within five business days of receipt of the termination for providers. (3.9.18.3.1.1, 3.9.18.3.2.1)	Substantially Met

Program Integrity Requirements and Confidentiality

ACDE 2021 Findings and Recommendations

ACDE has well-documented Compliance and Program Integrity (PI) programs consisting of an annual written Compliance Program and work plan, a Fraud, Waste, and Abuse plan, defined audit approach encompassing pre-payment, post-payment, service verification, and other data mining activities as well as, a corporate Code of Conduct and required annual training on compliance and program integrity. ACDE's website (Report Fraud, Waste, and Abuse — AmeriHealth Caritas Delaware), Member Handbook, and Provider Manual all include language on what constitutes fraud, waste, and abuse including an expanded definition of abuse that incorporates abuse, neglect, and exploitation of children and adults. Multiple reporting channels are provided and include telephone and links to the Office of the Inspector General: all allow anonymous reporting. Internally, ACDE staff can report suspected cases via an email box, tip line, or by bringing an issue to a manager; non-retaliation policies for good faith reporting are in place.

ACDE has a dedicated Compliance Officer (CO) who has a direct reporting relationship to the Board of Directors and is matrixed to the ACDE market Chief Executive Officer (CEO). The CO is the Chair of the local Compliance and Privacy committee, which met four times in 2020. All ACDE staff and contractors are assigned Compliance and Security trainings upon hire and annually thereafter. Completion of required training is tracked and monitored. When necessary non-compliant staff and contractors are escalated to managers and supervisors to ensure training is completed or the associate or contractor is terminated. As a result of the PHE and transition of office-based staff to a remote, work-at-home environment, ACDE's CO conducted refresher training to ensure remote worker policies including strategies to maintain confidentiality of information were provided to staff. In addition to guidance received in the Member Handbook, ACDE includes a Notice of Privacy Practices on its website (AmeriHealth Caritas Delaware Notice of Privacy Practices — AmeriHealth Caritas Delaware).

ACDE has appropriate processes in place to protect member medical records and other health and enrollment information. Corporate policies clearly outline what constitutes Protected Health Information (PHI) and Personally Identifying Information (PII) and provide members with a formalized process by which access to health records for review and revision, including instances where such information would not be shared; all appear in compliance with federal regulatory requirements. ACDE uses the State required file format to report breaches in confidentiality to the State and has adopted a Delaware specific policy for reporting that reflects the required timeframes for reporting to the State.

PI activities are provided through a shared services agreement with ACFC. ACFC staff work closely with local ACDE leadership and the State to identify and share information pertaining to potential instances of fraud, waste, and abuse. Training on what constitutes fraud, waste, and abuse is given upon hire and annually thereafter. Tracking compliance follows a similar process as that described for Privacy and Confidentiality training above.

All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

HHO 2021 Findings and Recommendations

HHO has well-documented Compliance and PI programs consisting of an annual written Compliance Program and work plan, a defined audit approach, and other data mining activities as well as, a corporate Code of Conduct and required annual training on compliance, confidentiality and privacy, and PI. HHO's website (Fraud, Waste, and Abuse [highmarkhealthoptions.com]), Member Handbook, and Provider Manual all include language on what constitutes fraud, waste, and abuse, including an expanded definition of abuse that incorporates abuse, neglect, and exploitation of children and adults. Multiple reporting channels are provided and include telephone and links to the Office of the Inspector General; all allow anonymous reporting. Internally, HHO staff can report suspected cases via an email box, tip line, or by bringing an issue to a manager; non-retaliation policies for good faith reporting are in place.

HHO has a dedicated CO, who has a direct reporting relationship to the Board of Directors and is matrixed to the HHO market CEO. All HHO staff and contractors are assigned Compliance and Security trainings upon hire and annually thereafter. Completion of required training is tracked and monitored. When necessary non-compliant staff and contractors are escalated to managers and supervisors to ensure training is completed or the associate or contractor is terminated. In addition to guidance received in the Member Handbook, HHO includes a Notice of Privacy Practices on its website (Privacy [highmarkhealthoptions.com]).

HHO has appropriate processes in place to protect member medical records and other health and enrollment information. Corporate policies clearly outline what constitutes PHI and PII and provide members with a formalized process by which access to health records for review and revision, including instances where such information would not be shared; all appear in compliance with federal regulatory requirements. HHO uses the State required file format to report breaches in confidentiality to the State and has adopted a Delaware specific policy for reporting that reflects the required timeframes for reporting to the State.

Program integrity activities occur within the local HHO MCO with linkages to the HHO CO. Staff work closely with local HHO leadership and the State to identify and share information pertaining to potential instances of fraud, waste, and abuse. Training on

what constitutes fraud, waste, and abuse is given upon hire and annually thereafter. Tracking compliance follows a similar process as that described for Privacy and Confidentiality training above.

All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

Prohibited Affiliations with Individuals Debarred by Federal Agencies

ACDE 2021 Findings and Recommendations

ACDE's credentialing department is responsible for performing initial and ongoing (monthly) checks of all network providers, and Corporate Audit validates internal staff members. By contract, the State requires the MCOs perform monthly checks against List of Excluded Individuals/Entities (LEIE), Excluded Parties List System/Excluded Parties List System (SAMS/EPLS), and the SSA DMF. Additionally, ownership disclosure information is collected at the time of credentialing and annually thereafter, and those entities who hit the threshold are shared with DMMA for further review and follow-up. There are clear processes to terminate network providers, vendors, and employees who are flagged as part of ACDE's systematic evaluation process.

Flow down requirements to ensure prohibited affiliation monitoring and oversight are in place attach to ACDE's vendors and credentialing delegates and are evidenced in ACDE submitted vendor contract templates, delegation audit tools, and evaluated during initial/annual delegation oversight audits. National vendors, overseen by ACFC corporate audit staff demonstrate consistency with local vendor oversight activities.

All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

HHO 2021 Findings and Recommendations

HHO's credentialing unit within the Provider Information Management department is responsible for performing initial and ongoing (monthly) checks of all network providers, and Corporate Audit validates internal staff members. By contract, the State requires the MCOs perform monthly checks against LEIE, SAMS/EPLS, and the SSA DMF. Additionally, ownership disclosure information is collected at the time of credentialing and annually thereafter, and those entities who hit the threshold are shared with DMMA for further review and follow-up. There are clear processes to terminate network providers, vendors, and employees who are flagged as part of HHO's systematic evaluation process.

Flow-down requirements to ensure prohibited affiliation monitoring and oversight are in place attach to HHO's vendors and credentialing delegates and are evidenced in HHO's submitted vendor contract templates, delegation audit tools, and evaluated during initial/annual delegation oversight audits.

All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

Grievance and Appeal Systems

ACDE 2021 Findings and Recommendations

The grievance system follows standard processes. Grievances can be received from members, member representatives, or providers orally through Member Services or through an ACDE staff member (e.g., the Member Advocate), or be written (i.e., filling out a form on the ACDE website and submitting it). If a grievance is received orally, the Grievance coordinator completes the Contact Center Grievance & Appeals Service Form and begins documenting the process using the EXP MACESS system. This system is a repository for all Member Grievances received via Member Services, Member Advocates, LTSS Case Managers, and the Pharmacy Department. There are five full-time equivalents (FTEs) dedicated to the Delaware line of business for grievance management. Appeals are handled out of the local ACDE office, using the Jiva medical management documentation system; there are three FTEs dedicate to appeal adjudication.

Grievance staff facilitate the grievance investigation, sending acknowledgement letters to members, and coordinating investigations with other impacted business units. For example, the Provider Network Management team will be sent quality of service grievances; a CM may be engaged due to member concerns about an assigned case manager. Any information that is sent to other units of ACDE for investigation is returned to the grievance unit along with the investigatory findings. EXP MACESS was defined as the "source of truth" for grievance resolution and is used for tracking the timeliness of resolution and housing all grievance documentation. QOC issues and other clinical issues are sent to the ACDE QM Department for further investigation and resolution by the Clinical Quality Performance Specialist (QPS). At the completion of the QOC investigation, the Clinical QPS sends an outcome letter to the provider (within one week of determination) and the QOC Grievance Member Resolution letter to the member (within two business days of the resolution). The Clinical QPS then uploads the QOC Grievance Member Resolution letter and documents that the letter was sent in EXP MACESS and Jiva (within two business days of the resolution of the grievance). Grievances are an opportunity to identify areas of improvement in the complete system of care; there is an opportunity for the MCO to change their culture to view grievances as beneficial to CQI within the MCO versus a failure in the system.

Similar to grievances, standard appeals are accepted both orally (through Member Services) or in writing (appeals form can be found on the ACDE website or on the last page of the member's Notice of Adverse Benefit Determination [NOABD] letter) and sent to ACDE via US mail, fax, or email. Oral appeals or appeals filed by providers are required to have written member consent. The appeal start date is the date the written appeal is received or the date the oral appeal is received, if written member consent is received within 10 calendar days from initial filing.

Appeals staff are responsible for sending out member correspondence including the initial acknowledgement letter, letters requesting additional information, and the resolution letter, as well as calling and/or faxing providers. If continuity of care is requested in the appeal, the analyst checks to ensure the proper steps have occurred and timelines are met. If an appeal hearing is requested, the member or member representative is invited to attend in person or via phone as well as the Member Advocate. Hearings are held on a weekly basis. The member or member representative has the opportunity to present the case and answer any questions. The case is deliberated, and a decision is issued and communicated to the member within two business days.

As noted in the UM section of this report, the National Imaging Associates Inc. (NIA) process for denial of service (NOABD) resulted in a high number of decisions being overturned or dismissed based on additional information received by UM while an appeal is pending. ACDE should continue to monitor NIA's process for approving services.

All of the required Final Rule and contract standards were met according to policies and handbooks. In general, the grievance system appears to function well. ACDE has a strong leadership team in place for both the Grievance and Appeal teams. Both teams have shown great ability to identify issues within their system and change processes to rectify these situations.

Grievance File Review

The grievance file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 grievance files was selected for review, representing Medicaid, CHIP, and DSHP Plus membership. Grievance subjects included categories such as access/availability of care, communication/relationships, transportation, QOC, and others. The files were assessed for compliance with Final Rule regulations, State contract requirements, and ACDE internal policy standards.

The assessment of the grievance files consisted of a review of the member's original grievance, internal notes and documents, letters produced by ACDE, and other documents supporting the investigation. Overall, the files reviewed were found to have greater than 90% compliance in the required elements. The grievance file review demonstrated a strong focus on members, as evidenced by outreach calls from Grievance Coordinators to ensure satisfaction with grievance resolutions, as well as strong documentation of investigative notes and timely acknowledgement letters sent to members. In addition, the file review found that QM department resolution letters contain appropriate information about the investigation and/or resolution.

Appeal File Review

The appeal file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 appeals files was selected for review, representing Medicaid, CHIP, and DSHP Plus membership. The sample contained appeals that were upheld, overturned, and withdrawn following or prior to the Appeals committee meeting. The files were assessed for compliance with Final Rule regulations, State contract requirements, and ACDE internal policy standards.

The assessment of the appeals files consisted of a review of NOABD letters, internal notes and documents, letters produced by ACDE, and other documents supporting the appeal investigation. Overall, the files reviewed were found to have greater than 90% compliance in the required elements. File review demonstrated that documents and timelines were met according to Final Rule and contract regulations. Of note, nine out of 13 NIA appeals (69%) were overturned prior to or during appeals committee.

All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

HHO 2021 Findings and Recommendations

The grievance system follows standard processes. Grievances can be received from members, member representatives, or providers orally through Member Services or through an HHO staff member (e.g., the Member Advocate), or be written (i.e., filling out a form on the HHO website and sending it in). If a grievance is received orally, the Grievance coordinator completes a member grievance form and begins documenting the process. In June 2021, the Appeals and Grievance Department implemented a new process to determine whether a grievance is an issue of QOC versus quality of service. When a grievance is received, it is reviewed by a registered nurse (Clinical Nurse Reviewer) to reduce the number of grievance categories previously identified as “other”. Once a determination is made by the Clinical Nurse Reviewer, the case is assigned to a grievance analyst who follows the case through resolution and notification.

Grievance staff take the lead on investigations, sending acknowledgement letters to members, sending letters, and faxes and/or making calls to providers to obtain information regarding the grievance. Depending upon the nature of the grievance, other HHO departments may be involved in the investigation and resolution process. For instance, Provider Relations will be sent quality of service grievances and Provider Contracting will be sent vision grievances; the Quality department will be sent QOC issues and other clinical issues. If both QOC and quality of service issues are identified from the original grievance, a new unique ID is assigned to the respective investigation essentially creating two grievance cases that are attributed to the Member ID. This new process appears to be leaving open feedback loops and potentially creating confusion for the member about whether an investigation has been completed and by whom. Additionally, parsing out a grievance to multiple departments for review does not promote effective grievance CM and may be a disservice to the member.

Similar to grievances, standard appeals are accepted both orally (through Member Services) or in writing (through a form on the HHO website or through the form on the last page of the member's NOABD letter) and sent to HHO. Oral appeals, or appeals filed by providers, are required to have written member consent to move forward with the appeal process. The appeal process start date is the date the written appeal is received or the date the oral appeal is received, if written member consent is received within 10 calendar days from initial filing. Following CMS updates to the Final Rule effective December 14, 2020, HHO no longer requires written member consent for appeals filed by the member.

Appeals analysts are responsible for sending out member correspondence including the initial acknowledgement letter, letters requesting additional information, and the resolution letter, as well as calling and/or faxing providers. If continuation of current services is requested while the appeal is pending, the analyst checks to ensure the proper steps have occurred and timelines are met. If an appeal hearing is requested, the member or member representative is invited to attend in person or by phone. The Member Advocate also attends, along with the Standing committee. Hearings are held weekly. The member or member representative may present the case and answer questions. The case is deliberated, and a decision is made and communicated to the member within two business days.

In addition to the opportunities listed below, HHO should consider reviewing their P&Ps around oversight of delegated or subcontracted entities. During this review, evidence of a high rate of overturned appeals, before going to the hearing committee, emerged. For instance, NIA is granted initial UM decision making authority for the approval of high cost imaging services. Even though NIA and HHO use the same clinical guidelines to determine medical necessity, there were a large number of files that exhibited overturned appeals by HHO. This would suggest a flaw in the initial UM decision process by NIA and does not reflect the member and provider-centric intentions of the DMMA contract. Further information on the UM process can be found in Section 6: Clinical Practice Guidelines and Coverage and Authorization of Services of this report.

Grievance File Review

The grievance file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 grievance files was selected for review, representing Medicaid, CHIP, and DSHP Plus membership. Grievance subjects included categories such as access/availability of care, communication/relationships, transportation, QOC, and others. The files were assessed for compliance with BBA regulations, State contract requirements, and HHO internal policy standards.

The assessment of the grievance files consisted of a review of the member's original grievance, internal notes and documents, letters produced by HHO, and other documents supporting the investigation. Five of 30 grievance files were found to not be fully investigated prior to issuing a final grievance resolution letter. For example, in unique ID # G20351363453 (regarding a quality of service issue) a decision letter was sent to the member stating, "You will receive a separate decision letter regarding your concerns about the care you received". Four other case files identified as either QOC or quality of service had similar messaging. During the interviews with

the MCO, it was explained that the case that was selected was a piece of a larger grievance file. When the original grievance was filed, three QOC and three quality of service issues were identified and the original grievance broken into six for independent investigations and resolution, with six different unique IDs. HHO sent the other five sections of the grievance for Mercer to review. Each of the additional case files demonstrated the same language in the resolution letter stating that another department was completing the investigation and a separate resolution letter would be sent. There was no evidence that this grievance was fully investigated and appropriately resolved. Overall, the files reviewed were found to have between 75% and 89% compliance in the required elements.

Appeal File Review

The appeal file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 appeals files was selected for review, representing Medicaid, CHIP, and DSHP Plus membership. The sample contained appeals that were upheld, overturned, and withdrawn following or prior to the Appeals committee meeting. One expedited appeal was reviewed. The files were assessed for compliance with BBA regulations, State contract requirements, and HHO internal policy standards.

The assessment of the appeals files consisted of a review of NOABD letters, internal notes and documents, letters produced by HHO, and other documents supporting the appeal investigation. Five of 30 appeals files were found to be missing written consent from the member when a provider or representative filed an expedited appeal on the member's behalf. During the interviews with the MCO, it was explained that the MSA states that member's written consent is not needed in this circumstance. After further discussion, it was determined that not requiring member written consent when a provider or representative files and appeal on behalf of the member does not align with federal regulations and the MCO must adhere to what is federally required. Other aspects of the file review evidenced that documents and timelines were met according to BBA and contract regulations. Overall, the files reviewed were found to have between 75% and 89% compliance in the required elements.

Metric Description	2021 Score
The MCO has a process to evaluate the compliance of its delegates responsible for adjudication of a grievance and appeals. Delegation oversight tools and file review clearly demonstrate evaluation of the delegates grievances system for compliance with federal requirements including: grievance system structure, accurate definitions, rural exceptions, adverse benefit determination language, resolution timeframes, expedited appeal processes, how information is shared with provider, continuation of benefits, and effectuation of reversed appeals. (42 CFR 438.400 (Sub-part F) and 5.1.2.2)	Not Met
The MCO has a process to ensure that all QOC and quality of service grievances are fully investigated prior to issuing final grievance resolution. (3.13.3)	Partially Met

Metric Description	2021 Score
Expedited authorization decisions are provided as expeditiously as the member's health condition requires and no longer than 72 hours after receipt of the request to make a decision. Period could be extended for 14 days under the same circumstances as apply for standard decisions if the MCO/Behavioral Health Managed Care Organization (BH-MCO) extends the timeframe, it must: • Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires. (42 CFR 438.210(d)(2) and 3.12.6.5.2.3)	Partially Met

Sub-contractual Relations and Delegation

ACDE 2021 Findings and Recommendations

ACFC provides support to ACDE for oversight of national subcontractors and delegates via its Delegated Vendor Audit Department; tools, processes, and results appear robust and systematized. Results of the Delegated Vendor Audit Department activities are shared with ACDE via its Quality committee structure. ACDE is responsible for delegation oversight at the local level, which includes credentialing oversight of CCHS, DCSN, and Nemours, which is conducted with assistance from the National Credentialing department. All delegated activities follow NCQA standards and consist of a signed agreement documenting the delegated responsibilities and other pertinent contract elements, including any flow-downs from the MSA ACDE has signed with DMMA. ACDE ensures that all delegates undergo a pre-delegation audit; the MCO also ensures routine reporting, and that an annual delegation audit occur within the required timeframes. Delegation oversight audit tools have been developed to capture both NCQA and Delaware specific requirements. Audit results are reported out at the NCQA and Delaware-specific requirement levels and CAPs are requested when results fall below established thresholds. CAP oversight is shared between ACFC and ACDE. ACDE retains the final determination on decisions affecting delegated relationships.

The following tables provides a high-level overview by delegated entity and the associated delegated responsibilities.

Entity	Responsibilities
ACFC/Corporate	Human resources, Corporate Finance, Legal, Corporate Communications, Corporate Medical Management, Facilities, Enterprise Operations (claims, contact center, enrollment), Information Systems, Purchasing, Provider Credentialing and Provider Data Management, and Special Investigations and PI
PerformRx	Pharmacy Benefit Management, Provider Network Development and Management, UM (PA and peer-to-peer review)

Entity	Responsibilities
Avēsis Vision Vendor	Provider Network Development and Management, Provider Call Center (provider complaints), Claims Payment, UM (PA and peer-to-peer review)
SKYGEN Dental Vendor	Provider Network Development and Management, Provider Call Center (provider complaints) Claims Payment, Utilization/Benefit Management
Carenet	Nurse Advise Line/Health Information
NIA	UM (PA, peer-to-peer review) and UM call center
CCHS	Credentialing, Recredentialing, Primary Source Verification, Credentialing Committee
DCSN	Credentialing, Recredentialing, Primary Source Verification, Credentialing Committee
Nemours	Credentialing, Recredentialing, Primary Source Verification, Credentialing Committee

All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

HHO 2021 Findings and Recommendations

Changes to HHO's delegation oversight program were in process throughout 2020 and continue into 2021. In part, these changes are a result of HHO transitioning responsibilities from Gateway back into the local HHO plan and represent the creation of a Medicaid specific Vendor Management Oversight (VMO) team housed in HHO's new MBU. Additionally, contracts previously held by Gateway or other operating entities have been moved to Highmark contracts with Delaware Medicaid addendums or onto HHO owned contracts. The following paragraphs provide a programmatic overview of HHO's new VMO structure and approach. For the remainder of this section vendor and delegate are used synonymously.

Delegation oversight previously performed by Gateway was transitioned back to HHO throughout 2020, with the exception of Pharmacy benefits, and HHO continues to build its VMO capabilities internally. HHO's MBU provides support to HHO for oversight of its vendors (i.e., delegates) via its VMO team. Delegate oversight occurs in a matrixed fashion involving the VMO, Compliance, Quality, and FBOs (e.g., UM, credentialing, etc.). The VMO acts as the liaison with the delegate from an oversight perspective and works with the Compliance unit to ensure the VMO framework is compatible with the contract. FBOs are identified within each business unit and aligned with the delegate's scope of services. FBOs are responsible for the day-to-day operations and overall delegate relationship management including performing operational oversight, training, and audits. Results of delegate oversight activities are shared through the Quality committee structure (QI/UM Committee). All delegated activities follow NCQA standards and

consist of a signed agreement documenting the delegated responsibilities and other pertinent contract elements, including any flow-downs from the MSA HHO has signed with DMMA. HHO ensures that all delegates undergo a pre-delegation audit, ensures routine reporting and evaluation of performance vis-à-vis the vendor scorecard, and ensures an annual delegation audit occurs within the required timeframe. Delegation oversight audit tools have been developed to capture both NCQA and Delaware specific requirements. Audit results are reported out at the NCQA and Delaware-specific requirement levels and CAPs are requested when results fall below established thresholds. CAP oversight is shared between the FBO and VMO. HHO retains the final determination on decisions affecting delegated relationships.

After review and evaluation of HHO's delegation oversight program the EQRO finds that HHO was compliant in how it conducted delegate oversight activities in 2020. The creation of the new VMO unit resulted in several process improvements including development of a delegate scorecard to track delegate compliance and performance, the implementation of the semi-annual delegate attestation process, establishment of the Vendor Oversight Governance Board, and rigorous oversight of Davis Vision's implementation progress of its CAPs all demonstrate HHOs commitment to building a strong and outcomes-oriented delegate oversight model. However, the RFI submission and in interviews with HHO leadership, HHO was not able to consistently identify the services delegated to each vendor. These inconsistencies make it difficult to ensure VMO activities conducted comport with the actual delegation scope of work assigned to each vendor.

The following tables provides a high-level overview by delegated entity and the associated delegated responsibilities.

