State of Delaware

Quality Strategy Review

Division of Medicaid & Medical Assistance (DMMA)
July 13, 2022

Contents

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Introduction

Background

The State of Delaware (Delaware or State) Division of Medicaid & Medical Assistance (DMMA), within the Department of Health and Social Services (DHSS), provides healthcare benefits and services to members in Medicaid and Medicaid managed care; the Children's Health Insurance Program (CHIP); Medicaid Long–Term Care (LTC), including nursing facilities, home- and community-based services (HCBS); assisted living; and dually certified Medicare/Medicaid funded programs. The DMMA mission is to improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost-effective manner.

DMMA strives to meet the diverse needs of Delawareans through innovation and a quality structure. The Quality Strategy (QS) provides a framework for implementing DMMA's mission to improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost-effective manner. The QS identifies the State's monitoring and oversight activities, focusing on quality improvement. The monitoring activities allow DMMA to identify and address compliance issues and report variances from expected results and represent the State's ongoing actions to ensure compliance with federal and State contract standards and promote an environment focused on performance improvement. The QS also aims to identify trends and opportunities for quality improvement related to Medicaid programs, waivers, policy and procedure development, and systems change initiatives.

Purpose: The framework of the QS has been designed to understand the population DMMA serves, addressing needs of the enrolled population, while continually updating the QS to address and support ongoing system transformation efforts.

To demonstrate compliance with Centers for Medicare & Medicaid Services (CMS)'s quality strategy evaluation requirements set forth in 42 CFR 438.340(c)(i), the State has evaluated its QS to measure its effectiveness and usefulness to help shape health care delivery and policy for the DMMA QS going forward. That evaluation is summarized in this report and will provide an overview of monitoring activities and achievement of improvement initiatives from 2018 through 2020.

Managed Care Environment

DMMA purchases medical care coverage through contracts with two managed care organizations (MCOs). The QS is incorporated, by reference, into each MCO contract and used to align and guide MCO quality strategies and activities with the DMMA quality vision and structure.

Highmark Health Options (HHO) has been contracted by DMMA since January 1, 2015, to provide Medicaid managed care services in Delaware. The State contracted with AmeriHealth Caritas Delaware (ACDE) to provide Medicaid managed care services effective January 1, 2018. Prior to implementation, the State's External Quality Review Organization (EQRO), in conjunction with DMMA staff, completed a targeted Readiness Review of ACDE. The review concluded that ACDE had adequate and appropriate processes to address continuity of care, ensure member health and safety, pay claims, and ensure an adequate network composition.

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Measurement and Compliance

Oversight

Monitoring Infrastructure

DMMA is the lead Medicaid agency within the State and is responsible for the quality oversight activities for the Diamond State Health Plan (DSHP), CHIP, and DSHP Plus programs. DMMA has delegated its direct quality oversight for the Medicaid PROMISE (Promoting Optimal Mental Health for Individuals through Supports and Empowerment) program to the Division of Substance Abuse and Mental Health (DSAMH). The DMMA quality unit staff are responsible for oversight and monitoring of quality improvement activities, as outlined in the QS and through the multi-disciplinary statewide Quality Improvement Initiative (QII) Task Force.

The QII Task Force is one of the various mechanisms to collaborate on quality improvement initiatives and solicit input from stakeholders for improvements for Medicaid beneficiaries. During the QII Task Force meetings, planned quarterly, information is disseminated about a variety of quality activities such as federal and State initiatives. Performance results for the DSHP, DSHP Plus, and PROMISE Medicaid and CHIP populations are also reviewed. Results from the external quality review (EQR) technical report are presented to provide data to focus quality activities and plan for future program development.

Members of the QII Task Force include representatives from DMMA, the Department of Public Health (DPH), DSAMH, EQRO, and Medicaid MCOs. Information from the QII Task Force is shared with the Medical Care Advisory Committee (MCAC) oversight committee.

In 2018 and 2019, the QII was chaired by the Director of Quality at DMMA. Starting early in 2020, DMMA’s Chief Medical Officer (CMO) assumed responsibility for DMMA’s Quality unit at which point the CMO or her designee acted as the Chair of the QII. The meetings provide the opportunity for data and performance presentations, identification of best practices exchange of information, dialogue, and DMMA Quality Unit updates. The current DMMA quality team has identified the opportunity to increase QII Task Force meeting participation from MCOs, DPH, DSAMH, and other stakeholder agencies as needed.

DMMA added the Compliance Officer position in October of 2020 to strengthen the Division's ability to provide oversight and contractual adherence to all DMMA contracts. The position is responsible for monitoring compliance in the administration of contracts and developing and enforcing appropriate sanctions for vendors who do not meet contractual standards. The Compliance Officer works closely with the Quality Team to assist with the management of the MCO's quality performance requirements.

An additional example of DMMA's structure to oversee the quality of services provided to Delaware Medicaid members includes audits called Joint Visits completed by DMMA staff. The Joint Visit process includes representatives from DMMA and the contracted MCOs. A Joint Visit is an onsite monitoring visit between a member, the MCO's case manager and a DMMA staff member. In accordance with DMMA's Master Service Agreement, each MCO provides a complete list of scheduled visits which allows DMMA to select which visits to attend. DMMA will record their observations from these visits in a tool which generates a compliance score and produces regular monitoring reports of their findings. In the 4th Quarter 2019, DMMA staff completed approximately 224 joint visits with MCOs, including nursing facilities and community-based settings. DMMA reviewed the findings with each MCO and discussed opportunities for improvement.

Feedback Cycle

DMMA strives to employ a process of ongoing, continuous feedback to facilitate changes and improve the quality of care to members. Within this process, opportunities are identified to develop collaborative quality activities that span across the DSHP, DSHP Plus and PROMISE Medicaid and CHIP programs. Ongoing communications between DMMA quality staff and the QII Task Force create a feedback loop that can facilitate quality of care improvements for DSHP, DSHP Plus and PROMISE Medicaid and CHIP members. The MCAC reviews QS activities and provides feedback and support for quality-related issues.

Results are reviewed and assessed for the need for intervention that can include:

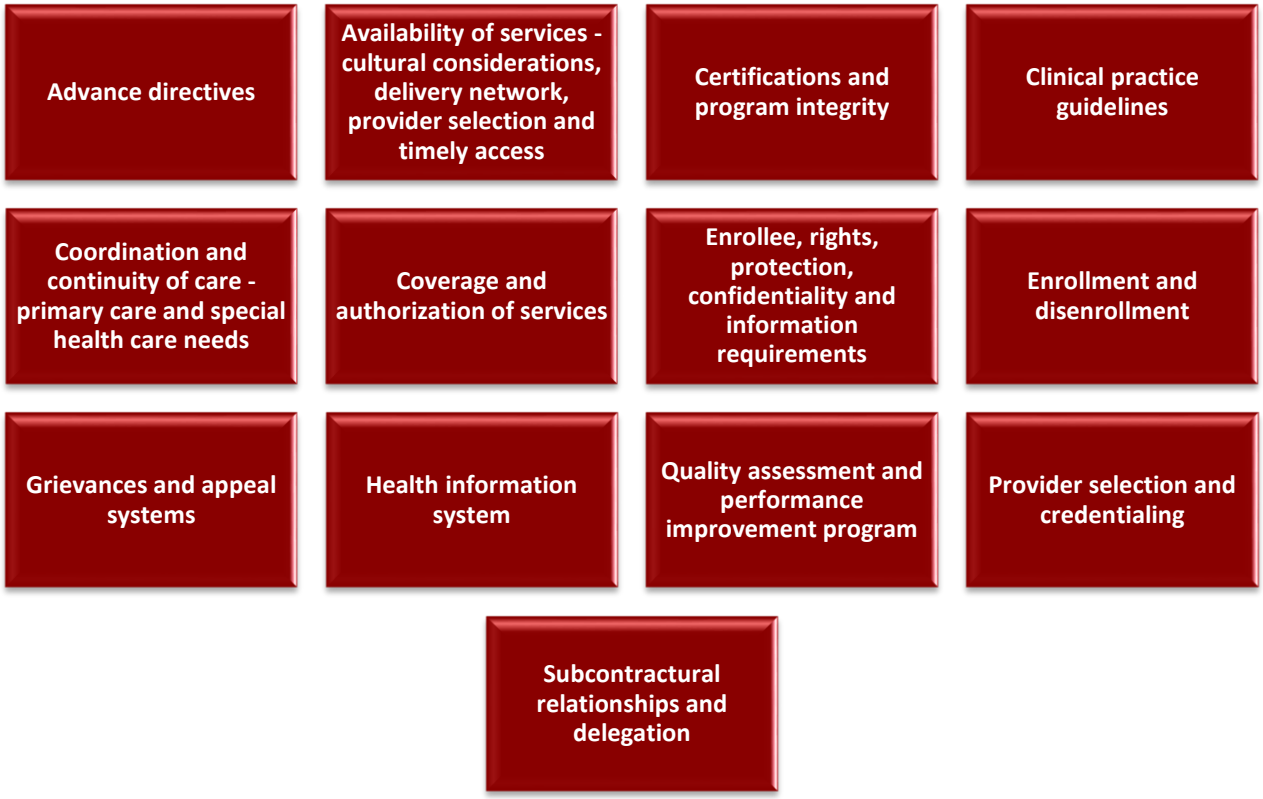
- Corrective Action Plan (CAP) — When the MCO is not in compliance with one or more requirements in the Contract, the MCO will develop a CAP, submit the CAP for approval by the State, and implement the activities within ten days from notification. The State will monitor improvement via reports and/or onsite reviews, the content of which will be specific to the violation and defined by the State. Performance, free of violation, must occur for 60 days or until the State agree the violation has been corrected and is not likely to recur. If the CAP is not successful, intermediate sanctions will be applied.

- Intermediate Sanctions — Should the need arise, part of the Delaware Quality Management (QM) process is the existence of sanctions and conditions for contract termination that may be imposed should the continuous quality improvement process not be effective. These sanctions meet the federal requirements of 43 CFR Subpart I, as well as Delaware State requirements for sanctions and terminations. In addition to financial sanctions, whenever the State determines that the MCO is failing to meet performance standards, it may suspend the MCO's right to enroll new members.

EQRO Monitoring and Improvement Activities

CMS requires an EQRO to provide a comprehensive compliance review of the State's contracted Medicaid MCOs, using the CMS protocol "Assessment of Compliance with Medicaid Managed Care Regulations".

The EQRO, completed a comprehensive compliance review of DMMA contracted MCOs. The comprehensive compliance review encompassed a review of the following areas:



The information below details EQRO activities, as directed by DMMA, during 2018, 2019, and 2020.

2018

In 2018, DMMA directed the EQRO to conduct a post-implementation assessment of MCO A. The purpose of this review was to ensure that MCO A was stabilizing operations, moving toward full compliance with contract expectations and would be on sound footing for a comprehensive compliance review in 2019. Mercer also conducted a CAP review of MCO B in July 2018 that encompassed the three mandatory activities, compliance review, validation of performance measures (PMs) and validation of performance improvement projects (PIPs).

During 2018 DMMA, through their EQRO, completed the following focused studies:

- **Opioid Use Disorder (OUD): treatment engagement differences and best practices among Delaware Medicaid members.**
- **Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Focused Study.**

2019

During 2019 the EQRO completed a comprehensive compliance review of MCO A and MCO B that encompassed the three mandatory activities: compliance review including an Information System Capabilities Assessment (ISCA), validation of PMs and validation of PIPs for both MCOs.

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

- Encounter Data Validation of its Medicaid encounter data received from contracted MCOs within the state.
- Readiness review for delivery of acute medical services to Individuals with Intellectual/Developmental Disabilities (I/DD) receiving residential services through the State's Lifespan Waiver.
- Technical assistance with Case Management (CM) and Care Coordination (CC) PM reporting.
- Technical assistance with the Quality and Care Management Measurement Report (QCMMR) for both DSHP/CHIP and DSHP-Plus.

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 and State standards.
- Review of compliance with contract standards for:
  - DSHP and DSHP-Plus CM
  - DSHP All Member Level Coordination, Level I Resource Coordination and Level II Clinical Care Coordination
- PIP validation
- PM validation

The independent review assessed 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.

2020

In 2020, the EQRO completed a CAP review of MCO A and MCO B that encompassed the three mandatory activities, CAP items review, validation of PMs, and validation of PIPs for both MCOs; Mercer also completed a CAP ISCA.

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

- Readiness review follow up for delivery of acute medical services to Individuals with I/DD receiving residential services through the State's Lifespan Waiver.
- Readiness review for integration of the adult dental benefit.
- Implementation of the 2019–2020 National Core Indicators-Aging and Disabilities (NCI-AD) Adult Consumer Survey.
- Technical assistance with CM and CC Performance Measure reporting.
- Technical assistance with QCMMR.

The objective for the 2020 EQR was to assess Delaware MCO performance toward achieving the Delaware QS goals, which are:

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

Compliance Evaluation

The EQRO compliance evaluation assigns the MCO score for each metric that makes up the four review areas identified in the table below. The assessment of "Met", "Substantially Met", "Partially Met", "Minimally Met" and "Not Met" is assigned to each of the four standards. The regulation mandates MCOs develop a required CAP for all metrics resulting in a "Substantially Met", "Partially

Met", "Minimally Met" or "Not Met" rating. All CAPs are reviewed and approved for implementation by DMMA prior to implementation.

ACDE and HHO demonstrated partial compliance during the 2018–2020 time period. There are opportunities for improvement with Enrollee Rights and Protection and Quality Assessment and Performance Improvement. Findings of the compliance review indicate room for improvement at HHO for Quality Assessment and Performance Improvement (QAPI) measures. Identifying which parts of a healthcare system need attention requires a strong QAPI framework — a key to quality improvement throughout complex healthcare delivery systems. The table below identifies compliance ratings for selected key compliance areas.

Table 1: 2019 MCO Overall Compliance Ratings

Content Area	AmeriHealth Caritas Delaware			Highmark Health Options		
	2018 Percent	2019 Percent	2020 Percent	2018 Percent	2019 Percent	2020 Percent
Enrollee Rights and Protections	NR	96.5%	100.0%	83.3%	95.7%	100.0%
Quality Assessment and Performance Improvement	NR	95.4%	98.9%	95.0%	77.9%	88.8%
Grievances and Appeals	NR	95.1%	100.0%	90.0%	97.8%	98.9%
Certifications and Program Integrity	NR	98.8%	100.0%	100.0%	100.0%	100.0%
Total	**NR**	**96.5%**	**99.7%**	**92.1%**	**92.8%**	**96.9%**

Information Systems Capability Assessment

The EQR conducted a comprehensive ISCA review in 2018. This independent review of the managed care organization's information systems was conducted as an enhancement to the EQR mandatory activity outlined in 42 CFR § 438.358. To complete this assessment the EQRO utilized the current version of the CMS EQR Protocol 8, along with comprehensive enhancements to the ISCA to reflect State-specific regulations, standards and requirements communicated to the MCO through their contract with DMMA. The EQR ISCA process included review of submitted materials and information, as well as onsite interviews and "live" systems demonstrations. Areas included in the ISCA assessment were:

Results from the ISCA were shared with each MCO, including compliance on desk review times, strengths, and opportunities.

