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Diamond State Health Plan

Section 1115 2019 Annual and 4th Quarterly Report

Demonstration Years 23 and 24: (1/1/2019 – 7/31/2019) and 24 (8/1/2019 – 12/31/2019)

Federal Fiscal Quarter 4-2019: 10/1/2019 – 12/31/2019

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Table of Contents

Introduction

Delaware's Diamond State Health Plan (DSHP) 1115 Demonstration Waiver was initially approved in 1995, and implemented beginning on January 1, 1996. The original goal of the demonstration was to improve the health status of low-income Delawareans by expanding access to healthcare to more individuals throughout the State; creating and maintaining a managed care delivery system with an emphasis on primary care; and controlling the growth of healthcare expenditures for the Medicaid population. The DSHP 1115 Demonstration was designed to mandatorily enroll eligible Medicaid recipients into managed care organizations (MCOs) and create cost efficiencies in the Medicaid program that could be used to expand coverage. Delaware achieved its objective of implementation of mandatory managed care focused on primary care in 1996 and invested the resulting waiver savings in Delaware's Medicaid eligibility coverage expansion to uninsured adults up to 100% of the federal poverty level (FPL). Long before Medicaid expansion under the Affordable Care Act, Delaware was a pioneer in coverage expansion for individuals who would otherwise not be eligible for Medicaid. Delaware built upon this success with the eventual expansion of coverage for family planning services, leading up to participating in Medicaid expansion under the Affordable Care Act (ACA) in 2014.

Through an amendment approved by CMS in 2012, Delaware was authorized to create the Diamond State Health Plan Plus (DSHP-Plus), which is Delaware's managed long-term services and supports (MLTSS) program. Additional state plan populations to receive services through MCOs, including:

(1) individuals receiving care at nursing facilities (NF) other than intermediate care facilities for the mentally retarded (ICF/MR);
(2) children in pediatric nursing facilities;
(3) individuals who receive benefits from both Medicaid and Medicare (dual eligibles); and
(4) workers with disabilities who buy-in for coverage.

This amendment also added eligibility for the following new demonstration populations:

(1) individuals who would previously have been enrolled through the 1915(c) home and community based services (HCBS) waiver program for the Elderly and Disabled. This include those receiving services under the Money Follows the Person demonstration;
(2) individuals who would previously have been enrolled though the 1915(c) HCBS waiver for Individuals with Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS) Related Diseases;
(3) individuals residing in NF who no longer meet the current medical necessity criteria for NF services; and
(4) adults and children with incomes below 250 percent of the Supplemental Security Income Federal Benefit Rate who are at risk for institutionalization.

Additionally, this amendment expanded HCBS to include:

(1) cost-effective and medically necessary home modifications;
(2) chore services; and
(3) home-delivered meals.

In 2013, the demonstration was renewed and amended to provide authority to extend the low income adult demonstration population to individuals with incomes up to 100 percent of the FPL until December 31, 2013. After that date, the demonstration population was not necessary because it was included under the approved state plan as the new adult eligibility group authorized under the ACA. The new adult group, for individuals with incomes up to 133 percent of the FPL, receive medical assistance through enrollment in MCOs pursuant to this demonstration. In addition, Delaware's authority for the family planning expansion program under this demonstration expired December 31, 2013, when individuals became eligible for Medicaid expansion or Marketplace coverage options.

The demonstration was amended in 2014 to authorize coverage for enhanced behavioral health services and supports for targeted Medicaid beneficiaries through a voluntary program called Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) starting in 2015. PROMISE enrollees include Medicaid beneficiaries who have a severe and persistent mental illness (SPMI) and/or a substance use disorder (SUD) and require HCBS to live and work in integrated settings.

Technical changes were incorporated into the demonstration in October 2017 and an amendment was approved in December 2017 to add coverage for out-of-state former foster care youth.

In July 2019, the demonstration was extended for an additional five years and an amendment approved to provide the state with authority to provide high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD).

Delaware's goals in operating the demonstration are to improve the health status of low-income Delawareans by:

- Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS;
- Rebalancing Delaware's LTC system in favor of HCBS;
- Promoting early intervention for individuals with, or at-risk, for having, LTC needs;
- Increasing coordination of care and supports;
- Expanding consumer choices;
- Improving the quality of health services, including LTC services, delivered to all Delawareans;
- Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTSS services where appropriate;
- Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles;
- Improving overall health status and quality of life of individuals enrolled in PROMISE;
- Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population; and

- Increase enrollee access and utilization of appropriate SUD treatment services; decrease use of medically inappropriate and avoidable high-cost emergency and hospital services; increase initiation of follow-up SUD treatment after emergency department discharge; and reduce SUD readmission rates.

The DSHP demonstration includes five distinct components: 1) The DSHP Medicaid managed care program provides Medicaid state plan benefits through a comprehensive managed care delivery system to most recipients eligible under the state plan; 2) The DSHP Plus program provides long-term care services and supports (LTSS) to certain individuals under the State Plan, and to certain demonstration populations; 3) The PROMISE program provides enhanced behavioral health services fee-for-service (FFS) to Medicaid beneficiaries with a higher level of behavioral health needs and functional limitations who need HCBS to live and work in integrated settings; 4) Coverage for former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care at age 18 (or such higher age as elected by the state), were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid; and 5) Coverage for high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as IMDs.

In accordance with the STCs of the DSHP 1115 demonstration, the Delaware Division of Medicaid and Medical Assistance submits this fourth quarter report (for the quarter ending December 31, 2019) and annual report for Calendar Year 2019, Demonstration Years 23 and 24 (due to the impact of a temporary extension of the demonstration.)

Enrollment Information and Enrollment Counts

Q4 Enrollment

Demonstration Populations	Current Enrollees (to date)	Disenrolled in Current Quarter
Population 1: Former AFDC Children less than 21 (DSHP TANF Children)	88,094	6,368
Population 2: Former AFDC Adults aged 21and over (DSHP TANF Adult)	30,392	3,705
Population 3: Disabled Children less than 21 (DSHP SSI Children)	5,355	249
Population 4: Aged and Disabled Adults 21 and older (DSHP SSI Adults)	6,605	354
Population 5: Infants less than one year of age with income levels above 185 percent FPL through 200 percent FPL; optional targeted low income children (DSHP MCHIP)	0	N/A
Population 6: Uninsured Adults up to 100% FPL (DSHP Exp. Pop.)	67,390	7,915
Population 7: Family Planning Expansion (FP Expansion)	None; program terminated in 2013	N/A
Population 8: DSHP-Plus State Plan	10,284	587
Population 9: DSHP-Plus HCBS	5,361	236
Population 10: DSHP TEFRA-Like	282	N/A
Population 11: Newly Eligible Group	10,178	1,129
Population 12: PROMISE	1,430	52
Population 13: Former Foster Care Youth	0	N/A

Definition: "Current Enrollees (to date) is an unduplicated count of clients in the MCO for at least one day in the October 1, 2019 to December 31, 2019 period based on capitation claims and for the MC and PROMISE enrollment and eligibility files. Clients who were in more than one eligibility category during the quarter are reported based on their last status (most recent month). Age calculated as of the first day of the most recent month of enrollment, consistent with reporting of member months.