Entity	Responsibilities
Delegation Oversight Conducted by Gateway	
CVS Health	Pharmacy Benefit Management, Provider Network Development and Management, Utilization/Benefit Management
Delegation Oversight Conducted by Health Options	
Highmark Inc./Shared Services	Provider Information Management, Credentialing
Gateway	Oversight of CVS Health
Davis Vision	Provider Network Development and Management, Claims Payment, Utilization/Benefit Management
eviCore (High Dollar Radiology)	UM Decision Making
Envolve	Nurse Advise Line
CCHS	Credentialing, Recredentialing, Primary Source Verification, Credentialing Committee
Nemours/A.I. DuPont	Credentialing, Recredentialing, Primary Source Verification, Credentialing Committee

Metric Description	2021 Score
The MCO has a clear P&P to evaluate a delegate, subcontractor or sister entities' compliance with State contract and federal requirements including pre-delegation, ongoing monitoring and oversight, and annual audits. The policy should indicate the ability to terminate delegated arrangements including requests from the State for termination. (5.1.2.1)	Substantially Met

Clinical Practice Guidelines and Coverage, and Authorization of Services

ACDE 2021 Findings and Recommendations

The UM department presents with strong internal leadership and an emphasis on the use of critical thinking to manage cases. UM staff are encouraged to consult with their peers for input on their cases when appropriate before involving supervisors, managers, and physicians. Interdisciplinary rounds are an opportunity for UM staff to obtain feedback and recommendations on complex cases. A trigger alert has been identified to facilitate cases that would benefit for referral by the UM staff to the CC team. The DMMA approved organizational chart depicted the key positions within the UM department both on a local and corporate level. All UM positions are local. The Regional President and Corporate Director of UM Operations positions provide corporate leadership and oversight to the local MCO positions, though it was reported there were plans to create a local director position.

The UM staffing is determined based on a calculation including estimated volume, productivity requirements, and shrinkage. UM leadership monitors incoming work, timelines, and staff performance through daily, weekly, and monthly reports and activities. Of note, there were several UM staffing summaries submitted that contained different counts of FTEs and it is unclear if the staffing plan is approved by DMMA.

UM decision making, timeframes, timeliness, tracking, and trending of UM denials are well defined through P&Ps. There are no services that require a PCP referral and covered services that require PA are transparent to both providers and members. The UM P&Ps are consistent and clearly state the policy and the process or procedure to be followed.

ACDE reports a comprehensive training plan is in place for UM to address the requirements of the P&Ps and support staff in performing job duties. An online portal (Anytime Learning) sends reminders for mandatory trainings, tracks completions, and generates a transcript of completed trainings. However, the desk materials submitted only included reference to three trainings in 2020.

UM decisions for LTSS services are authorized through LTSS CM; however, there is a subset of enhanced benefits that require PA. The P&Ps did not include the process for approval or the criteria used to make the decisions on authorizing this subset of enhanced benefits.

ACDE has four delegated arrangements that perform UM functions. The first is Avēsis, which manages the administration of the vision benefits; however, documentation clarifying the UM delegation was not included. The second is NIA, which manages radiology services and is delegated for the call center and UM. Both Avēsis and NIA are responsible for PA and peer-to-peer review functions. SKYGEN administers the adult dental benefit and is responsible for UM. Last, BHM Healthcare Solutions is delegated to perform UM for BH services. The oversight of these entities is coordinated by AmeriHealth Caritas Delegation Oversight Department who provides Delaware specific training and conducts audits. The Avēsis annual delegation audit conducted in September 2020 resulted in a UM score of 98% due to sending a denial letter to both the member and the provider. The status of the Avēsis 2020 CAP was unclear. The NIA audit completed in May 2020 resulted in a score of 100% for the call center and 98% for UM functions due to a finding that NIA was not taking the full 10 calendar days to collect information needed for the requests. A subsequent review demonstrated compliance with this process although only one case was available for the sample as the volume of denial and appeals is very low.

Metric Description	2021 Score
The MCO and its delegates have a process for assessing its staffing needs relative to UM and decision making. (3.21.2.1.11)	Minimally Met
UM staffing plan is complete and submitted to DMMA for approval. (3.12.2.2.1)	Partially Met
Organizational chart demonstrates how PH, BH, and LTSS UM functions are managed and coordinated within the MCO and across any delegates and/or sister entities. (3.4.1.2)	Partially Met
The MCO has training materials specific to UM that reflect Medicaid managed care federal requirements and DMMA specific contractual standards. This includes a roster of staff who completed the trainings in the year under review. (3.20.3)	Not Met
The MCO and its delegates have a training program that covers fundamental UM concepts, contractually required topics, and addresses federal regulatory requirements as well as a process for identifying and addressing ad hoc training needs based on audit or other self-evaluation activities. (3.20.3.7)	Minimally Met
The MCO has a process to evaluate the training program of its delegates responsible for UM decision making, this may include results of delegation oversight audits and/or agendas, minutes or reports presented at a joint operating/delegation oversight committee. (5.1.2.3.1)	Minimally Met
The MCO has a process to evaluate a delegated entity's compliance with federal requirements set forth under 42 CFR 438.210, which includes: UM, program structure, coverage, authorization of service, NOABD (standard authorization and expedited), and the compensation for utilization activities. (42 CFR 438.210)	Partially Met
The MCO has a process to evaluate the compliance of its delegates responsible for UM decision making. Delegation oversight tools and file review should clearly demonstrate evaluation of the delegate's UM program for compliance with requirements set forth under 42 CFR 438.210 and Delaware contract standards. (42 CFR 438.210)	Partially Met

Metric Description	2021 Score
The MCO has a well-defined UM work plan outlining all required UM activities, responsible parties, and timeline and deliverable dates. The UM work plan reflects the goals and objectives of the UM program description. There is evidence that the CMO, BH CMO, LTSS CMO, Health Services Director, UM coordinator, and the QM/QI coordinator are involved with developing the annual work plan and evaluation. (3.12.1.3)	Minimally Met
The MCO's medical necessity definition is consistent with the State's definition in the contract and when appropriate uses the Delaware American Society for Addiction Medicine (DE-ASAM) criteria for BH services. (3.4.5, 3.12.6.3.2)	Partially Met
The MCO has a process to monitor and ensure UM decisions for routine and expedited service requests meet required timeframes and that requests for extension, regardless of requestor, are clearly documented and available to DMMA or its designee for review. (3.12.6.5.2)	Partially Met
UM decision criteria/clinical guidelines are based on evidence-based practices and nationally recognized clinical standards or as required by DMMA for BH services (DE-ASAM criteria). The standards used are available to members and providers upon request and clearly documented in the NOABD. (3.12.6.3)	Partially Met
UM decision criteria are based on evidence-based practices and decisions for Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) participants receiving SUD services, members requiring organ transplants, and members with HIV/AIDS needing oral nutrition and are made by appropriately qualified staff and meet requirements of the DSHP Benefit Package. (3.4.2.2)	Partially Met
The MCO has a process to ensure that decisions for UM, member education, coverage of services, and other areas to which the practice guidelines apply are consistent with the guidelines. (42 CFR 438.236(d) and 3.13.6.3)	Partially Met
The MCO has a process to coordinate benefits provided by the State, such as dental services for children, prescribed pediatric extended care, day habilitation, non-emergency transport, specialized services as identified through Preadmission Screening and Resident Review (PASRR) assessments, Pathways employment services, and BH services (children and adult). The process also provides a means for coordination of benefits with Medicare, and with other State payment guidelines. (3.4.1.2)	Partially Met
The MCO has a process to coordinate UM decisions (e.g., pharmacy, high dollar radiology, BH, etc.) across business units, sister entities, delegates, and with input from assigned care coordinators or case managers. (3.4.1.2)	Partially Met
The MCO has a process to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. (42 CFR 438.206(c)(2))	Partially Met
The MCO has a process to ensure PH and BH UM decisions are coordinated and that the authorization process is consistent and seamless for members and/or providers. (3.4.1.2)	Substantially Met

HHO 2021 Findings and Recommendations

The structure and the vision of the UM department is described within the UM program description and reviewed comprehensively through the annual program evaluation. Ongoing oversight is provided through participation within the QI/UM committee. Tracking and trending of data is reviewed to evaluate the processes in place. The UM department oversight is led by the CMO, along with the Vice President of Care Management. Additional organizational structure includes the Director of UM with teams that report through a Manager of UM CC. Each UM team has a supervisor, licensed UM reviewers, and UM Support associates. All UM staff are 100% dedicated to HHO Delaware business. The Director of UM also oversees the delegated relationships with eviCore, Davis Vision, and UCD. It is not clear, however, the oversight plan or the process that is followed when a vision service requested is not granted. HHO's 2021 staffing plan was approved by DMMA in March 2021. HHO has made progress in the efforts to integrate UM with other internal departments including CC and CM.

UM decision-making and timeliness are well defined through P&Ps. UM processes, decisions, and notifications are made in accordance with applicable federal and State requirements, DMMA contract, and accrediting bodies such as NQCA. Covered services that require PA are transparent to both providers and members and there are no services that require a PCP referral. UM continues to follow the COVID-19 authorization guidelines implemented in March 2020/April 2020 with some authorization requirements waived or extended. HHO developed training and guidance to improve discharge planning but audits revealed three areas that did not meet the 85% threshold.

HHO submitted a robust training plan along with a plan to utilize Interqual as a certified trainer. Staff completed a baseline inter-rater reliability (IRR) assessment through training resources from the Interqual Learning Library in the Change Healthcare platform. BH UM reviewers also attended training sessions on the ASAM criteria.

HHO transitioned from NIA to eviCore in February 2021. Operational processes including reporting requirements, claims processes, and meeting cadence were aligned with HHO. HHO also developed a strong oversight plan that includes annual training, IRR, evidence of policies, meeting schedules, reporting, tracking and trending of data, and follow-up collaboration for members who have received a service denial.

Metric Description	2021 Score
The MCO has a process to evaluate a delegated entity's compliance with federal requirements set forth under 42 CFR 438.210, which includes: UM, program structure, coverage, authorization of service, NOABD (standard authorization and expedited), and the compensation for utilization activities. (42 CFR 438.210)	Minimally Met

Metric Description	2021 Score
The MCO has a formal approach to ensure a successful transition of care such that the P&P to identify, authorize, and ensure discharge planning needs are fully addressed identifies the roles and responsibilities of all individuals who may be taking part in the discharge planning process (i.e., PROMISE members, those with comprehensive needs or those at-risk for readmission). (3.12.2.1.13)	Partially Met
The MCO has a process to coordinate benefits provided by the State, such as dental services for children, prescribed pediatric extended care, day habilitation, non-emergency transport, specialized services as identified through PASRR assessments, Pathways employment services, and BH services (children and adult). The process also provides a means for coordination of benefits with Medicare, and with other State payment guidelines. (3.4.1.2)	Substantially Met
The MCO has a process to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. (42 CFR 438.206(c)(2))	Substantially Met

Enrollment and Disenrollment

ACDE 2021 Findings and Recommendations

ACDE has a well-defined process to onboard new enrollees that includes new member welcome calls, new member welcome kits, completion of a HRA, and in-person new member orientation meetings (video conferencing during the PHE). New members coming into ACDE are subject to a continuity period for any services and/or treatment plans that were in effect at the time of entry into managed care, regardless of whether the member transitioned from the fee-for-service system or another Medicaid MCO. ACDE's transition of care policies are consistent with regulatory requirements.

The State requires the use of the Member Transfer Continuity of Care Form to be used to exchange critical information between the sending and receiving MCO (for MCO-to-MCO transfers); this form is built into ACDE's Plan to Plan Transfer policy and supports ongoing service delivery during the transitional period. The required form includes information such as: open authorizations, current service providers, amount and duration of currently authorized services, recent ED or inpatient hospital stays, etc. When necessary the State or the sending MCO may exchange historical claim information with the receiving MCO to supplement information received on the State required form.

Per Federal regulation, members are able to switch to another MCO without cause within the first 90-days of enrollment, during the open enrollment period, or re-enroll with the same MCO under automatic re-enrollment after a short period of ineligibility. For cause termination, P&Ps are consistent with regulatory requirements and apply to instances such as lack of provider specialty or service availability, loss of a network direct service or other long-term services providers that may impact a member's housing situation (for members receiving DSHP Plus benefits), or for moral and religious objections over the services the member seeks. The MCO's

internal P&Ps evidence compliance with the federal requirements; while the MCO is afforded a right to request disenrollment of a member under certain circumstances, ACDE has not requested relief under this provision.

Should a member request disenrollment from the Medicaid program or request a transfer from ACDE to another MCO, ACDE directs those members to the State's Health Benefit Manager (HBM) for additional assistance. If during the interaction with the MCO, a member expresses dissatisfaction with an aspect of ACDE or the Medicaid program and requests disenrollment or a transfer, ACDE engages its Member Advocates to outreach and offer assistance to members to address unresolved concerns; they also assist members in moving through the transfer or disenrollment process.

Mechanisms to identify and notify the State of members whose circumstances may support disenrollment from ACDE and/or the Medicaid program are in place and are communicated to the State via the Weekly Issues spreadsheet; associated P&Ps are consistent with requirements. Reports submitted evidence compliance with requirements.

All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

HHO 2021 Findings and Recommendations

HHO has a well-defined process to onboard new enrollees that includes new member welcome calls, new member welcome kits, completion of a HRA, and in-person new member orientation meetings (Zoom video conferencing during the PHE). New members coming into HHO are subject to a continuity period for any services and/or treatment plans that were in effect at the time of entry into managed care, regardless of whether the member transitioned from the fee-for-service system or another Medicaid MCO. HHO's transition of care policies are consistent with regulatory requirements.

The State requires the use of the Member Transfer Continuity of Care Form to be used to exchange critical information between the sending and receiving MCO (for MCO-to-MCO transfers); this form is built into HHO's member transfers between MCOs policy and supports ongoing service delivery during the transitional period. The required form includes information such as: open authorizations, current service providers, amount and duration of currently authorized services, recent ED or inpatient hospital stays, etc. When necessary the State or the sending MCO may exchange historical claim information with the receiving MCO to supplement information received on the State required form.

Per federal regulation, members are able to switch to another MCO without cause within the first 90-days of enrollment, during the open enrollment period, or re-enroll with the same MCO under automatic re-enrollment after a short period of ineligibility. For cause termination P&P's are consistent with regulatory requirements and apply to instances such as lack of provider specialty or service availability, loss of a network direct service or other long-term services providers that may impact a member's housing situation (for

members receiving DSHP Plus benefits), or for moral and religious objections over the services the member seeks. While the MCO is afforded a right to request disenrollment of a member under certain circumstances and given the MCO's internal P&Ps evidence compliance with the federal requirements, HHO has not requested relief under this provision.

Should a member request disenrollment from the Medicaid program or request a transfer from HHO to another MCO, HHO directs those members to the State's HBM for additional assistance. Through its submitted policies and in interviews with HHO leadership, HHO does not appear to engage the Member Advocate should identified concerns about HHO be raised by the member. HHO may benefit from assessing member reasons for transfer and, as appropriate, engaging the Member Advocate or other MCO staff to outreach and offer assistance to members to address unresolved concerns; they could also assist members in moving through the transfer or disenrollment process such as having medical records transferred.

Mechanisms to identify and notify the State of members whose circumstances may support disenrollment from HHO and/or the Medicaid program are in place and are communicated to the State via the Weekly Issues spreadsheet; associated P&Ps are consistent with requirements. Reports submitted evidence compliance with requirements.

All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

Quality Assessment and Performance Improvement Program

ACDE 2021 Findings and Recommendations

There is strong leadership in the QM/QI department that is supported by senior leadership within ACDE. There is evidence of integration of quality throughout the organization as evidenced by Quality Assessment and Performance Improvement meeting minutes and team involvement in the development, implementation, and progress in PIPs. The 2020 Quality Improvement Program Evaluation includes a description of the QI activities and initiatives throughout 2020, including but not limited to the quality and safety of clinical care and quality of service activities. The evaluation includes a summary of overall QI program effectiveness. The analysis included evaluation of service indicators, provider satisfaction, evaluation of clinical care, evaluation of the LTSS program, and audit activities. The annual evaluation included a number of data analyses with conclusions and recommendations for improvement in 2021.

Cross-functional teams are used to support integration of QM/QI throughout the organization. Annual QM training is required for all and the curriculum includes specific examples to demonstrate how individual roles impact quality. The Quality Assessment and Performance Improvement committee met five times in 2020; committee minutes show appropriate discussion with a significant

amount of effort put into program document and report review and approval. The Quality of Service committee met six times in 2020. The MCO has a comprehensive continuity staffing plan and transition plan to ensure that QI initiatives continue in case of turnover within the department.

While the Peer Review subcommittee is part of the QM/QI committee structure and seems to be functioning well, it lacks a process for routine peer reviews of participating provider practice methods and patterns, including quality outcomes, prescribing patterns, morbidity/mortality rates, and QOC/quality of service grievances. The MCO will need to develop a process for these routine peer reviews in order for the Peer Review subcommittee to be effective. ACDE did not submit or demonstrate evidence of a policy, procedure, or workflow for initiation or approval of a member request to amend or correct the medical record. ACDE will need to establish a process for amendments/corrections to medical records when requested by members. ACDE has had some challenges with the submission of their Quarterly Clinical Reports. The reports have lacked data accuracy and completeness as well as staff knowledge in being able to fully respond to questions in regards to the data results.

Metric Description	2021 Score
The Peer Review subcommittee is part of the QM/QI committee structure and the CMO or designee chairs the committee. (3.13.7.1.6)	Substantially Met
The MCO complies with member request to amend or correct the medical record. (3.13.12.9)	Partially Met
The MCO creates, reviews, and approves all contractually required reports that ensures accuracy and timely submission. (Note: Review passed year QCMMR and Clinical Reports to identify ongoing areas of inaccuracy.) (3.21.1.2)	Partially Met

HHO 2021 Findings and Recommendations

The QM/QI department of HHO has faced significant challenges throughout the past several years. In 2017, the department did not evidence the anticipated maturation of the department expected since the MCO started operations in 2014. At the time of the 2018 EQR, positions were added to support expanded management of the QM/QI unit and program and to provide greater coordination of QM/QI activities. Early in 2019, it was determined that the department leadership and supporting staff were not meeting the need for improvement in the QM/QI department; an Acting Director of Quality stepped in to assess existing team members, QM/QI initiatives, and overall approach to QM and improvement throughout HHO. Early in 2020, HHO hired a Quality Director, fulfilling the contractual requirements for this position. Throughout 2020, the Quality Director assessed the QM/QI department staff and operations, assessed the need for additional staff, and approaches to quality initiatives; open positions were filled and new positions were added to the department. Additional positions of note are: the Strategy Program Manager position that is focused on the PCP profile, True Performance, Emergency Medical Record (EMR) Resident Assessment Protocol, Provider Liaison, and the four additional QM Analyst positions to support quality initiatives — particularly PIPs. The Strategy Program Manager position has been instrumental in gaining access to EMRs for improvement in collecting information to improve HEDIS rates. The QM Analyst positions are tasked with

driving improvement in the PIPs and working closely with the Performance Measurement team to ensure correct application of PIP measure specifications and to assess the effectiveness of interventions. With the additional staff and the current direction of the QM/QI department described below, the EQRO is cautiously optimistic about the direction in which the department is headed. Innovation and successful implementation and management of initiatives will be key to achieving the results the MCO anticipates.

The 2020 Quality Program Description contains appropriate goals and objectives and annual work plan; it also integrates information about the quality initiatives in place by subcontracted/delegated entities who serve the Delaware membership. The document describes the committee structure and the roles and responsibilities of the various subcommittees that report to the HHO QI/UM committee. The committee serves as the primary oversight body for those day-to-day functions as detailed in the QI and UM Program requirements of the State Managed Care Contract, Delaware Health and Social Services, and DMMA. The committee bylaws detail the QI/UM committee and internal QI subcommittee accountability structure, the purpose of the committees, the membership, and the function of committee meetings. The roster of committee members identified in the meeting agenda was lengthy; however, there was a significant number of members identified who did not attend any of the meetings in 2020. The roster of members should be reviewed to ensure that it is accurate and members should be held accountable for regular meeting attendance and participation.

One of the achievements identified by HHO for 2020 was monitoring and ameliorating health disparities through a systematic approach utilizing data to identify health disparities. The goals of the program are to ensure the delivery of culturally and linguistically appropriate services for the diverse HHO membership, focus on identified QI intervention opportunities that reduce health care disparities, and improve access to care. These efforts to leverage data to identify health disparities and implement interventions to reduce disparities are steps in the right direction, but the challenges of accurate and complete race, language, and ethnicity data persist, and the effectiveness of the efforts has not been fully assessed.

The annual evaluation of the QI/UM program includes a description of the QI and UM activities and initiatives throughout 2019. The analysis included evaluation of service indicators, consumer and provider satisfaction, evaluation of clinical care, evaluation of the LTSS program, audit activities, and recommendations for 2020. The annual evaluation included a number of data analyses, particularly related to HEDIS measures and quality PMs for value-based purchasing, with conclusions and recommendations for improvement noted.

The MCO conducted the Adult CAHPS, Child CAHPS, Adult Experience of Care and Health Outcomes (ECHO), Child ECHO, and a CM satisfaction survey to assess member satisfaction with the MCO and health care services. In response to the pandemic, NCQA released guidance about the HEDIS CAHPS program in March 2020. While NCQA did not extend the data submission deadline of May 2020, they did allow for modifications to the protocol. In April 2020, NCQA released additional guidance regarding scoring for Health Plan Ratings. While NCQA required submission of HEDIS and CAHPS data for commercial and Medicaid plans, they are not scoring plans using Health Plan Ratings in 2020. The top three adult CAHPS results for HHO were Rating of Specialist, Getting Care Quickly, and Getting Needed Care. The bottom three results in need of improvement were Coordination of Care, Customer Service,

and Rating of Personal Doctor. Overall, as compared to the scores in 2019, the 2020 Child CAHPS survey scores were high/improved in most areas with some opportunities for improvement in Getting Needed Care and Getting Care Quickly. Survey results are made available to members via newsletters. Overall, the 2020 Adult ECHO survey results were satisfactory. HHO's BH team provided information about different kinds of counseling/treatment and educating members about online support groups like Digital All Recovery and online Alcoholics Anonymous. To address the lowest scoring questions in the ECHO, HHO added staff training about the different treatment options and different types of peer-run supports and sober supports in the community.

One area under the purview of the QI/UM Department that warrants attention is provider profiling; the MCO has not taken a robust approach to ongoing provider profiling. Provider practice analysis should be reviewed regularly to assess a provider's practice methods and patterns, including quality outcomes, prescribing patterns, morbidity/mortality rates, and all grievances filed against the provider related to medical treatment. The MCO Peer Review committee, which should be responsible for this regular assessment, has not consistently met to review patterns and trends within a provider group or for an individual provider.