ACDE

ACDE became a contracted Medicaid MCO in the Delaware market on January 1, 2018. Based upon the ISCA review, ACDE has successfully maintained the required systems and support services to effectively support Delaware's Medicaid managed care program. Items that were identified in 2019, requiring a CAP were scored as Met in 2020. The desk and onsite reviews of the 2020 ISCA items resulted in 37 of the 41 desk review items (90.24%) receiving a review score of Met.

Review findings revealed that ACDE exhibits proactive problem solving and team collaboration. ACDE is staffed with subject matter experts for claims systems and operations, and its leadership has shown a commitment to internal training and knowledge expansion. Also, the MCO created a new enterprise data analytics department to better serve ACDE's analytic needs.

The MCO should develop ongoing internal evaluations of any quality or performance improvement activities to advance outcomes such as more robust testing of any system changes/configuration updates. The monthly audit sample size and targeted areas of focus should align with claims findings other areas identified as problematic in the past.

HHO

HHO demonstrated 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

back in-house from the delegate, Gateway Health, but continued to process claims on the same claims platform, Optimal System for Claims and Reimbursement (OSCAR). The insights gained from HHO's ISCA desk review confirmed HHO's efforts to improve the claims operations and the underlying infrastructure to ensure accurate claims processing. The desk and onsite reviews of the 2020 ISCA items resulted in 36 of the 56 desk review items (64.29%) receiving a review score of Met.

Review findings revealed that HHO and Gateway maintained strong collaboration during the transition from delegation of claims processing from Gateway to HHO. HHO has taken action to improve issue tracking mechanisms, but co-mingling of operational and systemic issues into one category titled 'remediation' was not beneficial for HHO's ongoing operations improvement activities. There has been inconsistent traceability of issue management and related decisions regarding the resolution of the issues. Many of the ongoing claims issues and mass clean-up projects were related to provider information. HHO should implement improved processes and quality assurance to ensure the provider contract information is set up correctly at the time of initial contract loading. Similar to the complexity of HHO's provider data systems, the OSCAR claims system does not appear to have been designed to accommodate some of the more sophisticated adjudication logic and rules that are often required to support the complexities of managing the Medicaid benefits. Despite previous ISCA recommendations to increase the audits percentages of all Delaware claims processed, HHO's audit percentages in 2019 were consistently below 2%.

HHO's internal and external performance monitoring and management mechanisms were insufficient and efforts to implement core performance measures, subcontractor service level agreements and scorecards had yet to show improved performance and successful subcontractor oversight.

HEDIS Performance Measurement

DMMA annually reviews MCO Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures. Results are compiled, and comparative results between MCOs relative to the Quality Compass® national benchmarks are reviewed by DMMA. The State requires its MCOs to address all measures that fall below the established benchmark of the 75th percentile.

In this section, the following symbols are used to present MCO results relative to the Quality Compass® national percentiles. Note: ACDE was contracted by DMMA with a go-live date of January 1, 2018 and was not required to submit HEDIS measures and CAHPS survey findings for calendar year 2018.

HEDIS Performance Measure Score Scale		
●	◕	◒
MCO results met or exceeded the national benchmark for the 90th percentile	MCO results fell between the national benchmarks for the 50th and the 89th percentile	MCO results fell below the national benchmark for the 50th percentile

Evaluation of Access to Health Care

The Delaware QS prioritizes the improvement of timely access to appropriate care and services for adults and children, emphasizing primary preventive care and remaining in a safe and least-restrictive environment. Providing timely access to preventive and primary care services promotes the goal of a comprehensive health care delivery system for Delaware Medicaid.

Timely Access to Primary and Preventive Services

Medicaid enrollees who utilize primary and preventive services are better equipped to manage acute and chronic medical conditions than those who do not utilized these services. Members with adequate access to primary care are more likely to have preventive care and consistent care for chronic conditions. Both have been shown to reduce unnecessary emergency department visits and inpatient hospital admissions.

Table 2: Timely Access to Primary and Preventive Services

HEDIS Performance Measure	2018 ACDE Results	2019 ACDE Results	2020 ACDE Results	2018 HHO Results	2019 HHO Results	2020 HHO Results
Children's access to primary care physician (PCP) (Ages 12 months–24 months)	NR	◒	◒	◕	◕	◕
Children's access to PCP (Ages 25 months–6 years)	NR	◒	◒	◕	◕	◕
Children's access to PCP (Ages 7 years–11 years)	NR	NR	◒	◕	◕	◕
Adolescent's access to PCP (Ages 12 years–19 years)	NR	NR	◒	◕	◕	◕
Adult's access to preventive/ambulatory health services (Ages 20 years–44 years)	NR	◒	◒	◕	◕	◒
Adult's access to preventive/ambulatory health services (Ages 45 years–64 years)	NR	◒	◒	◕	◕	◕

Table 2: Timely Access to Primary and Preventive Services						
HEDIS Performance Measure	**2018 ACDE Results**	**2019 ACDE Results**	**2020 ACDE Results**	**2018 HHO Results**	**2019 HHO Results**	**2020 HHO Results**
Adult's access to preventive/ambulatory health services (Ages 65+ years)	NR	◕	◕	◕	◕	◕

Results are **relative** to the Quality Compass® national percentiles:
●**:** *Results met or exceeded the national benchmark for the 90th percentile.*
◕: *Results fell between the national benchmarks for the 75th and the 90th percentile.*
◒: *Results fell below the national benchmark for the 75th percentile.*
NR: *A designation given by National Committee for Quality Assurance (NCQA) to indicate either the MCO chose not to report the measure or the measure received an NR designation during a NCQA HEDIS Compliance Audit.*

ACDE was below the 50th percentile for the two reporting years (2019 and 2020) in all of the child and adult access to preventive services with the exception of adult's ages 65+ years. HHO was at or above 50th percentile on all seven timely access to primary and preventive services measures for all three reporting years (2018, 2019, and 2020).

Access to Maternal and Pregnancy Services

Early and consistent access to quality prenatal care services can improve the chances of delivering healthy babies and decreasing maternal and infant deaths. Providing access to comprehensive maternal and prenatal services impacts maternal and fetal health outcomes, and may prevent lifelong disability. ACDE performed below the 50th percentile for access to maternal and pregnancy services during 2019 and 2020. HHO performed above the 50th percentile for timeliness of prenatal care for 2019 but scored below the 50th percentile for postpartum care for all three evaluation years.

Table 3: Access to Maternal and Pregnancy						
HEDIS Performance Measure	**2018 ACDE Results**	**2019 ACDE Results**	**2020 ACDE Results**	**2018 HHO Results**	**2019 HHO Results**	**2020 HHO Results**
Prenatal and postpartum care – timeliness of prenatal care	NR	◕	◒	◒	◒	◒
Prenatal and postpartum care – postpartum care	NR	◒	◒	◒	◒	◒

Results are **relative** to the Quality Compass® national percentiles:
●**:** *Results met or exceeded the national benchmark for the 90th percentile.*
◕: *Results fell between the national benchmarks for the 75th and the 90th percentile.*
◒**:** *Results fell below the national benchmark for the 75th percentile.*
NR: *A designation given by National Committee for Quality Assurance (NCQA) to indicate either the MCO chose not to report the measure or the measure received an NR designation during a NCQA HEDIS Compliance Audit.*

Overall Access Performance

The reportable-HEDIS data compared to the Quality Compass® national benchmarks, indicate both MCOs need to focus quality improvement strategies for access to preventive and maternity care based on the three year performance trend. Due to this trend, DMMA has selected the topic of Maternal Child Health as an area of focus for clinical quality improvement for Delaware's MCOs. In 2021, DMMA, with assistance from its EQRO, will be conducting a focus study of the maternal health care coordination provided by the State's MCOs. The purpose of this study will be to identify strengths and opportunities and provide technical assistance specific to the provision of effective maternal health care coordination in MCOs' programs. Additionally, DMMA will be requiring the MCOs to report on a state-defined maternal health PIP which aims to help improve the outcomes of this population.

Evaluation of Effectiveness of Care

The Delaware Medicaid QS includes goals of improving quality of care and services provided to DSHP, DSHP Plus and CHIP members. Quality-related performance measures (PMs) describe attributes of health services provided to members. These PMs provide an overview of the effectiveness of a health care delivery system by looking at service utilization, members' health outcomes, and comprehensiveness of disease management services for common causes of morbidity and mortality.

Evaluation of Early Life Services

As shown in the following table, ACDE performed below the 50th percentile in all three quality of early life measures in 2019 and 2020. HHO improved performance in 2020 from below the 50th percentile in all measures in 2019 to performance between the 50th and 75th percentile in 2020.

Table 4: Quality of Early Life Services

HEDIS Performance Measure	2018 ACDE Results	2019 ACDE Results	2020 ACDE Results	2018 HHO Results	2019 HHO Results	2020 HHO Results
Childhood immunization status (Combination 2)	NR	◒	◒	◕	◒	◕
Sufficient (6+) well-child visits in first 15 months of life	NR	NR	◒	◕	◒	◕
Well-child visits in years 3-6	NR	◒	◒	◕	◕	◕

Results are **relative** to the Quality Compass® national percentiles:
●: *Results met or exceeded the national benchmark for the 90th percentile.*
◕: *Results fell between the national benchmarks for the 75th and the 90th percentile.*
◒: *Results fell below the national benchmark for the 75th percentile.*
NR: *A designation given by National Committee for Quality Assurance (NCQA) to indicate either the MCO chose not to report the measure or the measure received an NR designation during a NCQA HEDIS Compliance Audit.*

Evaluation of Early Detection Services

Routine screenings and early detection services allow providers to identify and address health concerns, often preventing costly and invasive interventions associated with later detection. As shown below, ACDE performed below the 50th percentile for cervical cancer screening for 2019 and 2020 reporting periods. HHO also performed below the 50th percentile for both breast cancer and cervical cancer screening in 2019 and 2020 reporting periods. The trend in performance for screening show significant opportunities for MCOs to focus on improvement initiatives.

Table 5: Early Detection Service Quality

HEDIS Performance Measure	2018 ACDE Results	2019 ACDE Results	2020 ACDE Results	2018 HHO Results	2019 HHO Results	2020 HHO Results
Breast cancer screenings	NR	NR	NR	◒	◒	◒
Cervical cancer screenings	NR	◒	◒	◕	◒	◒

Results are **relative** to the Quality Compass® national percentiles:
●: *Results met or exceeded the national benchmark for the 90th percentile.*
◕: *Results fell between the national benchmarks for the 75th and the 90th percentile.*
◒: *Results fell below the national benchmark for the 75th percentile.*
NR: *A designation given by National Committee for Quality Assurance (NCQA) to indicate either the MCO chose not to report the measure or the measure received an NR designation during a NCQA HEDIS Compliance Audit.*

Quality of Diabetes Management Services

Often associated with inadequate diabetes management, comorbidities such as hypercholesterolemia (high cholesterol), hypertension (high blood pressure) and other chronic conditions merit attention. Comprehensive care for this disease includes a variety of monitoring services. As shown below, both MCOs' HEDIS scores (performance below the 50th percentile) indicate the need for improvement in diabetes care.

Table 6: Quality of Diabetes Management

HEDIS Performance Measure	2018 ACDE Results	2019 ACDE Results	2020 ACDE Results	2018 HHO Results	2019 HHO Results	2020 HHO Results
Comprehensive diabetes care — HbA1c testing	NR	◒	◒	◒	◒	◒
Comprehensive diabetes care — dilated retinal eye exam	NR	◒	◒	◒	◒	◒

Results are **relative** to the Quality Compass® national percentiles:
●**:** *Results met or exceeded the national benchmark for the 90th percentile.*
◕: *Results fell between the national benchmarks for the 75th and the 90th percentile.*
◒: *Results fell below the national benchmark for the 75th percentile.*
NR: *A designation given by National Committee for Quality Assurance (NCQA) to indicate either the MCO chose not to report the measure or the measure received an NR designation during a NCQA HEDIS Compliance Audit.*

Weight and Nutrition Management Quality

When initiated early in life, proper nutrition, physical activity, weight assessment and control effectively prevent obesity and the associated disease burden. Nutrition counseling is an important means of educating individuals in order to help them lead healthier, more productive lives. ACDE is at or above the 50th percentile for counseling for nutrition and physical activity among children. HHO is below the 50th percentile for all of the clinical quality of weight and nutrition management measures for all three annual reporting periods.

Table 7: Clinical Quality of Weight and Nutrition Management

HEDIS Performance Measure	2018 ACDE Results	2019 ACDE Results	2020 ACDE Results	2018 HHO Results	2019 HHO Results	2020 HHO Results
Body mass index assessment	NR	NR	◒	◒	◒	◒
Counseling for nutrition	NR	◕	◕	◒	◒	◒
Counseling for physical activity	NR	◕	◕	◒	◒	◒

Results are **relative** to the Quality Compass® national percentiles:
●: *Results met or exceeded the national benchmark for the 90th percentile.*
◕: *Results fell between the national benchmarks for the 75th and the 90th percentile.*
◒: *Results fell below the national benchmark for the 75th percentile.*
NR: *A designation given by National Committee for Quality Assurance (NCQA) to indicate either the MCO chose not to report the measure or the measure received an NR designation during a NCQA HEDIS Compliance Audit.*

Overall Healthcare Delivery Performance

The reportable-HEDIS data compared to the Quality Compass® national benchmarks indicate both MCOs need to focus quality initiatives toward improving the effectiveness of healthcare delivery and management of target populations based on the three year performance. This illustrates an opportunity to better align the Quality Strategy, MCO Performance Improvement Projects, and measure prioritization for reporting as the 2021 Quality Strategy is implemented and the DMMA Quality Unit operationalizes quality monitoring and improvement activities.

As mentioned previously, DMMA has plans for requiring its MCOs to participate in focus studies, report on State-defined performance improvement projects, as well as assessing penalties for quality performance measure targets not being met.

Strengths and Opportunities

ACDE overall performance on measures pertaining to timely access to primary and preventive services and effectiveness of care measures fell well below the expected performance. While performing between the 50th and 75th Quality Compass national percentiles on access to primary and prevention services, counseling for nutrition and physical activity, and improving in 2020 on quality of early life service, HHO's other measures remain below the 50th percentile.

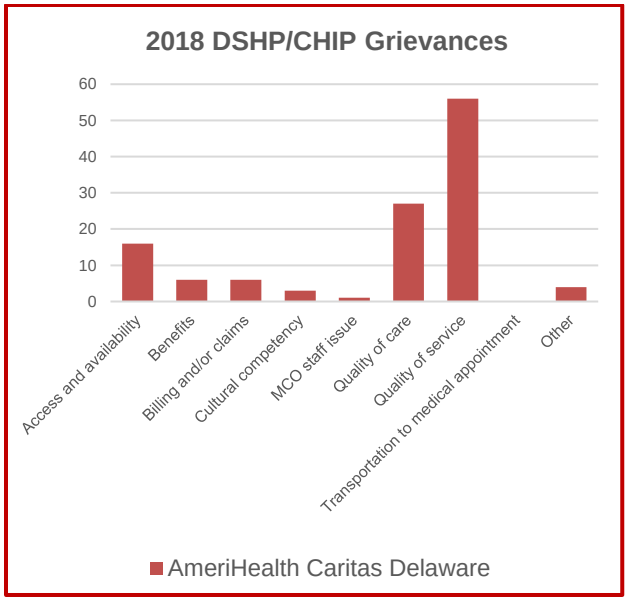
Both MCOs have opportunities for significant improvement with early detection and service intervention as well as with diabetes management. Recognizing these opportunities for improvement, DMMA is invested in identifying and implementing more frequent interim reporting to support and monitor on-going improvement activities to improve access, preventive services and effectiveness of care.

