

Delaware External Quality Review

2025 Technical Report

State of Delaware
Division of Medicaid and Medical Assistance

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Section 1

Introduction

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

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

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

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

In an effort to deliver member-focused care, hold MCOs accountable, drive innovation, and align with other State initiatives in delivering quality services to DSHP and DSHP Plus members, DMMA issued a Request for Proposal on December 15, 2021. DMMA opted to contract with the two incumbent MCOs, ACDE and HHO, as well as contract with a new plan, Delaware First Health (DFH) with a planned go-live date of January 1, 2023. Readiness review activities for DFH commenced in November 2022.

In 2023, Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, conducted post-implementation and mid-year post-implementation reviews of DFH. The purpose of these reviews were to ensure that DFH was stabilizing operations, moving toward full compliance with contract expectations, and would be on sound footing for a comprehensive compliance review in 2024. Mercer also conducted a corrective action plan (CAP) review of ACDE and HHO that encompassed the three mandatory activities, validation of PIPs, validation of Performance Measures (PMs), and compliance review, as well as completed a CAP Information Systems Capabilities Assessment (ISCA).

In 2024, Mercer completed a comprehensive review of ACDE, DFH, and HHO that encompassed the four mandatory activities, validation of PIPs, validation of PMs, compliance review, and validation of network adequacy for all three MCOs; Mercer also completed a comprehensive ISCA.

Additionally, in 2025, Mercer completed a CAP review of ACDE, DFH, and HHO that encompassed the four mandatory activities, validation of PIPs, validation of PMs, compliance review, and validation of network adequacy for all three MCOs; Mercer also completed a CAP ISCA. In addition to the completion of mandatory activities, the External Quality Review Organization (EQRO) conducted the following activities, detailed throughout the report:

- Encounter Data Validation.
- National Core Indicators — Aging and Disability Survey.

Section 2

External Quality Review Overview

External Quality Review Objectives

Mercer's objective for the 2025 CAP External Quality Review (EQR) was to assess Delaware MCO performance toward achieving the Delaware Quality Strategy (QS) goals in place at the time of the review, which were:

1. To improve maternal and infant health.
2. To improve chronic condition management.
3. To reduce communicable diseases.
4. To improve behavioral health (BH) condition identification and management.
5. To improve member experience of care.

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

- Assessing the implementation of CAP activities by the MCOs for those items that scored less than "Met" in 2024.
- Assessing the quality of services provided, the timeliness of services provided, and access to care and recommendations to the MCOs and DMMA for continued improvement.
- Comparison of MCO PM results with national benchmarks.
- Evaluation of PIPs.
- Evaluation of MCO network adequacy.

Technical Methods for Data Collection and Analysis

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

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



Standards Reviewed in the Current Reporting Cycle	
§438.56 Disenrollment Requirements and Limitations	§438.214 Provider Selection
§438.100 Enrollee Rights Requirements	§438.224 Confidentiality
§438.114 Emergency and Post-Stabilization Services	§438.228 Grievance and Appeal (G&A) Systems
§438.206 Availability of Services	§438.230 Subcontractual Relationships and Delegation
§438.207 Assurances of Adequate Capacity of Services	§438.236 Practice Guidelines
§438.208 Coordination and Continuity of Care	§438.242 Health Information Systems
§438.210 Coverage and Authorization of Services	§438.330 Quality Assurance and Performance Improvement (QAPI)

Request for Information

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

Review Tool

Mercer utilized a comprehensive EQR compliance review tool (tool) adapted from CMS protocols for the compliance section of the review. The tool design included State standards reflecting key issues and priorities of DMMA. The tool assisted the reviewers in logically coordinating the review process, consistent with the flow of Federal Regulations for Medicaid Managed Care (FRMMC) and State standards and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Mercer's desk review results helped to focus observations and interviews to gather additional information during the on-site review.

File Review Protocol

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

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

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

File Review Compliance Level Definitions	
	For file reviews, the MCO must have achieved 90.0% compliance or greater.
	For file reviews that scored between 75.0% and 89.0% compliance.
	For file reviews that scored less than 74.0% compliance.

Analysis and Reporting

Information from all phases of the review process was gathered, and a comprehensive analysis was completed. The MCO-specific report sections present the topics reviewed, the MCO team members who participated in the review, as well as the metrics requiring a CAP as a result of the 2025 review (i.e., Substantially Met, Partially Met, Minimally Met, Not Met). Summary results of the analysis make up this report. The table below outlines the five-tiered system utilized to determine compliance findings.

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

Healthcare Effectiveness Data and Information Set (HEDIS®)¹ and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)² measures the MCOs reported were compiled and comparative results between MCOs and relative to national benchmarks are included. The following rating scale is used to present these results:

¹ HEDIS® is a registered trademark of NCQA.

² CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Description of the Data Obtained

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

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

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

Conclusions Based on the Data Analysis

Compliance review results are presented in Section 3 of the report and were assigned a domain of quality, timeliness, and/or access to care. MCOs were given a rating of Met, Substantially Met, Partially Met, Minimally Met, or Not Met for each standard (see Analysis and Reporting above for full definitions). Comparative summary results reveal that ACDE was fully compliant or “Met” all expectations in five of the 14 standards reviewed in the current reporting cycle (disenrollment requirements and limitations, availability of services, grievance and appeal systems, practice guidelines and quality assurance and performance improvement). The scores for the nine

standards that were not fully compliant ranged from 94.0% to 99.8% with ACDE receiving a total compliance score of 98.5% for all 14 standards. DFH was fully compliant in six of the 14 areas (disenrollment requirements and limitations, availability of services, assurances of adequate capacity of services, emergency and post-stabilization services, grievance and appeal systems and practice guidelines). The scores for the eight standards that were not fully compliant ranged from 93.8% to 98.9% with DFH receiving a total compliance score of 97.7% for all 14 standards. HHO was fully compliant in five of the 14 areas (disenrollment requirements and limitations, enrollee rights requirements, availability of services, subcontractual relationships and delegation, and grievance and appeal systems). The scores for the nine standards that were not fully compliant ranged from 88.0% to 99.7% with HHO receiving a total compliance score of 98.1%. Additionally, the number of items across standards needing a CAP, which is scoring less than "Met," was higher for DFH (29) than ACDE (26) and HHO (19).

Based on the ISCA CAP review, all three MCOs continued to demonstrate effective partnerships and collaboration between the local MCO and the enterprise teams, as well as with operations and systems. As such, all three MCOs continued to perform well in supporting the system-related requirements of Delaware's managed Medicaid program. The insights gained from the MCOs' ISCA CAP desk review and on-site discussions confirmed compliance with 42 CFR § 438.242, section 6504(a) of the Affordable Care Act, and section 1903(r)(1)(F) of the Social Security Act. All three MCOs continued to exhibit a strong process orientation and mature systems capabilities, along with a deep understanding of DMMA requirements. As a result of the 2025 CAP review, ACDE was found to have successfully addressed all four outstanding CAP items from the previous year. Although ACDE fully addressed the four CAP items identified in the 2024 review, the 2025 ISCA review identified two new areas where ACDE could further strengthen its commitment to excellence. The desk and on-site reviews of the 2025 ISCA items resulted in 42 of the 44 desk review items (95.5%) receiving a review score of "Met" for ACDE. DFH was found to have successfully addressed seven of the nine outstanding CAP items from the previous year. Two outstanding CAP items from the 2024 comprehensive review, as well as two new items, were identified as areas where DFH could further strengthen its commitment to excellence. The desk and on-site reviews of the 2025 ISCA items resulted in 46 of the 50 desk review items (92.0%) receiving a review score of "Met" for DFH. Additionally, HHO was found to have successfully addressed five of the seven outstanding CAP items from the previous year. Two outstanding CAP items from the 2024 comprehensive review were identified as areas where HHO could further strengthen its commitment to excellence. The desk and on-site reviews of the 2025 ISCA items resulted in 42 of the 44 desk review items (95.5%) receiving a review score of "Met" for HHO.

Although all three MCOs continue to collaborate with DMMA and Gainwell to address encounter data submission issues, which is beneficial to stakeholders, Mercer offers recommendations to enhance DMMA's encounter data validation efforts. Mercer suggests DMMA strengthen its master service agreement by including detailed criteria for assessing the completeness, accuracy, and consistency of encounter data. This should include ongoing monitoring of data quality at the field level to ensure submissions can be successfully ingested by state systems and submitted to CMS per T MSIS specifications. Additionally, Mercer recommends DMMA investigate the root causes of discrepancies in specific data elements such as allowed amounts, present on admission (POA) indicators, provider data, modifiers, and tooth surface. The report provides targeted recommendations based on data analysis in sections covering data integrity, completeness, and accuracy.

The MCOs have processes to generate standardized PMs (e.g., HEDIS and CAHPS) to meet contractual obligations. However, validation of PM results revealed opportunities for improvement in state-specific reporting across all three MCOs. The EQRO expressed high confidence in four common state-specific measures for all three MCOs, with two measures indicating room for improvement:

- UM — Dental: Follow-up after emergency department (ED) visit for non-traumatic dental conditions showed high confidence for HHO, low confidence for ACDE, and could not be validated for DFH.
- UM — Inpatient (IP) Services: Medical admits per 1,000 members had low confidence for ACDE and could not be validated for DFH and HHO.

A detailed description of the PM validation process is provided in Section 5 of the report.

There is a significant opportunity for improvement in HEDIS results for all three MCOs. Of the 28 reported measures for ACDE, two measures, Cardiac Rehabilitation — Achievement (Total) and Well-Child Visits in the First 30 Months of Life (15–30 months), were at or above the 90th percentile. Eighteen measures were reported to be at or above the 50th percentile, including three of those measures being at or above the 75th percentile. ACDE reported 24 measures where the HEDIS rate improved by one percentage point or more, two measures where the HEDIS rate did not change by more than one percentage point, and two measures where the HEDIS rate declined by one percentage point or more from 2024 to 2025. Eight of ACDE's HEDIS results for these 28 measures (28%) were below the 50th percentile. Of the 28 reported measures for DFH, zero measures were at or above the 90th percentile. One measure, Appropriate Treatment for Upper Respiratory Infection (Total), was reported to be at or above the 75th percentile. Four measures were at or above the 50th percentile. DFH reported 19 measures where the HEDIS rate improved by one percentage point or more, zero measures where the HEDIS rate did not change by more than one percentage point, and nine measures where the HEDIS rate had declined by one percentage point or more from 2024 to 2025. Twenty-three of DFH's HEDIS results for these 28 measures (82%) were below the 50th percentile. Of the 28 reported measures for HHO, zero measures were at or above the 90th percentile. Eighteen measures were reported to be at or above the 50th percentile, including five measures being at or above the 75th percentile. HHO reported 12 measures where the HEDIS rate improved by one percentage point or more, four measures where the HEDIS rate changed by less than one percentage point, and 12 measures where the HEDIS rate declined by one percentage point or more from 2024 to 2025. Ten of HHO's HEDIS results for these 28 measures (35.0%) were below the 50th percentile.

Through ongoing waiver and grant projects, as well as engagement with the provider community, DMMA supports the efforts of the MCOs to ensure that care is coordinated and managed appropriately with timely access to a stable and robust provider network that provides high-quality care. However, the compliance and HEDIS results represent opportunities for continued collaborative work with the MCOs to achieve Goal 2 (to improve chronic condition management), and Goal 4 (to improve BH condition identification and management) detailed in the QS.

Goal number 5 listed in the Delaware Medicaid QS relates to improving member experience of care. The CAHPS survey captures reliable information from consumers about their experiences with healthcare and focuses on quality aspects such as the communication skills of providers and ease of access to healthcare services. All three MCOs' performance from 2024 to 2025 showed improvement. ACDE's members reported the highest scores at or above the 90th percentile for child rating of all healthcare. ACDE's members reported the lowest scores, below the 50th percentile for the following measures: adult rating of personal doctor, adult rating of specialist, adult composite getting care quickly, adult composite how well doctors communicate, adult composite coordination of care, adult composite customer service, child composite how well doctors communicate, child composite customer service, and child composite ease of filling out forms. Out of the 20 categories surveyed, ACDE improved its performance year over year in nine categories, had changes of less than one percentage point in two categories, and declined its performance in nine categories. DFH's members reported the highest scores, at or above the 90th percentile, for adult composite coordination of care and child rating of personal doctor. DFH's members reported the lowest scores, below the 50th percentile, for the following measures: adult rating of personal doctor, adult rating of specialist, adult composite getting needed care, child composite getting care quickly, child composite getting needed care, child composite coordination of care, and child composite customer service. Out of the 20 categories surveyed, DFH improved its performance year over year in 15 categories, had changes of less than one percentage point in one category, and declined its performance in four categories. HHO's members reported the highest scores, at or above the 90th percentile, for adult rating of how well doctors communicate, adult composite coordination of care and child rating of health plan. HHO's members reported the lowest scores, below the 50th percentile, for the following measures: adult composite getting care quickly, adult composite getting needed care, adult composite customer service, adult composite ease of filling out forms, child rating of specialist, child rating of how well doctors communicate, child composite customer service, and child composite ease of filling out forms. Out of the 20 categories surveyed, HHO improved its performance year over year in 11 categories, has changes of less than one percentage point in one category, and declined its performance in eight categories.

Per DMMA's 2023 QS, each MCO is required to conduct a minimum of two PIPs: one in the area of opioid use disorder (OUD) in pregnant and postpartum persons (PPP) and one non-clinical service-related improvement area. For the 2025 compliance review cycle, the EQRO validated two required PIPs. The first State-mandated clinical PIP topic is focused on identifying PPP with an OUD who are receiving medication for OUD, consistent with evidence-based standards of care. The second PIP topic allows for a topic selected by the individual MCO that is non-clinical or service-related and approved by DMMA. All three MCOs demonstrate a strong understanding of PIP design and implementation. The MCOs utilize PIP workgroups for continuous quality improvement (QI), including review and analysis of initiatives, interventions, and barrier analysis. PIPs are clearly written, detailed, and align with identified population health concerns. Since the PPP with OUD PIP is in the first remeasurement year, the majority of the on-site discussion focused on the initial interventions developed, the PMs, and remeasurement results. The evaluation demonstrated a high degree of confidence in the foundational steps. All three MCOs have met the requirements for PIPs based on the Delaware QS and the EQRO has a moderate level of confidence in the reported results for validated PIPs. Although the PIPs are clearly written, there is room to strengthen the PMs to better track the PIP performance over time and the evaluation of impact of the interventions as well as ensuring all necessary documentation is included when submitting PIP information for validation to support the results.

Section 3

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

At the request of the State, Mercer, DMMA’s EQRO, conducted a comprehensive review of Delaware’s MCOs, ACDE, DFH, and HHO, assessing compliance with federal regulations. Below is a crosswalk of the standards reviewed by the EQRO to the standards in 42 CFR 438.56, 438.100, 438.114, 42 CFR subpart D, and 42 CFR 438.330, MCO scores, as well as the timeframe for the review.

Standard Reviewed by the EQRO	Standards	ACDE	DFH	HHO	Last Reviewed
Total		98.5%	97.7%	98.1%	

Mercer completed this review as part of the mandatory EQR required by federal law using applicable CMS EQR protocols, released in February 2023. Areas included in the assessments were:

- Review of MCO compliance with FRMMC, the CHIPRA, and State standards.
- Review of compliance with contract standards for:
 - DSHP and DSHP Plus CM.
 - DSHP CC, Low-Risk Maternity Care Coordination (MCC), and High-Risk MCC.
- PIP validation.
- PM validation.
- Network Adequacy assessment.

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

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

To begin the EQR, Mercer developed and distributed to each MCO a timeline that chronologically summarized the EQR deliverables and their due dates for 2025. The 2025 CAP review covered the MCO's calendar year (CY) 2024 operations, including any new or updated policies, procedures, processes, or other relevant changes during CY 2024. It also incorporated the previous year's CAP review findings and focused file reviews on the period from January 1, 2024, through December 31, 2024. The 2024 EQR process began on June 20, 2025, when Mercer delivered the RFI to each MCO. Mercer used a Health Insurance Portability & Accountability Act (HIPAA) compliant secure file transfer protocol site, SharePoint, to allow a secure exchange of information among Mercer, DMMA, and the MCOs. MCO materials were uploaded to the SharePoint site by July 25, 2025. The desk review was a CAP review of P&Ps and supporting documents related to FRMMC, CHIPRA, and State contract standards. In addition, Mercer reviewed CC, MCC, CM, grievances and appeals (G&As), provider, HCBS and facility credentialing, provider termination and pharmacy prior authorization (PA) files, and submitted preliminary findings to all three MCOs to prepare for the on-site review.

The annual on-site review was conducted by Mercer, with DMMA staff in attendance, from September 11, 2025 to September 12, 2025, for ACDE; from September 23, 2025 to September 24, 2025 for DFH; and from October 7, 2025 to October 8, 2025 for HHO. The documentation reviews and staff interviews were conducted to gain a more complete and accurate understanding of the operations of the MCOs and how those operations contribute to its compliance with federal and State regulations and requirements, consistency with internal P&Ps and processes, and adherence to contractual standards in the provision of healthcare services to its members.

Compliance Review

This review was conducted based on information submitted by ACDE, DFH, and HHO through the RFI and through on-site meetings. The table below provides a sense of the MCOs' progress toward full compliance with expectations by review area.

MCO Corrective Action Plan						
EQRO Review Section	ACDE		DFH		HHO	
	Number of CAP Items Identified in 2024	Number of CAP Items Identified in 2025	Number of CAP Items Identified in 2024	Number of CAP Items Identified in 2025	Number of CAP Items Identified in 2024	Number of CAP Items Identified in 2025
Administration and Organization	14	4 (1 Newly Identified)	10	4 (2 Newly Identified)	12	1
CC	20	6 (3 Newly Identified)	13	0	6	1
Delegation	0	0	3	0	3	0
G&A	11	2	8	7 (2 Newly Identified)	3	0
LTSS CM	8	2	17	5 (2 Newly Identified)	12	5 (2 Newly Identified)
Pharmacy	0	3 (3 Newly Identified)	1	1 (1 Newly Identified)	1	2 (1 Newly Identified)
Provider Network	18	5 (1 Newly Identified)	20	4 (1 Newly Identified)	18	5
Quality	1	0	13	5	2	1
UM	8	4 (2 Newly Identified)	6	3	3	4 (3 Newly Identified)
Total	80	26	91	29	60	19

2025 Findings and Recommendations for the State's Quality Strategy

Delaware's Medicaid managed care program focuses on designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Delaware Medicaid health ecosystem. The goals and objectives of the QS provide a persistent reminder of program direction and scope. The following five goals equate to areas of focus for clinical QI in Delaware as listed in the State's QS:

- Goal 1:** To improve maternal and infant health.
- Goal 2:** To improve chronic condition management.
- Goal 3:** To reduce communicable diseases.
- Goal 4:** To improve BH condition identification and management.
- Goal 5:** To improve member experience of care.

Below are tables with the EQRO's 2025 findings and recommendations for DMMA's QS broken out by a goal.

Information from the 2023 QS		
Goal: 1. To improve maternal and infant health		
QS Expectations	EQRO Finding or HEDIS Rates	EQRO Suggestions for the State
MCC File Compliance	The sample of MCC files reviewed identified several areas of strength: - Documentation includes comprehensive screenings that address BH, prenatal care, and social determinants of health, enabling early identification of member needs. - Referrals to resources such as breast pumps, doulas, WIC, home health, and community supports are effectively coordinated, with follow-up processes in place to ensure referral completion and address complex needs. - Screening protocols are established and consistently applied across cases.	The State should continue reviewing contractually required quarterly clinical reports and, when necessary, conduct file reviews to ensure that level of care evaluations and member assessments are being completed and properly documented. To promote best practices among MCOs, the following actions are recommended: - Ensure that pregnancy history is thoroughly assessed and clearly documented. - Follow up consistently to confirm that referrals and resources are completed and received. - Enhance screening processes to provide comprehensive coverage and enable the timely identification of postpartum needs and other risk factors.

Information from the 2023 QS Goal: 1. To improve maternal and infant health				
QS Expectations	EQRO Finding or HEDIS Rates			EQRO Suggestions for the State
Developmental Screening in the First Three Years of Life (OHSU: DEV-CH)	ACDE: 65.70%	DFH: 61.90%	HHO: 92.70%	
Lead Screening in Children (NCQA: LSC-CH)	ACDE: 81.80%	DFH: 75.20%	HHO: 82.70%	
Prenatal and Postpartum Care — Postpartum Care (HEDIS: PPC)	ACDE: 83.61%	DFH: 82.73%	HHO: 87.98%	

Information from the 2023 QS				
Goal: 1. To improve maternal and infant health				
QS Expectations	EQRO Finding or HEDIS Rates			EQRO Suggestions for the State
				members to improve the quality of maternal and infant care.
Prenatal and Postpartum Care —Timeliness of Prenatal Care (HEDIS: PPC)	ACDE: 87.54%	DFH: 82.97%	HHO: 91.80%	
Well-Child Visits in the First 30 Months of Life (15 Months–30 Months) (HEDIS: W30)	ACDE: 82.18%	DFH: 75.87%	HHO: 79.64%	

Information from the 2023 QS Goal: 2. To improve chronic condition management				
QS Expectations	EQRO Finding or HEDIS Rates			EQRO Suggestions for the State
Controlling High Blood Pressure (HEDIS: CBP)	ACDE: 68.61%	DFH: 64.72%	HHO: 73.92%	The State should ensure MCOs are engaging in best practices (e.g., Delaware Diabetes and Heart Disease Prevention and Control Program) and with community partners (e.g., Quality Insights, Delaware Cardiovascular Health Learning Collaborative, etc.) to drive improved quality of comprehensive cardiovascular care.
Glycemic Status Assessment for Patients With Diabetes - Glycemic Status <8.0% (HEDIS: GSD)	ACDE: 61.71%	DFH: 59.61%	HHO: 62.77%	The State should ensure MCOs are engaging in best practices (e.g., Delaware Diabetes and Heart Disease Prevention and Control Program) and with community partners (e.g., Quality Insights, Delaware Diabetes Coalition, etc.) to drive improved quality of comprehensive diabetes care.
Statin Therapy for Patients with Cardiovascular Disease — Received Statin Therapy (HEDIS: SPC)	ACDE: F 40–75: 79.02% M 21–75: 78.76% Total: 78.86%	DFH: F 40–75: 63.83% M 21–75: 65.33% Total: 64.75%	HHO: F 40–75: 80.24% M 21–75: 83.48% Total: 82.10%	The State should ensure MCOs are engaging in best practices (e.g., CC, Medication Therapy Management, electronic health record prompts, etc.) and with community partners (e.g., Quality Insights, Delaware Cardiovascular Health Learning Collaborative, etc.) to drive improved quality of comprehensive cardiovascular care.
Statin Therapy for Patients with Cardiovascular Disease — Statin Adherence 80% (HEDIS: SPC)	ACDE: F 40–75: 76.11% M 21–75: 71.91% Total: 73.54%	DFH: F 40–75: 60.00% M 21–75: 71.43% Total: 67.09%	HHO: F 40–75: 58.29% M 21–75: 58.99% Total: 58.70%	The State should ensure MCOs are engaging in best practices (e.g., CC, Medication Therapy Management, electronic health record prompts, etc.) and with community partners (e.g., Quality Insights, Delaware Cardiovascular Health Learning Collaborative, etc.) to drive improved quality of comprehensive cardiovascular care.

Information from the 2023 QS				
Goal: 2. To improve chronic condition management				
QS Expectations	EQRO Finding or HEDIS Rates			EQRO Suggestions for the State
Statin Therapy for Patients with Diabetes — Received Statin Therapy (HEDIS: SPD)	ACDE: 65.33%	DFH: 48.57%	HHO: 63.91%	The State should ensure MCOs are engaging in best practices (e.g., CC, Medication Therapy Management, electronic health record prompts, etc.) and with community partners (e.g., Quality Insights, Delaware Diabetes Coalition, etc.) to drive improved quality of comprehensive diabetes care.
Statin Therapy for Patients with Diabetes — Statin Adherence 80% (HEDIS: SPD)	ACDE: 67.89%	DFH: 63.80%	HHO: 56.16%	The State should ensure MCOs are engaging in best practices (e.g., CC, Medication Therapy Management, electronic health record prompts, etc.) and with community partners (e.g., Quality Insights, Delaware Diabetes Coalition, etc.) to drive improved quality of comprehensive diabetes care.

Information from the 2023 QS				
Goal: 3. To reduce communicable diseases				
QS Expectations	EQRO Finding or HEDIS Rates			EQRO Suggestions for the State
Adult Immunization Status Age 19 and Older (NCQA: AIS-AD) - Influenza	ACDE: 19–65: 15.60% 66+: 36.40%	DFH: 19–65: 7.50% 66+: 22.20%	HHO: 19–65: 9.20% 66+: 28.90%	The State should ensure MCOs are engaging in best practices (e.g., educating members on importance of vaccines, educational materials for providers, etc.) and with community partners and programs (e.g., Vaccines for Children program, Immunization Coalition of Delaware, etc.) to drive the reduction in communicable diseases.

Information from the 2023 QS Goal: 3. To reduce communicable diseases				
QS Expectations	EQRO Finding or HEDIS Rates			EQRO Suggestions for the State
Appropriate Treatment for Upper Respiratory Infection (HEDIS: URI)	ACDE: 3–17: 94.89% 18–64: 82.60% 65+: 100.00% Total: 91.79%	DFH: 3–17: 95.07% 18–64: 86.70% 65+: 88.89% Total: 93.03%	HHO: 3–17: 93.68% 18–64: 83.14% 65+: 82.35% Total: 90.49%	The State should ensure MCOs are engaging in best practices (e.g., educating members on viral colds, educational materials for providers on antibiotics overuse for viral respiratory syndromes, etc.) and with community partners and programs (e.g., eBrightHealth, Quality Insights, Delaware Technical Community College, etc.) to drive the appropriate treatment for upper respiratory infections.
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 18 and Older (NCQA: AAB-AD)	ACDE: 18–64: 59.80% 65+: 57.10%	DFH: 18–64: 58.40% 65+: 20.00%	HHO: 18–64: 65.40% 65+: 0.00%	The State should ensure MCOs are engaging in best practices (e.g., educating members on viral colds, educational materials for providers on antibiotics overuse for viral respiratory syndromes, etc.) and with community partners and programs (e.g., eBrightHealth, Quality Insights, etc.) to drive the avoidance of antibiotic treatment for acute bronchitis/bronchiolitis.
Childhood Immunizations Status (NCQA: CIS-CH)	ACDE: Combo 3: 64.90% Combo 10: 27.00%	DFH: Combo 3: 30.60% Combo 10: 12.20%	HHO: Combo 3: 75.20% Combo 10: 36.50%	The State should ensure MCOs are engaging in best practices (e.g., educating members on importance of vaccines, educational materials for providers, etc.) and with community partners and programs (e.g., Vaccines for Children program, Immunization Coalition of Delaware, etc.) to drive the reduction in communicable diseases.
Chlamydia Screening in Women Ages 21 to 24 (NCQA: CHL-AD)	ACDE: 70.90%	DFH: 70.90%	HHO: 67.20%	The State should ensure MCOs are engaging in best practices (e.g., educating members on importance of sexually transmitted infections prevention during routine healthcare visits, educational materials for providers, etc.) to drive the reduction in communicable diseases.

Information from the 2023 QS Goal: 3. To reduce communicable diseases				
QS Expectations	EQRO Finding or HEDIS Rates			EQRO Suggestions for the State
Cervical Cancer Screening (NCQA: CCS-AD)	ACDE: 54.10%	DFH: 39.00%	HHO: 55.20%	The State should ensure MCOs are engaging in best practices (e.g., educating members on importance of preventive screenings, electronic health record prompts, etc.) and with community partners and programs (e.g., Delaware Breast Cancer Coalition, Women's Health Screening Van, etc.) to drive the reduction in communicable diseases.
Colorectal Cancer Screening (NCQA: COL-AD)	ACDE: 46–50: 26.20% 51–65: 40.90% 66–75: 36.90%	DFH: 46–50: 17.20% 51–65: 26.20% 66–75: 17.10%	HHO: 46–50: 30.70% 51–65: 44.30% 66–75: 38.50%	The State should ensure MCOs are engaging in best practices (e.g., educating members on importance of preventive screenings, electronic health record prompts, etc.) and with community partners and programs (e.g., Delaware Cancer Consortium, Delaware 211, etc.) to drive the reduction in communicable diseases.
HIV Viral Load Suppression (HRSA: HVL-AD)	ACDE: 18–64: 26.80% 65+: 16.70%	DFH: 18–64: 19.30% 65+: 5.30%	HHO: 18–64: 12.60% 65+: 20.00%	The State should ensure MCOs are engaging in best practices (e.g., educating members on importance of vaccines, CM services, etc.) and with community partners and programs (e.g., Delaware HIV Consortium, etc.) to drive the reduction in communicable diseases.

Information from the 2023 QS				
Goal: 4. To improve BH condition identification and management				
QS Expectations	EQRO Finding or HEDIS Rates			EQRO Suggestions for the State
Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (NCQA: ADD-CH) — Continuation and Maintenance Phase	ACDE: 53.30%	DFH: 48.10%	HHO: 47.10%	The State should ensure MCOs are engaging in best practices (e.g., educating members on importance of medication adherence, CC services, etc.) and with community partners and programs (e.g., Children and Adults with Attention Deficit/Hyperactivity Disorder [CHADD] of Delaware, Nemours Children's Health, etc.) to drive improved quality of BH care.
Follow-up Care for Children Prescribed ADHD Medication (NCQA: ADD-CH) — Initiation Phase	ACDE: 36.10%	DFH: 32.00%	HHO: 35.50%	The State should ensure MCOs are engaging in best practices (e.g., educating members on importance of medication adherence, CC services, etc.) and with community partners and programs (e.g., CHADD of Delaware, Nemours Children's Health, etc.) to drive improved quality of BH care.
Follow-up After ED Visit for Mental Illness — Age 18 and Older (NCQA: FUM-AD) (within seven days of the ED visit) Total	ACDE: 18–64: 35.80% 65+: 0.00%	DFH: 18–64: 30.00% 65+: 0.00%	HHO: 18–64: 36.70% 65+: 0.00%	The State should ensure MCOs are engaging in best practices (e.g., appropriate discharge processes, member education, scheduling follow-up appointments prior to discharge, etc.) and with community partners and programs (e.g., Help Is Here Delaware, atTack addiction, Brandywine, etc.) to drive improved quality of BH care.
Follow-up After ED Visit for Mental Illness — Age 18 and Older (NCQA: FUM-AD) (within 30 days of the ED visit) Total	ACDE: 18–64: 48.40% 65+: 0.00%	DFH: 18–64: 40.00% 65+: 0.00%	HHO: 18–64: 52.30% 65+: 50.00%	The State should ensure MCOs are engaging in best practices (e.g., appropriate discharge processes, member education, scheduling follow-up appointments prior to discharge, etc.) and with community partners and programs (e.g., Help Is Here Delaware, atTack addiction, Brandywine, etc.) to drive improved quality of BH care.

Information from the 2023 QS				
Goal: 4. To improve BH condition identification and management				
QS Expectations	EQRO Finding or HEDIS Rates			EQRO Suggestions for the State
Follow-up After Hospitalization for Mental Illness — Age 18 and Older (NCQA: FUH-AD) (within seven days after discharge) Total	ACDE: 18–64: 27.50% 65+: 50.00%	DFH: 18–64: 27.00% 65+: 50.00%	HHO: 18–64: 24.30% 65+: 0.00%	The State should ensure MCOs are engaging in best practices (e.g., appropriate discharge processes, member education, scheduling follow-up appointments prior to discharge, etc.) and with community partners and programs (e.g., Help Is Here Delaware, atTack addiction, Brandywine, etc.) to drive improved quality of BH care.
Follow-up After Hospitalization for Mental Illness — Age 18 and Older (NCQA: FUH-AD) (within 30 days after discharge)	ACDE: 18–64: 44.20% 65+: 50.00%	DFH: 18–64: 44.00% 65+: 50.00%	HHO: 18–64: 38.10% 65+: 25.00%	The State should ensure MCOs are engaging in best practices (e.g., appropriate discharge processes, member education, scheduling follow-up appointments prior to discharge, etc.) and with community partners and programs (e.g., Help Is Here Delaware, atTack addiction, Brandywine, etc.) to drive improved quality of BH care.
Initiation and Engagement of Substance Use Disorder Treatment — Initiation of SUD Treatment (HEDIS: IET) Total	ACDE: 13–17: 0.00% 18–64: 60.83% 65+: 0.00% Total: 60.68%	DFH: 13–17: 37.50% 18–64: 58.48% 65+: 32.00% Total: 56.68%	HHO: 13–17: 24.79% 18–64: 53.75% 65+: 62.50% Total: 52.68%	The State should ensure MCOs are engaging in best practices (e.g., educating members on importance of medication adherence, education on medication-assisted treatment, educational materials for providers, etc.) and with community partners and programs (e.g., Help Is Here Delaware, atTack addiction, Brandywine, etc.) to drive improved quality of BH care.
Initiation and Engagement of Substance Use Disorder Treatment — Engagement of SUD Treatment (HEDIS: IET) Total	ACDE: 13–17: 0.00% 18–64: 38.96% 65+: 0.00% Total: 38.86%	DFH: 13–17: 20.83% 18–64: 28.92% 65+: 4.00% Total: 27.50%	HHO: 13–17: 4.96% 18–64: 26.26% 65+: 12.50% Total: 25.42%	The State should ensure MCOs are engaging in best practices (e.g., educating members on importance of medication adherence, education on medication assisted treatment, educational materials for providers, etc.) and with community partners and programs (e.g., Help Is Here Delaware, atTack addiction, Brandywine, etc.) to drive improved quality of BH care.

Information from the 2023 QS				
Goal: 4. To improve BH condition identification and management				
QS Expectations	EQRO Finding or HEDIS Rates			EQRO Suggestions for the State
Screening For Depression And Follow-Up Plan: Age 18 And Older (CMS: CDF-AD)	ACDE: 18–64: 5.60% 65+: 5.90%	DFH: 18–64: 5.90% 65+: 4.80%	HHO: 18–64: 3.70% 65+: 4.10%	The State should ensure MCOs are engaging in best practices (e.g., using standardized tools, universal screening, perinatal support, educational materials for providers, etc.) and with community partners and programs (e.g., Mental Health Association in Delaware, Delaware 211/Help Me Grow, etc.) to drive improved quality of BH care.
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (NCQA: APP-CH)	ACDE: 1–11: 36.40% 12–17: 48.30%	DFH: 1–11: 62.50% 12–17: 60.00%	HHO: 1–11: 62.70% 12–17: 50.40%	The State should ensure MCOs are engaging in best practices (e.g., educating members on importance of medication adherence, CC services, etc.) and with community partners and programs (e.g., Delaware Child Psychiatry Access Program, Nemours Children’s Health, etc.) to drive improved quality of BH care.

Information from the 2023 QS				
Goal: 5. To improve member experience of care				
QS Expectations	EQRO Finding or HEDIS Rates			EQRO Suggestions for the State
CAHPS Rating of Personal Doctor	ACDE: Adult: 69.40% Child: 80.30%	DFH: Adult: 70.60% Child: 83.70%	HHO: Adult: 73.70% Child: 81.90%	The State should continue to monitor MCO grievance, denial, and fair hearing outcomes to identify targeted areas for improvement. DMMA could establish MCO benchmarks for CAHPS® ratings and provide guidance for MCOs to initiate improvement projects, conduct root cause analyses of lower ratings, and implement targeted strategies to meet these benchmarks.

Information from the 2023 QS Goal: 5. To improve member experience of care				
QS Expectations	EQRO Finding or HEDIS Rates			EQRO Suggestions for the State
CAHPS Rating of All Healthcare	ACDE: Adult: 57.60% Child: 79.10%	DFH: Adult: 62.00% Child: 75.70%	HHO: Adult: 63.60% Child: 77.80%	The State should continue to monitor MCO grievance, denial, and fair hearing outcomes to identify targeted areas for improvement. DMMA could establish MCO benchmarks for CAHPS® ratings and provide guidance for MCOs to initiate improvement projects, conduct root cause analyses of lower ratings, and implement targeted strategies to meet these benchmarks.
CAHPS Rating of Health Plan	ACDE: Adult: 63.90% Child: 78.40%	DFH: Adult: 64.70% Child: 75.10%	HHO: Adult: 62.40% Child: 82.40%	The State should continue to monitor MCO grievance, denial, and fair hearing outcomes to identify targeted areas for improvement. DMMA could establish MCO benchmarks for CAHPS® ratings and provide guidance for MCOs to initiate improvement projects, conduct root cause analyses of lower ratings, and implement targeted strategies to meet these benchmarks.
CAHPS Getting Needed Care Composite	ACDE: Adult: 85.40% Child: 84.60%	DFH: Adult: 81.90% Child: 81.80%	HHO: Adult: 80.60% Child: 89.20%	The State should continue to monitor MCO grievance, denial, and fair hearing outcomes to identify targeted areas for improvement. DMMA could establish MCO benchmarks for CAHPS® ratings and provide guidance for MCOs to initiate improvement projects, conduct root cause analyses of lower ratings, and implement targeted strategies to meet these benchmarks.

Information from the 2023 QS Goal: 5. To improve member experience of care				
QS Expectations	EQRO Finding or HEDIS Rates			EQRO Suggestions for the State
CAHPS Getting Care Quickly Composite	ACDE: Adult: 80.20% Child: 88.00%	DFH: Adult: 82.80% Child: 85.20%	HHO: Adult: 79.60% Child: 87.60%	The State should continue to monitor MCO grievance, denial, and fair hearing outcomes to identify targeted areas for improvement. DMMA could establish MCO benchmarks for CAHPS® ratings and provide guidance for MCOs to initiate improvement projects, conduct root cause analyses of lower ratings, and implement targeted strategies to meet these benchmarks.
CAHPS Customer Service Composite	ACDE: Adult: 87.20% Child: 83.30%	DFH: Adult: 89.60% Child: 86.40%	HHO: Adult: 85.30% Child: 88.40%	The State should continue to monitor MCO grievance, denial, and fair hearing outcomes to identify targeted areas for improvement. DMMA could establish MCO benchmarks for CAHPS® ratings and provide guidance for MCOs to initiate improvement projects, conduct root cause analyses of lower ratings, and implement targeted strategies to meet these benchmarks.