Metric Description	2021 Score
Departmental leads demonstrate active roles within PIPs and other QI initiatives.	Substantially Met
The MCO and its delegates have a training program that covers fundamental QM concepts and QI methodologies. (3.20.3.1)	Partially Met
The MCO has defined roles, functions, and responsibilities of the QM/QI committee that specify the following: • The committee has oversight responsibility and input on all QM/QI activities. • The committee is accountable to the MCO's executive management. • Membership includes a representative from the provider community and the member community. • At a minimum, regularly scheduled quarterly meetings. • Maintenance of appropriate documentation of committee meetings, activities, findings, recommendations, and actions. • Departmental leads actively participate in the Delaware Quality committee. (3.13.1.4.2)	Substantially Met
The MCO participates in efforts to prevent, detect, and remediate CIs. (42 CFR 438.330 (b) and 3.13.3.5)	Partially Met
The MCO participates in efforts to improve health disparities identified through data collection. (3.13.3.6)	Substantially Met

Metric Description	2021 Score
The MCO has a process in place to regularly evaluate services provided to members and identify areas for improvement. This process includes analysis of: • Over- and under-utilization of services. • Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. • Member satisfaction. • Provider satisfaction. • CIs. • Grievances and appeals. (42 CFR 438.330 (b) and 3.13.3)	Partially Met
The MCO P&Ps ensures that medical records are preserved and maintained for a minimum of seven years after contract. (3.13.12.10)	Not Met
The MCO has a CI management system that includes reporting, documenting, and investigating CIs in compliance with State law and policy. (3.13.9.1)	Partially Met
The MCO provider practice analysis includes review of a provider's practice methods and patterns, including quality outcomes, prescribing patterns, morbidity/mortality rates, and all grievances filed against the provider related to medical treatment. (3.13.7.1.1)	Partially Met
The MCO provider practice analysis includes implementation of a CAP, if necessary. (3.13.7.1.3)	Partially Met
The MCO provider practice analysis includes development of policy recommendations to maintain or enhance the QOC provided to members. (3.13.7.1.4)	Partially Met
The MCO provider practice analysis includes a review of the appropriateness of diagnosis and subsequent treatment, maintenance of provider medical/case records, and adherence to generally accepted standards in terms of outcome and care. (3.13.7.1.5)	Partially Met
The MCO peer review process includes receipt and review of all written and oral allegations of inappropriate or aberrant service by a provider. (3.13.7.1.7)	Partially Met

Coordination and Continuity — Primary Care and Special Health Care Needs

ACDE 2021 Findings and Recommendations

The MCO began operations in Delaware in 2018 and has, since the inception of the program, struggled to meet contractual requirements for the provision of a comprehensive CC program. Challenges include, but are not limited to, turnover in the Health Services Director position; significant difficulty developing and validating a functional risk stratification plan and methodology; inability to maintain contractually required Level 2 CCC staff ratios; the absence of a formal Training Plan; failure to ensure integration of PH

and BH, including SUDs; inability to develop and implement member case file audit processes that evaluate both quantitative and qualitative aspects of CC provided to members; and failure to address longstanding non-compliance identified in EQR CAPs.

The MCO lacks nationally recognized standards for the CC program that address core competencies for care coordinators and evidence-based disease management standards for CC of members with PH conditions, BH conditions, and SUDs. There is little evidence that CC supports meet the needs of members with HRSNs. There is a need to develop standards and processes for the provision of integrated CC in order to addresses members' PH, BH, and SUDs.

The MCO lacks an effective infrastructure for the CC program, including processes, workflows, job aids, and desk level procedures to operationalize contract specific requirements and to ensure internal operating P&Ps are consistently communicated and followed.

A comprehensive CC training plan for initial orientation and ongoing training for all levels of CC is needed. The plan should demonstrate compliance with contract requirements and include an evaluation component to ensure the training provided results in the provision of competent, evidence-based CC at all levels.

The MCO has struggled to develop and validate a risk stratification plan and methodology for the CC program. The risk stratification plan was updated and revised in the fourth quarter of 2020 and the MCO provided documentation indicating validation of the methodology was completed; however, based on member case file reviews, it appears members with multiple comorbidities and complex conditions are being assigned to Level 1 Resource Coordination as opposed to the more appropriate Level 2 CCC.

A formal QI process is needed to evaluate the extent to which the CC is meeting State, MCO, and member goals and objectives. The process should address how member case file reviews are conducted to ensure files reflect appropriate outreach, assessment, care planning (when appropriate), follow-up to member identified needs, and fidelity to generally accepted medical record documentation standards.

All Member Level Coordination

The MCO's efforts to complete HRAs with at least 50% of new members within 60 days of enrollment have not resulted in compliance with contractual requirements.

Level I Resource Coordination

The MCO has been unable to develop an effective Level 1 Resource Coordination program, struggles with member engagement, and has failed to demonstrate that members being discharged from inpatient facilities are receiving effective discharge or transition supports. In addition, there is evidence in member case files suggesting that members with complex needs are being stratified for Level 1 Resource Coordination and assigned to resource coordinators who do not have the requisite expertise to manage these

members. The MCO lacks functional processes for ensuring members are appropriately reassigned to Level 2 CCC when appropriate and does not have effective member case file auditing processes in place to assess the extent to which members are receiving appropriate resource coordination supports.

Level 1 Resource Coordination File Review

Mercer completed a review of 15 Level 1 Resource Coordination files. The files were reviewed for compliance with contract standards and to evaluate the extent to which the cases successfully met the four domains identified on the standardized scoring tool: Outreach and Engagement, Coordination of Care, Condition Management and BH/SUD, and HRSNs. Domains were scored as “substantially met” when all or most of the expectations for resource coordination were reached and documented appropriately. Domains were scored as “partially met” when documentation reflected that some resource coordination activity was present. Domains were scored as “not met” when documentation demonstrated that resource coordination expectations were not reached. For members who were reached and declined resource coordination, the Outreach and Engagement domain was the only domain that could be assessed, so all subsequent domains were scored as “Not Applicable” (N/A). For the members who were unable to be reached, the only domain that was able to be scored was Outreach and Engagement, so all subsequent domains were scored as N/A.

The preliminary findings were reviewed with DMMA and ACDE at the onsite interview and two member records were reviewed in the ACDE CC system.

Of the 15 Level 1 Resource Coordination case files reviewed, only five were outreached, engaged, and able to be fully scored and evaluated. Four members declined resource coordination, three were never reached, and one was initially reached and then agreed to the program but was lost to care. Two cases were not able to be scored, as there were no outreach attempts made directly to the member within the review period. Of the five fully scored cases, scores ranged from 0% to 100%. Many of the members had significant medical or BH conditions that appeared to be too complex for Level 1 Resource Coordination.

The following chart displays the strengths and weaknesses broken down by domains. Please consider that not all sections of the case files could be scored as the numerator of outreached and engaged members was very small.

Review Area	Strengths	Opportunities
Outreach and Engagement	Resources coordinators generally made outreach calls per protocol and outreached pharmacies and other providers to obtain accurate contact information.	There were missed opportunities to outreach hospitalized members or those routinely seeking treatment, such as a daily methadone provider. Several members were initially reached but not engaged long enough to develop a plan of care or address any identified needs. Risk stratification was an issue in most of the cases reviewed. Many of the files reviewed included information indicating a potential need for restratification. Many of the Level 1 cases were quite complex and could have benefited from a referral to Level 2.
Coordination of Care	One file had documented attempts to completed foster care outreach and coordinate with Department of Services for Children, Youth and their Families caseworker.	Members were referred to resource coordination post hospitalization but if member was not reached, there was no evidence of outreach to the provider to determine if the appointment was kept.
Condition Management/BH SUD	The 24 hour a day, seven days a week Nurse Line and Member Services phone number were provided to several members.	Many files indicated a SUD but this was rarely addressed in the notes nor was the care coordinated with a SUD provider.
HRSNs	When screenings were completed, members were asked about food, transportation, housing, and other HRSN.	While resources were provided when a need was identified in some cases, follow-up was not routinely provided to close the loop and ensure that the member had made contact with the resources provided and that the member's needs were then met.

Level 2 Clinical Care Coordination

The MCO has been unable to develop an effective Level 2 CCC program or address noncompliance with Level 2 CCC caseload ratios. The MCO lacks effective member case file auditing process to assess the extent to which members are receiving appropriate CC supports, including comprehensive assessment of member PH, BH, substance use, and HRSNs. Evidence of comprehensive, member centric care planning was not found.

Level 2 Clinical Care Coordination File Review

Mercer completed a review of 15 Level 2 CCC files. The files were reviewed for compliance with contract standards and to evaluate the extent to which the cases successfully met the five domains identified on the standardized scoring tool: Outreach and Engagement, HRSNs, Assessment, Coordination of Care, and Care Plan Development. Domains were scored as “substantially met” when all or most of the expectations for CC were reached and documented appropriately. Domains were scored as “partially met” when documentation reflected that some CC activity was present. Domains were scored as “not met” when documentation demonstrated that CC expectations were not reached. For members who were reached and declined CC, the Outreach and Engagement domain was the only domain that could be assessed, so all subsequent domains were scored as N/A. For the members who were unable to be reached, the only domain that was able to be scored was Outreach and Engagement, so all subsequent domains were scored as N/A.

Of the 15 Level 2 CCC case files reviewed, only six were outreached, engaged, and able to be fully scored and evaluated. One member declined CC, and nine were never reached. Of the six fully scored cases, scores ranged from 45% to 75%.

The following chart displays the strengths and weaknesses broken down by domains. Please consider that not all sections of the case files could be scored as the numerator of outreached and engaged members was very small.

Review Area	Strengths	Opportunities
Outreach and Engagement	Members who were reached were largely agreeable to enroll in CC. Care coordinators routinely used language line interpreters for members who did not speak English as a primary language.	In many cases, members agreed to enroll in CC upon initial engagement, but then were unable to reach or opted out during follow-up outreach for assessment. There are significant challenges in reaching members or maintaining engagement with members. There were missed opportunities for outreach during member hospitalizations.
HRSNs	When screenings were completed, members were asked about food, transportation, housing, and other HRSN.	While resources were provided when a need was identified in some cases, follow-up was not routinely provided to close the loop and ensure that the member had made contact with the resources provided and that the member’s needs were then met.

Review Area	Strengths	Opportunities
Assessment	When members were reached and agreed to the program, the care coordinator started the assessment.	Although gaps in care were routinely identified in the file, the interventions to address them largely consisted of informing the member; there was little evidence of gaps in care being closed. Many scored cases had incomplete assessments due to inconsistent contact with members.
Coordination of Care	One case demonstrates effective support and coordination of services to the parent of a young child.	There is not consistent internal coordination between Level 1 and Level 2 programs. Collaboration with PCP, BH SUD, and other providers was inconsistent in the scored cases.
Care Plan Development	When members were engaged, the care coordinator started the care planning process.	Most scored cases had incomplete plans of care due to inconsistent contact with the member. One care plan was developed but never shared with the parent.

Metric Description	2021 Score
The MCO has an organizational chart for the CC program that includes the names of senior and departmental management, the number of FTEs per department/position, the staff supporting the Delaware population, including those shared across other State programs (if applicable), and notes staff situated in Delaware and identifies any open positions. (Note: Assess organizational chart for all three levels of CC.) (3.20.1)	Partially Met
The MCO and its delegates have a process for assessing its staffing needs relative to mandated caseload requirements and CC decision making. (Note: Assess staffing approach and caseloads to address all three levels of CC.) (3.6.3.4.3.4)	Minimally Met
The MCO has a process to ensure that staff who require supervision, including clinical care coordinators, are provided adequate supervision by qualified staff. Supervisor to clinical care coordinator should not exceed 1:15. (Note: Assess for all three levels of CC.) (3.6.3.4.3.5.1)	Minimally Met
The MCO has field based staff allocated by county and can adjust based on membership thresholds to support appointment referral and linkage requirements. Clinical care coordinator caseloads should not exceed a ratio of 1:50. The job responsibilities and qualifications by position are appropriate and certification standards are met where appropriate. Staffing should reflect assignment of a nurse and social worker as care coordinators to any member receiving more than eight hours of Private Duty Nursing. (3.6.3.2.2.3.1, 3.6.3.4.3.2, 3.6.3.4.3.4, 3.7.1.5.3)	Minimally Met

Metric Description	2021 Score
The MCO has designated, qualified BH specialists to support the needs of members with BH and substance use treatment needs. (3.20.1.1)	Partially Met
The MCO ensures that care coordinators are provided with adequate orientation and ongoing training and maintains documentation of training dates and staff attendance as well as copies of materials used. (3.6.3.4.3.3)	Partially Met
The MCO provided data regarding HRA completion, evidences compliance with 60-day outreach standard and demonstrates active outreach and engagement within the first 30 days. (3.6.2)	Partially Met
The MCO has an integrated CC program that eliminates fragmentation in care and promotes education, communication, and access to health information for members and providers to optimize QOC and member health outcomes. The CC program is based on risk stratification and rooted in a population health model, touches members across the entire care continuum, promotes healthy behaviors, provides face-to-face (or virtual) CC as needed, and is supported by evidence-based medicine and national best practices. (3.6.1.1, 3.6.1.2)	Minimally Met
The MCO has a well-defined process to ensure comprehensive CC to all members based on member's risk level. CC efforts incorporate pharmacy, BH providers, Division of Substance Abuse and Mental Health (DSAMH), and other community-based entities including school-based wellness centers. The process should address coordination of PH and BH conditions and social determinants of health needs. (3.6.1)	Minimally Met
The MCO provided data, regarding CC stratification and outreach, demonstrating successful strategies for outreach and engagement of members in appropriate levels of CC. (3.6.3.1)	Partially Met
The MCO's predictive model identifies eligible Level 1 members and includes the following conditions/factors: pregnancy, one or more chronic conditions, gaps in preventive care, comorbid PH-BH conditions, high inpatient utilization, polypharmacy, and high rates of low-acuity, non-emergent (LANE) ED utilization. The MCO's predictive model identifies eligible Level 2 members and includes the following conditions/factors: multiple chronic conditions, complex service needs, history of poor outcomes, utilization patterns that suggest linkage to primary and preventative care, or other indicators of high-risk or potential for poor outcomes. (3.6.2.2.2, 3.6.2.2.1)	Partially Met
The MCO's CC program incorporates clinical practice guidelines, cultural, and linguistic needs and demonstrates coordination between PH and BH providers. (3.6.4)	Partially Met
The MCO's CC program provides identification of and assistance with securing an ongoing source of primary care including access to a specialist, if appropriate. Care coordinators can identify primary care panel status and make referrals to the network unit when provider information is inaccurate and requires correction. (3.6.3.4.6.2)	Not Met
The MCO has a documented process to identify and track gaps in care inclusive of all elements of EPSDT services and applicable HEDIS measures. (3.4.6.3.4, 3.6.3.4.6.2.7)	Partially Met
The MCO has a process to identify and refer members who could benefit from a wellness program. (3.6.3.2.2.1)	Partially Met

Metric Description	2021 Score
The MCO has a process to utilize stratification results to identify members most appropriate for Level 1 Resource Coordination CC and such a process includes the ability to restratify a member to a higher level. (3.6.2.5)	Partially Met
The MCO provides orientation and ongoing training for resource coordinators on subjects relevant to the population served. The MCO maintains documentation of training dates and staff attendance as well as copies of materials used. (3.6.2.10.3.2)	Partially Met
The MCO has created a threshold for high rates of LANE ED utilization, which determines the members identified for outreach and engagement into the primary care setting. The MCO has a process to actively outreach and engage members who have reached the threshold of having LANE ED utilization and has taken steps to identify and remove barriers as well as coordinate linkage to primary care services to mitigate further LANE ED utilization. (3.6.3.3.2, 3.6.3.3.2)	Partially Met
The MCO has a process to actively engage PCPs whose members have reached the established threshold for LANE ED utilization that incorporates other business units such as quality and/or provider services to identify barriers and influence PCP behavior, as appropriate. (3.6.3.3.2)	Not Met
The MCO uses CQI activities to reduce LANE ED utilization and address identified barriers to primary care. (3.6.3.3.2)	Minimally Met
The MCO has a process to identify hospitalized members experiencing an acute episode of care (i.e., acute inpatient, psych inpatient, ambulatory surgery, inpatient rehabilitation) in a timely manner. The process should include how discharge planning activities (e.g., appointments, referrals and linkages to services, coordination of DME, PA) are conducted after-hours, weekends, and holidays. (3.6.3.3.1)	Minimally Met
The MCO has a process for outreaching to members experiencing an acute episode of care (i.e., acute inpatient, psych inpatient, ambulatory surgery, inpatient rehabilitation) to assist with identification and coordination of discharge planning needs (e.g., appointments, referrals and linkages to services, coordination of DME, PA). (3.6.3.3.1)	Minimally Met
The MCO has a process to assist providers (e.g., hospital case managers, social workers) in discharge planning activities for Level 1 members to ensure all services are authorized and equipment delivered to support the transition of care. (3.6.3.3.1)	Minimally Met
The MCO engages CQI efforts to enhance transition and discharge planning, reduce readmissions, and improve member experience and outcomes of care. (3.6.3.2.1.2.1)	Not Met
The MCO has a process to monitor and oversee non-clinical resource coordinators, including appropriate supervisor to staff ratios, conducting IRR and file audits, taking action on identified gaps in knowledge, and variance from approved processes. (3.6.3.3.1)	Minimally Met
The MCO has a process to evaluate the success of the Resource Coordination Program, which includes metrics and benchmarks for performance, activities to close identified gaps or variances, and incorporates CQI activities. (3.6.8.1)	Partially Met

Metric Description	2021 Score
The MCO has P&Ps that indicate all initial outreach occurs within 15 days of member being identified as eligible; with a minimum of five attempts made within the first 90 days, including at least one documented face-to-face (or virtual) attempt. If after 90 days or member declines participation, the Clinical Care Coordinator notes all outreach attempts and can close the case. If the member is identified as high-risk, BH or SUD, the MCO outreaches to DMMA, DSAMH, Division of Developmental Disabilities Services, or other agencies or providers prior to closing the case. (3.6.3.4.4.2)	Partially Met
The MCO's P&Ps require clinical care coordinators to outreach to eligible members within 30 calendar days to complete a comprehensive assessment (e.g., PH, BH, social, environmental, cultural, psychological needs) including input from the member's caregivers, family, PCP, and other providers, as appropriate. All outreach and coordination efforts are documented within the member's file and demonstrate active and good faith efforts to incorporate provider involvement in CC activities. (3.6.3.4.5.1-3.6.3.4.5.3)	Partially Met
The MCO's P&Ps, file reviews, and/or tracer scenarios evidence person-centered planning processes. All plans of care include at a minimum prioritized goals and actions, effective and comprehensive transition of care plan, a communication plan with PCP and other providers, list of providers delivering services to the member, listing of other services received by programs other than those provided by the MCO (to avoid duplication), evidence of referral to community or social support services, HRSNs, frequency of ongoing member contacts, and identification and plans to close gaps in care. Documentation demonstrates that a member receives a copy of their plan of care. (3.6.3.4.6.2)	Partially Met
The MCO has a process to monitor care plans and initiate updates and revisions to member's plan of care, as necessary. This includes a minimum of one face-to-face/virtual contact every six months with members enrolled in Level 2 CCC and requires documentation of all outreach attempts. (3.6.3.4.7)	Partially Met
Supervisors and Level 2 CCC staff receive reports to monitor timeliness of outreach efforts and consistency with outreach and contact timeframes and develop staff and/or departmental corrective actions, if necessary. (3.21.6.1.3)	Minimally Met
The MCO has tools and processes to conduct IRR and Level 2 CCC file audits, taking action on identified gaps in knowledge and variance from approved processes. The file audit tool assesses completeness of the plan of care addressing member needs and personal goals. The goals must be specific and measurable with achievement timeframes and desired outcomes. (3.6.3.4.6.3, 3.6.3.4.6.4)	Partially Met
The MCO has a process to evaluate the success of the Level 2 CCC Program, which includes metrics and benchmarks for performance, activities to close identified gaps or variances, and incorporates CQI activities. (3.6.2.3, 3.21.6.2)	Partially Met

HHO 2021 Findings and Recommendations

The MCO has a strong and effective infrastructure for the CC program inclusive of processes, workflows, job aids, and desk level procedures, which support ongoing operations and ensure contract requirements are met. There is a comprehensive CC training plan that addresses both initial and ongoing training. The MCO has maintained consistent and competent leadership for the CC program

and the MCO resource coordinators and clinical care coordinators demonstrate a commitment to improving the lives of Medicaid members.

The MCO demonstrated assertive outreach and support during the COVID-19 PHE and has begun the process of reinstating community-based face-to-face CC visits, including visits with incarcerated members. The MCO has developed and implemented strong oversight and focused case file auditing processes and utilizes audit findings to address individual and systemic issues.

All Member Level Coordination

The MCO has increased HRA completion rates based on enhanced outreach and through incentive offers.

Level I Resource Coordination

The MCO is in the process of developing a plan for implementing the Coleman Discharge Planning Model in an effort to improve discharge and transition supports to members with complex needs. The MCO recently revised its risk stratification plan and methodology where the majority of revisions are in compliance with contract standards; however, the MCO needs to address gaps in the approach to risk stratification for members being discharged from inpatient PH and BH stays to ensure assignment to Level 2 CCC when appropriate. The MCO also needs to evaluate the role and expectations of Level 1 resource coordinators to ensure they are not making clinical judgements that are beyond their scope of knowledge or expertise, particularly as it relates to member risk stratification.

Level 1 Resource Coordination File Review

Mercer completed a review of 15 Level 1 Resource Coordination files. The files were reviewed for compliance with contract standards and to evaluate the extent to which the cases successfully met the four domains identified on the standardized scoring tool: Outreach and Engagement, Coordination of Care, Condition Management and BH SUD, and HRSNs. Domains were scored as “substantially met” when all or most of the expectations for resource coordination were reached and documented appropriately. Domains were scored as “partially met” when documentation reflected that some resource coordination activity was present. Domains were scored as “not met” when documentation demonstrated that resource coordination expectations were not reached. For members who were reached and declined resource coordination or who were unable to be reached, the Outreach and Engagement domain was the only domain that could be assessed, so all subsequent domains were scored as N/A. The member files were submitted in a well-organized format.

The preliminary findings were reviewed with DMMA and HHO at the virtual onsite interview. During the interview, two member records were reviewed in the HHO CC system and it was recommended they review a third case independently due to the medical complexity of the case.

Of the 15 Level 1 Resource Coordination case files reviewed, three members were successfully outreached, engaged, and able to be fully scored and evaluated. Eight members declined resource coordination, two were never reached, and two were initially reached, agreed to the program but then could no longer be contacted. Of the three fully scored cases, one scored 30%, one scored 58%, and the highest score was 85%. Many of the members had significant medical or BH conditions that appeared to be outside of the scope of practice for Level 1 Resource Coordination.

The following chart displays the findings by domains, identifying strengths and opportunities. Please consider that not all sections of the case files could be scored as some members were unable to be reached or declined to participate in resource coordination, thus the numerator of outreached and engaged members was very small.

Review Area	Strengths	Opportunities
Outreach and Engagement	The files demonstrated a great deal of outreach activities.	There were missed opportunities to outreach hospitalized members. There is a recurrent issue of needs being identified on the initial call and then subsequent efforts to engage or reach the member are unsuccessful, leaving needs unaddressed. The MCO may benefit from ensuring assistance is offered during the initial touch point to engage the member. Stratification was an issue in most of the cases reviewed. Many of the Level 1 cases were quite complex and could have benefited from a referral to level 2. While some cases were restratified numerous times, there was not any reference to previous outreach attempts or member participation/declination. Notes from resource coordinators often indicate a scripted process and an inability to understand the clinical picture, affecting their ability to refer appropriately.
Coordination of Care	One file demonstrated that the resource coordinator appropriately suggested a referral to LTSS. In another case, the UM department coordinated with the resource coordinator to help secure an appointment.	The files contained appropriate referrals and coordination; however, there was not documentation indicating confirmation of the referred services.