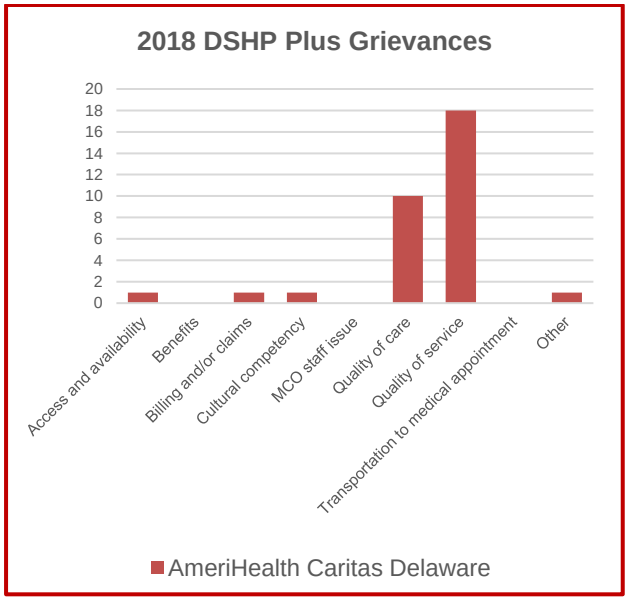
QCMMR and QCMMR Plus Measures and Results

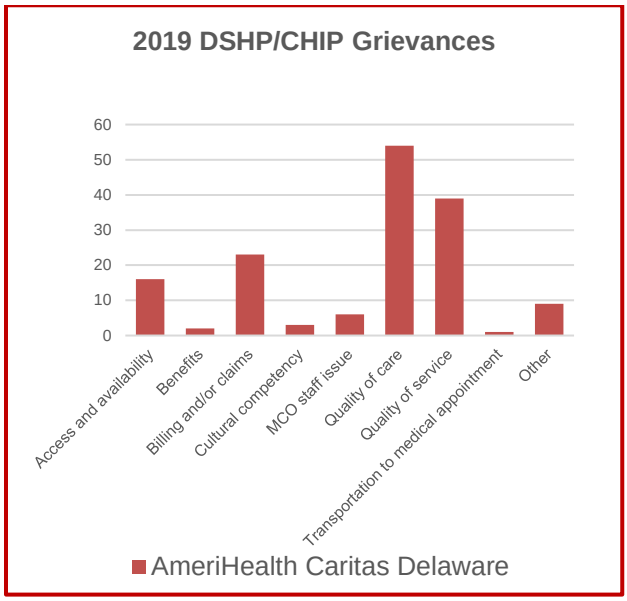
As part of ongoing monitoring and to serve as an "early warning system" for DMMA of potential concerns, MCOs are required to submit Quality and Care Management Measurement Reporting (QCMMR) data on a monthly, quarterly, and annual basis. The data elements that comprise the QCMMR at a minimum include: (i) health risk assessments; (ii) case management; (iii) access — timely appointments; (iv) network availability; (v) customer service; (vi) grievances; (vii) appeals; (viii) quality of care and quality of services issues; (ix) provider disputes; (x) inpatient services; (xi) outpatient services and physician visits; (xii) outreach and education; and (xiii) behavioral health.

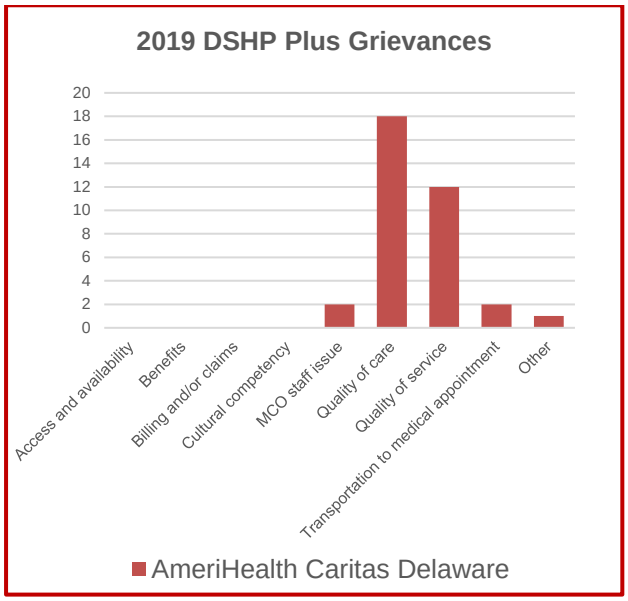
Technical specifications for the QCMMR clinical data submission template were effective January 1, 2018. A separate QCMMR Plus reporting guide for long-term services and support (LTSS) plan members includes dually eligible members and those in HCBS and institutional settings. QCMMR and QCMMR Plus specifications promote consistent and uniform reporting of performance measures of interest. The purpose of QCMMR reporting is to monitor quality, access, timeliness, and care management aspects of operations of the Medicaid contracted MCOs. The reports are organized to alert DMMA to current or potential areas of underperformance or suspected problems in MCO operations for further investigation. Results from selected QCMMR measures are displayed in the following charts.

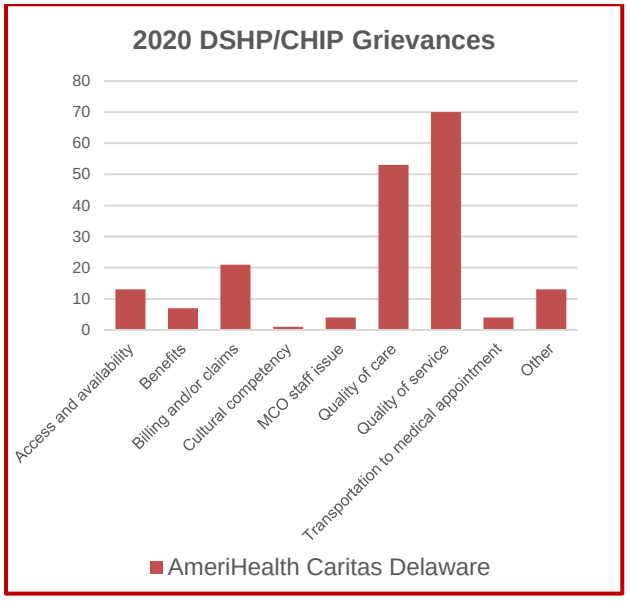
2018-2020 ACDE Grievances

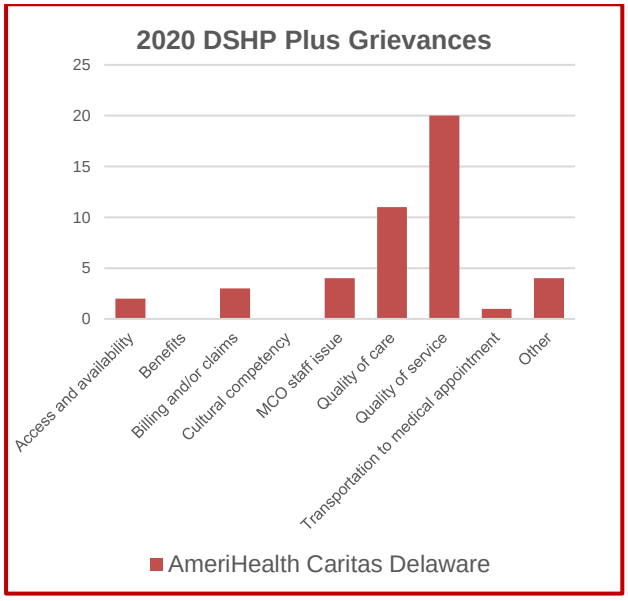




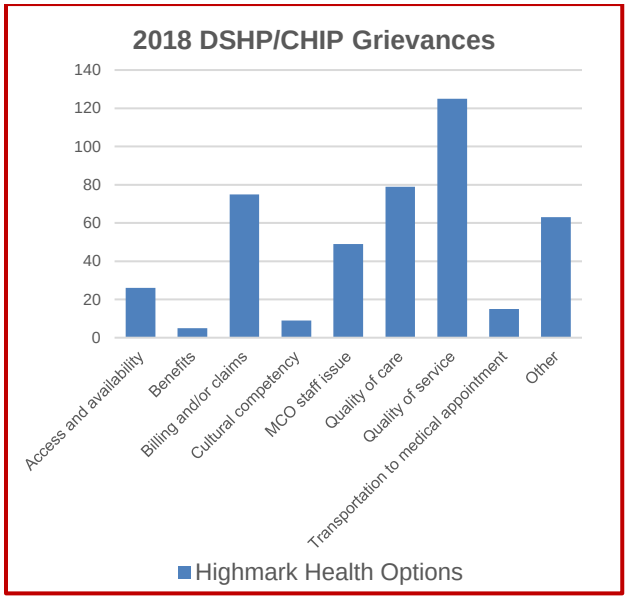

2019 DSHP/CHIP Grievances
60
50
40
30
20
10
0
Access and availability
Benefits
Billing and/or claims
Cultural competency
MCO staff issue
Quality of care
Quality of service
Transportation to medical appointment
Other
AmeriHealth Caritas Delaware

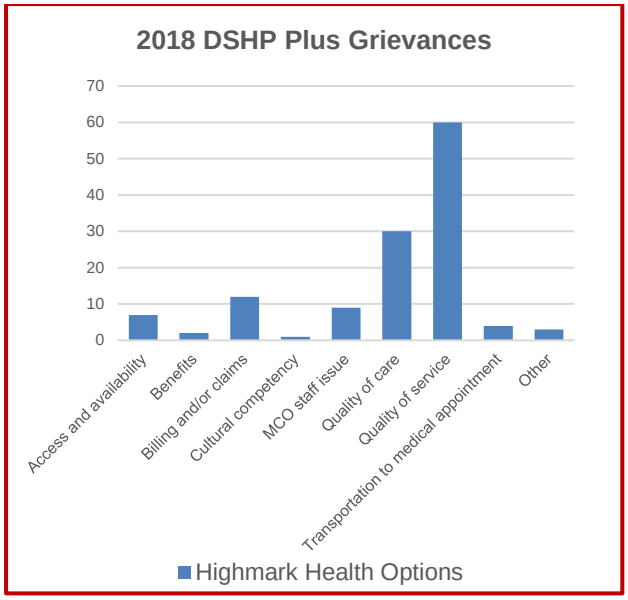

2019 DSHP Plus Grievances
20
18
16
14
12
10
8
6
4
2
0
Access and availability
Benefits
Billing and/or claims
Cultural competency
MCO staff issue
Quality of care
Quality of service
Transportation to medical appointment
Other
AmeriHealth Caritas Delaware

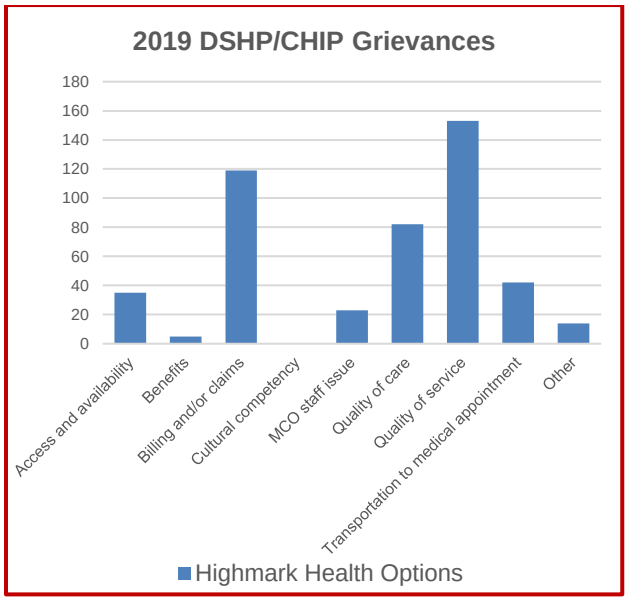

2020 DSHP/CHIP Grievances
80
70
60
50
40
30
20
10
0
Access and availability
Benefits
Billing and/or claims
Cultural competency
MCO staff issue
Quality of care
Quality of service
Transportation to medical appointment
Other
AmeriHealth Caritas Delaware

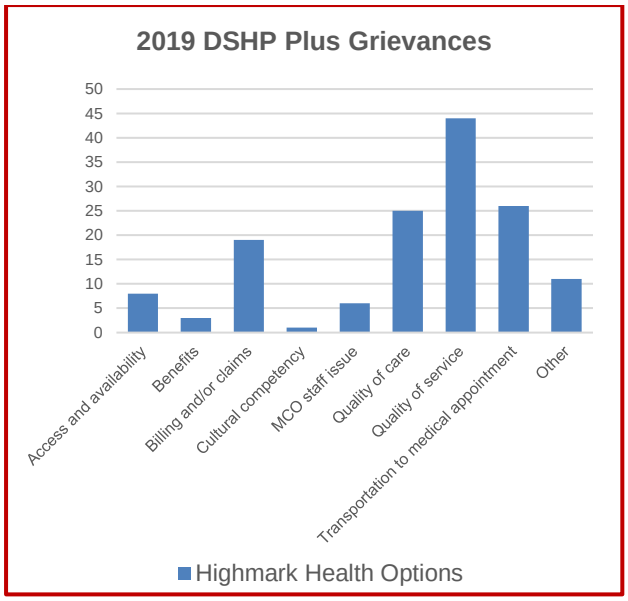

2020 DSHP Plus Grievances
25
20
15
10
5
0
Access and availability
Benefits
Billing and/or claims
Cultural competency
MCO staff issue
Quality of care
Quality of service
Transportation to medical appointment
Other
AmeriHealth Caritas Delaware