2019 Annual Enrollment

Demonstration Populations	Current Annual Enrollees (to date)
Population 1: Former AFDC Children less than 21 (DSHP TANF Children)	103,758
Population 2: Former AFDC Adults aged 21and over (DSHP TANF Adult)	40,316
Population 3: Disabled Children less than 21 (DSHP SSI Children)	5,717
Population 4: Aged and Disabled Adults 21 and older (DSHP SSI Adults)	7,206
Population 5: Infants less than one year of age with income levels above 185 percent FPL through 200 percent FPL; optional targeted low income children (DSHP MCHIP)	0
Population 6: Uninsured Adults up to 100% FPL (DSHP Exp. Pop.)	74,903
Population 7: Family Planning Expansion (FP Expansion)	None; program terminated in 2013
Population 8: DSHP-Plus State Plan	11,680
Population 9: DSHP-Plus HCBS	5,784
Population 10: DSHP TEFRA-Like	301
Population 11: Newly Eligible Group	12,083
Population 12: PROMISE	1,690
Population 13: Former Foster Care Youth	0

Outreach/Innovative Activities

Q4 MCO and State Outreach Events, Special Topic Meetings and Workgroups

Highmark Health Options Outreach Events

Here are two examples of Highmark Health Options outreach events for this quarter:

- Operation Warm - In December 2018, HHO partnered with Operation Warm to provide 500 brand new winter coats to students at Anna P. Mote Elementary School in Wilmington Delaware. In 2019, HHO has renewed its commitment to students in Delaware by hosting two events to distribute approximately 1000 coats to grade school children, Pre-K through 5th grade. Approximately 99% of the entire student body at both schools qualify for FARM (Free and Reduced Meal Program, below poverty and low-income households). The first event was held at Dover Elementary in Kent County on November 26th, 2019. The second event took place in Wilmington at William C. Lewis Elementary on December 5, 2019. Over 115 volunteers from HHO and other Highmark Delaware markets volunteered to fit each child with a brand-new coat for the upcoming winter season.

- Delaware Healthcare Association - Highmark Health Options President and CEO Todd Graham participated in a panel discussion at the Delaware Healthcare Association's annual Health Care forum. This panel discussed the new value-based contract with Christina Care Health System and how to break the barriers between payers and providers. Jennifer Schwartz of Christiana Care and Emmilyn Lawson of AmeriHealth Caritas DE also participated on the panel. The panel was moderated by Tom Brown, Nanticoke Physician Network, and they looked at the keys to creating these successful value based partnerships, including trust in one another.

AmeriHealth Caritas Outreach Events

Here are two examples of AmeriHealth Caritas DE outreach events for this quarter:

- Behavioral Health Provider Forums – In November 2019, Dr. Weisman completed all of the AmeriHealth Caritas DE (ACDE) Behavioral Health specific provider forums throughout the state. Rockford and Dover Behavioral Health Hospitals attended our New Castle County Forum. Providers in attendance in Kent and Sussex counties included Bayhealth, Thresholds, FHR, Dover Behavioral Health, Sun Behavioral Health, Hudson RTF, Wayne Singleton, Addiction Medical Facilities, Nanticoke Physicians Network, Milestones, Healing Pathways Counseling, Peace of Minds, Connections, At Home Care, Gateway Foundation, and AMF Your Center. The Forum Agenda included Naloxone discussion, Behavioral Health and ASAM Levels of Care in Delaware, SB109, ADHD Clinical Practice Guidelines as well as prior authorizations, billing, and reimbursement issues.

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- Delaware Dementia Conference - On November 20, 2019 AmeriHealth Caritas DE participated in the Delaware Dementia Conference in Dover, DE. The focus of this conference is on educating and providing participants with various resources to support families and loved ones who suffer from Dementia.

Special Interest Meetings/Conferences

Pharmacy Reimbursement Task Force Meeting - The Medicaid Director attended the second meeting of the Pharmacy Reimbursement Task Force on October 9, 2019. The group continues to review legislative and regulatory actions in other states related to oversight of Pharmacy Benefit Managers. A primary focus is development of regulatory authority in the Department of Insurance to register or license PBMs and associated transparency requirements.

Advancing Health Equity Learning Collaborative - DMMA, Amerihealth Caritas Delaware, and Nemours/AI Dupont are working together to reduce health disparities as members of the Advancing Health Equity Learning Collaborative. Dr. Elizabeth Brown represented DMMA at the kick-off on October 2-3, 2019 that included teams from all seven participating states. In order to participate, teams needed representation from a state Medicaid agency, a Medicaid MCO, and a Medicaid provider that agreed to work over the course of two years to design integrated payment and health care delivery reforms to reduce health disparities and address social determinants of health. Advancing Health Equity, AHE is based at the University of Chicago and conducted in partnership with the Institute for Medicaid Innovation and the Center for Health Care Strategies.

Western Medicaid Pharmacy Administrators Association (WMPAA) – Christiana Ogunremi, DMMA Pharmacy Director, attended WMPAA (Western Medicaid Pharmacy administrators association) October 5-9, 2019 in Idaho. The meeting was attended by over 25 Medicaid states with topics focusing on Value Based Purchasing, 340B & Rebate challenges and drug price transparency issues with PBM's and MCOs. There was a large focus on the Ohio program beginning in 2017, which uncovered major issues with spread pricing. Subsequently, analyses have been conducted in New York, Illinois, Michigan, and Kentucky. Spread pricing was found in every State.

Medicaid Evidence-Based Decision (MED) - DMMA Medical Director, Dr. Elizabeth Brown attended the MED project Fall meeting Nov. 10-11. The meeting focused on child health policy. The MED team facilitated discussions across states on topics like engaging foster youth, school-based wellness, and models of perinatal care.

State Testing Collaborative (STC) - DMMA will be participating in a Quality Rating Scale State Testing Collaborative (STC). The multistate STC is being facilitated by Mathematica and CMS. Working through the two test measures, pediatric preventive dental care and hospitalizations for diabetes complications, with our MCOs will help us improve our quality analytics skills and also provide feedback to CMS to inform the development of the future MCO quality rating scale.

National Governor's Association Health Summit on Pharmaceuticals & Vaccine Preventable Disease – DMMA Pharmacy Director, Christiana Ogunremi, R.Ph., attended the NGA Fall Conference at Washington DC, December 3 – 5, 2019. There was participation from 35 States. The discussions centered on how programs can provide access to vulnerable populations while ensuring affordability and PBM strategies.

Delaware Family Voices - DE Medicaid continues to support Delaware Family Voices. Caring for children with special needs is often complex, and Delaware Family Voices and the Family to Family Health Information Center is in the unique position to help. This organization states that "We help families of children with special needs become informed, experienced, and self-sufficient advocates for their children and themselves." DMMA and our managed care organizations, Highmark Health Options and AmeriHealth Caritas DE participate in these monthly calls assisting families to navigate the complex healthcare field. There were three monthly calls this quarter: October 8, November 12, and December 10, 2019. DMMA stays in regular contact with Delaware Family Voices outside of scheduled calls to assist any Medicaid family in need.