Review Area	Strengths	Opportunities
Condition Management and BH SUD	The 24 hours a day, seven days a week Nurse Line and Member Services phone number were provided to several members.	BH conditions were not routinely addressed; for instance, a 17 year old post-partum woman with a history of MH counseling and an Edinburgh scale of 10 was not acknowledged as a concern or referred to treatment.
HRSNs	In one case, the resource coordinator assisted a new mother with receiving a pack and play through the HHO incentive program.	While resources were provided when a need was identified in some cases, follow-up was not routinely provided to close the loop and ensure that the member had made contact with the resources provided and that the member's needs were then met.

Level 2 Clinical Care Coordination

The MCO has formalized the use of evidence-based disease management standards for CC and is working to reduce care coordinator ratios below the required level in order to allow care coordinators more time to address the needs of complex members. The MCO needs to continue its efforts to audit member files to ensure care coordinators are consistently utilizing disease management standards and to ensure member case files reflect appropriate assessment, care planning, follow-up to identified member needs, and documentation standards.

Level 2 Clinical Care Coordination File Review

Mercer completed a review of 15 Level 2 CCC files. The files were reviewed for compliance with contract standards and to evaluate the extent to which the cases successfully met the five domains identified on the standardized scoring tool: Outreach and Engagement, HRSNs, Assessment, Coordination of Care, and Care Plan Development. Domains were scored as "substantially met" when all or most of the expectations for CC were reached and documented appropriately. Domains were scored as "partially met" when documentation reflected that some CC activity was present. Domains were scored as "not met" when documentation demonstrated that CC expectations were not reached. For members who were reached and declined CC, the Outreach and Engagement domain was the only domain that could be assessed, so all subsequent domains were scored as N/A. For the members who were unable to be reached, the only domain that was able to be scored was Outreach and Engagement, so all subsequent domains were scored as N/A.

Of the 15 Level 2 CCC case files reviewed, nine were outreached, engaged, and able to be fully scored and evaluated. Three members declined CC, two were never reached although efforts were made to communicate with inpatient providers, and one person was reached and agreed to the program but was lost to follow-up. Of the nine fully scored cases, scores ranged from 25% to 100%.

The following chart displays the findings by domains, identifying strengths and opportunities. Please consider that not all sections of the case files could be scored as some members were unable to be reached or declined to participate in CCC, thus the numerator of outreached and engaged members was limited to nine individuals.

Review Area	Strengths	Opportunities
Outreach and Engagement	Members who were reached were largely agreeable to enroll in CC. The files demonstrated a great deal of outreach activities.	In many cases, members agreed to enroll in CC upon initial engagement, but then were unable to be reached consistently. Members are outreached when they restratify, which occurs frequently, but there is not reference to previous attempts to outreach or of member declining or participating in the program.
HRSNs	When screenings were completed, members were asked about food, transportation, housing, and other HRSNs and needs were documented. One case demonstrated assistance in arranging transportation through Logisticare.	While resources were provided when a need was identified in some cases, follow-up was not routinely provided to close the loop and ensure that the member had made contact with the resources provided and that the member's needs were then met.
Assessment	When members were engaged, care coordinators made attempts to complete the assessment.	Many scored cases had incomplete assessments due to inconsistent contact with members. Other assessments were not consistently dated, making it difficult to evaluate compliance with timeframes.
Coordination of Care	Several cases demonstrated coordination between the care coordinator and inpatient social workers for hospitalized members.	There is not consistent internal coordination between Level 1 Resource Coordination and Level 2 CCC programs. Members appear to stratify between Level 1 and Lever 2 without clear internal communication or acknowledgement of transition. Collaboration with PCP, BH SUD, and other providers was inconsistent in the scored cases. Lengthy wait for PROMISE services results in unmet BH needs and poor outcomes.

Review Area	Strengths	Opportunities
Care Plan Development	Gaps in care were routinely identified.	Gaps in care were not adequately addressed beyond reminding the member that a test or screening was overdue. Most scored cases had incomplete plans of care due to inconsistent contact with the member. It was unclear if plan of care was shared with member or providers in some cases.

Metric Description	2019 Score
The MCO's predictive model identifies eligible Level 1 members and includes the following conditions/factors: pregnancy, one or more chronic conditions, gaps in preventive care, comorbid PH-BH conditions, high inpatient utilization, polypharmacy, or high rates of LANE ED utilization. The MCO's predictive model identifies eligible Level 2 members and includes the following conditions/factors: multiple chronic conditions, complex service needs, history of poor outcomes, utilization patterns that suggest linkage to primary and preventative care, or other indicators of high-risk or potential for poor outcomes. (3.6.2.2.2, 3.6.2.2.1)	Substantially Met
The MCO has developed a program to implement wellness programs within network providers and to train providers on wellness activities. The MCO has a DMMA approved Wellness Provider Training plan. (3.6.3.2.3.4, 3.6.3.2.3.3)	Substantially Met
The MCO has a process to utilize stratification results to identify members most appropriate for Level 1 Resource Coordination CC and such a process includes the ability to restratify a member to a higher level. (3.6.2.5)	Substantially Met
The MCO has P&Ps that indicate all initial outreach occurs within 15 days of member being identified as eligible; with a minimum of five attempts made within the first 90 days, including at least one documented face-to-face (or virtual) attempt. If after 90 days or member declines participation, the CCC notes all outreach attempts and can close the case. If the member is identified as high-risk, BH, or SUD, the MCO outreaches to DMMA, DSAMH, Division of Developmental Disabilities Services, or other agencies or providers prior to closing the case. (3.6.3.4.4.2)	Partially Met
The MCO's P&Ps require clinical care coordinators to outreach to eligible members within 30 calendar days to complete a comprehensive assessment (e.g., PH, BH, social, environmental, cultural, psychological needs) including input from the member's caregivers, family, PCP, and other providers as appropriate. All outreach and coordination efforts are documented within the member's file and demonstrate active and good faith efforts to incorporate provider involvement in CC activities. (3.6.3.4.5.1-3.6.3.4.5.3)	Substantially Met
Supervisors and Level 2 CCC staff receive reports to monitor timeliness of outreach efforts and consistency with outreach and contact timeframes and develop staff and/or departmental corrective actions, if necessary. (3.21.6.1.3)	Partially Met

Dental

On September 21, 2020, Mercer conducted a readiness review of both ACDE's and HHO's ability to effectively delivery a new dental benefit for the State's adult Medicaid population. A post-implementation review was planned for Quarter 1, 2021. To complete a more comprehensive post-implementation review, DMMA requested that Mercer conduct the review as part of the annual EQR and include data through Quarter 1, 2021.

To evaluate compliance with contractual requirements regarding dental services, Mercer conducted a thorough review of both MCO's policies, procedures, and supporting documentation including dental program management structure, program highlights and updates since the October 1, 2020 go-live date, and P&Ps to address issues or concerns identified during the readiness review. This review was conducted based on information submitted by the MCOs through the RFI and through virtual onsite meetings held August 3, 2021–August 5, 2021 for ACDE and August 10, 2021–August 12, 2021 for HHO.

ACDE 2021 Findings and Recommendations

Mercer performed a complete compliance review, with a particular focus on areas of opportunity identified during the readiness review. Of the six opportunities identified during readiness review, two remain: develop a process for SKYGEN to report provider satisfaction survey results; and SKYGEN to finalize and implement third-party liability P&Ps regarding member claims and recoupment efforts. Overall, Mercer found minor issues regarding the MCO's ability to manage the adult dental benefit. ACDE demonstrates appropriate oversight of their Dental Benefit Manager evidenced by the 2020 Annual Delegation Review memo and the Quarter 1, 2021 audit. SKYGEN is delegated provider call center functions, provider network management, UM, claims processing and payment, and provider appeals and complaints.

An opportunity for improvement exists with SKYGEN's process for PA of the emergency/extended dental benefit. When SKYGEN receives a PA request that does not contain enough supportive documentation to make a favorable determination, the PA automatically denies and there is no follow-up with the provider to gain additional information. The provider (on the member's behalf) must submit an appeal for a redetermination. This creates an administrative burden for providers, which may limit how many members utilize the extended benefit. For example, more than half of PAs submitted for access to the emergency/extended benefit in Quarter 4, 2020 and Quarter 1, 2021 were denied, but only one appeal was submitted. SKYGEN should review current predetermination policies and revise to align with ACDE's policy *to make reasonable efforts to contact the requesting provider to bridge any gap in information, clarify medical needs, and reach agreement on a plan of care that will meet the member's needs* (ACDE Utilization Management Program Description 2020). This should also include an opportunity for peer-to-peer discussion.

Metric Description	2021 Score
The MCO provided a copy of the Dental Benefit Manager contract. (5.1.2.2)	Not Met
The MCO has policies, procedures, and adopted clinical guidelines for PA of covered dental services. (3.12.6.5)	Partially Met

HHO 2021 Findings and Recommendations

Of the four opportunities identified during the readiness review, none remain unaddressed. UCD receives member grievances through the call center and forwards a service form to HHO for follow-up and resolution. As part of vendor oversight, HHO should ensure that member grievances received by UCD are recognized for tracking and trending purposes by HHO. As of the date of the virtual MCO interviews, HHO had not conducted an audit of UCD's call center to ensure that all grievances are being identified and handled appropriately. Based on virtual onsite interviews the following items do not warrant a CAP, however HHO and UCD should review P&Ps, and provider educational materials for consistency and applicability to the State's adult dental program.

All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

Section 4
Validation of Performance Measures

The PM review process included a review of the written desk P&Ps that are followed when the reports and measure scores are generated. As a cornerstone of the review, the assessment and applicability of the CMS protocol entitled "Validating Performance Measures" was completed. This protocol's goal was guiding the assessment of the compliance with identified specifications applicable to each PM. The measures reviewed for 2021 included a combination of CMS adult and pediatric core measures, as well as QCMMR measures. To assess the compliance, some of the adult and pediatric core measures selected relied on the hybrid method to calculate the scores.

Compliance Findings

High Confidence	Moderate Confidence	Low Confidence	No Confidence
All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.	After review of the documentation and discussion with MCO staff, it is determined that the MCO has met most of the requirements as required for the Met category.	MCO staff describes and verifies the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice.	After review of the documentation and discussion with MCO staff, it is determined that although some requirements have been met, the MCO has not met most of the requirements.

ACDE Performance Measures Overall Assessment

Overall Assessment

ACDE has a process in place to generate standardized reports to fulfill contractual obligations required by DMMA. This process differs between HEDIS required reporting and reports and measures generated for regulatory reporting. ACDE depends on internal processes to assess data integrity and establish acceptable data quality. Internal teams such as regulatory, compliance, reporting, informatics, and management collaborate together to manage the development of data reports and/or products that enhance the overall performance of the business and monitor adherence to the timelines of regulatory reporting. All reporting generated by the

Regulatory Reporting department is reviewed for data integrity by analysts and management as well as the Chief Operating Officer (COO), who provides final sign-off of the reports. The standard review process includes verifying that all requested data elements are provided, data are within the reporting period requested, and that all data fit specific criteria requested. Where possible, reports will be checked for reasonableness through benchmarking and/or trend analysis. When summary and detailed files are available (dependent on the type of report), the two are reconciled to each other.

The Regulatory Reporting department follows a multi-step process for each report completed within the unit. The Director/Manager of the department works with the associate responsible for the completion of the report to assist in addressing issues identified during the completion phase. A review session is then held with the Manager/Director and Specialist/Analyst to review in detail a final draft of the report. During this review, the report is checked for accuracy and reasonableness of the data. As appropriate, a report may be reviewed with other internal department management. Given the vast number of the reports, changes within the health care industry as well as changes within the ACDE organization, developing a robust process of data governance, as noted during the ISCA, could greatly benefit the MCO operation. For consistency, each data element used in the reporting, should have clear definitions, acceptable value domains, a clear owner, and defined purpose and use. Additionally, on a regular basis (e.g., annually) all reports and data elements should be reviewed to ensure no changes are required to the report such as adding new Current Procedural Terminology (CPT) codes, provider taxonomies, and other health care nomenclature. Moreover, the review of the reports and data elements would allow ACDE to determine if any changes based on system changes (i.e., upgrades and enhancements) necessitate report modifications to account for these transformations.

ACDE utilizes the NCQA certified HEDIS software, Inovolon, for calculating all HEDIS PMs and non-HEDIS core measures; this source code is considered fully compliant. Monthly, ACDE loads HEDIS data into the HEDIS software for interim and final reporting. Data sources include, and are not limited to, medical claims, provider claims, pharmacy claims, lab results, dental claims, vision claims, pharmacy claims, supplemental data sources, and non-supplemental data sources. Claims data come from the FACETS reporting environment, and most other sources come from the Data Warehouse. The final audit statement from Healthcare Data Company, LLC, the HEDIS Compliance Auditor, did not identify any findings or anomalies.

The EQRO has a high level of confidence in the validity of the PMs generated using NCQA certified HEDIS software and nationally recognized specifications and moderate confidence in the QCMMR measure Adult PCPs with Closed Panels.

Overall Results

PM	Confidence in Reported Results
PM 1: Adult PCPs with Closed Panels	Moderate confidence
PM 2: 30-Day Aging Provider Complaints	High confidence

PM	Confidence in Reported Results
PM 3: Comprehensive Diabetes Control (Poor Control >9%)	High confidence
PM 4: Immunizations for Adolescents (IMA-CH)	High confidence
PM 5: Follow-Up Care for Children Prescribed ADHD Medication	High confidence
PM 6: Plan All Cause Readmissions (PCR-AD)	High confidence

Adult PCPs with Closed Panels

1. Overview of PM
Managed Care Plan (MCP) name: AmeriHealth Caritas Delaware
PM name: PM 1: Adult PCPs with Closed Panels
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☐ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☒ No measure steward, developed by State/EQRO ☐ Other measure steward (specify): _____
Is the PM part of an existing measure set? (check all that apply) ☐ HEDIS® ☐ CMS Child or Adult Core Set ☒ Other (specify): QCMMR and QCMMR Plus Reporting Requirements
What data source(s) was used to calculate the measure? (check all that apply) ☐ Administrative data (describe): Claims ☐ Medical records (describe): _____ ☒ Other (specify): Providers found within FACETS. FACETS is the business operating system for ACFC.
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)

1. Overview of PM

Definition of denominator (describe):
Number of Adult Medicaid PCPs in the network.

Definition of numerator (describe):
Number of Adult Medicaid PCPs in the network not accepting additional members as new patients.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2020–December 31, 2020

2. PM Results (If measure contains more than one rate, add columns to the table)

PM	Rate 1	Rate 2	Rate 3	Rate 4	Rate 5	Rate 6	Rate 7	Rate 8	Rate 9	Rate 10	Rate 11	Rate 12
Numerator	82	84	83	83	86	86	86	93	93	175	189	178
Denominator	650	651	651	661	675	647	647	653	684	687	684	681
Rate	13%	13%	13%	13%	13%	13%	13%	14%	14%	25%	28%	26%

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There are no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
There were no findings from the ISCA that affected the reliability or validity of the PM results.
☐ Not applicable (ISCA not reviewed)

Describe any findings from medical record review that affected the reliability or validity of the PM results.
☒ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
The ACDE policy states that the data are reviewed monthly to ensure that the closed panel numbers remain consistent and any outliers are reviewed. However, starting with October 2020 a significant rate increase was observed and during the virtual onsite meeting, no explanation as of the reason for this increase was provided. Mercer recommends that when this type of measure result difference is observed, that the measure undergo closer validation to ensure there are no data anomalies, that a description of the variance in the results be provided, and there is no adverse effect on the care delivered to the members.

3. PM Validation Status

Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

Conduct a comprehensive validation to ensure there are no data anomalies when a significant change in results is observed. Add a description of the variance in the results and monitor the rate to ensure there is no adverse effect on the care delivered to the members.

30-Day Aging Provider Complaints

1. Overview of PM

MCP name: AmeriHealth Caritas of Delaware

PM name: PM 2: 30-Day Aging Provider Complaints

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☐ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☒ No measure steward, developed by State/EQRO
☐ Other measure steward (specify): _____

Is the PM part of an existing measure set? (check all that apply)

☐ HEDIS®
☐ CMS Child or Adult Core Set
☒ Other (specify): QCMMR and QCMMR Plus Reporting Requirements

What data source(s) was used to calculate the measure? (check all that apply)

☐ Administrative data (describe) MCO claims_____
☐ Medical records (describe) Member medical records_____
☒ Other (specify): Macess EXP and FACETS

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

1. Overview of PM

Definition of denominator (describe):
N/A

Definition of numerator (describe): 30 day aging provider complaints — The number of provider payment disputes for clean claims that were filed and resolved within 30 days of filing.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2020–December 31, 2020

2. PM Results (If measure contains more than one rate, add columns to the table)

PM	Rate 1	Rate 2	Rate 3	Rate 4	Rate 5	Rate 6	Rate 7	Rate 8	Rate 9	Rate 10	Rate 11	Rate 12
Numerator	494	121	81	272	606	280	358	383	251	377	212	274
Denominator	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There are no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
There were no findings from the ISCA that affected the reliability or validity of the PM results.
☐ Not applicable (ISCA not reviewed)

Describe any findings from medical record review that affected the reliability or validity of the PM results.
There were no findings from the medical record review that affected the reliability or validity of the PM results.
☐ Not applicable (medical record review not conducted)

3. PM Validation Status

Describe any other validation findings that affected the accuracy of the PM calculation.

The report compiles all provider complaints received via written correspondence by ACDE claims department, the MCO and all subcontractors as well as those received and forwarded to ACDE by DMMA. Mercer recommends development of clear guidance and training for the provider team to ensure the criteria for the measure are clearly specified and not ambiguous. Data governance can provide data guidance to ensure all required data are collected and included in the rate calculation.

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

Develop clear guidance and training for the provider team to ensure the criteria for the measure are clearly specified and not ambiguous. Establish data governance to ensure all required data are collected and included in the rate calculation.

Comprehensive Diabetes Control (Poor Control >9%)

1. Overview of PM

MCP name: AmeriHealth Caritas of Delaware

PM name: PM 3: Comprehensive Diabetes Control (Poor Control >9%)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☒ Other measure steward (specify) Health Resources and Services Administration

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS®
☐ CMS Child or Adult Core Set
☐ Other (specify) _____

1. Overview of PM
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe): FACETS claims (Core Claims Processing) and PerformRx claims (Pharmacy) ☒ Medical records (describe): Medical record review was conducted, as this measure was reported via the hybrid method, to find latest HbA1c test date and latest HbA1c test result. ☒ Other (specify): Supplemental Data, including Lab (LabCorp claims and results), Electronic Health Record (EHR) (CCHS, I2I, St. Francis, and United Medical), historical claims (United Healthcare), and year round medical record abstraction.
If the hybrid method was used, describe the sampling approach used to select the medical records: Systematic sampled was performed per the NCQA HEDIS 2020 Volume 2 Technical Specifications for Health Plans, Guidelines for Calculations and Sampling, Systematic Sampling Methodology. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): The denominator was identified per the NCQA HEDIS 2020 Volume 2 Technical Specifications for Health Plans, Comprehensive Diabetes Care measure. High-level: Members 18–75 years of age with diabetes (type 1 and type 2).
Definition of numerator (describe): The numerator was identified per the NCQA HEDIS 2020 Volume 2 Technical Specifications for Health Plans, Comprehensive Diabetes Care measure. High-level: The member is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%.
Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP
Measurement period (start/end date): January 1, 2019–December 31, 2019

2. PM Results (If measure contains more than one rate, add columns to the table)	
PM	Comprehensive Diabetes Care (Poor Control >9%)
Numerator	299
Denominator	548
Rate	54.56%

3. PM Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). There were no deviations from the NCQA HEDIS 2020 Volume 2 Technical Specifications for Health Plans, Comprehensive Diabetes Care measure.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. There were no findings from the ISCA that affected the reliability or validity of the PM results. ☐ Not applicable (ISCA not reviewed)
Describe any findings from medical record review that affected the reliability or validity of the PM results. ☒ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the PM calculation. NCQA-Certified HEDIS® Compliance Auditor examined ACDE's submitted measures for conformity with the technical specifications for Federal Fiscal Year (FFY) 2019 for the Adult Core Set. The audit followed the NCQA HEDIS® Compliance Audit standards and P&Ps. Although this measure is a HEDIS measure and has been certified by ACDE's HEDIS vendor, Mercer recommends ACDE familiarize itself with the detailed specification for this measure, as both a HEDIS measure and an Adult Core Set measure to ensure all the data extracts submitted for the rate calculation are correct. During the virtual onsite, ACDE did not recognize that for the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 75.
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.
EQRO recommendations for improvement of PM calculation: None.

Immunizations for Adolescents (IMA-CH)

1. Overview of PM
MCP name: AmeriHealth Caritas of Delaware
PM name: PM 4: Immunizations for Adolescents (IMA-CH)

1. Overview of PM

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☒ Other measure steward (specify) Oregon Health and Sciences University

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS®
☒ CMS Child or Adult Core Set
☐ Other (specify) _____

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): FACETS claims (Core Claims Processing)
☒ Medical records (describe): Medical record review was conducted, as this measure was reported via the hybrid method, to find meningococcal/tetanus, diphtheria toxoids and acellular pertussis (Tdap)/human papillomavirus (HPV) vaccines.
☒ Other (specify): Supplemental Data, including Delaware State immunization registry, and historical claims (United Healthcare).

If the hybrid method was used, describe the sampling approach used to select the medical records:

Systematic sampled was performed per the NCQA HEDIS 2020 Volume 2 Technical Specifications for Health Plans, Guidelines for Calculations and Sampling, Systematic Sampling Methodology.

☐ Not applicable (hybrid method not used)

Definition of denominator (describe):

The denominator was identified per the NCQA HEDIS 2020 Volume 2 Technical Specifications for Health Plans, Immunizations for Adolescents (IMA) measure/CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for FFY 2020 Reporting, Immunizations for Adolescents (IMA-CH) measure.

High-level: Adolescents 13 years of age.

1. Overview of PM

Definition of numerator (describe):

The numerators were identified per the NCQA HEDIS 2020 Volume 2 Technical Specifications for Health Plans, Immunizations for Adolescents (IMA) measure/CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for FFY 2020 Reporting, Immunizations for Adolescents (IMA-CH) measure.

High-level: One dose of meningococcal vaccine, one tetanus, Tdap vaccine, and have completed the HPV vaccine series by their thirteenth birthday. The measure calculates a rate for each vaccine and two combination rates.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2019–December 31, 2019

2. PM Results (If measure contains more than one rate, add columns to the table)

PM	Meningococcal	Tdap	HPV	Combo 1	Combo 2
Numerator	46	53	29	42	18
Denominator	77	77	77	77	77
Rate	59.74%	68.83%	37.66%	54.55%	23.38%

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

As a result of the COVID-19 pandemic's impact to Medical Record Review in early 2020, for measure year 2019 (HEDIS 2020), NCQA allowed for the rotation of hybrid measures to use the rate reported for measure year 2018 (HEDIS 2019). The Immunizations for Adolescents measure was rotated to use the measure year 2018 (HEDIS 2019) rates.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

There were no findings from the ISCA that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

Describe any findings from medical record review that affected the reliability or validity of the PM results.