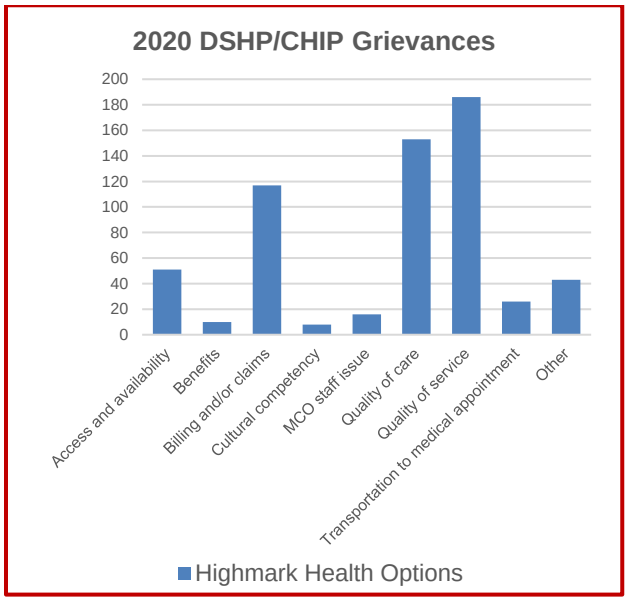
2018-2020 HHO Grievances

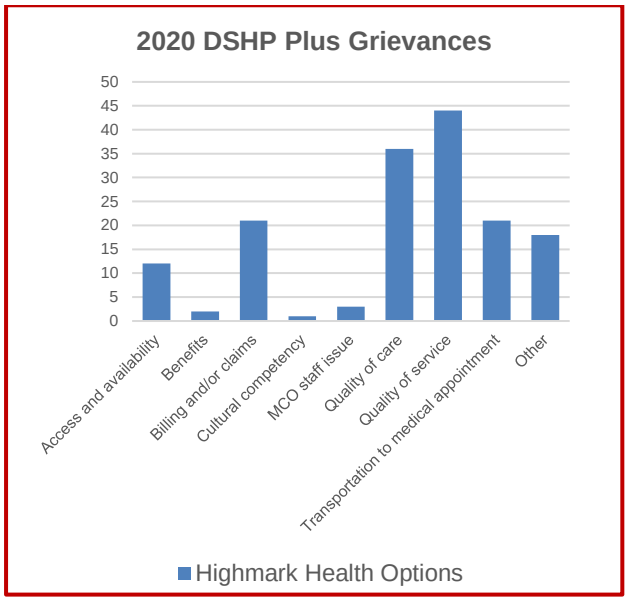






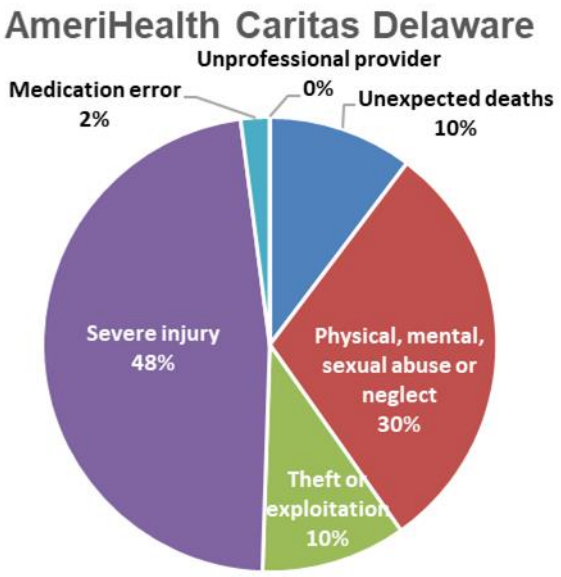


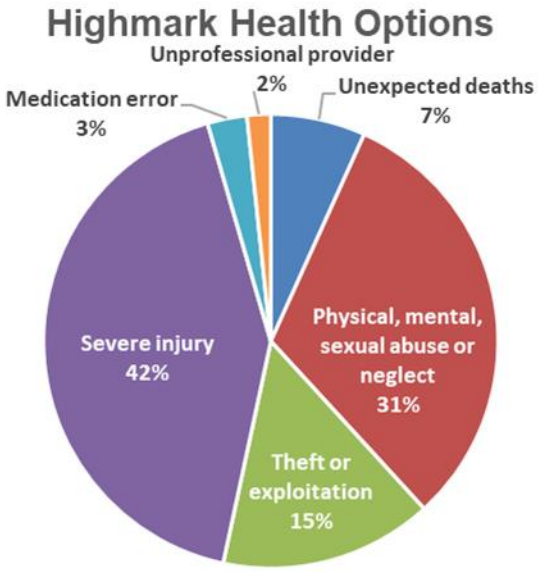




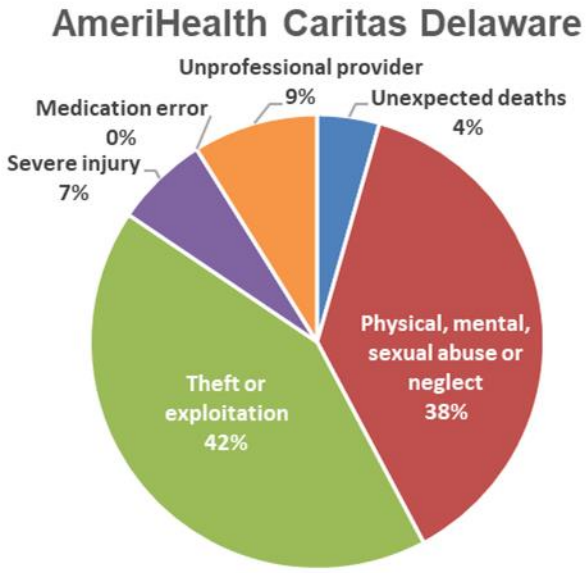
Safety and Wellness

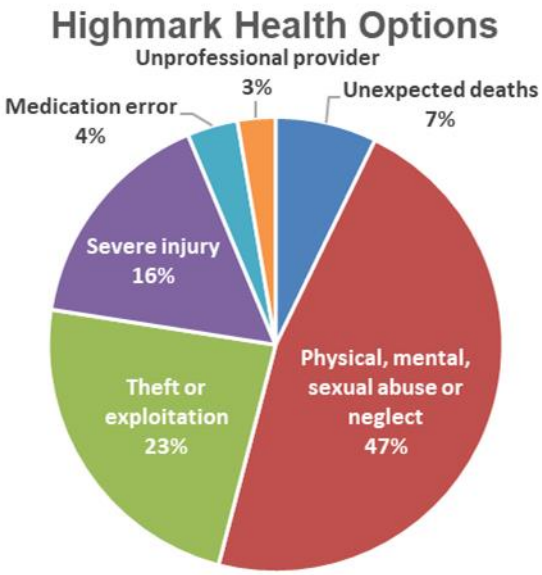
2018 Critical Incidents by Type



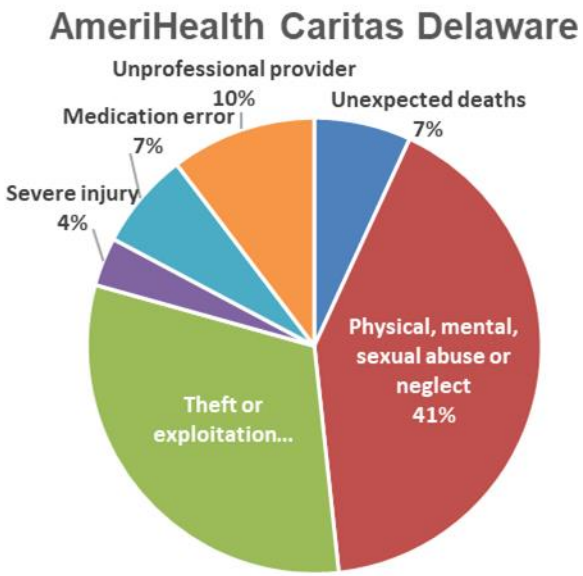


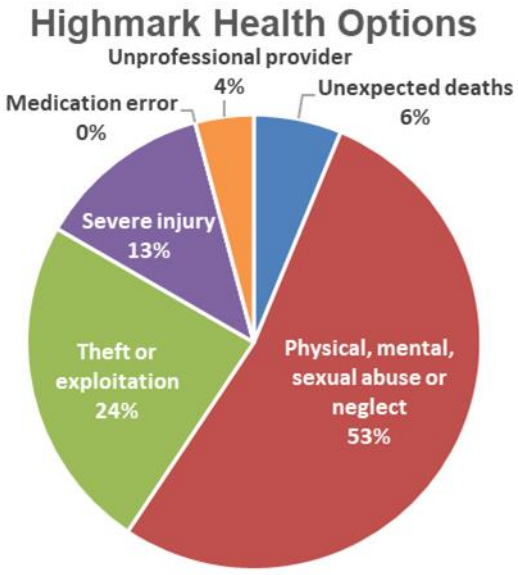
2019 Critical Incidents by Type





2020 Critical Incidents by Type





Critical Incident Reporting

DMMA is responsible for operating an incident management reporting system that meets the state's established policies, procedures, and regulations. The reporting system includes the requirement to report, document, and investigate incidents of abuse, neglect, exploitation, and any unexplained deaths. If an incident occurs, the state is obligated to analyze the critical incident to make necessary changes to prevent reoccurrence. The ultimate goal for the state is not to eliminate all incidents but to minimize preventable incidents from occurring. CMS encourages states to define critical incidents to, at a minimum, include unexpected deaths and broadly defined allegations of physical, psychological, emotional, verbal and sexual abuse, neglect, and exploitation.

The State of Delaware received a request in 2019 from CMS to complete an evaluation describing the incident management process for the Lifespan Waiver. This was part of a broader effort on the part of CMS to assess the current state of incident processes and improve processes across the country. States are encouraged to conduct audits of their incident management systems to ensure that information on all occurrences meeting the state's definition of a critical incident, are reported appropriately, and lead to investigations to determine the need for any corrective actions.

Delaware also decided to consider investigating the community-based populations within the DSHP Plus and PROMISE programs. DMMA also identified that the reporting process seemed unclear.

DMMA, therefore, contracted with Mercer to conduct an evaluation of the critical incident process. The project includes:

- A systemic review and evaluation of policies and processes
- Make necessary revisions and evaluation such as reporting frequency
- Identify and develop existing data sources
- Updating existing formats
- Training of stakeholder groups, which could include members, advocates, providers and MCOs.
- Mercer providing the "train-the-trainer" approach to help State staff conduct training. To be undertaken after revisions make to policies and procedures.
- Provider strategy support and technical assistance to State staff implementing the new policies and processes.

In 2020 Mercer worked with DMMA on an initial Critical Incident project focusing on two (2) areas:

1. Staff assignments, role responsibilities, and data tracking

2. Contract and Policy compliance of critical incident reporting (time frame reviewed was December 1, 2019–March 31, 2020.

Mercer reviewed documents including contract language, DMMA policy and procedures and training materials, facilitated discussions with DMMA staff and evaluated four months of critical incident reporting data. This review provided DMMA with the updated critical incident reporting workbook, critical incident report form, DMMA policy and training materials. The project will eventually provide a systemic approach to identify needed revisions to policy and process, evaluate data sources, leverage opportunities for a coordinated approach and provide training to DMMA, MCO's, and stakeholders.

Health Risk Assessments (Rate of Completion)

- ACDE declined in 2019, increased in 2020.
- HHO inconsistent in 2018, increased consistently in 2019 and 2020.

Member Services

Having a well-trained and responsive member services staff is critical to a MCOs success. Aside from providers, these staff members are often those in most frequent contact with the vast majority of Medicaid members. Both MCOs consistently surpass the required customer service metrics. ACDE was above a the 80% threshold in answering calls within 30 seconds in 2019 and above 80% threshold 2020 with the exception of one month ((November).) HHO was above the 80% threshold in answering calls within 30 seconds in 2020, 2019 and 2018 with the exception of one month (January 2018).

Network

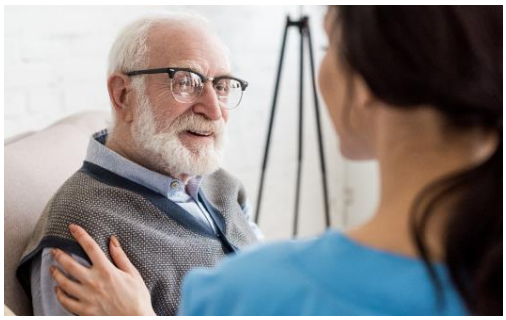
Developing and maintaining an adequate network of primary care and specialty providers is fundamental to provide timely access to high quality care for members. The state of Delaware as a whole faces challenges maintaining a robust provider community, particularly in rural areas of the state. Even with the overall challenges, the MCOs are compliant with the established time and distance standards for both PCPs and specialty providers.

Summary

In 2018 the QCMMR was updated to align with the most current contractual requirements. As with any significant reporting revisions, DMMA has identified reporting challenges to be addressed with QCMMR and QCMMR Plus measures. By way of example, reporting sometimes requires collecting data from sources that are not automated and relies on manual data submissions; this can be administratively burdensome and allow for inconsistency in data collection. DMMA acknowledges there is a need for continued refinement of reporting expectations and technical specifications for MCOs to use when collecting, analyzing, and reporting QCMMR and QCMMR Plus measure results.

Member and Provider Experience

CAHPS



One goal in the Delaware Medicaid QMS relates to assurance of member satisfaction with services and emphasizes 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 CAHPS survey captures information from consumers about their experiences with health care. It 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 members (administered to parents or guardians).

The MCOs conduct the Adult CAHPS, Child CAHPS, and a care management satisfaction survey to assess member satisfaction with MCO healthcare services.

ACDE, as a new MCO in 2018, did not administer the CAHPS survey in 2018 and 2019. ACDE's CAHPS adult and child survey response rates were below 15% and results in 2020 overall below the 50th percentile for three adult CAHPS measures and six child measures. HHO's performance on the CAHPS survey demonstrated moderate results but improvement across all three evaluation years (2018, 2019, and 2020) on seven measures for both and adult and child CAHPS measures. The 2020 HHO CAHPS response rate was below 15%.

The following results and comparison to Quality Compass national benchmarks are based on the CAHPS composite scores developed by combining individual survey questions into broader topics.

Table 8: Adult CAHPS Results

Measure Description	2018 ACDE Results	2019 ACDE Results	2020 ACDE Results	2018 HHO Results	2019 HHO Results	2020 HHO Results
Rating of personal doctor	NR	NR	◒	◒	◒	◒
Rating of specialist	NR	NR	◕	◕	◒	◕
Rating of all health care	NR	NR	◒	◒	◒	◒
Rating of health plan	NR	NR	◕	◒	◒	●

Table 8: Adult CAHPS Results

Measure Description	2018 ACDE Results	2019 ACDE Results	2020 ACDE Results	2018 HHO Results	2019 HHO Results	2020 HHO Results
Getting needed care	NR	NR	◒	●	●	●
Getting care quickly	NR	NR	◒	◒	◒	●
How well doctors communicate	NR	NR	◒	◕	◒	◒
Shared decision making	NR	NR	Retired Measure	◒	◒	Retired Measure

Results are **relative** to the Quality Compass® national percentiles:
●**:** *Results met or exceeded the national benchmark for the 90th percentile.*
◕: *Results fell between the national benchmarks for the 75th and the 90th percentile.*
◒: *Results fell below the national benchmark for the 75th percentile.*
NR: *A designation given by National Committee for Quality Assurance (NCQA) to indicate either the MCO chose not to report the measure or the measure received an NR designation during a NCQA HEDIS Compliance Audit.*

Table 9: Child CAHPS Results

Measure Description	2018 ACDE Results	2019 ACDE Results	2020 ACDE Results	2018 HHO Results	2019 HHO Results	2020 HHO Results
Rating of personal doctor	NR	NR	◒	●	◕	●
Rating of specialist	NR	NR	◒	◒	◒	◒
Rating of all health care	NR	NR	◒	◕	◒	◒
Rating of health plan	NR	NR	◒	●	●	●
Getting needed care	NR	NR	◒	◒	◒	◒
Getting care quickly	NR	NR	◒	◕	◒	◒
How well doctors communicate	NR	NR	◒	●	◒	◒

Table 9: Child CAHPS Results

Measure Description	2018 ACDE Results	2019 ACDE Results	2020 ACDE Results	2018 HHO Results	2019 HHO Results	2020 HHO Results
Shared decision making	NR	NR	Retired Measure	◒	◒	Retired Measure

Results are **relative** to the Quality Compass® national percentiles:
●**:** *Results met or exceeded the national benchmark for the 90th percentile.*
◕: *Results fell between the national benchmarks for the 75th and the 90th percentile.*
◒: *Results fell below the national benchmark for the 75th percentile.*
NR: *A designation given by National Committee for Quality Assurance (NCQA) to indicate either the MCO chose not to report the measure or the measure received an NR designation during a NCQA HEDIS Compliance Audit.*

Member Experience with Care

Overall, ACDE showed opportunities for improvement with member experience with care for adult members and even more so with child members. HHO performed moderately well on both the adult and child CAHPS survey but results still suggest opportunities for improvement, particularly in the member experience for children.