Post-award Public Forum

No comments were received on the approved renewal of the DSHP 1115 Waiver.

2019 Annual Report on MCO and State Outreach Activities, Special Topic Meetings and Workgroups

MCO Outreach Activities - DSHP MCOs continue to be very engaged in community outreach and engagement, participating in events that have included, but are not limited to, Delaware's Dementia Conference, Operation Warm, Wellness events and community safety meetings.

DMMA Outreach Activities, Special Topic Meetings and Workgroups - Examples of DMMA's outreach activities in 2019 include:

- Monthly calls with the MCOs and Family Voices, which represents children with special health care needs.

- Working with stakeholders to address the needs of children with medical complexity through the Children with Medical Complexity Advisory Committee (CMCAC). This group meets quarterly to strengthen the system of care, increase collaboration across agencies, encourage community involvement, and ultimately ensure that every child with medical complexity has the opportunity to receive the adequate and appropriate health care services they need and deserve.

- Attending the National Governor's Association Opioid Summit for New Administrations. Stephen Groff participated in a panel discussing Access to Non-Pharmacologic Treatments for pain along with the Medical Director for the Oregon Health Evidence Review Commission. The

meeting focused strongly on data/surveillance efforts and emerging threats, including stimulants and methamphetamines as well as harm reduction strategies.

- Attending the National Governor's Association Health Summit on Pharmaceuticals & Vaccine Preventable Disease. DMMA Pharmacy Director, Christiana Ogunremi, R.Ph., attended the NGA Fall Conference at Washington DC, December 3 – 5, 2019. There was participation from 35 States. The discussions centered on how programs can provide access to vulnerable populations while ensuring affordability and PBM strategies.

- Attending the Advancing Health Equity Learning Collaborative. DMMA, Amerihealth Caritas Delaware, and Nemours/AI Dupont are working together to reduce health disparities as members of the Advancing Health Equity Learning Collaborative. Dr. Elizabeth Brown represented DMMA at the kick-off on October 2-3, 2019 that included teams from all seven participating states.

- Participating in the Interagency Pharmaceuticals Purchasing Study Group – In September 2019, the Medicaid Director participated in the second meeting of the Study Group. This Study Group was established in House Concurrent Resolution 35 by the state Legislature to research and evaluate opportunities to leverage the bulk purchasing of pharmaceuticals in Delaware to negotiate lower prices including inter-agency purchasing contracts and contracts with a multi-state consortium.

- Participating in the Medicaid Medical Director's Learning Network - Dr. Elizabeth Brown, DMMA Medical Director, attended the Medicaid Medical Director's Learning Network meeting in Washington, DC on September 18, 2019. The conference focused on maternal morbidity and mortality, and included sessions on learning from maternal mortality reviews, innovative models to treat neonatal abstinence syndrome, and the role of Medicaid in postpartum health.

- Participating in the Child and Adult Core Set Stakeholder Workgroup – Stephen Groff was selected to serve on the Child and Adult Stakeholder Workgroup for the 2020 Annual Review. The Workgroup is charged with assessing the 2019 Core Sets and making recommendations to CMS for removal or addition of measures to strengthen and improve the Core Sets for 2020.

- Participating in three panel discussions at the Spring Symposium for National Association of States United for Aging and Disabilities (NASUAD, now Advancing States): "Seniors and Persons with Disabilities want to Work, how can we help them", "It's not just HCBS Tackling Institutional Care" and "Feeducation": How States, Health Plans, and Community Based Organizations Can Work Together to End Senior Hunger." The Spring Symposium was focused on Managed Long Term Supports and Services in Medicaid and Services for Adults under the Older Americans Act.

Q4 Innovative Activities and 2019 Annual Summary of Innovative Activities

Social Determinants of Health

During 2019, DMMA has been developing a strategy to understand the social determinants of health and address social needs for our beneficiaries. Building off of information gathered during discussions with our managed care partners, providers in the community, and other state agencies, we have begun to implement a multi-pronged approach. On April 4, 2019, DMMA convened a group of providers and payers to kick-off our work around Social Determinants of Health. Dr. Brown, DMMA Medical Director, facilitated the meeting that was attended by the MCOs, health systems, federally qualified health centers, and behavioral health providers. The purpose of the meeting was to discuss existing efforts to identify and address SDOH, identify shared barriers, and share opportunities for collaboration.

In the 4th quarter of 2019, DMMA developed a plan for 2020 to more explicitly require the MCOs to collect information on social determinants of health on health risk assessments include up-to-date information about community resources to address social needs in their resource directories.

As part of a DHSS-wide effort, DMMA is also exploring what information we have on social needs in the community and for our individual members, and are considering ways to use existing data to connect families with resources that may be preventing them from achieving optimal health. Finally, DMMA is in the planning stages of a potential pilot program for 2020 that will provide incentives to the MCOs to develop deeper relationships with community based organizations and collaborate on a project to address problems with unstable housing or food insecurity in their population.

Medicaid/CHIP Accountable Care Organization Program (Medicaid ACO Program)

DMMA, under the direction of DHSS, is developing a Medicaid ACO Program for the purpose of improving health outcomes while reducing costs through value based purchasing (VBP) arrangements which include downside financial risk for ACOs. The Medicaid ACO program is part of the strategies DMMA is pursuing to advance the adoption of participating Medicaid VBP models and total cost of care (TCOC) strategies. In the 4th quarter of 2019, DMMA developed an application to allow qualified provider organizations to apply to become Medicaid ACOs and subsequently contract directly with our Medicaid managed care organizations (MCOs) in a TCOC payment arrangement. These applications will be due by May 15, 2020. DMMA believes that by working together, Medicaid ACOs and MCOs can better coordinate care for Delaware's Medicaid and CHIP members, providing better health outcomes and lower costs.

Operational/Policy Developments/Issues

Q4 Operational and Policy Issues

Policy and Legislative developments

Medicaid Adult Dental Benefit – On August 2019, Governor Carney signed S.S.1 for S.B. 92 into law, expanding Medicaid dental benefit to adults, effective April 2020. For Q4, DMMA planned for the policy and operational details required to implement this new benefit by April and continued stakeholder engagement. DMMA will work with CMS on a state plan amendment to add adult dental to

the state plan and submit an 1115 waiver amendment in order to deliver the benefit through mandatory managed care.

Primary Care Collaborative – Delaware continues to work on this collaborative, which focuses on primary care in Delaware and what support can be provided to the primary care practices in the state.

MCO Operational Issues

DMMA and the MCOs have successfully transitioned Lifespan 1915(c) waiver enrollees to managed care for their state plan benefits.

DSHP 1115 Waiver Administration

- Substance Use Disorder (SUD) Amendment – DMMA submitted the SUD Implementation Plan to CMS on November 1, 2019.