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
PIP Validation			
ACDE	ACDE has met the requirements for the PIPs based on the Delaware QS, and the EQRO has assigned a moderate level of confidence in the reported results for both validated PIPs. Regarding the PPP with OUD PIP, ACDE demonstrated improvement in eight of the sixteen quantifiable measures, with four of these measures showing statistically significant improvement. For the	While the ED LANE PIP was well-written, detailed, and aligned with population health concerns, the Aim Statement lacks specificity and measurability regarding the overall time frame. The Aim Statement should clearly specify the start and end dates of the PIP. Additionally, ACDE should continue rapid cycle analysis, identify barriers, and update interventions to boost provider and member engagement.	Quality, Access, Timeliness

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
PIP Validation			
	ED Low-Acuity Non-Emergent (LANE) PIP, all six of the quantifiable measures showed improvement, with four of these measures achieving statistical significance. The PIP documentation was well-written and comprehensive, including detailed descriptions of interventions, barrier analysis, and identification of opportunities for further improvement.	Although improvements are evident across several measures for both PIPs, ACDE should review their measures to ensure they are clear, concise, and effectively capture the intended outcomes. Well-defined, objectively measured variables increase confidence in PIP results.	
DFH	DFH has met the requirements for the PIPs based on the Delaware QS, and the EQRO has assigned a moderate level of confidence in the reported results for both validated PIPs. Regarding the PPP with OUD PIP, DFH demonstrated improvement in nine of the eleven quantifiable measures, with one of these measures showing statistically significant improvement. For the Delaware Welcome Call PIP, two of the three quantifiable measures showed improvement. The PIPs were well-written, detailed, and aligned with population health concerns.	While the PPP OUD PIP was well-written, detailed, and aligned with population health concerns, the Aim Statement lacks specificity and measurability. The Aim Statement should clearly specify the intervention, define the target population and time frame, and outline the measurable impact. Although DFH is making progress in nine of eleven PMs, they should consider revisiting and simplifying measures to ensure they are clear, concise, and accurately reflect the intended outcomes. Well-defined, objective, and reliably measured variables increase confidence in PIP results. DFH should continue rapid cycle analysis, identify barriers, and update interventions to boost provider and member engagement. Additionally, while progress was observed in two of three quantifiable measures for the Delaware Welcome PIP, limited documentation was submitted to fully support the data, analysis, and interpretation. No statistical testing was performed to determine the significance of performance changes. Future PIP submissions should include comprehensive documentation to support validation.	Quality, Access, Timeliness

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
PIP Validation			
HHO	HHO has successfully met the requirements for the PIPs based on the Delaware QS, and the EQRO has assigned a moderate level of confidence in the reported results for both validated PIPs. Regarding the PPP with OUD PIP, HHO demonstrated improvement in one of the eight quantifiable measures. Additionally, two measures are currently in the planning phase, indicating ongoing efforts to address this population. For the PAs PIP, HHO showed improvement in three of the five quantifiable measures, with all three measures demonstrating statistically significant improvements. The PIP documentation was thorough, well-written, and comprehensive. It included detailed descriptions of the interventions implemented, a thorough barrier analysis, and clear identification of opportunities for further improvement. This level of detail supports a strong understanding of the strategies employed and the progress made.	As HHO plans to revamp the approach to the PPP with OUD PIP, HHO should revisit previously completed barrier analyses and evaluate the effectiveness of the selected interventions. It is important to ensure consistency in remeasuring the PMs and to conduct statistical testing to determine the significance of the results. Thorough documentation of all analyses, decisions, and outcomes will facilitate transparency and accountability. Finally, establishing a plan for ongoing monitoring and timely adjustments will help sustain improvements and address emerging challenges. Additionally, although the PAs PIP is clearly written, detailed, and aligns with the identified population health concerns, the Aim Statement lacks specificity and measurability. The Aim Statement should include the PIP intervention, define the population and time period, and specify the measurable impact.	Quality, Access, Timeliness

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
PM Validation			
ACDE	ACDE employs a comprehensive approach to validating PMs that combines technology, processes, and personnel to calculate PMs and Healthcare Effectiveness Data and Information Set rates to support the delivery of reliable data for reporting.	ACDE submitted code that was not in alignment with the PM specification. Developing and implementing a process for peer review and the annual review of the PM code should ensure alignment with PM specifications.	Quality, Timeliness

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Network Adequacy Validation			
ACDE	The EQRO has a high level of confidence for Time and Distance, Panel Size and LTSS personal care attendant (PCA) standards and a moderate-level of confidence for Appointment Wait Time standards.	For the Appointment Wait Time Standards, the provider audits/surveys used were not secret for most of the year. Callers identified themselves as calling on behalf of the MCO. The EQRO noted access and availability call logs specific to BH included less details than the call logs for other provider types.	Timeliness, Access
DFH	The EQRO has a high level of confidence for Time and Distance, Panel Size and LTSS PCA standards and a moderate level of confidence for Appointment Wait Time standards.	For the Appointment Wait Time Standards, the provider audits/surveys used were not secret for most of the year. Callers identified themselves as calling on behalf of the MCO.	Timeliness, Access
HHO	The EQRO has a high level of confidence for Time and Distance, Panel Size and LTSS PCA standards and a moderate to high level of confidence for Appointment Wait Time standards.	None.	Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance Review			
ACDE	ACDE continues to demonstrate stability in key personnel roles such as the Chief Executive Officer (CEO), Chief Operations Officer (COO), Chief Medical Officer (CMO), and others, with limited turnover. Efforts are underway to fill any vacancies, supported by a well-structured framework that encourages participation across the organization. In particular, the UM leadership team is dedicated to promoting ongoing staff development by fostering collaboration across disciplines and implementing an operational structure to assess and oversee staff performance and the internal coordination of care.	It is recommended that organizational charts and standard operating procedures (SOPs) be enhanced to more clearly illustrate and explicitly define communication and coordination workflows between departments. While ACDE has established P&Ps, Mercer suggests further refinement to incorporate a comprehensive and transparent communication framework across all relevant departments and programs. Additional training programs should be implemented for subcontractors and entities responsible for adjudication in areas such as grievances and PA. Regular evaluation of compliance with these training requirements is also necessary to ensure ongoing adherence and effectiveness.	Quality, Timeliness, Access
	ACDE's CM program has a well-established infrastructure, including effective staffing models, adherence to member caseload ratios, updated plans for acute transitions and nursing facility diversion, and a strong commitment to detailed auditing and oversight. Additionally, the CC management team has remained stable, with all supervisors and managers holding education, training, or licensure in BH. The CC teams are nearly fully staffed, and policies, standard operating procedures, checklists, and job aids are largely in compliance with the Master Services Agreement (MSA).	As in previous years, although the CC documentation demonstrates timely outreach attempts, a very high percentage of members are either unreachable or initially agree to the program but do not remain engaged. ACDE recognizes that many members are in the precontemplation stage and that the member population has a higher prevalence of mental health (MH) and substance use disorder (SUD) conditions. To address these challenges, ACDE should regularly analyze outreach and engagement data to identify patterns and inform strategy adjustments. Additionally, the use of predictive analytics can help identify members at the highest risk of disengagement, allowing for targeted prioritization of outreach efforts. The review also highlighted the need for ACDE to develop and implement targeted audits to ensure timely discharge planning and post-discharge follow-up, including monitoring the prompt initiation and follow-up of HCBS referrals.	Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance Review			
	ACDE's Delaware-dedicated pharmacy director and pharmacy support team have maintained consistency over several years, fostering strong familiarity with DMMA and the state's provider community. Additionally, the Pharmacy Benefit Manager (PBM) subcontracted to handle pharmacy PAs is adequately staffed to ensure timely reviews and effective management of pharmacy call center responsibilities. The PBM representatives are well-trained and possess in-depth knowledge of Delaware-specific UM practices, supporting efficient and reliable pharmacy operations.	Enhanced oversight of the PBM's pharmacy utilization review activities is necessary to ensure that Notice of Adverse Benefit Determination (NOABD) letters adhere to contractual requirements, particularly regarding the use of person-centered and clear, easily understandable language.	Quality, Timeliness, Access
	ACDE demonstrates a strong understanding of PIP design and implementation, effective use of workgroups for continuous QI, and well-written PIPs that align with population health concerns. ACDE also has a comprehensive approach to validating PMs that integrates technology, processes, and personnel to calculate PMs and HEDIS rates, ensuring quality data for reporting.	ACDE submitted code that was not aligned with the PM specifications. Establishing and implementing a formal process for peer review, along with an annual review of the PM code, will help ensure ongoing compliance and alignment with the PM specifications.	Quality, Timeliness, Access
	ACDE demonstrates a commitment to member rights, with materials available in multiple languages and formats, as well as comprehensive member education during enrollment and ongoing training for staff regarding nondiscrimination provisions.		Quality, Timeliness, Access
	ACDE has a clear structure for handling G&As, with dedicated staff and established protocols for timely acknowledgment, investigation, and resolution.		Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance Review			
	ACDE's Quality Management (QI) program has demonstrated progress in quality initiatives and effective integration of quality throughout the organization. The program has shown strong performance in quality assessments, and there is a robust training program for staff and delegates that covers essential quality topics.		Quality, Timeliness, Access
DFH	DFH has comprehensive P&Ps that ensure member rights, including the availability of language interpretation services and the distribution of member handbooks in multiple formats.	DFH's website uses language inconsistent with the provider manual and member handbook. DFH should implement a process to regularly update all materials, including the provider manual, member handbook, and website, to ensure consistent language and terminology across all documents.	Quality, Timeliness, Access
	The DFH CC team effectively presented their work on the MCC program, highlighting the integration of Doula and Postpartum Nutrition benefits. This included member and provider notifications, as well as staff education and training initiatives. DFH's LTSS CM demonstrates a strong commitment to member outreach, assessment, and engagement through community-based activities, including frequent face-to-face visits. The organization has also enhanced its electronic member record system to improve documentation and CC processes. Additionally, DFH has placed a significant emphasis on community outreach, exemplified by its baby shower events, which have been successful in engaging members. These events, promoted through social media, have seen participation grow from approximately 30 members to about 100 members, reflecting the program's expanding reach and impact.	Last year, it was noted that DFH's CC program could improve Health Risk Assessment (HRA) completion rates and strengthen provider coordination with member care plans. Additionally, documentation within the LTSS CM program revealed inconsistencies in HIPAA compliance, particularly regarding telephonic outreach, notification of changes in member conditions by NFs, and the timeliness of follow-up on identified member needs and services. Addressing these areas will promote more effective and compliant care management processes.	Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance Review			
	The Pharmacy program's review process demonstrated a solid understanding of regulatory and contractual provisions. DFH acknowledged and corrected identified issues, reflecting a commitment to continuous improvement. Additionally, a dedicated training team, supported by robust processes and training materials, ensures appropriate staffing and backup coverage for the Delaware pharmacy program.	DFH's Pharmacy PA denial letter templates, denial language, and processes need to be updated to ensure adherence to MSA requirements.	Quality, Timeliness, Access
	Under the shared services model, the UM department receives support for staffing, oversight of UM services, and meeting departmental performance metrics.	To ensure effective oversight and compliance within the UM department, a comprehensive Delaware-specific delegated auditing process must be developed. This process should encompass detailed P&Ps, a clearly defined audit methodology, and standardized reporting of findings. Implementing these components will enable consistent, transparent, and effective evaluation of delegated activities, supporting ongoing compliance with state requirements and enhancing the overall quality of UM operations.	Quality, Timeliness, Access
	DFH's continues to exhibit a strong understanding of PIP design and implementation, effective use of workgroups for continuous QI, and well written PIPs that align with population health concerns.		Quality, Timeliness, Access
		The most significant opportunity for enhancement within delegation oversight pertains to DFH's oversight of its parent company, Centene, particularly in areas designated as Centene Management Company Support. Effective delegation oversight is a vital component of MCO operations and necessitates robust, consistent, and ongoing monitoring to ensure that DMMA and MCO contract requirements are properly operationalized by the delegate. To	Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance Review			
		strengthen this oversight, it is recommended that DFH develop and implement comprehensive documentation of oversight processes, including clear procedures and criteria. Additionally, establishing a framework for continuous monitoring and reporting will facilitate timely identification and resolution of issues. Ensuring that all delegated services consistently meet DMMA and MCO contractual obligations is essential to maintaining compliance and operational integrity.	
		DFH currently reviews grievance and appeal records; however, it lacks a formal policy outlining this process. It is essential to establish a comprehensive policy that clearly defines procedures for capturing and integrating all grievance and appeal data, including BH appeals and grievances from Modivcare. Developing a systematic process and an integrated system to ensure consistent documentation and review of all relevant information will enhance oversight. Additionally, a formal process should be implemented to evaluate the entities responsible for adjudicating appeals, ensuring accountability and compliance with federal regulatory requirements. To support these efforts, DFH should enhance training programs and conduct regular evaluations of subcontractors to ensure their familiarity with grievance and appeal procedures and regulatory compliance. Implementing these recommendations will strengthen the integrity and effectiveness of DFH's grievance and appeal review practices.	Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance Review			
HHO	HHO has established a comprehensive infrastructure for LTSS CM, including P&Ps, job aids, and ongoing training. The CM staffing model features dedicated case managers for Transition of Care (TOC), Nursing Facility Transition, and PROMISE programs, all supported by an LTSS Support Center. HHO has implemented processes to ensure coordination across programs and continuous monitoring, incorporating several updates based on feedback from the 2024 EQR. HHO's CC files demonstrate consistent and timely outreach and engagement with members. Additionally, the MCC program actively educates members about the postpartum nutrition benefit and encourages its utilization. Members who access this service exhibit high rates of postpartum and well-baby care visits.	HHO has established internal processes for LTSS CM; however, ongoing staffing challenges have contributed to inconsistent outcomes. Reviews of CM files indicate opportunities to improve consistency in timely documentation and follow-up after emergency room visits and hospital admissions. Additionally, the files highlight the need for further training of CM staff to enhance documentation of member care gaps within the electronic record platform.	Quality, Timeliness, Access
	HHO's Delaware-dedicated Pharmacy Director, along with pharmacy leadership at the corporate level, has maintained consistent tenure over several years, fostering strong familiarity with DMMA and the State's provider community. The pharmacy materials provided for ongoing staff updates and meeting notes were thorough and reflect a well-coordinated and engaged team.	HHO's pharmacy PA team often allowed nearly the entire 24-hour review period to elapse before reviewing case documentation, leaving little time for prescribers to provide additional information if needed. Conducting staff-level assessments to ensure adequate resources are available to facilitate timely case reviews should help address this issue and improve the review process.	Quality, Timeliness, Access
	The organizational structure demonstrates clear leadership from the corporate entity to the local health plan, which is essential for effective governance and reflects a strong commitment to service excellence. Furthermore, the integration of technology to enhance service delivery and improve member outcomes is evident.		Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance Review			
	The UM leadership incorporated recommendations from the 2024 EQR by developing P&Ps to address previously unmet requirements. These include protocols for subcontractor training and a clear delineation of roles and responsibilities related to out-of-network authorizations and single-case agreements.		Quality, Timeliness, Access
	HHO has established robust processes and systems to track G&As, demonstrating effective organization, cross-departmental communication, and compliance with all required elements, regulations, and internal policies.		Quality, Timeliness, Access
		There is a need for consistent and accurate language across member and provider materials, particularly concerning Doula Services and Postpartum Nutrition Supports. Current inconsistencies and omissions in the descriptions of these services within the member and provider handbooks highlight this issue. To address this, HHO should establish a formal process to ensure that any new benefits or changes outlined in the MSA are consistently and promptly reflected in both the Member Handbook and the Provider Manual. This process will promote clarity, accuracy, and alignment across all member and provider communications.	Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance Review			
		As HHO plans to revamp its approach to the PPP OUD PIP, the MCO should revisit prior barrier analyses and evaluate the effectiveness of selected interventions. Consistent remeasurement of PMs and statistical testing to assess result significance are essential. Additionally, establishing a plan for ongoing monitoring and timely adjustments will help sustain improvements and address emerging challenges.	Quality, Timeliness, Access
		Provider credentialing lacks adequate auditing to identify missing federal and contractual documents. An increase in audit activities is necessary to detect and address these gaps. Additionally, HHO's HCBS credentialing and recredentialing files did not include provider setting assessments as required by the MSA.	Quality, Timeliness, Access

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

ACDE 2025 Findings and Recommendations

Member Rights, Responsibilities, and Communication Requirements

ACDE has policies in place to ensure member rights, including but not limited to the availability of member materials in English, Spanish, and any other prevalent languages. Member rights are published in the member handbook and on ACDE's member website. Members are advised of their rights and responsibilities upon enrollment and annually thereafter. Upon enrollment, the member is mailed a welcome kit that includes a quick guide, information about the reward program, and information regarding how to set up the member portal. ACDE submitted documentation to indicate that orientation sessions are conducted for all new members, in person or via phone. However, ACDE did not demonstrate that members are offered options to complete new member orientation via webinar.

Staff members are educated about member rights as part of new hire orientation; training emphasizes the requirements found in Section 1557 of the Patient Protection and Affordable Care Act, which outlines the nondiscrimination provisions prohibiting discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Corporate P&Ps globally address member rights and responsibilities and specifically address member requests for access to health records and the right to change information. These include instances where access to and the right to change information are denied along with the due process and grievance pathways. Delegates are required to follow all Delaware contract requirements, and when necessary ACDE/corporate works with its delegates to provide training on key topics pertinent to the Delaware contract.

Information regarding member rights and protections, available benefits, and how to access emergency versus urgent care are included within the member handbook. Alternative formats of the member handbook, including braille, audio tapes, teletype, and language translation services (including American Sign Language) are available to members at no cost. The member handbook includes a full list of covered benefits, including those not covered by ACDE, and addresses all contractually required elements. The provider directory allows members to search by type, distance, and further filter by accessibility. ACDE shared that the provider directory can be made available in a third language by request and provided the process for both members and providers to make this request.

Member call center operations are operated out of Philadelphia, Pennsylvania and Jacksonville, Florida. The call center works 24/7/365. During the 2025 on-site review, Mercer and DMMA staff listened to three member calls. Overall, the member calls were handled as expected and met MSA requirements. A few missed opportunities within the calls include triggers for discussing other services, and transfer appropriateness.

Emergency and Post-Stabilization Services

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

Marketing

ACDE maintains a Delaware-specific policy governing the development, production, and distribution of marketing materials for members. This policy meets federal requirements pertaining to member communications with the availability of materials in alternative formats, including braille. Additionally, ACDE has an annual marketing plan in accordance with its contract requirements with the State. The annual plan is submitted to DMMA for review and approval at the beginning of each year, as are all member-facing

wellness and marketing materials. As noted, ACDE implemented a redesign for marketing to improve overall user experience and enhance marketing.

ACDE’s approach to developing and distributing marketing materials includes quality control processes to ensure materials are accurate and do not mislead, confuse, or defraud members or the State. The State requires ACDE to disclose events and activities it plans to sponsor and/or participate in during the year and to ensure its annual sponsorship budget does not exceed a State-defined threshold. Member and marketing materials are submitted to the State for approval. During the review of marketing materials, it was identified that some items still did not include the DHSS logo, which is an MSA requirement. ACDE shared a plan to address this requirement, with full implementation expected by the end of 2025.

During the on-site review in 2024, Mercer reviewed documentation and discussed enrollee rights and protections further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. ACDE provided updated documentation within member materials, the provider directory, the member website, and the call center providing consistent direction and documentation.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
- The MCO marketing materials use language and a format that is easily understood and worded at a sixth grade reading level. - Marketing Materials are available in Spanish and any other Prevalent Non-English Languages specified by the State. - All video or print material carries the DHSS logo. (3.3)	Substantially Met	Substantially Met	ACDE has not updated all marketing materials to include the DHSS logo. It was stated during the on-site review that this was to be completed by the end of CY 2025.	Update all marketing materials to ensure they carry the DHSS logo in the specified colors, as appropriate.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The Health and Wellness Education Plan includes a member education program that uses classes, individual or group sessions, videotapes, written material, media campaigns, and modern technologies (e.g., mobile applications and tools, social media). All instructional materials are provided in a manner and format that is easily understood and in keeping with requirements for written member materials as prescribed in the Contract. (3.14.13, 3.14.26.1)	New Finding for 2025	Substantially Met	ACDE provided the 2024 Health and Wellness Education Plan Evaluation but did not submit the 2024 Health and Wellness Education Plan. ACDE submitted the 2025 Health and Wellness Education Plan.	Develop and implement a process or policy to ensure the timely drafting and review of the annual Health and Wellness Education Plan.

DFH 2025 Findings and Recommendations

Member Rights, Responsibilities, and Member Communication Requirements

DFH has P&Ps in place to ensure member rights, including the availability of oral interpretation services. Member rights are published in the member handbook, provider manual, and on the DFH website. Members are advised of their rights and responsibilities upon enrollment and annually. At enrollment, members receive a new member packet that includes an identification card, welcome letter, member handbook, and HIPAA Privacy Notice. Staff are educated about member rights as part of new hire orientation. This training emphasizes the requirements in Section 1557 of the Patient Protection and Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Corporate policy addresses member rights and requests for access to health records and corrections, including circumstances under which access or changes may be denied, as well as associated due process and grievance pathways. Delegates are contractually required to follow all Delaware MSA requirements, and DFH provides training on key MSA-related topics to delegates as needed.

Information on member rights and protections, available benefits, and how to access emergency versus urgent care is contained in the member handbook, which is available in English and Spanish. Alternative formats, including braille, audio, teletype (TTY), and language translation services (including American Sign Language), are available at no cost. Members are advised via the member handbook and DFH website to contact Member Services through DFH's toll-free number to request translation assistance. DFH Member Services has access to oral interpretation services that can be added to calls. Providers are reminded via newsletters that they can call to access immediate interpretation. A full list of covered benefits is included in the member handbook, which is available

online through DFH's website. The handbook and website also explain what conditions constitute an emergency and how to access emergency services, as well as when to use urgent or primary care.

The new member orientation policy and procedure includes some, but not all, of the minimum required content outlined in the MSA. Current content addresses benefit information, availability of services, and rights related to G&As. However, it does not include required information such as how to make appointments; contact information for Member Services, the nurse line, and the pharmacy line; the State Fair Hearing process; Member Advocate information; or the member's option to attend orientation in person. The DFH provider directory is a combined English and Spanish version. DFH is working to enhance the Spanish-language presentation for members. If a member requests a handbook in another language, DFH submits an internal request to have the handbook translated into the appropriate language and provided to the member.

Member call center operations remain fully remote. During the on-site review, Mercer and DMMA staff monitored four member calls. Member Services operations appeared smooth and reflected a customer-centric approach, with staff demonstrating a commitment to assisting members to the best of their ability. One call involved confirming the network status of a border-state provider, and DFH was able to verify that the provider directory information for that provider was accurate.

Emergency and Post-Stabilization Services

DFH offers definitions of emergency and post-stabilization services, which are consistent with federal rules and State contract requirements and does not limit an emergency condition by diagnosis or symptom. These definitions are found in the 2024-member handbook. Education about what constitutes an emergency versus an urgent care need is defined in member materials. Policies authorizing payment for post-stabilization services reflect federal definitions and include care provided in- and OON.

Marketing

DFH maintains a Delaware-specific policy governing the development of member marketing materials, which complies with federal requirements for member communications. DFH also develops an annual marketing plan in accordance with its State contract requirements. During the 2023 launch, DFH focused its marketing efforts on the open enrollment period. Because members were auto-assigned at that time and DFH determined that most membership growth was occurring through auto-assignment rather than open enrollment marketing, the strategy has shifted toward brand awareness. In 2024, marketing efforts emphasized health and wellness content, and overall marketing spending was reduced to allow greater focus on provider relationships. The State requires that DFH disclose events and activities the MCO plans to sponsor and/or participate in during the year. In addition, the annual budget for sponsorship cannot exceed a pre-determined threshold set by the State. The annual plan was submitted to DMMA for review and approval. The annual budget was deemed appropriate. DFH tracks all member events, including member advisory stakeholder meeting, and submits a weekly calendar of events to the State.

Member and marketing materials are submitted to the State for approval. Some materials, however, included the DHSS logo in incorrect colors. DHSS requires the logo to appear in maroon and gray. Because DFH's color palette includes shades of pink, DFH requested and received approval from DMMA to use a black-and-white DHSS logo on specific member marketing materials. Some remaining materials still require updates to fully meet the contractual requirement for DHSS logo inclusion. All DFH materials are reviewed to ensure they are easily understood and written at approximately a sixth-grade reading level. DFH reported a strong focus on community outreach, including an increase in the sponsorship budget from \$50,000 to \$100,000. DFH cited its baby shower events as an example of successful outreach; promoted through social media, participation in these events has grown from approximately 30 members to about 100 members.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
- The MCO Marketing Materials use language and a format that is easily understood and worded at a sixth grade reading level. - Marketing Materials are available in Spanish and any other Prevalent Non-English Languages specified by the State. - All video or print material carries the DHSS logo. (3.3)	Substantially Met	Substantially Met	During review it was observed that all printed marketing materials did not include the DHSS logo. The following handout examples do not include the DHSS logo: - VAB Flyer – HC & Spn - BG Club – Eng, Spn, HC - EPSDT Eng - EPSDT Spn & HC - Tutoring Eng, Spn & HC - Rewards Eng & Spn In addition to the handouts listed above, billboard examples, bus wrap examples, digital kiosk examples, pharmacy bag examples, and social media examples also do not include the DHSS logo.	Update all marketing materials to ensure they carry the DHSS logo in the specified colors, as appropriate.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The Health and Wellness Education Plan includes a member education program that uses classes, individual or group sessions, videotapes, written material, media campaigns, and modern technologies (e.g., mobile applications and tools, social media). All instructional materials are provided in a manner and format that is easily understood and in keeping with requirements for written member materials as prescribed in the Contract. (3.14.13, 3.14.26.1)	New Finding for 2025	Substantially Met	DFH did not provide evidence that a health and wellness plan was in place for 2024. AO_19_2024 DFH HW Plan.pdf was provided, the plan is not dated and there are notes included.	Develop and implement a process or policy to ensure the timely drafting and review of the annual Health and Wellness Education Plan.
The MCO conducts orientation sessions for all new members. The new member orientation includes the option for members to participate in person, by phone, or via webinar. (3.14.15)	New Finding for 2025	Substantially Met	DFH has a new member orientation policy and procedure that contains some required content including benefit information, availability of services, rights on G&As; however, it does not include all the minimum required information outlined in the MSA. The policy is missing: • How to make appointments • Contact information for member services line, nurse line, pharmacy line • State Fair Hearing Process • Member Advocate information Member option to attend orientation in person.	Update the new member orientation policy and procedures to ensure all minimum required information is included.

HHO 2025 Findings and Recommendations

Member Rights, Responsibilities, and Member Communication Requirements

HHO has policies in place to ensure member rights, including the availability of materials in both English and Spanish. Materials in additional languages are available upon request. Member rights are published in the member handbook and on HHO's member website. Members are advised of their rights and responsibilities upon enrollment and annually thereafter. Upon enrollment, members receive a welcome letter that includes a "Welcome Kit" and a QR code linking to the member handbook and member website. The MCO conducts orientation sessions for all new members. New member orientation sessions are available in person or virtually and are offered following meetings of the Member Advisory Committee (MAC). HHO has increased MAC membership from 2–3 members to 17 members, providing expanded member feedback on processes and communications. Examples of MAC feedback include recommendations to provide language ID cards indicating members' preferred languages and to use QR codes in member materials.

Staff are educated about member rights as part of new hire orientation. This training emphasizes the requirements found in Section 1557 of the Patient Protection and Affordable Care Act, which outlines the nondiscrimination provisions prohibiting discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Corporate policy globally addresses member rights, member requests for access to health records, and the right to change information. The right to change information includes instances in which access to and the right to change are denied, along with due process and grievance pathways. Delegates are required to follow all Delaware contract requirements and, when necessary, HHO/Corporate works with its delegates to provide training on key topics pertinent to the Delaware contract.

Information regarding member rights and protections, available benefits, and how to access emergency versus routine care is included in the member handbook. HHO received approval to provide a separate member handbook for LTSS members, allowing for targeted information specific to LTSS, whose benefits and services differ from those available to Medicaid, CHIP, and community well members. The member handbook is available online, with an option to toggle between English and Spanish. The handbook includes a list of covered benefits and services not covered by HHO; however, the new benefits for doula services and postpartum nutritional services are not included. The provider directory allows members to search by provider type and distance and to filter by accessibility. Members may request a hard copy of the directory from the Member Services Department. Provider directories are available in Spanish upon request.

Member call center operations continue to be based in Pittsburgh, Pennsylvania, with agents working remotely. The dental call center is based in Camp Hill, Pennsylvania, with agents also working remotely. The nurse advice line operates 24/7/365 and is provided by the subcontractor Health Dialog. Staffing for the member call center is determined using Delaware-specific membership and program needs, with forecasting and performance trends used to ensure adequate coverage. During the 2025 on-site review, Mercer and DMMA staff monitored four member calls. Member Services operations appeared smooth and reflected customer-centric staff

dedicated to assisting members to the best of their ability. Three of the four calls required the agent to transfer the caller to the State for coverage inquiries, and these transfers were handled appropriately.

Emergency and Post-Stabilization Services

HHO offers definitions of emergency and post-stabilization services that are consistent with federal rules and State contract requirements and do not limit emergency conditions by diagnosis or symptom. These definitions are included in P&Ps and in the member handbook. Member materials also explain what constitutes an emergency versus an urgent care need. Policies authorizing payment for post-stabilization services align with federal definitions and cover care provided both in-network and OON, and they reflect that the treating physician determines when a member is stable for transfer to in-network providers. The automated phone system provides guidance to callers regarding what to do in the event of an emergency at the beginning of the message.

Marketing

HHO maintains a Delaware-specific policy governing the development, production, and distribution of marketing materials for members. This policy complies with federal requirements for member communications, including the availability of materials in alternative formats such as braille. HHO also develops an annual marketing plan in accordance with its State contract requirements. The annual plan, along with all member-facing wellness and marketing materials, is submitted to DMMA for review and approval at the beginning of each year. In 2024, HHO submitted educational materials related to DSNP; no additional marketing materials required approval that year. HHO coordinated with DMMA to obtain and include the DHSS logo on marketing materials.

HHO emphasizes the importance of community connection, as evidenced by the many community events held, often open to all Delaware residents and not limited to HHO members. The HHO Community Liaison coordinated participation in more than 45 events in 2024. Examples of 2024 events include several Women's Health Days, the Easter Seals caregivers conference, a diabetes blitz, a winter coat distribution event, Food Bank of Delaware nutrition and distribution events, a Hispanic festival, and Pride Day. Community partners recognized these efforts, and the HHO Community Liaison received a Health & Wellness Award. The State requires HHO to disclose the events and activities it plans to sponsor and/or participate in each year and to ensure the annual sponsorship budget does not exceed a State-defined threshold. Member and marketing materials are submitted to the State for review and approval prior to distribution.

During the CAP review in 2025, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

Advance Directives

ACDE 2025 Findings and Recommendations

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed Advance Directives (ADs) further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. All required documentation was present, MCO staff provided responses consistent with each other and with the documentation, or a State defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

DFH 2025 Findings and Recommendations

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed ADs further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. All required documentation was present, MCO staff provided responses consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

HHO 2025 Findings and Recommendations

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed Advance Directives further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. All required documentation was present, MCO staff provided responses consistent with each other and with the documentation, or a State defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

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

ACDE 2023 Findings and Recommendations

Contractually, ACDE is required to develop and maintain a Provider Network Development and Management Plan (PNDMP). The PNDMP acts as the Network Management PD, outlining the different populations served, goals, objectives, outcomes, and action steps taken to develop, monitor, and maintain ACDE's network of providers. Although the expectation is that ACDE uses the PNDMP as a living document, updating it as the year unfolds, annually the State requires an evaluation of the effectiveness of the PNDMP; with the results of the evaluation used as the basis for the next year's plan. ACDE spoke to their capabilities to use geo-spatial analytics, grievance reporting, and critical incident data, as well as member and provider experience information, to evaluate the effectiveness of its PNDMP. However, the plan provided did not detail the minimum requirements as outlined in the MSA.

The Provider Network Account Executives (AEs) are assigned to providers and play a critical role in communicating ACDE policy, conducting training on new business processes and providing technical assistance to their assigned provider community. Site visits in 2024 were a combination of both virtual and in-person visits, with a goal to return to face-to-face visits with all providers. During the visit, AEs review and discuss a high-level claim summary, plan updates concerning P&Ps, claim dispute process, wellness program overview, Quality Enhancement Program, Electronic Funds Transfer/Electronic Remittance Advice set up, demographics, provider education, and training opportunities. During site visits the AEs may also distribute the provider tool kit for new providers. AEs are also responsible for researching and resolving any relevant provider's complaints, which are reviewed, tracked, and trended in monthly meetings.

ACDE maintains a large network of providers and offers a Mobile Wellness and Opportunity Center, a community hub offering programs that address education, safety, transportation, nutrition, and preventive health services. It also provides a Community Resources Directory to assist members in accessing online and local, in-person health and wellness resources. The provider directory offers an enhanced option to let members search for providers offering telehealth services. A high-level overview of the ACDE network follows.

Provider Types	Number of Providers
Primary Care Provider (PCP)	1,069
Specialty Care Physician	1,067
BH	1,359

ACDE operates a provider website and contracts with NaviNet for its online provider portal. The NaviNet portal allows for claims status check, eligibility verification, PA submission and response, as well as provider complaint submission. ACDE has several cross-functional workgroups that review NaviNet trends, weekly denied claim reports, and provider complaints. The workgroups proactively engage with PNM and often reach out to providers to educate and remediate incorrect claim denials or billing issues before they become a provider complaint.

Providers have access to training and education materials through the NaviNet portal and receive new provider orientation when entering the network. Links are available for cultural competency trainings and various online training opportunities for BH topics, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) training, Wellness Registry training, and webinars. ACDE introduced Project ECHO (Extension for Community Healthcare Outreach) training for providers, which covers navigating telehealth care for providers.

PNM uses various tools and processes to identify and remediate network capacity issues or deficiencies within the network. Non-participating providers are identified, and review of the single case agreement log is used to initiate outreach and begin contracting efforts. PNM also monitors access and availability reports and member grievances to help determine whether a

geographic location requires additional specialty types. Using Geo-Access summaries, PNM continually monitors the provider network to identify member growth areas, network deficiencies, and service delivery needs to ensure adequacy is met. PNM monitors its closed PCP and monthly provider termination reports along with access and availability reports to gauge any deficiencies.

In 2024 PNM provided monthly Provider Post Bulletins to highlight programs and process to providers, as well as quarterly newsletters. The quarterly provider newsletters highlighted a variety of topics, including balanced billing, provider credentialing rights, wellness programs, and the provider complaint system.

During the comprehensive compliance review in 2025, Mercer reviewed documentation and discussed Availability of Services further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. However, the PNDMP did not address all components required in the contract and multiple provider contract templates need to be updated to better demonstrate compliance with the contract.

Provider Selection and the Credentialing File Review Process

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

ACDE delegates credentialing and recredentialing of providers, in the local market, to Capital Vision Services, LLC, Christiana Care Health System (CCHS), Delaware Chiropractic Services Network, MDLive Provider Services, LLC, Nemours Children's Health, and Tidal Health Peninsula Regional, Inc. Delegation oversight of these credentialing entities includes review of standards and review of credentialing/recredentialing files as well as implementation of corrective actions when deficiencies are identified. ACFC and ACDE also delegate credentialing to national partners Avēsis and DentaQuest; these entities are overseen by the vendor management team.

The credentialing file review was performed using the File Review Protocol methodology outlined in Section 3. File review encompassed initial and recredentialing activities for organizational providers and independent providers. A sample of 30 credentialing files from non-HCBS independent providers, 30 credentialing files from HCBS independent providers, and 30 credentialing files from non-HCBS organizational providers were selected. The files were assessed for compliance with Final Rule regulations, State contract requirements, and ACDE internal policy standards. The following elements were included in the review:

- Credentialing entity

- Verification of medical licensure, board certification, Drug Enforcement Administration licensure (if applicable), and malpractice insurance coverage
- Documentation of National Practitioner Data Bank and/or Office of Inspector General queries including but limited to:
 - List of Excluded Individuals and Entities, National Plan and Provider Enumeration System, System for Award Management, Excluded Parties List System, and Social Security Administration Death Master File
- Assessment of provider setting
- Signed and dated provider application and attestation
- Date of previous credentialing when recredentialing, if applicable
- Logs of attempts to reach providers for credentialing, if applicable
- Documentation of internal quality review, if applicable (excludes peer review documentation)

Non-HCBS Provider Credentialing File Review Results

Overall, the majority of the non-HCBS providers reviewed demonstrated compliance with DMMA's required 45-day turnaround time (TAT) for all initial applications. Evidence of sanction and debarment checks, SSA DMF review, review of quality data for recredentialed providers, and provider disclosure forms were all evidenced in the file review or supported by P&Ps. Files reviewed demonstrated recredentialing activities occurred within the three-year cycle for non-HCBS practitioners. Interview sessions dedicated to the file review demonstrated consistency with ACDE's submitted written response. However, some files were missing evidence of the date the delegate notified the MCO of the credentialing decision. Overall, the non-HCBS provider credentialing files reviewed were found to have scored between 75% and 89% compliance in the required elements.

HCBS Provider Credentialing File Review Results

Overall, the HCBS providers reviewed demonstrated compliance with DMMA's required 45-day TAT for all initial applications. Evidence of sanction and debarment checks, SSA DMF review, review of quality data for recredentialed providers, and provider disclosure forms were all evidenced in the file review or supported by P&Ps. Some files evidenced that recredentialing activities did not occur within the one-year cycle for HCBS practitioners. Interview sessions dedicated to the file review demonstrated consistency with ACDE's submitted written response. However, all files were missing provider setting assessments which is a DMMA MSA requirement. Overall, the non-HCBS provider credentialing files reviewed were found to have scored less than 75% compliance in the required elements.

Non-HCBS Facility Credentialing File Review Results

Overall, the non-HCBS organizational providers reviewed demonstrated compliance with DMMA's required 45-day TAT for all initial applications. Evidence of sanction and debarment checks, SSA DMF review, collection of Clinical Laboratory Improvement Amendments waivers, and provider disclosure forms were all evidenced in the file review or supported by P&Ps. The majority of the files reviewed demonstrated compliance with recredentialing activities occurring within the three years for non-HCBS institutions. Interview sessions dedicated to the file review demonstrated consistency with ACDE's submitted written response. Overall, the non-HCBS facility credentialing files reviewed were found to have achieved 90% compliance or greater in the required elements.

Provider Terminations and the Provider Termination File Review Process

When a provider is terminated from an MCO network, members who had an established relationship with the provider or who had an ongoing plan of care (POC) can experience disruption in access and availability. ACDE verifies that members connected to terminated providers transition to new providers. Provider groups are requested to identify providers for members to transition to, while also ensuring members have options to transition to providers of their choice. To decrease the impact to members, ACDE provides assistance to members requesting to transfer medical records and/or locate a new provider. ACDE's provider termination P&Ps reflect the appropriate look-back periods to determine established relationships and consider any open service authorizations to limit disruption to members. Letters are sent to members and members are encouraged to call member services should they need assistance with locating a new provider.

Avēsis is ACFC's national vendor for vision benefit services and is used in the Delaware market by ACDE to provide vision benefits to its membership. Avēsis is responsible for developing ACDE's Optometry and Vision Service Provider Network. As part of its network management functions, Avēsis is required to operate a provider call center (subject to the call center requirements outlined in ACDE's MSA with the State), implement a provider complaint system, and process provider terminations from the network.

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

- Provider demographics
- All provider communication received and sent, including mailings (with postmark), electronic communication, and phone logs, including date
- Documentation of termination decision and justification, with date
- Documentation of termination of all applicable contracts, with date

- Notification to provider and members, if applicable

At Mercer's request, ACDE submitted a Universe file listing of all terminated providers in 2024. A total of 868 terminated providers were identified. Termination reasons appeared primarily voluntary in nature, including for non-response for recredentialing, provider no longer at practice, or at the provider's request. ACDE demonstrated the audit trail associated with provider terminations, incorporating member informing notices and review of provider panel information for PCP terminations. Overall, the files reviewed were found to have achieved 90% compliance or greater in the required elements.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
• Organizational structure demonstrates leadership from the Corporate entity to the local Health Plan and includes relationships with sister entities, subcontractors and delegates. • Administration and staffing structure appears sufficient to successfully implement contract requirements. (3.20.1.3).	Substantially Met	Substantially Met	The MCO's organizational chart for the Provider Network that includes the names of senior and departmental management. However, the reporting structure for the Network Development Director, Full-Time Workforce Development Manager, Director overseeing Provider Billing/Payment Issues, and the Provider Services Director was not aligned with the 2024 MSA, which is the year under review.	Revise ACDE's organizational chart to ensure alignment with the MSA or obtain State-approved exception documentation for any deviations from the MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO has a Provider Network Development and Management Plan that at minimum includes: - Summary of participating providers, by type and geographic location in the State. - Demonstration of monitoring activities to ensure that access standards are met and that members have timely access to services, per the requirements of this Contract. - A summary of participating provider capacity issues by service and county, the Contractor's remediation and QM/QI activities and the targeted and actual completion dates for those activities. - Network deficiencies by service and by county and interventions to address the deficiencies. - Ongoing activities for provider network development and expansion taking into consideration identified participating provider capacity, network deficiencies, service delivery issues and future needs. (42 CFR 438.207 and 3.9.1.2.4, 3.9.3)	Partially Met	Partially Met	ACDE's PNDMP includes a network summary by provider type and county, Geo-Access and appointment access monitoring results, and a summary of provider recruitment and retention. While there are brief summaries of network deficiencies included in the PNDMP, interventions to address the deficiencies are missing from the plan as well as the remediation and QM/QI activities and the targeted and actual completion dates for those activities.	Revise the Provider network Development and Management Plan to include: - A summary of participating provider capacity issues by service and county. - Remediation and QM/QI activities to address the deficiencies with targeted and actual completion dates.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO has a template for the MCO's provider participation agreements, including agreements with nursing facilities and HCBS providers that have been approved by the State and adheres to contract requirements. (3.10)	Substantially Met	Substantially Met	The Ancillary, Hospital, and Physician Agreement templates reflect the incorrect number of years for provider record retainment requirements. The agreements all list seven years, as opposed to the 10-year requirement as indicated by the MSA.	Revise Ancillary, Hospital, and Physician Agreement templates to require that records be retained for a minimum of 10 years.
The MCO monitors providers for compliance with credentialing standards and takes appropriate action against non-compliant providers. (3.9.9.14, 3.16.6.2.8)	New Finding for 2025	Not Met	Overall, ACDE's credentialing file review included all federally and contractually required items. However, during file review it was identified that all of the HCBS credentialing and recredentialing files were missing provider setting assessments as required by the MSA.	Develop P&Ps that demonstrate ACDE monitors and ensures compliance with the MSA requirement of including a provider setting assessment in all HCBS credentialing and recredentialing files.
The MCO contract templates are compliant with contract requirements. (3.22.2.3.5)	Partially Met	Substantially Met	There is contradictory information in the provider agreements templates regarding the number of years providers must retain records. One section of the contract template indicates seven years, while another section indicates ten years, which is the requirement indicated by the MSA.	Revise contract templates to clearly and consistently require that records be retained for a minimum of ten years, which is the requirement indicated by the MSA.

DFH 2025 Findings and Recommendations

DFH incorporated recommendations from the 2024 EQR and updated its PNDMP to clearly describe the populations served, goals, objectives, outcomes, and action steps taken to develop, monitor, and maintain DFH's network of providers. DFH also provided evidence of effective monitoring activities, which included Geo-Access reports, monthly network adequacy reports, daily team

huddles, provider feedback, grievances, and provider engagement meetings. These efforts successfully brought previous CAP items into compliance.

As required, DFH's provider network includes hospital systems, BH facilities, federally qualified health centers, Medicaid accountable care organizations, and independent providers. A high-level overview of the DFH network follows.

Provider Type	Number of Providers
PCP	1,059
Specialty Care Physicians	1,670
BH Providers	1,330

DFH operates a provider website and an online provider portal. The Provider Portal Overview presentation included screenshots and step-by-step instructions for accessing member eligibility, requesting authorizations, viewing member panels and care gaps, and submitting, reviewing, and editing claims through the provider portal. However, there was no evidence that providers can submit and track complaints via the portal. The Provider Engagement team conducts targeted, proactive outreach based on operational trends and offers one-on-one assistance to help providers submit clean and accurate claims, thereby minimizing claim denials.