There were no findings from the medical record review that affected the reliability or validity of the PM results.

☐ Not applicable (medical record review not conducted)

3. PM Validation Status

Describe any other validation findings that affected the accuracy of the PM calculation.

NCQA-Certified HEDIS® Compliance Auditor examined ACDE's submitted measures for conformity with the technical specifications for FFY 2019 for the Child Core Set. The audit followed the NCQA HEDIS® Compliance Audit standards and P&Ps.

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

None.

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

1. Overview of PM

MCP name: AmeriHealth Caritas of Delaware

PM name: PM 5: Follow-Up Care for Children Prescribed ADHD Medication

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify) _____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS®
☒ CMS Child or Adult Core Set
☐ Other (specify) _____

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): FACETS claims (Core Claims Processing) and PerformRx claims (Pharmacy)
☐ Medical records (describe) _____
☐ Other (specify) _____

1. Overview of PM

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

The denominator was identified per the NCQA HEDIS 2020 Volume 2 Technical Specifications for Health Plans, Follow-Up Care for Children Prescribed ADHD Medication (ADD) measure/CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for FFY 2020 Reporting, Follow-Up Care for Children Prescribed ADHD Medication (ADD-CH) measure.

High-level: Children 6–12 years of age newly prescribed ADHD medication.

Definition of numerator (describe):

The numerators were identified per the NCQA HEDIS 2020 Volume 2 Technical Specifications for Health Plans, Follow-Up Care for Children Prescribed ADHD Medication (ADD) measure/CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for FFY 2020 Reporting, Follow-Up Care for Children Prescribed ADHD Medication (ADD-CH) measure.

High-level:

- Initiation Phase. The percentage of members 6–12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
- Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2019–December 31, 2019

However, please note some of the complexity around the timeframes/denominator identification windows for this measure:

- Intake Period: The 12-month window starting March 1 of the year prior to the measurement year and ending the last calendar day of February of the measurement year.
- Negative Medication History: A period of 120 days (four months) prior to the IPSD when the member had no ADHD medications dispensed for either new or refill prescriptions.
- IPSD: The earliest prescription dispensing date for an ADHD medication where the date is in the intake period and there is a negative medication history.

2. PM Results (If measure contains more than one rate, add columns to the table)

PM	Initiation Phase	C&M Phase
Numerator	47	10

2. PM Results (If measure contains more than one rate, add columns to the table)		
PM	**Initiation Phase**	**C&M Phase**
Denominator	149	35
Rate	31.54%	28.57%

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the NCQA HEDIS 2020 Volume 2 Technical Specifications for Health Plans, Follow-Up Care for Children Prescribed ADHD Medication (ADD) measure/CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for FFY 2020 Reporting, Follow-Up Care for Children Prescribed ADHD Medication (ADD-CH) measure.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

There were no findings from the ISCA that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

Describe any findings from medical record review that affected the reliability or validity of the PM results.

☐ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

None.

Plan All Cause Readmissions (PCR-AD)

1. Overview of PM

MCP name: AmeriHealth Caritas of Delaware

PM name: PM 6: Plan All Cause Readmissions (PCR-AD)

1. Overview of PM

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify) _____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS®
☒ CMS Child or Adult Core Set
☐ Other (specify) _____

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): FACETS claims (Core Claims Processing) and Avēsis Vision claims (part of risk stratification portion of the measure)
☐ Medical records (describe) _____
☐ Other (specify) _____

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

The denominator was identified per the NCQA HEDIS 2020 Volume 2 Technical Specifications for Health Plans, Plan All-Cause Readmissions (PCR) measure/CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for FFY 2020 Reporting, Plan All-Cause Readmissions (PCR-AD) measure.

High-Level: For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year.

Definition of numerator (describe):

The numerator was identified per the NCQA HEDIS 2020 Volume 2 Technical Specifications for Health Plans, Plan All-Cause Readmissions (PCR) measure/CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for FFY 2020 Reporting, Plan All-Cause Readmissions (PCR-AD) measure.

High-level: Count of Observed 30-Day Readmissions

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

1. Overview of PM

Measurement period (start/end date): January 1, 2019–December 31, 2019

However, please note the timeframes/denominator identification windows for this measure:

- Index Hospital Stay (IHS): An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year, as identified in the denominator.
- Index Admission Date: The IHS admission date.
- Index Discharge Date: The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
- Index Readmission Stay: An acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
- Index Readmission Date: The admission date associated with the Index Readmission Stay.

2. PM Results (If measure contains more than one rate, add columns to the table)

PM	Observed Readmission Rate
Numerator	309
Denominator	2,646
Rate	11.68%

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the NCQA HEDIS 2020 Volume 2 Technical Specifications for Health Plans Plan All-Cause Readmissions (PCR) measure/CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for FFY 2020 Reporting, Plan All-Cause Readmissions (PCR-AD) measure.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

There were no findings from the ISCA that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

Describe any findings from medical record review that affected the reliability or validity of the PM results.

☒ Not applicable (medical record review not conducted)

3. PM Validation Status
Describe any other validation findings that affected the accuracy of the PM calculation. N/A
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.
EQRO recommendations for improvement of PM calculation: None.

HHO Performance Measures Overall Assessment

Overall Assessment

HHO has a process in place to generate the standardized reports to fulfill contractual obligations required by the DMMA. The process differs between the HEDIS required reporting and reports and measures generated for regulatory reporting. HHO depends on the internal processes to assess data integrity and establish acceptable data quality. Internal teams such as analytics, quality, and UM collaborate together to manage the development of data reports and/or products that enhance the overall performance of the business and monitor adherence to the timelines of regulatory reporting.

Business requirements and technical specifications are documented for each regulatory report. Any changes to technical specifications are routed through the Report coordinator to facilitate the work. Monthly regulatory reports are completed by each functional area responsible for data within their given area, including subcontractors. Reports are developed by team members who populate the templates, review for variances (investigating any variances with a 10% variance from month-to-month), and draft any narratives. After the report development, department Directors review and validate the data, adjust narratives, and attest to the report. A Report coordinator monitors submissions for timeliness, completeness, and accuracy working directly with functional areas and analytics if changes or additional explanations are needed. HHO's COO is accountable for non-clinical content of the reports and the CMO attests to clinical topics covered in the reports.

Given the vast number of the reports, changes within the health care industry as well as changes within the HHO organization, developing a robust process of data governance, as noted during the ISCA, could greatly benefit the MCO operation. For consistency, each data element used in the reporting should have clear definitions, acceptable values domains, a clear owner, and defined purpose and use. Additionally, on a regular basis (e.g., annually) all reports and data elements should be reviewed to ensure no changes are required to the reporting such as adding new CPT codes, provider taxonomies, and other health care nomenclature.

Moreover, the review of the reports would allow HHO to determine if any changes based on the system changes (i.e., upgrades and enhancements) necessitate report modifications to account for these transformations.

HHO utilizes the NCQA certified HEDIS software, Inovolon, for calculating all HEDIS PMs and this source code is considered fully compliant. HHO has a team comprised of management, technical, and clinical analysts to oversee the execution of the HEDIS project. Additionally, HHO contracts with a certified HEDIS data management vendor who receives and processes administrative and supplemental data and calculates rates for each of the measures in the HEDIS technical specifications. All claims, encounter, provider, and membership data is extracted from the EHR (the core claims processing solution), and loaded into the warehouse before being extracted and sent to the HEDIS data management vendor. Claims data from subcontractors including CVS, Davis Vision, and LabCorp are loaded to the data warehouse before being extracted and sent to the HEDIS data management vendor. The data analyst and manager review the results from each data processing cycle against the results of previous cycles as a quality check. Any measure outside of the expected value (i.e., >2%) will be investigated to determine the root cause behind the change(s).

HHO engages Inovolon, who uses the base HEDIS proprietary source code, to program and calculate the non-HEDIS Core Measures as well. The sampling process, tools, and IRR testing for generating hybrid measure results appear appropriate. The EQRO has a high level of confidence in the validity of the PMs generated using NCQA certified HEDIS software and nationally recognized specifications.

PM	Confidence in Reported Results
PM 1: Adult PCPs with Closed Panels	Low confidence
PM 2: Provider Complaints	Low confidence
PM 3: Comprehensive Diabetes Control (Poor Control >9%)	High confidence
PM 4: Immunizations for Adolescents (IMA-CH)	High confidence
PM 5: Follow-Up Care for Children Prescribed ADHD Medication	High confidence
PM 6: Plan All Cause Readmissions (PCR-AD)	High confidence

Adult PCPs with Closed Panels

1. Overview of PM
MCP name: Highmark Health Options
PM name: PM 1: Adult PCPs with closed panels

1. Overview of PM

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☐ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☒ No measure steward, developed by State/EQRO
☐ Other measure steward (specify): _____

Is the PM part of an existing measure set? (check all that apply)
☐ HEDIS®
☐ CMS Child or Adult Core Set
☒ Other (specify): QCMMR

What data source(s) was used to calculate the measure? (check all that apply)
☐ Administrative data (describe): _____
☐ Medical records (describe): _____
☒ Other (specify): Credentialing Provider Repository (CPR) — Provider Data Source

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
In-network Adult PCPs

Definition of numerator (describe):
Number of adult PCPs with closed panels

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): N/A

2. PM Results (If measure contains more than one rate, add columns to the table)

PM	January 2020	June 2020	December 2020	Average Rate for 2020
Numerator	17	26	28	24

2. PM Results (If measure contains more than one rate, add columns to the table)				
PM	**January 2020**	**June 2020**	**December 2020**	**Average Rate for 2020**
Denominator	543	536	535	534
Rate	3%	5%	5%	4%

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (e.g., deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

None to review.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

There were no findings from the ISCA that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

Describe any findings from medical record review that affected the reliability or validity of the PM results.

☒ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

In the initial submission, HHO did not include any rates for this measure. During the virtual onsite, HHO committed to submitting the completed rates. However, only selected rates were included as part of the follow-up documentation. Additionally, during the meeting, HHO was not able to explain what was or should be included as numerator and denominators nor was able to clearly articulate who is responsible for the measure, rate calculation, and how the values are used in the QI activities. Moreover, the notes, included in the follow-up documentation, indicate that there is no clear owner of the process to generate and monitor this measure. Mercer recommends the comprehensive review of the specifications to identify the owner of the measure and data elements used for the rate calculation.

Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

Conduct a comprehensive review of the specifications for the measure, identify the owner of the measure for review and reporting as well as those responsible for use of the measure for ongoing QI initiatives; ensure DMMA received accurate and complete information.

Provider Complaints

1. Overview of PM
MCP name: Highmark Health Options
PM name: PM 2: Provider complaints
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☐ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☒ No measure steward, developed by State/EQRO ☐ Other measure steward (specify): _____
Is the PM part of an existing measure set? (check all that apply) ☐ HEDIS® ☐ CMS Child or Adult Core Set ☒ Other (specify): QCMMR
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe): Administrative complaints — emails, fax, and verbal ☐ Medical records (describe): _____ ☒ Other (specify): Reports pulled from INSINQ
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): N/A
Definition of numerator (describe): N/A
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date): Monthly

2. PM Results (If measure contains more than one rate, add columns to the table)	
PM	**Not Applicable for Provider Complaints**
Numerator	N/A
Denominator	N/A
Rate	N/A

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (e.g., deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

N/A

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

There were no findings from the ISCA that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

Describe any findings from medical record review that affected the reliability or validity of the PM results.

There were no findings from the medical record review that affected the reliability or validity of the PM results.

☐ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

The initial submission did not include any numbers related to the provider complaints. The additional documentation including the specifications used for evaluation of the measure and extractions of the number were going to be submitted as part of the follow-up documentation. However, only internal notes were included in the submission and no meaningful and explanatory information has been submitted as part of the follow-up documentation. Mercer strongly recommends, HHO review the specifications for the measure, identify clear owner, and improve internal processes of clear delineation of the required mandatory reporting to ensure DMMA received accurate and complete information.

Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

Conduct a comprehensive review of the specifications for the measure, identify the owner of the measure for review and reporting as well as those responsible for use of the measure for ongoing QI initiatives; ensure DMMA received accurate and complete information.

Comprehensive Diabetes Control (Poor Control >9%)

1. Overview of PM

MCP name: Highmark Health Options

PM name: PM 3: Comprehensive Diabetes Control (Poor Control >9%)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify): _____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS®
☒ CMS Child or Adult Core Set
☐ Other (specify): _____

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☒ Medical records (describe): HEDIS hybrid data medical record review campaign
☐ Other (specify): _____

If the hybrid method was used, describe the sampling approach used to select the medical records:
Sampling based on HEDIS measurement year (MY) 2020 Specifications.
☐ Not applicable (hybrid method not used)

Definition of denominator (describe):
Denominator compliance is applied in accordance with HEDIS MY 2020 Specifications.

Definition of numerator (describe):
Numerator compliance is applied in accordance with HEDIS MY 2020 Specifications.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2020–December 31, 2020

2. PM Results (If measure contains more than one rate, add columns to the table)				
PM	**Rate 1**	**Rate 2**	**Rate 3**	**Rate 4**
Numerator	151			
Denominator	411			
Rate	38.44%			

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (e.g., deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

There were no findings from the ISCA that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

Describe any findings from medical record review that affected the reliability or validity of the PM results.

There were no findings from the medical record review that affected the reliability or validity of the PM results.

☐ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

NCQA-Certified HEDIS® Compliance Auditor examined HHO's submitted measures for conformity with the technical specifications for FFY 2019 for the Adult Core Set. The audit followed the NCQA HEDIS® Compliance Audit standards and P&Ps. Although this measure is HEDIS and has been certified by the HEDIS vendor, Mercer recommends HHO understand the detailed specification to ensure all the data extracts submitted for the rate calculation are correct. During the virtual onsite, HHO did not present full recognition of the measure specifications such as that measure applies to beneficiaries' ages 18 to 75, and for the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 75.

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

Submit rates for all age stratifications. Calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 75.

Immunizations for Adolescents (IMA-CH)

1. Overview of PM

MCP name: Highmark Health Options

PM name: PM 4: Immunizations for Adolescents (IMA-CH)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify): _____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS®
☒ CMS Child or Adult Core Set
☐ Other (specify) _____

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☒ Medical records (describe): HEDIS hybrid data medical record review campaign
☐ Other (specify): _____

If the hybrid method was used, describe the sampling approach used to select the medical records:
Sampling based on HEDIS MY 2020 Specifications.
☐ Not applicable (hybrid method not used)

Definition of denominator (describe):
Denominator compliance is applied in accordance with HEDIS MY 2020 Specifications.

Definition of numerator (describe):
Numerator compliance is applied in accordance with HEDIS MY 2020 Specifications.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2020–December 31, 2020

2. PM Results (If measure contains more than one rate, add columns to the table)					
PM	**Rate 1 — Meningococcal**	**Rate 2 — Tdap**	**Rate 3 — HPV**	**Rate 4 — CO1**	**Rate 5 — CO2**
Numerator	323	340	202	315	178
Denominator	411	411	411	411	411
Rate	78.59%	82.73%	49.15%	76.64%	43.31%

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (e.g., deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
There were no findings from the ISCA that affected the reliability or validity of the PM results.
☐ Not applicable (ISCA not reviewed)

Describe any findings from medical record review that affected the reliability or validity of the PM results.
There were no findings from the medical record review that affected the reliability or validity of the PM results.
☐ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
NCQA-Certified HEDIS® Compliance Auditor examined HHO's submitted measures for conformity with the technical specifications for FFY 2019 for the Child Core Set. The audit followed the NCQA HEDIS® Compliance Audit standards and P&Ps.

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:
None.

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

1. Overview of PM

MCP name: Highmark Health Options

PM name: PM 5: Follow-Up Care for Children Prescribed ADHD Medication

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify): _____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS®
☒ CMS Child or Adult Core Set
☐ Other (specify) _____

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe): _____
☐ Other (specify): _____

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Denominator compliance is applied in accordance with HEDIS MY 2020 Specifications.

Definition of numerator (describe):
Numerator compliance is applied in accordance with HEDIS MY 2020 Specifications.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2020–December 31, 2020

2. PM Results (If measure contains more than one rate, add columns to the table)				
PM	**Rate 1 — Initiation**	**Rate 2 — Continuation Phase**	**Rate 3**	**Rate 4**
Numerator	396	134		
Denominator	1032	279		
Rate	38.37%	48.03%		

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (e.g., deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
There were no findings from the ISCA that affected the reliability or validity of the PM results.
☐ Not applicable (ISCA not reviewed)

Describe any findings from medical record review that affected the reliability or validity of the PM results.
☒ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:
None.

Plan All Cause Readmissions (PCR-AD)

1. Overview of PM

MCP name: Highmark Health Options

PM name: PM 6: Plan All Cause Readmissions (PCR-AD)

1. Overview of PM

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify): _____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS®
☒ CMS Child or Adult Core Set
☐ Other (specify): _____

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe): _____
☐ Other (specify): _____

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
N/A

Definition of numerator (describe):
N/A

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2020–December 31, 2020

2. PM Results (If measure contains more than one rate, add columns to the table)

PM	
Numerator	N/A

2. PM Results (If measure contains more than one rate, add columns to the table)	
PM	
Denominator	N/A
Rate/Observed versus Expected Ratio	1.12

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (e.g., deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

There were no findings from the ISCA that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

Describe any findings from medical record review that affected the reliability or validity of the PM results.

☒ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

Similar to the other HEDIS measures, Mercer recommends HHO become versed in the HEDIS measures, calculations, and use for QIs activities. During the virtual onsite, HHO was not able to articulate why the submitted information was N/A and what was the observed versus expected readmission ratio. Mercer rates this measure as high confidence given that it was reviewed and certified by the HEDIS vendor; however, Mercer recommends more engagement on HHO's part to use the data in a meaningful way to improve member outcomes.

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

None.

Section 5
Validation of 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 a minimum of five PIPs; the PIP topics must cover the following:

- Oral health of the LTSS population (this PIP is prescriptive in nature)
- BH and PH integration
- Pediatric population
- LTSS population
- Non-clinical or service related

Review Methodology

The summary results and recommendations presented below are based on EQR PIP Validation Protocol Steps 4–10 which include:

- Review the sampling method
- Review the selected PIP variables
- Review the data collection procedures
- Review data analysis and interpretation of PIP result
- Assess the improvement strategies
- Assess the likelihood that significant and sustained improvement occurred
- Perform overall validation and reporting of PIP results

The EQRO provides and overall validation rating of the PIP results. The validation rating refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced evidence of significant improvement.

Confidence in Reported Results			
High	**Moderate**	**Low**	**No Confidence**
Fully compliant with standard protocol.	Substantially validated and only minor deviations from standard protocol.	Deviated from protocol such that the reported results are questionable.	Deviated from protocol such that reported results are not validated.

ACDE Performance Improvement Project Overall Assessment

Of the five required PIPs, the State required the EQRO to validate three PIPs during the 2020 compliance review cycle. The first PIP was the State-mandated study topic and study question (oral health of the LTSS population). The second PIP was a State-mandated topic but MCO developed study questions (BH and PH integration). The third required PIP allows for a topic selected by the individual MCO that is relevant to its population and approved by DMMA. ACDE's selected topic focused on the impact of provider education on clinical practice guidelines for ADHD and member compliance with medication and outpatient therapy.

The PIPs and the specifications to be applied included:

- Oral health for DSHP Plus LTSS members — State-developed specifications.
- Benzodiazepines and opioids concomitant use — MCO-developed specifications.
- ADHD clinical practice guidelines, medication, and therapy — MCO-developed specifications.

Overall Results

DMMA has mandated that each MCO conduct a minimum of five PIPs covering specific topics. ACDE did have a sufficient number of PIPs in place, however the MCO did not have a service related PIP in process. ACDE should assess opportunities across the spectrum of the organization and business units to identify and implement at least one service related PIPs to be compliant with contractual requirements.

PIP	Confidence in Reported Results
Oral health for DSHP Plus LTSS members	Moderate

PIP	Confidence in Reported Results
Benzodiazepines and opioids concomitant use	High
ADHD clinical practice guidelines, medication, and therapy	High

Oral Health for DSHP Plus LTSS Members

1. General PIP Information
MCP Name: AmeriHealth Caritas Delaware
PIP Title: DSHP Plus Oral Health
PIP Aim Statement: Does education of HCBS and skilled nursing facility (SNF) providers on the importance of daily oral care, increase the number of DSHP Plus members' receiving daily oral care?
Was the PIP State-mandated, collaborative, statewide, or plan choice? (check all that apply) ☒ State-mandated (State required plans to conduct a PIP on this specific topic.) ☐ Collaborative (Plans worked together during the planning or implementation phases.) ☒ Statewide (The PIP was conducted by all MCOs and/or PIHPs within the State.) ☐ Plan choice (State allowed the plan to identify the PIP topic.)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children ***If PIP uses different age threshold for children, specify age range here**: N/A
Target population description, such as duals, LTSS, or pregnant women (please specify): DSHP Plus LTSS population
Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) • Quarter 1 2020: CM education to members one-on-one in SNFs and members in HCBS including distributing free toothbrushes to all members seen during their scheduled 180 day visits January 2020 and February 2020. This intervention was placed on hold March 2020 due to COVID-19 Pandemic Restrictions. • Quarter 2 2020: Telephonic and Zoom member outreach with education about essentials of daily oral health care.

2. Improvement Strategies or Interventions (Changes tested in the PIP)

- Quarter 3 2020: Continued telephonic and Zoom member outreach with education about essentials of daily oral health care.
- Quarter 4 2020: Continued telephonic and Zoom member outreach with education about essentials of daily oral health care.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- Quarter 1 2020: Presented two Train the Trainer provider education seminars. Training invitations were sent to 68 HCBS and SNF provider locations. Providers received the training invitation via mail four weeks prior to training session. Additional provider outreach for the training sessions include a telephonic reminder two weeks prior to the session and a fax reminder one week prior to the session. Attendees received Continuing Education Units (CEUs) according to licensure. This intervention was placed on hold March 2020 due to COVID-19 Pandemic Restrictions.
  - Kent County Seminar January 31, 2020
  - Sussex County Seminar February 26, 2020.