- HCBS Assurance Assessment – DMMA submitted this Assessment to CMS on November 27, 2019 as required by STC #43.

- Retroactive Eligibility - DMMA is required by STC #22 to provide retroactive coverage as of August 1, 2019 to pregnant women, women who are 60 days or less postpartum, infants under age 1, and individuals under age 19. This requirement must be operationalized by July 1, 2020 and must include a process for retroactive eligibility for individuals who would be eligible for retro-active coverage beginning August 1, 2019. In Q4, DMMA worked on a variety activities to implement this STC including:

    - Identification of changes to the Integrated Eligibility IT system to support retroactive coverage for the new populations;
    - Identification of changes to the Integrated Eligibility application to add questions related to retroactive coverage for new populations (both paper and on-line versions);
    - Development of processes to address retroactive coverage for individuals who are eligible between August 1, 2019 and July 1, 2020 ;
    - Development of process for claims payment for individuals eligible for retroactive coverage;
    - Development of outreach strategy to educate individuals, advocates and providers regarding retroactive eligibility;
    - Development of education and outreach materials for individuals, advocates and providers including fact sheets and timelines.

Other Program Issues

Support Act Grant - DMMA was awarded a $3.58 million planning grant from CMS to assess and expand our capacity to treat substance use disorder (SUD) in Medicaid. These funds will support an examination of our reimbursement system for SUD treatment providers, additional data analytic capacity to track SUD in the Medicaid population, and training for outpatient providers to increase the number of providers

treating SUD. DMMA began planning activities for the grant work in Q4.

Electronic Visit Verification – Delaware has continued working toward implementation of EVV and requested a Good Faith extension from CMS's required January 1, 2020 start date.

Program Integrity – The Surveillance and Utilization Review (SUR) Unit worked diligently in the final quarter of 2019 to identify, correct and prevent fraud waste and abuse in the Delaware Medicaid Program. These efforts included continuing to identify ways to utilize and analyze MCO encounter data to ensure proper payment of claims. The unit worked to educate pharmacists on ways they can help to reduce fraud and waste as it relates to prescription drugs for Medicaid recipients. The unit also conducted compliance reviews of providers who were identified as outliers in the use of claim modifiers.

The SUR team used various data mining strategies to guide the post payment auditing and review efforts of the unit. Recent data mining projects have focused on chiropractic services, pharmacy claims and private duty nursing/personal care claims. The SUR data analyst worked with both the MCOs and the MFCU to ensure that efforts are not duplicative but remain effective for fighting fraud.

To strengthen the relationship with NEMT provider LogistiCare, the SUR team initiated monthly collaborative meetings designed to discuss areas of the program that may be vulnerable to fraud, waste or abuse. The collaboration will continue to find innovative ways to ensure proper use of the non-emergency transportation benefit and proper payment of the claims associated with this service.

Delaware Medicaid continues to place high value on the collaborative fraud detection efforts with both MCOs providing services to Delaware Medicaid recipients. The monthly meetings with each MCO, as well as the joint quarterly sessions held in conjunction with our Medicaid Fraud Control Unit (MFCU), have proven to be effective in identifying aberrant billing patterns and provider misconduct within the Medicaid program. This collaborative approach is also helping to ease the transition of auditing encounter data, as MCO input is essential to the success of this effort. The partnership with the Unified Program Integrity Contractor (UPIC), SafeGuard Services (SGS), continues to be beneficial to the SUR team. The contractor consistently provides invaluable resources to benefit the SUR team in fraud prevention and detection.

2019 Annual Report on Operational and Policy Issues

During 2019, DMMA focused on a number of priority operational and policy issues, including:

- Securing an extension of the DSHP 1115 waiver for an additional 5 years and receiving approval of the SUD amendment to the DSHP 1115. After the extension and SUD amendment were approved on July 31, 2019, DMMA invested significant resources into the implementation of the new waiver STCs, development of the SUD Implementation Plan, submission of the HCBS Assurances Assessment, and addressing budget neutrality reporting issues identified during the waiver negotiations.

- Preparing to enroll the Lifespan 1915(c) Waiver enrollees into Medicaid managed care for their state plan benefits on July 1, 2019 and monitoring the post-implementation period to ensure a successful transition. On July 1, 2019, approximately 1200 Lifespan Waiver enrollees living in residential settings began enrolling in the DSHP MCOs. DMMA conducted rigorous readiness planning and review activities leading up to this date and successfully implemented the transition to DSHP MCOs.

- Planning for the implementation on July 1, 2020 of Medicaid retroactive eligibility for pregnant/post-partum women and children.

- Planning for the implementation of an adult dental benefit in 2020. While initially planned for an April 1, 2020 start date, DMMA decided it was in the best interest of the members to delay the start of this project, allowing time for all stakeholders to implement their systems, establish their dental provider networks and properly test systems. The new benefit start date is scheduled for October 1, 2020.

- Applying for a SUPPORT Act planning grant from CMS to assess and expand our capacity to treat substance use disorders in Medicaid. DMMA was awarded a grant in September 2019. These funds will support an examination of our reimbursement system for SUD treatment providers, additional data analytic capacity to track SUD in the Medicaid population, and training for outpatient providers to increase the number of providers treating SUD.

- Continuing robust program integrity initiatives that require collaboration with the DSHP MCOs and the NEMT transportation broker, holding joint quarterly sessions with our MFCU, and efforts that focus on chiropractic services, pharmacy claims and private duty nursing/personal care claims.

Expenditure Containment Initiatives

Q4 Expenditure Containment Initiatives and 2019 Annual Report on Expenditure Containment Initiatives

Medicaid/CHIP Accountable Care Organization Program (Medicaid ACO Program) - DMMA, under the direction of DHSS, is developing a Medicaid ACO Program for the purpose of improving health outcomes while reducing costs through value based purchasing (VBP) arrangements which include downside financial risk for ACOs. The Medicaid ACO program is part of the strategies DMMA is pursuing to advance the adoption of participating Medicaid VBP models and total cost of care (TCOC) strategies. DMMA released an RFI to solicit potential interest and stakeholder feedback. In Q4, DMMA developed an application to allow qualified provider organizations to apply to become Medicaid ACOs and subsequently contract directly with our Medicaid managed care organizations (MCOs) in a TCOC payment arrangement. These applications will be due by May 15, 2020. DMMA believes that by working together, Medicaid ACOs and MCOs can better coordinate care for Delaware's Medicaid and CHIP members, providing better health outcomes and lower costs.

Financial/Budget Neutrality Development/Issues

Q4 Financial/Budget Neutrality/Issues

DMMA has been working on the budget neutrality reconciliation issues associated with the MBES Schedule C reporting. DMMA submitted to CMS the reconciliation work plan and timeline due to CMS by December 31, 2019 as described in STC #71.

DMMA has identified adjustments that must be made through the MBES systems particularly related to drug rebate adjustments affecting demonstration years 2014 - 2019. DMMA continues to quantify the amounts impacting MBES reporting. DMMA will be scheduling meetings with CMS financial and waiver staff later this year to discuss the adjustments that have been identified and developed a strategy to accurately and appropriately make those adjustments.