DFH enhanced its provider training to include a telehealth toolkit that outlines acceptable practices and offers providers virtual training options, including recorded sessions, as well as in-person training when appropriate. Providers have access to training and educational materials through the portal, monthly training sessions, and ad hoc training as needed. Provider training materials focus on the Cures Act and the Secure Provider Portal Overview. While portal training provides administrative details for billing and claims, it does not cover other topics.

DFH updated its annual Staff Training Evaluation, the Provider Training and Outreach Plan and the PNDMP to address all components required in the contract. Additionally, DFH drafted a Workforce Analysis and Development plan and implemented quarterly Provider Advisory Council meetings.

DFH must collaborate with its dental vendor to correct the appointment standards outlined in the P&Ps. Additionally, minor clarifications are needed in the PNDMP Evaluation report concerning the use of secret shopper calls. Finally, DFH must provide evidence that providers can submit and track complaints through the provider portal.

Provider Selection and the Credentialing File Review Process

DFH has a clear credentialing and recredentialing process, which includes the use of a Credentialing Committee, chaired by the Medical Director with network providers, and MCO staff participating. There are established standards for conducting the functions of selection and retention for network providers. These standards include practices for individual and organizational/facility credentialing,

re-credentialing, and ongoing monitoring that meet the qualifications of applicable state and federal government regulations, applicable standards of accrediting bodies, including the NCQA, and DFH requirements.

Providers who have an independent relationship with DFH must complete an application, submit copies of applicable supporting documentation, meet minimum administrative requirements, and meet credentialing qualifications. Re-credentialing is performed at least every 36 months (HCBS performed annually), and the re-credentialing cycle begins with the date of the initial credentialing decision. The DFH credentialing team verifies applications using primary and secondary sources, which are reviewed, date stamped and placed in the applicant's file prior to the credentialing decision.

The MCO has designated a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions. The Credentialing Committee provides advice and expertise for credentialing decisions, reviews credentials for practitioners and providers who do not meet established thresholds, and ensures files meet established criteria.

DFH delegates credentialing to Christiana Care Health System, Centene Dental Services, Centene Vision Services, Delaware Chiropractic Services Network, ModivCare, Nemours Children's Health, and Tidal Health. Corporate and DFH have a strong policy to guide oversight of delegated credentialing.

The credentialing file review was performed using the File Review Protocol methodology outlined in Section 3. File review encompassed initial and recredentialing activities for organizational providers and independent providers. A sample of 30 credentialing files from non-HCBS independent providers, six credentialing files from HCBS independent providers, and 18 credentialing files from non-HCBS organizational providers were selected. The files were assessed for compliance with Final Rule regulations, State contract requirements, and DFH internal policy standards. The following elements were included in the review:

- Credentialing entity
- Verification of medical licensure, board certification, Drug Enforcement Administration licensure (if applicable), and malpractice insurance coverage
- Documentation of National Practitioner Data Bank and/or Office of Inspector General queries including but limited to:
 - List of Excluded Individuals and Entities, National Plan and Provider Enumeration System, System for Award Management, Excluded Parties List System, and Social Security Administration Death Master File
- Assessment of provider setting
- Signed and dated provider application and attestation
- Date of previous credentialing when recredentialing, if applicable

- Logs of attempts to reach providers for credentialing, if applicable
- Documentation of internal quality review, if applicable (excludes peer review documentation)
- Documentation of decision and decision date

DFH's file submission was difficult to review. The required Cover Sheets were either not used, not used with the appropriate type of file, or buried within the file, which made the review process more time-consuming or, in some cases, impossible. An entire section needed to be resubmitted as a follow-up, and Mercer then needed to rereview the files. These issues could have been avoided if the files had undergone an internal review prior to submission, ensuring quality control and attention to detail. Overall, the submission fell short of the expected standards, resulting in delays and additional work for the review team.

Non-HCBS Provider Credentialing File Review Results

Overall, the majority of the non-HCBS providers reviewed demonstrated compliance with DMMA's required 45-day TAT for all initial applications. Evidence of sanction and debarment checks, SSA DMF review, review of quality data for recredentialed providers, and provider disclosure forms were all evidenced in the file review or supported by P&Ps. Files reviewed demonstrated recredentialed activities occurred within the three-year cycle for non-HCBS practitioners. Interview sessions dedicated to the file review demonstrated consistency with DFH's submitted written response. However, half of the files reviewed were missing evidence of the date the delegate notified the MCO of the credentialing decision. Overall, the non-HCBS provider credentialing files reviewed were found to have scored less than 75% compliance in the required elements.

HCBS Provider Credentialing File Review Results

Overall, the HCBS providers reviewed demonstrated compliance with DMMA's required 45-day TAT for all initial applications. Evidence of sanction and debarment checks, SSA DMF review, review of quality data for recredentialed providers, and provider disclosure forms were all evidenced in the file review or supported by P&Ps. The files reviewed evidenced that recredentialed activities did occur within the one-year cycle for HCBS practitioners. Interview sessions dedicated to the file review demonstrated consistency with HHO's submitted written response. However, all files were missing provider setting assessments which is a DMMA MSA requirement. Overall, the non-HCBS provider credentialing files reviewed were found to have scored less than 75% compliance in the required elements.

Non-HCBS Facility Credentialing File Review Results

Overall, the non-HCBS organizational providers reviewed demonstrated compliance with DMMA's required 45-day TAT for all initial applications. Evidence of sanction and debarment checks, SSA DMF review, collection of Clinical Laboratory Improvement Amendments waivers, and provider disclosure forms were all evidenced in the file review or supported by P&Ps. The files reviewed demonstrated compliance with recredentialed activities occurring within the three years for non-HCBS institutions. Interview sessions

dedicated to the file review demonstrated consistency with ACDE's submitted written response. Overall, the non-HCBS facility credentialing files reviewed were found to have achieved 90% compliance or greater in the required elements.

Provider Terminations and the Provider Termination File Review Process

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

The provider termination file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 provider termination files were selected for review; sampling included organizational providers and individual providers representing DFH and delegated credentialing entities. The following elements were included in the review:

- Provider demographics
- All provider communication received and sent, including mailings (with postmark), electronic communication, and phone logs, including date
- Documentation of termination decision and justification, with date
- Documentation of termination of all applicable contracts, with date
- Notification to provider and members, if applicable

At Mercer's request, DFH submitted a Universe file listing of all terminated providers in 2024. A total of 562 terminated providers were identified. Termination reasons appeared primarily voluntary in nature, including for non-response for recredentialing, provider no longer at practice, or at the provider's request. DFH demonstrated the audit trail associated with provider terminations and incorporation of member informing notices. However, all files reviewed were missing evidence that panel and open authorization information was reviewed for PCP terminations. Overall, the files reviewed were found to have scored less than 75% compliance in the required elements.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO's provider recruitment P&Ps include effective strategies to ensure adequate access to all covered services in accordance with the State's access standards. (42 CFR 438.206(c)(1)) and 3.9.1.2.4, 3.9.15)	Substantially Met	Substantially Met	The Dental Member Access to Providers policy incorrectly states that Urgent Dental Care appointments will be provided within 72 hours and that initial, routine, or working appointments will be available within 36 business days.	Update dental policies, procedures, and processes to ensure Urgent Dental Care appointments are available within 48 hours of the request and routine appointments are available within three weeks.
The MCO has the capacity to provide covered services to members in accordance with the State's standards for access to care in terms of provider to member ratios, distance requirements, appointment standards, and office waiting times. (42 CFR 438.68(c)) and 3.9.10, 3.19.14, 3.9.15)	Substantially Met	Substantially Met	The 2024 PNDMP Evaluation Report indicates that the secret shopper script was not used; however, DFH submitted follow-up scripts demonstrating that some calls did utilize a secret shopper script.	Update the 2025 PNDMP Evaluation Report to include the secret shopper scripts.
The MCO has a secure provider portal that includes functionality as required by the contract. (3.9.7.4.2)	Substantially Met	Substantially Met	The Provider Portal Overview presentation included screenshots and step-by-step instructions for accessing member eligibility, requesting authorizations, viewing member panels and care gaps, and submitting, reviewing, and editing claims on the provider portal. However, there was no evidence that providers can submit and track complaints via the provider portal.	Demonstrate that providers have the ability to submit and track complaints via the provider portal.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO monitors providers for compliance with credentialing standards and takes appropriate action against non-compliant providers. (3.9.9.14, 3.16.6.2.8)	New Finding for 2025	Not Met	Overall, DFH's credentialing file review included all federally and contractually required items. However, during file review it was identified that all of the HCBS credentialing and recredentialing files were missing provider setting assessments as required by the MSA.	Develop P&Ps that demonstrate DFH monitors and ensures compliance with the MSA requirement to include a provider setting assessment in all HCBS credentialing and recredentialing files.

HHO 2025 Findings and Recommendations

The Provider Training and Outreach Plan describes how HHO educates providers, by outlining training methodologies and types of provider communication. The list of topics included in training covers billing processes, conditions of participation, provider responsibilities, clinical issues, opioid risk factors, wellness and disease management, and the provider manual topics. HHO hosted monthly provider forums and posted presentation decks online, along with training materials for other topics. These online training materials are available to providers 24/7. HHO developed a New Provider Orientation checklist used by Provider Account Liaisons to verify new providers are thoroughly oriented to all aspects of HHO and the Delaware Medicaid program.

The PNDMP Evaluation demonstrates HHO's capacity to provide covered services to members, using geographic access reports, surveys, and member grievances. The evaluation also lists multiple ways HHO complies with the availability of services. A high-level overview of HHO's network follows.

Provider Type	Number of Providers
PCP	804
Specialty Care Provider	642
BH	1,013

HHO's Provider Network Development Recruitment and Retention policy outlines processes for developing and monitoring the network, provider recruitment activities, provider retention activities, and how urgent network changes are addressed. The Workforce Development Plan describes different workforce data collection methodologies and related analysis results. The plan outlines methodology and data sources used to inform gaps and network activities and describes training and technical assistance given to

providers regarding workforce development. Stakeholder engagement is described and includes collaboration with other MCOs and committees.

During the on-site portion of the review, staff described encouraging providers to participate in cultural competency training through provider orientation, one-on-one meetings, and at the provider advisory council. HHO is partnering with other MCOs to develop employment resource and helping members prepare for job interviews.

HHO's Provider Network Development Recruitment and Retention policy outlines processes for developing and monitoring the network, provider recruitment activities, provider retention activities, and how urgent network changes are addressed. The Workforce Development Plan describes different workforce data collection methodologies and related analysis results. The plan outlines methodology and data sources used to inform gaps and network activities and describes training and technical assistance given to providers regarding workforce development. Stakeholder engagement is described and includes collaboration with other MCOs and committees.

During the comprehensive compliance review in 2025, Mercer reviewed documentation and discussed Availability of Services further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. However, HHO will need to revise its PNDMP to ensure all contractual requirements are included and develop P&Ps that illustrate how HHO provides access to home visiting services, Nurse Family Partnership and Health Family America, for eligible members. HHO must clarify or remove contract language that requires providers who continue to meet credentialing requirements to continue treating patients for 120 days after termination.

Provider Selection and the Credentialing File Review Process

Credentialing support is provided by Highmark Shared Services and is conducted in accordance with NCQA standards and modified as necessary for Delaware-specific requirements. Highmark Shared Services is responsible for coordinating the national credentials committee, while the HHO CMO is responsible for chairing the PRC. Findings and recommendations from the PRC are communicated to the national credentialing committee. HHO maintains written P&Ps outlining its provider selection activities, which comport with federal and, at times, State-specific requirements. HHO's internal guidance documents for provider selection include non-discrimination language and providers are also required to practice non-discrimination in their approach to patient selection and treatment planning. Recredentialing follows a three-year cycle except for HCBS provider types, which are recredentialed annually. Peer review activities are operated at the local level by the CMO or designee and follow all confidentiality protections, including a code of conduct for non-employee committee participants.

HHO currently delegates credentialing and recredentialing of practitioners, in the local market, to AmWell, CCHS, Davis Vision, Matrix Medical Network, Nemours Children's Health and UCD. Delegation oversight of these credentialing entities includes review of standards and review of recredentialing files.

The credentialing file review was performed using the File Review Protocol methodology outlined in Section 3. File review encompassed initial and recredentialing activities for organizational providers and independent providers. A sample of 30 credentialing files from non-HCBS independent providers, 30 credentialing files from HCBS independent providers, and 30 credentialing files from non-HCBS organizational providers were selected. The files were assessed for compliance with Final Rule regulations, State contract requirements, and HHO internal policy standards. The following elements were included in the review:

- Credentialing entity
- Verification of medical licensure, board certification, Drug Enforcement Administration licensure (if applicable), and malpractice insurance coverage
- Documentation of National Practitioner Data Bank and/or Office of Inspector General queries including but limited to:
 - List of Excluded Individuals and Entities, National Plan and Provider Enumeration System, System for Award Management, Excluded Parties List System, and Social Security Administration Death Master File
- Assessment of provider setting
- Signed and dated provider application and attestation
- Date of previous credentialing when recredentialing, if applicable
- Logs of attempts to reach providers for credentialing, if applicable
- Documentation of internal quality review, if applicable (excludes peer review documentation)
- Documentation of decision and decision date

Non-HCBS Provider Credentialing File Review Results

Overall, the majority of the non-HCBS providers reviewed demonstrated compliance with DMMA's required 45-day TAT for all initial applications. Evidence of sanction and debarment checks, SSA DMF review, review of quality data for recredentialed providers, and provider disclosure forms were all evidenced in the file review or supported by P&Ps. Files reviewed demonstrated recredentialing activities occurred within the three-year cycle for non-HCBS practitioners. Interview sessions dedicated to the file review demonstrated consistency with DFH's submitted written response. Overall, the non-HCBS provider credentialing files reviewed were found to have achieved 90% compliance or greater in the required elements.

HCBS Provider Credentialing File Review Results

Overall, most of the HCBS providers reviewed demonstrated compliance with DMMA's required 45-day TAT for all initial applications. Evidence of sanction and debarment checks, SSA DMF review, review of quality data for recredentialed providers, and provider disclosure forms were all evidenced in the file review or supported by P&Ps. All of files reviewed evidenced that recredentialed activities did occur within the one-year cycle for HCBS practitioners. Interview sessions dedicated to the file review demonstrated consistency with HHO's submitted written response. However, all files were missing provider setting assessments which is a DMMA MSA requirement. Overall, the non-HCBS provider credentialing files reviewed were found to have scored less than 75% compliance in the required elements.

Non-HCBS Facility Credentialing File Review Results

Overall, most of the non-HCBS organizational providers reviewed demonstrated compliance with DMMA's required 45-day TAT for all initial applications. Evidence of sanction and debarment checks, SSA DMF review, collection of Clinical Laboratory Improvement Amendments waivers, and provider disclosure forms were all evidenced in the file review or supported by P&Ps. The majority of the files reviewed demonstrated compliance with recredentialed activities occurring within the three years for non-HCBS institutions. Interview sessions dedicated to the file review demonstrated consistency with ACDE's submitted written response. Overall, the non-HCBS facility credentialing files reviewed were found to have achieved 90% compliance or greater in the required elements.

Provider Terminations and the Provider Termination File Review Process

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

The provider termination file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 provider termination files were selected for review; sampling included organizational providers and individual providers representing HHO and delegated credentialing entities. The following elements were included in the review:

- Provider demographics
- All provider communication received and sent, including mailings (with postmark), electronic communication, and phone logs, including date

- Documentation of termination decision and justification, with date
- Documentation of termination of all applicable contracts, with date
- Notification to provider and members, if applicable

At Mercer's request, HHO submitted a Universe file listing all terminated providers in 2024. A total of 820 terminated providers were identified. Termination reasons were primarily voluntary, including non-response to recredentialing, providers no longer practicing, or terminations at the provider's request. HHO demonstrated a clear audit trail associated with provider terminations, which included member notification notices and reviews of provider panel information for PCP terminations.

During the comprehensive review of 2024, termination files revealed that provider licenses had expired three to six months prior to HHO becoming aware of the expiration, resulting in termination of the provider. This year's review demonstrated the success of HHO's newly implemented process for license comparison, as well as ongoing monitoring of providers for compliance with credentialing standards. Overall, the files reviewed were found to have achieved 90% compliance or greater in the required elements.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
- Organizational structure demonstrates leadership from the Corporate entity to the local Health Plan and includes relationships with sister entities, subcontractors and delegates. - Administration and staffing structure appears sufficient to successfully implement contract requirements. (3.20.1.3)	Substantially Met	Substantially Met	The MCO's organizational chart for the Provider Network that includes the names of senior and departmental management. However, the reporting structure for the Network Development Director, Full-Time Workforce Development Manager, Director overseeing Provider Billing/Payment Issues, and the Provider Services Director was not aligned with the 2024 MSA, which is the year under review.	Revise HHO's organizational chart to ensure alignment with the MSA or obtain State-approved exception documentation for any deviations from the MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
MCO has P&Ps regarding provider preventable conditions, including reporting and reimbursement. (3.18.4.9.3)	Partially Met	Substantially Met	The Provider Preventable Conditions and Hospital Acquired Conditions P&P clearly states that the Plan will not reimburse facilities or professional providers for costs related to PPC and HACs. The policy requires providers to report occurrences to the health plan within 10 days; however, it does not specify where or how to submit these reports.	Revise all relevant P&Ps to incorporate detailed instructions for providers on the procedures for reporting PPCs and HACs.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO has a Provider Network Development and Management Plan that at minimum includes: • Summary of participating providers, by type and geographic location in the State. • Demonstration of monitoring activities to ensure that access standards are met and that members have timely access to services, per the requirements of this Contract. • A summary of participating provider capacity issues by service and county, the Contractor's remediation and QM/QI activities and the targeted and actual completion dates for those activities. • Network deficiencies by service and by county and interventions to address the deficiencies. • Ongoing activities for provider network development and expansion taking into consideration identified participating provider capacity, network deficiencies, service delivery issues and future needs. (42 CFR 438.207 and 3.9.1.2.4, 3.9.3)	Minimally Met	Partially Met	The 2024 PNDMP included some, but not all contract requirements including: • A summary of participating providers, by type and geographic location in the State. • A summary of participating provider capacity issues by service and county. • The Contractor's remediation and QM/QI activities and the targeted and actual completion dates for those activities. • Network deficiencies by service and by county and interventions to address the deficiencies.	Update the PNDMP to include all specified contract requirements.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO provides access to home visiting services, Nurse Family Partnership and Health Family America, for eligible members. (3.4.6.7)	Partially Met	Not Met	HHO did not provide any documentation governing their home visiting services. During the on-site visit, HHO stated that they contracted with the Nurse Family Partnership in January 2025.	Develop P&Ps that illustrate how HHO provides access to home visiting services, Nurse Family Partnership and Health Family America, for eligible members.
The MCO monitors providers for compliance with credentialing standards and takes appropriate action against non-compliant providers. (3.9.9.14, 3.16.6.2.8)	Partially Met	Not Met	Overall, HHO's credentialing file review included all federally and contractually required items. However, during file review it was identified that all of the HCBS credentialing and recredentialing files were missing provider setting assessments as required by the MSA.	Develop P&Ps that demonstrate HHO monitors and ensures compliance with the MSA requirement of including a provider setting assessment in all HCBS credentialing and recredentialing files.

Program Integrity Requirements and Confidentiality

ACDE 2025 Findings and Recommendations

As a wholly owned subsidiary of ACFC, ACDE is committed to the policy guidance and directives outlined in the Corporate Compliance Program and Program Integrity P&Ps, as well as ACDE's enterprise-wide P&Ps. The Compliance Program is structured to encourage collaborative participation at all levels of the organization and to foster a culture of compliance. Administration of ACDE's Compliance Program includes maintaining full Compliance and Special Investigations Unit staffing and conducting daily departmental operations. ACDE has well-documented compliance activities, including an annual written Compliance Program Work Plan and ongoing management of ACDE P&Ps. The ACDE Regulatory Compliance Committee meets at least quarterly. The Compliance Officer (CO) reports on the Compliance Program to ACDE's Executive Management Team and the ACDE Board of Directors. The Regulatory Compliance Committee supports the Market CO with implementation and oversight of the Compliance Program.

ACDE maintains procedures for ongoing monitoring and auditing of ACDE systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous QI activities, and provider activities. ACDE's Program Integrity Plan outlines multiple tracking and analysis methods for monitoring fraud, waste, and abuse (FWA). ACDE's website, member handbook, and provider manual include language describing FWA, including an expanded definition of abuse that

incorporates abuse, neglect, and exploitation of children and adults. Multiple reporting channels are available, including telephone and links to the Office of Inspector General, all of which allow anonymous reporting. Internally, ACDE staff can report suspected issues via an email box or tip line, or by raising concerns with a manager. Non-retaliation policies for good faith reporting are in place.

All ACDE staff and contractors receive training during onboarding to ensure they understand the Compliance Program and other relevant compliance topics, including State and federal laws, regulations, P&Ps, and guidance. Computer-based learning is provided to all associates and includes education and guidance on ethics and legal compliance policies, the Code of Conduct and Ethics, FWA issues, and procedures for reporting and investigating compliance concerns. This training includes information on available reporting mechanisms that associates and contractors may use to report issues related to non-compliance, privacy, or FWA. In addition, the ACFC Corporate Compliance Department and the ACDE Compliance Department jointly host an Annual Compliance and Ethics Week, focusing on activities that express and reinforce the organization's commitment to "Doing the Right Thing in the Right Way."

ACDE has appropriate processes in place to protect member medical records and other health and enrollment information. Corporate policies clearly define Protected Health Information (PHI) and personally identifying information and provide members with a formal process to access health records for review and amendment, including in situations when the requested information would not typically be shared. These processes appear to comply with federal regulatory requirements. ACDE uses the State-required file format to report breaches of confidentiality to the State and has adopted a Delaware-specific reporting policy that reflects required State timeframes.

Mercer reviewed documentation and discussed Program Integrity further with MCO staff during the on-site session. The MCO staff demonstrated an understanding of the regulatory and contractual provisions. During the comprehensive compliance review in 2024, the EQRO identified one item that required a CAP. It was identified that the MCO did not have a process to notify the State of changes in member or provider eligibility. In response, ACDE developed a process and P&Ps for notification when a member's or participating provider's circumstances change. These align with contractual requirements and now demonstrate compliance.

During the CAP review in 2025, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

DFH 2025 Findings and Recommendations

DFH has Compliance and PI programs that include an annual written Compliance Program and work plan; an FWA plan; a defined audit approach encompassing pre-payment, post-payment, service verification, and other data-mining activities; a corporate Code of Conduct; and required annual compliance and PI training. DFH's website, member handbook, and provider manual all include language describing FWA, including an expanded definition of abuse that incorporates abuse, neglect, and exploitation of children and adults. Multiple reporting channels are available, including telephone numbers and links to the DHSS and DFH abuse hotlines.

Internally, FWA can be reported anonymously and confidentially by anyone through several channels, including the referral mailbox, the SIU Fraud Hotline, and direct contact with the DFH VP of Compliance.

The Compliance Program is managed by the DFH CO. The CO, with support and direction from the Corporate Compliance Department, works closely with compliance representatives throughout the organization. The Compliance Program is monitored on an ongoing basis, and an assessment of the Compliance Program is completed annually. The Compliance Program and annual work plans are designed to adapt to new regulatory and legal developments and to implement changes identified through audits or investigations. DFH has a dedicated CO who chairs the local Compliance and Privacy Committee, which meets at least quarterly, with ad hoc meetings and votes as needed. DFH provides mandatory compliance training, including FWA training, to all associates (including claims personnel, agents/underwriters, auditors, and consumer services personnel), officers, and directors.

DFH has appropriate processes in place to protect member medical records and other health and enrollment information. Corporate policies clearly define PHI and personally identifying information and provide members with a formalized process to access health records for review and revision, including situations in which such information would not typically be shared. These processes appear to comply with federal regulatory requirements. DFH uses the State-required file format to report breaches of confidentiality to the State and has adopted a Delaware-specific reporting policy that reflects required State timeframes. DFH provided evidence of a combined FWA and Compliance Plan, with Delaware-specific timelines included in an addendum, meeting MSA requirements. DFH confirmed that there have been no changes to the process for notifying the PI Unit and the Medicaid Fraud Control Unit of all suspected FWA cases within two days of discovery.

During the CAP review in 2025, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

HHO 2025 Findings and Recommendations

HHO has well-documented Compliance and Program Integrity programs, including an annual written Compliance Program and work plan, a defined audit approach, and data-mining activities, as well as a corporate Code of Conduct and required annual training on compliance, confidentiality and privacy, and program integrity. HHO's website (Fraud, Waste, and Abuse [highmarkhealthoptions.com]), member handbook, and provider manual all include language on what constitutes FWA, including an expanded definition of abuse that incorporates abuse, neglect, and exploitation of children and adults. Multiple reporting channels are available, including telephone and links to the Office of Inspector General; all allow anonymous reporting. Internally, HHO staff can report suspected cases via an email inbox, tip line, or by raising concerns to a manager, and non-retaliation policies for good-faith reporting are in place.

HHO has a dedicated CO with a direct reporting relationship to the Board of Directors and a matrixed reporting relationship with the HHO market CEO. All HHO staff and contractors are assigned Compliance and Security training upon hire and annually thereafter.

Completion of required training is tracked and monitored. When necessary, non-compliant staff and contractors are escalated to managers and supervisors to ensure training is completed or the associate or contractor is terminated. In addition to the guidance provided in the member handbook, HHO includes a Notice of Privacy Practices on its website (Privacy [highmarkhealthoptions.com]).

HHO has appropriate processes in place to protect member medical records and other health and enrollment information. Corporate policies clearly define PHI and Personally Identifiable Information and provide members with a formal process to access, review, and request corrections to their health records, including instances in which such information would not be shared; these processes appear compliant with federal regulatory requirements. HHO uses the State-required file format to report breaches of confidentiality and has adopted a Delaware-specific reporting policy that reflects State-required reporting timeframes.

Program integrity activities occur within the local HHO MCO and are linked to the HHO CO. Staff work closely with local HHO leadership and the State to identify and share information related to potential FWA. Training on what constitutes FWA is provided upon hire and annually thereafter and tracking of completion follows a process similar to that used for Privacy and Confidentiality training.

Mercer reviewed documentation and discussed Program Integrity further with MCO staff during the on-site session. The MCO staff demonstrated an understanding of the regulatory and contractual provisions. During the comprehensive compliance review in 2024, it was identified that the MCO's Provider Participation Agreement policy did not include a step to confirm providers are enrolled with DMAP per the MSA. In response, HHO updated the policy to include a provision that the provider must be screened to ensure enrollment with DMAP prior to executing a provider participation agreement. This policy now aligns with contractual requirements and demonstrates compliance.

During the CAP review in 2025, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

Prohibited Affiliations with Individuals Debarred by Federal Agencies

ACDE 2025 Findings and Recommendations

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed Prohibited Affiliations with Individuals Debarred by Federal Agencies further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. All required documentation was present, MCO staff provided responses consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

DFH 2025 Findings and Recommendations

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed Prohibited Affiliations with Individuals Debarred by Federal Agencies further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. All required documentation was present, MCO staff provided responses consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

HHO 2025 Findings and Recommendations

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed Prohibited Affiliations with Individuals Debarred by Federal Agencies further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. All required documentation was present, MCO staff provided responses consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

Grievance and Appeal Systems

ACDE 2025 Findings and Recommendations

The grievance system follows standard processes. Grievances may be submitted by members, authorized representatives, or providers, either verbally through Member Services or an ACDE staff member (e.g., case manager, member advocate), or in writing (e.g., by completing a form and submitting it by mail). When a grievance is received, the Grievance Team Lead reviews completed Service Forms in the EXP/MACCESS system by generating an Employee Production Report. Service Forms are also copied onto the Employee Production Audit Form to track the timeliness of all steps within the grievance process. EXP/MACCESS serves as the repository for all member grievances received. If a Service Form is found to be incomplete or not properly handled or documented, the Team Lead notifies the Grievance Associate and the Grievance Supervisor via email to provide feedback and coaching.

There are currently 10 full-time employees (FTEs) dedicated to grievance management for the Delaware line of business. Grievance staff are responsible for facilitating grievance investigations, issuing written acknowledgment letters to members, and coordinating investigations with other impacted business units. Any information sent to other ACDE units (e.g., pharmacy) for investigation is returned to the grievance team along with the investigatory findings. Quality of Care (QOC) issues and other clinical concerns are referred to the QM Program, where a Clinical Quality Performance Specialist (QPS) conducts further investigation and determines the resolution. The Clinical QPS sends an outcome letter to the provider within one week of the determination and sends the QOC Grievance Member Resolution letter to the member within two business days of the resolution. The Clinical QPS uploads the QOC

Grievance Member Resolution letter, along with documentation that the letter was sent, into EXP/MACESS within two business days of the grievance resolution.

Similar to grievances, standard appeals may be submitted verbally through Member Services or in writing (e.g., by completing an appeals form available on the ACDE website or on the last page of the member's NOABD letter and submitting it via U.S. mail, fax, or email). Appeals are processed by the local ACDE office using the Jiva™ medical management documentation system. Appeals filed by a provider or member representative on behalf of a member require written member consent within 10 days of the initial filing. The appeal start date is the date the member files the appeal (verbally or in writing), or the date written member consent is received if the appeal was filed on the member's behalf. If written consent is not received, the appeal is dismissed. Once the member appeal is entered into Jiva™, the Appeals Nurse is notified to review the request, prepare a case summary, and facilitate an appeals meeting. There are currently four FTEs dedicated to appeal management for the Delaware line of business.

During the on-site review, Mercer examined documentation and held discussions with MCO staff regarding the grievance and appeal system. In reviewing grievance and appeal files, Mercer identified an opportunity for improvement: ACDE could enhance its standard operating procedures to more explicitly define communication workflows between departments. For example, in one case file, it was unclear how communication flowed between the corporate entity, the CC team, and the Bright Start program. It appeared that some departments and programs did not respond promptly, contributing to a delay in member resolution. While ACDE has clearly defined P&Ps in place, Mercer recommends that ACDE further enhance these policies to include a clear workflow for communication among all relevant departments and programs.

ACDE uses a robust training program that covers fundamental G&A concepts for internal staff; however, it is unclear whether a process exists to train subcontractors on these concepts. Additionally, there does not appear to be a method for evaluating the effectiveness and outcomes of G&A training for subcontractors. This presents an opportunity for ACDE to strengthen training for all staff and subcontractors who may interact with members, ensuring that everyone is aware of federal regulatory requirements and familiar with the G&A process.

Grievance File Review

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

- Documentation of member correspondence and grievance details.
- Accuracy of classification and named provider.

- Grievance investigation and resolution.
- Timely acknowledgement.
- Timely resolution.
- Timely notification of resolution.
- File completeness.

The assessment of grievance files included a review of the member's original grievance, internal notes and documentation, letters produced by ACDE, and other materials supporting the investigation. Overall, the EQRO continues to observe an increase in the number of member grievances captured and investigated by the MCO. All grievance files reviewed were found to be in 100% compliance with the required elements.

Appeal File Review

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

- Documentation of NOABD, member appeal, member consent, and supplemental information submitted by member or member's provider.
- Timely filing based on the NOABD date.
- Timely acknowledgement.
- Timely resolution.
- Timely notification of resolution.
- File completeness.

The assessment of the appeals files consisted of a review of NOABD letters, internal notes and documents, letters produced by ACDE, and other documents supporting the appeal investigation. Overall, the files reviewed were found to have greater than 90% compliance in the required elements. The files were well-organized and included all federally and contractually required items and

met all contractually required timelines. Out of the 10 files reviewed, five were overturned (50%), one was partially overturned (10%), two were upheld (20%), and two were withdrawn (20%).

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO and its subcontractors have a training program that covers fundamental grievance and appeal concepts, DMMA-specific contract standards, and federal regulatory requirements as well as a process for identifying and addressing ad hoc training needs based on audit or other self-evaluation activities. Training materials and roster of staff, who have completed the trainings, clearly demonstrate MCO's fundamental grievance and appeal training program. (3.20.3)	Substantially Met	Partially Met	It is unclear if ACDE has a process to train all subcontractors on fundamental grievance and appeal concepts. ACDE does not demonstrate how their annual training will be tracked on a yearly basis.	Implement a training program for all subcontractors on fundamental grievance and appeal concepts, DMMA-specific contract standards, federal regulatory requirements, as well as ACDE's grievance and appeal process, even if they do not perform the grievance and appeal process.
The MCO has a process to evaluate the effectiveness and outcomes of the training provided to its subcontractors responsible for adjudication of G&As; this may include results of delegation oversight audits and/or agendas, minutes or reports presented at a joint operating/delegation oversight committee. (3.20.3.7)	Not Met	Partially Met	It is unclear if ACDE has a process to evaluate all subcontractors on fundamental grievance and appeal concepts. ACDE does not demonstrate how their annual training will be tracked/evaluated on a yearly basis.	Implement a process to evaluate the effectiveness and outcomes of training provided to all subcontractors/delegates.

DFH 2025 Findings and Recommendations

Grievances may be submitted by members, an authorized representative, or a provider who has obtained the member's written consent, either orally through the Member Services Department, in writing, via fax, or through the DFH website. The Member Services Department serves as the primary intake point for grievances received by phone, mail, or in person, and documents the grievance before routing it to a Grievance Coordinator. For grievances received via fax, the Grievance Coordinator retrieves the request from the fax server and scans it into the system on the same day. All grievances are logged into the Tracking PRIME database. The Grievance Coordinator provides acknowledgment to the member and begins the investigation process. The Grievance

Coordinator determines the grievance type, assesses whether the issue is a Quality of Services or QOC concern, and routes it to the appropriate department, if necessary. If the issue is related to QOC, it is referred to the QOC Nurse, who investigates and tracks the case using WellSky, TruCare, and an internal tracking template. Once the resolution is complete, the Grievance Coordinator reviews it for accuracy and notifies the member of the outcome. There are five FTEs dedicated to the Delaware line of business for G&A management.

Similar to grievances, standard appeals are accepted orally through the Member Services Department, in writing, via fax, through the member portal, or in person. All oral inquiries seeking to appeal an adverse benefit determination are treated as appeals to establish the earliest possible filing date. A Clinical Appeals Coordinator is notified of the appeal, obtains the appeal information from the member relations documentation system, and records the details of the request within the clinical documentation system. Appeals filed by a provider or member representative on behalf of a member require written member consent; however, DFH does not have a policy or procedure in place to ensure that member consent is obtained. Additionally, DFH states that it does not delegate G&A activities; however, DFH's BH, pharmacy, and dental appeals are adjudicated by Shared Services. DFH did not provide evidence of a process or tool to evaluate the compliance of delegates responsible for adjudicating appeals. The evaluation process should clearly demonstrate an assessment of the delegate's appeals system for compliance with federal and MSA requirements. Mercer recommends strengthening collaboration between Shared Services and DFH to better support the adjudication processes.

DFH uses a training program that covers fundamental G&A concepts for internal staff. However, DFH did not provide information on practices used to train subcontractors; as a result, there is no way to evaluate the effectiveness and outcomes of G&A training for subcontractors. This presents an opportunity for the MCO to enhance training for any staff and subcontractors who may interact with members, as all should be aware of federal regulatory requirements and be familiar with the G&A process. During the on-site review, Mercer examined documentation and held discussions with MCO staff regarding the grievance and appeal system. While DFH has G&A P&Ps in place, some of the language in current P&Ps does not align with MSA requirements. Additionally, member- and provider-facing materials, such as the provider manual and member website, contain inconsistent language related to the appeals process. Mercer recommends that DFH enhance all G&A standard operating P&Ps to clearly align with the MSA and ensure there is a formal process for updating materials — including the provider manual, member handbook, and website — to maintain consistent language and terminology when describing the appeals process.

DFH states that, on a monthly basis, the Performance Improvement Team reviews G&As per thousand members with the goal of maintaining specific thresholds (less than one grievance per thousand members and less than three appeals per thousand members). DFH uses this approach to track, trend, and review G&As for the purposes of QAPIP. Data is stratified by category, and the QI/UM Committee reviews these data on a quarterly basis to identify results that exceed thresholds and to conduct root cause analyses and develop mitigation plans. While DFH has a strong process in place to review grievance and appeal records, a formal policy is not in place to describe this process, however, is it clear how all grievance and appeal data are incorporated (e.g. BH appeals, Modivcare grievances, etc.). Mercer recommends that DFH establish policy and a comprehensive process and system to capture and include all grievance and appeal information in this review.

Grievance File Review

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

- Documentation of member correspondence and grievance details.
- Accuracy of classification and named provider.
- Grievance investigation and resolution.
- Timely acknowledgement.
- Timely resolution.
- Timely notification of resolution.
- File completeness.
- CC/continuity of care.

The assessment of grievance files included a review of the member's original grievance, internal notes and documentation, letters produced by DFH, and other materials supporting the investigation. Overall, the files contained all federally and contractually required items; however, the review identified that grievance acknowledgment letters included incorrect timelines, some files were missing documentation of member consent, and one file was submitted without a cover sheet. The files reviewed were found to have scored less than 75% compliance with the required elements.

Appeal File Review

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

- Documentation of NOABD, member appeal, member consent, and supplemental information submitted by member or member's provider.
- Timely filing based on the NOABD date.
- Timely acknowledgement.
- Timely resolution.
- Timely notification of resolution.
- File completeness.

The assessment of the appeals files included a review of NOABD letters, internal notes and documentation, letters produced by DFH, and other materials supporting the appeal investigation. Overall, the files reviewed were found to have scored between 75% and 89% compliance with the required elements. Three files submitted included duplicative documents, one file did not include an acknowledgment letter, and one file did not address all issues within the appeal. Of the 11 files reviewed, five were upheld (45%) and six were overturned (55%).

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO P&Ps specific to the GA system clearly outline the system in place for members that includes a grievance process, an appeal process, and access to the State's Fair Hearing system. (42 CFR 438.402 and 3.15.1.1)	New Finding for 2025	Partially Met	The current DFH P&Ps contain language that does not align with the MSA requirements regarding State Fair Hearings and the reading level for resolution letters: - The Member Appeals System Description (CC.AP.03) states that "the member has no less than 90 calendar days and no more than 120 calendar days" to request a State Fair Hearing; however, the MSA specifies that "members may request a State Fair Hearing within 90 calendar days from the date on the Contractor's notice of resolution upholding the Adverse Benefit Determination" (3.15.8.1). - Policy GA_18_Member Grievance_SOP states that the "reading level can be not higher than 6.5," whereas the MSA requires materials to be "at or below a sixth grade reading level" (3.14.2.2).	Revise P&Ps to ensure they include accurate language regarding State Fair Hearings and specify the correct reading level requirements for resolution letters in accordance with the MSA.
P&Ps clearly identify that a member can file a grievance, appeal, or request a State Fair Hearing either orally or in writing. Policies clearly identify that the member's provider, acting on behalf of the member, may file an appeal either orally or in writing. (42 CFR 438.402(c)(3) and 3.15.1.7)	New Finding for 2025	Minimally Met	DFH does not have a policy or procedure to ensure that member consent is obtained when a provider requests a grievance or appeal on behalf of the member.	Develop P&Ps that clearly specify that a member's provider, acting on behalf of the member, may file an appeal or grievance only with the member's written consent.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO has a process to evaluate the effectiveness and outcomes of the training provided to its subcontractors responsible for adjudication of G&As; this may include results of delegation oversight audits and/or agendas, minutes or reports presented at a joint operating/delegation oversight committee. (3.20.3.7)	Not Met	Partially Met	DFH does not have a process in place to evaluate the effectiveness and outcomes of training provided to subcontractors.	Develop a process and tools to evaluate the effectiveness and outcomes of training on fundamental G&A concepts for subcontractors.
The MCO has a process to evaluate the compliance of its delegates responsible for adjudication of a grievance and appeals. Delegation oversight tools and file review clearly demonstrate evaluation of the delegates grievances system for compliance with federal requirements including grievance system structure, accurate definitions, rural exceptions, Adverse Benefit Determination language, resolution timeframes, expedited appeal processes, how information is shared with provider, continuation of benefits and effectuation of reversed appeals. (42 CFR 438.400 and 3.22.2.2)	Not Met	Minimally Met	DFH's BH, Pharmacy, and Dental appeals are adjudicated by shared services. However, DFH did not provide evidence of a process or tool to evaluate the compliance of delegates responsible for adjudicating appeals. The evaluation process should clearly demonstrate an assessment of the delegate's appeals system for compliance with federal and MSA requirements.	Develop a process and tools to evaluate the compliance of delegates responsible for the adjudication of appeals.
Member handbook, MCO website, Provider Manual and any additional new member/provider orientation materials have consistent language on process for filing a grievance: - Member may file a grievance at any time. - Member may file a grievance either orally or in writing. (42 CFR 438.402(c)(2-3) and 3.14.6.2.1.18)	Substantially Met	Substantially Met	DFH's website does not use consistent language with the provider manual and member handbook regarding the grievance filing process. The language on the website is unclear about the process and associated timeframes.	1. Update the website to ensure consistent language and terminology are used to describe the grievance filing process. 2. Develop a process for updating materials, including the provider manual, member handbook, and website, to maintain consistent language and terminology across all documents.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO has a well-documented process and system to capture all grievance information; including PBM and subcontractors, investigation, actions, decisions, timeframes and/or education to providers regarding the grievance and reviews the information as part of the State's Quality Strategy. - Quality Committee meetings evidence grievance reporting. - Process to identify trends and take action is in place, including when there are very high or very low grievance numbers. - There is a process to performance barrier analysis and continuous QI based on findings. (42 CFR 438.416 and 3.15.7)	Substantially Met	Minimally Met	DFH's supporting documentation does not demonstrate the existence of a formal policy for capturing all BH grievance and appeal information, however, does it provide evidence of an established process and system for recording all grievance and appeal data.	Establish a comprehensive process and system to capture all grievance and appeal information, including details from subcontractors, investigation findings, actions taken, decisions made, applicable timeframes, provider education related to G&As, and the review of this information as part of the State's QS.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
Member handbook, MCO website, Provider Manual and any additional new member/provider orientation materials have consistent language on process for filing an appeal: - Following receipt of a notification of an Adverse Benefit Determination by an MCO, prepaid inpatient health plans (PIHP), or PAHP, and member has 60 calendar days from the date on the notice in which to file a request for an appeal. - Member may request an appeal either orally or in writing. (42 CFR 438.402(c)(2-3) and 3.15.1.6, 3.15.1.8)	Substantially Met	Partially Met	DFH's provider manual and website currently contain inaccurate and inconsistent information regarding the appeals process. - Provider manual: - On page 90 the manual states "A final determination of the review will be communicated within 45 days of receipt of the appeal"; this timeframe does not align with contractual requirements. - On Page 91 there is a section titled "Second Level Medical Necessity Appeals (Post-Service Appeal)"; however, providers should not have appeals right for medical necessity determinations — only members, or providers appealing on behalf of a member, may do so. Additionally, there is no provision for a second level of appeal for medical necessity. Per MSA 3.15.1.2 and CFR § 438.402. only one level of appeal is permitted for members.	- Revise the provider manual to ensure all language regarding the appeals process is fully compliant with contractual requirements. - Establish a formal process for updating materials, including the provider manual, member handbook, and website, to maintain consistent language and terminology when describing the appeals process. - Update the DFH website to clearly communicate the specific timeframes for filing an appeal.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
			The website states "If a service is denied, you have the right to appeal that decision. You will be sent a letter explaining how to make an appeal. All appeal requests are decided according to your request, condition and benefits." This language does not provide members with the required, specific information about appeal timeframes.	