  Training materials included:
  - PowerPoint Presentation
  - Oral Health Toolkit for provider education that included: toothbrushes (Proxa and Collis Curve), surgical tape, tongue blades, gauze, and mini trifold oral health pocket brochures.
  - Oral health flyer to post at SNFs and HCBS agencies in staff areas about training session on oral health education for staff.
- Quarter 3 2020: Train the Trainer education transitioned to Zoom webinar. Training invitations were sent to 119 HCBS and SNF provider locations. Providers received the training invitation via mail four weeks prior to training session. Additional provider outreach for the training sessions include a telephonic reminder two weeks prior to the session and a fax reminder one week prior to the session. Attendees received CEUs according to licensure.
  - Webinar scheduled for August 13, 2020 was cancelled due to no provider RSVP.
  - Webinar scheduled for September 24, 2020 was cancelled due to last minute conflicts with registered providers' offices.
- Quarter 4 2020: Continued Train the Trainer education via Zoom webinar. Training invitations were sent to 112 HCBS and SNF provider locations. Providers received the training invitation via mail four weeks prior to training session. Additional provider outreach for the training sessions include a telephonic reminder two weeks prior to the session and a fax reminder one week prior to the session. Attendees received CEUs according to licensure.
  - There were five attendees at the November 5, 2020 Webinar. CEUs were distributed via email to four attendees. One attendee did not provide licensure for CEUs.
  - ACDE Provider Forums held in Quarter 4 2020 in each county in the State included oral health education specific to PCP.

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

- Quarter 2 2020: Identified three additional trainers from LTSS Staff to facilitate the Train the Trainer seminars/webinars.
  - QM, LTSS, and PNM continued to collaborate and refine the definition of HCBS providers (denominator) and applicable type of HCBS providers that provide oral health care during April 29, 2020 and June 17, 2020 workgroup meetings.

2. Improvement Strategies or Interventions (Changes tested in the PIP)

- LTSS Case Managers educated on documentation of oral health care plan goals and interventions on April 17, 2020.

• Quarter 3 2020: LTSS CMO, QM, LTSS, and PNM refined definition of HCBS provider during August 26, 2020 workgroup meetings.

- LTSS Case Managers educated on common goal name to identify oral health care plan goals on August 7, 2020.

3. PMs and Results (Add rows as necessary)

PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Lead 1: Percentage of HCBS providers educated about the importance of daily oral health care.	2018	Sample Size: 26 Rate: 7.69%	2020	Sample Size: 65 Rate: 5.0%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 2: Percentage of SNF providers educated about the importance of oral health care.	2018	Sample Size: 40 Rate: 27.5%	2020	Sample Size: 47 Rate: 2.0%	☐ Yes ☒ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lead 3: Percentage of DSHP Plus member care plans (community) updated to include daily oral health goal(s).	2018	Sample Size: 10 Rate: N/A	2020	Sample Size: 1767 Rate: 46.2%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): No baseline rate
Lead 4: Percentage of SNF service plans evaluated to ensure daily oral care is documented and included as an intervention.	2018	Sample Size: 73 Rate: N/A	2020	Sample Size: 508 Rate: 50.8%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lag 1: Percentage of DSHP Plus members in SNF with documented daily oral care.	2018	Sample Size: 944 Rate: N/A	2020	Sample Size: 1180 Rate: 20.8%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
Lag 2: Percentage of DSHP Plus members in the community who report a minimum of daily oral care (self-administered or through support services).	2018	Sample Size: 1273 Rate: 49.33%	2020	Sample Size: 2064 Rate: 82.2%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.0000
Lag 3: Percentage of all DSHP Plus care plans that include meaningful oral health goals.	2018	Sample Size: 2217 Rate: 0.27%	2020	Sample Size: 2275 Rate: 47.2%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.0000

4. PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

4. PIP Validation Information

Validation phase (check all that apply):
☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year
☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Multiple re-measurement periods for lead measures and lag measures that are based on quarterly data.
Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence
"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP:
The EQRO noted in the 2020 report that there was a decrease in the number of members in SNF with documented daily oral care. The 2020 results show that one lead measure (Percentage of SNF providers educated about the importance of oral health care) and one lag measure (Percentage of DSHP Plus members in SNF with documented daily oral care) showed statistically significant improvement. One of the noted MCO interventions was additional training of the LTSS care managers on documentation of oral health care plan goals and interventions. DMMA has retired this State-mandated PIP.

Benzodiazepine and Opioid Use

1. General Information

MCP Name: AmeriHealth Caritas of Delaware

PIP Title: Benzodiazepine and Opioid Use

PIP Aim Statement: Does education of providers and members on the risks of benzodiazepines and opioids decrease the number of members receiving benzodiazepines and decrease ED visits for overdose?

Was the PIP State-mandated, collaborative, statewide, or plan choice? (check all that apply)
☐ State-mandated (State required plans to conduct a PIP on this specific topic.)
☐ Collaborative (Plans worked together during the planning or implementation phases.)
☐ Statewide (The PIP was conducted by all MCOs and/or PIHPs within the State.)
☒ Plan choice (State allowed the plan to identify the PIP topic.)

Target age group (check one):
☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children
***If PIP uses different age threshold for children, specify age range here**: N/A

Target population description, such as duals, LTSS, or pregnant women (please specify):
N/A

1. General Information

Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- There were no member-focused interventions in 2020. This PIP was retired June 11, 2020.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- There were no provider-focused interventions in 2020. This PIP was retired June 11, 2020.

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

- Quarter 1 2020: Data analyzed for outcomes Lag Measures # 1 and #2 assessment. Collaboration of Interdisciplinary PIP Workgroup reviewed changing PIP study question and Lag 2 to "all ED visits" and removing "ED overdose" as that data is not available through claims capture due to coding. Further collaboration led to review of low in size of members for scripts of benzodiazepines and opioids (Lag 1).
- Quarter 2 2020: This PIP was retired on June 11, 2020. Benzodiazepine, Alprazolam, transitioned to non-preferred drug and denied prescriptions filled.

3. PMs and Results (Add rows as necessary)

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Lead 1: Percentage of providers who prescribed opioid(s) and benzodiazepine(s) to the member cohort and who were educated on the risks of benzodiazepine(s) and opioids(s) use together.	2018	Sample Size: 46 Rate: 84.8%	2019	Sample Size: 21 Rate: 100%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.0589
Lead 2: Percentage of providers who prescribed opioid(s) to the	2018	Sample Size: 117 Rate: 89.7%	2019	Sample Size: 76	☒ Yes	☒ Yes ☐ No

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
member cohort and who were educated on the risks of benzodiazepine(s) and opioid(s) use together.				Rate: 100%	☐ No	Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lead 3: Percentage of providers who prescribed benzodiazepine(s) to the member cohort and who were educated on the risks of benzodiazepine(s) and opioid(s) use together.	2018	Sample Size: 135 Rate: 88.9%	2019	Sample Size: 86 Rate: 100%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lead 4: Percentage of members in the member cohort that had prescriptions filled for benzodiazepine(s) and opioid(s) that have been educated on the risks of concomitant use.	2018	Sample Size: 177 Rate: 100%	2019	Sample Size: 135 Rate: 100%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.0000
Lag 1: Percentage of members in the member cohort who had prescriptions filled for benzodiazepine(s) and opioid(s) in the quarter following the education.	2018	Sample Size: 177 Rate: 33.9%	2020	Sample Size: 135 Rate: 33.3%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.9167
Lag 2: Percentage of members in the member cohort who had an ED visit for overdose.	2018	Sample Size: 177 Rate: 0.0565%	2020	Sample Size: 135 Rate: 0.0%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify): 0.3817

4. PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First re-measurement ☒ Second re-measurement ☐ Other (specify): **Validation rating**: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: Four of the six quantifiable measures demonstrated improvement, two of those four measures of improvement were statistically significant. The PIP has accomplished the goals established by educating providers and members on the risks of concomitant use of benzodiazepines and opioids, decreasing the number of members receiving benzodiazepines and opioids and decreasing ED visits for overdose.

ADHD Clinical Practice Guidelines, Medication, and Therapy

1.General PIP Information
MCP Name: AmeriHealth Caritas of Delaware
PIP Title: Increase in Compliance to the American Academy of Pediatrics (AAP) Clinical Practice Guidelines for ADHD
PIP Aim Statement: Will Pediatric PCPs, Nurse Practitioners, Psychologists, Psychiatrists, Licensed Professional Counselors and Licensed Clinical Social Workers, and Neurologists educated on the AAP Clinical Practice Guidelines for ADHD increase member compliance to both stimulant medication and outpatient BH therapy at least once every four weeks in the 6 to 12 years old population of AmeriHealth Caritas membership?
Was the PIP State-mandated, collaborative, statewide, or plan choice? (check all that apply) ☐ State-mandated (State required plans to conduct a PIP on this specific topic.) ☐ Collaborative (Plans worked together during the planning or implementation phases.) ☐ Statewide (The PIP was conducted by all MCOs and/or PIHPs within the State.) ☒ Plan choice (State allowed the plan to identify the PIP topic.)
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here**: 6 to 12 years old

1.General PIP Information

Target population description, such as duals, LTSS, or pregnant women (please specify):
N/A

Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

This is a provider focused PIP. There were no member interventions for this PIP in 2020.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- Quarter 1 2020: Published article in the Winter 2020 Provider Connections Newsletter, "ACDE Works with Providers to Increase Adherence to the American Academy of Pediatrics Clinical Practice Guideline for ADHD," available on the ACDE website.
  - Provider Education presented at Sussex County Health Coalition — Behavioral Health Task Group in February 2020 about the AAP Clinical Practice Guideline for ADHD of behavioral therapy and medications by BH CMO. Thirty-nine external organizations were represented.
- Quarter 2 2020: Provider education included a synopsis of the AAP Guidelines for the Assessment and Treatment of ADHD in the form of a mailing to 334 providers (prescribing and BH therapy providers). The education and 6" laminated ruler (imprinted with ADHD clinical guideline) was distributed to targeted providers on June 11, 2020.
- Quarter 3 2020: None.
- Quarter 4 2020: Provider Education presented at provider forums for three counties October 2020 about the AAP Clinical Practice Guideline for ADHD of behavioral therapy and medications by BH CMO.

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

- Quarter 1 2020: Reviewed and updated targeted providers for mailing distribution based on 12 month review of FACETS claims for members ages 6 to 12 with a diagnosis of ADHD.
- Quarter 2 2020: Refined technical specifications for Lag Measures #5 and #6: member follow-up 30 days and 60 days after a new diagnosis of ADHD.
- Quarter 3 2020: None.
- Quarter 4 2020: Identified three new metrics to assess member follow-up after a prescription for a new stimulant. Metrics included one new Lead Measure to educate prescribers and two new Lag Measures to assess member follow-up.
  - Developed new prescriber educational mailing for follow-up after dispensing a new prescription for a stimulant.

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lead 1: Percentage of ACDE contracted Pediatric PCPs, Nurse Practitioners, Psychiatrists, Psychologists, Licensed Professional Counselors, Licensed Clinical Social Workers, and Neurologists within the provider cohort educated about the AAP's Clinical Practice Guidelines for ADHD, specifically prescribing stimulant medications and outpatient BH therapy at least once every four weeks.	2019	Sample Size: 291 Rate: 93.8%	2020	Sample Size: 334 Rate: 94.9%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Provider Education N/A
Lag 1: Percentage of members diagnosed with ADHD ages 6 to 12 years old that did not receive outpatient BH therapy at least once every four weeks and were not prescribed stimulants within 45 days after seeing an ACDE contracted Pediatric PCP, Nurse Practitioner, Psychiatrist, Psychologist, Licensed Professional Counselor, Licensed Clinical Social Worker, or Neurologist who was educated about AAP's Clinical Practice Guidelines for ADHD.	2018	Sample Size: 756 Rate: 27.8%	2020	Sample Size: 1052 Rate: 26.6%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.5835
Lag 2: Percentage of members diagnosed with ADHD ages 6 to 12 years old that did receive	2018	Sample Size: 756 Rate: 16.7%	2020	Sample Size: 1052 Rate: 24.1%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
outpatient BH therapy at least once every four weeks and were prescribed stimulants within 45 days after seeing an ACDE contracted Pediatric PCP, Nurse Practitioner, Psychiatrist, Psychologist, Licensed Professional Counselor, Licensed Clinical Social Worker, or Neurologist that was educated about the importance of the AAP's Clinical Practice Guidelines for ADHD.						Other (specify):
Lag 3: Percentage of members diagnosed with ADHD aged 6 to 12 years old that did not receive outpatient BH therapy at least once every four weeks and were prescribed stimulants within 45 days after seeing an ACDE contracted Pediatric PCP, Nurse Practitioner, Psychiatrist, Psychologist, Licensed Professional Counselor, Licensed Clinical Social Worker, or Neurologist educated about the importance of the AAP's Clinical Practice Guidelines for ADHD.	2018	Sample Size: 756 Rate: 46.4%	2020	Sample Size: 1052 Rate: 21.6%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 4: Percentage of members diagnosed with ADHD aged 6 to	2018	Sample Size: 756 Rate: 9.1%	2020	Sample Size: 1052 Rate: 27.7%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value:

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
12 years old that did receive outpatient BH therapy at least once every four weeks and were not prescribed stimulants within 45 days after seeing an ACDE contracted Pediatric PCP, Nurse Practitioner, Psychiatrist, Psychologist, Licensed Professional Counselor, Licensed Clinical Social Worker, or Neurologist educated about the importance of the AAP's Clinical Practice Guidelines for ADHD.						☒ <.01 ☐ <.05 Other (specify):
Lag 5: Percentage of members who had a Pediatric PCPs, Nurse Practitioners, Psychiatrists, Psychologists, Licensed Professional Counselors, Licensed Clinical Social Workers, or Neurologists second provider follow-up visit in 30 days from initial diagnosis of ADHD.	Quarter 1 2020	Sample Size: 645 Rate: 15.0%	2020	Sample Size: 546 Rate: 19.2%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.0548
Lag 6: Percentage of members who had a Pediatric PCPs, Nurse Practitioners, Psychiatrists, Psychologists, Licensed Professional Counselors, Licensed Clinical Social Workers, or Neurologists	Quarter 1 2020	Sample Size: 645 Rate: 13.2.0%	2020	Sample Size: 546 Rate: 16.8%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.0759

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
provider two follow-up visits (a second and third visit) in 30 days and 60 days from initial diagnosis of ADHD.						

4. PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☒ Baseline year ☐ First re-measurement ☒ Second re-measurement ☒ Other (specify): Multiple re-measurement periods for lead measures and lag measures that are based on quarterly data. **Validation rating**: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: The PIP appears to be improving provider adherence to AAP Clinical Practice Guidelines for ADHD. Six of the seven quantifiable measures showed improvement, and three of the six showing statistically significant improvement. The MCO should consider the range of provider types who may be engaging in management of ADHD medication, continue exploring innovative approaches to provider education, and pursue engagement with community partners for additional avenues for provider education.

HHO Performance Improvement Project Overall Assessment

Of the five required PIPs, the State required the EQRO to validate three PIPs during the 2020 compliance review cycle. The first PIP was the State-mandated study topic and study question (oral health of the LTSS population). The second PIP was a State-mandated topic but MCO developed study questions (BH and PH integration). The third required PIP allows for a topic selected by the individual

MCO that is relevant to its population and approved by DMMA. HHO's selected topic focused on improving the rate of completion of HRA within 60 days.

The PIPs and the specifications to be applied included:

- Oral health for DSHP Plus LTSS members — State-developed specifications
- PH and BH CC — MCO-developed specifications
- HRA Standards

Overall Results

As noted earlier in this report, the HHO Quality department has faced challenges in leadership and staffing over the past several years, including the review period of 2020 as evidenced by quantifiable measure results and the confidence in reported results. The majority of interventions implemented have been passive in nature (e.g., newsletter articles, mailings, etc.), which have not resulted in the improvement intended with PIPs. The MCO must take a more aggressive approach to developing innovative interventions that show active engagement with members and community partners. At the time of the review in 2021, the EQRO and DMMA are cautiously optimistic that HHO now has the resources and team to focus efforts particularly as it relates to PIP. Specifically, the Manager of QI, Regulatory, and Accreditation exhibited a strong base knowledge to identify PIP topics, develop an appropriate question, select quantifiable lead and lag measures, and implement and assess interventions all of which are supported by enhanced analytics.

PIP	Confidence in Reported Results
Oral Health for DSHP Plus LTSS members	Low
PH and BH CC	Low
HRA	Moderate

Oral Health for DSHP Plus LTSS Members

1. General PIP Information
MCP Name: Highmark Health Options
PIP Title: DSHP Plus Oral Health

1. General PIP Information

PIP Aim Statement: Would educating HCBS and SNF providers on the importance of daily oral care increase the number of members receiving regular oral care?

Was the PIP State-mandated, collaborative, statewide, or plan choice? (check all that apply)

☒ State-mandated (State required plans to conduct a PIP on this specific topic.)
☐ Collaborative (Plans worked together during the planning or implementation phases.)
☐ Statewide (The PIP was conducted by all MCOs and/or PIHPs within the State.)
☐ Plan choice (State allowed the plan to identify the PIP topic.)

Target age group (check one):

☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children

***If PIP uses different age threshold for children, specify age range here**: N/A

Target population description, such as duals, LTSS, or pregnant women (please specify):

DSHP Plus LTSS population

Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- The focus of this PIP is to determine if provider education on oral health care would affect the care of members at home and at SNFs of the LTSS population.
  - In fall 2020, an article was placed in the member newsletter, “Oral Health = Total Health.”
  - In October 2020, a flash link was placed on the member website to announce the dental benefit changes.
  - In winter 2020, an announcement was placed in the member newsletter to alert member of the enhancement of the dental benefits for adults, as well as children under 21 “Adult Dental Benefits Exclusions and Limitations.”

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- In the fall 2020, Provider Update Article “Oral Health Is Everybody’s Business” alerting the providers to link and review the educational video to stay updated on proper oral health. This is an educational video, which on completion of an attestation, the provider may receive flip cards with vital oral heal information.

2. Improvement Strategies or Interventions (Changes tested in the PIP)

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

- Quarter 1 2020: Provider oral health toolkit is in its first full quarter of circulation, via Member Advocates and Community Health Workers.
- Quarter 2 2020: Revised study questions to represent the correct population, targets, and timelines (as applicable); revised all measures to ensure that metrics (numerators/denominators) are quantifiable and will answer the hypotheses posed in the study question. Confirmed all data sources are readily accessible and the best source of truth for each metric; and set up monthly reporting to ensure close and effective monitoring, tracking, and trending of the data.
- Quarter 3 2020: Met with analytics team and LTSS team to discuss the way the data was being pulled. HHO found several areas where data can be pulled in a more comprehensive manner. Based on these ongoing meetings, metrics have been reviewed to assure appropriate data capture. PIP Data reporting will now take place monthly.

3. PMs and Results (Add rows as necessary)

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Lead 1: Percentage of HCBS providers who have been educated about the importance of daily oral health care.	2019	Sample size based on denominator. Denominator: 41 Rate: 17.1%	Quarter 3 2020	Quarter 3 2020 Sample Size: 58 Rate: 0/58 (0%) Goal: 42% PIP retired fourth Quarter 2020	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 2: Percentage of SNF providers who have been educated about the importance of daily oral health care.	2019	Sample size based on denominator. Denominator: 41 Rate: 17.1%	Quarter 3 2020	Quarter 3 2020 Sample Size: 41 Rate: 0/41 (0%) Goal: 42% PIP retired fourth Quarter 2020	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lead 3: Percentage of DSHP Plus LTSS HCBS members, including those in assisted living, who have home health care/attendant care and have daily oral care documented as an intervention on the agency care plan.	2018	Sample size based on denominator. Denominator: 997 Rate: 75%	Quarter 3 2020	Quarter 3 2020 Sample Size: 3414 Rate: 3029/3414 (91.56%) Goal: 90% PIP retired fourth Quarter 2020	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): No baseline rate
Lead 4: Percentage of DSHP Plus LTSS SNF members who have daily oral care documented as an intervention on the facility care plan.	2018	Sample size based on denominator. Denominator: 950 Rate: 85%	Quarter 3 2020	Quarter 3 2020 Sample Size: 1744 Rate: 1741/1744 (99.83%) Goal: 100% PIP retired fourth Quarter 2020	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 5: Percentage of HCBS DSHP Plus LTSS members, including those in assisted living, who report having been educated about the importance of daily oral health care.	2016	Sample size based on denominator. Denominator: 5,037 Rate: 71%	Quarter 3 2020	Quarter 3 2020 Sample Size: 3720 Rate: 3593/3720 (96.59%) Goal: 95% PIP retired fourth Quarter 2020	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lag 1: The Percentage of all DSHP Plus LTSS care plans that include meaningful and achievable (daily oral cleansing) oral health goals.	2018	Sample size based on denominator. Denominator: 5,037 Rate: 32%	Quarter 3 2020	Quarter 3 2020 Sample Size: 5730 Rate: 80/5730 (1.4%) Goal: 10% PIP retired fourth Quarter 2020	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lag 2: Percentage of DSHP Plus LTSS HCBS members, including those in assisted living, who report that they complete daily oral care (self-administered or through support services).	2016	Sample size based on denominator. Denominator: 5,037 Rate: 66%	Quarter 3 2020	Quarter 3 2020 Sample Size: 3720 Rate: 3515/3720 (94.49%) Goal: 97% PIP retired fourth Quarter 2020	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lag 3: Percentage of SNF DSHP Plus LTSS members who report to their care manager that they complete daily oral care (self-administered or through support services).	2016	Sample size based on denominator. Denominator: 2,516 Rate: 16%	Quarter 3 2020	Quarter 3 2020 Sample Size: 1744 Rate: 1723/1744 (98.8%) Goal: 100% PIP retired fourth Quarter 2020	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lag 4: Percentage of DSHP Plus LTSS HCBS members, excluding those in assisted living, who have home health care/attendant care, are not independent in oral care, and have daily oral care documented as an intervention on the agency care plan.	2018	Sample size based on denominator. Denominator: 862 Rate: 72%	Quarter 3 2020	Quarter 3 2020 Sample Size: 1891 Rate: 845/1891 (44.69%) Goal: 45% PIP retired fourth Quarter 2020	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Multiple re-measurement periods for lead measures and lag measures that are based on quarterly data. **Validation rating**: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: The State-mandated PIP study topic and question was intended to include mandated quantifiable measures as well. HHO modified these measures, which limits the comparability between MCO results. For the measures HHO included, HHO demonstrated improvement in six of the quantifiable measures, but none of the improvement was statistically significant. DMMA has retired this State-mandated PIP.