2019 Annual Report on Financial/Budget Neutrality/Issues

During 2019, DMMA and CMS worked together to reach agreement on a new 5-year budget neutrality agreement for the demonstration extension. This agreement included a transitional phase-down of newly accrued savings, as described in State Medicaid Director Letter # 18-009. During the budget neutrality negotiations, DMMA identified an issue with budget neutrality reporting. Since DY 19 (01/01/14 through 12/31/2014), Delaware has not reported demonstration expenditures consistently to CMS through the CMS-64 reports, leading to significant discrepancies between the expenditures reported on budget neutrality monitoring spreadsheets and the CMS-64. For the remainder of 2019, DMMA has been working on these budget neutrality reconciliation issues. DMMA submitted to CMS the reconciliation work plan and timeline due to CMS by December 31, 2019 as described in STC 71.

Member Month Reporting and With-Waiver PMPMs

Q4 2019 Member Months

Eligibility Group	Month 1 Oct 2019 Member Months	Month 2 Nov 2019 Member Months	Month 3 Dec 2019 Member Months	Total Quarter ending Dec 31, 2019
DSHP TANF CHILDREN	83,987	84,102	83,862	251,951
DSHP TANF ADULT	28,639	28,702	28,640	85,981
DSHP SSI CHILDREN	5,233	5,254	5,284	15,771
DSHP SSI ADULTS	6,197	6,201	6,209	18,607
DSHP MCHP (Title XIX match)*	0	0	0	
DSHP ADULT GROUP	62,870	62,916	63,195	188,981
DSHP-Plus State Plan	10,308	10,355	10,343	31,006
DSHP-Plus HCBS	5,128	5,217	5,251	15,596
DSHP TEFRA-Like**	275	277	278	830
PROMISE	1375	1373	1373	4121

* This EG does not include children funded through title XXI. Please note within the report, if the state must use title XIX funds for other uninsured children meeting the definition specified in section 2110(b)(1) of the Social Security Act if the state exhausts title XXI funds

***These TEFRA counts are PROXY Counts compiled by taking 5% of total SSI Children (and reducing the SSI Children by that Amount)

Q4 2019 Member Months and WW PMPMs

Eligibility Group	Total Member Months for the Quarter	PMPM	Total Expenditures
DSHP TANF CHILDREN	251,951	$331	$83,429,552
DSHP TANF ADULT	85,981	$548	$47,122,496
DSHP SSI CHILDREN	15,771	$1,721	$27,147,589
DSHP SSI ADULTS	18,607	$1,480	$27,543,088
DSHP MCHP (Title XIX match)		0	0
DSHP ADULT GROUP	188,981	$688	$129,966,143
DSHP-Plus State Plan	31,006	$3,738	$115,911,387
DSHP-Plus HCBS	15,596	$6,932	$108,107,710
DSHP TEFRA-Like	830	$1,721	$1,428,821
PROMISE	4121	$83	$341,761

For Informational Purposes Only (Q4)

Eligibility Group	Month 1 Oct 2019 Member Months	Month 2 Nov 2019 Member Months	Month 3 Dec 2019 Member Months	Total Quarter ending Dec 31, 2019
DSHP MCHP (Title XXI match)	1,326	1,298	1,300	3,924

2019 Annual Report on Budget Neutrality Calculations – Member Months

Eligibility Group	Q1 2019 Member Months	Q2 2019 Member Months	Q3 2019 Member Months	Q4 2019 Member Months	Total Year ending Dec 31, 2019
DSHP TANF CHILDREN	256,920	254,889	252,885	251,951	1,016,645
DSHP TANF ADULT	90,812	89,704	87,902	85,981	354,399
DSHP SSI CHILDREN	15,491	15,713	15,684	15,771	62,659
DSHP SSI ADULTS	18,687	18,704	18,663	18,607	74,661
DSHP MCHP (Title XIX match)*	0	0	0	0	
DSHP ADULT GROUP	189,518	188,847	188,763	188,981	756,109
DSHP-Plus State Plan	26,668	26,811	30,770	31,006	115,255
DSHP-Plus HCBS	14,295	14,609	15,086	15,596	59,586
DSHP TEFRA-Like	815	827	825	830	3,297
PROMISE	4,136	4,111	4,134	4,121	16,502

* This EG does not include children funded through title XXI. Please note within the report, if the state must use title XIX funds for other uninsured children meeting the definition specified in section 2110(b)(1) of the Social Security Act if the state exhausts title XXI funds

2019 Annual Report on Budget Neutrality Calculations - Member Months and WW PMPMs

Eligibility Group	Total Member Months for the Year	PMPM	Total Year Ending 12/31/2019
DSHP TANF CHILDREN	1,016,645	$363	$369,397,241
DSHP TANF ADULT	354,399	$598	$212,084,977
DSHP SSI CHILDREN	62,659	$2,080	$130,358,790
DSHP SSI ADULTS	74,661	$1,641	$122,534,714
DSHP MCHP (Title XIX match)			0
DSHP ADULT GROUP	756,109	$672	$508,243,270
DSHP-Plus State Plan	115,255	$1,839	$211,932,677
DSHP-Plus HCBS	59,586	$6,553	$390,447,620
DSHP TEFRA-Like	3,297	$2,081	$6,860,989
PROMISE	16,502	$32	$535,292

For Informational Purposes Only (Annual)

Eligibility Group	Q1 Member Months	Q2 Member Months	Q3 Member Months	Q4 Member Months
DSHP MCHP (Title XXI match)	3,742	**3,626**	**3,819**	3,924

Per STC #67(e), DMMA certifies to the accuracy of this member month information.

Consumer Issues

Q4 Consumer Issues

There were no notable complaints or problems consumers identified about the program in the current quarter.

HBM (Enrollment Broker) Update – Automated Health Systems (AHS) successfully completed Open Enrollment in October 2019. AHS mailed information to all heads of households and followed up with a telephone campaign to get the word out. As DMMA's new Health Benefits Manager, we continue to closely monitor AHS's activity for accuracy.

Children with Medical Complexity Advisory Council – This Advisory Council continued to work on this effort of importance to medically complex children, their families and the providers that serve these families. The Council's focus is on workforce development and data. DMMA is working to define this vulnerable population, including where they are located in the state and what services they can access.

Justice Involved Populations Steering Committee – DMMA was commissioned to make a significant change to Medicaid benefits for incarcerated individuals (aka the Justice Involved Population). Previously, Medicaid benefits were terminated for individuals who were entering the prison system, and it took many hours or days to get the benefits reinstated once they were released from the Department of Correction (DOC). However, the new process will only suspend benefits during incarceration and individuals will have full benefit coverage at the time of their prison release.

Medical Care Advisory Council – The MCAC met on October 23, 2019 and no additional consumer issues were identified.

2019 Annual Report on Consumer Issues

DMMA received feedback from Family Voices, who reported concerns about ABA services and the need to increase the network. DMMA is reviewing the concerns and working with the MCOs to ensure they are continuing enrolling/credentialing providers to increase the network.