HHO 2025 Findings and Recommendations

The grievance system follows standard processes. There are currently 13 FTEs dedicated to grievance and appeal management for the Delaware line of business. Grievances may be submitted by members, a member's representative, or a provider acting on the member's behalf, either orally through Member Services, in writing, via fax, or through the web portal (e.g., by completing a form on the HHO website). When a grievance is received, an Intake Coordinator assigns the case to a Grievance Analyst to initiate and facilitate the investigation and forwards the grievance to a G&A nurse to perform a clinical review and determine whether a QOC concern is present. The Grievance Analyst also provides an acknowledgment to the member and begins the data collection process by categorizing the grievance by type and involving any other departments that may need to participate in the investigation and resolution (e.g., Provider Relations, Quality department, CC, vendors/delegates). All grievances are documented in GuidingCare, which serves as the repository for all grievance information.

HHO continues to address grievances involving members receiving bills for covered services through telephonic resolution. If the member is satisfied with the outcome during the initial call, the grievance is documented as telephonically resolved and included in tracking and trending reports to identify providers that continue to balance bill members. When a pattern of balance billing is identified, a provider may be referred to FWA. The practice of telephonically resolving grievances remains effective in providing members with a more immediate and satisfactory resolution.

Similar to grievances, standard appeals are accepted orally, in writing, via fax, or through the HHO web portal. Appeal data is stored in the GuidingCare platform. Appeals Analysts begin the data collection process by categorizing appeals by type, which allows the

G&A department to identify trends and related root causes. Appeals Analysts are responsible for all member correspondence, including providing acknowledgment within five business days of receipt of the appeal. The appeal start date is the date the member files the appeal (verbally or in writing), or the date written member consent is received if the appeal was filed on the member's behalf. The G&A department continues to identify and collaborate with Marketing, Provider Relations, Medical Management, and UM to develop educational tools and process improvements. These improvements have helped eliminate unnecessary appeals and enhance both member and provider's experience.

Grievance File Review

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

- Documentation of member correspondence and grievance details.
- Accuracy of classification and named provider.
- Grievance investigation and resolution.
- Timely acknowledgement.
- Timely resolution.
- Timely notification of resolution.
- File completeness.

The assessment of grievance files included a review of the member's original grievance, internal notes and documentation, letters produced by HHO, and other materials supporting the investigation. One file reviewed did not meet the timeliness standard for written resolution. Overall, the files were well organized, easy to understand, and demonstrated 90% compliance with the required elements.

Appeal File Review

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

Rule regulations, State contract requirements, and HHO internal policy standards. The following elements were included in the review:

- Documentation of NOABD, member appeal, member consent, and supplemental information submitted by member or member's provider.
- Timely filing based on the NOABD date.
- Timely acknowledgement.
- Timely resolution.
- Timely notification of resolution.
- File completeness.

The assessment of the appeals files consisted of a review of NOABD letters, internal notes and documents, letters produced by HHO, and other documents supporting the appeal investigation. Overall, the files reviewed were found to have 100% compliance in the required elements. All of the files reviewed met timeliness requirements for appeal resolution, were well organized, included all federally and contractually required items, met all timeliness standards, included member-friendly language in all communications, and contained excellent documentation of cases, provider outreach, and rationale. Out of 10 reviewed files, six were overturned (60%), one was partially overturned (10%), two were upheld (20%), and one was dismissed (10%).

During the CAP review in 2025, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

Subcontractual Relations and Delegation

ACDE 2025 Findings and Recommendations

Oversight of delegated UM activity is coordinated by the ACFC Delegation Oversight Department. Delegated UM activities include: Avēsis Vision — Administration of vision benefits, Evolent (NIA) — Radiology Benefit Manager, PerformRx — PBM, Skygen — Dental Benefit (terminated end of July 2024), and DentaQuest — Dental Benefit (beginning August 2024). The Delegation Oversight Department conducts audits of these entities, including follow-up activities as appropriate, and provides Delaware-specific training on an ongoing basis.

Corporate ensures that all delegates undergo a pre-delegation audit, as well as a file review for new delegates within their first 90 days. The MCO also requires routine reporting and an annual delegation audit within required timeframes. Annually, Corporate Clinical and Delegate Auditing conducts an assessment to ensure delegates remain able to perform delegated functions. This assessment may be conducted as a desktop review, on-site, or both, and evaluates the delegate's quality program, including QI goals and performance improvement activities related to the delegated functions. The annual assessment also includes an evaluation of the delegate's ability to meet all applicable standards, including NCQA standards, federal, State, or other agency standards, and any more stringent ACDE-specific standards. During the annual assessment, revised P&Ps are reviewed to ensure they are being followed, and file reviews are conducted as appropriate. If a delegate does not pass the annual assessment, Clinical and Delegate Auditing may recommend that ACDE consider terminating some or all of the Delegation Agreement. If ACDE chooses to continue the delegation, Corporate Clinical and Delegate Auditing issues and manages a CAP.

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

Entity	Responsibilities
PerformRx	Claims Adjudication, PNM, Provider Services, Credentialing, Provider Contact Center, Member Contact Center, UM
Avēsis Vision Vendor	Claims Adjudication, PNM, Provider Services, Credentialing, Provider Contact Center, UM
Skygen (terminated July 2024)	Claims Adjudication, PNM, Provider Services, Credentialing, Provider Contact Center, UM
DentaQuest (started August 2024)	Claims Adjudication, PNM, Provider Services, Credentialing, Provider Contact Center, UM
Evolent Health	Radiology UM
Infomedia Group, Inc. dba Carenet Healthcare Services	Member Triage/Advice Line
ChristianaCare Health Services	Credentialing, Recredentialing, Primary Source Verification, Credentialing Committee
Delaware Chiropractic Services Network	Credentialing, Recredentialing, Primary Source Verification, Credentialing Committee
Nemours Children's Health	Credentialing, Recredentialing, Primary Source Verification, Credentialing Committee
TidalHealth Peninsula Regional Inc.	Credentialing, Recredentialing, Primary Source Verification, Credentialing Committee

Entity	Responsibilities
MDLive Provider Services, LLC	Credentialing, Recredentialing, Primary Source Verification, Credentialing Committee
Capital Vision Services, LLC	Credentialing, Recredentialing, Primary Source Verification, Credentialing Committee

During the CAP review in 2025, Mercer reviewed documentation and discussed subcontractual relationships and delegation with MCO staff. MCO staff demonstrated an understanding of regulatory and contractual provisions. All required documentation was present, staff responses were consistent with one another and with the documentation, and a State-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual requirements.

DFH 2025 Findings and Recommendations

The DFH vendor oversight program is a multi-pronged, collaborative, risk-based model. Contracts are structured to include performance expectations, risk allocation, and regulatory requirements. The Vendor Management Team ensures that all delegated entities comply with contractual obligations, Medicaid laws and regulations, and sub-regulatory guidance. As part of this oversight, DFH implements ongoing monitoring of vendors, including regularly scheduled Joint Operations Committee meetings, monthly reporting, necessary policy updates, review of metrics, capacity and forecasting planning, and day-to-day issue resolution. When deficiencies are identified, CAPs are issued to delegates. The compliance teams further assess subcontractor compliance with managed care obligations through audits, ongoing monitoring activities, remediation efforts, and reporting on CAPs. Annual audits include policy review, file review, and review of compliance plans, core business standards, and financial solvency. These annual audits are performed using Delaware-specific files, and results can be reported on a Delaware-specific basis.

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

Entity	Responsibilities
Modivcare-NEMT	Value-Add Transportation: Non-Emergency Transportation providing customer service, claims/payment, credentialing, network management, complaints, and grievances
MRIOA	UM
Evolent-NIA	UM and provider customer service
Centene Dental Services (formerly known as Envolve Dental)	Dental Benefit Manager providing account management, credentialing, customer service, network management, provider services, provider relations, and UM

Entity	Responsibilities
Centene Vision Services (formerly known as Envolv Vision)	Vision Benefit Manager providing account management, credentialing, customer service, network management, provider services, and provider relations
Express Scripts (ESI)	PBM providing claim adjudication, pharmacy network, and drug rebate information
Skygen USA	Dental claims adjudication platform: Dental
Voiance	Over the phone interpretation
Language Services Associates	Over the phone and in-person interpretation
Centene Management Company	Health plan administrative services providing management information systems, financial systems and services, claims administration, provider and enrollee services, UM, quality assurance, and billing and collections
Corporate Pharmacy Shared Services	Administrative pharmacy services providing benefit design, formulary development and management, UM, compliance oversight and FWA, coordination of benefits, and medication therapy management
Tidal Health Nanticoke	Credentialing
Tidal Health	Credentialing
Delaware Chiropractic Network	Credentialing
Christiana Care	Credentialing

During the CAP review in 2025, Mercer reviewed documentation and discussed subcontractual relationships and delegation with MCO staff. The MCO staff demonstrated a clear understanding of regulatory and contractual provisions. All required documentation was present, and staff responses were consistent with one another and aligned with the documentation. Additionally, a State-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory and contractual requirements.

However, the greatest opportunity for improvement within delegation oversight lies in DFH's oversight of its parent company, Centene, particularly in areas designated as Centene Management Company Support. Delegation oversight is a critical component of MCO operations and requires robust, consistent, and ongoing monitoring to ensure that DMMA and MCO contract requirements are properly operationalized by the delegate. Documentation related to DFH's oversight of Centene needs to be developed and implemented to establish strong monitoring and oversight of the services delegated to Centene.

HHO 2025 Findings and Recommendations

HHO uses a three-pronged structure for subcontractor oversight: the VMO, the FBOs, and the ER&G team. Delegate oversight occurs in a matrixed fashion involving the VMO, Compliance, Quality, and FBOs (e.g., UM, credentialing). The VMO acts as the primary liaison with the delegate from an oversight perspective, maintains vendor scorecards, and works with the Compliance unit to ensure the VMO framework aligns with contractual requirements. FBOs are identified within each business unit and aligned with the delegate's scope of services. FBOs are responsible for day-to-day operations and overall delegate relationship management, including operational oversight, training, and audits. The ER&G team reviews P&Ps to ensure federal exclusions are monitored, escalated, and documented appropriately. Results of delegate oversight activities are shared through the Quality committee structure (QI/UM Committee). All delegated activities follow NCQA standards and are governed by a signed agreement documenting the delegated responsibilities and other pertinent contract elements, including any flow-downs from the MSA HHO has signed with DMMA.

The process begins with capturing all relevant regulations from governing bodies (e.g., Delaware, specifically DMMA, CMS, Blue Cross Blue Shield Association, and NCQA). During initial sourcing and contracting, HHO ensures that vendors can meet all regulatory requirements and that the MSA includes all required contract terms and SLAs. HHO's Vendor Management Policy governs vendors providing goods and services to Highmark Medicaid (including HHO) in compliance with applicable CMS federal, DMMA state, and NCQA organizational requirements. HHO ensures that its subcontractors, downstream entities, and high-risk vendors comply with all regulatory requirements. Responsibility for the quality and completion of all work performed by vendors rests with HHO, which monitors vendor performance on a monthly and annual basis. The oversight approach focuses on vendor onboarding and education, vendor monitoring, vendor contract maintenance, and onboarding assessments. Delegation oversight audit tools have been developed to capture both NCQA and Delaware-specific requirements and include scorecards, comprehensive oversight templates, and vendor attestation questionnaires. Audit results are reported at both the NCQA and Delaware-specific requirement levels, and CAPs are requested when results fall below established thresholds. CAP oversight is shared between the FBO and VMO. HHO retains final decision-making authority over matters affecting delegated relationships.

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

Entity	Responsibilities
American Well (Amwell)	Telemedicine Provider
CVS/Caremark	PBM, Claims/Encounters, Provider Call Center, Provider Network, Provider Licensing, Provider Contracting, Enrollment
Davis Vision (Versant Health)	Vision Benefit Services

Entity	Responsibilities
eviCore	Utilization Review Services for Multiple Medical Services (Radiology, Cardiology, Musculoskeletal)
Health Dialog	24/7 Nurse Line for Members
Icario	HRA Solution, Multi-Channel HRA Solution
UCD	Adult Dental Benefit Services
CCHS	Provider Credentialing
Matrix Medical Network (Community Care Health Network, LLC)	Provider Credentialing
Nemours Children's Health	Provider Credentialing
UCD	Adult Dental Benefit Services

During the CAP review in 2025, Mercer reviewed documentation and discussed subcontractual relationships and delegation with MCO staff. MCO staff demonstrated an understanding of regulatory and contractual provisions. All required documentation was present, staff responses were consistent with one another and with the documentation, and a State-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual requirements.

Clinical Practice Guidelines and Coverage, and Authorization of Services

ACDE 2025 Findings and Recommendations

The ACDE UM organizational chart shows that all UM positions are currently filled, except for the UM Operations Oversight Manager, a key personnel role. At the time of this review, ACDE had identified a candidate and was in the process of preparing an offer. The UM program includes staff dedicated to Delaware Medicaid, as well as personnel operating within corporate shared services. Both ACDE and each delegate provided a staffing plan and methodology to assess staffing needs.

The ACDE CMO has direct oversight of the UM department, including both shared services and those specific to Delaware Medicaid. The UM Operations Oversight Manager reports directly to the CMO and serves as a subject matter expert, ensuring regulatory standards are met while acting as the UM liaison among plan providers, delegates, and healthcare vendors.

Delaware-specific delegates include:

- Avēsis Third Party Administrators, Inc.: UM of vision services; contract termination date December 31, 2024.

- Evolent: UM of radiology.
- SKYGEN USA, LLC: Management of the Adult Dental Benefit Administration; contract termination date July 31, 2024.
- DentaQuest, LLC: Management of the Adult Dental Benefit Administration; contract start date August 1, 2024.

ACDE has improved the delegation oversight process by focusing on Delaware-specific contractual requirements and Delaware-specific file reviews used for monitoring and oversight. ACDE provided updated information through the desk submission on prior CAP items related to the Delegation section of the MSA. As noted above, Skygen's contract was terminated effective July 31, 2024, and replaced by DentaQuest effective August 1, 2024.

During the comprehensive compliance review in 2024, the EQRO identified eight CAP items. Analysis of the desk review submission and on-site meetings provided evidence of full compliance with six of the eight identified CAP items. ACDE updated the member handbook to include coverage of family planning providers and services of the member's choice, including allowing out-of-network family planning services without requiring PA. Additionally, the MCO updated P&Ps related to discharge planning, training, LTSS reporting, EPSDT service identification, and notifying the State of requests to extend the timeframe for service authorization decisions. ACDE revised the Member Handbook and related policies to align with contractual requirements, thereby demonstrating compliance.

One area of opportunity identified as a CAP item during the 2024 comprehensive EQRO review was the need to clearly define administrative denials versus clinical denials. Since the decision-making processes and responsible team members differ for these two types of denials, a recommendation was made for ACDE to update P&Ps to define both administrative and clinical (medical necessity) denials. ACDE specifies the staff authorized to make administrative denials versus those authorized to make clinical denials. DentaQuest also provided a policy that defines each type of denial. However, the documents from Skygen and Evolent do not differentiate between administrative and medical necessity determinations. Additionally, ACDE and DentaQuest provided documentation of a formal process for adverse benefit determinations. In contrast, Skygen and Evolent lack information in their submitted documents regarding the process for notifying members, guardians, and providers, as well as the process for peer-to-peer discussions.

New benefits were added within the 2024 Delaware MSA, including doula services, postpartum nutrition support, and the expansion of Non-Emergent Medical Transportation (NEMT) to DHCP members. Once additional services are identified, effective communication with both members and providers is essential to facilitate utilization. Team member education is also critical to support member and provider awareness and linkage to these services. While ACDE provided materials specific to doula and postpartum nutrition supports, updates reflecting the new benefits were not present in the Member Handbook or the Provider Manual. ACDE shared the process in place to review annual MSA updates and communicate changes downstream to department directors for review and implementation. A recommended follow-up is to evaluate this process, identify any missed steps related to including the new benefits for 2024, and provide an update for validation.

During the 2025 compliance review, Mercer examined documentation and engaged in further discussions with ACDE staff regarding UM. Staff demonstrated a solid understanding of regulatory and contractual requirements. However, certain elements within ACDE's processes and policies were found to be missing required components.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO has clear definitions of administrative versus clinical denials and outlines the staff who can make administrative denials versus staff who can make clinical denials. (3.12.2.1.22)	Substantially Met	Substantially Met	The MCO has clear definitions of administrative versus clinical denials and specifies the staff authorized to make administrative denials versus those authorized to make clinical denials. However, subcontractor policy submissions (Skygen and Evolent) lack definitions of administrative versus clinical denials and do not specify the staff authorized to make administrative or clinical denials. Skygen's contract has been terminated as of July 31, 2025.	Ensure all delegated policies (Evolent, as Skygen has been terminated) are revised to include definitions of administrative versus clinical denials and to specify the staff authorized to make administrative denials versus those authorized to make clinical denials.
The MCO has a formal process for adverse benefit determinations that includes staff who can make adverse determinations; process for notifying member/guardians; and provider(s); and a process for peer-to-peer discussions. (42 CFR 438.210 and 3.12.8.1.1)	Partially Met	Substantially Met	The MCO has a formal process for adverse benefit determinations; however, subcontractor policy submissions (Skygen and Evolent) lack information on the process for notifying members/guardians and providers, as well as a process for peer-to-peer discussions.	Ensure all delegated policies (Skygen and Evolent) are revised to include information on the process for notifying members/guardians and providers, as well as the process for peer-to-peer discussions.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO has a process to ensure that federally excluded services and certain services (OON family planning) to DHCP members are excluded from coverage per Contract. (3.4.4) The MCO has updated communication for DHCP coverage of NEMT.	New Finding for 2025	Partially Met	The MSA updates were not implemented (i.e., CHIP coverage for NEMT, doula services, postpartum nutrition supports) as evidenced by the lack of documentation in the Member Handbook and the Provider Manual.	Develop and implement a process to ensure all new MSA benefits are implemented and disseminated throughout the organization and included in all distributed member and provider materials.
The MCO has a process to provide members and providers with information regarding covered services for eligible DSHP, DHCP and DSHP Plus members (i.e., Member Handbook, Provider Manual, website, etc.). (3.4.1.3)	New Finding for 2025	Partially Met	ACDE provided materials that are specific to Doula and Postpartum Nutrition Supports; however, this information is not available in the Member Handbook, or the Provider Manual.	1. Update the Member Handbook and the Provider Manual to reflect the added benefits of doula services and postpartum nutrition support. 2. Develop a process to ensure that new benefits or changes within the MSA are included in both the Member Handbook and Provider Manual.

DFH 2025 Findings and Recommendations

DFH provided an organizational chart for the UM department that includes the names of UM team members, their positions, and their reporting structure. All UM positions were filled at the time of submission. DFH uses a shared services approach for UM functions, with specific team members reviewing Delaware Medicaid cases and a calculated percentage of their time attributed to Delaware Medicaid.

The organizational chart indicates that the UM Manager reports directly to the VP, PHCO, a corporate position that is 100% dedicated to Delaware Medicaid. The VP, PHCO, reports to the CMO. However, the MSA requires that the UM Manager report directly to the CMO. The organizational chart submitted by DFH shows that the reporting structure for the UM Manager remained unchanged from the comprehensive review conducted the previous year and remains non-compliant with the MSA for 2024.

During the on-site review, this issue was discussed, and DFH indicated that an exception form had been submitted to DMMA requesting approval for this deviation from MSA requirements. However, follow-up submissions confirmed that formal approval for the deviation in reporting structure was not granted by DMMA for 2024.

The CMO is also responsible for oversight of the delegated entities with which DFH subcontracted in 2024, as follows:

- Envolve Benefit Options: Dental and vision services.
- Evolent (formerly National Imaging Associates, Inc. — NIA): UM of advanced imaging and interventional pain management.
- Centene Pharmacy Solutions (CPS): Pharmacy claims processing, pharmacy network management, and pharmacy rebate processing. Further details related to CPS are included within the pharmacy section of this report.
- Medical Review Institute of America, LLC (MRloA): Medical Director secondary coverage/weekend.

DFH provided documentation regarding the evaluation of the compliance of its delegates responsible for UM decision-making. This documentation included audit processes, audit tools, annual audit result summaries, and Joint Operating Committee meeting slide decks presenting audit results. Delegation oversight tools and file reviews demonstrate effective oversight of the delegates' UM program, ensuring compliance with the requirements set forth under 42 CFR 438.210 and Delaware contract standards.

DFH developed and implemented a SOP and training for coordinating benefits provided by the State. These benefits include dental services for children, NEMT, prescribed pediatric extended care, day habilitation, non-emergency transportation, specialized services identified through PASRR assessments, Pathways employment services, and BH services for both children and adults.

Additionally, DFH submitted a summary of their "Value-Added Services," which are additional benefits beyond the required benefit packages. The summary included an overview of the services, any criteria or eligibility requirements, and the approval process. These benefits are communicated by DFH to members and providers through multiple channels. These submissions successfully brought the previous three CAP items into compliance.

Several areas of opportunity were identified during the 2024 EQR. Two CAP items remain open and are detailed in the table below. Additionally, a new CAP item was opened due to a finding that DFH was unable to provide evidence that all subcontractor team members (Evolent) completed new hire training. It is recommended that DFH develop a process and policy to ensure the evaluation of training programs for its subcontractors responsible for UM decision-making. This should include documentation of training dates, attendees, completion rates, and related information.

During the 2025 compliance review, Mercer examined documentation and engaged in further discussions with DFH staff regarding UM. The DFH staff demonstrated an understanding of regulatory and contractual provisions. However, certain elements within the organizational structure and documentation of training completed by delegated staff were missing. As a result, some contractual requirements were found to be non-compliant with all elements of the 2024 MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO has an organizational chart for the UM program that includes the names of senior and departmental management, the number of FTEs per department/position, the staff supporting Delaware population, including those shared across other State programs (if applicable), and notes staff situated in Delaware and identifies any open positions. The organizational chart clearly indicates the UM Coordinator reports directly to the CMO; the CMO has ultimate responsibility for the UM activities. (3.12.2.1.8, 3.12.2.2, 3.12.2.16, 3.20.2.1.10)	Substantially Met	Substantially Met	The MCO's organizational chart for the UM department includes the names of senior and departmental management. However, the reporting structure for the UM Manager was not aligned with the 2024 MSA, which is the year under review.	Revise DFH's organizational chart to ensure alignment with the MSA or obtain State-approved exception documentation for any deviations from the MSA.
The MCO has a process to evaluate the training program of its subcontractors responsible for UM decision making, this may include results of delegation oversight audits and/or agendas, minutes or reports presented at a joint operating/delegation oversight committee. (3.12.4.3.5, 3.22.2.3.1-7)	Partially Met	Substantially Met	DFH was unable to submit proof of all subcontractor team members (Evolent) completing new hire training.	Develop a process and policy to ensure DFH evaluates the training program of its subcontractors responsible for UM decision-making, documenting training dates, attendees, completion rates, and related information.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO has a formal process for adverse benefit determinations that includes staff who can make adverse determinations; process for notifying member/guardians; and provider(s); and a process for peer-to-peer discussions. (42 CFR 438.210 and 3.12.8.1.1)	Partially Met	Partially Met	The delegated entities (Evolent, Centene Eye, and Centene Dental) will render adverse determinations and send the required denial letters. DFH uses a corporate-based auditing process, with audits performed by Centene's Third Party Risk Management Office. The results shared with the plans are aggregate findings across all state plans within Centene. However, the expectation is for DFH to provide delegated entity oversight and auditing specific to Delaware membership, rather than information on all of Centene's state delegated entities.	Develop a process to provide Delaware-specific delegated auditing results, including the development of P&Ps, methodology, and reporting of findings.

HHO 2025 Findings and Recommendations

HHO submitted an organizational chart for the UM department, effective December 31, 2024, detailing all staff members, their positions, and reporting structure. At the time of the review, there were no vacancies within the UM department. All UM staff are fully dedicated to Delaware Medicaid, with no shared services across HHO.

The submitted organizational chart indicates that the reporting structure for the UM Manager remained unchanged from the previous year's comprehensive review and continues to be non-compliant with the 2024 MSA. Discrepancies were noted between the RFI submission and the organizational chart regarding the number of UM staff and some position titles. HHO provided follow-up documentation confirming the number of full-time staff and clarifying staff titles within the UM department. However, HHO was unable to provide evidence that the UM Manager's reporting structure, deviating from contract standards, had received approval from the Delaware DMMA.

HHO subcontracts with eviCore for UM medical necessity determinations related to PA requests in Radiology, Cardiology, and Musculoskeletal services. EviCore's organizational chart confirms no vacancies. HHO provided comprehensive documentation on the

evaluation and training of both internal UM staff and eviCore personnel, including training rosters, as well as oversight and audit processes to ensure effective subcontractor management.

During the previous EQR, it was identified that HHO lacked a written process defining roles and responsibilities for authorizations related to out-of-network services and Single Case Agreements. HHO has since finalized and implemented its Single Case Agreement policy.

HHO also provided its delegation oversight process and associated tools. However, the scoring of “substantially met” reflects the absence of analysis regarding a high rate of appeal overturns in 2024 for eviCore denials. This information is critical to the oversight process. It is recommended that HHO revise its delegation oversight process and update related tools to incorporate comprehensive analysis and trending methods, enabling effective evaluation of compliance by delegates responsible for UM decision-making.

Additionally, HHO did not provide evidence of disseminating clinical guidelines to providers and members for CY 2024. It is recommended that HHO develop and implement a process to ensure clinical guidelines are distributed to all affected participating providers and made available upon request to members and potential members.

Delaware Medicaid added Doula Services and Postpartum Nutrition Supports as new benefits effective January 1, 2024; however, HHO’s member materials inconsistently reflected these updates. The 2024 Member Handbook’s “Medical and Behavioral Health Benefits” section lists doula care as covered, but doula care is neither defined nor described in the “Maternity and Newborn Benefits” or “Family Planning” sections. Additionally, Postpartum Nutrition Supports are not addressed anywhere in the Member Handbook. It is recommended that HHO update the Member Handbook to accurately reflect the addition of doula services and postpartum nutrition supports. Further, HHO should develop a process to ensure that new benefits or changes within the MSA are consistently incorporated into both the Member Handbook and Provider Manual.

During the 2025 compliance review, Mercer examined documentation and engaged in further discussions with HHO staff regarding UM. Staff demonstrated a solid understanding of regulatory and contractual requirements. However, certain elements within the organizational structure, processes, and policies were found to be missing required components.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO has an organizational chart for the UM program that includes the names of senior and departmental management, the number of FTEs per department/position, the staff supporting Delaware population, including those shared across other State programs (if applicable), and notes staff situated in Delaware and identifies any open positions. The organizational chart clearly indicates the UM Coordinator reports directly to the CMO; the CMO has ultimate responsibility for the UM activities. (3.12.2.1.8, 3.12.2.2, 3.12.2.16, 3.20.2.1.10)	Substantially Met	Substantially Met	The MCO's organizational chart for the UM department includes the names of senior and departmental management. However, the reporting structure for the UM Manager was not aligned with the 2024 MSA, which is the year under review.	Revise HHO's organizational chart to ensure alignment with the MSA or obtain State-approved exception documentation for any deviations from the MSA.
The MCO has a process to evaluate the compliance of its delegates responsible for UM decision making. Delegation oversight tools and file review should clearly demonstrate evaluation of the delegate's UM program for compliance with requirements set forth under 42 CFR 438.210 and Delaware contract standards. (42 CFR 438.230(b)(1) and 3.22.2.3.1)	New Finding for 2025	Substantially Met	HHO provided the process for delegation oversight, along with the tools used. The scoring of substantially met reflects the omission of analysis for a high rate of appeal overturns in 2024 for eviCore denials. This information is evidentiary to the oversight process.	Revise the delegation oversight process and update the associated tools to incorporate robust analysis and trending methods, enabling effective evaluation of compliance by delegates responsible for UM decision-making.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO has adopted health care practice guidelines that: • Are based on valid and reliable clinical evidence or a consensus of health care professionals. • Consider the needs of members. • Are adopted in consultation with participating health care professionals. • They are reviewed and updated periodically as appropriate and in accordance with guidance in the QMS. (3.13.6.4) • Outline how guidelines are disseminated to all affected participating providers and upon request to members and potential members. (42 CFR.236(b)(1), (2), (3), (4) and 3.13.6.1)	New Finding for 2025	Partially Met	HHO did not provide evidence for the practice of disseminating clinical guidelines to providers and members for CY 2024.	Develop and implement a process to ensure clinical guidelines are disseminated to all affected participating providers and upon request to members and potential members.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO has a process to provide members and providers with information regarding covered services for eligible DSHP, DHCP and DSHP Plus members (i.e., Member Handbook, Provider Manual, website, etc.). (3.4.1.3)	New Finding for 2025	Partially Met	- Delaware Medicaid added Doula Services and Postpartum Nutrition Supports as new benefits effective January 1, 2024; however, member materials were inconsistent in reflecting these updates. - In the 2024 Member Handbook, the "Medical and Behavioral Health Benefits" section lists doula care as covered; however, doula care is neither defined nor described in the "Maternity and Newborn Benefits" or "Family Planning" sections. Additionally, Postpartum Nutrition Supports are not addressed anywhere in the Member Handbook.	- Update the Member Handbook to reflect the added benefits of doula services and postpartum nutrition support. - Develop a process to ensure that new benefits or changes within the MSA are included in both the Member Handbook and Provider Manual.

Enrollment and Disenrollment

ACDE 2025 Findings and Recommendations

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed Enrollment and Disenrollment further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. All required documentation was present, MCO staff provided responses consistent with each other and with the documentation, or a State defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

DFH 2025 Findings and Recommendations

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed Enrollment and Disenrollment further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. All required documentation

was present, MCO staff provided responses consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

HHO 2025 Findings and Recommendations

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed Enrollment and Disenrollment further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. All required documentation was present, MCO staff provided responses consistent with each other and with the documentation, or a State defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

Quality Assessment and Performance Improvement Program

ACDE 2025 Findings and Recommendations

ACDE has a strong QM/QI program supported by senior leadership within ACDE. The program has continued to demonstrate progress in its quality initiatives, resulting in strong performance across all quality areas assessed during the 2025 review. Evidence of quality integration throughout the organization is documented in QAPI committee meeting minutes.

The 2024 QI Program Evaluation includes a detailed description of QI activities and initiatives throughout 2024, including, but not limited to, a summary of program effectiveness and recommendations for 2025, QI initiatives, evaluations of accessibility and availability of services, clinical care assessments, audit activities, medical record reviews, and regulatory and accreditation activities. The annual evaluation also incorporated multiple data analyses with conclusions and recommendations for improvement in 2025.

In 2024, ACDE held seven QAPI Committee meetings. These meetings provided oversight of approved policies and program documents for QM, CC, UM, and LTSS CM. Additionally, reports on clinical care quality, Quality of Service, safety, and member experience were reviewed, along with updates to the QAPI and UM Work Plans. Monthly Provider Forums continued throughout 2024, covering topics such as the 21st Century Cures Act, third-party liability and coordination of benefits, balance billing, access and availability, electronic visit verification, and provider satisfaction.

Four MAC meetings were held in 2024, conducted both in person and virtually with very low attendance. Guest speakers included representatives from United Way of Delaware, Christiana Care Community Health Outreach, Delaware Breast Cancer Coalition, Helen Graham Cancer Center, and Do Care Doula. ACDE has increased incentives for the MAC meetings and has observed higher attendance at these meetings in 2025.

The MCO conducted the measurement year (MY) 2023 Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.1H for the Adult, Child and CHIP populations to assess member satisfaction with the MCO and health care services. The top three adult CAHPS results for ACDE were Customer Service, Rating of Health Care, and How Well Doctors Communicate. The

bottom three results in need of improvement were Getting Care Quickly, Rating of Personal Doctor, and Coordination of Care. The top three Child CAHPS survey scores were Rating of Health Plan, Getting Care Quickly, and Rating of Health Care. The bottom three measures were Getting Needed Care, Coordination of Care, and How Well Doctors Communicate. The top three Child (CHIP) CAHPS survey scores were Rating of Health Plan, Customer Service, and Coordination of Care. The bottom three measures were Getting Care Quickly, How Well Doctors Communicate, and Rating of Specialist. Overall, as compared to the previous year's scores (MY 2022), the MY 2023 Child CAHPS survey scores were high/improved in most areas with some opportunities for improvement in Rating of Health Care Quality and Getting Care Quickly.

Mercer reviewed documentation and discussed Quality Assessment and the PIP further with MCO staff during the on-site session and the MCO staff demonstrated understanding of regulatory and contractual provisions. During the comprehensive compliance review in 2024, the EQRO identified one item that required a CAP. It was identified that there were elements within the Member Handbook and related policies were missing contractual requirements regarding the member's right to request and receive a copy of their medical records. ACDE revised the Member Handbook and related policies to align with contractual requirements, which now demonstrates compliance.

During the CAP review in 2025, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

DFH 2025 Findings and Recommendations

For 2024, DFH continued to build their QM/QI department with the primary goal of improving members health status through a variety of QI activities, which have been implemented across all care settings and are aimed at improving the QOC of the services delivered. This is evidenced by a strong QM/QI department that is supported by senior leadership within DFH. Integration of quality is seen throughout the organization, as evidenced by QI/UM committee meeting minutes.

The 2024 QI Program Evaluation includes an overview of the quality program which includes their committee structure, any changes during the evaluation year, scope of the QI program and cultural competency. The evaluation describes the quality and utilization program effectiveness, including, but not limited to, strengths and opportunities, population characteristics, quality PMs and outcomes, credentialing and recredentialing, member rights and responsibilities, preventive health outcomes, medical record evaluation and delegation oversight. The evaluation also includes data analysis and the opportunities for improvement identified in 2024.

In 2024, DFH held five QI/UM Committee meetings. These meetings provided oversight of approved policies and program documents related to QM, CC, UM, and LTSS CM. Additionally, topics discussed during these meetings included, but were not limited to, population health, inter-rater reliability, PM, accreditation status, PCP profiling, over and underutilization, member and customer service, grievance and appeals data, critical incidents, QOC, CAHPS, provider network, cultural needs, preventive health, clinical

practice guidelines, credentialing delegation, and member experience, along with updates to the Quality Assessment and Performance Improvement and UM Work Plans.

Three Member Advisory Council meetings were held in 2024, conducted both in person and virtually. Topics included, but were not limited to, overview of DFH including priorities and goals, care gaps, resources and partnerships, Member Advocate roles, transportation, community wellness programs, Asthma management, incentive plans, CAHPS, provider network, and health equity. As a best practice, DFH allocates time during all meetings for members to share and provide feedback, enabling a better understanding of their needs and identifying opportunities for improvement.

The MCO conducted the MY 2023 Medicaid CAHPS 5.1H for the Adult and CHIP populations to assess member satisfaction with the MCO and health care services. The top three adult CAHPS results for HHO were How Well Doctors Communicate, Getting Needed Care and Rating of Specialist. The bottom three results in need of improvement were Coordination of Care, Rating of Health Plan and Customer Service. The top three Child CAHPS survey scores were Rating of Health Care, Getting Care Quickly, and Customer Service. The bottom three measures were Rating of Personal Doctor, How Well Doctors Communicate, and Coordination of Care. Overall, as compared to the previous year's scores (MY 2022), the MY 2023 Child CAHPS survey scores were high/improved in most areas with some opportunities for improvement in Rating of Health Care Quality and Getting Care Quickly.

Mercer reviewed documentation and discussed Quality Assessment and the PIP further with MCO staff during the on-site session and the MCO staff demonstrated understanding of regulatory and contractual provisions. During the comprehensive compliance review in 2024, the EQRO identified 13 items that required a CAP. The CAP items included the MCO's QM/QI Director job responsibilities document not aligning with the MSA, the absence of a subcontractor training program that covers fundamental quality concepts with a corresponding evaluation, the absence of a process to evaluate DFH's delegates QM/QI program ensuring alignment with the Delaware Quality Strategy, the absence of a policy or process documenting DFH's provider practice review and elements within the member handbook and related policies were missing contractual requirements regarding the member's right to request and receive a free copy of the member's medical record. HHO was able to revise documents to align with contractual requirements, which now demonstrates compliance in nine of the 13 CAP items.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO has defined roles, functions, and responsibilities of the QM/QI committee that specify the following: - The committee has oversight responsibility and input on all QM/QI activities. - The committee is accountable to the MCO's executive management. - Membership includes a representative from the provider community and the member community. - At a minimum, regularly scheduled quarterly meetings. - Maintenance of appropriate documentation of committee meetings, activities, findings, recommendations, and actions. (3.13.1.4.2)	Substantially Met	Substantially Met	DFH has a QM/QI committee structure with defined roles, functions, and responsibilities that include oversight responsibility and input on all QM/QI activities, accountability to the MCO's executive management, representation from the provider community, regular cadence of meetings, and maintenance of appropriate documentation of committee meetings, activities, findings, recommendations, and actions. However, the QM/QI committee has not had any member representation during the meetings for 2024, which is a requirement of the MSA.	Revise strategies for engaging members in the QM/QI committee meetings to not only ensure their participation but also to retain their involvement in 2025 and beyond.
The peer review subcommittee is part of the QM/QI committee structure and the CMO or designee chairs the committee, includes participating providers and peers of any participating provider being reviewed, and meets at least bimonthly (every other month). (3.13.7.1.1)	Partially Met	Substantially Met	DFH has a peer review subcommittee that is part of the QM/QI committee structure; CMO chairs the committee and includes participating providers. However, the peer review subcommittee meets quarterly, not bimonthly as required by the MSA.	Update the frequency of the peer review subcommittee meetings to meet bimonthly to align with the MSA or gain State approved exception documentation for this deviation from the MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO, upon written request of the member, furnishes a copy of the member's medical record within 10 calendar days of the request. Each member is entitled to one free copy. Any charges for additional copies of medical records do not exceed time and materials used to compile and furnish the records. (3.13.13.9)	Partially Met	Partially Met	DFH's Member handbook includes verbiage stating that a member can request and receive a copy of the member's medical record. However, the handbook does not state that the member's medical record will be furnished within 10 calendar days of the member's request and is free of charge.	Update the member handbook and any related policies to state that members are entitled to one free copy of their medical records and once requested, the medical records will be furnished within 10 calendar days of the member's request, to align with the requirements outlined in the MSA.
The MCO provider practice review includes development of policy recommendations to maintain or enhance the QOC provided to members. (3.13.7.1.2.2.5)	Not Met	Not Met	DFH has developed a provider practice review policy which includes the majority of the MSA required elements; however, the document does not include verbiage specifying the development of policy recommendations to maintain or enhance the QOC provided to members.	Revise Policy DE.QI.04 Provider Practice and Medical Record Review to include verbiage specifying that the provider practice review includes the development of policy recommendations to maintain or enhance the QOC provided to members.
The MCO educates members and MCO staff about the peer review process so that members and staff can notify the peer review committee of any situations or problems related to providers. (3.13.7.3)	Not Met	Not Met	DFH has developed a provider practice review policy which includes the majority of the MSA required elements; however, the document does not include verbiage on how the MCO educates members and MCO staff about the peer review process so that members and staff can notify the peer review committee of any situations or problems related to providers.	Revise Policy DE.QI.04 Provider Practice and Medical Record Review to include verbiage on how the MCO educates members and MCO staff about the peer review process so that members and staff can notify the peer review committee of any situations or problems related to providers.

HHO 2025 Findings and Recommendations

HHO has a strong QM/QI department that is supported by senior leadership within HHO. The QM/QI department has continued to demonstrate progress in their quality initiatives, resulting in strong performance in each of the quality areas assessed during the 2025 review. Integration of quality is seen throughout the organization, as evidenced by QI/UM committee meeting minutes.