The NCQA CAHPS team recommends aiming for a response rate of at least 40%. This figure is based on extensive experience with partners and field trials regarding what is possible with a reasonable amount of effort and expense. Survey sponsors and vendors that follow the recommended sampling and data collection protocols, including follow-up with non-respondents, can achieve 40% or higher response rates.[1] Response rates for both ACDE and HHO on CAHPS surveys were below 15%. These low response rates are of concern as lower response rates reduce the confidence that the sample represents the population. As well race/ethnicity reported the sample of participants responding was over 58% white.

The CAHPS results and the response rates have triggered DMMA to review how MCOs are attempting to improve member experience, particularly as health equity is a priority. Emphasis is progressing to develop reporting methodologies to analyze variation in measures among different races/ethnicities to identify disparities that can lead to initiatives to address gaps. Some example actions that DMMA and the EQRO are considering are to recommend MCOs have a sampling plan that includes stratified sampling, oversampling minority populations, and expanding data collection methodologies beyond mail and phone. Also, DMMA will be requiring its MCOs obtain an accreditation in Health Equity from NCQA. Health Equity Accreditation focuses on organizational diversity, equity,

[1] https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/survey3.0/fielding-the-survey-cg30-2033.pdf

inclusion and reducing bias; collecting gender identity and sexual orientation data; and reporting race/ethnicity stratified HEDIS measures.

National Core Indicators-Aging and Disabilities

The National Core Indicators-Aging and Disabilities (NCI-AD) initiative aims to assess Medicaid programs and delivery systems performance to improve services for older adults and individuals with physical disabilities. The State of Delaware chose to utilize the NCI-AD survey due to the large number of LTSS available to this population in both facility-based and HCBS settings. This NCI-AD survey collects valid and reliable person-reported data that measures the impact of the states' publicly funded LTSS and their impact on the quality of life and outcomes of older adults and adults with physical disabilities. This survey is used as a benchmark to compare Delaware with other states, to better understand how to provide optimal LTSS, enhance quality assurance activities, and strengthen LTSS policy.

The NCI-AD Adult Consumer Survey measures outcomes across 18 broad domains and key areas of concern. These 18 domains are comprised of approximately 50 core indicators which are the standard measures used across states to assess experiences and outcomes of services, including rights and respect, service coordination, care coordination, health, safety, etc. DMMA chose to partner with ADvancing States and Human Services Research Institute (HSRI) to obtain national survey participation and engaged their EQRO (Mercer) to oversee the survey process. The survey process utilized Vital Research, a national social sciences survey group, who conducted the NCI-AD survey face-to-face with members in Delaware. Vital Research then compiled and submitted their survey results to HSRI.

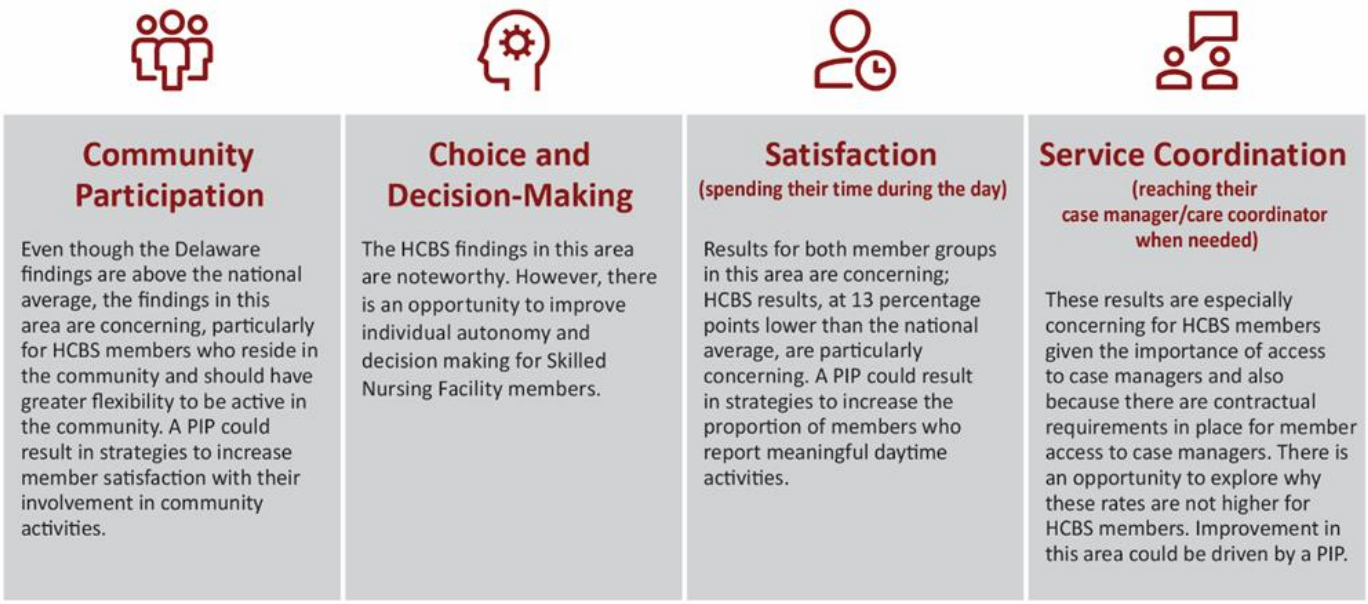
The state of Delaware has been administering the NCI-AD surveys since 2015, and conducts them every two years. Below are the survey results for 2017-2018 and 2019-2020, which both included NCI-AD's optional module on PCP and additional state-specific questions to the standard. The program populations included in these surveys were Division of Services for Aging and Adults with Physical Disabilities (DSAAPD), DMMA Diamond State Health Plan Plus (DSHP Plus) enrollees, and Home Delivered Meals Only. The survey has since been paused due to the COVID-19 pandemic, but DMMA plans to continue to implement the survey in future years.

2017–2018 Survey:

DSAAPD and DSHP Plus were the two program populations surveyed in 2017–2018. DSAAPD provides a broad range of services and support to people ages 60 and older and to people ages 18–64 who are physically disabled, and require LTSS in order to remain in a community setting. Services include: adult day services, assistive devices, attendant services, community living, home modifications, personal care services, personal emergency response system, and respite care services. Ninety-two people (N=92) from this program were included for analysis. DSHP Plus provides improved access to community-based long-term care services and increases flexibility to effectively

address individual needs, and to better control rising long-term care costs that significantly affect Medicaid. Three hundred fourteen people (N=314) from this program were included for analysis.

Recommendations from the 2017–2018 NCI-AD survey results include the following:

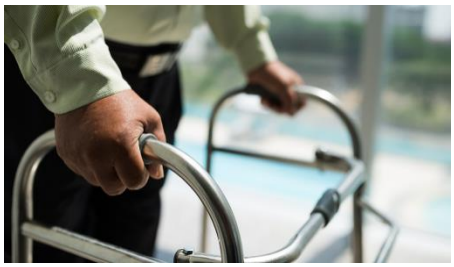


2019–2020 Survey:

DSAAPD, DSHP Plus, and Home Delivered Meals were surveyed in 2019–2020. Thirty-two people (N=32) from the DSAAPD program were interviewed and included for analysis. Three hundred sixty one people (N=361) from the DSHP program were interviewed and included for analysis. Home Delivered Meals program, funded through the Older American Act for those ages 60 and older, provides nutritionally balanced, hot meals during the day to homebound persons. Some people also receive cold, bagged meals so that they will have food available in the evening as well. Fifty-eight people (N=58) from this program were interviewed and included for analysis.

Impact of COVID-19 on 2019–2020 Data Collection and Reporting: Due to the COVID-19 Pandemic the 2019–2020 Adult Consumer Survey data collection period was unexpectedly abbreviated with all data collection being stopped in March, 2020. At the time surveying ended, states were in many different stages of survey administration. Very few states had completed data collection. NCI-AD made the decision to offer to provide state reports to all states that collected data during the 2019–20 survey year. As states were in various stages of completion, some demographics — including program populations — may not be fully represented. Therefore, data presented for 2019–2020 reporting are for internal state use only and data should not be used as a true comparison between states this year or in previous years.

Delaware specific results can be located at
https://nci-ad.org/upload/state-reports/DE_19-20_NCI-AD_State_Report.pdf



DMMA continues to work collaboratively with MCOs to ensure the quality and effectiveness of LTSS services. In addition, ongoing NCI-AD stakeholder engagement activities occur with key partners in the community, including the Delaware Aging Network and the Governor's Advisory Council on Services for Aging and Adults with Physical Disabilities to identify further opportunities and progress toward goals.

Provider Experience

MCOs conduct annual provider satisfaction surveys and each MCO identifies opportunities for improvement based on survey results. During the 2018–2020 time period, opportunities identified included: provider portal function, education on use of the portal (e.g., how to access, submitting authorization requests, claims submissions, etc.), claims payment (e.g. faster payment, improved accuracy and consistency, etc.), and improved provider processes (e.g., easier pharmacy authorizations, direct access to a life provider service representative, written authorization confirmation). Survey results are made available to providers via newsletters.

There is recognition that with the evolution from the triple aim to the quadruple aim, there is an emphasis on improving the work life of health care providers which is an important factor contributing to the improvement to the historic three pillars of the triple aim. DMMA recognizes there is no standard set of questions that each MCO uses to evaluate the provider experience. This presents an opportunity to develop targeted questions for each MCO to include in their provider surveys that can lead to identifying opportunities to improve the provider experience.

Additional Performance Measurement

PROMISE Performance Measurement

The PROMISE program targets individuals with behavioral health needs and functional limitations to offer an array of HCBS that are person-centered, recovery-oriented, and aimed at supporting beneficiaries in the community. Adult populations meeting the severe and persistent mentally ill and substance use disorders eligibility criteria for PROMISE services have the choice to receive specialty behavioral health care services throughout the State. The PROMISE program will help improve clinical and recovery outcomes, reduce unnecessary institutional care through better care coordination, and reduce overall program costs. To institutionalize the PROMISE Program, appropriate identification and referral is required. The Table below reflects that measurement.

Table 10: PROMISE Reporting for DSHP Medicaid & CHIP Population						
Measurement Item	2018		2019		2020	
	ACDE	HHO	ACDE	HHO	ACDE	HHO
Members identified for PROMISE	371	138	188	395	204	222
Members referred to PROMISE	177	103	70	122	41	130
Members successfully outreached for PROMISE	325	92	180	140	158	135
Members enrolled in PROMISE	12	420	1	203	4	81
Members who participate in PROMISE	213	960	8	89	2	44
Members unable to contact for PROMISE	48	40	2	57	55	8
Members declining PROMISE	96	17	81	26	89	8

Table 11: PROMISE Reporting for DSHP Plus Population						
Measurement Item	2018		2019		2020	
	ACDE	HHO	ACDE	HHO	ACDE	HHO
Members identified for PROMISE	29	35	30	75	31	60
Members referred to PROMISE	16	24	12	18	13	31
Members successfully outreached for PROMISE	28	24	26	4	23	20
Members enrolled in PROMISE	4	149	1	71	3	42
Members who participate in PROMISE	29	404	3	0	10	6
Members unable to contact for PROMISE	1	8	0	1	8	0
Members declining PROMISE	2	0	8	0	7	0

EPSDT

DMMA reviews submitted Early and Periodic Screening, Diagnostic and Treatment (EPSDT) data in addition to the EPSDT 416 Report annually. The table below reviews reported data from the last three years of data available. Due to the irregularity of data reporting, DMMA made the decision to conduct a focus study on EPSDT data. (See Focus Study description on page 36.)

Table 12: EPSDT						
Measurement Item	2017 Delaware	2017 National	2018 Delaware	2018 National	2019 Delaware	2019 National
Screening Ratio*	84%	74%	76%	78%	71%	79%
Participant Ratio**	54%	59%	54%	59%	55%	60%

**Screening Ratio represents the number of total number of screenings received out of the expected number of screenings.*
***Participant Ratio represents the number of eligible members receiving at least one initial or periodic screening out of the total eligible members that should be receiving at least one initial or periodic screening.*

Network Adequacy and Availability

DMMA requires each MCO to develop an annual Provider Network Development and Management Plan (PNDMP). The PNDMP must contain the following information describing network assurances:

Summary of participating providers, by type and geographic location in the State (ex: Geo-spatial analysis results).

Demonstration of monitoring activities to ensure that access standards are met and that members have timely access to services, per the requirements of this Contract (ex: appointment availability canvassing, and missed and late visit information for HCBS 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 (ex: grievance data, member experience from CAHPS and NCI-AD surveys).

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 (ex: action plans, use of single case agreements).The PNDMP provides for a structure to review network access and availability along with monitoring and improvement activities. The PNDMP includes an annual assessment of the effectiveness of the previous year's PNDMP. Since 2018 each MCO has received feedback from the EQRO regarding the strengths and opportunities with each MCO's PNDMP. The EQRO has recommended adding detail and specificity around required elements to be used for analyzing network adequacy. Stating that the PNDMP should capture all of MCO's activities and findings relative to network development and management; when used correctly, the PNDMP can act as the single source document for the MCO's network management activities. The MCO's have shown significant improvements in the development of their current PNDMP, with updates including the addition of cultural needs and preference information, access and availability standards, member/provider ratios, panel status, panel size standards and benchmarks, provider recruitment and retention philosophy, staffing and organization structure, provider directory maintenance and reporting requirements.

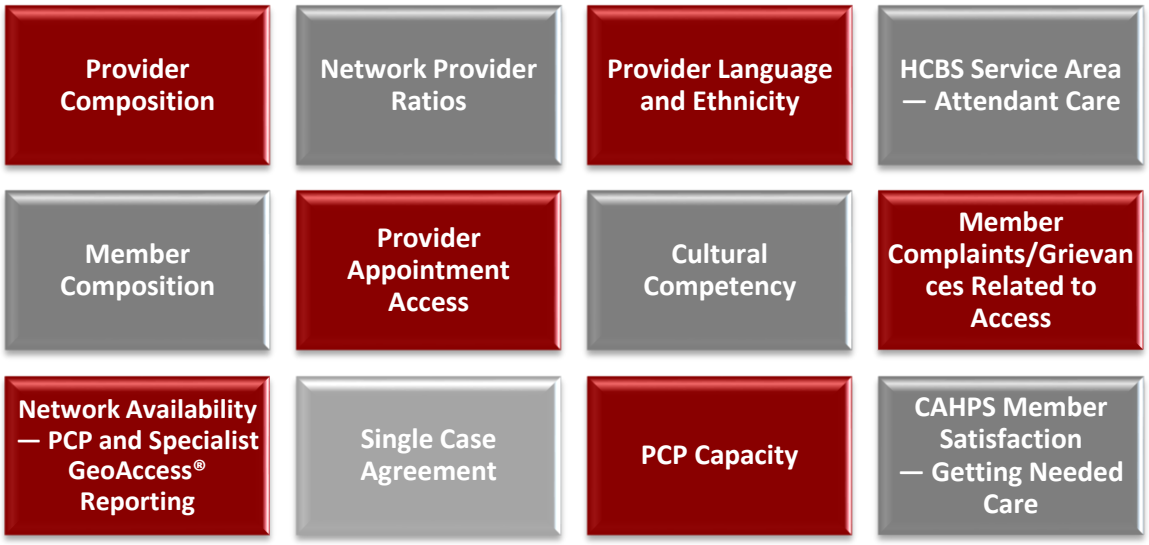
MCOs run geo-spatial analysis reports to provide data for analyzing member access to network providers, measuring time/distance standards by provider type, and other various network monitoring data. The analysis identifies geographic areas of the State with insufficient access.