Behavioral Health and Physical Health Care Coordination

2.General PIP Information
MCP Name: Highmark Health Options
PIP Title: BH and PH CC
PIP Aim Statement: Does the coordination of care interventions for adult members 18–64 years of age with either a schizophrenia diagnosis or schizo-affective disorder diagnosis who also have a diabetes diagnosis, increase the number of members who had both the LDL-C test and an HbA1c test during the MY?
Was the PIP State-mandated, collaborative, statewide, or plan choice? (check all that apply) ☒ State-mandated (State required plans to conduct a PIP on this specific topic.) ☐ Collaborative (Plans worked together during the planning or implementation phases.) ☐ Statewide (The PIP was conducted by all MCOs and/or PIHPs within the State.) ☐ Plan choice (State allowed the plan to identify the PIP topic.)
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here**: N/A

2.General PIP Information

Target population description, such as duals, LTSS, or pregnant women (please specify):
N/A

Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- In spring 2020, an article was placed in the Member Newsletter. “How to Handle Low Blood Sugar”.
- In spring 2020, an article was placed in the Member Newsletter. “Lifestyle Management/Wellness Programs”.
- In fall 2020, an article was placed in the Member Newsletter. “Lifestyle Management/Wellness Programs”.
- In winter 2020, an article was placed in the Member Newsletter. “Diabetes Corner”.
- In winter 2020, an article was placed in the Member Newsletter. “Lifestyle Management/Wellness Programs”.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- In summer 2020, an article was placed in the Provider Update. “Preventing and Managing Hypoglycemia in Patients with Diabetes”.
- In summer 2020, an article was placed in the Provider Update. “Links to Wellness Programs and Services”.
- In summer 2020, an article was placed in the Provider Update. “Lifestyle Management/Wellness Programs”.
- In fall 2020, an article was placed in the Provider Update. ‘Diabetes Prevention for Behavioral Health Patients”.
- In fall 2020, an article was placed in the Provider Update. “Help Us Help Our Members Prevent Diabetes”.
- In fall 2020, an article was placed in the Provider Update. “Links to Wellness Programs and Services”.
- In fall 2020, an article was placed in the Provider Update. “Lifestyle Management/Wellness Programs”.
- In fall 2020, an article was placed in the Provider Update. “2020 Clinical Practice Guidelines”.
- In winter 2020, an article was placed in the Provider Update. “Lifestyle Management/Wellness Programs”.

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

- Quarter 1 2020: Quality team implemented a new BH-PH PIP Workgroup. This workgroup consists of an interdisciplinary team of staff: Clinical QM Analysts, Care Coordinators, BH CC Manager, and Medical Director, specializing in Psychiatry.
- Quarter 2 2020: Revised study questions to represent the correct population, targets, and timelines (as applicable). Revised all measures to ensure that metrics (numerators/denominators) are quantifiable and will answer the hypotheses posed in the study question; confirmed all data sources are readily accessible and the best source of truth for each metric; and set up monthly reporting to ensure we can closely monitor, track, and trend data effectively.

2. Improvement Strategies or Interventions (Changes tested in the PIP)

- Quarter 3 2020: Medicaid analytics has ensured that the metrics are quantifiable. HHO now closely monitors corrected population. By adding a third lag question, HHO can accurately monitor member compliance with HbA1c and LDL-C testing. HHO is now receiving monthly reporting from Medicaid analytics to monitor closely data efficacy. HHO has added Lag 3 to determine the impact of the intervention to see if members received both screenings (LDL-C and HbA1c).

3. PMs and Results (Add rows as necessary)

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Lead 1: Percentage of adult members 18–64 years of age with either a schizophrenia diagnosis or schizo-affective disorder diagnosis, who have elected CC services. (Elected is defined as those who have completed the task of an acquired and consent form.).	2020	Sample size based on denominator. Denominator: 85 Rate: 2.35%	Quarter 4 2020	Quarter 4 2020 Sample Size: 155 Rate: 17/155 (15.4%) Goal: 10%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 2: Percentage of adult members 18–64 years of age with either a schizophrenia diagnosis or schizo-affective disorder diagnosis, who have elected CC services, and who are engaged in care. (Engaged is defined as members who have completed the following tasks: create care plan, HRA, coordination with PCP/Specialist or OB/GYN, patient self-management guide [PSMG], and a face-to-face intervention.)	2020	Sample size based on denominator. Denominator: 85 Rate: 0%	Quarter 4 2020	Quarter 4 2020 Sample Size: 168 Rate: 6/168 (3.57%) Goal: 25%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lag 1: Percentage of adult members 18–64 years of age with either a schizophrenia diagnosis or schizo-affective disorder diagnosis, who have elected CC services, and who are engaged in CC, and who after receiving an intervention completed their LDL-C test.	2020	Sample size based on denominator. Denominator: 0 Rate: 0%	Quarter 4 2020	Quarter 4 2020 Sample Size: 6 Rate: 2/6 (33.33%) Goal: 50%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lag 2: Percentage of adult members 18–64 years of age with either a schizophrenia diagnosis or schizo-affective disorder diagnosis, who have elected CC services, and who are engaged in CC, and who after receiving an intervention completed their HbA1c test.	2020	Sample size based on denominator. Denominator: 0 Rate: 0%	Quarter 4 2020	Quarter 4 2020 Sample Size: 6 Rate: 3/6 (50%)	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lag 3: Percentage of adult members 18–64 years of age with either a schizophrenia diagnosis or schizo-affective disorder diagnosis, who have elected CC services, and who are engaged in CC, and who after receiving an intervention completed both their HbA1C and LDL-C diabetic screeners	2020	Sample size based on denominator. Denominator: 0 Rate: 0%	Quarter 4 2020	Quarter 4 2020 Sample size: 6 Rate: 2/6 (33.33%) Goal: 50%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☒ Second re-measurement ☐ Other (specify):

Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP:

There is significant concern about the denominator size for this PIP; the small denominator size leads to statistical volatility. The denominator is based on the member's choice to engage in CC; the lack of engagement in CC has been noted in other sections of this report as a concern. Four of the five quantifiable measures demonstrated improvement; however, no improvement was statistically significant. This PIP faced particular challenges in 2020 due to the COVID-19 PHE; however, persistently HHO has employed passive interventions (e.g., provider and member newsletter articles, mailings), which have shown limited effectiveness.

Health Risk Assessment Standards

1. General PIP Information

MCP Name: Highmark Health Options

PIP Title: HRA Standards

PIP Aim Statement: Would member advocate outreach initiatives for members who have been on the plan for 30 days or greater, with no completed HRA, lead to an increase in overall HRA completions?

Was the PIP State-mandated, collaborative, statewide, or plan choice? (check all that apply)

☐ State-mandated (State required plans to conduct a PIP on this specific topic.)

☐ Collaborative (Plans worked together during the planning or implementation phases.)

☐ Statewide (The PIP was conducted by all MCOs and/or PIHPs within the State.)

☒ Plan choice (State allowed the plan to identify the PIP topic.)

Target age group (check one):

☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children

***If PIP uses different age threshold for children, specify age range here**: 6 to 12 years old.

1. General PIP Information

Target population description, such as duals, LTSS, or pregnant women (please specify):
N/A

Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- In 2020, an article was placed in the Member Handbook, “Health Risk Assessment.”

Provider-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- None.

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

- Quarter 1 2020: Member Advocate were not performing HRAs currently.
- Quarter 2 2020: In 2020, HHO incorporated the recommendations of DMMA that HHO categorize telephonic outreach and outcomes of the calls. Those outcomes include: number of outreach attempts where members were contacted, number of members who completed surveys, number of members refusing to complete survey, and number of members who had messages left on voicemail. The measures were updated to 30 days instead of the previous measure of 60 days. Revised study questions to represent the correct population, targets, and timelines (as applicable); revised all measures to ensure that metrics (numerators/denominators) are quantifiable and will answer the hypotheses posed in the study question; confirmed all data sources are readily accessible and the best source of truth for each metric; and set up monthly reporting to ensure we can closely monitor, track, and trend data effectively.
- Quarter 3 2020: The process for completing the HRA has changed to disallow “partially completed” surveys; therefore, lead 4 will be removed in future submissions.
- Quarter 4 2020: Lead and Lag measures have been modified to reflect accurate measure of identified population. The interventions and the results of those interventions.

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lead 1: The percentage of HHO members who received telephonic outreach by a Member Advocate after being identified as on the plan for 30 days, with no documented HRA, and now have a completed HRA.	2020	Sample size based on denominator. Denominator: 290 Rate: 19.2%	Quarter 4 2020	Quarter 4 2020 Sample Size: 2383 Rate: 790/2383 (33%)	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 2: The percentage of HHO members who received telephonic outreach by a Member Advocate, after being identified as on the plan for 30 days with no documented HRA, but the advocate was unable to reach the member.	2020	Sample size based on denominator. Denominator: 290 Rate: 0%	Quarter 4 2020	Quarter 4 2020 Sample Size: 2383 Rate: 1640/2383 (68.8%) Goal: 90%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 3: The percentage of HHO members who received telephonic outreach by a Member Advocate, after being identified as on the plan for 30 days, with no documented HRA, but the member declined outreach (refused to complete survey) from the Member Advocate.	2020	Sample size based on denominator. Denominator: 290 Rate: 0%	Quarter 4 2020	Quarter 4 2020 Sample Size: 2383 Rate: 64/2383 (2.68%)	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lead 4: The percentage of HHO members who received telephonic outreach by a Member Advocate, after being identified as on the plan for 30 days, with no documented HRA, but the HRA was only partially completed (not all qualifying questions are answered on the survey; one or more qualifying questions are unanswered/omitted).	2020	Sample size based on denominator. Denominator: 290 Rate: 0%	Quarter 4 2020	Quarter 4 2020 Sample Size: 290 Rate: 0/290 (0%) Goal: 0%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lag 1: The percentage of HHO members who have completed a HRA within 60 days of enrollment.	2020	Sample size based on denominator. Denominator: 1,563 Rate: 13.95%	Quarter 4 2020	Quarter 4 2020 Sample Size: 790 Rate: 597/790 (75.50%) Goal: 50%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

4. PIP Validation Information

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☒ Baseline year

☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Multiple re-measurement periods for lead measures and lag measures that are based on quarterly data.

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP:

Four of the five quantifiable measures showed demonstrated improvement; however, none of the measures showed statistically significant improvement. This PIP challenges in 2020 due to the COVID-19 PHE; however, persistently HHO has employed passive interventions (e.g., provider and member newsletter articles, mailings), which have shown limited effectiveness.

Section 6

Information Systems Capabilities Assessment

At the request of DMMA Mercer conducted the EQR ISCA comprehensive review of ACDE and HHO for the time period of January 2020–December 2020. This independent review of the MCO's information systems was conducted as an enhancement to the EQR mandatory activity outlined in 42 CFR § 438.358. To complete this assessment Mercer utilized the current version of the CMS EQR Protocol 8 — Appendix V, Attachment A, along with comprehensive enhancements to the ISCA to reflect State-specific regulations, standards, and requirements communicated to the MCO through the contract with DMMA. Mercer's EQR ISCA process included review of submitted materials and information, as well as interviews and live systems demonstrations that were conducted virtually due to the PHE declared January 31, 2020 (i.e., COVID-19). The annual ISCA evaluation was conducted by Mercer, with DMMA staff in attendance via video conference on June 8, 2021 through June 10, 2021 for ACDE and June 15, 2021 through June 17, 2021 for HHO and focused on the core information systems listed below:

- Claims systems processing procedures, training, and personnel
- Reporting and analytics procedures, training, and personnel
- Encounter data processing procedures, training, and personnel
- Core systems — eligibility/enrollment, claims, provider, encounters, data warehouse
- Claims and encounter data reporting
- Claims systems configuration, claims edits, claims requiring manual intervention
- Claims and encounters subcontractor oversight

ACDE Overall Assessment

Based upon the ISCA review, ACDE continues to demonstrate effective partnership and collaboration between the local health plan and the enterprise ACFC teams, operations, and systems and, as such, continues to perform well in supporting the systems-related requirements of Delaware's managed Medicaid program. ACDE's ongoing collaboration with DMMA and Gainwell on identifying and remediating encounter data submission issues has been beneficial to stakeholders. The insights gained from ACDE's ISCA desk review and virtual discussions confirmed a strong infrastructure, claims and encounters subject matter expertise, teamwork, and

commitment to Delaware. The desk and onsite reviews of the 2021 ISCA items resulted in 91 of the 99 desk review items (91.9%) receiving a review score of Met.

As implied through their well organized and thoughtful RFI response, ACDE continued to exhibit strong process orientation and mature systems capabilities, along with a deep understanding of DMMA requirements. Additionally, ACDE continued to demonstrate effective partnership and collaboration between the MCO and the AmeriHealth enterprise support services.

ACDE Strengths

Based on the documentation submitted and virtual onsite review Mercer identified the following strengths in the ACDE systems, operations, and leadership capabilities:

- ACDE's systems are strategically designed to ensure seamless operations including provider data management, management of claims, encounter systems, and data.
- ACDE's data security systems, standards, personnel, and policies lead the industry; this includes ACDE's approach to ensuring their subcontractor data security for DMMA's data.
- ACDE is employing a forward thinking approach to establish the enterprise-wide data analytics platform to meet DMMA's reporting requirements and the federal interoperability regulations.
- ACDE has strong implementation plans for the data lake that include the incorporation of external data sources, such as the Delaware Health Information Network (DHIN) and public health data, to gain improved and timely insights into ACDE's members.
- ACDE's encounter data reporting dashboards with drill down capability are very beneficial for monitoring encounter data submissions and trends.

ACDE Opportunities

The review also identified areas where ACDE could strengthen its commitment to excellence:

- ACDE's current data governance processes for enterprise-wide data analytics and acquisition are meeting minimum standards. To support ACDE's efforts to move towards enhanced interoperability, ACDE should augment and further delineate data governance standards, data definitions, oversight, and ownership to mitigate potential vulnerabilities.

- The MSA with DMMA requires that contractual expectations and standards flow down to delegates and subcontractors for any services they provide. Oversight and management of delegates and subcontractors remains an area with a number of opportunities for improvement by ACDE. The following bullets summarize opportunities related to this area:
  - Delegate and subcontractor oversight is managed at the enterprise level, and while staffing and operations departments have performed oversight since the inception of ACDE, the Joint Oversight committee only recently instituted regular review of subcontractor audit findings (Quarter 1 2021).
  - ACDE uses Equian, a third party payment integrity vendor, to ensure claims payment accuracy, however the claims adjustment explanation and related details are not readily available to providers via the portal nor to provider relations staff responsible for responding to provider inquiries.
  - ACDE should monitor vendor's requirements for cross checks for accuracy and completeness of paper claims. Mercer noted a case in which a paper claim paid incorrectly as a result of a scanning misread. This error could have been caught and the claim rejected or redirected for manual review if the "total amount" field had been required. Additionally, a check of billed amount against allowed amount for unit based services (i.e., anesthesia, etc.) could also have proactively prompted manual intervention and proper claim payment.
  - Mercer's claims review demonstrated Avēsis' duplicate claims identification resulted in inadvertent flagging of non-duplicate claims as duplicates. ACDE must enhance its subcontractor oversight process to ensure subcontracted benefit providers employ appropriate duplicate claim identification processes to ensure accuracy.
  - The dental subcontractor's (SKYGEN) claims procedures did not automatically reprocess claims after PA redeterminations. For dental service benefit redeterminations (approvals), SKYGEN did not reprocess the corresponding claim unless the dental provider called again to request reprocessing. In addition to a risk of inaccurate claims processing, this approach is an undue burden for dental providers.
  - Avēsis has a special character constraint in their eligibility and enrollment systems that adversely impact encounter file submissions. Specifically, the member first name field cannot accept certain special characters (e.g., apostrophes). This system limitation results in Delaware Medicaid Enterprise Systems (DMES) encounter rejections because the member name does not align with DMES data. It is imperative that the MCO and its subcontractors be able to store and submit member enrollment and encounter information in the manner it was received without delay or issue.
  - Avēsis should review claim editing logic to confirm that claim edits related to diagnosis codes and place of service (POS) are appropriately applied. Avēsis presented a scenario in which their claims system encountered an issue related to POS 11

(office) when certain diagnosis codes were submitted. As POS 11 is the primary POS for Avēsis provider and member interactions, this resulted in Avēsis having to reprocess claims.

HHO Overall Assessment

Based upon the ISCA review, HHO demonstrated their continued efforts to improve their claims processing operations to effectively support Delaware's Medicaid managed care program. Since 2017, HHO has evolved their systems and support structure to better align with DMMA's expectations and the needs of DMMA's managed Medicaid populations and providers. In the latter part of 2019, HHO brought the claims operations in-house from the delegate, Gateway Health, but continued to process claims on the same claims platform, OSCAR. HHO has made substantial progress in claims remediation activities, as well as identifying and implementing process improvements that improve claims processing outcomes overall. HHO's ongoing collaboration with DMMA and Gainwell on diagnosing and remediating encounter data submission issues has been beneficial to all the stakeholders. The insights gained from HHO's ISCA desk review and virtual discussions confirmed HHO's efforts to improve the claims operations and underlying infrastructure to ensure accurate claims processing. The desk and onsite reviews of the 2020 ISCA items resulted in 89 of the 99 desk review items (89.9%) receiving a review score of Met.

As implied through their well organized and thoughtful RFI response, HHO continued to exhibit strong process orientation, along with a deep understanding of DMMA requirements. Additionally, HHO continued to demonstrate effective partnership and collaboration between the MCO and the HHO enterprise support services.

HHO Strengths

Based on the documentation submitted and virtual onsite review Mercer identified the following strengths in the HHO systems, operations, and leadership capabilities:

- HHO's continued, diligent work resulted in improvements to the workflows and processes applied during the claims processing. HHO has evidenced the organization's ability to develop and implement comprehensive enhancements and an operations transformation plan. HHO's approach to developing the transformation plan helped to ensure the outcomes would bring the highest benefit to HHO.
- HHO's is employing a forward thinking approach to establishing the enterprise-wide data analytics platform to meet DMMA's reporting requirements and the federal interoperability regulations.
- HHO's encounter data management team has been instrumental in working with DMMA and Gainwell on driving resolution to the historical encounter submission challenges. HHO's ongoing contributions are key to improving the overall quality of DMMA's encounters.

HHO Opportunities

The review also identified areas where HHO could strengthen its commitment to excellence:

- HHO demonstrated progress on the audit selection and sample sizes for HHO's and subcontractor's claims; however, the volume of manually entered claims continue to pose a risk that could be mitigated with additional audits (e.g., claims outliers, etc.) leveraging the data analytics.
- The MSA with DMMA requires that contractual expectations and standards flow down to delegates and subcontractors for any services they provide. Oversight and management of delegates and subcontractors remains an area with a number of opportunities for improvement by HHO. The following bullets summarize opportunities related to this:
  - During the virtual onsite, HHO disclosed that an automated encounters file exchange process between Davis Vision had not been working and that vision encounters had not been submitted to the DMES system for the last two years. Neither HHO, nor Davis Vision had taken appropriate actions to ensure that the encounter submissions and encounter rejections were being monitored and resolved on a regular basis.
  - HHO should closely monitor Davis Vision denial letters to ensure that providers are receiving appropriate information on denied services. Davis Vision must end the process of overwriting diagnosis codes on denied claims with the denial letter code in their claims system.
  - HHO should implement claims triggers and regular review processes when claims payment exceeds billed amount. Once the contracted rate has been confirmed to be correct, notification and guidance should be sent to the provider to ensure the contracted rate, at a minimum, is billed. The correct amount must be included on the encounter.
  - HHO should monitor subcontractor systems, identify deficiencies, recommend enhancements and monitor compliance to ensure all requirements of the DMMA MSA are met.
  - CVS is not receiving valid response files for all encounter submissions and as such CVS is not able to perform reconciliation. HHO performs some parsing of the data to provide the information on encounters rejected; however, the detail necessary for successful resubmission is not available. HHO must monitor the response file to ensure that information necessary for encounter submission is collected and used for encounters correction and resubmission.

Section 7

Maternal Health Care Coordination Focus Study

Medicaid is the largest single payer of pregnancy-related services, having financed 42.3% of all births in the United States in 2018 and an even higher percentage of births among women of color. Similarly, in Delaware, over 40% of all pregnancies are financed by Medicaid. Two out of three adult women enrolled in Medicaid are in their reproductive years: this group reports higher rates of obesity, high blood pressure, and diabetes than women with private insurance. They are more than twice as likely to have a subsequent pregnancy less than six months after a previous live birth as women with private insurance, increasing the likelihood of adverse fetal and infant outcomes, spontaneous preterm delivery, maternal mortality, and severe maternal morbidity (SMM).[2]

Poor maternal and infant outcomes not only have lasting effects on the mother and the infant, but also on the cost of health care services and the overall health of the Medicaid population.

DMMA contracts with two Medicaid MCOs to manage the care of Medicaid and CHIP beneficiaries, including women and infants enrolled in DSHP. DSHP members who are pregnant are eligible for CC services.[3]

For the purpose of this study, pregnant members are defined as any DSHP member who is pregnant in the first, second, or third trimester, as well as any postpartum member who is within 84 days of delivery.

One of the ways in which MCOs can achieve improved maternal and infant outcomes is through the provision of effective, evidence-based maternal health CC. In order to understand the extent to which DSHP members who are pregnant are receiving evidence-based standards of CC, DMMA requested its contracted EQRO, Mercer, complete a focus study of the maternal health CC provided by the State's MCOs.

---

[2] Bigby J, Anthony J, Hsu R, Fiorentini C, Rosenbach M. Recommendations for Maternal Health and Infant Health Quality Improvement in Medicaid and the Children's Health Insurance Program. Mathematica: December 18, 2020. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-expert-workgroup-recommendations.pdf

[3] See Appendix D for State Program Requirements found in the MCO MSA.

Study Question

The purpose of the study is to identify strengths and opportunities and to provide technical assistance specific to the provision of effective maternal health CC in the managed care program and to assess the following study question: Are DSHP members who are pregnant receiving evidence-based standards of CC?

Study Methodology

To complete the Maternal Health Care Coordination Focus Study (Focus Study), Mercer followed CMS EQR Protocol 9: Conducting Focus Studies of Health Care Quality.

The extent to which the MCOs are providing evidence-based CC for pregnant members was evaluated in July 2021 using both qualitative and quantitative approaches and was accomplished through the completion of the following study activities:

- Interviews with key DMMA program administrators.
- Review of Delaware MCO MSA requirements specific to CC and maternal health.
- Research to identify national professional CC practice standards and pregnancy management CC standards.
- Development of a RFI, to elicit information about MCO maternal health CC provided by the MCO.
- Completion of a desk audit documenting MCO responses to the RFI.
- Interviews with MCO leadership and administrative staff in order to better understand the information provided in the MCO RFI responses.
- Review of tracer scenarios with front line maternity CC staff to evaluate coordinators' competency to respond to pregnant members' needs and challenges.
- Review and scoring of member case files to assess the extent to which coordinators adhere to contractual requirements and other standards for the provision of CC to pregnant members.

This report provides a summary of the strengths and opportunities identified in the MCOs' CC programs. A detailed report that described the MCO's approach to maternal health CC and identified strengths and opportunities of the MCO's approach was developed for each MCO.

Conclusion

Effective maternal health CC programs are based on national standards of professional and clinical practice, and are provided by personnel with the appropriate experience, expertise, and training. These programs clearly identify the primary outcomes of effective maternal health care management, including how they will promote maternal and infant health and wellness, eliminate preventable maternal mortality, prevent SMM, reduce health disparities, and address HRSNs.

Results of the case file reviews for Level 1 Resource Coordination and Level 2 CCC suggest a need for both MCOs to assertively address opportunities for improvement in the provision and documentation of comprehensive maternal health CC across all domains and to address the overall level of member engagement. In particular, there is an opportunity to align processes for how the MCOs are assessing, addressing, and following up to ensure member HRSNs are met.

MCO A was unable to demonstrate that its maternal health CC program includes robust elements of an effective CC program, nor was it able to show that the program is founded on evidence-based standards of clinical practice or pregnancy/disease management. The EQRO provided several resources in the MCO specific report to inform the MCO's development of an evidence-based maternal health CC program. The MCO is encouraged to utilize these resources to develop and implement a robust evidenced-based maternal health CC program. Further, MCO A has struggled with maintaining stable CC program leadership and structure, which has negatively impacted overall program performance.