The 2024 QI/UM Annual Program Evaluation includes a detailed description of QI activities and initiatives throughout 2024, a focus on monitoring the quality and appropriateness of care offered by providers, and the effectiveness and efficiency of systems and processes that support the healthcare delivery system. The annual Program Evaluation included data analyses of service indicators, clinical care, the LTSS program, the provider network, and audit activities with conclusions and recommendations for improvement in 2025.

In 2024, HHO held eight QI/UM Committee meetings. These meetings provided oversight of approved policies and program documents related to QM, CC, UM, and LTSS CM. Additionally, reports on clinical care quality, Quality of Service, pharmacy denials, provider network, credentialing delegation, safety, and member experience were reviewed, along with updates to the Quality Assessment and Performance Improvement and UM Work Plans. Furthermore, HHO conducted nine Internal QI Subcommittee meetings. These meetings covered various topics, including, but not limited to, member demographics and ethnicity, provider accessibility and availability, provider language availability, appeals, grievances, call center performance, enrollment and disenrollment, denial audit file results, member and provider portal utilization, member satisfaction findings, and PCP profiling activities.

Four Member Advisory Council meetings were held in 2024 across Delaware, with attendance ranging from approximately 20 to 100 participants. Topics included, but were not limited to, benefit quick guides, blood pressure monitoring, breast cancer screening, CAHPS, cervical cancer screening, coat drives, colorectal cancer screening, cultural and linguistic preferences, the Healthy Rewards program, language barriers and related issues, PCP engagement, member advocates, and vaccination hesitancy. As a best practice, HHO allocates time during all meetings for members to share and provide feedback, enabling a better understanding of their needs and identifying opportunities for improvement.

The MCO conducted the MY 2023 Medicaid CAHPS 5.1H for the Adult, Child and CHIP populations to assess member satisfaction with the MCO and health care services. The top three adult CAHPS results for HHO were Rating of Health Plan, How Well Doctors Communicate, and Coordination of Care. The bottom three results in need of improvement were Rating of Specialist, Getting Care Quickly and Customer Service. The top three Child CAHPS survey scores were Rating of Health Care, Rating of Personal Doctor, and Rating of Specialist. The bottom three measures were Getting Care Quickly, Rating of Health Plan, and Getting Needed Care. The top three Child (CHIP) CAHPS survey scores were Rating of Specialist, How Well Doctors Communicate, and Rating of Health Care. The bottom three measures were Getting Needed Care, Coordination of Care, and Customer Service. Overall, as compared to

the previous year's scores (MY 2022), the MY 2023 Child CAHPS survey scores were high/improved in most areas with some opportunities for improvement in Rating of Health Care Quality and Getting Care Quickly.

Mercer reviewed documentation and discussed Quality Assessment and the PIP further with MCO staff during the on-site session and the MCO staff demonstrated understanding of regulatory and contractual provisions. During the comprehensive compliance review in 2024, the EQRO identified two items that required a CAP. It was identified that there were elements within the member handbook and related policies that were missing contractual requirements regarding the member's right to request and receive a free copy of the member's medical record. HHO revised the Member Handbook and related policies to align with contractual requirements, which now demonstrates compliance. However, the reporting structure for the QM/QI Director remained misaligned with the 2024 MSA, which remained a CAP item for the 2025 review.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO has an organizational chart for the QM/QI Business Unit that demonstrates the unit is separate and distinct from other units and departments within the MCO and the QM/QI Director is accountable directly to the CMO. This chart indicates whether staff are dedicated to the DMMA contract, identifies all open positions and action plans in order to fill any open positions. (3.13.1.2, 3.20.2.1.22)	Substantially Met	Substantially Met	HHO has an organizational chart for the QM/QI Business Unit that demonstrates the unit is separate and distinct from other units, submitted evidence identifying staff dedicated to the DMMA contract, open positions, and action plans in order to fill any open positions. However, the reporting structure for the QM/QI Director was not aligned with the 2024 MSA, which is the year under review.	Revise HHO's organizational chart to ensure alignment with the MSA or obtain State-approved exception documentation for any deviations from the MSA.

Coordination and Continuity — Primary Care and Special Health Care Needs

ACDE 2025 Findings and Recommendations

ACDE submitted a CC program description that utilizes a Population Health Management framework and strategy, matching members to the level of support needed to address their medical, BH, and social needs. The goal of this person-centered approach is to identify members with conditions that, without appropriate and timely intervention, could lead to potentially avoidable healthcare services. By identifying these higher-risk members, ACDE ensures they receive interventions aimed at improving health outcomes and reducing unnecessary or preventable services.

This equitable, person-centered approach emphasizes empowering at-risk members to regain optimal health. ACDE offers a specific maternity CC program called Bright Start, designed for pregnant and postpartum individuals. The CC team is multidisciplinary, including nurses, licensed social workers, BH clinicians, non-clinical care connectors, community health navigators, clinical pharmacists, plan medical and BH directors, PCPs, specialists, and community agencies. CC services are typically delivered both telephonically and face-to-face.

The ACDE CC risk stratification process, which has been approved and designed to identify members in need of CC, is run monthly on the 19th for the entire ACDE population. Members identified through this process receive, at a minimum, the interventions outlined in the MSA. The risk stratification categorizes CC members into either Moderate Risk (Tier 2) or High Risk (Tier 3). The CC program includes the Bright Start program for pregnant and postpartum individuals. The ACDE CC Program Description is specific to Delaware and aligns with the MSA.

ACDE submitted an organizational chart of CC leadership and the individual teams as outlined below:

- The Manager of BH and Complex Adult CC oversees four supervisors responsible for four separate teams.
 - A supervisor that leads the Interdisciplinary Care Team (ICT) for members with chronic physical and/or BH conditions in Kent/Sussex Counties staffed by Clinical Care Coordinator positions.
 - A supervisor that leads the ICT for members with chronic physical and/or BH conditions in New Castle County staffed by Clinical Care Coordinator positions.
 - A supervisor that oversees the TOC/Embedded team, which includes Clinical Care Coordinators, Resource Coordinators, and Community Health Navigators to serve members hospitalized in acute care settings. Staff are on-site in 12 facilities.
 - A supervisor that oversees resource coordination/outreach with a team of Resource Coordinators and Community Health Navigators who outreach members identified for CC in a timely manner.
- A manager of CC Lifespan Waiver (Division of Developmental Disabilities Services [DDDS]) has two reporting supervisors and a senior Clinical Care Coordinator.
 - Supervisor for members with the Lifespan Waiver and includes 10 Clinical Care Coordinator and one Resource Coordinator.
 - Supervisor for members with the Lifespan Waiver and includes 11 Clinical Care Coordinators.
- A Manager of Department of Corrections (DOC)/PROMISE/BH CHNs with three supervisors:
 - Two supervisors of the BH CHN teams that oversees Community Health Navigators.

- A supervisor of the CRT south team that oversees Community Health Navigators.
- A supervisor of the DOC/PROMISE team that includes Clinical Care Coordinators, Resource Coordinators, and Community Health Navigators who serve justice-involved members preparing for release and coordination and collaboration for members enrolled in PROMISE.
- Manager of Bright Start/Pediatrics that oversees two Supervisors and a senior Care Coordinator.
 - The supervisor of Bright Start maternity team includes Clinical Care Coordinators for the high-risk team and Resource Coordinators and Care Connectors for the low-risk team.
 - The supervisor of the pediatric team serves children with SHCNs, Self-Directed Attendant Care, private duty nursing (PDN), foster care, and respite care and includes Clinical Care Coordinators, Resource Coordinators, and a Community Health Navigator.

All ACDE CC positions are full-time, field-based, operate remotely, and are dedicated solely to Delaware Medicaid. The entire CC team reports to the Director of CC, who in turn reports to the CMO. The Director of Maternal Child Health provides clinical support to the maternity and pediatrics team but does not have direct supervisory responsibility for that team. Two housing managers are shared between CC and LTSS and report directly to the CMO. The CC team includes the following positions: three Care Connectors (one dedicated to low-risk MCC), 21 Resource Coordinators (one dedicated to low-risk MCC), two senior Resource Coordinators, 72 Clinical Care Coordinators, 12 HR MCC, four senior Clinical Care Coordinators, 11 CC Supervisors, four CC Managers, one Director of CC, and 28 Community Health Navigators. At the time of the review, one Community Health Navigator and one MCC position were open and in recruitment. ACDE does not delegate CC tasks or activities.

Care Connectors perform telephonic outreach, triage calls, assist with referrals to community services, complete ED diversion surveys, and participate in the Rapid Response Outreach Team (RROT). CC team members with BH expertise are identified by managers and noted on the staffing roster. These members primarily work with SUD cases but also conduct LANE ED follow-up and engage in community outreach. ACDE reports that Community Health Navigators focus on populations who do not qualify for or who refuse CC services.

ACDE assesses staffing needs using membership data, predictive modeling stratification data, and information from providers, referrals, UM, HRA, and caseload reports. Membership reductions have occurred due to Medicaid redetermination and the entry of a third MCO into the market. Caseload reports are reviewed daily or weekly by senior care coordinators, supervisors, and managers to ensure appropriate ratio balance, using caseload capacity reports and staffing dashboards. Caseloads have remained in compliance with the MSA.

ACDE submitted documentation indicating supervisory ratios of 1:15 for clinical staff and 1:12 for non-clinical staff. Staff caseloads were shown to be within 1:50 for Clinical Care Coordinators and 1:40 for the Bright Start program. CC caseloads are maintained through consistent application of criteria for ending CC services and/or closing cases. Supervisors may take on cases as necessary, and senior care coordinators also carry smaller caseloads.

ACDE has a comprehensive CC training program for staff. Some training is provided by corporate enterprise, while other sessions are conducted by ACDE and are specific to Delaware Medicaid. ACDE provided a comprehensive list of trainings along with a staff roster of participants. However, the training roster did not include subcontractors and delegates responsible for referrals to CC, such as the dental vendor. Additionally, no other materials were provided to verify training completion, although it was acknowledged that such training is contractually required but not tracked in the Enterprise system.

ACDE conducts monthly audits of CC documentation. The corporate auditing team uses a clinical audit tool that incorporates MSA, NCQA, and CMSA requirements. A passing score of 95% is required, and supervisors review the scores with associates within 10 days to discuss opportunities and successes. Audit areas include adherence to timelines, sufficient outreach and engagement, completion of assessments and plans of care, continuity of care, TOC and discharge support, health education, and addressing health-related social needs (HRSN). There is also an evaluation tool for recorded calls. ACDE reports overall rates within the goal range; however, opportunities remain for improvement in areas such as assessment and care planning. CC staff also perform self-audits. In addition to auditing, weekly team meetings are held, and most teams conduct daily huddles to provide real-time case discussion and guidance. Leadership support and consultation are always available. Quarterly inter-rater reliability exercises are completed by supervisors, along with monthly phone audits and “ride-alongs” for new staff or as warranted. In 2025, there was continued emphasis on enhancing care planning, with the POC playbook promoted as a helpful tool for care coordinators.

The Bright Start program description aligns with the MSA materials. It outlines the requirements, timeframes, and interventions associated with both the high-risk and low-risk programs. The policy also lists all available services for members, including the doula and postpartum nutrition programs. Additionally, the high-risk and low-risk checklists include these available services.

ACDE views service coordination as a function rather than a distinct job position. Service coordination activities are managed across multiple departments, including Member Services, Member Engagement, the RROT, the Housing Transition Team, LTSS, and CC, specifically the TOC, Discharge of Care, outreach and coordination, and PROMISE teams. The pediatric and adult service coordination checklists include some language regarding escalation protocols for non-clinical issues; however, they do not include protocols for non-clinical staff to consult with clinical staff for discharge planning and other situations. Additionally, the service coordination checklists and related policies do not clearly define the responsible parties or timelines for coordinating services that members receive from the State’s CC program.

ACDE utilizes a risk stratification plan that was approved by DMMA in Q4 2022 and implemented in January 2023. No changes have been made to the plan; however, ACDE is currently evaluating it and plans to discuss updates with DMMA at the end of Q3 2025. The

stratification process is performed monthly. Each referral is reviewed and assigned by the Supervisor of Risk Stratification/Outreach and the Manager of Complex Adult Coordination, who apply internal risk categories, low risk, moderate/emerging risk, and high risk, to assign members to the appropriate staff. These categories are defined in the CC Program Description. The outreach team makes the initial contact for the respective assigned team.

The CC Program Description includes a description of the Predicting Impact of CC Success system, which assigns a risk score to each member. Members with risk scores in the top 1% are classified as High Risk, Tier 1, while those with scores in the top 2%–5% are classified as Moderate Risk, Tier 2. Both tiers are assigned to CC. All other members are placed into Low Risk, Tier 3.

Referrals for the CC and MCC programs are also identified through HRAs, providers, the Obstetrical Notification Assessment Form, self-referrals, and interdepartmental staff. PROMISE members are identified via the 834-enrollment file. ACDE reports that referrals from these other sources generally represent individuals who would not have been identified through risk stratification.

Although outreach was generally noted to be timely, quarterly CC reports indicate high rates of members who are unable to be reached in clinical CC. ACDE attributes this, in part, to their member population having a higher concentration of individuals with BH and SUD conditions compared to other plans. In contrast, the Bright Start program had a much lower percentage of unreachable members, as well as a smaller overall member population.

Quarter	Number of Members Identified as Eligible for CC	Number of unique Members Identified as Eligible for CC who Received Outreach	Number of Members Identified or Referred to CC who were Unable to Contact	Percentage of Members Identified or Referred to CC who were Unable to Contact	Number of Members Declining CC
Q1 2024	9597	4477	2214	49.45%	88
Q2 2024	9406	4328	2045	47.25%	95
Q3 2024	8813	4540	2309	50.86%	79
Q4 2024	7760	3131	1593	50.88%	78

Quarter	Number of Members Identified as Eligible for High Risk MCC	Number of unique Members Identified as Eligible for High Risk MCC who Received Outreach	Number of Members Identified or Referred to High Risk MCC who were Unable to Contact	Percentage of Members Identified or Referred to High Risk MCC who were Unable to Contact	Number of Newly Identified High Risk MCC Members who declined MCC
Q1 2024	816	749	47	6.28%	26
Q2 2024	836	767	32	4.17%	14
Q3 2024	879	816	21	2.57%	14
Q4 2024	757	709	51	7.19%	8

Quarter	Number of Members Identified as Eligible for Low Risk MCC	Number of unique Members Identified as Eligible for Low Risk MCC who Received Outreach	Number of Members Identified or Referred to Low Risk MCC who were Unable to Contact	Percentage of Members Identified or Referred to Low Risk MCC who were Unable to Contact	Number of Newly Identified Low Risk MCC Members who declined MCC
Q1 2024	415	385	42	10.9%	10
Q2 2024	340	322	14	4.3%	4
Q3 2024	345	330	24	7.3%	2
Q4 2024	323	304	20	6.6%	4

During the CAP review in 2025, Mercer reviewed documentation and discussed CC topics further with MCO staff. MCO staff demonstrated an understanding of regulatory and contractual provisions. Mercer identified several opportunities for ACDE to enhance the evaluation of their program's success. ACDE reported that the program is monitored using various reports, including the Annual Impact Analysis, Member Experience Surveys, and Clinical Measure Results. However, upon reviewing the Annual Impact Analysis, Mercer noted that the outcomes largely fell short of the defined targets, with discrepancies identified within the report's results.

Key findings include:

- The readmission rate increased and did not meet the goal of a 5% decrease. The highest rates for readmission were for MH disorders.

- The hospital discharge with aftercare demonstrated an increase but did not meet the goals of 70%, and the results in the narrative did not match the figures in the graph.
- The rate of prenatal immunizations for Tdap, influenza and combination did not meet the goals of the NCQA 75th percentile.
- The member experience survey for CC used a sample of 200 members, with 31 surveys completed, resulting in a response rate of 6.5%. None of the indicators met the goal of 85%. Among respondents, 58.1% rated their satisfaction with their care manager as excellent or very good, and 61.3% rated their overall satisfaction with the CM program as excellent or very good. Additionally, 41.9% agreed that the program helped them achieve their health goals.
- The MCC member experience survey had the same sample size and response rate as the CC survey. Twelve of fifteen indicators met the goal of 85%, and 90.3% of respondents rated their satisfaction with their care manager and the Bright Start program as excellent or very good. Additionally, 100% of respondents felt the program helped them achieve their pregnancy goals.
- The rate of improved glycemic control for members with diabetes met the goal of 50%, and the target has been increased for 2025.

CC File Review

Mercer completed a review of nine Clinical Care Coordination (CCC) files, seven low-risk MCC files, and 14 high-risk MCC files using the File Review Protocol outlined in Section 3. Although 10 files from each population were requested, several of the files were actually high-risk MCC. Mercer requested that ACDE select a sample of files they believed demonstrated excellent CC in accordance with MSA standards.

Many files reflected individuals with high PH, BH, and SUD needs, as well as significant HRSNs, including homelessness or unstable housing, food insecurity, and financial strain. Documentation demonstrates consistent outreach attempts per protocol, including initial outreach and monitoring for ED visits and hospitalizations, even when members have declined services. However, there were missed opportunities for coordination with embedded staff and other members of the care team.

Maintaining engagement with members continues to be a challenge. While members and providers were provided with copies of the POCs, actual collaboration with providers was limited. Difficulty remains in determining members' pregnancy history from the documentation. Many cases are complex and require creative solutions to engage and support members, rather than categorizing them as reluctant and not ready for change.

ACDE leadership reports multiple opportunities exist to discuss challenging cases, including daily huddles, weekly rounds, and meeting requests; however, documentation did not reflect evidence of seeking supervision or contacting DMMA for challenging cases. One file involved a member with an extensive BH and SUD history who was identified as pregnant. Prior to this, the member had

fifteen ED visits and six IP BH admissions in 2024. The CC team made numerous outreach calls to the member and providers, which were largely unsuccessful. The member had unstable housing but was discharged to “home” and was tragically struck by a car and killed one day after discharge. The documentation did not reflect any evidence of case consultation with leadership, discussion with the provider network, or referral to DMMA to identify potential interventions.

The EQR file reviews reflected consistent and generally timely outreach, and even when members declined CC, outreach was conducted following triggers such as ED visits.

Numerous files submitted by ACDE could not be fully scored. Of the 10 CC files, six were fully scored, one was declined, two could not be fully scored due to inability to contact the member during the episode, and one case was a high-risk MCC file that was reassigned. Among the six fully reviewed CC files, one scored above 90% compliance, one scored between 75% and 89%, and four scored below 75% compliance in the required elements. The partial scoring was largely related to plans of care and CC activities, indicating missed opportunities to support the member. There was evidence of intervention and assistance even when members declined CC or refused assessment or plan of care, as well as repeated attempts to reach members who were unable to be contacted after ED and IP visits.

Of the 10 low-risk MCC files, four were escalated to high risk, two members opted out or were unable to be reached, and four files were fully scored. Among the fully scored files, two scored between 75% and 89% compliance, and two scored below 75% compliance in the required elements. Members who were unreachable or declined services were routinely contacted every 30 days and after delivery and did receive some services.

Due to reassignment, 14 files were categorized as High-Risk MCC. Four members declined services, two were unable to be reached or were lost to follow-up, and one member was deceased during the episode. Of the eight fully scored cases, two scored over 90%, two scored between 75% and 89% compliance, and four scored below 75% in the required elements.

The following table displays the strengths and weaknesses broken down by domain. Please note that not all sections of the case files could be scored due to the small number of file reviews and the fact that several cases could not be fully evaluated.

Review Area	Strengths	Opportunities
Outreach and Engagement (for all levels)	Member outreach is generally timely and conducted in accordance with requirements. File reviews demonstrate contact with facilities by embedded care coordinators.	Develop strategies to address the lack of engagement after initial outreach
Screening (for low-risk MCC)	Members were routinely provided with resources to receive a breast pump, educated on doulas and postpartum nutrition and other services.	Ensure that pregnancy history is assessed and clearly documented.

Review Area	Strengths	Opportunities
Assessment (for CCC and high-risk maternity)	Numerous screenings and surveys are available to further explore needs identified on the initial assessment. A workflow is available to help determine appropriate additional assessments.	Develop strategies to address the lack of engagement and ability to perform the full complement of CC activities.
POC (for CCC and high-risk maternity)	Plan of Care playbook offers guidance and structure to facilitate care planning.	Develop strategies to address the lack of engagement and ability to perform the full complement of CC activities.
CC Activities (for all levels)	Members who opted out continue to be followed/monitored Maternity files consistently demonstrate education and referral to doulas and the postpartum nutrition program.	Improve case documentation to reflect efforts and interventions. Ensure follow-up occurs to ensure referrals/resources are completed and received.

The preliminary findings were reviewed with DMMA and ACDE at the on-site interview and member records from CCC and high- and low-risk MCC were reviewed in the ACDE electronic CC system.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO provided CC training materials, as well as a roster of staff that completed training, including training information pertaining to any delegates or subcontractors with responsibility for CC activities. (3.6.5.3.3, 3.6.7.5)	Partially Met	Partially Met	ACDE states that delegates are trained internally on Delaware-specific benefits by their own training teams, as delegates do not have access to ACDE's training systems. ACDE informs subcontractors of the required trainings for the year and receives attestations from the delegates confirming that the trainings were completed.	Develop a process to track CC trainings and evaluations for all delegates or subcontractors with responsibility for CC activities.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO provided data, regarding CC stratification and outreach, demonstrating successful strategies for outreach and engagement of members in appropriate levels of CC. (3.6.6.2.3, 3.6.7.7)	New Finding for 2025	Partially Met	ACDE monitors outreach and engagement of members by auditing files and reports a high rate of compliance with this process. However, the rate of members unable to reach remains high, which ACDE attributes to having a higher population of BH/SUD members than the two other plans.	Develop a plan that outlines strategies to enhance successful outreach and engagement of members across all populations and levels of care.
The MCO has an escalation protocol for non-clinical discharge planners to consult and involve clinical staff in discharge planning as necessary. (3.8.2.11.4.1)	Partially Met	Partially Met	ACDE submitted a Discharge Planning/TOC workflow, a service coordination checklist, and several other checklists. The documents include some language about escalation; however, it is specific to lack of response from providers and other non-clinical issues. While there is language addressing LTSS referrals, pregnant members, and members requesting CC, the documentation does not include prompts for other situations that might warrant a clinical consultation.	Develop an escalation protocol for non-clinical staff to consult with clinical staff for discharge planning including prompts for other situations that might warrant a clinical consultation.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO's P&Ps, file reviews and/or tracer scenarios evidence person-centered planning processes. All plans of care include at a minimum prioritized goals and actions, effective and comprehensive TOC plan, a communication plan with PCP and other providers, list of providers delivering services to the member, listing of other services received by programs other than those provided by the MCO (to avoid duplication), evidence of referral to community or social support services, health related social needs, frequency of ongoing member contacts, and identification and plans to close gaps in care. Documentation demonstrates that a member receives a copy of their Plan of Care. (3.6.6.3)	Not Met	Partially Met	The file audit sample demonstrated timely and consistent outreach, including community outreach. However, engagement remains challenging, with few charts showing completed assessments, plans of care, and ongoing contact. Missed opportunities to address member needs were noted, and documentation could be improved to better reflect the interventions and efforts made to support members.	Develop strategies to address the lack of engagement and ability to perform the full complement of CC activities.
The MCO has a process to evaluate the success of the program which includes metrics and benchmarks for performance, activities to close identified gaps or variances, and incorporates continuous QI activities. (3.21.6.3, 3.21.6.4)	New Finding for 2025	Minimally Met	The CC program description document outlines the program and its purpose but does not specifically include metrics to evaluate the program's effectiveness or outcomes. ACDE reports that the program is monitored using various reports, including the Annual Impact Analysis, Member Experience Surveys, Clinical Measure Results, etc. After reviewing the Annual Impact Analysis, Mercer noted that the outcomes largely fell short of the defined targets, with discrepancies found within the report's results.	1. Develop and implement a process to evaluate the success of the program, including defining metrics and benchmarks for performance, identifying and addressing gaps or variances, and incorporating continuous QI activities. 2. Ensure that the evaluation activities undergo a thorough peer review process to verify the accuracy and reliability of the results.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO has a process to coordinate the services the member receives from the State's FFS program. (42 CFR 438.208(b)(2)iii and 3.8.2.5.3)	New Finding for 2025	Minimally Met	ACDE's Service Coordination Checklist does not appear to include the process for coordinating with the FFS program.	Develop a process to coordinate the services the member receives from the State's FFS program.

DFH 2025 Findings and Recommendations

DFH has developed an integrated CC program with specific goals to keep members healthy, manage those with emerging risks, and support members with chronic illnesses and complex health conditions. Additionally, DFH offers the MCC program, Smart Start for Your Baby, serving pregnant and postpartum individuals up to 90 days post-delivery. This program was revamped to include more comprehensive assessments and supporting documentation. Furthermore, the Doula and Postpartum Nutrition benefit was implemented to enhance maternal support. DFH facilitated access by partnering with community organizations and leveraging the Find Help platform to ensure timely, culturally competent services. This included expanding the in-network doula panel by adding Haitian Creole-speaking doulas and enhancing CC. In April 2024, the Housing team was transitioned to report within the CC organizational structure.

Both the MCC and CC programs report to the Vice President of PHCO, who reports to the CMO. The programs share the same CMO, LTSS Medical Director, and BH Medical Director. The CC program does not use any delegates; however, Centene Management began supporting Health Care Analysis, Clinical Auditing, and Clinical Training.

All DFH Care Coordinator positions are full-time and dedicated solely to Delaware Medicaid. There are no delegates or temporary/contingent staff. DFH CC managers and supervisors assign referrals based on identified needs and member location. Caseloads are monitored daily, with submitted documentation showing average caseloads ranging from 18 to 47, well within the required ratio of 1:50. MCC caseloads averaged 40, also meeting the required ratio of 1:40.

The CC team includes one manager, three supervisors, 20 care coordinators, five discharge planners, four program coordinators, three of whom were added specifically to support SUD and Serious and Persistent Mental Illness (SPMI) monitoring, one housing manager, and two housing specialists who also support LTSS. No additional CC positions were added. Care Coordinators are assigned by county and are field based. A specialized team of ten Care Coordinators with extensive BH expertise manages members with BH or SUDs, supported by additional staff from Integrated Physical Health and Discharge Planning.

In 2024, all members requiring over eight hours of PDN were assigned to both a Registered Nurse and a Social Worker. Two experienced RN Care Coordinators manage most PDN cases, supported by three Licensed Master Social Workers from Integrated

Physical Health, four pediatric BH staff, and one discharge planner with pediatric expertise. The team holds weekly rounds to collaboratively address the physical, behavioral, and social needs of PDN members.

The MCC program functions as its own team and has 11 dedicated full-time staff members, including five Care Coordinators, five Program Coordinators, one of whom is dedicated to low-risk MCC, and a Community Health Worker who supports outreach and education in the community. One Care Coordinator is certified as a BH MH therapist and doula, and another is enrolled in a perinatal MH certification program. The BH team provides additional support as needed. MCC caseloads are monitored daily, with submitted documents demonstrating average caseloads ranging from 28 to 34, meeting the required 1:40 ratio. DFH created an addendum to the Start Smart policy specific to Delaware Medicaid members.

Leadership staff for both CC and MCC have system access for real-time monitoring of caseloads, assigned tasks, and due dates. Weekly rounds provide opportunities to discuss cases, and supervisors and the Medical Director are available for case reviews or consultations.

The DFH CC and Service Coordination departments work closely together, utilizing a single documentation platform, linked workflows, and integrated department meetings. Service Coordination Program Coordinators conduct outreach for HRA completion, ED diversion, care gap closure, and risk stratification. They also educate members about CC benefits. Leadership from both teams meets weekly to manage referrals and resolve issues. Referrals are tracked and assigned electronically based on member needs and location. Both teams operate under Population Health and Clinical Operations, sharing training and leadership.

The Service Coordination team, staffed with Program Coordinators, leads outreach efforts using multiple methods, including at least three telephonic attempts at varied times and face-to-face visits by Community Health Representatives if phone contact fails. Coordinators also utilize internal and external databases to update member contact information and engage members effectively.

The HRA report monitors staff outreach performance and completion rates, enabling leadership to identify training needs and improve processes. In 2024, HRA completion rates fell below 50% in Q1 and Q4, though completion among successfully contacted members remained high. To address this, DFH assigned dedicated Program Coordinators to HRA outreach, enhanced member engagement, increased incentives, and adjusted staff schedules.

The challenge of maintaining consistent HRA completion rates was first identified in 2023 and persisted into 2024, with dips in early and late quarters. Nevertheless, both years showed strong completion rates among successfully contacted members, and 2024 saw focused interventions aimed at improving overall outreach and completion.

DFH also submitted an HRA report demonstrating the rate of completion for members who had successful contact. The DFH HRA tool included all required elements of the MSA.

Quarter	Discrete Number of Outreach Calls Made	Number of HRAs Completed Within 60 Days of New Enrollment	Percentage of All HRAs Completed Within 60 Days of New Enrollment
Q1 2024	43,873	1,308	44.32%
Q2 2024	40,070	1,306	50.42%
Q3 2024	39,343	1,314	53.72%
Q4 2024			

DFH created a dashboard to define LANE ED visits using a Potentially Preventable Visit (PPV) dashboard developed in collaboration with Centene and 3M. This dashboard analyzes claims data using 3M's Enhanced Ambulatory Patient Group codes to identify visits that could be managed in lower-acuity settings. The PPV dashboard provides retrospective data updated monthly, while a real-time daily ED visit report from the Delaware Health Information Network supports timely outreach efforts.

Service Coordination leadership reviews the PPV dashboard monthly to identify trends, high utilizers, and provider patterns, which inform provider engagement and intervention strategies. Daily ED reports enable supervisors to assign cases for follow-up outreach, including contacting members with a standardized ED Risk Screening Tool to assess needs and provide tailored interventions such as education, appointment scheduling, and referrals to CC.

DFH conducts outreach for 100% of ED visits, including LANE cases. Members with multiple ED visits who cannot be reached by phone receive in-person outreach from Community Health Workers. Outreach effectiveness is monitored through monthly dashboards, audits, and quality reviews.

When LANE utilization is identified, Program Coordinators engage members' PCPs to reconnect members to primary care. For members without a PCP, coordinators assist in selecting and scheduling appointments. For those facing access barriers, coordinators collaborate with providers to resolve issues. All outreach and coordination activities are documented and audited to ensure compliance and continuity of care.

Quarter	Number of Members at Least 1 ED Visit	Number of Members With 3 or More ED Visits	Number of Members Outreached by MCO After an ED Visit	Number of ED Visits Identified as LANE	Percentage of Members with ED Visit with a PCP Visit Within 30 Days of ED Visit
Q1 2024	2,970	177	2,266	2,146	39.9%
Q2 2024	2,858	150	2,265	1,997	40.3%
Q3 2024	2,830	190	2,346	1,951	39.6%

Quarter	Number of Members at Least 1 ED Visit	Number of Members With 3 or More ED Visits	Number of Members Outreached by MCO After an ED Visit	Number of ED Visits Identified as LANE	Percentage of Members with ED Visit with a PCP Visit Within 30 Days of ED Visit
Q4 2024	3,176	207	2,599	2,221	33.7%

The discharge planning team conducts outreach to members within 48 hours of an IP admission and within 72 hours of a known ED visit. UM and Discharge Planners may follow members for up to 30 days post-admission to assist with post-discharge appointments, help members understand their treatment plans, obtain medications, and address barriers that could lead to readmission. Members requiring a high level of coordination are referred to a Care Coordinator.

For transition planning, the CC team monitors youth nearing BH service limits, completes transfer forms for members changing MCOs, and assigns Care Coordinators to members transitioning to LTSS programs. This ensures smooth handoffs through case conferences and transfer documentation.

From 2023 to 2024, the number of members with at least one IP stay steadily increased each quarter, while those with three or more stays remained relatively stable. MCO outreach following IP stays significantly increased in 2024, and the percentage of members having a PCP visit within 30 days of discharge improved by 7 to 15 percentage points across all quarters.

Quarter	Number of Members With at Least 1 IP Stay	Number of Members With 3 or More IP Stays	Number of Members Outreached by MCO After an IP Stay	Percentage of Members with an IP Stay with a PCP Visit Within 30 Days of the IP Stay
Q1 2024	713	38	566	41%
Q2 2024	778	30	613	44%
Q3 2024	790	31	636	43%
Q4 2024				

Non-clinical Program Coordinators, who assist members with appointment linkage, transportation, and resource coordination, are supervised at a ratio of no more than 12 staff per supervisor. The Business Process and Standards team conducts monthly audits using the DFH Non-Clinical Audit Tool.

The 2024 CC audit scores consistently outperformed those of 2023, starting at 88% in February 2024 compared to 64% in March 2023, and maintaining a stable range of 88% to 92% throughout the year. In contrast, 2023 showed steady improvement from 64% to 90%. MCC audit scores in 2024 were consistently strong, ranging from 93% to 98%, reflecting excellent performance.

In addition to chart auditing, performance is assessed through documentation of telephonic and face-to-face interactions, customer satisfaction surveys, and productivity metrics.

Care Coordination Audit Scores 2024												
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
CC	88%	91%	89%	89%	90%	92%	90%	92%	90%	91%	90%	92%
MCC	98%	96%	97%	97%	96%	98%	93%	94%	95%	95%	97%	96%

DFH monitors HEDIS care gaps using the Centene Clinical Action platform, with all Care and Service Coordination staff trained by mid-2024. Aggregate and staff-level intervention reports became available in Q2 2025 through a dashboard. Monthly Performance Improvement Team meetings review care gap rates, supported by specialized workgroups focused on key health areas. CC leadership emphasizes HEDIS education, and staff have real-time access to member care gap data to incorporate into care plans.

Care plans are audited monthly, focusing on nine specific audit elements related to care planning, including the development of SMART goals that reflect member and caregiver preferences. In 2024, care planning was a key focus, supported by quarterly trainings and preparation for NCQA accreditation. These efforts led to many care plans being rebuilt and improved audit scores. DFH has designated care plan champions to mentor staff and drive ongoing education.

2024 Care Coordination Care Plan Audit Elements														
Questions	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total	
Assessment of social determinants of health.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Documented evidence that member agreed to the care plan.	96%	100%	79%	91%	84%	91%	81%	94%	84%	100%	95%	95%	90%	
Care Plan was updated per required timeframes.	71%	87%	96%	87%	100%	96%	95%	95%	100%	100%	100%	100%	93%	
Development of case management plans, including prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the CCM program.	80%	91%	66%	70%	43%	48%	57%	67%	55%	53%	69%	74%	64%	

In 2024, DFH achieved NCQA accreditation, reflecting significant progress since its launch in 2023. Staff retention remained strong, and staffing levels met contractual requirements, supporting new initiatives such as postpartum nutrition and SUD/SPMI monitoring. Audit scores improved steadily, and staff reported increased confidence and satisfaction.

The CC team completed 835 in-person visits and 1,758 additional outreach attempts, collaborating closely with state and community partners. Value-Added Benefits addressing social needs were actively promoted and utilized.

The MCC team supported 139 members with personalized birth plans and played a key role in implementing the doula and postpartum nutrition benefits, which demonstrated strong engagement and positive outcomes, including high postpartum and well-child visit rates. The doula network expanded from two to eight providers in 2024. MCC also led community engagement efforts by hosting quarterly baby showers focused on maternal and infant health education.

Enhancements to the Start Smart for Your Baby assessments improved care planning and regulatory reporting accuracy, reducing administrative burden and allowing more focus on member care.

CC File Reviews

Mercer conducted a review of 30 case files using the File Review Protocol outlined in Section 3. The sample included 10 CCC files, nine Low-Risk MCC files, and 11 High-Risk MCC files. Many files revealed significant BH and SUD concerns, either as primary or co-occurring conditions.

Overall, the CCC files received scores ranging from 38% to 100%, with six out of 10 files scoring above 88%. The maternity case files consistently demonstrated member education regarding Doula services. Among the low-risk maternity cases, four files scored in the 80% range, while the remaining six achieved perfect scores of 100%. For the high-risk maternity cases, seven files scored between 50% and 88%, and the remaining four files scored 100%

- **HR MCC:** Scores ranged from 50% to 100%, with seven files scoring between 50% and 88%, and four files scoring 100%. Pregnant members aged 18–53 with high-risk medical and social factors received timely outreach, trimester-specific education, and referrals, though some declined services or were unreachable. Care plans included SMART goals and facilitated transitions, but documentation gaps and missed postpartum outreach were noted.
- **LR MCC:** Scores ranged from 80% to 100%, with four files in the 80% range and six files scoring 100%. Pregnant members aged 23–33 with varied medical and social histories experienced consistent outreach, education, and referrals. Language barriers were addressed. Coordination faced documentation challenges, and some members required transfer to other programs. Strong engagement was observed despite areas needing improvement.

- **CC:** Members with complex medical and BH needs received timely outreach and assessments, with SMART goal-driven care plans and support for transitions. Provider coordination was maintained, but documentation and CC gaps persisted. BH referrals were often declined, yet social needs were addressed through community resources

The following table displays the strengths and weaknesses broken down by domains. **This is based on a small case file sample.**

Review Area	Strengths	Opportunities
Outreach and Engagement (for all levels)	Outreach efforts across all levels are generally timely and consistent, involving multiple tailored attempts to engage members and providers while addressing language barriers and social needs, with particularly strong advocacy and support in the LR MCC and CC teams.	Opportunities exist to address gaps where members decline services or are unreachable and to enhance engagement strategies, particularly for BH referrals.
Screening (for low-risk MCC)	Comprehensive screenings address BH, prenatal care, and social determinants of health to identify member needs early.	Enhance screening processes to ensure comprehensive coverage and timely identification of postpartum needs and other risk factors.
Assessment (for CCC and high-risk MCC)	Individualized assessments inform tailored care plans with SMART goals and facilitate ongoing communication and collaboration with members and providers.	Improve the completeness and accuracy of assessments to better capture member needs and support more effective, individualized care planning.
POC (for CCC and high-risk MCC)	Effective referrals to resources like breast pumps, doulas, WIC, home health, and community supports are complemented by follow-up processes and coordination with providers and community partners to ensure referral completion and address complex needs.	Efforts should focus on closing documentation gaps related to provider collaboration, member agreement, and referral follow-up, while strengthening care plan development to consistently include all essential elements such as SMART goals and timelines.
CC Activities (for all levels)	Transitions to LTSS are facilitated when appropriate through strong collaboration with state and community partners, demonstrating a steadfast commitment to member-centered care despite challenges.	Enhancing member participation and engagement, improving provider coordination and communication, and refining processes to support transitions and social determinants of health are key opportunities for improvement.

The preliminary findings were reviewed with DMMA and DFH at the on-site interview and member records from each group were reviewed in the DFH CC system.

During the CAP review in 2025, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

HHO 2025 Findings and Recommendations

The HHO CC department continues to demonstrate success with its CC program. The organizational hierarchy illustrates the CC Director reporting to the Senior Vice President rather than to the CEO, which is a MSA requirement. HHO requested an exception to the MSA which was denied for 2025; however, 2025 contract changes should result in future compliance.

The program comprises both clinical and non-clinical positions. Care Coordinators are experienced professionals holding at least a bachelor's degree and licensure as registered nurses or licensed social workers. Specialized positions are staffed with individuals whose skills and experience align with the populations they serve, for example, those with intellectual and developmental disabilities (I/DD) expertise for the DDDS population, CADC credentials for BH and SUD (BH/SUD) staff, and experience within the prison system to manage DOC members. The triage reference guide details each staff member's credentials and areas of expertise, including BH. Service Coordinators, while non-licensed, possess healthcare backgrounds with experience in physical and BH. They assist with outreach, appointment support, linkage to PCPs, and other coordination activities. In 2024, the HRA team transitioned from the member experience team to the CC department, now comprising seven full-time and two part-time non-clinical outreach representatives supervised by the HRA/Service Coordination Supervisor. This restructuring enhances cohesive member outreach, coordination, and communication. Additionally, a disease management team was established in 2024 to focus on members with conditions such as COPD, congestive heart failure, chronic kidney disease, and inflammatory bowel disease.

All positions are dedicated exclusively to Delaware. At the time of the on-site review, there was one open Care Coordinator position and one Housing Specialist position actively in recruitment. Staffing levels met the required caseload ratios, maintaining no more than 1:50 for CCC and 1:40 for MCC. Supervisors conduct daily assessments of caseload volumes, while the Triage and Outreach Pod evaluates members based on risk stratification and daily caseload reports. After-hours coverage, including weekends and holidays, is provided by departmental managers and supervisors, ensuring members have consistent access to Care Coordinators. Additionally, HHO has established a backup staffing plan to cover Care Coordinator absences due to leave.

The MCC program includes dedicated staff with relevant expertise, comprising a Maternal Child Health Director, one supervisor, six care coordinators, and three service coordinators. Maternity care coordinators, both high- and low-risk, are licensed Registered Nurses or Practical Nurses with specialized maternal care experience. They conduct monthly outreach to members and providers to assess needs, provide education, and develop individualized care plans. Members identified as at risk for adverse maternal outcomes are escalated to a high-risk maternity care coordinator. While service coordinators do not directly manage low-risk maternity cases, they support screenings, benefit education, and assess equipment needs, such as breast pumps. HHO ensures that service

coordination staff have direct access to licensed clinicians for consultation, with escalation criteria documented within the member record in Guiding Care. Service coordinators can submit referrals through Guiding Care or contact their supervisor as needed.