Timely appointment access for regular, routine, urgent, specialty care, and LTSS is monitored by each MCO through provider site-specific surveys and also through tracking and trending grievances regarding appointment availability.

Highmark Health Options

The HHO PNDMP for 2020 provided a roadmap of next steps to ensure continuous improvement in meeting our members' healthcare needs, meeting State and Federal regulatory requirements, and meeting NCQA accreditation standards. 2020 presented several new and complex challenges including logistics of managing and servicing providers during COVID-19 pandemic, transition of network management from a sister entity, Gateway Health, to Highmark, Inc., updating the online provider directory and provider portal, as well as challenges in filling open network management positions.

Provider network reporting in the PNDMPM included:



AmeriHealth Caritas Delaware

On a quarterly basis, ACDE assesses its membership access to participating providers. ACDE collects and analyzes geographic distribution and provider to member ratios through use of GeoAccess software, a managed care industry’s standard instrument for measuring healthcare network access. The software provides maps, graphs, and tabular reports for analyzing member access to network providers. ACDE reviews and assesses availability for practitioners providing primary, specialty and behavioral healthcare. If and when opportunities are identified for improvement related to practitioner availability, interventions are implemented to ensure adequate member access to practitioners.

Provider network reporting in the PNDMP included:

Summary

Developing the PNDNP framework allows each MCO to communicate their capacity to meet network requirements and member access needs. DMMA sets standards for MCOs to review all aspects of network reporting (e.g. access standards, appointment availability, capacity issues, etc.) in a connected and systemic fashion. The goal is to analyze the network in a way that will lead to pinpointing network gaps that need to be addressed to meet the needs of the population (e.g., geographic location, specialty, convenience for time/location, etc.). This will remain a priority for the 2021 quality strategy.

Validation of Performance Measures

The objective of the PM validation in the compliance process is to validate the accuracy of Medicaid, CHIP and DSHP/DSHP Plus PMs reported by the MCOs to DMMA. The measures reviewed for 2018–2020 were mandated by the State and used technical specifications developed as part of the State's QCMMR and CMS Adult and Pediatric Core Measure reporting. To validate the PMs, Mercer referenced the annual Compliance Review and Information Systems Capabilities Assessment (ISCA) and requested information responses with supporting documentation from MCOs. The following table shows a breakdown of validated PMs during 2018–2019 and their compliance rating as met, partially met. In 2020, the compliance rating was changed to high, moderate, or low:

Table 13: 2018-2020 Performance Measure Validation

2018 Performance Measure Validated	Compliance Rating	2019 Performance Measure Validated	Compliance Rating	2020 Performance Measure Validated	Compliance Rating
Annual monitoring for patients on persistent medication	**ACDE**: N/A **HHO**: Met	Controlling high blood pressure (HEDIS)	**ACDE**: Met **HHO**: Met	Chlamydia Screening in Women (HEDIS)	**ACDE**: High **HHO**: High
Well child visits (3, 4, 5, 6 years)	**ACDE**: N/A **HHO**: Met	Children and adolescents' access to primary care practitioners (HEDIS)	**ACDE**: Met **HHO**: Met	Prenatal and postpartum care (timeliness of prenatal care) (HEDIS)	**ACDE**: High **HHO**: High
Prevention Quality Indicators 01: Diabetes short-term complications admission rate	**ACDE**: N/A **HHO**: Met	Asthma in younger adults admission rate (HEDIS)	**ACDE**: Met **HHO**: Met	HIV Viral Load Suppression	**ACDE**: High **HHO**: High
Developmental screening in the first three years of life	**ACDE**: N/A **HHO**: Met	Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (HEDIS)	**ACDE**: Met **HHO**: Met	Developmental screening in the first three years of life	**ACDE**: High **HHO**: High
Health risk assessments	**ACDE**: N/A **HHO**: Met	30-day readmission rate (State-defined)	**ACDE**: Met **HHO**: Met	Access — timely appointments Maternity 3rd trimester	**ACDE**: Moderate **HHO**: High
Percent of DSHP Plus members receiving BH services	**ACDE**: N/A **HHO**: Partially Met	Percent of DSHP Plus members receiving BH services (State-defined)	**ACDE**: Met **HHO**: Met	CM Reassessments	**ACDE**: Low **HHO**: High

Validation of Performance Measure Assessment — Summary

The validation process revealed that both ACDE and HHO reported performance measurement was substantially compliant with the validity of the PMs generated using NCQA certified HEDIS software and nationally recognized specifications. However, ACDE did not demonstrate a high level of confidence in the State-defined QCMMR measure rate of institutional and HCBS reassessments completed within 30 days of the due date. This evaluation alerted DMMA to the need for improvements in documentation and education for data collection and reporting specifications for State defined measures.

While both MCOs are substantially compliant with most performance measures included in the validation, the findings point to some DSHP Plus measures that may warrant continued investigation into appropriate data collection and reporting.

Race, Ethnicity, and Language Data Collection

DMMA provides race, ethnicity, and language data on eligibility files provided to MCOs. The MCO uses information on race/ethnicity, language, and disability status to provide interpretive services, develop educational materials for employee training and facilitate member needs in the context of their culture, language, and ability requirements.

Until the Medicaid and CHIP eligibility process implements mandatory disclosure of race and ethnicity and primary language, the State relies on demographic updates to the enrollment data file as well as MCO data collection reporting. This is a priority area of focus for DMMA for improvement in order to identify and address health disparities.

Social Determinants of Health (SDOH)

On April 4, 2019, DMMA convened a group of providers and payers to kick-off a workgroup to address social determinants of health (SDOH). Dr. Elizabeth Brown, DMMA Medical Director, facilitated the meeting that was attended by the MCOs, health systems, Federally Qualified Health Centers (FQHCs), and behavioral health providers. The purpose of the meeting was to discuss existing efforts to identify and address SDOH, identify barriers, and share opportunities for collaboration. As a result of the meeting, DMMA began developing a strategy to address the social needs of beneficiaries. Building on information gathered during the discussion with MCOs, providers in the community, and other state agencies, DMMA has begun implementing a foundational approach. In 4th quarter 2019, DMMA developed a plan for 2020 to more explicitly require MCOs to collect information on SDOH as part of the contractually required health risk assessment, include up-to-date information about community resources on the MCO website and as part of MCO staff desk materials, and address social needs in the member resource directory.

3
Improvement

Performance Improvement

DMMA expects MCOs to use resources to identify and put actions in place to improve performance and quality of care. Each MCO is expected to implement performance improvement projects that address opportunities for improvement through implementation of targeted activities actions to improve HEDIS results. In addition DMMA has sought to utilize Focus Studies to investigate identified problems and suggest solutions.

Performance Improvement Projects

Performance Improvement Projects (PIPs) are required by CMS as an essential component of an MCO's quality program and are used to identify, assess, and monitor improvement in processes or outcomes of care. DMMA has mandated that each MCO conduct five PIPs. Two PIPs are a State-mandated clinical study topics and study question. (1) Oral Health of the LTSS population which is prescriptive in nature, and 2) behavioral and physical health integration. PIPs are required by CMS as an essential component of an 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 three PIPs.

PIP Overall Assessment

DMMA requires PIPs are reported quarterly — due within 18 days of the quarter. The PIPs must be clearly written, detailed and aligned with identified population health concerns. The EQR evaluation demonstrated a high degree of confidence in the foundational steps for PIPs for 2018–2020.

Table 14: PIP Topics

AmeriHealth Caritas Delaware	Highmark Health Options
Oral health for DSHP Plus LTSS members (2019, 2020)	Oral health for DSHP Plus LTSS members (2018, 2019, 2020)
ADHD clinical practice guidelines, medication and therapy (2019, 2020)	Physical Health and Behavioral Health CC (2020)
Benzodiazepines and Opioids concomitant use (2019, 2020)	Pediatric Lead Screening (2020)
	Achieving primary care visits and medication adherence for HHO PROMISE members with a diagnosis of hypertension (2018, 2019)

Table 14: PIP Topics	
	Reducing pediatric 10-day readmissions at AI DuPont Hospital for Children through implementation of a single point of contact strategy. (2018)
	Achieving call center standards for MCO member services. (2019)

In 2018 the EQRO reported significant improvement was still needed in the PIP process to produce meaningful and sustained results.

In 2019, there was some improvement in outcomes of the PIPs in comparison to previous years; however, documentation of the PIP processes, limited statistical analysis, staffing issues including a lack of stability and continuity in the QM/QI department resulted in only moderate confidence in the reported results and the sustainability of improvement for two of the three PIPs validated.

In 2020, there continued to be little improvement in the outcomes of the PIPs. The MCOs continued to struggle with PIPs that lacked a strong design, with lead and lag measures that were not well-defined as well as interventions that were not highly effective. The majority of interventions implemented were passive in nature (e.g., newsletter articles, mailings, etc.), which did not result in the improvement intended for the PIPs. During the EQRO review, feedback was given to the MCOs to take a more aggressive approach to developing innovative interventions that show active engagement with members and community partners as well as selecting quantifiable lead and lag measures, and implementing and assessing interventions which are supported by enhanced analytics.

Due to previous challenges in PIP reporting, DMMA is initiating a three year PIP to be implemented by the MCOs in 2022 intended to ensure that pregnant and postpartum persons (PPP) with OUD are receiving evidence-based standards of care. DMMA will be providing the MCOs with the study question, aim statement, performance measures and technical specifications as well as technical assistance to ensure the MCOs gain understanding in proper PIP design to improve performance.

EPSDT Focus Study

In order to better understand the extent to which the Delaware EPSDT program is meeting the needs of Delawarean children and the federal reporting requirements of the EPSDT program, DMMA, requested its contracted EQRO complete a focused study of the State's EPSDT federal reporting processes. The purpose of the EPSDT focused study was to identify best practices and opportunities in the State's EPSDT program data collection, monitoring and reporting systems and, ultimately, utilize the data to support initiatives focused on ensuring timely access to EPSDT services for Medicaid members under age 21. The extent to which this is accomplished is measured in part through mandatory CMS reporting of the EPSDT Participation Report (Form CMS-416). CMS has established a minimum EPSDT program participation threshold of 80%.

To complete the EPSDT focused study, Mercer followed the CMS EQR Protocol 8: Conducting Focused Studies of Health Care Quality (revised 2012).[2]

Study Question

Is current guidance provided by DMMA regarding EPSDT reporting sufficient to allow for accurate and complete reporting on the EPSDT Participation Report (Form CMS-416)?

Study Methodology

Mercer worked with identified key study informants including personnel within DMMA, the State's contracted Medicaid MCOs and DXC Technology (DXC), DMMA's Medicaid Fiscal Agent and administrator of the State's Medicaid Management Information System known as the Delaware Medicaid Enterprise System (DMES), to provide input into the study.

The study included an in-depth review of policies and procedures, program manuals, analysis of technical specifications, face-to-face interviews and data sources used to generate the Form CMS-416 report.

Recommendations

The recommendations are related to opportunities identified throughout the course of this study and are focused on policies, tools and processes used to produce the Form CMS-416 report.

Finding 1: Establish an evidence-based State Periodicity Schedule for EPSDT screening and publish as such. Update program manuals, the MCO Contract and other EPSDT guidance to reflect the State-required medical Periodicity Schedule.

Finding 2: Revise the MCO Contract to require that corrective treatment identified as part of the EPSDT screening be provided as quickly as medically necessary but no later than 90 days from the EPSDT screening.

Finding 3: Establish an evidence-based State Periodicity Schedule for dental services, including when a child should be referred for their first dental visit. Update program manuals, the MCO Contract and other EPSDT guidance to reflect the State-required Periodicity Schedule.

Finding 4: Review instances of service denials related to fluoride treatment services. Determine if there is an indication that a significant number of denials occurred due to greater than one fluoride treatment provided to a child between the age of six months and five years within a six-month period.

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[2] Medicaid.gov. (2012). *EQR Protocol 8: Conducting Focused Studies of Health Care Quality, A Voluntary Protocol for External Quality Review (EQR)*. [online] Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-8.pdf [Accessed 25 Nov. 2018].

If the analysis determines that a significant number of denials occurred, develop a process to educate providers on how to determine when fluoride varnish was last applied.

Finding 5: The specifications regarding identification of data to include in the Form CMS-416 must be updated to align with the CMS-416 Instructions.

Finding 5: Implement a quality validation process and timeline to confirm results of the Form CMS- 416 prior to submission to CMS.

Finding 5: Develop a process to ensure that the most recent CMS-416 Instructions are reviewed annually to confirm the DXC Specifications utilized to identify information for inclusion into the Form CMS-416 are current.

Finding 6: The Form CMS-416 report should not include members in a stand-alone CHIP program. Exclude Delaware Healthy Children Program members from the information included in the Form CMS-416 report submitted to CMS.

Finding 6: Develop an internal process to ensure that the State's adopted Periodicity Schedule for well child visits is shared with DXC to ensure visit information is reported appropriately on Form CMS-416.

Finding 7: Issue guidance to both MCOs notifying them that they are not following contractual requirements to ensure that necessary referrals are made and to track referrals and treatments (MCO Master Service Agreement, 3.4.6.3.4).

Finding 7: Develop a process to monitor the MCOs to ensure that they are meeting their contractual obligation to track referrals and ensure that treatments associated with the referrals are provided within the appropriate timeframe.

Finding 8: Administratively denied claims, such as due to untimely filing, should be included in encounter submissions to DMES to allow for inclusion in the Form CMS-416 reporting. DMMA should explore the feasibility of allowing these encounters to flow into DMES so that all unduplicated services provided to eligible members are included in Form CMS-416 reporting regardless of payment status.

Finding 9: Evaluate bundled billing practices by certain clinics and the effect such practices have in regards to identification and quantification of discreet EPSDT screening services; this applies to fee-for-service and managed care.

DMMA's commitment to improving compliance with EPSDT is evident in the hiring and onboarding of an EPSDT Coordinator in 2017 who is responsible for driving EPSDT improvements in collaboration with contracted MCOs. Some highlights of the work done to improve EPSDT includes adoption of a standardized periodicity schedule, alignment of 416-reports with CMS guidance for EPSDT reporting

and activities to drive improvements especially between receipt of a positive screening and tracking referral for diagnosis and treatment, as appropriate.

Pharmacy Focus Study

The purpose of the pharmacy focus study was to identify differences in treatment engagement levels for Medicaid members prescribed buprenorphine for an Opioid Use Disorder (OUD) and potential, underlying reasons for any noted differences. Buprenorphine is a prescription drug used to treat OUDs. While medication is an important part of successfully treating certain addictions, including OUD, research has shown that Medicated Assisted Treatment (MAT) is most beneficial when combined with counseling, other behavioral therapies, peer support, and/or self-help groups.