DMMA provided updates on issues impacting Medicaid enrollees at the August 28, 2019 Medical Care Advisory Committee (MCAC). Updates included information on DMMA's planning for an adult dental benefit, the approval of the 1115 extension and SUD amendment, the establishment of Medicaid retroactive eligibility for children and certain adults, DMMA's Justice-Involved Populations Steering Committee, information on DMMA's Children with Medical Complexity initiative, and an update on DMMA's social determinants of health efforts. No public comments were received.

The HBM (enrollment broker) successfully completed Open Enrollment in October 2019. The HBM mailed information to all heads of households and followed up with a telephone campaign to get the word out.

DMMA continues to work on issues of importance to consumers, such as those being addressed at the Children with Medical Complexity Advisory Council and the Justice Involved Population Steering Committee.

Quality Assurance/Monitoring Activity

The Delaware Quality Strategy (QS) incorporates quality assurance (QA) monitoring and ongoing quality improvement (QI) processes to coordinate, assess and continually improve the delivery of quality care. The Quality Improvement Initiative (QII) Task Force, whose membership includes a multi-disciplinary statewide group of external contractors and state agencies, participates in oversight and monitoring of quality plans and improvement activities of Medicaid and Title XXI DSHP-funded programs based upon the goals identified in the QS. The QII Task Force assists in monitoring the goals of the DSHP 1115 demonstration.

The QS goals serve as a basis for guiding QII Task Force activities for all Task Force membership. The QII Task Force guiding values and principles are to: seek to achieve excellence through ongoing QII activities; employ a multi-disciplinary approach to identify, measure and access timeliness and quality of care of services to members; hold providers of care accountable; identify collaborative activities; achieve cultural sensitivity; link the community and other advocacy and professional groups; create a forum for communication and open exchange of ideas.

Q4 Quality Assurance/Monitoring Activity

QII Task Force - During the 4rd quarter of this monitoring period, the QII Task force reviewed Goal # 3 of the Quality Strategy: To control the growth of health care expenditures.

The QII Task Force presented and discussed ways that their collective agencies and organizations were working to control the growth of health care expenditures and implement any strategies and interventions to address barriers identified. One MCO provided an overview of its Payment Integrity Program. Another MCO presented an overview of its efforts to reduce low-acuity non-emergency (LANE) emergency department utilization. The group also reviewed measures to assess behavioral health access to services and focused on the performance measure for utilization of behavioral health services for SUD, inpatient and outpatient services. A planned future intervention is to assess inpatient SUD services by determining the success of the initiative in engaging members and coordinating outpatient services. If there is a resultant decrease in inpatient utilization, there is the potential for resulting cost savings to the MCO.

Well-Child visits in the Third, Fourth, Fifth and Six Year were also discussed with the group, including the identification of well-child visit barriers. The MCOs have initiated over 21 interventions and planned future interventions were reviewed.

Case Management Oversight - In the 4th quarter 2019, DMMA oversight staff completed approximately 224 joint visits with the MCO's which included Nursing Facilities and Community based settings. DMMA meets with each MCO quarterly to discuss joint visit findings and collaborates on ways to improve. DMMA case management oversite staff completed 4th quarter onsite file reviews with Highmark Health Options and AmeriHealth Caritas. DMMA reviewed the findings with each MCO and discussed opportunities for improvement for our Medicaid members.

DMMA/MCO Managed Care Meetings - The Bi-Monthly Managed Care meetings are a forum to discuss issues in a collaborative manner. The meeting is used to collaborate on common practices, identify issues, plan resolutions and establish connections to our sister agencies for coordination of care.

DMMA met with the MCOs on November 19, 2019 and discussed the new Web Based PASRR System and our newly integrated DDDS (Lifespan 1915(c) waiver) population into our MCOs for their non-HBCS services.

Incident Management System - DMMA worked with a contractor to complete a comprehensive review of its incident management processes for DSHP and DSHP-Plus. The goal of the review was to improve the overall performance of the incident management system, aligning practice and policy and integrating best practices. Activities included review and analysis of DMMA's current incident management regulations, policies, procedures, 1115 language and MCO contract language. In addition, interviews with staff were conducted in order to understand how incident management processes are operationalized. A literature review to identify best practices was completed and a gap analysis performed in order to identify areas of improvement. A series of recommendations were developed focusing on the areas of: policy and operations, data collection and reporting, training and IT systems. DMMA developed and is set to implement a multi-phase work plan to operationalize many of the recommendations.

2019 Annual Report on Quality Assurance/Monitoring Activity

QII Task Force - The QII Task force reviewed Goals 1-3 from the Quality Strategy during the four quarterly meetings in 2019 and reviewed effective strategies as well as barriers and solutions for meeting these goals.

Case Management Oversight - DMMA oversight staff completed approximately 754 joint visits with the MCOs which included Nursing Facilities and Community based settings. DMMA meets with each MCO quarterly to discuss joint visit findings and collaborates on ways to improve. DMMA case management oversite staff completed onsite file reviews each quarter with Highmark Health Options and AmeriHealth Caritas. DMMA reviewed the findings with each MCO and discussed opportunities for improvement for our Medicaid members.

DMMA/MCO Meetings - DMMA holds bi-monthly meeting with the two MCOs. These meetings are a forum to discuss issues in a collaborative manner. These meetings are used to collaborate on common practices, identify issues, plan resolutions and establish connections to our sister agencies for coordination of care. Examples of issues covered include: NEMT challenges for members; the transition of Lifespan 1915(c) Waiver enrollees from fee for service to managed care for their state plan services; the new Web Based PASRR System; and post-implementation review of the newly integrated Lifespan 1915(c) waiver population into MCOs.

Quality Strategy Review - DMMA is also evaluating the effectiveness of the current Quality Strategy. We are in the process of updating the Quality Strategy to make it more effective by moving away from measures that focus on compliance to measures that further quality improvement.