In 2024, HHO used internal outreach staff as the primary approach to completing an HRA with the member/member representative. Other HHO staff that support completion efforts include Service Coordinators, and Care Coordinators who complete HRAs with a member during their interactions if they do not see a completed HRA within the Guiding Care clinical platform. Within 60 days of enrollment, at least three telephonic outreach attempts are completed to contact the member using the phone number most recently reported by the member. The three attempts occur on different calendar days, at different hours of the day, including day and evening hours and after business hours, Monday through Friday 8am–8pm and weekends 8am–4pm. A letter is sent after three unsuccessful attempts that provides instructions on completing the HRA through the member portal. HHO continues to contact members to complete the HRA even after the 60-day requirement. HRA reports are submitted on a monthly and quarterly basis. HHO reports that the HRA data has led to an increased focus on addressing HRSN.

Quarter	Discrete Number of Outreach Calls Made	Number of HRAs Completed Within 60 Days of New Enrollment	Percentage of All HRAs Completed Within 60 Days of New Enrollment
Q1 2024	23,960	1,859	68.3%
Q2 2024	17,476	1,625	70.6%
Q3 2024	16,234	1,339	68.2%

HHO provided information about programmatic updates that were made to enhance the CC program:

- As described above, the HRA team transitioned from member services to CC in January 2024 and added disease management in March 2024.
- HHO achieved NCQA re-accreditation and received high praise for complex CM files.
- Member satisfaction surveys' results demonstrate high satisfaction for CC: 91.3% positive responses.
- Wayspring engagement and expansion: Wayspring has helped to get an increase in the penetration of services. Efforts are underway with Wayspring to provide a training for providers who work with pregnant women with a SUD.
- Implementation of Doula and postpartum nutrition benefit: Implementation of a doula workgroup to focus on increasing number of doulas in the network. The provider relations team has hired a doula liaison, and this is collaborative effort.

- MCC rounds and interdisciplinary case reviews for high risk MCC members at Wayspring, CCHS/Care/Vio and Banyan.
- HHO implemented changes to their Risk Stratification process, which were approved by DMMA on April 30, 2024. Updates included shifting maternity cohorts from weekly to daily stratification, removing the risk score provided by the vendor Lucina, and eliminating the Mkaena cohort following its market withdrawal. These adjustments aim to enhance the identification of all members who could benefit from CC.
- Maternity and post-partum members have access to the mobile app, Pacify®, which provides lactation support, including access to a consultant. Pacify also provides trimester-specific information to members, and care coordinators receive a weekly report that shows who has accessed the app.
- Field staff have Highmark branded apparel which raises visibility and recognition.

HHO conducts monthly case file audits, reviewing two charts and one telephone call, along with a field audit every six months as part of CC monitoring. Supervisory audit scores are tracked monthly, reviewed by managers, and incorporated as a key data point in the annual performance management process. Audit tools used by supervisors were updated to reflect the 2024 contract requirements. Additionally, the audit team completed a focused review of care plan compliance, achieving an average compliance rate of 85.5% for 2024. To support continuous improvement, tips are emailed every Friday to all CC staff. These tips are further reinforced during monthly department training sessions and through one-on-one meetings between supervisors and individual staff members following audits.

Quarter	Call Audit	Chart Audit	Field Audit	Care Plan Audit
Q1 2024	96.81%	97.58%	100%	81%
Q2 2024	97.60%	96.02%	99.26%	82%
Q3 2024	96.83%	97.80%	99%	89%

HHO also provided monthly data on outreach, discharge planning, and TOC activity audits as part of the CAP reconciliation. Scores were generally above 90%, with the exception of a decline in discharge planning and TOC performance in November 2024.

Outreach Audit Results											
January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024
96.55%	99.26%	98.27%	98.94%	98.18%	98.31%	97.46%	99.46%	99.26%	98.60%	100%	92.08%

Discharge Planning and Transition of Care Audit Results											
January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024
93.98%	93.75%	96.13%	98.21%	97.22%	95.51%	100%	97.04%	95.31%	100%	80.56%	97.78%

Six CAP items were identified from the 2024 comprehensive review. During the 2025 CAP review, Mercer assessed documentation and discussed CC topics with MCO staff. The MCO staff demonstrated an understanding of regulatory and contractual provisions and presented updated documentation and system enhancements to achieve compliance. As a result, HHO satisfied five of the six previously identified CAP items, while one CAP item from 2024 remained non-compliant in 2025.

CC File Reviews

Mercer completed a review of 30 files using the File Review Protocol, which included 10 clinical CC files, 10 low-risk maternity CC files, and 10 high-risk MCC files. Mercer also requested that HHO submit files they believed exemplified excellent CC in accordance with MSA standards.

Overall, the review identified some challenges related to understanding how members are triggered for CC, as well as discrepancies in the documentation of dates for member coordination and outreach activities. The files demonstrated consistent outreach, reassessment, and care planning, along with ongoing collaboration efforts among care team members. Clinical CC files scored between 40% and 100%, with one member having opted out of the program.

The maternity case files consistently showed education provided to members regarding doula services. Notably, all low-risk maternity cases scored 100%, indicating that CC reliably delivers educational materials, referrals, assistance, and follow-up to ensure member access.

Outreach efforts were timely and consistent, with cases remaining open for members who were unable to be reached. Among the high-risk maternity case files, three scored between 25% and 75%, while the remaining seven scored 100%. One member was unable to be reached, and another opted out of the program. Additionally, assessments for gravida and para were unclear in some cases. Outreach was consistent and timely, and notes were clear and thorough in the high-risk maternity care files.

The following table summarizes key strengths and opportunities identified in the file reviews, organized by domain.

Review Area	Strengths	Opportunities
Outreach and Engagement (for all levels)	Consistent and timely outreach efforts documented. Multiple attempts to engage members, including follow-ups for those unable to be reached. Cases remain open for members who are unable to be reached.	Enhance documentation to reduce discrepancies in outreach dates. Address challenges related to members opting out or being unreachable to improve engagement rates.
Screening (for low-risk MCC)	Screening protocols are in place and consistently applied.	Enhance screening tools to better identify emerging risks early in pregnancy.
Assessment (for CCC and high-risk MCC)	Demonstrated understanding of regulatory and contractual requirements by staff. Comprehensive assessments and reassessments have a process and are conducted regularly.	Improve clarity in documentation, specifically regarding assessment of gravida and para. Improve clarity and consistency in assessment documentation, especially regarding clinical indicators. Incorporate more detailed protocols for non-clinical staff to consult clinical staff during assessments.
POC (for CCC and high-risk MCC)	Care plans are thorough, with clear and detailed notes.	Enhance coordination of care and services beyond exchange of information.
CC Activities (for all levels)	Consistent collaboration with other care team members. Consistent education is provided to members, including information on Doula services. High scores (100%) in reviewed files indicate strong delivery of educational materials, referrals, and follow-up.	Address high rates of unreachable members, particularly among populations with BH and SUD.

The preliminary findings were reviewed with DMMA and HHO at the on-site interview and member records from CCC, and high- and low-risk MCC were reviewed in the HHO electronic CC system.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO has an organizational chart for the CC program (including clinical CC, high- and low-risk MCC, and service coordination) that includes the names of senior and departmental management, the number of FTEs per department/position, the staff supporting DE population, including those shared across other state programs (if applicable), and notes staff situated in Delaware and identifies any open positions. (3.6.5, 3.6.7.4, 3.20.2.18)	Partially Met	Substantially Met	The MCO has an organizational chart for the CC program that includes the names of senior and departmental management. However, the reporting structure for the CC Director was not aligned with the 2024 MSA, which is the year under review.	Revise HHO's organizational chart to ensure it aligns with the MSA or obtain State-approved exception documentation for any deviations from the MSA.

Section 4

Validation of 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 a minimum of two PIPs; the PIP topics must cover the following:

- PPPs with OUD
- Non-Clinical or Service-Related

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

ACDE PIP Overall Assessment

Overall Results

ACDE continues to demonstrate a strong understanding of PIP design and implementation. ACDE utilizes PIP workgroups for continuous QI, including review and analysis of initiatives, interventions, and barrier analysis. ACDE's PIPs are clearly written, detailed, and align with identified population health concerns. Since the Prenatal and Postpartum Persons with OUD PIP is in the first remeasurement year, the majority of the on-site discussion focused on the initial interventions developed, the PMs, and remeasurement results. The evaluation demonstrated a high degree of confidence in the foundational steps. Although the PIPs are clearly written, there is room to strengthen the PMs to better track the PIP performance over time and the evaluation of impact of the interventions.

PIP Name	Confidence PIP Adhered to Acceptable Methodology for All Phases
PIP 1: PPPs with OUD.	

PIP Name	Confidence PIP Produced Evidence of Significant Improvement
PIP 1: PPP with OUD.	
PIP 2: ED LANE	High Confidence

PPP with OUD PIP

1. General PIP Information
Managed Care Plan (MCP) Name: ACDE
PIP Title: PPP with OUD.
PIP Aim Statement: Increase the use of methadone and/or buprenorphine therapy for OUD treatment for pregnant and postpartum members with OUD by 5% through targeted CM services and provider education of the Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines for Medication for Opioid Use Disorder (MOUD) as evidenced by paid pharmacy and medical claims by December 31, 2027.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)
☒ State-mandated (State required plans to conduct a PIP on this specific topic.) ☐ Collaborative (Plans worked together during the planning or implementation phases.) ☐ Statewide (The PIP was conducted by all MCOs and/or PIHPs within the State.) ☐ Plan choice (State allowed the plan to identify the PIP topic.)
Target age group (check one):
☐ Children only (ages 0–17 years)* ☐ Adults only (ages 18 years and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here: All members aged 11 and older that are or have to ability to become pregnant.
Target population description, such as duals, LTSS, or pregnant people (please specify):
All PPP with OUD

1. General PIP Information

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

Member-focused interventions implemented in 2024 by Quarter (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach).

- Quarter 1 2024:
 - Bright Start Care Managers continued to outreach to members for engagement in Bright Start Program. CC has staff who are bilingual in Spanish and utilize the language line when appropriate to engage members in their preferred language.
 - Implemented the Doula benefit and educated members and providers on these benefits as an additional resource for members.
 - CC reviewed and updated care plans to include more relevant detail and create SMART goals.
- Quarter 2 2024:
 - Bright Start Care Managers continued to outreach to members for engagement in Bright Start Program. CC has staff who are bilingual in Spanish and utilize the language line when appropriate to engage members in their preferred language.
 - Continued Doula benefits.
- Quarter 3 2024:
 - Bright Start Care Managers continued to outreach to members for engagement in Bright Start Program. CC has staff who are bilingual in Spanish and utilize the language line when appropriate to engage members in their preferred language.
 - Continued Doula benefits.
- Quarter 4 2024:
 - Bright Start Care Managers continued to outreach to members for engagement in Bright Start Program. CC has staff who are bilingual in Spanish and utilize the language line when appropriate to engage members in their preferred language.
 - Implemented an outreach program to those members who are not enrolled in Bright Start Maternity program or another CC program for medication adherence through the 12-month postpartum period. Members identified as non-adherent at least one month during the reporting period are outreached to assess for needs and offered support and education to continue or resume MOUD as appropriate.
 - Continued Doula benefits.

Provider-focused interventions implemented in 2024 by Quarter (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach).

- Quarter 1 2024:
 - Implemented Doula benefit and educated members and providers on benefits.
 - Closed the provider survey on SUD. The provider survey was open for 11 months with multiple reminders and fax blasts, presentation of the survey and how to access it at meetings and forums, and the provider newsletter. There was a total of five responses, which were incorporated into the root cause analysis.

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

- AmeriHealth Caritas DE's Provider Webpage has online training specific to OUD which includes education on treating persons who are pregnant and postpartum with OUD.
- Quarter 2 2024:
 - Presentation of PIP including background, focus, State mandate, and outcomes presented at ACO Quality meetings. Requested input and offered opportunities for collaboration in provider education. Participating ACOs: Kidwell, DMQP, QHA, Aledade, United Medical.
 - Presentation of PIP including background, focus, standards of practice and resources available to the Delaware Perinatal Quality Collaborative. Dr. Allen stated there was pushback from the OBs, but no specifics were discussed.
 - Presentation of PIP including background, focus, State mandate, and outcomes presented at two ACO Joint Operating Committee (JOC) meetings. Requested input and offered opportunities for collaboration in provider education. Feedback: ACO leadership at one meeting requested a one-page flyer for providers to review and post in office. This was developed and distributed (see Q4 2024).
 - Presentation of PIP including background, focus, State mandate, and outcomes presented at June Provider Forum. Requested input and offered opportunities for collaboration in provider education. at the Provider Forum. Feedback from providers is incorporated into the analysis and intervention planning. There was no feedback from the providers.
 - AmeriHealth Caritas DE's Provider Webpage has online training specific to OUD which includes education on treating persons who are pregnant and postpartum with OUD.
- Quarter 3 2024:
 - ACDE's Provider Webpage has online training specific to OUD which includes education on treating persons who are pregnant and postpartum with OUD.
 - Implemented development of Provider One Page flyer on Education for PPP with OUD as requested by ACO leadership so the information can be posted in the provider office (See 6/24 JOC meeting). The final draft for the provider flyer was completed in November 2024 and posted on ACDE's Provider Website under Training and education. The flyer is distributed electronically to ACOs, practitioners and provider offices on request and is available on the ACDE's Provider Webpage. Hard copies are distributed by account executives during office visits.
- Quarter 4 2024:
 - ACDE's Provider Webpage has online training specific to OUD which includes education on treating persons who are pregnant and postpartum with OUD.
 - Completed Provider One Page flyer on Education for PPP with OUD as requested by ACO leadership and posted to ACDE's Provider Website under Training and education. Account Executives are distributing the information to providers during office visits and CC, Quality, Provider Network Management, and other provider facing departments are distributing the flyer digitally on request.
 - Presentation of PIP including background, focus, State mandate, and outcomes presented at ACO Quality meetings. Requested input and offered opportunities for collaboration in provider education. Participating ACOs: Kidwell, DMQP, QHA, Aledade, United Medical.
 - **Feedback:**
 - 10/24: One ACO requested further evidence of racial bias in prescribing MOUD to present to network providers. This information was presented at the February 2025 ACO meeting.

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

- 10/24: One ACO provided feedback that their member population does not meet the criteria which was clarified by educating them on the population ages included. The ACO verbalized that information regarding OUD is generally received through SDOH/HRSN and depression screenings. Babies with neonatal opioid withdrawal syndrome or neonatal abstinence syndrome. The ACO physician responded yes. When this occurs, the ACO makes additional inquiries and has an unofficial referral process or pathway to facilitate treatment and care of the mother and baby dad.
- Presentation of PIP including baseline data 4/1/2023–3/31/2024 and comparison of buprenorphine and/or methadone use was presented at October Provider Forum. Provided education on standards of care, potential racial bias, and that the State considers the postpartum period to extend to 12 months post end of pregnancy. Requested input and offered opportunities for collaboration in provider education. at the Provider Forum. Feedback from providers is incorporated into the analysis and intervention planning. There was no feedback from the providers.

MCP-focused interventions/System changes implemented in 2024 by Quarter (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools).

- Quarter 1 2024:
 - Continued to expand services to members through contracting doulas and providing doula benefits.
 - Staff attended monthly training sessions January, February, and March provided by the Maryland Addiction Consulting Services (MACS) for Maternal OUD Spring ECHO series. Topics included SUD treatment and pregnancy, breastfeeding and SUD, birth outcomes, and Xylazine and pregnancy.
 - Continued staff education during team meetings. In January, topics included SUD and working with members with SUD, including working with members, outreaching to providers, ensuring members are connected to both a medical (OB/PCP) and a BH provider. Krames on Demand (KOD) educational brochures reviewing the importance of prenatal care.
- Quarter 2 2024:
 - Data collection transitioned to a new department. Ongoing meetings from May through October regarding data technical specifications, coding, duplication reduction and data errors.
 - Staff continued monthly training sessions in April and June provided by the MACS for Maternal OUD Spring ECHO series. Topics included SUD treatment and pregnancy, breastfeeding and SUD, birth outcomes, and Xylazine and pregnancy.
 - Ongoing education during team meetings included KOD educational brochures for Pregnancy and SUD.
 - Health Equity Training with all Bright Start CC staff.
 - CC staff attended the CMS Maternal Health Summer Webinar Series promoting maternal health, maternal MH, and equity through collaboration. Sixteen Bright Start CC Staff attended the May presentation.
 - CC staff attended an all-day training provided by SAMHSA: Clinical Guidance for Treating Pregnant and Parenting Women with OUD and Their Infants.
- Quarter 3 2024:
 - Ongoing meetings from May through October to enhance the coding process to mitigate errors and duplication.
 - CC staff attended a two-part webinar on Pregnancy and Substance Use: Holistic Prenatal Care.

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

- Staff attended a webinar on Labor and Delivery: Birth in Context of Substance Use.
- CC staff who did not attend the May training, attended an all-day training provided by SAMHSA: Clinical Guidance for Treating Pregnant

3. PMs and Results (Add rows as necessary)

PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable):	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
#1 Quantifiable Measure: Lead #1: Rate of ACDE network providers educated by ACDE during interactive Webinars, Provider Forums, and Committee Meetings about the SAMHSA Clinical Guidelines for management of pregnant and postpartum members with OUD, specifically prescribing medication assisted therapy with either methadone or buprenorphine, available CC resources within ACDE, available OUD resources with the geographic area, and billing code to report the discussion of OUD treatment options between clinician and patient. The Provider cohort is identified as those contracted providers who are identified via credentialing as treating members ages 11 and older.	Q2 2024	Sample Size 4082 Rate 0.66%	2024	Sample Size 4082 Rate 0.29%	Yes ☒ No	☒ Yes No Specify P-value: ☐ <.01 ☒ <.05 Other (specify): 0.01596

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable):	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
#2 Quantifiable Measure: Lead #2: Rate of newly identified pregnant members with an OUD diagnosis that are outreached for enrollment into Bright Start CC. Definition: Member with diagnosis/procedure code indicating pregnancy.	Q2 2024	Sample Size 97 Rate 52.58%	2024	Sample Size 29 Rate 62.07%	☒ Yes No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.36812
#3 Quantifiable Measure: Lead #3: Rate of newly identified postpartum members with an OUD diagnosis that are outreached for enrollment into Bright Start CC. Definition: Member with diagnosis/procedure code indicating termination of pregnancy due to abortion, fetal demise or stillbirth.	Q2 2023- Q1 2024	Sample Size 98 Rate 37.76%	2024	Sample Size 11 Rate 36.36%	☒ Yes No	Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.92828

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable):	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
#4 Quantifiable Measure: Lead #4: Rate of pregnant and postpartum members with an OUD diagnosis that are engaged with the Bright Start CC. Outreach for this PIP is defined as either telephonic/virtual member outreach or home visit by the Clinical Care Coordinator (Registered Nurse, Social Worker). Definition of Engaged Members: All identified pregnant members are engaged when reached through telephonic/virtual, or face to face engagement and complete the Initial Maternity Assessment while in the pre-natal period or the Post-Partum Survey and the Initial Adult Assessment for those members identified in the postpartum period.	Q2 2023-Q1 2024	Sample Size 211 Rate 20.38%	2024	Sample Size 147 Rate 16.33%	Yes ☒ No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.33204
#5 Quantifiable Measure: Lead #5: Rate of pregnant and postpartum members with an OUD diagnosis that are monitored via CC for IP stays, emergency room visits, triage, and other complications during pregnancy due to opting out of Bright Start CC or unable to reach.	Q2 2023-Q1 2024	Sample Size 211 Rate 2.37%	2024	Sample Size 147 Rate 1.36%	Yes ☒ No	Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.4965

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable):	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
#6 Quantifiable Measure: Lead #6: Rate of pregnant and/or postpartum members who initiate Medical Assisted Treatment with methadone and/or buprenorphine.	Q2 2023- Q1 2024	Sample Size 211 Rate 4.27%	2024	Sample Size 147 Rate 2.72%	Yes ☒ No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.4413
#7 Quantifiable Measure: Lead #7: Rate of pregnant members with an OUD diagnosis who experience an early termination of pregnancy due to fetal demise, spontaneous abortion, reason not specified, or deliver a stillborn baby outreached for CC.	Q2 2023- Q1 2024	Sample Size 8 Rate 25.00%	2024	Sample Size 0 Rate 0%	Yes ☒ No	☒ Yes No Specify P-value: ☒ <.01 <.05 Other (specify): < 0.00001
#8 Quantifiable Measure: Lead #8: Rate of pregnant and postpartum members, including members who experience early termination or stillbirth, with an OUD diagnosis who are referred to a community support program, excluding MAT referrals (i.e., Promise, Brandywine, Marigold, etc.).	Q2 2023- Q1 2024	Sample Size 209 Rate 19.14%	2024	Sample Size 147 Rate 40.14%	☒ Yes No	☒ Yes No Specify P-value: ☒ <.01 <.05 Other (specify): < 0.00001
#9 Quantifiable Measure: Lead #9: Rate of members who are 12 weeks postpartum with an OUD diagnosis that are transitioned from Bright Start CC to another AmeriHealth Caritas DE CC program.	Q2 2023- Q1 2024	Sample Size 93 Rate 24.73%	2024	Sample Size 18 Rate 33.33%	☒ Yes No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.4427

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable):	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
#10 Quantifiable Measure: Lead #10: Rate of members who are 13 through 52 weeks postpartum with and OUD diagnosis that are engaged in a CC program.	Q2 2023- Q1 2024	Sample Size 133 Rate 3.76%	2024	Sample Size 73 Rate 2.74%	Yes ☒ No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.69654
#11 Quantifiable Measure: Lag 1: Rate of pregnant members with an OUD diagnosis receiving buprenorphine or methadone.	Q2 2023- Q1 2024	Sample Size 542 Rate 42.62%	2024	Sample Size 172 Rate 34.30%	Yes ☒ No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.05238
#12 Quantifiable Measure: Lag 2: Rate of postpartum persons with an OUD diagnosis receiving buprenorphine or methadone.	Q2 2023- Q1 2024	Sample Size 1192 Rate 39.68%	2024	Sample Size 226 Rate 46.90%	☒ Yes No	☒ Yes No Specify P-value: <.01 ☒ <.05 Other (specify): 0.04236
#13 Quantifiable Measure: Lag 3: Rate of buprenorphine utilization in pregnant persons with OUD.	Q2 2023- Q1 2024	Sample Size 542 Rate 26.57%	2024	Sample Size 172 Rate 8.72%	Yes ☒ No	☒ Yes No Specify P-value: ☒ <.01 <.05 Other (specify): <0.00001
#14 Quantifiable Measure: Lag 4: Rate of buprenorphine utilization in postpartum persons with OUD.	Q2 2023- Q1 2024	Sample Size 1192 Rate 20.30%	2024	Sample Size 226 Rate 23.01%	☒ Yes No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.35758

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable):	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
#15 Quantifiable Measure: Lag 5: Rate of methadone utilization in pregnant persons with OUD.	Q2 2023- Q1 2024	Sample Size 542 Rate 18.08%	2024	Sample Size 172 Rate 25.58%	☒ Yes No	☒ Yes No Specify P-value: <.01 ☒ <.05 Other (specify): .03156
#16 Quantifiable Measure: Lag 6: Rate of methadone utilization in postpartum persons with OUD.	Q2 2023- Q1 2024	Sample Size 1192 Rate 19.46%	2024	Sample Size 226 Rate 25.22%	☒ Yes No	☒ Yes No Specify P-value: <.01 ☒ <.05 Other (specify): .04884

4. PIP Validation Information
Was the PIP validated? ☒ Yes No “Validated” means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations. Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☒ First re-measurement Second re-measurement Other (specify): Validation rating #1: EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis, and interpretation of PIP results. ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence Validation rating #2: EQRO’s overall confidence that the PIP produced significant evidence of improvement. ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence ☐ N/A — Planning phase

4. PIP Validation Information

- Although the PIP is clearly written, detailed, and aligns with the identified population health concerns, ACDE should continue to do rapid

clear, concise, and measuring the intended outcome of the PIP. Clearly defined, objectively and reliably measured variables lead to higher

ED Low-Acuity Non-Emergent PIP

1. General PIP Information

MCP Name: ACDE

PIP Title: ED LANE: Increase PCP follow-up for members seen in the ED with a LANE diagnosis within 30 days through increased identification and outreach

PIP Aim Statement: Use of Delaware Health Information Network (DHIN) A08 information in addition to ADT (Admit, Discharge, Transfer) data to identify members seen in the ED with a LANE diagnosis to improve member outreach and increase the rate for successful PCP follow up within 30 days.

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

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

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

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

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

Target age group (check one):

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

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

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

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

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

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

- Quarter 1 2024:
 - RROT and CC continue to outreach to members identified via ADT or A08 as seen in the ED for one of the five targeted diagnoses. RROT and CC have staff who are bilingual in Spanish and Haitian-Creole and utilize Language Line services to facilitate communication in the member's preferred language.
 - RROT and CC utilize the ER Diversion survey assessment tool for post ED outreach which includes assessment of HRSN. Staff provide education and offer assistance with resolving barriers to care through plan and community resources.
 - Two-way texting by ED LANE team to encourage engagement.
- Quarter 2 2024:
 - RROT and CC continue to outreach to members identified via ADT or A08 as seen in the ED for one of the five targeted diagnoses. RROT and CC have staff who are bilingual in Spanish and Haitian-Creole and utilize Language Line services to facilitate communication in the member's preferred language.
 - RROT and CC utilize the ER Diversion survey assessment tool for post ED outreach which includes assessment of HRSN. Staff provide education and offer assistance with resolving barriers to care through plan and community resources.
 - Two-way texting by ED LANE team to encourage engagement.
- Quarter 3 2024:
 - RROT and CC continue to outreach to members identified via ADT or A08 as seen in the ED for one of the five targeted diagnoses. RROT and CC have staff who are bilingual in Spanish and Haitian-Creole and utilize Language Line services to facilitate communication in the member's preferred language.
 - RROT and CC utilize the ER Diversion survey assessment tool for post ED outreach which includes assessment of HRSN. Staff provide education and offer assistance with resolving barriers to care through plan and community resources.
 - Two-way texting by ED LANE team to encourage engagement.
- Quarter 4 2024:
 - There were no PIP related activities.
 - RROT and CC continue to outreach to members identified via ADT or A08 as seen in the ED for one of the five targeted diagnoses. RROT and CC have staff who are bilingual in Spanish and Haitian-Creole and utilize Language Line services to facilitate communication in the member's preferred language.
 - RROT and CC utilize the ER Diversion survey assessment tool for post ED outreach which includes assessment of HRSN. Staff provide education and offer assistance with resolving barriers to care through plan and community resources.
 - Two-way texting by ED LANE team to encourage engagement.

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

- Quarter 1 2024:

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

- Presented ED LANE at one ACO Subcommittee Meeting.
Feedback: Discussion included how the ACO coordinated ED LANE visits to PCPs for follow-up care. ACO responded that the facilities staff ED Case Managers and appointments are made directly from the ED. In addition, the ED Case Managers review gaps in care, assessment of HRSN, and offer assistance as needed.
- Quarter 2 2024:
 - Presentation of PIP including background, focus, State mandate, and outcomes presented at ACO Quality meetings. Requested input and offered opportunities for collaboration in provider education. Participating ACOs: Kidwell, DMQP, QHA, Aledade, United Medical.
 - Presentation of PIP including background, focus, State mandate, and outcomes presented at June Provider Forum. Requested input and offered opportunities for collaboration in provider education. at the Provider Forum. Feedback from providers is incorporated into the analysis and intervention planning. There was no feedback from the providers.
- Quarter 3 2024:
 - Presented ED LANE at one ACO Subcommittee Meeting. There was no provider feedback.
- Quarter 4 2024:
 - There were no PIP related activities. ACDE continued to review ED Utilization with the ACOs during JOCs, Value Base Meetings, and other contract required meetings.

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

- Quarter 1 2024:
 - Continued data analysis. Identified some members are captured via both the ADT and A08 notes and clarified that these members are counted in the ADT reporting. As more members are identified via ADT, identification via A08 declines but still captures some members.
 - Reviewed and updated Root Cause Analysis. Identified third party liability as a barrier that has no intervention as we do not pay the claim.
- Quarter 2 2024:
 - Continued data analysis. Deep dive to see if data connects from member identification to follow-up.
 - Reviewed coding to assess for decline in Lead 1: The total number of members seen in the ED with one of the five targeted LANE diagnoses using ADT and A08 documentation that are not automatically assigned for outreach by CC or RROT.
- Quarter 3 2024:
 - Continued data analysis. All measures are trending improvement.
 - Determined Deep Dive Analysis could not be completed based on data provided due to differing reporting structures.
 - Submitted retired memo and final QIA to DMMA for consideration. The process was determined to be successful, statistically significant, and sustainable. The PIP was retired September 3, 2024, and the process expanded to additional diagnoses codes.
- Quarter 4 2024:
 - There were no PIP related activities. ACDE continued the process of including member identification through use of DHIN A08 notes for ED LANE visits and expanded the process according to data and resources.

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
#1 Quantifiable Measure: Lead #1: The percentage of total members seen in the ED with one of the five targeted LANE diagnoses using ADT and A08 documentation that are not automatically assigned for outreach by CC or RROT.	2022	Sample Size: 497 Rate: 98.4%	2024	Sample Size 654 Rate 96.3%	☒ Yes No	☒ Yes No Specify P-value: <.01 ☒ <.05 Other (specify): P= 0.035
#2 Quantifiable Measure: Lead Measure #2: The percentage of total members seen in the ED with one of the five targeted LANE diagnoses using ADT documentation that are not automatically assigned for outreach by CC or RROT.	2022	Sample Size: 489 Rate: 88.8%	2024	Sample Size 630 Rate 97.0%	☒ Yes No	☒ Yes No Specify P-value: ☒ <.01 <.05 Other (specify): <.00001
#3 Quantifiable Measure: Lead Measure #3: The percentage of total members seen in the ED with one of the five targeted LANE diagnoses using A08 documentation that are not automatically assigned for outreach by CC or RROT.	2022	Sample Size: 489 Rate: 11.2%	2024	Sample Size 630 Rate 3.0%	☒ Yes No	☒ Yes No Specify P-value: ☒ <.01 <.05 Other (specify): <.00001

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
#4 Quantifiable Measure: Lag Measure #1: The percentage of total members that were seen in the ED with one of the five targeted LANE diagnoses using ADT and A08 documentation who were outreached via the LANE Emergency Room Outreach Non-Clinical pathway.	2022	Sample Size: 470 Rate: 33.4%	2024	Sample Size 630 Rate 53.2%	☒ Yes No	☒ Yes No Specify P-value: ☒ <.01 <.05 Other (specify): <.00001
#5 Quantifiable Measure: Lag Measure #2: The percentage of total members that were seen in the ED with one of the five targeted LANE diagnoses using ADT and A08 documentation with claims or encounter data for a medical follow-up visit (PCP or Specialist) within 30 days of the ED visit.	2022	Sample Size: 489 Rate: 36.6%	2024	Sample Size 630 Rate 41.0%	☒ Yes No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.139
#6 Quantifiable Measure: Lag Measure #3: The percentage of members that were seen in the ED with one of the five targeted LANE diagnoses using ADT and A08 documentation with claims or encounter data for a PCP follow-up visit within 30 days of the ED visit.	2022	Sample Size: 489 Rate: 29.0%	2024	Sample Size 630 Rate 33.8%	☒ Yes No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.089

4. PIP Validation Information

Was the PIP validated? ☒ Yes No

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

Validation phase (check all that apply):

PIP submitted for approval Planning phase Implementation phase Baseline year

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

Validation rating #1: EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis, and interpretation of PIP results.

High confidence ☒ Moderate confidence Low confidence No confidence

Validation rating #2: EQRO’s overall confidence that the PIP produced significant evidence of improvement.

☒ High confidence Moderate confidence Low confidence No confidence N/A — Planning phase

EQRO recommendations for improvement of PIP:

- All six of the quantifiable measures demonstrated improvement; four of those six measures of improvement were statistically significant. The PIP documentation is clearly written and includes detailed interventions, barrier analysis, and identification of opportunities for improvement.
- Although the PIP documentation is clearly written, detailed, and aligns with the identified population health concerns, the Aim Statement lacks specificity and measurability in relation to the overall time period of the PIP. The Aim Statement should include a clearly defined time period that establishes the start and end of the PIP.
- This PIP was shown to have been successful with sustainable processes to continue the use of DHIN A08 information to increase identification of members seen in the ED with a LANE diagnosis to improve member outreach and increase PCP follow up within 30 days. The PIP was retired on September 3, 2024, with DMMA approval.

DFH PIP Overall Assessment

Overall Results

DFH continues to demonstrate a strong understanding of PIP design and implementation. DFH utilizes PIP workgroups for continuous QI, including the review and analysis of initiatives, interventions, and barrier assessments. DFH’s PIPs are clearly written, detailed, and aligned with identified population health concerns. Since the Prenatal and Postpartum Persons with OUD PIP is in its first remeasurement year, the majority of the on-site discussion focused on the initial interventions developed, the PMs, and the remeasurement results. The evaluation demonstrated a high degree of confidence in these foundational steps. Although the PIPs are clearly written, there is room to strengthen the Aim Statement of the PPP with OUD PIP by including the specific PIP intervention, clearly defining the population and time period, and specifying the measurable impact. DFH should also continue to conduct rapid cycle analyses of the PIPs, assess barriers, and update intervention strategies accordingly to increase provider and member

engagement for both PIPs. Additionally, it is important to ensure that all necessary documentation is included when submitting PIP information for validation to support the results.

PPP with OUD PIP

1. General PIP Information
MCP Name: DFH
PIP Title: PPP with OUD PIP
PIP Aim Statement: Increase by 5% the rate at which PPP with OUD utilize pharmacotherapy (buprenorphine or methadone) for treatment by December 2029.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)
☒ State-mandated (State required plans to conduct a PIP on this specific topic.) ☐ Collaborative (Plans worked together during the planning or implementation phases.) ☐ Statewide (The PIP was conducted by all MCOs and/or PIHPs within the State.) ☐ Plan choice (State allowed the plan to identify the PIP topic.)
Target age group (check one):
☐ Children only (ages 0–17 years)* ☐ Adults only (ages 18 years and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here: N/A
Target population description, such as duals, LTSS, or pregnant people (please specify): Pregnant and postpartum women with OUD
Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

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

Member-focused interventions implemented in 2024 by Quarter (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

Barriers	Interventions to Address Barrier	Date Implemented
Member engagement with prenatal care.	Member incentives for attending prenatal visits: \$50 Prenatal Visit within First Trimester or 42 Days of Enrollment Once per pregnancy. \$20 Prenatal Visits Reward requires three prenatal visits. Earn rewards after the third and sixth visits.	07/2024
Member engagement with postpartum care.	Member incentives for attending postpartum visits: \$40 Postpartum Visit One per pregnancy. Must be completed 7–84 days after delivery.	07/2024
Lack of awareness of harm reduction strategies and evidence-based care for PPP	Implementation of assessments for member outreach beyond >90 days postpartum	11/2024
- Unable to reach/locate members - Lack of awareness of harm reduction strategies	Compiled over 500 Narcan and safe sex kits for distribution through Impact Life mobile outreach and Attack Addiction center	12/2024

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

Provider-focused interventions implemented in 2024 by Quarter (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

Barriers	Interventions to Address Barrier	Date Implemented
- Engagement with obstetrical care - Lack of awareness of harm reduction strategies and evidence-based care for PPP. - Unable to reach/locate members	- Established recurring touch points with SUD providers, including outpatient and residential treatment centers. - Outreached to OB providers to initiate recurring touch points.	09/2024
Lack of awareness of harm reduction strategies and evidence-based care for PPP.	Provider training on Perinatal HBV, HCV, and HIV in partnership with the Mid-Atlantic Aids Education Center.	09/2024
- Engagement with obstetrical care - Lack of awareness of harm reduction strategies and evidence-based care for PPP.	Promotion of Birth Equity webinar series and SAMHSA conference to provider network and internal teams.	09/2024–11/2024
Unable to reach members/member engagement: Despite strengthening internal outreach processes, many of our members remained unable to be reached/located during their pregnancy and/or postpartum and/or declined CC services. Providers are not utilizing harm reduction CPT codes	Developed harm reduction reference guide for providers and actively educating providers to bill utilizing the reference guide to capture this being completed. Aim is to capture providers who are educating members and billing appropriately.	12/2024
Lack of awareness of barriers that SUD and OBGYN providers may be experiencing with their patients as it relates to harm reduction for OUD.	Distribution of harm reduction survey to SUD and OBGYN provider network.	12/2024

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

MCP-focused interventions/system changes implemented in 2024 by Quarter (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

Barriers	Interventions to Address Barrier	Date Implemented
Lack of awareness of harm reduction strategies and evidence-based care for PPP.	Trained 83 DFH staff members on HIV prevention & treatment and relationship to SUD and stigma See attachment PIP_5_HIV Training <i>Note: There were more DFH attendees, however, this was an external training event, and not all attendees were captured due to data errors. We have since moved to have training registration go through our Learning Management System.</i>	08/2024
Lack of awareness of harm reduction strategies and evidence-based care for PPP.	Sponsorship of Impact Life's Harm Reduction conference which was attended by over 400 people	08/2024
- Engagement with obstetrical care - Lack of awareness of harm reduction strategies and evidence-based care for PPP.	Promotion of Birth Equity webinar series and SAMHSA conference to provider network and internal teams.	09/2024–11/2024
- Engagement with obstetrical care - Lack of awareness of harm reduction strategies and evidence-based care for PPP. - Unable to reach/locate members	Initiated conversations with DSAMH in collaboration with MCOs to present at SOR conference on May 15, 2025 titled "Enhancing Care for Pregnant and Parenting Individuals with OUD: Medicaid and MCO Collaboration Strategies".	10/2024

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable)	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
Lead Measure #1: Percentage of pregnant members with OUD who were engaged into prenatal care.	4/1/2023–3/28/2024	Sample Size: 13/21 Rate: 62%	2024	Sample Size: 18/22 Rate: 82%	☒ Yes No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.185 (Fisher's exact test)
Lead Measure #2: Percentage of pregnant and postpartum individuals who received education on harm reduction strategies.	4/1/2023–3/28/2024	Sample Size: 0/0 Rate: 0%	2024	Sample Size: 19/50 Rate: 38%	☒ Yes No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): N/A
Lead Measure #3: Percentage of OUD members >90 days through one year postpartum with an SUD screen.	4/1/2023–3/28/2024	Sample Size: 0/21 Rate: 0%	2024	Sample Size: 12/23 Rate: 52%	☒ Yes No	☒ Yes No Specify P-value: <.01 <.05 Other (specify): <0.001 (Fisher's exact test)
Lead Measure #4: Percentage of postpartum members with OUD that received postpartum care.	4/1/2023–3/28/2024	Sample Size: 4/21 Rate: 19%	2024	Sample Size: 8/22 Rate: 36%	☒ Yes No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.310 (Fisher's exact test)
Lead Measure #5: Percentage of providers engaged to review PPP with OUD challenges and opportunities to improve the system of care.	4/1/2023–3/28/2024	Sample Size: 0/0 Rate: 0%	2024	Sample Size: 73/97 Rate: 75%	☒ Yes No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): N/A

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable)	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
Lag Measure #1: Rate of pregnant persons with an OUD diagnosis receiving buprenorphine or methadone.	4/1/2023–3/28/2024	Sample Size: 14/57 Rate: 25%	2024	Sample Size: 6/20 Rate: 30%	☒ Yes ☐ No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.856 (Chi-squared test)
Lag Measure #2: Rate of postpartum persons with an OUD diagnosis receiving buprenorphine or methadone.	4/1/2023–3/28/2024	Sample Size: 15/52 Rate: 29%	2024	Sample Size: 8/22 Rate: 36%	☒ Yes ☐ No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.716 (Chi-squared test)
Lag Measure #3: Rate of buprenorphine utilization in pregnant persons with OUD.	4/1/2023–3/28/2024	Sample Size: 4/57 Rate: 7%	2024	Sample Size: 3/20 Rate: 15%	☒ Yes ☐ No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.367 (Fisher's exact test)
Lag Measure #4: Rate of buprenorphine utilization in postpartum persons with OUD.	4/1/2023–3/28/2024	Sample Size: 5/52 Rate: 10%	2024	Sample Size: 5/22 Rate: 23%	☒ Yes ☐ No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.256 (Chi-squared test)
Lag Measure #5: Rate of methadone utilization in pregnant persons with OUD.	4/1/2023–3/28/2024	Sample Size: 10/57 Rate: 18%	2024	Sample Size: 3/20 Rate: 15%	Yes ☒ No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 1 (Fisher's exact test)

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable)	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
Lag Measure #6: Rate of methadone utilization in postpartum persons with OUD.	4/1/2023–3/28/2024	Sample Size: 10/52 Rate: 19%	2024	Sample Size: 3/22 Rate: 14%	Yes ☒ No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.743 (Fisher's exact test)

4. PIP Validation Information
Was the PIP validated? ☒ Yes No “Validated” means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): PIP submitted for approval Planning phase Implementation phase Baseline year ☒ First re-measurement Second re-measurement Other (specify): Validation rating #1: EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. High confidence ☒ Moderate confidence Low confidence No confidence Validation rating #2: EQRO’s overall confidence that the PIP produced significant evidence of improvement. ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence ☐ N/A — Planning phase

4. PIP Validation Information

- Although the PIP is clearly written, detailed, and aligns with the identified population health concerns, the Aim Statement lacks specificity and measurability. The Aim Statement should include the PIP intervention, define the population and time period, and specify the measurable

Although DFH is showing improvement across nine out of eleven PMs, DFH should consider revisiting and simplifying some of their measures to guarantee the measures are clear, concise, and measuring the intended outcome of the PIP. Clearly defined, objectively, and

Delaware Welcome Call PIP

1. General PIP Information

MCP Name: DFH

PIP Title: Delaware Welcome Call PIP

PIP Aim Statement: Increase member engagement and HRA completion by 10% by converting the outreach method of Welcome Calls to newly enrolled DFH Medicaid members from robocalls to live agents and updating the caller ID to reflect the Plan by December 2026.