Study Questions

The study questions addressed focused on the members who demonstrated active and ongoing engagement in treatment. Medical claims for these members were analyzed to assess commonalities and outcomes. Mercer explored the following questions:

1. Do members with more treatment engagement visits for OUD have better outcomes than those with only two, or another limited number of visits?

2. Do members with more treatment engagement visits for OUD have particular providers, clinics, and/or prescribers in common?

3. Do members with more treatment engagement visits for OUD have similar buprenorphine claim types (NDC claims filled at a retail pharmacy vs. Healthcare Common Procedure Coding System (HCPCS) claims from a visit to an Opioid Treatment Program)?

4. Are there additional common characteristics to be noted for those members who remain engaged in treatment for OUD?

Study Methodology

To help understand the differences in engagement levels for members prescribed buprenorphine for OUD, Mercer searched DMMA's National Council for Prescription Drug Programs and HCPCS pharmacy data from 2017 to find encounters for buprenorphine. This search resulted in a dataset of 3,130 members who were prescribed buprenorphine. Mercer studied medical encounter data for these members to analyze the differences in engagement levels and attempt to find commonalities among those members with higher engagement rates when compared to those who were less engaged in ongoing treatment.

Recommendations

- Mercer recommended collaboration and further study with the providers shown to be most successful in retaining members in ongoing treatment to determine if the members under their care

are truly successful in treatment. If so, perhaps there are best practices they can identify and share with their colleagues. A survey with members who have demonstrated higher/stronger engagement with these providers could further inform strategies and factors that have contributed to their successful engagement.

- Mercer recommended leveraging national efforts to expand access to MAT by leveraging physicians, nurse practitioners, and physician assistants in a variety of practice environments, including primary care. While these provider types can, and should, be part of the solution in addressing the opioid epidemic and in treating OUD, non-behavioral health providers could benefit from additional educational opportunities addressing engagement and retention best practices.

- Mercer recommended leveraging claims and utilization data to identify clinicians whose opioid-prescribing patterns go against clinical guidelines. Outreach to these clinicians can provide feedback to assist in creating more effective treatment options for their members.

- Mercer recommended more intensive care coordination and intervention for members who have proven to be more difficult to engage and retain in treatment; these members may benefit from referral to a behavioral health provider.

- Mercer recommended further study, research, and collaboration with providers who dispense buprenorphine in smaller quantities but with frequent in-person visits. These providers may have valuable insight into how and why they use this dispensing method rather than sending members to a retail pharmacy, and perhaps will be able to further support or refute the higher engagement indicated in this study.

- Mercer recommended DMMA, the MCOs, and other stakeholders continue to support efforts to broaden access to buprenorphine prescriptions and remove prescriber capacity limits to avoid forcing members to find a prescriber outside of their behavioral health facility.

4
State Initiatives Supporting Quality

As a part of the broader system of healthcare in Delaware, DMMA has the opportunity to partner or participate in additional State initiatives supporting quality improvements and/or in providing delivery of services. Some of these additional initiatives in varying stages of development, implementation, and sustainability are highlighted in this chapter.

Accountable Care Organizations

DMMA began an application process in 2019/2020 for entities to demonstrate interest and readiness to contract as Accountable Care Organizations (ACOs). DMMA decided to contract with five approved ACO's. In the future, these contracts, quality measures will be linked to payment. The intent is to move value bar and negotiating for gain sharing. Using shared risk/shared savings models and calculations based on the total cost of providing care instead of fees charged per each service provided, ACOs establish financial incentives for individual providers. These incentives promote the value of care over the volume of services and encourage providers to coordinate care with other providers, address patients' behavioral health and social needs, and improve patients' overall experience of receiving care. The ACO initiative, along with Delaware's health care spending and quality benchmarks, are major pieces in Delaware's Road to Value – a plan to transform the way that health care is delivered and paid for in the state.

Children with Medical Complexity Advisory Committee

In 2017, the State of Delaware's Legislature instructed the Delaware DHSS to develop and publish a comprehensive plan for managing the health care needs of Delaware's children with medical complexity (CMC). DMMA formed a CMC steering committee comprised of multiple community partners, sister divisions, MCOs, provider agencies, parents, caregivers, and other advocates to develop a comprehensive plan (the Plan) for identifying and managing the health care needs of Delaware's CMC. The Plan, published in May 2018, can be found on the CMC web page at: https://dhss.delaware.gov/dhss/dmma/children_with_medical_complexity.html.

Children with medical complexity are a subset of children and youth with special health care needs because of their extensive health care utilization. For the purpose of this work, a child is considered medically complex if she/he falls into two or more of the following categories:

- Having one or more chronic health condition(s) associated with significant morbidity or mortality;

- High risk or vulnerable populations with functional limitations impacting their ability to perform Activities of Daily Living (ADLs);
- Having high health care needs or utilization patterns, including requiring multiple (3 or more) subspecialties, therapists, and/or surgeries;
- A continuous dependence on technology to overcome functional limitations and maintain a basic quality of life.

In 2018, the work of the CMC Steering Committee was transitioned to a new group, the CMC Advisory Committee (CMCAC), which is charged with implementing the recommendations described in the Plan. The purpose of Delaware's Children with Medical Complexity Advisory Committee (CMCAC) is to strengthen the system of care, increase collaboration across agencies, encourage community involvement, with the goal of ensuring that every child with medical complexity has the opportunity to receive the adequate and appropriate health care services they need and deserve.

Between 2018 and 2021, the CMCAC addressed a number of the priorities and recommendations outlined in the Plan including:

- Launching a dedicated CMC webpage and posting resources, CMCAC meeting materials, and the Delaware-specific definition of CMC.
- Performing a comprehensive data analysis to identify the Medicaid/CHIP population of CMC.
- Reviewing emergency department and inpatient hospital utilization.
- Reviewing gaps in skilled home health nursing utilization.
- Developing a Private Duty Nursing (PDN) Emergent Care Decision Tree.
- Conducting a Family Satisfaction Survey.
- Conducting a study of PDN Workforce Capacity Study.
- Developing a Prior Authorization "Toolkit".
- Drafting "What to Expect" and "Welcome" letters for MCOs to give to families newly introduced to PDN services.
- Providing input to the Delaware Family Voices Family Centered Care Competency Training Curriculum.
- Collaborating with Delaware Community Aid Society, Inc. (DECLASI) to develop the Affidavit for Temporary Health Care Authorization.

- Researching online materials/webinars for Family Centered Care and posted links on the CMC website.
- Providing recommendations for revisions to the DMMA Medicaid Policy Manual to address MCO processes for PDN Prior Authorizations.
- Providing a presentation at the national 2020 ADvancing States Home and Community Based Services (HCBS) virtual conference. DMMA, a parent representative on the CMCAC, Vital Research and Mercer highlighted the committee's work on the Family Satisfaction Survey.
- Supporting a new workgroup convened to address issues and challenges identified specific to Durable Medical Equipment [DME]/Supplies.
- Exploring issues related to DME/Supplies, coordination of benefits and third party liability with the DMMA Program Integrity Unit.

DMMA continues to encourage, support and value the work of the CMCAC and looks forward to continued progress in 2021 and 2022 during which the group will review the findings from the Family Satisfaction Survey and PDN Workforce Capacity Study and develop a plan for addressing the issues/challenges identified in the studies.

Coronavirus Aid, Relief, and Economic Security (CARES) Act Funding Distribution

On March 13, 2020, the United States President, declared a public health emergency, and CMS announced aggressive actions and regulatory flexibilities to help healthcare providers and states respond to and contain the spread of 2019 Novel Coronavirus Disease (COVID-19). The program provided funds from the U.S. Department of the Treasury intended to alleviate some of the financial stressors caused by the COVID-19 pandemic on the health care industry. DHSS received Health Care Relief Funds in 2020. DHSS contracted with Mercer to develop a plan and processes to distribute CARES Act funds in a consistent and fair manner.

The program consisted of eight different fund types.

The Health Care Relief Fund supported providers throughout the health care industry that have been on the front lines fighting COVID-19 in Delaware. This included: includes:

- home health care agencies,
- intellectual and developmental disability providers,

- nursing homes and assisted-living facilities,
- behavioral health service providers,
- Delaware's hospital systems.

Healthy Communities Delaware, a statewide public-private partnership that works to address social determinants of health, also received funding for distribution to Delaware communities that have been disproportionately affected by COVID-19.

DHSS accomplished its goal of distributing CARES Act Funds to Delaware providers prior to the end of 2020. This was completed on a very short timeline. Summarized below are lessons learned from the effort, including both successes and challenges:

Issue Area	Successes	Challenges
Timeline	All applications initially reviewed and funding recommendations were provided to DHSS by December 11, 2020.	The timeline for completion was very short, which presented several challenges. • Delaware-specific policy was still under development when the program started. • Application forms required revision by DHSS after release. • No opportunity to collaborate or test applications prior to release • Limited opportunity to test processes prior to go live

Issue Area	Successes	Challenges
Requirements	DHSS used their website to communicate program requirements effectively. Mercer developed Delaware-specific policy based on review of federal guidelines published and communicated by DHSS. Policy documentation provided guidance to application reviewers and may serve as a resource for DHSS should they determine the need to perform a similar task in the future.	Not all requirements were thoroughly developed. • Provider eligibility for some funds was not well defined. This resulted in extensive time devoted to determining formulary-based awards and development of policy to guide reviewers. • Applicants often applied for programs for which they were not eligible. In some instances, providers were able to reapply for other funds. • Use of funds varied by fund type. Applicants did not always understand what expenses were eligible under a particular fund. • Applicants did not appear to understand application requirements. Reviewers sent over 100 requests for additional information needed to complete the application.
Communications	Regular bi-weekly meeting with DHSS team allowed both DHSS and Mercer to be well informed. Use of a single mailbox for questions provided an opportunity for Mercer to clarify DHSS's intent for the program as needed. Mercer reviewers report that allowing direct communication with applicants through a standard additional information request form was effective. Most applicants provided requested information in a timely manner.	• Multiple COVID related guidelines with sometimes overlapping and conflicting requirements caused challenges for both providers and reviewers.

Issue Area	Successes	Challenges
Human Resources	Working collaboratively with DHSS staff, Mercer staff provided individuals who performed the following tasks: Analyzed provider payments in order to provide guidance on master formulary for funding amounts by fund type and/or individual provider. Established a tracking and reporting system for applications received and processed. Developed policy and process documentation to be used for processing applications. Reviewed and recorded information submitted by applicants, including processing 134 requests for additional information. Provided recommendations to DHSS regarding approvals or denial of funding request for 229 applications.	Project timeline was fluid, volume was unknown and very short lead time. Challenge to have the "right" amount of staff available and trained at the time the work was needed.
Reporting	Mercer provided regular updates to DHSS in the form of reports, which tracked all applications received and their status in the review process. Reports were modified to allow DHSS to utilize electronic information in their mail-merge process without the need to reenter applicant information.	DHSS would have preferred to have direct access to the tracking report to view application status. DHSS and Mercer utilized the DHSS email system to share application information and other large files. Although this was effective, it would be more efficient to develop a shared location to exchange large files and other documents.
Data Management	Mercer was able to utilize a current tool (SharePoint) and adjust as needed without significant build time or programmer resources.	Since there was insufficient time to set up an online portal for data entry, all application information had to be manually entered by reviewers. This was time consuming and resulted in some errors in demographic information requiring correction.

Delaware Contraceptive Access Now

Launched in 2014, Delaware Contraceptive Access Now (DelCAN) is a statewide initiative aimed at reducing unintended pregnancy through increasing access to the full range of contraceptives for women in Delaware. All publicly funded health centers and private providers have access to training, technical assistance, and quality improvement provided by Upstream USA. Through public/private partnership, there has been a reduction of unplanned pregnancies among Title X members ages 20-39 by 24% and LARC use increased from 13.7 to 31.5%. Delaware is sustaining the DelCAN initiative in collaboration with the Delaware Division of Public Health. The focus will remain on ensuring a system is in place for uninsured and underinsured women working with publicly funded family planning providers across the state.

Dental Benefit

Early 2019 a plan was started to provide oral health benefits to adults. In order to implement the adult Dental Benefit DMMA was required to submit both a state plan and 1115 waiver amendment. To help ensure a successful launch of the Adult Dental Benefit DMMA needed to engage with the Dental Society and Dental Providers in the selection of the delivery system model, benefit design and fee schedule. Their buy in to the design of the program was crucial for the successful launch of the new benefit and helped to ensure an adequate provider network was available to members. DMMA met with the Dental Society and Dental providers over several months working out the details of the program. This extensive stakeholder process, while necessary, did result in delays in finalizing the benefit design and fee schedule. The adult dental benefit was implemented via a non-risk arrangement with the MCOs.

Mercer completed a readiness review of each MCO for delivery of adult dental benefits prior to the go-live date of October 1, 2020. DMMA requested that the EQRO gather information and facilitate interviews with MCO leadership, supervisory and management staff engaged with delivering dental benefits and/or overseeing a dental benefit manager (DBM) as well as evaluate information systems readiness. A post-implementation review was planned for early 2021 to evaluate implementation of the adult dental benefit, ensure Delaware-specific policies and procedures have gone through committee approval and issues or concerns identified during the readiness review were resolved

During October through December 2020, 343 adult members received dental care under the new adult dental benefit, and nine adult members accessed the enhanced emergency benefit.

Electronic Visit Verification

Delaware is subject to the requirements of the 21st Century CURES Act which requires states to implement an electronic visit verification (EVV) system for Personal Care Services (PCS) and Home Health Services (HHS). The Act requires states have an EVV system to electronically confirm six key

data elements related to Medicaid funded PCS and HHS services. While the Act required states to have an EVV system in place by January 1, 2020 for PCS and by January 1, 2023 for HHS, CMS granted DMMA a Good Faith Extension to allow for the implementation of EVV on January 1, 2021.

EVV systems work to prevent fraud, waste, and abuse by requiring the person providing PCS or HHS to log into an electronic system using a phone, tablet, or other device to confirm the service has been provided each time they provide care to a Medicaid member in his/her home. EVV systems can also collect more information than what is required by federal law and can serve as an alert system for missed or late visits, take the place of paper timesheets, and provide access to up to date medical information.

In 2019 DMMA began working with stakeholders to solicit input into the state's EVV model and design, including the development of the EVV Steering Committee, a dedicated EVV mailbox for input/questions, attendance at provider association meetings, public meetings in each county to walk through the proposed design of the EVV system with stakeholders and development of a provider survey. An EVV web page, populated with information about DE EVV, was developed and can be found at: https://dhss.delaware.gov/dhss/dmma/info_stats.html. The state decided to allow for maximum flexibility by selecting an Open Model which provides one state sponsored, statewide EVV system for data collection and data aggregation. This allows providers to use their own EVV system if they already have one in place and provides access to an EVV system for those providers that don't have a system in place.

The Delaware DMMA procured an EVV system called AuthentiCare in early 2020 and is continuing its work toward EVV implementation in 2021.

HCBS Transitional Care

DMMA prioritized improving HCBS Transitional Care requirements in 2018 through 2020 implementing provisions of a Transition Plan. The Transition Plan developed by DMMA identified on-going monitoring for HCBS services, to assure services were provided in settings that meet federal requirements. DMMA developed an approach to assessment of members, providers, and MCOs. An assessment tool and process was developed to enable Case Managers, as part of the annual assessment and plan of care development, to collect information to ensure members are getting services from the appropriate setting, engaged by providers, and engaged in the community. Tools were developed for provider self-assessment to make sure provider settings meet federal standards; the provider self-assessment is submitted to the MCO and can be validated during an onsite visit to a provider's facility. Assessment tools also are available for the MCO to determine appropriate monitoring with providers for meeting requirements.