Once developed and implemented, it will be critical for MCO A to train all CC staff on the new program standards and the policies, procedures and workflows that provide the underpinnings for the newly developed program framework. It will also be critical for the MCO to develop a quality assurance process to ensure fidelity to program standards and to measure the effectiveness of the program. This quality assurance process should include not only quantitative measures, but also qualitative assessments by qualified supervisory staff. There is an opportunity to address the stability of the leadership of the maternal health CC program. Filling the leadership vacancies in the Health Services Director position and in the Maternity Supervisor position will be key to achieving leadership stability.

MCO B demonstrated many of the elements necessary for an effective maternal health CC program such as a draft program description, policies, and desk level procedures to guide the work of the resource coordinators and the clinical care coordinators. The CC department leadership is stable and knowledgeable about standards of practice, strong standards for CC with appropriate subject matter expertise, particularly in maternal health. There is a comprehensive CC training program in place. Focused member file audit procedures have been developed and include assessment of quantitative and qualitative aspects of CC. In order to fully achieve the goal of providing evidence-based CC to pregnant DSHP members, MCO B is encouraged to finalize and review the draft program description and framework to ensure it aligns with the elements of an effective, evidence-based maternal health CC program.

Once the program description and framework have been finalized, it will be important for MCO B to train all CC staff on the policies, procedures, and desk-level procedures that provide the underpinning for the newly developed program framework and provide ongoing monitoring and oversight to ensure fidelity to program standards.

Section 8

Performance Measurement and Reporting Technical Assistance

Strong State monitoring and oversight programs have both prospective and retrospective components. For Delaware, the QCMMR tool is one of the primary means of performance measurement used by DMMA. Additional critical means of oversight and monitoring are the quarterly CC and CM reports. Throughout 2021 the EQRO provided technical assistance to the MCOs to improve the accuracy, completeness, and consistency between MCOs of information submitted in both the QCMMR and the CC/CM reports.

Care Coordination Reports

DMMA requires the MCOs to report quarterly on CCC, resource coordination, and CM as one path to ensure access to timely quality care for DSHP and DSHP Plus members. In 2019, in an effort to alleviate challenges for DMMA with gathering accurate and reliable PMs, Mercer developed standard reporting templates for submission of the PMs by both MCOs and refined the technical specifications. In 2020 and 2021, Mercer continued to facilitate technical assistance sessions for the use of the required standardized templates and technical specifications with DMMA and the MCOs as well as validate the quarterly PMs for accuracy and consistency in information and analysis of the data submitted and answer ongoing questions from the MCOs.

The following tables present data on CCC activities through quarter 4 2021. As described previously in this report, ACDE began operating in Delaware in 2018; the membership distribution between HHO and ACDE was approximately 2:1. While there has been some redistribution of membership, HHO still manages the majority of members.

Resource Coordination (Level 1)	MCO	Quarter 1 2021	Quarter 2 2021	Quarter 3 2021	Quarter 4 2021
Number of members identified as Level 1 during the quarter.	ACDE	8,807	6,407	7,169	8,615
	HHO	4,120	3,615	3,705	3,554
Number of Level 1 members who received assistance from Contractor's resource coordination staff with discharge planning following a PH inpatient stay and/or follow a BH inpatient stay.	ACDE	48	261	103	203
	HHO	156	162	177	378

Resource Coordination (Level 1)	MCO	Quarter 1 2021	Quarter 2 2021	Quarter 3 2021	Quarter 4 2021
Number of Level 1 members who received discharge planning assistance following a PH or BH inpatient visit who were seen by a PCP within 14 calendar days of the MCO being notified of their discharge from the inpatient facility.	ACDE	8	66	66	164
	HHO	35	34	43	91
The number of Level 1 members who received discharge planning assistance following a PH or BH inpatient visit but were readmitted to an inpatient facility within 30 calendar days.	ACDE	17	130	39	82
	HHO	25	22	23	83

Level 2 CCC	MCO	Quarter 1 2021	Quarter 2 2021	Quarter 3 2021	Quarter 4 2021
Total number of members identified as Level 2, including members newly identified to Level 2 during the quarter.	ACDE	3,746	3,746	2,895	3,831
	HHO	4,431	4,975	4,925	5,326
Number and percent of Level 2 members who CCC staff were unable to contact.	ACDE	418 11%	349 9%	359 12%	586 15%
	HHO	416 9%	424 9%	572 12%	365 7%
Number of newly identified Level 2 members who declined participation in CCC.	ACDE	4	2	2	6
	HHO	1,043	1,113	912	1,025
Number of virtual face-to-face interactions CCC staff had with Level 2 members in the community, member homes, and in provider locations.	ACDE	239	131	46	101
	HHO	774	1,130	165	139
Number of Level 2 members who were reassessed as eligible to move to a lower level of CC (i.e., Level 1 or All Member level).	ACDE	28	23	25	7
	HHO	105	122	105	83

Quality Care Management and Measurement Reporting

The QCMMR acts as an early alert system to address potential, emerging concerns about the quality, access, and timeliness of care management operations of the State-contracted MCOs. As an early alert system, the report relies on self-reported data from the MCOs, which is submitted monthly via a secure file transfer protocol site using standardized data-submission templates in Microsoft Excel. When variance in expected results occurs, the MCOs are expected to provide a brief description of the corrective action or

steps taken to remediate the variance. The EQRO provides technical assistance to the MCOs to ensure the data submitted to DMMA are complete, accurate, and reliable. Trends regarding the data are analyzed quarterly and comparisons are made within each MCO and across MCOs, and when changes in trends are identified, the MCOs are asked to provide a response.

Summary of Diamond State Health Plan QCMMR Findings through Quarter 4 2021

Health Risk Assessment

HRAs serve as a key to identifying and engaging members in need of services early in their experience with an MCO. The DMMA contractors, ACDE and HHO, are contractually required to complete HRAs with at least 50% of their newly enrolled members within 60 days of enrollment. Both MCOs have fallen short of that contractual obligation through 2021; the Year-to-Date (YTD) average percentage of HRAs completed was 33% for ACDE and 48% for HHO, which was an improvement from Q4 2020.

Access to Care

Through Quarter 4 2021 for all standards, ACDE reported the following access:

- Primary care practitioner (Adult) access — routine 100.0%
- Primary care practitioner (Adult) access — urgent 100.0%
- Primary care practitioner (Adult) access — emergency 100.0%
- Primary care practitioner (Pediatric) access — routine 100.0%
- Primary care practitioner (Pediatric) access — urgent 100.0%
- Primary care practitioner (Pediatric) access — emergency 100.0%

Through Quarter 4 2021 for all standards, HHO reported the following access to care:

- Primary care practitioner (Adult) access — routine 92.0%
- Primary care practitioner (Adult) access — urgent 94.0%

- Primary care practitioner (Adult) access — emergency 87.5%
- Primary care practitioner (Pediatric) access — routine 96.0%
- Primary care practitioner (Pediatric) access — urgent 100.0%
- Primary care practitioner (Pediatric) access — emergency 100.0%

Appeals

Appeals are documented in the month in which they are filed, and any appeals resolved are counted in the month during which they have been resolved. The appeals process for both HHO and ACDE needs continued monitoring due to a large percentage of withdrawn appeals at both ACDE and HHO. ACDE had fewer overturned appeals than HHO. Given the difference in membership between the two MCOs more data may be needed before conclusions about differences between the MCOs can be drawn. The following are YTD appeals rates through Quarter 4 2021.

- Appeals were overturned prior to appeals committee at a higher rate at HHO (41%) verses ACDE (27%)
- Appeals were overturned at appeals committee at a higher rate at ACDE (16%) verses HHO (12%)
- Appeals were withdrawn at a higher rate at HHO (24%) verses ACDE (23%)

Grievances

As with the appeals information displayed above, the difference in membership makes comparisons between the MCOs difficult for the topic of grievances. HHO had a slightly higher rate of grievances per 1,000 members (1.36) compared to ACDE (0.49). All data presented below are through Quarter 4 2021.

- Quality of service: The highest percentage of grievances for both MCOs was in this category. The YTD total grievances related to QOC for HHO was 65 and for ACDE was 15.
- Access and availability: ACDE reported a smaller percentage of overall grievances in this category than HHO.
- QOC: ACDE reported 4 and HHO reported 42 grievances in this category.
- Transportation to medical appointment: HHO had a small number (12) of transportation grievances, while ACDE reported one.

- Cultural competency: A small percentage of grievances for both MCOs was related to cultural competency.
- Billing and/or claims: HHO had a much larger percentage of grievances in this category than ACDE. This result was not surprising given the ongoing challenges HHO faced following its claims payment system migration.

Utilization Management — Inpatient

The inpatient utilization (medical, surgical, maternity, neonatal intensive care unit, rehab/SNF, BH, MH/SUD rehab) data was similar in comparing the MCOs for all categories, with the exception of Surgical and Behavioral Health Acute Care rates. HHO's numbers for inpatient surgical services are significantly higher than ACDE while ACDE's inpatient BH acute care services were significantly higher than HHO. HHO acknowledged the surgical utilization increase was driven by services during the month of December. ACDE inpatient BH acute care services are consistent across quarters.

Utilization Management — Outpatient

The outpatient utilization data was similar for both MCOs with a few exceptions. The average rate of ambulatory care outpatient visits for HHO was approximately 30 times higher than the rate reported for ACDE. Lastly, the average rate of MH outpatient visits for ACDE was approximately three times higher than the rate reported by HHO.

Summary of Diamond State Health Plan Plus QCMMR Findings for 2021

Access and Availability

The number of providers for both MCOs are similar with a few exceptions. For Quarter 4, HHO has a slightly higher number of Home Health providers than ACDE. For BH, ACDE reports on average 1,481 providers while HHO reports on average 1,459 providers. For Atypical, HHO reports on average 132 providers while ACDE reports on average 80 providers. For Dental, HHO reports on average 151 providers while ACDE reports on average 106 providers. These findings are consistent with Quarter 3 provider numbers.

Case Management

For the Quarter 4 DSHP Plus membership, there are more members active in CM for HHO in comparison to ACDE, which is an expected result given the differences in membership between the MCOs. Comparing the rates, HHO is averaging 87% of HCBS reassessments being completed within 30 days while ACDE is averaging 82% of HCBS reassessments being completed within 30 days for Quarter 4. For institutional reassessments, HHO is averaging 78% while ACDE is averaging 87%.

Safety/Welfare

As anticipated, the distribution of CIs is heavily concentrated on HCBS versus institutional services. The MCOs are responsible for identifying and reporting all potential CIs to DMMA. DMMA works closely with other State agencies and entities to investigate all reported CIs. Each reported incident is thoroughly investigated by the appropriate State agency and CI data is analyzed for trends and when appropriate, performance improvement activities are implemented to address identified issues. The CIs reported by category[4] through Quarter 4 2021 were:

- Unexpected deaths: ACDE reported 1, HHO reported 2
- Physical, mental, sexual abuse, or neglect: ACDE reported 4, HHO reported 8
- Theft or exploitation: ACDE reported 3, HHO reported 3
- Severe injury: ACDE reported 0, HHO reported 2
- Medication error: ACDE reported 2, HHO reported 0
- Unprofessional provider: ACDE reported 2, HHO reported 3

Grievances

Through Quarter 4 2021, there were 33 grievances filed by DSHP Plus members in ACDE and 162 in HHO. While a higher number of grievances is not desired as this indicates some level of dissatisfaction, in previous years there was a significant concern that, based on the extremely low numbers reported, grievances were not being appropriately identified, tracked, and trended.

Appeals

The overall number of appeals is low, ACDE reported one appeal during Quarter 4 which was upheld (100%). HHO reported 10 appeals during Quarter 4, two of which were denied (20%), five were withdrawn (50%), two were upheld (20%), and one was overturned at appeals committee (10%).

[4] *Data reported in this table pertains to potential CIs and does not represent the final disposition of the event once it is investigated.*

Utilization Management — Inpatient

The medical admissions/1000 and ALOS metrics were comparable between the MCOs with the exception of days/1000 where ACDE was higher at 169.6 and HHO at 145.4. Reviewing surgical services, days/1000 for HHO was higher during Quarter 3, with HHO at 56.8 and ACDE at 2.1. HHO had much higher inpatient utilization for rehab/SNF than ACDE with the days/1000 during Quarter 3 for HHO at 56.8 and ACDE at 6.6. ACDE has slightly higher BH utilization than HHO.

Utilization Management — Outpatient

Outpatient utilization rates per 1,000 members show striking differences in utilization patterns. These differences indicate a need for additional investigation.

- Outpatient ED visits: ACDE reported 90.7, HHO reported 71.8
- Outpatient BH services: ACDE reported 897.4, HHO reported 115.1
- Adult physical exam visits: ACDE reported 9.6, HHO reported 1.0
- DME services: ACDE reported 122.9, HHO reported 132.0
- Imaging/radiology services: ACDE reported 185.4, HHO reported 214.0

HEDIS and CAHPS Results

HEDIS

These sections provide an overview of two of the six HEDIS domains: Access to Care and QOC. Data for this report include information from medical charts and provider claims (e.g., encounter data from EHRs, claims data from billing systems, etc.) within Delaware's Medicaid managed care network. The NCQA originally designed HEDIS to allow consumers to compare health plan performance against the quality of other health plans and national/regional benchmarks. In this section, the following rating scales are used:

			
HEDIS rating met or exceeded the national benchmark for the 90th percentile	HEDIS rating fell between the national benchmarks for the 75th and the 90th percentile	HEDIS rating fell between the national benchmarks for 50th and the 75th percentile	HEDIS ratings fell below the national benchmark for the 50th percentile

There is significant opportunity for improvement in HEDIS results for both MCOs. Presented below are 36 select HEDIS measures across various domains of care.

Of the 36 reported measures for ACDE, one measure, inpatient utilization — surgery ALOS, was at or above the 90th percentile. Seven measures, postpartum care, appropriate treatment for children with upper respiratory infection, inpatient utilization (surgery days/1,000), total inpatient days/1,000, total inpatient ALOS, and MH utilization (inpatient services and intensive outpatient and partial hospitalization), were at or above the 75th percentile. ACDE reported four measures where the HEDIS rate improved by one percentage point or greater, 15 measures where the HEDIS rate did not change by more than one percentage point, and three measures where the HEDIS rate declined by one percentage point or greater from 2020 to 2021. Sixteen of ACDE's HEDIS results for these 36 measures (44%) were below the 50th percentile.

Of the 36 reported measures for HHO, two measures, timeliness of prenatal care and inpatient utilization — total inpatient ALOS, were at or above the 90th percentile. Ten measures, well-child visits in the first 30 months of life (15–30 months), inpatient utilization (maternity and surgery ALOS), medicine, surgery, and total days/1,000, medicine, surgery, and total discharges/1,000 and MH utilization (any services), were at or above the 75th percentile. HHO reported four measures where the HEDIS rate was a one percentage point or greater, 24 measures where the HEDIS rate did not change by more than one percentage point, and two measures where the HEDIS rate had declined by one percentage point or greater. Fifteen of HHO's HEDIS results for these 36 measures (42%) were below the 50th percentile.

2021 HEDIS Measure	2021 ACDE Ratings	2021 HHO Ratings
Access and Availability of Services		
Child and adolescent well-care visits — 12 years to 17 years	47.60%	56.13%
Child and adolescent well-care visits — 18 years to 21 years	22.78% 	27.96% 
Child and adolescent well-care visits — 3 years to 11 years	57.19%	62.95%
Child and adolescent well-care visits — Total	48.47% 	55.68% 

2021 HEDIS Measure	2021 ACDE Ratings	2021 HHO Ratings
Adults' access to preventive services — 20 years to 44 years	68.70%	74.72%
Adults' access to preventive services — 45 years to 64 years	79.58%	83.63%
Adults' access to preventive services — 65 years and older	83.62%	85.48%
Timeliness of prenatal care	87.78%	92.21%
Postpartum care	80.28%	70.07%
Prevention and Screening		
Lead screening in children	65.45%	77.37%
Breast cancer screening	45.80%	51.80%
Cervical cancer screening	45.99%	62.29%
Diabetes		
Comprehensive diabetes care — HbA1C screening	78.10%	81.02%
Comprehensive diabetes care — eye exam (retinal)	45.50%	42.58%
Cardiovascular Conditions		
Controlling high blood pressure	46.96%	49.64%
Overuse/Appropriateness		
Appropriate treatment for children with upper respiratory infection	95.02%	93.53%
Behavioral Health		
Antidepressant medication management — acute phase	53.31%	54.06%
Antidepressant medication management — continuation phase	38.26%	38.56%
Utilization		
Well-child visits in the first 30 months of life — first 15 months	77.80%	65.25%
Well-child visits in the first 30 months of life —15 through 30 months	57.32%	78.00%

2021 HEDIS Measure	2021 ACDE Ratings	2021 HHO Ratings
Inpatient utilization — maternity days/1,000	7.66	6.15
Inpatient utilization — maternity discharges/1,000	2.93	2.18
Inpatient utilization — maternity ALOS	2.62	2.83
Inpatient utilization — medicine days/1,000	13.73	18.25
Inpatient utilization — medicine discharges/1,000	2.92	3.69
Inpatient utilization — medicine ALOS	4.71	4.95
Inpatient utilization — surgery days/I,000	15.61	17.71
Inpatient utilization — surgery discharges/1,000	1.51	1.78
Inpatient utilization — surgery ALOS	10.30	9.97
Inpatient utilization — total inpatient days/1,000	35.24	40.20
Inpatient utilization — total inpatient discharges/1,000	6.69	6.97
Inpatient utilization — total inpatient ALOS	5.27	5.77
MH utilization — inpatient services	1.49%	1.22%
MH utilization — intensive outpatient and partial hospitalization	0.71%	0.28%
MH utilization — outpatient	11.08%	12.78%
MH utilization — any	15.25%	16.63%

According to NCQA, "*Discharge rates may be high when a health plan's population is unusually sick, and will be higher when a plan serves an older population. However, high rates are often a sign that access to high-cost inpatient care is not appropriately managed, or that ambulatory care is not used effectively. With mental illness widely under diagnosed, higher rates may mean that more patients with mental illness have been identified and have begun treatment. Lower rates may signal poorer rates of detection or barriers to care for patients with mental illness. However, especially where behavioral health care is carved out, low rates may indicate that*

necessary data are not available to the health plan. In this case, patients may be receiving care, but without access to the data, there is no assurance of this. It is best to view this statistic in the context of other data that determine utilization of mental health services."[5]

For the reasons listed above, the measures listed below are considered "inverse" measures and MCOs reporting in lower percentiles generally illustrate more appropriate utilization. In this section, the following scale is used:

			
HEDIS rating met or exceeded the national benchmark for the 50th percentile	HEDIS rating fell between the national benchmarks for the 25th and the 50th percentile	HEDIS rating fell between the national benchmarks for 10th and the 25th percentile	HEDIS ratings fell below the national benchmark for the 10th percentile

2021 HEDIS Measure	2021 ACDE Ratings	2021 HHO Ratings
Utilization		
Ambulatory care — ED Visits/1,000	47.92 ★	41.91 ★
MH utilization — ED	0.02% ●	0.01% ●

As the table above displays, the MCOs are performing relatively well in these utilization areas. Both MCOs reported rates increased in the area of ambulatory care and no change in for MH utilization — ED from the previous year.

CAHPS

The CAHPS survey captures reliable information from consumers about their experiences with health care and focuses on quality aspects such as communication skills of providers and ease of access to health care services. There are separate versions of the survey for adult and pediatric patients (administered to parents or guardians). Additionally, unlike HEDIS, which evaluates performance from the prior year, CAHPS evaluates a member's experience within the past three-months. The tables below present CAHPS measures results and composite scores. Composite scores are created by grouping results for questions that address a

[5] *Quality Compass, "2019 Medicaid: Interpreting the Measures, HEDIS and CAHPS," March 19, 2021,* https://www.qualitycompass.org/QcsExternal/HelpDoc.aspx?docID=1.

specific topic (e.g., Getting Care Quickly). The NCQA uses survey results for health plan performance reporting, to inform accreditation decisions and to create nationally comparative benchmarks for care.

Goal number 4 listed in the Delaware Medicaid Quality Strategy relates to assurance of member satisfaction with services. Delaware has emphasized the importance of the service experience of Medicaid enrollees. Enrollees possessing confidence in services delivered to them may engage those services more effectively and more often, which increases the likelihood of a healthier membership population. The following results include CAHPS composite scores developed by combining individual items to form a broader focus to assign to a single number.

ACDE's performance from 2020 to 2021 demonstrated improvement. ACDE's members gave the highest scoring for the measure All Health Care, which was above the 90th percentile on both the adult and child CAHPS surveys. However, both the adult and child CAHPS surveys highlight a significant opportunity for improvement across Getting Needed Care and Getting Care Quickly measures with ratings falling below the 50th percentile in both categories. In 2021, respondents gave the highest scores on the Rating of Personal Doctors, Rating of Specialists, and Ratings of the Health Plan measures; and gave the lowest scores on Getting Needed Care, Getting Care Quickly, and How Well Pediatric Doctors Communicate measures.

HHO's performance from 2020 to 2021 demonstrated improvement. HHO's members gave the highest scoring to the Rating of Health Plan measure which was above the 90th percentile on both the adult and child CAHPS surveys. Additionally, adult CAHPS survey respondents gave the highest rating to the Getting Care Quickly measure; and for the child CAHPS survey, respondents gave the highest rating to Rating of Personal Doctor measure. There was one area, Getting Needed Care, where HHO showed a decline in performance. All seven measures for the HHO adult CAHPS survey and four measures for the HHO child CAHPS survey were above the 50th percentile. The child CAHPS survey highlight a significant opportunity for improvement across Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate.

The following shows the rating scale applied by EQRO evaluators to assess MCO and provider performance:

			
CAHPS rating met or exceeded the national benchmark for the 90th percentile	CAHPS rating fell between the national benchmarks for the 75th and the 90th percentile	CAHPS rating fell between the national benchmarks for 50th and the 75th percentile	CAHPS ratings fell below the national benchmark for the 50th percentile

Delaware Medicaid MCO CAHPS Survey Results — Adults

Adult CAHPS Ratings	2021 ACDE Ratings	2021 HHO Ratings
Rating of personal doctor	87.00%	83.30%
Rating of specialist	85.50%	86.80%
Rating of all health care	83.10%	78.20%
Rating of health plan	83.90%	84.90%
Getting needed care	82.80%	88.40%
Getting care quickly	80.10%	88.60%
How well doctors communicate	94.40%	94.30%

Delaware Medicaid MCO CAHPS Survey Results — Children

Child CAHPS Ratings	2021 ACDE Ratings	2021 HHO Ratings
Rating of personal doctor	93.10%	94.80%
Rating of specialist	92.50%	87.80%
Rating of all health care	91.10%	89.40%
Rating of health plan	87.40%	92.20%
Getting needed care	84.50%	82.60%
Getting care quickly	88.10%	87.50%
How well doctors communicate	92.30%	94.50%

Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com