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

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

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

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

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

Target age group (check one):

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

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

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

Adult and Child newly enrolled Medicaid members.

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

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

- Live agents conduct outreach and onboarding for newly enrolled members. When agents are able to engage members on the phone, they are discussing New Member Orientation, ID cards, rewards, PCP on file, member portal, nurse advice line, and assisting with HRA

MCP-focused interventions/System changes implemented in 2024 by Quarter (MCP/system change interventions are aimed at

3. PMs and Results (Add rows as necessary)

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
Lead Measure #1: Increase Welcome Call reach rate, using live agents, by 10%.	12/1/2023–12/31/2024	Sample Size: Rate: 35%	2024	Sample Size: 1,273/2,505 Rate: 51%	☒ Yes No	☐ Yes ☐ No Specify P-value: <.01 <.05 Other (specify):

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
Lead Measure #2: Increase Welcome Call engagement rate, using live agents, by 10%.	12/1/2023–12/31/2024	Sample Size: Rate: 25%	2024	Sample Size: 144/1,273 Rate: 11%	Yes ☒ No	Yes No Specify P-value: <.01 <.05 Other (specify):
Lag Measure #1: Increase HRA completion within 60 days of enrollment for new Medicaid/CHIP members to 60%.	12/1/2023–12/31/2024	Sample Size: Rate: 49%	2024	Sample Size: 137/144 Rate: 95%	☒ Yes No	Yes No Specify P-value: <.01 <.05 Other (specify):

4. PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No “Validated” means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations. Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☒ First re-measurement Second re-measurement Other (specify): Validation rating #1: EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence Validation rating #2: EQRO’s overall confidence that the PIP produced significant evidence of improvement. ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence ☐ N/A — Planning phase EQRO recommendations for improvement of PIP: Although the PIP demonstrates success with two of the three quantifiable measures showing improvement, there was limited documentation submitted to fully collaborate the data collected, the analysis performed, and the interpretation of results. No testing was performed to assess the extent to which any change in performance was statistically significant. Ensure all necessary documentation is included when submitting PIP information for validation to support the results.

HHO PIP Overall Assessment

Overall Results

HHO continues to demonstrate a strong understanding of PIP design and implementation. The organization effectively utilizes PIP workgroups and ad hoc subgroups to support continuous QI, including initiative review and analysis, barrier identification, and variance assessment. HHO's PIPs are clearly articulated, detailed, and aligned with identified population health concerns. Following recent updates to the lead measures for the PPP with OUD PIP, the majority of the on-site discussion focused on the initial interventions developed, completed barrier analysis, baseline results, and plans to reassess the PIP strategy and approach.

PIP Name	Confidence PIP Adhered to Acceptable Methodology for All Phases

PPP with OUD PIP

1. General PIP Information
MCP Name: HHO
PIP Title: PPP with OUD
PIP Aim Statement: By the end of the 2029 plan year, increase the percentage by at least 20% of pregnant and postpartum individuals with OUD who initiate and continue MOUD treatment (methadone or buprenorphine) for at least 14 days within 30 days of outreach, compared to the baseline rate in 2023, through the implementation of a telephonic outreach program offering monetary incentives.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)
☒ State-mandated (State required plans to conduct a PIP on this specific topic.)
☐ Collaborative (Plans worked together during the planning or implementation phases.)
☒ Statewide (The PIP was conducted by all MCOs and/or PIHPs within the State.)
☐ Plan choice (State allowed the plan to identify the PIP topic.)

1. General PIP Information

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

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

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

Member-focused interventions implemented in 2024 by Quarter (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- Q1 and ongoing: To ensure broad awareness and reduce potential stigma, information about the PPP with OUD Incentive Program was included in monthly maternity mailers sent to all prenatal and postpartum members. This approach allowed members to self-identify and self-refer to the program. Furthermore, Resource and Care Coordinators proactively informed members identified as high-risk pregnancies due to opioid use of the program and offered referrals. For members who expressed initial interest but did not respond to the vendor's outreach, a notification was placed in the CM system, prompting Care Coordinators to address the program during their next scheduled contact.

PIP_05_Pregnant or just had a baby-Maternity Brochure

PIP_05_Montly Maternity Packets Mailing_Report_2024

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

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

Provider-focused interventions implemented in 2024 by Quarter (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- Q2: Providers were offered \$100 incentive for each referral to MOUD treatment for pregnant and postpartum women. Education was provided via the Provider forum and updates.
PIP_05_Provider Update June 22, 2024 Maternity referrals
- Q3: Recognizing that targeted providers (Primary Care Physicians, Obstetricians/Gynecologists) had not actively engaged in the program despite receiving education through various channels, including fax communications, website notifications via the provider portal, and presentations at provider forums, the three Delaware Medicaid MCOs pooled resources to implement a collaborative intervention. This collaboration culminated in a joint panel discussion at the SOR conference in May, 2025. The panel was led by the BH Medical Directors from each MCO.
- Q4: HHO identified seventeen facilities that administer methadone for treatment, individual training was provided to educate them on the process for verifying that members received their meds at the clinic visit, to initiative member incentive payment. Training was conducted in 2023, and retraining occurred in 2024.

PIP_05_PPPOUD One-Pager Treatment Facility cheat sheet sample

PIP_05_PPPOUD Treatment Facility training sample

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

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

MCP-focused interventions/system changes implemented in 2024 by Quarter (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

In 2023, and continuing forward, HHO integrated comprehensive stigma reduction training for all member-facing staff, including vendor partners such as Reciprocity. This strategy outlines an approach to education and training designed to alleviate general SUD stigma and facilitate MOUD Provider Network Education.

Building on HHO's ongoing commitment to SUD-related staff education, this plan expands the current framework to encompass Provider Network Education, an annual assessment and reporting cycle for implicit bias among staff, and a PIP for PPP with OUD.

Over the past year, HHO has prioritized reducing structural stigma surrounding SUDs through the following actions:

- Clinical Screening Tools: All clinical screening tools were updated to remove potentially stigmatizing language.
 - Supervisor audit tools were also revised to incorporate this review process.
- Training Curriculum:
 - The initial rollout to all current member-facing staff is complete.
 - The training is now a standard component of onboarding for all new hires.
 - Curriculum content and learner outcomes will be evaluated annually.
- Curriculum Topics:
 - Shatterproof Stigma Index: Pre-training Assessment
 - SUD Overview
 - SUD: The Impact of Language
 - Shatterproof Stigma Index: Post-training Assessment

The target audience for this training included staff from CC, LTSS, UM, Medical Directors, Member & Provider Services, Clinical Quality, Provider Relations, Business Analysis, Trainers, Claims, and Appeals & Grievances departments. Results from the Shatterproof Stigma Index indicated a positive shift in attitudes following the training. Shatterproof index results indicate training was effective and had a positive impact. Movement is in the desired direction.

See attachments:

PIP_05_Reducing Structural Stigma with SUD_PIP Report_2024

PIP_05_2024 Reducing Substance Use Disorder Stigma Course Completions Rosters(HHO)

PIP_05_2024 2024 Reducing Substance Use Disorder Stigma Course Completions Rosters (Reciprocity)

3. PMs and Results (Add Rows as Necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable)	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
#1 Lead Measure: Rate of pregnant members who received outreach and began MOUD treatment	2024	Numer: 8 Denom: 77 Rate: 7.69%	☒ <i>Not applicable — PIP is in planning or implementation phase, results not available</i> NOTE: Interventions Began in Q4 2024	N/A ☒ Not applicable — PIP is in planning or implementation phase, results not available	Yes No N/A — PIP is in planning or implementation phase, results not available	☐ Yes ☐ No Specify P-value: <.01 <.05 Other (specify): Not enough data to measure
#2 Lead Measure: Rate of postpartum members who received outreach and began MOUD treatment	2024	Numer: 2 Denom: 187 Rate: 1.07%	☒ <i>Not applicable — PIP is in planning or implementation phase, results not available</i> NOTE: Interventions Began in Q4 2024	N/A ☒ Not applicable — PIP is in planning or implementation phase, results not available	Yes No N/A — PIP is in planning or implementation phase, results not available	Yes No Specify P-value: <.01 <.05 Other (specify): Not enough data to measure
#1 Lag Measure: Rate of buprenorphine utilization in pregnant persons with OUD	2023	Numer: 197 Denom: 1457 Rate: 13.52%	☒ <i>Not applicable — PIP is in planning or implementation phase, results not available</i>	Numer: 32 Denom: 303 Rate: 10.58%	Yes ☒ No	Yes No Specify P-value: <.01 <.05 Other (specify): Not enough data to measure

3. PMs and Results (Add Rows as Necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable)	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
#2 Lag Measure: Rate of methadone utilization in pregnant persons with OUD	2023	Numer: 235 Denom: 1457 Rate: 16.13%	2024 ☒ <i>Not applicable — PIP is in planning or implementation phase, results not available</i>	Numer: 42 Denom: 303 Rate: 13.84%	Yes ☒ No	Yes No Specify P-value: <.01 <.05 <i>Other (specify): Not enough data to measure</i>
#3 Lag Measure: Rate of pregnant persons with an OUD diagnosis receiving buprenorphine or methadone	2023	Numer: 432 Denom: 1457 Rate: 29.6%	2024 ☒ <i>Not applicable — PIP is in planning or implementation phase, results not available</i>	Numer: 74 Denom: 303 Rate: 24.42%	Yes ☒ No	Yes No Specify P-value: <.01 <.05 <i>Other (specify): Not enough data to measure</i>
#4 Lag Measure: Rate of buprenorphine utilization in postpartum persons with OUD	2023	Numer: 384 Denom: 2929 Rate: 13.11%	2024 ☒ <i>Not applicable — PIP is in planning or implementation phase, results not available</i>	Numer: 85 Denom: 565 Rate: 15.58%	☒ Yes No	Yes No Specify P-value: <.01 <.05 <i>Other (specify): Not enough data to measure</i>

3. PMs and Results (Add Rows as Necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable)	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
Lag 5-Rate of methadone utilization in postpartum persons with OUD	2023	Numer 488 Denom: 2929 Rate: 16.66%	2024 ☒ <i>Not applicable — PIP is in planning or implementation phase, results not available</i>	Numer: 92 Denom: 565 Rate: 16.28%	Yes ☒ No	Yes No Specify P-value: <.01 <.05 <i>Other (specify): Not enough data to measure</i>
#6 Lag Measure: Rate of postpartum persons with an OUD diagnosis receiving buprenorphine or methadone	2023	Numer: 872 Denom: 2929 Rate: 29.77%	2024 ☒ <i>Not applicable — PIP is in planning or implementation phase, results not available</i>	Numer: 146 Denom: 565 Rate: 25.84%	Yes ☒ No	☐ Yes ☐ No Specify P-value: <.01 <.05 <i>Other (specify): Not enough data to measure</i>

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

4. PIP Validation Information

Validation rating #1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence ☐ N/A Planning phase

- The PIP is clearly written, detailed, and aligns with the identified population health concerns. The Aim Statement is clear, concise,
- HHO is showing improvement in one of the eight quantifiable measures, with two of the quantifiable measures being in the planning phase.
- As HHO plans to revamp the approach to this PIP, the MCO should revisit previously completed barrier analyses and evaluate the

PAAs PIP

1. General PIP Information

MCP Name: HHO

PIP Title: To decrease delays in treatment due to PAs for those on Opioid and ADHD Medications.

PIP Aim Statement: By December 31, 2026, Highmark will decrease the number of PA rejections by 10% for members and providers who currently experience two or more rejections and a rejection rate of 20% or higher within a month. This will be measured by comparing the rejection rates of this specific cohort from 2024 to 2026 and will contribute to improved member and provider satisfaction.

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

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

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

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

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

1. General PIP Information

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

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

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

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

Member-focused interventions implemented in 2024 by Quarter (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach).

- Q1: HHO has approved the vendor to move forward with registering HHO for the SMS campaign. Text messaging to members started.

“Never run out of prescription medicine.

Refill your prescription before you run out of medicine. Request a refill when you have about 20% of your medicine left. For example, for a 30-day prescription, request a refill five or six days before you need it. This is important because some refills must be approved. This approval is called PA. A refill on your prescription medicine may be delayed if your pharmacy needs to get PA. HHO, your doctor, and your pharmacy need time to communicate when PA is needed.”

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

Provider-focused interventions implemented in 2024 by Quarter (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach).

- Q1: We visited 29 provider offices with “Prior Auths are a Priority” pens and PA cheat sheets. The CME application was approved in December 2023 for the Opioid and ADHD CME Course and made available as of December 18. A fax blast with a link to the course went out to advertise this.
- Q2: We continue to visit provider offices with pens and cheat sheets. We now advertise the CME course in Provider Forums monthly. We have developed a 20-minute provider office staff education course on PAs for opioid and ADHD medications. Staff who participate are put in a lottery for a \$100 Panera’s gift card. We have advertised both educational opportunities in the Provider Update. We had participation from one office.
- Q3: The team determined that adding a flyer to the pen and cheat sheet distribution at offices may increase the number of providers and staff taking advantage of the education offered. Four provider offices were outreached this month.
- See attachment PIP_11_Flyer for offices on educational opportunities.

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

3. PMs and Results (Add rows as necessary)

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
Lead Measure #1: The percentage of opioid and ADHD prescribers with two or more and 20% or more rejections who received the education.	2023	Numer: 139 Denom: 1858 Rate: 7.50%	2024	Numer: 547 Denom: 5580 Rate: 9.93%	☒ Yes No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag Measure #1: The percentage of opioid and ADHD prescribers who were educated who have a lower rate of rejections in a rolling year following education compared to the year prior to education.	2023	Numer: 64 Denom: 188 Rate: 34.00%	2024	Numer: 276 Denom: 547 Rate: 50.37%	☒ Yes No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lead Measure #2: The percentage of members with two or more and 20% or more rejections who received the education.	2023	Numer: 3547 Denom: 5867 Rate: 60.50%	2024	Numer: 16706 Denom: 17880 Rate: 80.26%	☒ Yes No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re measurement year (if applicable)	Most recent re measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P value
Lag Measure #2: The percentage of members who were educated who have a lower rate of rejections in a year following education compared to the year prior to education	2023	Numer: 613 Denom: 5694 Rate: 10.77%	2024	Numer: 4493 Denom: 127865 Rate: 3.67%	Yes ☒ No	☒ Yes No Specify P-value: ☒ <.01 <.05 Other (specify):
Lag Measure #3: The percentage of rejections in the MY's month for opioid and ADHD prescriptions.	2023	12/31/2023 Numer: 2015 Denom: 13925 Rate: 14.5% 12/31/2024 Numer: 2080 Denom: 14066 Rate: 14.8%	2024	Subtractee:44.30% Subtractor: 8.30% Rate: 0.15%	Yes ☒ No	Yes ☒ No Specify P-value: <.01 <.05 Other (specify): 0.45

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

4. PIP Validation Information

Validation phase (check all that apply):

PIP submitted for approval Planning phase Implementation phase Baseline year

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

Validation rating #1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

High confidence ☒ Moderate confidence Low confidence No confidence

Validation rating #2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

High confidence ☒ Moderate confidence Low confidence No confidence N/A Planning phase

EQRO recommendations for improvement of PIP:

- HHO is showing improvement in three of the five quantifiable measures, with all three of those rates showing statistically significant improvement. The PIP documentation is clearly written and includes detailed interventions, barrier analysis, and identification of opportunities for improvement.
- Although the PIP is clearly written, detailed, and aligns with the identified population health concerns, the Aim Statement lacks specificity and measurability. The Aim Statement should include the PIP intervention, define the population and time period, and specify the measurable impact.

Section 5

Validation of Performance Measures

The PM validation process included a review of the written P&Ps the staff follow when reports and measure scores are generated. The CMS protocol “Validating Performance Measures” guided the assessment of compliance with identified specifications applicable to each PM. The measures reviewed for 2025 included a combination of CMS adult and child core measures, HEDIS measures, and QCMR measures. Additionally, the HEDIS roadmap was reviewed for additional details specific to HEDIS reporting.

Compliance Findings

High Confidence	Moderate Confidence	Low Confidence	No Confidence
	After a review of the	MCO staff describes and verifies the existence of compliant practices during the interview(s), but the required documentation is incomplete or inconsistent with practice.	After a review of the documentation and discussion with MCO staff, it is determined that although some requirements have been met, the MCO has not met most of the requirements.

ACDE PMs Overall Assessment

Overall Assessment

ACDE developed a comprehensive approach that relies on technology, processes, and people to calculate the PMs and HEDIS rates, as well as to create DMMA-required reporting.

In 2024, ACDE calculated the HEDIS measures’ rates using the NCQA-certified vendor Inovalon, Inc (product Converged Analytics). ACDE contracted with HealthcareData Company, LLC, a HEDIS-licensed organization, for completing the MY 2024 HEDIS audit.

ACDE systems include core processing systems which, along with supplemental data, support the data loading and extraction to and from the Enterprise Data Warehouse (EDW). Before the data enters the systems used for PM (or any reporting) processing, the data

are validated for accuracy, quality, and completeness to ensure only quality data are used for reporting. Once the data are validated, the HEDIS extract file is generated from the EDW and loaded into Converged Analytics for interim, and later final processing. The HEDIS extract files rely on data from different systems and sources and include, but are not limited to, medical claims, pharmacy claims, laboratory results, dental claims, vision claims, medical records, and electronic data sources. The MCO also implemented appropriate processes to review and validate the results and calculated HEDIS rates.

The files are generated and loaded into the Inovalon product for monthly processing, which allows ACDE to review the rates, monitor for discrepancies, and address identified deficiencies in a timely manner.

ACDE's medical record review (MRR) abstraction and overread functions for hybrid measures was completed by organization staff and their contracted vendor, Reveeler. Robust training and interrater reliability processes are in place to ensure the accuracy of the MRRs.

ACDE has established processes, policies, and systems to support regulatory reporting, including DMMA-specific reporting. ACDE relies on its parent company to gather the requirements, develop the necessary code, and generate the DMMA-specific reports. The local ACDE team is responsible for monitoring the report production, reviewing results, and providing final approval, as the accuracy of some reports depends on the market-specific experience and expertise. All reporting generated by the Regulatory Reporting team are reviewed by analysts and the business owner, with the COO providing final sign-off. The standard review process includes verifying that all requested data elements are included, that data fall within the specified reporting period, and that all data meet the defined criteria.

The claims systems, provider systems, eligibility systems, and data integration from the vendor and any auxiliary data were assessed during the ISCA and summary and any findings and recommendations are included in that section of the report.

Overall Results

PM	Confidence in Reported Results
PM 1: UM — IP Services: Medical Admits/1,000 members	Low Confidence
PM 2: UM — Dental: Rate of Medicaid members who had follow-up after ED visit for non-traumatic dental conditions	Low Confidence
PM 3: Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	High Confidence
PM 4: Prenatal and Postpartum Care — Timeliness of Prenatal Care (PPC)	High Confidence
PM 5: Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	High Confidence
PM 6: Glycemic Status Assessment for Patients with Diabetes (GSD-AD)	High Confidence

UM — IP Services: Medical Admits/1,000 members

1. Overview of PM 1
MCP name: ACDE
PM name: UM — IP Services: Medical Admits/1,000 members
Measure steward: Agency for Healthcare Research and Quality (AHRQ) Centers for Disease Control and Prevention (CDC) CMS NCQA The Joint Commission (TJC) ☒ No measure steward, developed by State/EQRO Other measure steward (specify): Click or tap here to enter text.
Is the PM part of an existing measure set? (check all that apply) HEDIS® CMS Child or Adult Core Set ☒ Other (specify): QCMMR Requirements
What data source(s) was used to calculate the measure? (check all that apply) Administrative data (describe): Medical records (describe): Click or tap here to enter text. ☒ Other (specify): Facets
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): Number of Medicaid/CHIP members.
Definition of numerator (describe): Number of medical acute care IP admissions for Medicaid/CHIP members.
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date): January 2024 to December 2024

2. PM 1 Results (If measure contains more than one rate, add columns to the table)						
PM DHSP	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024
						375
						67,094
						5.6
PM	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
					367	411
					63,672	63,422
					5.8	6.5
PM DHSP Plus	2024					
	-					

3. PM 1 Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). ACDE reported no deviations from technical specifications. However, the EQRO identified that the code submitted to calculate the measure did not align with the measure's technical specifications for age inclusion. ACDE's age calculation code did not include members 18 years of age.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. ☐ Not applicable (ISCA not reviewed) No findings.
Describe any findings from MRR that affected the reliability or validity of the PM results. ☒ Not applicable (MRR not conducted)
Describe any other validation findings that affected the accuracy of the PM calculation. ACDE submitted updated code following the on-site meeting discussions; however, these changes will only affect future results.

³ The reported numerator, denominator, and rate do not align: $(477 \div 64,335) \times 1000 = 7.4$

⁴ NR: Not Reported. The organization did not report the metrics for DHSP Plus.

3. PM 1 Validation Status

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

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

- Ensure ACDE’s processes for peer review and annual review of the code are implemented to ensure alignment with PM specifications.
- Provide DHSP Plus data for QCMMR measures with future submissions.
- Ensure the calculated rates are accurately reported with future submissions.

UM — Dental: Rate of Medicaid Members Who Had Follow-up After ED Visit for Non-Traumatic Dental Conditions

1. Overview of PM 2

MCP name: ACDE

PM name: UM — Dental: Rate of Medicaid members who had follow-up after ED visit for non-traumatic dental conditions

Measure steward:

AHRQ
CDC
CMS
NCQA
TJC

☒ No measure steward, developed by State/EQRO
Other measure steward (specify): [Click or tap here to enter text.](#)

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

HEDIS®
CMS Child or Adult Core Set

☒ Other (specify): QCMMR Requirements

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

Administrative data (describe):

Medical records (describe): [Click or tap here to enter text.](#)

☒ Other (specify): Facets and Enterprise Data Warehouse

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

☒ Not applicable (hybrid method not used)

1. Overview of PM 2

Number of ambulatory care sensitive non-traumatic dental condition ED visits in the reporting period.

Number of ambulatory care sensitive non-traumatic dental condition ED visits in the reporting period for which the Medicaid member visited a

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

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

PM	7 Days (Medicaid/CHIP)	30 Days (Medicaid/CHIP)	7 Days (DSHP Plus)	30 Days (DSHP Plus)
Numerator	-	181	-	-
Denominator	-	983	-	-
Rate	NR ⁵	18.41% ⁶	NR ³	NR ³

3. PM 2 Validation Status

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

ACDE reported no deviations from technical specifications. However, the EQRO found that both the original and resubmitted code used to calculate the measure did not fully comply with these specifications. In particular, the code did not appear to include the required age calculation.

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

☐ Not applicable (ISCA not reviewed)

No findings.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

⁵ NR: Not reported. The organization did not report the metrics.

⁶ Due to small numerators, the EQRO calculated the annual rates based on the organization's submitted monthly rates.

3. PM 2 Validation Status

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

None.

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

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

- Ensure ACDE’s processes for peer review and annual review of the code are implemented to ensure alignment with PM specifications.
- Update the code used to calculate the measure to ensure alignment with the measure’s technical specifications. While ACDE submitted updated code based on the on-site meeting discussion, the additional code requested for age calculation was not identified in the resubmitted code.
- Provide DHSP Plus data for QCMMR measures with future submissions.
- Provide all results for measures with more than one rate with future submissions.

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

1. Overview of PM 3

MCP name: ACDE

PM name: Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Measure steward:

AHRQ

CDC

CMS

☒ NCQA

TJC

No measure steward, developed by State/EQRO

Other measure steward (specify): California HealthCare Foundation.

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

☒ HEDIS®

CMS Child or Adult Core Set

Other (specify): Click or tap here to enter text.

1. Overview of PM 3

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

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

The denominator was identified per the NCQA HEDIS MY2024 Volume 2 Technical Specifications for Health Plans, ECDS-Depression Screening
Summary: The percentage of members 12 years of age or older who were screened for clinical depression using a standardized instrument and,

The numerator was identified per the NCQA HEDIS MY2024 Volume 2 Technical Specifications for Health Plans, ECDS-Depression Screening

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

2. PM 3 Results

PM	Depression Screening	Follow Up on Positive Screening
Numerator	913	45
Denominator	22,992	84
Rate	3.97%	53.57%

3. PM 3 Validation Status

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

No deviations from technical specifications.

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

☐ Not applicable (ISCA not reviewed)

No findings.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

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

None.

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

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

None.

PPC — Timeliness of Prenatal Care

1. Overview of PM 4

MCP name: ACDE

PM name: PPC — Timeliness of Prenatal Care

Measure steward:

☐ AHRQ

☐ CDC

☐ CMS

☒ NCQA

☐ TJC

☐ No measure steward, developed by State/EQRO

☐ Other measure steward (specify): [Click or tap here to enter text.](#)

1. Overview of PM 4

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

☐ Other (specify): Click or tap here to enter text.

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

☒ Medical records (describe): Medical record review was conducted, as this measure is reported via the hybrid method to find the percentage of

☐ Not applicable (hybrid method not used)

Systematic sampling was performed per the NCQA HEDIS MY2024 Volume 2 Technical Specifications for Health Plans, PPC measure.

Definition of denominator (describe):

The denominator was identified per the NCQA HEDIS MY2024 Volume 2 Technical Specifications for Health Plans, PPC measure.

The numerator was identified per the NCQA HEDIS MY2024 Volume 2 Technical Specifications for Health Plans, PPC measure.

Summary: The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42

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

2. PM 4 Results

PM	Timeliness of Prenatal Care
Numerator	267
Denominator	305
Rate	87.54%

3. PM 4 Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator,

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

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

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)

1. Overview of PM 5

MCP name: ACDE

PM name: Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)

Measure steward:

AHRQ

☐ CDC

☐ CMS

☒ NCQA

☐ TJC

☐ No measure steward, developed by State/EQRO

☐ Other measure steward (specify): [Click or tap here to enter text.](#)

1. Overview of PM 5

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

- ☒ HEDIS®
☒ CMS Child or Adult Core Set

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

- ☒ Administrative data (describe): FACETS claims (core claims processing)
☐ Medical records (describe): Click or tap here to enter text.
☐ Other (specify): Click or tap here to enter text.

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

- ☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

The denominator was identified per the NCQA HEDIS MY2024 Volume 2 Technical Specifications for Health Plans, Follow-Up After Hospitalization for Mental Illness (FUH) measure.

Summary: Discharges for members age 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis between 1/1/2024 and 12/1/2024.

Definition of numerator (describe):

The numerator was identified per the NCQA HEDIS MY2024 Volume 2 Technical Specifications for Health Plans, Follow-Up After Hospitalization for Mental Illness (FUH) measure.

Summary: The percentage of discharges that received follow-up care within 30 days and 7 days after discharge.

Other elements of numerator compliance are in accordance with HEDIS MY2023 Specifications.

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

Measurement period (start/end date): 1/1/2024–12/31/2024

2. PM 5 Results

PM	FUH (7 Days)	FUH (30 Days)
Numerator	-	-
Denominator	0	0
Rate	NA ⁷	NA ⁵

⁷ NA: Not applicable. The organization reported zero members in the measure denominator.

3. PM 5 Validation Status

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

No deviations from technical specifications.

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

Not applicable (ISCA not reviewed)

No findings.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

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

None

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

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

None.

Glycemic Status Assessment for Patients with Diabetes (GSD-AD)

1. Overview of PM 6

MCP name: ACDE

PM name: Glycemic Status Assessment for Patients with Diabetes (GSD-AD)

Measure steward:

AHRQ

CDC

CMS

☒ NCQA

TJC

No measure steward, developed by State/EQRO

Other measure steward (specify): [Click or tap here to enter text.](#)

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

1. Overview of PM 6

☒ HEDIS®
 ☒ CMS Child or Adult Core Set
 Other (specify): [Click or tap here to enter text.](#)

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): FACETS claims (core claims processing), RX data (Pharmacy claims)
☒ Medical records (describe): Medical record review was conducted, as this measure is reported via the hybrid method to find the percentage of members 18–75 years old who had a diagnosis of diabetes and whose A1c or glucose management indicator was adequately controlled < 8.0% during the MY.
☒ Other (specify): Supplemental data: DHIN, JIVA NSSD, i2i, CCHS, Aledade, ATHENA, Labcorp

If the hybrid method was used, describe the sampling approach used to select the medical records:
 Not applicable (hybrid method not used)
 Systematic sampling was performed per the NCQA HEDIS MY2024 Volume 2 Technical Specifications for Health Plans, Glycemic Status Assessment for Patients with Diabetes (GSD) measure.

Definition of denominator (describe):
 The denominator was identified per the NCQA HEDIS MY2024 Volume 2 Technical Specifications for Health Plans, Glycemic Status Assessment for Patients with Diabetes (GSD) measure.
 Summary: Members between 18–75 as of December 31, 2024 who were diagnosed with diabetes in the MY or year prior, or who were dispensed insulin or hypoglycemics/antihyperglycemics during the MY or the prior year.

Definition of numerator (describe):
 The numerator was identified per the NCQA HEDIS MY2024 Volume 2 Technical Specifications for Health Plans, Glycemic Status Assessment for Patients with Diabetes (GSD) measure.
 Summary: Identify the most recent A1c or GMI taken during the MY.

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

Measurement period (start/end date): 1/1/2024–12/31/2024

2. PM 6 Results		
PM	Less than 8	Greater than 9
Numerator	253	117
Denominator	410	410
Rate	61.71%	28.54%

3. PM 6 Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). No deviations from technical specifications.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. Not applicable (ISCA not reviewed) No findings.
Describe any findings from MRR that affected the reliability or validity of the PM results. Not applicable (MRR not conducted) No findings.
Describe any other validation findings that affected the accuracy of the PM calculation. None.
Validation rating: ☒ High confidence Moderate confidence Low confidence No confidence “Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.
EQRO recommendations for improvement of PM calculation: None.

DFH PMs Overall Assessment

Overall Assessment

DFH developed a comprehensive approach that relies on technology, processes, and people to calculate the PMs and HEDIS rates, as well as to create DMMA required reporting.

In 2024, DFH calculated the HEDIS measures’ rates using the NCQA certified vendor Inovalon, Inc (product Converged Analytics). DFH contracted with Attest Healthcare Advisors (Attest), a HEDIS licensed organization, for completing the MY 2024 HEDIS audit.

DFH systems include core processing systems which, along with supplemental data, support the loading and extraction of data to and from the EDW. Before the data enters the systems used for PM or any reporting processes, they are validated for accuracy, quality, and completeness to ensure that only high-quality data are used for reporting. Once validated, the HEDIS extract file is generated from the EDW and loaded into Converged Analytics for interim and, subsequently, final processing. The HEDIS extract files draw on data from various systems and sources, including, but not limited to, medical claims, pharmacy claims, lab results, dental claims, vision claims, medical records, and electronic data sources. The MCO has also implemented appropriate processes to review and validate the results and the calculated HEDIS rates.

The files are generated and loaded into the Inovalon product for monthly processing, which allows DFH to review the rates, monitor for discrepancies, and address identified deficiencies in a timely manner.

DFH (and its parent company Centene) did not delegate the MRR abstraction and overread functions for hybrid measures but rather developed the necessary skills and competencies internally to successfully complete the review. Centene provided the structure and chase logic and DFH performed the retrieval, abstraction, and overread of the medical records.

DFH has established processes, policies, and systems to support regulatory reporting, including DMMA specific reporting. DFH relies on its parent company to gather the requirements, develop the necessary code, and generate the DMMA specific reports. The local DFH role includes monitoring the report production, reviewing results, and providing final approval, as the accuracy of some reports depends on the market specific experience and expertise.

The claims systems, provider systems, eligibility systems, and data integration from the vendor and any auxiliary data were assessed during the ISCA, and summary and any findings and recommendation are included in that section of the report.

PM	Confidence in Reported Results
PM 1: UM — IP Services: Medical Admits/1,000 members	Unable to Validate
PM 2: UM — Dental: Rate of Medicaid members who had follow-up after ED visit for non-traumatic dental conditions	Unable to Validate
PM 3: Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	High Confidence
PM 4: Prenatal and Postpartum Care — Timeliness of Prenatal Care (PPC)	High Confidence
PM 5: Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	High Confidence
PM 6: Hemoglobin A1c Control for Patients with Diabetes (GSD-AD)	High Confidence

UM — IP Services: Medical Admits/1,000 members

1. Overview of PM 1
MCP name: DFH
PM name: PM 1: UM — IP Services: Medical Admits/1,000 members

1. Overview of PM 1

Measure steward:

AHRQ
CDC
CMS
NCQA
TJC

No measure steward; developed by State/EQRO

☒ Other measure steward (specify): DMMA

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

HEDIS®

CMS Child or Adult Core Set

☒ Other (specify): State QCMMR

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

☒ Administrative data (describe): Administrative data includes information from claims and encounters, such as diagnosis codes, procedure codes, dates of service, and provider details. It may also include pharmacy claims, enrollment records, and demographic data. This data is used to assess the delivery and QOC without requiring manual chart reviews.

Medical records (describe): Click or tap here to enter text.

Other (specify): Click or tap here to enter text.

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

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Number of Medicaid/CHIP members. Rate = (numerator/denominator) * 1,000

Definition of numerator (describe):

Number of medical acute care IP admissions for Medicaid/CHIP members.

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

Measurement period (start/end date): 1/1/2024–12/31/2024

2. PM 1 Results						
PM DHSP	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024
	89	78	90	120	113	89
	30,695	30,464	30,399	30,544	30,578	29,776
	2.90	2.56	2.96	3.93	3.70	2.99
PM	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
	118	107	96	112	93	128
	30,048	30,729	31,118	31,419	31,943	32,369
	3.93	3.48	3.09	3.57	2.91	3.95
PM DHSP Plus	2024					
	147					

3. PM 1 Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). DFH reported no deviations from the technical specifications. However, the EQRO was unable to verify whether the measure was calculated in accordance with the technical specifications because DFH did not provide the raw code in the original or follow-up submissions.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. Not applicable (ISCA not reviewed) No findings.
Describe any findings from MRR that affected the reliability or validity of the PM results. ☒ Not applicable (MRR not conducted)
Describe any other validation findings that affected the accuracy of the PM calculation. None.

⁸ The EQRO calculated the numerators using the rates and denominators provided by the organization.

⁹ Due to small numerators, the EQRO calculated the annual rate from the monthly rates the organization submitted.

3. PM 1 Validation Status

Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ Unable to validate
“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

- Provide the raw code used to calculate the measure, highlighting the measure specification details (CPT codes, rev codes, age stratification, taxonomies, etc.).
- Develop a standard process at the plan level for maintaining and tracking code updates for plan specific reports.
- Ensure numerators are provided with future submissions. DFH resubmitted monthly results without numerators.

UM — Dental: Rate of Medicaid Members Who Had Follow-up After ED Visit for Non-Traumatic Dental Conditions

1. Overview of PM 2

MCP name: DFH

PM name: PM 2: UM —Dental: Rate of Medicaid members who had follow-up after ED visit for non-traumatic dental conditions

Measure steward:

AHRQ
CDC
CMS
NCQA
TJC

No measure steward; developed by State/EQRO

☒ Other measure steward (specify): DMMA

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

HEDIS®

CMS Child or Adult Core Set

☒ Other (specify): State QCMMR

1. Overview of PM 2

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

codes, dates of service, and provider details. It may also include pharmacy claims, enrollment records, and demographic data. This data is used

☐ Medical records (describe): Click or tap here to enter text.

☐ Other (specify): Click or tap here to enter text.

Definition of denominator (describe):

Definition of numerator (describe):

Number of ambulatory care sensitive non-traumatic dental condition ED visits in the reporting period for which the Medicaid member visited a

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

2. PM 2 Results

PM	7 Days (Medicaid/CHIP)	30 Days (Medicaid/CHIP)	7 Days (DSHP Plus)	30 Days (DSHP Plus)
Numerator	20	24	-	-
Denominator	312	312	9	9
Rate	6.41%	7.69%	NA ¹⁰	NA ⁵

¹⁰ NA: Not applicable. The organization reported the metric, but the denominator was too small (<30) to report a valid rate.

3. PM 2 Validation Status

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

DFH reported no deviations from the technical specifications. However, the EQRO was unable to verify whether the measure was calculated in accordance with the technical specifications because DFH did not provide the raw code for either the original or follow-up submissions.

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

☐ Not applicable (ISCA not reviewed)

No findings.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

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

None.

Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ Unable to validate

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

- Provide the raw code used to calculate the measure, highlighting the measure specification details (CPT codes, rev codes, age stratification, taxonomies, etc.).
- Develop a standard process at the plan level for maintaining and tracking code updates for plan specific reports.

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

1. Overview of PM 3

MCP name: DFH

PM name: PM 3: Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Measure steward:

☐ AHRQ

☐ CDC

☐ CMS

☒ NCQA

☐ TJC

☐ No measure steward; developed by State/EQRO

☐ Other measure steward (specify): Click or tap here to enter text.

1. Overview of PM 3

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

- ☒ HEDIS®
☐ CMS Child or Adult Core Set

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

- ☒ Administrative data (describe): Administrative data includes information from claims and encounters, such as diagnosis codes, procedure codes, dates of service, and provider details. It may also include pharmacy claims, enrollment records, and demographic data. This data is used to assess the delivery and QOC without requiring manual chart reviews.
☐ Medical records (describe): Click or tap here to enter text.
☐ Other (specify): Click or tap here to enter text.

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

- ☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Denominator 1 — Members 12 years of age and older at the start of the measurement period who also meet criteria for participation.
Denominator 2 — All members from numerator 1 with a positive depression screen finding between January 1 and December 1 of the measurement period.

Definition of numerator (describe):

Numerator 1 — Members with a documented result for depression screening, using an age-appropriate standardized instrument, performed between January 1 and December 1 of the measurement period.
Numerator 2 — Members who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days) OR Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.

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

Measurement period (start/end date): 1/1/2024–12/31/2024

2. PM 3 Results

PM	Depression Screening	Follow Up on Positive Screening
Numerator	290	-
Denominator	12,239	26

2. PM 3 Results		
PM	Depression Screening	Follow Up on Positive Screening
Rate	2.37%	NA ¹¹

3. PM 3 Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). No deviations from technical specifications.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. ☐ Not applicable (ISCA not reviewed) No findings.
Describe any findings from MRR that affected the reliability or validity of the PM results. ☒ Not applicable (MRR not conducted)
Describe any other validation findings that affected the accuracy of the PM calculation. None.
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence “Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.
EQRO recommendations for improvement of PM calculation: None.

PPC — Timeliness of Prenatal Care

1. Overview of PM 4
MCP name: DFH
PM name: PM 4: PPC — Timeliness of Prenatal Care

¹¹ NA: Not applicable. The organization reported the metric, but the denominator was too small (<30) to report a valid rate.

1. Overview of PM 4

Measure steward:

AHRQ

CDC

CMS

☒ NCQA

TJC

No measure steward; developed by State/EQRO

Other measure steward (specify): [Click or tap here to enter text.](#)

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

☒ HEDIS®

CMS Child or Adult Core Set

Other (specify): [Click or tap here to enter text.](#)

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

☒ Administrative data (describe): Administrative data includes information from claims and encounters, such as diagnosis codes, procedure codes, dates of service, and provider details. It may also include pharmacy claims, enrollment records, and demographic data. This data is used to assess the delivery and QOC without requiring manual chart reviews.

☒ Medical records (describe): Hybrid data combines administrative data (like claims and encounters) with clinical information collected through medical record reviews. This method is used when administrative data alone doesn't.

Other (specify): [Click or tap here to enter text.](#)

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

Sample drawn utilizing Guidelines for Calculations and Sampling outlined in MY2024 HEDIS Technical Specifications

Not applicable (hybrid method not used)

Definition of denominator (describe):

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Adult Core Set for additional information.

1. Overview of PM 4

Definition of numerator (describe):

Prenatal care visit to an OB/GYN or other prenatal care practitioner, or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred and evidence of one of the following: Documentation indicating the beneficiary is pregnancy or references to the pregnancy; A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used); Evidence that a prenatal care procedure was performed.

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

2. PM 4 Results

PM	Timeliness of Prenatal Care
Numerator	341
Denominator	411
Rate	82.97%

3. PM 4 Validation Status

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

No deviations from technical specifications.

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

☐ Not applicable (ISCA not reviewed)

No findings.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☐ Not applicable (MRR not conducted)

No findings.

3. PM 4 Validation Status

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

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)

1. Overview of PM 5

MCP name: DFH

PM name: PM 5: Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)

Measure steward:

AHRQ

CDC

☒ CMS

NCQA

TJC

No measure steward; developed by State/EQRO

Other measure steward (specify): Click or tap here to enter text.

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

☐ HEDIS®

☒ CMS Child or Adult Core Set

☐ Other (specify): Click or tap here to enter text.

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

☒ Administrative data (describe): Administrative data includes information from claims and encounters, such as diagnosis codes, procedure codes, dates of service, and provider details. It may also include pharmacy claims, enrollment records, and demographic data. This data is used to assess the delivery and QOC without requiring manual chart reviews.

☐ Medical records (describe): Click or tap here to enter text.

☐ Other (specify): Click or tap here to enter text.

1. Overview of PM 5

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

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

The eligible population as defined in Core Set Manual.