Managed Care Reporting Requirements

Q4 and Annual QCMMR and QCMMR Plus Reporting

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

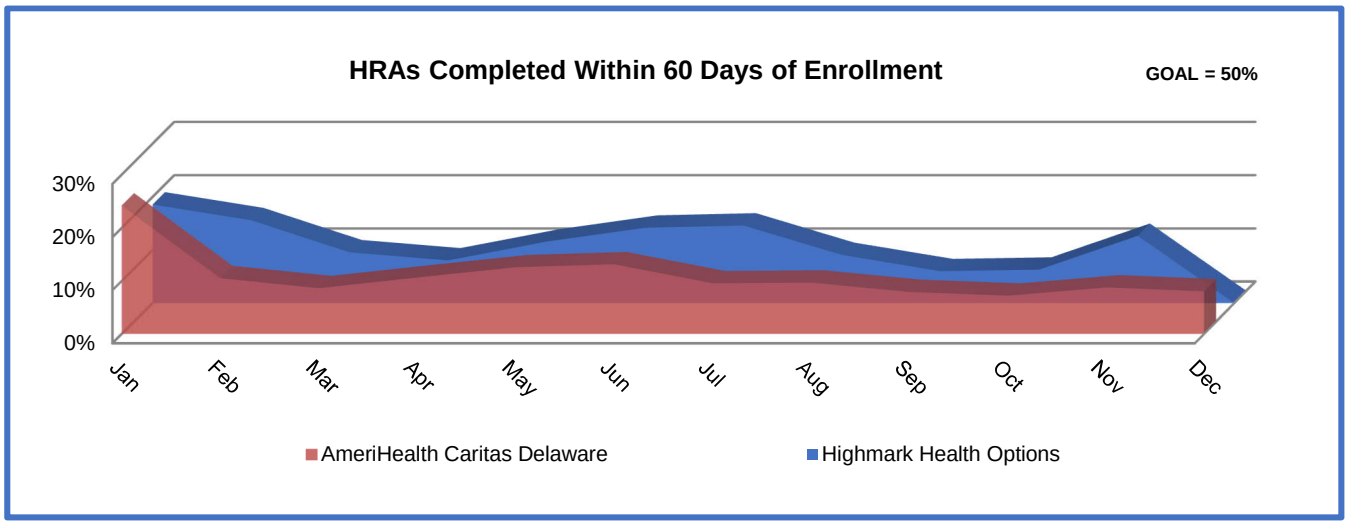
DMMA Managed Care Operations unit developed the full circle approach to the QCMMR and QCMMR Plus reporting. The reports are reviewed by the Managed Care Operations team and an agenda is developed for our monthly meeting with each MCO to discuss the findings from the reports. Manage

Care Operation's goal is to establish a partnership with the MCOs to improve quality of care for our Medicaid population.

DMMA continues to evaluate the QCMMR reports for both DSHP and DSHP Plus populations. DMMA has been working in conjunction with the MCOs to redefine and modify the reporting template to assure both MCOs are pulling and reporting the same data. Data historically reported to CMS in quarterly reports is provided below with additional detail provided on grievances and appeals. DMMA is in the process of developing a new format for additional QCMMR data to be reported to CMS as part of the quarterly and annual reports.

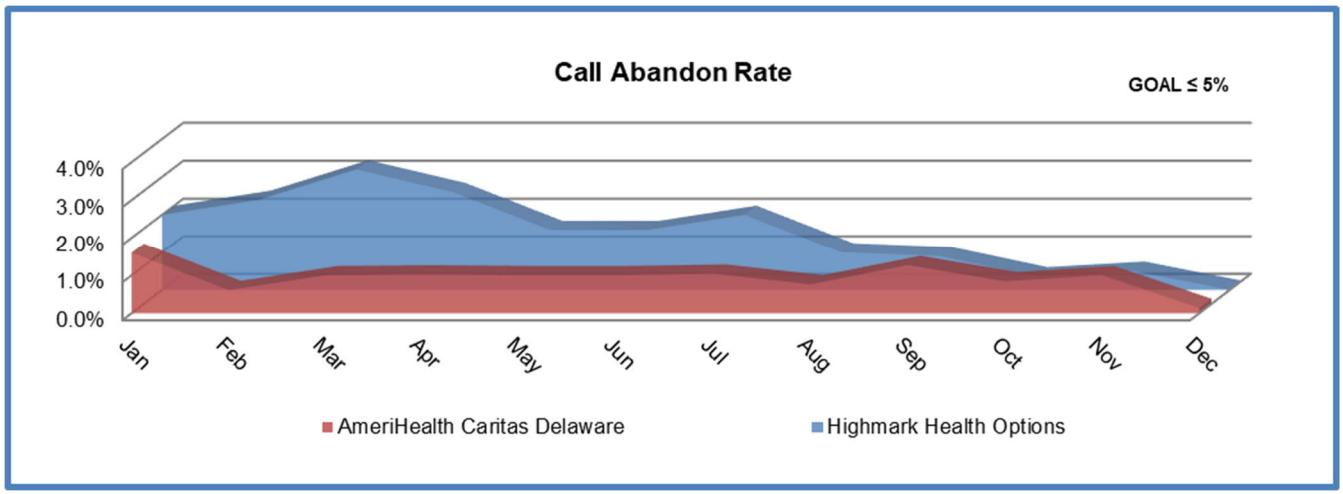
QCMMR Reporting Examples:

Health Risk Assessment (HRA) Completion Rate



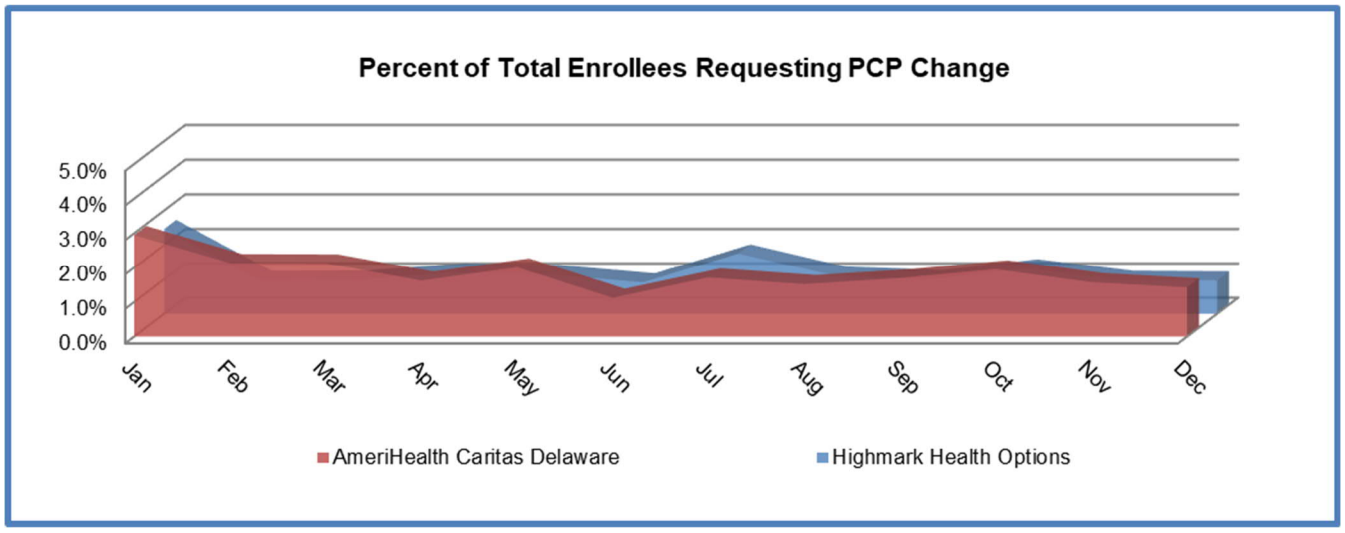
HRAs serve as a key to identifying and engaging members in need of services early in their experience with an MCO. The MCOs are contractually required to complete HRAs with at least 50% of their newly enrolled members within 60 days of enrollment. Both MCOs have fallen well short of that contractual obligation in Q4 and in 2019.