Health Information Technology

DMMA and other DHSS programs plan to leverage clinical and meaningful use data to meet federal goals to improve population health, reduce medical errors, improve health outcomes, and empower

Medicaid members to participate in their healthcare. The Delaware Health Information Network provides hospital event notification and information to enhance care coordination between providers. The Medicaid MCOs do submit data to the Delaware Health Information Network (DHIN) and DMMA submits fee-for-service data to the Health Care Claims Database portion of the DHIN.

The State Medicaid Health Information Technology (HIT) Plan (SMHP) with support from the State Innovation Models initiative included input from the health care community, including consumers, clinicians, community health centers, health systems, payers. The SMHP examines current resources to support HIT and identifies what is needed to build the infrastructure to support reporting on health care quality benchmarks including eight measures that will be tracked statewide with annual goals. The eight measures include:

DMMA and the Medicaid MCOs contribute spending and quality data to the DHCC that leads the benchmarking effort with input from stakeholders like DMMA/MCOs/insurers for reporting actual results against the benchmarks. For the CY 2020 (and CY 2021) performance reporting periods, Adult Tobacco Use and High school students who were physically active have been discontinued.

DMMA is working with the DHIN to obtain a quarterly data submission from the DHIN so that DMMA can conduct longitudinal studies of Medicaid people who come on/off the Medicaid membership rolls and other data analyses. The goal is to help build-out the DHIN to allow DMMA to benefit from obtaining DHIN non-Medicaid data and develop a plan on how to use this alternative data set. This data set is referred to by DMMA as the “HCCD” data to keep it distinct and separate from DMMA’s existing Medicaid Management Information System (MMIS) data warehouse information.

The SMHP strategy will contribute to the Delaware Quality Strategy by facilitating data-driven, evidence-based improvements in access, quality, and cost of healthcare and promoting and improving public health through increased transparency of accurate claims data and information. This can help identify areas for improvement, growth, and success across the healthcare system; understand and quantify health system performance and healthcare transformation; provide meaningful comparisons and actionable data and reports to help inform policy and consumer decisions.

Primary Care Collaborative

In 2018 Delaware enacted Senate Bill 227 to promote utilization of primary care services by creating a Primary Care Reform Collaborative (PCRC) under the DHCC. DMMA supported this initiative that aims to expand primary care services throughout Delaware through multi-payer advanced payment models.

In 2019 and 2020, the PCRC worked to obtain stakeholder input and determine affordability standards. The Co-chairs of the PCRC reached out to the DMMA to request support on a primary care delivery model to implement primary care reform across the State. The PCRC continues to meet as a public stakeholder workgroup composed of State staff, providers, insurers and legislative members to address challenges with and develop solutions to promote primary care in all delivery systems (e.g., commercial and government).

Quality Benchmarks

In response to Delaware per capita health care spending consistently ranking in the top ten highest spending states, on November 20, 2018 the Governor of Delaware issued Executive Order 25 and established the Delaware Economic and Financial Advisory Council health care spending benchmark subcommittee whose charge was to set healthcare spending benchmarks for the state of Delaware. The Delaware Health Care Commission (DHCC) was tasked with setting health care quality benchmarks.

The DEFAC and DHCC determined initial healthcare spending and quality benchmark measures, established baseline data and set goals. An implementation manual was produced to provide background on the project, to define measures, to identify data sources and submission protocols.

The first spending benchmark went into effect on January 1, 2019, and was set at 3.8%. That spending benchmark was not met, as the finalized health care spending for 2019 grew at a rate of 5.8%. For calendar year 2020, the spending benchmark was set at a more ambitious target of 3.5%. This benchmark was met as the 2020 Total Health Care Expenditures (THCE) per-capita change from the prior year was estimated at -1.2%. THCE encompasses health care spending associated with Delaware residents from private and public sources. THCE increased by $39 million in calendar year 2020, totaling $8.1 billion. However, with Delaware’s population increasing by 1.7% from 2019 to 2020, the per-capita total decreased from $8,268 in 2019 to $8,173 in 2020.

Adult Obesity

- The benchmark for 2020 was to reduce the percentage of Delaware adults who are obese to 29.4%. The 2020 result: 36.5%; an increase from 2019 and 7.1 percentage points higher than the benchmark.

Use of Opioids at High Dosages

- This is a new benchmark for 2020, which used the Delaware Prescription Monitoring Program to observe the rate at which high-dose opioids were prescribed. The 2020 benchmark: 12.4%; the 2020 result: 11.1%. This is a positive observation.

Optioid-Related Overdose Deaths

- The benchmark for 2020 was to reduce the mortality rate to 15.5 deaths per 100,000. The 2020 result: 43.9 deaths per 100,000. This is an increase from 2019.

Emergency Department Utilization

- The National Committee for Quality Assurance (NCQA) significantly changed the methodology for this quality measure, so it was given first-year status and no calendar year 2020 data was reported.

Persistence of Beta-Blocker Treatment after a Heart Attack

- The benchmark rate for 2020 was to increase the percentage of patients who receive beta-blocker treatment to 84.9% of commercial insurance patients and to 80.1% for Medicaid patients.The 2020 results: 91.7% for commercial insurance patients and 78.1% for Medicaid patients. While the Medicaid patients did not reach the benchmark, this is a significant improvement from the 2019 results of 73.5%.

Statin Therapy for Patients with Cardiovascular Disease

- The benchmark rate for 2020 was to increase the percentage of patients who receive statin therapy to 80.5% of commercial insurance patients and 61.5% for Medicaid patients. The 2020 results: 83.6% for commercial insurance patients; 72.6% for Medicaid patients. For both markets, results were better than the respective benchmark.

In CY 2022–2024 cycle, research will occur to evaluate indicators that are relevant to Delawareans. Based on results, further goals will be identified.

Social Determinants of Health Interventions (Food Box Delivery)

During 2020, DMMA recognized the need to address food insecurity needs identified in the Medicaid population which were made more evident during the public health emergency. In the summer of 2020, DMMA began planning for a partnership project with the Medicaid MCOs, the non-emergent medical transportation broker, the local Food Bank, and the hospitals deliver food boxes directly to the homes of women who are in their immediate postpartum period. These food boxes provide a family with three days' worth of meals without the need to go to the grocery store or find another source of food when they have multiple immediate competing priorities. Throughout the second half of 2020,

DMMA facilitated meetings with each entity to determine the roles and responsibilities to provide a seamless experience for those members and plan how DMMA could promote the program at the hospital after the delivery.

In the fourth quarter of 2020, DMMA completed the reporting templates required of the MCOs and their transportation broker to track the outreach and engagement with the postpartum population and track the actual deliveries made. DMMA also facilitated a meeting with the MCOs, the transportation broker, and the food bank to walk through the delivery process and ensure all parties understood their responsibilities to implement the project starting in the first quarter of 2021.

Substance Use Disorder Initiatives

Delaware has implemented several innovative programs aimed at substance use disorder (SUD) prevention, treatment, and long-term recovery. These programs are rooted in ensuring that services are accessible to Delawareans across the continuum of care. To date, DMMA has eliminated copays and prior authorizations for MAT and included naloxone on a universal preferred drug list. DMMA has also received recent approval for an 1115 SUD waiver that allows coverage for SUD services delivered in institutions for mental disease settings. With these improvements, gaps remain in service delivery. As such, DMMA remains focused on eliminating these gaps and improving SUD treatment and recovery services overall by using its already existing infrastructure and programs and implementing activities including:

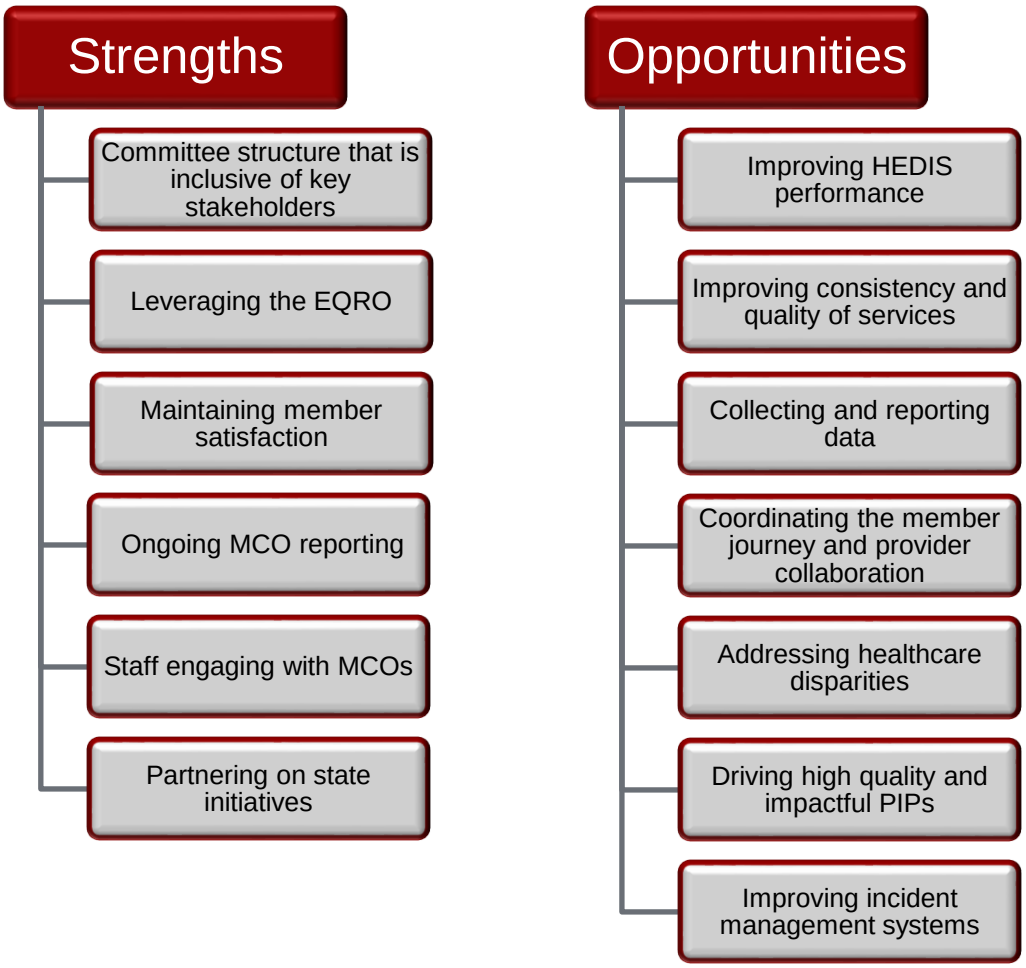
Proposed activities to recruit, train, and support providers include:

- Buprenorphine waiver training for PCPs;
- Adding Medicaid-Providers to the START Learning Collaborative;
- Medicaid-specific appendices for all provider change packets;
- Providing supports to meet the needs of high-risk populations;
- Identifying opportunities to increase care coordination support (peer-to-peer support models); and
- Assessing potential reimbursement and payment methodologies.

5
Strengths and Opportunities

This report reflects DMMA's continued emphasis to improve quality and outcomes for the DSHP/CHIP and DSHP Plus populations enrolled in the State's Medicaid Managed Care program. Infrastructure was evaluated to examine capability for monitoring and improving quality of services and outcomes. The evaluation results help set priorities and measurable objectives, assess the causes of suboptimal performance, and identify interventions to address challenges. This process has created a tool to focus improvement efforts and articulate in the development of the 2021 QS.

The graphic below outlines the strengths and opportunities identified from the Quality Strategy Evaluation presented in this document.



Strengths

- DMMA has a committee structure that is inclusive of key stakeholders including MCOs and the EQRO. This collaborative structure provides a mechanism for communication regarding results of monitoring activities and initiatives for improvement. As well, this provides DMMA and the EQRO, an opportunity for on-going education of MCO staff on the QS and DMMA priorities.

- DMMA leverages the EQRO to assist with areas beyond annual compliance reviews. For example, when data irregularities were identified with EPSDT data, DMMA requested the EQRO complete a focus study to identify root causes and develop recommendations for improvement. DMMA also engages the EQRO to provide technical assistance to the MCOs; this brings to bear a national perspective on high quality services, best practices toward engagement in care coordination and strong LTSS case management.

- DMMA uses the NCI-AD survey to evaluate the quality and effectiveness of LTSS services and generate recommendations for improvement. The NCI-AD allows DMMA to gain meaningful insights into the DSHP Plus program, comparing experiences between individuals served in home and community-based settings and those who reside in long-term care institutional settings.

- DMMA requires ongoing MCO reporting (QCMMR and QCMMR Plus) to monitor MCO operations. The QCMMR data acts as an early alert system to help identify potential problems, allowing for further investigation and remediation before issues impact members and the providers who serve them.

- DMMA has a structure for the review of HEDIS data to monitor MCO quality of services and member outcomes to encourage improvement.

- DMMA staff engage with staff from the MCOs to ensure a strong understanding of DMMA's programs and the quality measures associated with each waiver. The MCOs have begun to collect data regarding the waiver PMs and reporting which will expand in 2021.

- DMMA participates in State initiatives supporting quality improvements and/or enhancing services. These collaborations across stakeholders, state agencies and MCOs demonstrate DMMA's commitment to improving the DSHP/DSHP Plus program. These improvements promote greater efficiency and long-term sustainability of the program while taking into account the need to develop systems of care that are reflective of the unique needs of the members served, provider network and long-term goals to improve the outcomes of Delaware's most vulnerable citizens.

Opportunities

- Both MCOs have opportunities for significant improvement with HEDIS performance, especially early detection and service intervention as well as diabetes management. These topics has been an ongoing theme targeted by DMMA's QII task force and MCO quality committees.

- Recommendations based on the NCI-AD survey focus on improvement opportunities for community participation, choice and decision-making, satisfaction with daily life and service coordination. Through ongoing communications with key LTSS-specific stakeholders, the

engagement process will continue to grow as alignment among other state initiatives begins to emerge.

- QCMMR, QCMMR Plus and PROMISE Program reporting, while improving, still requires progress with data collection and compliance with reporting specifications.
- Findings from member and provider experience surveys show an opportunity to focus more on the member's perspective and provider collaboration.
- As the emphasis on addressing healthcare disparities increases, improving the data collection and reporting for race, ethnicity, and language should be prioritized. As well, there is a need to collect data indicating social determinants of health to establish baselines and the ability to help address healthcare disparity and address SDOH at the individual and population level.
- The MCOs continue to conduct PIPs, but without significant improvement in outcomes. This provides an opportunity to examine the quality improvement structure and processes used by the MCO to drive change or improvement. This type of assessment can then be leveraged to develop and implement activities to improve the PIP process and results.
- DMMA has the opportunity to improve incident management related to critical incident reporting. This could include strengthening investigative processes, increasing frequency of oversight and reporting, revising policy/auditing, broadening data sources, and linking incident management to fraud, waste, and abuse. Through these opportunities, DMMA can work to ensure critical incidents are reported appropriately, and investigations are conducted thoroughly.

State of Delaware
Division of Medicaid & Medical Assistance