Customer Service: Call Abandon Rate



Both MCOs met the goal for call abandon rate during Q4 and 2019.

Percent of Enrollees Requesting a Change in Primary-Care Provider



ACDE had a slightly higher percentage of PCP change requests in Q4 than HHO, but both MCOs have similar rates for 2019.

Access in Q4 – For DSHP, both MCOs have very similar size PCP networks. DMMA is scheduled to receive updated information on Timely Appointments in Q1 2020.

For DSHP Plus, the number of providers for Home Health for both MCOs are similar; both MCOs have

comparable numbers of Day Service and Home Health providers as well. For Home and Community-Based Services (HCBS) and Behavioral Health providers, one MCO has more than double the number of providers than the second MCO. For Atypical providers, one MCO has a robust number while the second MCO lacks providers in Kent, New Castle and Sussex counties.

Q4 Grievances – For DSHP, there were 135 grievances for Q4 and the distribution across MCOs was an expected result given the differences in membership between the MCOs. The breakdown across areas is described below:

- Access and availability: 15
- Benefits: 2
- Billing and/or claims: 16
- Cultural competency: 2
- MCO staff issue: 5
- Quality of care: 33
- Quality of service: 47
- Transportation to medical appointment: 11
- Other: 4

For DSHP Plus, there were 81 grievances for Q4. The breakdown across areas is described below:

- Access and availability: 2
- Benefits: 0
- Billing and/or claims: 3
- Cultural competency: 0
- MCO staff issue: 1
- Quality of care: 15
- Quality of service: 15
- Transportation to medical appointment: 8
- Other: 2
- Case management HCBS and institutional experience: 35

Q4 Appeals - The overall number of appeals was low. One MCO had 16 appeals in Q4 and 11 of those were overturned (69%). The second MCO had 8 appeals, 5 of which were overturned (63%).

Q4 Critical Incident Reporting - For Q4, there were 31 total critical incidents (CIs), out of 175 total for all of 2019. The distribution of CIs heavily concentrates on HCBS versus institutional services. Listed below are the categories for CIs for Q4:

- Unexpected deaths: 2
- Physical, mental, sexual abuse or neglect: 15

- Theft or exploitation: 9
- Severe injury: 3
- Medication error: 0
- Unprofessional provider: 2

Q4 External Quality Review Reporting

In Q4, Delaware's EQRO submitted a draft of the 2019 annual technical report to DMMA for review. This report was submitted to CMS on April 30, 2020.

2019 Annual External Quality Review Reporting

During 2019, Delaware's EQRO (Mercer) completed a comprehensive compliance review of the two DSHP MCOs that encompassed the three mandatory activities, compliance review, validation of Performance Measures (PMs) and validation of Performance Improvement Projects (PIPs) for both MCOs. The EQRO identified a number of strengths and opportunities for improvement for both MCOs. The annual technical report was submitted to CMS on April 30, 2020 and is available on DMMA's website.

The EQRO also completed a comprehensive ISCA. The Performance Measure Reporting ISCA items for both MCOs resulted in 13 of the 13 items receiving a score of "Met." There were no concerns identified with any processes for integrating Medicaid claims, encounter, membership, provider, subcontractor and other data to calculate Medicaid PMs.

In addition to completion of mandatory activities, the EQRO conducted the following activities:

- Encounter Data Validation (EDV) of Medicaid encounter data received from the two MCOs. Overall, the EQRO found the MCOs had appropriate processes and systems for managing their encounter data submissions, and made extra effort to work with DXC to diagnose and resolve encounter related issues.

- Readiness review for managed care enrollment of Individuals with Intellectual/Developmental Disabilities (I/DD) enrolled in the 1915(c) Lifespan Waiver. After the EQRO's initial review, the MCOs submitted follow up materials which were evaluated in an iterative process and technical assistance was provided when needed. A post go-live onsite follow up review was scheduled for 2020 to focus on best practices, lessons learned and prior authorization practices subsequent to the continuity of care period.

- Technical assistance with Case Management (CM) and Care Coordination (CC) Performance Measure reporting. DMMA requires the MCOs to report quarterly on Clinical Care Coordination (CCC), resource coordination and CM as one path to ensure appropriate care for DSHP and DSHP Plus members. Throughout 2018, the EQRO met with DMMA to discuss challenges with gathering

accurate and reliable data on the required CCC PMs. Challenges included the MCO data submissions in different formats and programs (i.e. Word, Excel, PDF), inconsistency in the completeness of the data, as well as explanations or narrative information provided to discuss any variances, or program interventions. The EQRO reviewed and analyzed the previously submitted reports in order to assess the current state of reporting described by the state.

Toward the end of 2018 and in early 2019, the EQRO began to develop updated reporting templates and guidance to ensure consistent reporting; the EQRO developed standard reporting templates for submission of the reports by both MCOs and refined the technical specifications. The new reporting templates were implemented in April 2019 when Mercer led technical assistance sessions for the use of the required standardized templates, reviewed the technical specifications and each metric within the reporting templates with the MCOs. Throughout the remainder of the year, the EQRO reviewed the quarterly PMs for accuracy and consistency in information and analysis of the data submitted as well as answered ongoing questions from the MCOs.

- Technical assistance with QCMMR. 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.

2019 Annual Critical Incident Reporting

For 2019, there were 156 total critical incidents, heavily weighted toward HCBS. DMMA regularly works with the DSHP MCOs to understand the nature of each incident, how the issues were resolved, and if there are opportunities for improvement. As noted earlier, DMMA has completed a comprehensive review of its incident management processes for DSHP and DSHP-Plus. The goal of the review was to improve the overall performance of the incident management system, aligning practice and policy and integrating best practices. Activities included review and analysis of DMMA's current incident management regulations, policies, procedures, 1115 language and MCO contract language. In addition, interviews with staff were conducted in order to understand how incident management processes are operationalized. A literature review to identify best practices was completed and a gap analysis performed in order to identify areas of improvement. A series of recommendations were developed focusing on the areas of: policy and operations, data collection and reporting (including the new quarterly and annual reporting requirements to CMS), training and IT systems. DMMA developed and is set to implement a multi-phase work plan to operationalize many of the recommendations.

Listed below are the categories for CIs for Q4:

- Unexpected deaths: 10
- Physical, mental, sexual abuse or neglect: 69
- Theft or exploitation: 45
- Severe injury: 21
- Medication error: 4
- Unprofessional provider: 7

Demonstration Evaluation

Q4 Demonstration Evaluation Activities and 2019 Annual Report on Demonstration Evaluation Activities

Since the renewal and extension of the DSHP 1115 Waiver in August 2019, Delaware has secured an independent 1115 evaluator and is in the process of developing the draft Evaluation Design. Delaware intends to submit separate evaluation design plans for the SUD component of the DSHP 1115 and the waiver as a whole. These draft evaluation design plans are due to CMS by June 1, 2020.

Enclosures/Attachments

None. The SUD Implementation Plan (including the SUD HIT Plan) and Monitoring Protocol have not yet been approved by CMS

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