Definition of numerator (describe):

Numerator 1: 30 Day Follow-up. A follow-up visit with a MH provider within 30 days after discharge. Do not include visits that occur on the date of discharge.

Numerator 2: 7 Day Follow-up. A follow-up visit with a MH provider within 7 days after discharge. Do not include visits that occur on the date of discharge.

For both indicators, any of the following meet criteria for a follow-up visit:

- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a MH provider.
- An outpatient visit (BH Outpatient Value Set) with a MH provider.

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

Measurement period (start/end date): 1/1/2024–12/1/2024

2. PM 5 Results

PM	FUH (7 Day)	FUH (30 Day)
Numerator	-	-
Denominator	3	3
Rate	NA ¹²	NA ⁷

3. PM 5 Validation Status

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

No deviations from technical specifications.

¹² NA: Not applicable. The organization reported the metric, but the denominator was too small (<30) to report a valid rate.

3. PM 5 Validation Status

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

Not applicable (ISCA not reviewed)
No findings.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

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

None.

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

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

None.

Glycemic Status Assessment for Patients with Diabetes (GSD-AD)

1. Overview of PM 6

MCP name: DFH

PM name: PM 6: Glycemic Status Assessment for Patients with Diabetes (GSD-AD)

Measure steward:

AHRQ

CDC

☒ CMS

NCQA

TJC

No measure steward; developed by State/EQRO

Other measure steward (specify): [Click or tap here to enter text.](#)

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

HEDIS®

☒ CMS Child or Adult Core Set

Other (specify): [Click or tap here to enter text.](#)

1. Overview of PM 6

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

- ☒ Administrative data (describe): Administrative data includes information from claims and encounters, such as diagnosis codes, procedure codes, dates of service, and provider details. It may also include pharmacy claims, enrollment records, and demographic data. This data is used to assess the delivery and QOC without requiring manual chart reviews.
- ☒ Medical records (describe): Hybrid data combines administrative data (like claims and encounters) with clinical information collected through medical record reviews. This method is used when administrative data alone doesn't.
- ☐ Other (specify): [Click or tap here to enter text.](#)

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

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Adult Core Set for additional information.

☐ Not applicable (hybrid method not used)

Definition of denominator (describe):

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Adult Core Set for additional information.

Definition of numerator (describe):

The most recent HbA1c level (performed during the MY) is <8.0% as identified by laboratory data or medical record review.

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

Measurement period (start/end date): 1/1/2024–12/31/2024

2. PM 6 Results

PM	Less than 8.0 (ages 18 64)	Less than 8.0 (ages 65 75)	Greater than 9.0 (ages 18 64)	Greater than 9.0 (ages 65 75)
Numerator	211	38	123	11
Denominator	363	54	363	54
Rate	58.1%	70.4%	33.9%	20.4%

3. PM 6 Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). No deviations from technical specifications.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. ☐ Not applicable (ISCA not reviewed) No findings.
Describe any findings from MRR that affected the reliability or validity of the PM results. ☒ Not applicable (MRR not conducted)
Describe any other validation findings that affected the accuracy of the PM calculation. None.
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence “Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.
EQRO recommendations for improvement of PM calculation: None.

HHO PMs Overall Assessment

Overall Assessment

HHO developed a comprehensive approach that relies on technology, processes, and people to calculate the PMs and HEDIS rates, as well as to create DMMA-required reporting.

In 2024, HHO calculated the HEDIS measures’ rates using the NCQA certified vendor Inovalon, Inc (product Converged Analytics). HHO contracted with DTS Group, a HEDIS licensed organization, for completing the MY 2024 HEDIS Audit.

HHO systems include core processing systems which, along with supplemental data, support the data loading and extraction to and from the EDW. Before the data enters the systems used for PMs (or any reporting) processing, the data are validated for accuracy, quality, and completeness to ensure only quality data are use. Once the data are validated, the HEDIS extract file is generated from the EDW and loaded into Converged Analytics for interim, and later final processing. The HEDIS extract files rely on data from different systems and sources and include, but are not limited to, medical claims, pharmacy claims, lab results, dental claims, vision claims, medical records, and electronic data sources. The MCO also implemented appropriate processes to review and validate the results and calculated HEDIS rates.

The files are generated and loaded into the Inovalon product for monthly processing, which allows HHO to review the rates, monitor for discrepancies, and address identified deficiencies in a timely manner.

HHO delegated the MRR functions for the hybrid measures to PalmQuest Inc. PalmQuest has been conducting MRRs for HHO since MY 2020. The HHO clinical staff overreads all abstracted charts that are numerator compliant or have exclusionary data.

HHO has established processes, policies, and systems to support regulatory reporting, including DMMA-specific reporting. HHO's Quality Department works closely with the Medicaid Analytics team to define scope and report design and generate the initial report for review. After all the assumptions are clarified and report outcomes are deemed reasonable, the report is moved to production for the automated process. Any significant variances are reviewed to ensure accuracy of the reported data.

The claims systems, provider systems, eligibility systems, and data integration from the vendor and any auxiliary data were assessed during the ISCA and summary and any findings and recommendation are included in that section of the report.

PM	Confidence in Reported Results
PM 1: UM — IP Services: Medical Admits/1,000 members	Unable to Validate
PM 2: UM — Dental: Rate of Medicaid members who had follow-up after ED visit for non-traumatic dental conditions	High Confidence
PM 3: Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	High Confidence
PM 4: PPC — Timeliness of Prenatal Care	High Confidence
PM 5: Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	High Confidence
PM 6: Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)	High Confidence

UM — IP Services: Medical Admits/1,000 members

1. Overview of PM 1
MCP name: HHO
PM name: UM — IP Services: Medical Admits/1,000 members

1. Overview of PM 1

Measure steward:

AHRQ
CDC
CMS
NCQA
TJC

☒ No measure steward, developed by State/EQRO
Other measure steward (specify): [Click or tap here to enter text.](#)

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

☒ HEDIS®
CMS Child or Adult Core Set
Other (specify): [Click or tap here to enter text.](#)

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

☒ Administrative data (describe): Claims
Medical records (describe): [Click or tap here to enter text.](#)
Other (specify): [Click or tap here to enter text.](#)

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

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Number of Medicaid members that are DSHP or DSHP plus by month.

Definition of numerator (describe):

Number of members that had a Medicaid admit during the period.

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

Measurement period (start/end date): 1/1/2024–12/31/2024

2. PM 1 Results						
PM DHSP	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024
Numerator	257	248	307	285	265	230
Denominator	134,938	130,941	129,403	127,859	125,795	123,786
Rate	1.90	1.89	2.37	2.23	2.11	1.86
PM	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Numerator	207	235	252	287	258	318
Denominator	118,153	117,036	116,292	115,458	114,507	113,419
Rate	1.75	2.01	2.17	2.49	2.25	2.80
PM DHSP Plus	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024
Numerator	170	111	114	147	137	142
Denominator	9,644	9,563	9,561	9,567	9,542	9,573
Rate	17.63	11.61	11.92	15.37	14.36	14.83
PM	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Numerator	146	118	126	138	113	146
Denominator	9,536	9,579	9,607	9,630	9,661	9,695
Rate	15.31	12.32	13.12	14.33	11.70	15.06

3. PM 1 Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). HHO reported no deviations from technical specifications. However, the EQRO was unable to determine whether the measure was calculated in accordance with the measure's technical specifications. Additional information is needed regarding included and excluded taxonomies. The submitted code used to calculate the measure was limited to four taxonomies: 282N00000X, 282NC0060X, 282NR1301X, and 275N00000X.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. ☐ Not applicable (ISCA not reviewed) No findings.
Describe any findings from MRR that affected the reliability or validity of the PM results. ☒ Not applicable (MRR not conducted)

3. PM 1 Validation Status

Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ Cannot be validated

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

Provide additional information on taxonomies included/not included in the rate calculation. Although HHO submitted additional documentation explaining how the code relates to the specifications, the information regarding which taxonomies were included or excluded from the rate

UM — Dental: Rate of Medicaid Members Who Had Follow-up After ED Visit for Non-Traumatic Dental Conditions

1. Overview of PM 2

MCP name: HHO

PM name: UM — Dental: Rate of Medicaid members who had follow-up after ED visit for non-traumatic dental conditions

Measure steward:

AHRQ
CDC
CMS
NCQA
TJC

☒ No measure steward, developed by State/EQRO

Other measure steward (specify): [Click or tap here to enter text.](#)

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

☐ HEDIS®

☐ CMS Child or Adult Core Set

☒ Other (specify): Internal data defined by Mercer/DMMA

1. Overview of PM 2

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

Definition of denominator (describe):

☐☐

2. PM 2 Results

PM	7 Days (Medicaid/CHIP)	30 Days (Medicaid/CHIP)	7 Days (DSHP Plus)	30 Days (DSHP Plus)
			-	-
			-	-
			NR ¹⁴	NR ²

3. PM 2 Validation Status

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

No deviations from technical specifications.

¹³ Due to small numerators, the EQRO calculated the annual rates from the quarterly rates the organization submitted.

¹⁴ NR: Not reported. The organization did not report the metrics for DHSP Plus.

3. PM 2 Validation Status

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

Not applicable (ISCA not reviewed)
No findings.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

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

None.

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

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

Provide DHSP Plus data for QCMMR measures with future submissions.

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

1. Overview of PM 3

MCP name: HHO

PM name: Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Measure steward:

AHRQ

CDC

CMS

☒ NCQA

TJC

No measure steward, developed by State/EQRO

Other measure steward (specify): [Click or tap here to enter text.](#)

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

☒ HEDIS®

CMS Child or Adult Core Set

Other (specify): [Click or tap here to enter text.](#)

1. Overview of PM 3

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

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

Definition of denominator (describe):

Members 12 years of age and older at the start of 2024. Other elements of denominator are in accordance with HEDIS MY 2024 Technical

Definition of numerator (describe):

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

2. PM 3 Results

PM	Depression Screening	Follow Up on Positive Screening
Numerator	1,749	96
Denominator	42,392	165
Rate	4.13%	58.18%

3. PM 3 Validation Status

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

No deviations from technical specifications.

3. PM 3 Validation Status

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

Not applicable (ISCA not reviewed)
No findings.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

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

None.

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

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

None.

PPC — Timeliness of Prenatal Care

1. Overview of PM 4

MCP name: HHO

PM name: PPC — Timeliness of Prenatal Care

Measure steward:

AHRQ

CDC

CMS

☒ NCQA

TJC

No measure steward, developed by State/EQRO

Other measure steward (specify): [Click or tap here to enter text.](#)

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

☒ HEDIS®

☒ CMS Child or Adult Core Set

Other (specify): [Click or tap here to enter text.](#)

1. Overview of PM 4

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

- ☒ Administrative data (describe): Claims data
- ☒ Medical records (describe): HEDIS hybrid data medical record review campaign
- ☒ Other (specify): Provider EMR data files, supplemental data sources (i.e.: Clinical Quality Feedback Loop)

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

Sampling based on HEDIS MY 2024 specifications

Not applicable (hybrid method not used)

Definition of denominator (describe):

Deliveries of live births on or between 10/8/2023 and 10/7/2024.

Definition of numerator (describe):

Timeliness of Prenatal Care: the percentage of deliveries: A prenatal visit during the required time frame as specified in MY 2024 specifications.

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

Measurement period (start/end date): 10/8/2023–10/7/2024

2. PM 4 Results

PM	Timeliness of Prenatal Care
Numerator	336
Denominator	366
Rate	91.80%

3. PM 4 Validation Status

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

No deviations from technical specifications.

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

Not applicable (ISCA not reviewed)

No findings.

3. PM 4 Validation Status

Describe any findings from MRR that affected the reliability or validity of the PM results.

Not applicable (MRR not conducted)
No findings.

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

None.

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

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:

None.

Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)

1. Overview of PM 5

MCP name: HHO

PM name: Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)

Measure steward:

AHRQ

CDC

CMS

☒ NCQA

TJC

No measure steward, developed by State/EQRO

Other measure steward (specify): [Click or tap here to enter text.](#)

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

☒ HEDIS®

☒ CMS Child or Adult Core Set

Other (specify): [Click or tap here to enter text.](#)

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

☒ Administrative data (describe): Claims data

Medical records (describe): [Click or tap here to enter text.](#)

Other (specify):

1. Overview of PM 5

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

Definition of denominator (describe):

Definition of numerator (describe):

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

2. PM 5 Results

PM	FUH (7 Days)	FUH (30 Days)
Numerator	-	-
Denominator	25	25
Rate	NA ¹⁵	NA ³

3. PM 5 Validation Status

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

No deviations from technical specifications.

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

☐ Not applicable (ISCA not reviewed)

No findings.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

¹⁵ NA: Not applicable. The organization reported the metric, but the denominator was too small (<30) to report a valid rate.

3. PM 5 Validation Status

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

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

Glycemic Status Assessment for Patients with Diabetes (GSD)

1. Overview of PM 6

MCP name: HHO

PM name: Glycemic Status Assessment for Patients with Diabetes (GSD)

Measure steward:

AHRQ

CDC

CMS

☒ NCQA

TJC

☐ No measure steward, developed by State/EQRO

☐ Other measure steward (specify): [Click or tap here to enter text.](#)

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

☒ HEDIS®

☒ CMS Child or Adult Core Set

☐ Other (specify): [Click or tap here to enter text.](#)

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

☒ Administrative data (describe): Claims data

☒ Medical records (describe): HEDIS hybrid data medical record review campaign

☒ Other (specify): Provider EMR data files, A1c home kit vendor data file, and other supplemental data sources (Clinical Quality Feedback Loop)

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

Sampling based on HEDIS MY 2024 specifications.

☐ Not applicable (hybrid method not used)

1. Overview of PM 6

Members 18–75 years of age with diabetes (type 1 or 2).

Rate 1: most recent glycemic status in 2024 < 8%

Rate 2: most recent glycemic status in 2024 > 9%

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

2. PM 6 Results

PM	Less than 8	Greater than 9
Numerator	258	123
Denominator	411	411
Rate	62.77%	29.93%

3. PM 6 Validation Status

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

No deviations from technical specifications.

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

☐ Not applicable (ISCA not reviewed)

No findings.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☐ Not applicable (MRR not conducted)

None.

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

None.

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

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology. None.

EQRO recommendations for improvement of PM calculation:

None.

Section 6

Validation of Network Adequacy

Validation Rating

Validation Score	Validation Rating
90.0% or greater	High confidence
51.0% to 89.9%	Moderate confidence
10.0% to 49.9%	Low confidence
Less than 10%	No confidence

ACDE Network Adequacy Validation Overall Assessment

ACDE uses Quest Analytics Software with data from their data warehouse to calculate network adequacy. Data from the data warehouse includes member and provider tables. The software uses member, and provider addresses to determine time and distance.

Provider and member address data are pulled from the data warehouse's member and provider tables, cleaned, transformed to ensure accuracy and consistency, then loaded to Quest Analytics software. Quest Suite geocodes the addresses with latitude and longitude. If the exact address is not accurate or available, the closest real address is used. The Quest Suite uses zip codes to determine if the addresses are urban, suburban, or rural zip codes, assigns pre-determined drive speeds, then calculates the drive time using the latitude and longitude coordinates for member address to the provider address. This is not a turn-by-turn analysis but an estimated analysis using geographic intelligence.

ACDE completes access and availability calls to PCPs, pediatric PCPs, high-volume specialty practitioners, pediatric high-impact specialty providers, OBGYNs, and BH practitioners monthly. ACDE PNM monitors access and availability grievances. If issues are reported regarding appointment scheduling, provider education is offered. The PNM team also collects information about availability through ongoing contact with member-facing teams.

In 2024, ACDE's vendor conducted outreach calls to measure availability of appointments; however, these callers identified themselves as calling on behalf of the health plan. Although the results indicated full compliance with availability standards, member grievances indicate members appointment availability is an issue. ACDE plans for its vendor to use blinded scripts in the future.

During the CAP review in 2025 Mercer reviewed documentation and discussed network adequacy further with MCO staff. ACDE provided Geo-Access reports, access and availability results, PCP panel counts, provider lists, provider directory review letter, CAHPS survey results, physician lists by county, information to support HEDIS measures, and secret shopper surveys. With consideration of the data available and provided, standards were assessed in four categories receiving a validation rating of low to high confidence.

- Time and Distance standards: High Confidence
- Appointment Wait Time standards: Moderate Confidence
- Panel Size standard: High Confidence
- LTSS PCA standard: High Confidence

The 2025 compliance review addressed network validation for the second time. ACDE provided requested materials and addressed questions during the review. Per CMS guidance, recommendations for ACDE Assessment of Network Adequacy are provided at the end of the subsequent tables. The EQRO continues to update the RFI and data requests to simplify future reviews. As a new protocol, lessons learned by all parties (MCO, EQRO, and DMMA) throughout this process will help guide future compliance reviews.

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Time and Distance standards: Proportion of adult members who have access to two adult PCPs within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Time and Distance standards: Proportion of adult and pediatric members who have access to one adult and pediatric BH provider within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed Missing	☒ High confidence Moderate confidence Low confidence No confidence Could not be validated	
Time and Distance standards: Proportion of adult members who have access to one Allergy and Immunology, Dermatology, Endocrinology, Hematology and Oncology, Infectious Disease, Nephrology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Podiatry, Pulmonology, Rheumatology, General Surgery, and Urology provider within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed Missing	☒ High confidence Moderate confidence Low confidence No confidence Could not be validated	
Time and Distance standards: Proportion of DSHP Plus LTSS members who have travel distance of no more than 30 miles or 45 minutes between an appropriate facility placement for their individualized needs and the member's residence before entering the placement.	☒ Addressed Missing	☒ High confidence Moderate confidence Low confidence No confidence Could not be validated	

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Time and Distance standards: Proportion of pediatric members who have access to one Pediatric Neurology, Cardiology, Otolaryngology, Pulmonology, and Orthopedic Surgery provider within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed Missing	☒ High confidence Moderate confidence Low confidence No confidence Could not be validated	
Time and Distance Standards: Proportion of pediatric members who have access to two pediatric PCPs within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed Missing	☒ High confidence Moderate confidence Low confidence No confidence Could not be validated	
Time and Distance Standards: Proportion of adult and pediatric members who have access to SUD care providers within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed Missing	☒ High confidence Moderate confidence Low confidence No confidence Could not be validated	
Time and Distance standards: Proportion of adult members who have access to an OBGYN provider within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed Missing	☒ High confidence Moderate confidence Low confidence No confidence Could not be validated	

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Time and Distance standards: Proportion of adult and pediatric members who have access to one hospital within 15 miles or 20 minutes from the member's primary residence.	☒ Addressed Missing	☒ High confidence Moderate confidence Low confidence No confidence Could not be validated	
Time and Distance standards: Proportion of adult and pediatric members who have access to one pharmacy within 15 miles or 20 minutes from the member's primary residence	☒ Addressed Missing	☒ High confidence Moderate confidence Low confidence No confidence Could not be validated	
Appointment Wait Time Standards: Proportion of members able to schedule prenatal care appointments: First trimester within three weeks of member request.	☒ Addressed Missing	High confidence ☒ Moderate confidence Low confidence No confidence Could not be validated	Appointment Wait Time Standards: Audits/surveys of providers were not secret for most of the year. Callers identified themselves as calling on behalf of the MCO.
Appointment Wait Time Standards: Proportion of members able to schedule prenatal care appointments: Second trimester within seven calendar days of member request.	☒ Addressed Missing	High confidence ☒ Moderate confidence Low confidence No confidence Could not be validated	

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Appointment Wait Time Standards: Proportion of members able to schedule prenatal care appointments: Third trimester within three calendar days of member request.	☒ Addressed Missing	High confidence ☒ Moderate confidence Low confidence No confidence Could not be validated	
Appointment Wait Time Standards: Proportion of members with high-risk pregnancies able to schedule appointment within three calendar days of identification of high-risk by the Contractor or maternity care provider, or immediately if an emergency exists.	☒ Addressed Missing	High confidence ☒ Moderate confidence Low confidence No confidence Could not be validated	
Appointment Wait Time Standards: Proportion of members who experienced a BH crisis and were immediately referred to a crisis provider, including a mobile team response.	☒ Addressed Missing	High confidence ☒ Moderate confidence Low confidence No confidence Could not be validated	
Panel Size standard: Proportion of PCPs with panel sizes under 2,500 members.	☒ Addressed Missing	☒ High confidence Moderate confidence Low confidence No confidence Could not be validated	The EQRO noted access and availability call logs specific to BH included less details than the call logs for other provider types.
			The MCO reviews MCO-specific panel size and identifies providers with more than 500 members assigned to further research whether the PCP's panel across all payers is approaching the 2,500-member limit.

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
LTSS PCA standard: Proportion of DSHP Plus LTSS members who have a choice of two providers of PCA services.	☒ Addressed Missing	☒ High confidence Moderate confidence Low confidence No confidence Could not be validated	

Recommendations to Improve Assessment of Network Adequacy	
Prior Recommendation Year:	2024
Current Recommendation Year:	2025
EQRO Current Recommendations for ACDE Assessment of Network Adequacy:	• Increase access and availability studies, ensuring blinded secret shopper call scripts are used. • Provider counts reported in the RFI by county should reflect unique providers, as opposed to reporting access points and provider locations in Geo-Access reporting. • Align Geo-Access specialties, list of standards, and provider types with the MSA list of specialties. • Enhance the process to track and identify the number of members referred to crisis providers. • Utilize member surveys/outreach to determine wait times. Access encounter data to determine appointment type and follow up with members directly. • Provider engagement staff should include panel inquiry in their annual visits; bi-annual audits should also be developed to verify panel size. Panel size should include a provider's full panel, including members from other payers (Medicare and private insurers).

DFH Network Adequacy Validation Overall Assessment

DFH has a clear process to collect, validate, and continuously monitor network adequacy data. Monthly network adequacy reports are run for DFH by corporate and use provider data stored in Portico and the corporate data management system. Member and Provider data is extracted from a historical database and transferred to an Excel spreadsheet that feeds into Geo-Access reporting. Quest Analytics Software is used to calculate time and distance. DFH also verifies minimum provider-to-member ratio standards set by the State by using member, provider, and service area data.

DFH has methods in place to assess the adequacy of its managed care networks including Geo-Access reporting, appointment audits, member surveys, member grievance reviews, and provider directory audits. Appointment audits have room to be improved, by ensuring all scripts used are blinded.

PCP panel size is monitored by the Network Operations team, which monitors PCP member assignments and reaches out to providers who near a determined threshold. DFH also requires a PCP panel size attestation form, in which providers attest to maintaining the panel size requirement.

Member surveys were minimal and were noted as an area for further exploration. Member surveys are encouraged, as they will provide DFH with important information on appointment wait times and accessibility. Provider phone audits often require member details (Medicaid ID, date of birth, etc.) making it difficult to truly conduct as a blind survey.

An ISCA review was conducted in 2025, prior to EQR; there are no concerns related to data sources that were used in the network adequacy validation.

DFH produced evaluation results to support network adequacy monitoring efforts. Four types of quantitative network adequacy standards specified in the State contract with DFH were considered in this initial assessment; time and distance, appointment wait time standards, panel size standard, and a PCA choice standard. Time and distance standards results are well supported through Geo-Access reporting. Appointment standards are assessed using appointment audits, panel size is continuously monitored, and LTSS PCA standards are validated using provider counts.

During the CAP review in 2025, Mercer reviewed documentation and engaged in further discussions with MCO staff. DFH's submission of materials was comprehensive and facilitated a collaborative discussion aimed at improving the process for validating the DFH network. DFH provided provider lists, a provider directory audit, audit scripting directories, audit call lists, CAHPS surveys, HEDIS data, and panel size determinations. With consideration of the data available and provided, standards were assessed across four categories, resulting in a validation rating ranging from moderate to high confidence.

- Time and Distance standards: High Confidence
- Appointment Wait Time standards: Moderate Confidence

- Panel Size standard: High Confidence
- LTSS PCA standard: High Confidence

The 2025 compliance review addressed network validation for the second time. DFH provided requested materials and addressed questions during the review. Per CMS guidance, recommendations for DFH Assessment of Network Adequacy are provided at the end of the subsequent tables. The EQRO continues to update the RFI and data requests to simplify future reviews. As a new protocol, lessons learned by all parties (MCO, EQRO, and DMMA) throughout this process will help guide future compliance reviews.

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Time and Distance standards: Proportion of adult members who have access to two adult PCPs within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	
Time and Distance standards: Proportion of adult and pediatric members who have access to one adult and pediatric BH provider within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Time and Distance standards: Proportion of adult members who have access to one Allergy and Immunology, Dermatology, Endocrinology, Hematology and Oncology, Infectious Disease, Nephrology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Podiatry, Pulmonology, Rheumatology, General Surgery, and Urology provider within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	
Time and Distance standards: Proportion of DSHP Plus LTSS members who have travel distance of no more than 30 miles or 45 minutes between an appropriate facility placement for their individualized needs and the member's residence before entering the placement.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	
Time and Distance standards: Proportion of pediatric members who have access to one Pediatric Neurology, Cardiology, Otolaryngology, Pulmonology, and Orthopedic Surgery provider within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Time and Distance Standards: Proportion of pediatric members who have access to two pediatric PCPs within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	
Time and Distance Standards: Proportion of adult and pediatric members who have access to SUD care providers within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	
Time and Distance standards: Proportion of adult members who have access to an OB/GYN provider within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	
Time and Distance standards: Proportion of adult and pediatric members who have access to one hospital within 15 miles or 20 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
			Appointment Wait Time Standards: Audits/surveys of providers were not secret for the majority of the year.

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments

Recommendations to Improve Assessment of Network Adequacy	
Prior Recommendation Year	2024
Current Recommendation Year	2025
EQRO Current Recommendations for DFH Assessment of Network Adequacy	- Continue to monitor the effectiveness of access and availability studies, ensuring vendors are using blinded secret shopper scripts. - Utilize member surveys/outreach to determine appointment wait times. Access encounter data to determine appointment type and follow up with members directly. - Include panel inquiry as part of the provider engagement staff's annual visits. Consider developing and using bi-annual audits. Panel size should include members from other lines of business and plans (Medicare and commercial/private).

HHO Network Adequacy Validation Overall Assessment

HHO uses a variety of tools and methods to determine network adequacy, such as provider directory audits, Quest Analytics for Geo-Access reporting, review of member grievances data, secret shopper surveys for appointment availability, and panel size review. HHO evaluates the network in its entirety monthly, based on a point in time for all active members and providers.

Quest Analytics uses latitude and longitude coordinates, assigned to all providers' and members' addresses, to estimate driving time and distance in miles from a member's location to provider locations. Calculations take into account the type of area (urban, suburban, rural, or frontier) and adjust speed accordingly for driving time calculation.

Member surveys were not conducted and are recommended as an area for further exploration, in addition to the secret shopper surveys. Member surveys are encouraged, as they will provide HHO important information on appointment wait times and access. Secret shopper surveys often require Member detail (Medicaid ID, date of birth, etc.) making it difficult to conduct as a blind audit.

An ISCA review was conducted in 2025, prior to EQR; there are no concerns related to data sources that were used in the network adequacy validation.

HHO provided evaluation results to support network adequacy monitoring efforts. Four types of quantitative network adequacy standards specified in the State contract with HHO were considered in this initial assessment: time and distance, appointment wait time, panel size, and PCA choice. The MCO is assessing each network adequacy standard through consistent and accurate reporting efforts. Time and distance standard results are well supported through Geo-Access reporting, appointment standards are assessed

through secret shopper surveys and member grievance reviews, panel size standards are continually monitored, and LTSS PCA standards are verified by provider counts.

During the CAP review in 2025, Mercer reviewed documentation and discussed Geo-Access reports, provider lists, provider directory audits, HEDIS reports, grievances, NCQA data, CAHPS survey, pharmacy details, and secret shopper scripts and surveys with MCO staff. With consideration of the data available and provided, standards were assessed in four categories and given a validation rating of moderate to high confidence.

- Time and Distance standards: High Confidence
- Appointment Wait Time standards: Moderate to High Confidence
- Panel Size standard: High Confidence
- LTSS PCA standard: High Confidence

The 2025 compliance review addressed network validation for the second time. HHO provided requested materials and addressed questions during the review. Per CMS guidance, recommendations for HHO Assessment of Network Adequacy are provided at the end of the subsequent tables. The EQRO continues to update the RFI and data requests to simplify future reviews. As a new protocol, lessons learned by all parties (MCO, EQRO, and DMMA) throughout this process will help guide future compliance reviews.

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Time and Distance standards: Proportion of adult members who have access to two adult PCPs within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed Missing	☒ High confidence Moderate confidence Low confidence No confidence Could not be validated	

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Time and Distance standards: Proportion of adult and pediatric members who have access to one adult and pediatric BH provider within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	
Time and Distance standards: Proportion of adult members who have access to one Allergy and Immunology, Dermatology, Endocrinology, Hematology and Oncology, Infectious Disease, Nephrology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Podiatry, Pulmonology, Rheumatology, General Surgery, and Urology provider within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	
Time and Distance standards: Proportion of DSHP Plus LTSS members who have travel distances of no more than 30 miles or 45 minutes between an appropriate facility placement for their individualized needs and the member's residence before entering the placement.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Time and Distance standards: Proportion of pediatric members who have access to one Pediatric Neurology, Cardiology, Otolaryngology, Pulmonology, and Orthopedic Surgery provider within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	
Time and Distance standards: Proportion of pediatric members who have access to two pediatric PCPs within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	
Time and Distance standards: Proportion of adult and pediatric members who have access to SUD care providers within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	
Time and Distance standards: Proportion of adult members who have access to an OBGYN provider within 30 miles or 45 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Time and Distance standards: Proportion of adult and pediatric members who have access to one hospital within 15 miles or 20 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	
Time and Distance standards: Proportion of adult and pediatric members who have access to one pharmacy within 15 miles or 20 minutes from the member's primary residence.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	
Appointment Wait Time standards: Proportion of members able to schedule prenatal care appointments: First trimester within three weeks of member request.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	
Appointment Wait Time standards: Proportion of members able to schedule prenatal care appointments: Second trimester within seven calendar days of member request.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Appointment Wait Time standards: Proportion of members able to schedule prenatal care appointments: Third trimester within three calendar days of member request.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	
Appointment Wait Time standards: Proportion of members with high-risk pregnancies able to schedule appointment within three calendar days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	
Appointment Wait Time standards: Proportion of members who experienced a BH crisis and were immediately referred to a crisis provider, including a mobile team response.	☒ Addressed ☐ Missing	☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	While the number of crisis providers enrolled with the MCO is low, the MCO also leverages claims data to identify which members are accessing crisis services.
Panel Size standard: Proportion of PCPs with panel sizes under 2,500 members.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	The MCO reviews MCO-specific panel size and continuously monitors the number of assigned members compared to a threshold.

Summary of Network Adequacy Validation Findings			
Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
LTSS PCA standard: Proportion of DSHP Plus LTSS members who have a choice of two providers of PCA services.	☒ Addressed ☐ Missing	☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	

Recommendations to Improve Assessment of Network Adequacy	
Prior Recommendation Year:	2024
Current Recommendation Year:	2025
EQRO Current Recommendations for HHO Assessment of Network Adequacy:	- Continue to monitor how secret shopper scripts are used for access and availability studies, taking into account potential roadblocks in identification requirements (e.g., lack of Medicaid ID). - Provider counts reported in RFI by county should reflect unique providers, as opposed to reporting access points and provider locations in Geo-Access reporting. - Implement use of member surveys/outreach to evaluate appointment wait times. Access encounter data to determine appointment type and follow up with members directly. - Include panel inquiry as part of provider engagement staff's annual visits and develop and implement bi-annual. Panel size should include a provider's full panel, including members from other plans (Medicare and private insurers).

Section 7

Information Systems Capabilities Assessment

At the request of the DMMA, Mercer conducted the EQR ISCA CAP review of ACDE, DFH, and HHO for the time period of January 2024 through December 2024. This independent review of the MCO's information systems was conducted as an enhancement to the EQR mandatory activity outlined in 42 CFR § 438.358. To complete this assessment, Mercer utilized the current version of the CMS EQR Protocol Appendix A, along with comprehensive enhancements to the ISCA to reflect State-specific regulations, standards, and requirements communicated to the MCO through the contract with DMMA. Mercer's EQR ISCA process included a review of submitted materials and information, as well as interviews and live systems demonstrations. The annual ISCA evaluation was conducted by Mercer, with DMMA staff in attendance in person from April 1, 2025 through April 2, 2025 for HHO; from April 15, 2025 through April 16, 2025 for ACDE; and April 29, 2025 through April 30, 2025 for DFH, and focused on the core information systems listed below:



ACDE Overall Assessment

ACDE continues to demonstrate effective partnership and collaboration between the local ACDE and the enterprise ACFC teams, as well as with operations and systems. As a result, ACDE continues to perform well in supporting the system related requirements of Delaware's managed Medicaid program. The insights gained from ACDE's ISCA desk review and on-site discussions confirmed compliance with 42 CFR § 438.242, section 6504(a) of the Affordable Care Act and section 1903(r)(1)(F) of the Social Security Act.

Throughout 2024, ACDE staff continued extensive collaboration with DMMA and other MCOs to ensure all providers are appropriately registered with the Delaware Medicaid Enterprise System to further implement the electronic visit verification system. ACDE worked closely with DMMA and Gainwell to plan and test the new pediatric dental program, as well as the new postpartum and doula benefits, which were implemented on January 1, 2025. Additionally, ACDE successfully implemented its business continuity plan to respond quickly and effectively to the Change Healthcare cyber event.

Although ACDE's core systems have remained consistent since the prior review, ACDE's contract with SkyGen terminated on July 31, 2024, and DentaQuest began providing dental services on August 1, 2024. ACDE staff members described the DentaQuest onboarding process and post go live reviews as successful, including claims audits, and confirmed that DentaQuest's performance is aligned with expectations. Additionally, as of January 1, 2025, ACDE began processing vision claims in house. ACDE staff prepared for this change in vision claims processing throughout 2024 with planning, coordination, and testing, and reported no issues. Finally, ACDE's pharmacy benefits manager, PerformRx, converted its PA platform from PerformPA to the MHK platform, CareProminence, on October 1, 2024. ACDE and PerformRx staff members reported a seamless transition.

ACDE's RFI response was comprehensive, and the appropriate personnel were available during the on-site interviews to address follow-up questions. Staff members responded to inquiries with minimal hesitation and provided ample detail, demonstrating a strong and thorough knowledge of processes and procedures. Presentations prepared by ACDE staff facilitated discussions and offered valuable insights into processes. Diagrams clearly illustrated processes and data flows. ACDE continued to exhibit a strong process orientation and mature systems capabilities, along with a deep understanding of DMMA requirements.

Implementation of Prior Recommendations

As a result of the 2025 CAP review, ACDE was found to have successfully addressed all four of the previous year's outstanding CAP items:

- The vision claims review included a case in which the claims processor entered incorrect information. In response, ACDE reviewed subcontractor P&Ps to confirm the quality review processes for claims that are manually entered. ACDE also revised its subcontractor oversight processes to require vendors to identify manually entered claims. Additionally, ACDE updated the stratification of its audit processes to include a review of manually entered claims.

- The dental data files submitted for the 2024 review included incorrect information regarding other insurance indicators, and the pharmacy file did not adhere to the provided specifications. ACDE utilized lessons learned from its previous dental vendor to inform pre delegation reviews of its new vendor and enhanced its review of subcontractor data prior to submission. The additional reviews appear to have been effective, as the issues observed with the data in 2024 were not present in the data submitted for the 2025 review.
- The other two corrective actions resulting from the 2024 review were also adequately addressed. ACDE shared processes to ensure system architecture and data governance diagrams are updated as part of the change request process and during quarterly reviews. Additionally, ACDE implemented a daily process to query and review all claim overrides from the previous day to confirm their appropriateness.
- ACDE was required to develop a process to regularly query and review all manual overrides (e.g., coordination of benefits claims manually overridden to pay as primary) to ensure their appropriateness. ACDE implemented a new process in which all claim overrides processed the previous day are manually reviewed for outliers.

ACDE Opportunities

Although ACDE fully addressed the four CAP items identified as a result of the 2024 review, the 2025 ISCA review identified two new areas in which ACDE could strengthen its commitment to excellence:

- During the claims review, one claim included six diagnosis codes billed as not present on admission; however, the claim appeared to have paid for all services. ACDE confirmed that the claim was not pended for review as it should have been. ACDE staff reported identifying this gap in processing and revising the workflow processes prior to the April 2025 on site review. ACDE should provide evidence that it queried its systems to identify all claims subject to the revised processing rules, as well as the number of claims reprocessed, and the total dollars identified for recoupment.
- ACDE submitted a claims processing policy for its new dental vendor, stating that DentaQuest will stop paying claims to precluded providers 90 days after the provider first appears on the Preclusion List. ACDE should validate that delegated vendors have P&Ps that accurately describe the processes for stopping payments to providers immediately upon notice of their preclusion or exclusion from participation. Additionally, the policies should outline the processes for recouping payments made to providers after they have been precluded or excluded.

ACDE ISCA Findings Requiring Corrective Action

The desk review in combination with detailed interviews resulted in two items receiving a review score of “not fully met.” All items that were not marked as “fully met” require ACDE to submit a CAP detailing their plans and timeframes for achieving full compliance. Review items that require a CAP are listed below.

Regulation/Contract/Systems Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO's systems and IT staff and operations must have P&Ps for prioritizing the required IT changes, fixes, and enhancements required to meet the State's contractual and performance expectations. If these functions are supported at the enterprise level, the MCO must ensure that required IT changes, fixes, and enhancements are managed independent of other business lines and markets the enterprise IT function must support to ensure the State's requirements are met in a timely manner. (3.19.3.15) For subsequent fixes/enhancements, the MCO must have P&Ps that document a description of system changes, the business case, timeframe, and a summary of testing results, including any corresponding mitigation plans for the State's review and approval prior to implementation. (3.19.3.17)	Substantially Met		All documentation is present, MCO staff responses are consistent with supporting documentation and provide evidence of compliance.	None.

Regulation/Contract/Systems Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO: - Requires National Provider Identifiers, State assigned provider IDs, and Health Insurance Portability and Accountability Act compliant formats for electronic claims submission in accordance with State and federal requirements (3.18.1.1.1) - Assigns unique identifiers for all claims received from all providers (3.18.1.1.2) - Records the date of receipt of all claims (3.18.1.1.4) - For IP claims, the POA indicator is included for each diagnosis, along with confirmation that payment was not made for any IP claim lines that are missing a POA indicator, or when the POA indicator indicates the diagnosis was not POA at facilities that are not exempt from POA requirements (3.18.2.3.13)	New finding for 2025	Substantially Met		- Provide evidence that after revising the workflow processes, ACDE queried systems to identify all claims that would be subject to revised processing rules and reprocessed to ensure appropriate payments. - Provide the number of claims reprocessed and dollars identified for recoupment.
The MCO's FWA compliance plan shall include a description of the specific controls in place for prevention and detection of potential FWA, including, but not limited to: - Frequency and type of routine exception reports. (3.16.6.2.11.5) - The MCO has P&Ps in place for appropriately managing and monitoring overrides and exceptions to claims edits.	Partially Met	Met	All documentation is present, MCO staff responses are consistent with supporting documentation and provide evidence of compliance.	None.

Regulation/Contract/Systems Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO and any of its subcontractors, Downstream Entities, or participating providers paying claims shall maintain claims processing capabilities. (3.18.1.1) The MCO has appropriate oversight processes for ensuring that subcontracted claims processing is performed accurately and timely. The MCO subcontractors have appropriate resources, including benefits configuration, to ensure that DMMA claims are processed in accordance with the MCO's contractual requirements.	Substantially Met	Met	All documentation is present, MCO staff responses are consistent with supporting documentation and provide evidence of compliance.	None.
The MCO shall not assign State funds/payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. The MCO shall ensure billing agents and alternative payees are subject to initial and monthly Federal exclusion (List of Excluded Individuals and Entities) and debarment (System for Award Management) screening if the alternative payee assignment is ongoing. (3.11.1.7)	New finding for 2025	Substantially Met		

Regulation/Contract/Systems Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
- The MCO receives information from its subcontractors for performance measure reporting. - The MCO has appropriate processes for evaluating/ensuring the quality of data received from its subcontractors. - The MCO identified no concerns with the quality of data received from its subcontractors used for performance measure reporting.	Substantially Met		All documentation is present, MCO staff responses are consistent with supporting documentation and provide evidence of compliance.	None.

DFH Overall Assessment

DFH continues to demonstrate effective partnership and collaboration between the local DFH and the enterprise teams, as well as with operations and systems. As a result, DFH continues to perform well in supporting the system-related requirements of Delaware’s managed Medicaid program. The insights gained from DFH’s ISCA desk review and on-site discussions confirmed compliance with 42 CFR § 438.242, section 6504(a) of the Affordable Care Act and section 1903(r)(1)(F) of the Social Security Act.

Throughout 2024, DFH staff continued extensive collaboration with DMMA and other MCOs to ensure all providers are appropriately registered with the Delaware Medicaid Enterprise System to further implement the electronic visit verification system. DFH worked closely with DMMA and Gainwell to plan and test the new pediatric dental program, as well as the new postpartum and doula benefits, which were implemented on January 1, 2025. Additionally, DFH successfully implemented its business continuity plan to respond quickly and effectively to the Change Healthcare cyber event.

Since the 2024 comprehensive review, DFH staff have reported organizational changes that include the welcoming of a new chief medical officer, as well as a name change for DFH’s dental and vision vendors from “Envolve Dental and Vision” to “Centene Dental and Vision Services.” DFH has also implemented an additional position dedicated to Medicaid training and invested considerable effort in enhancing its processes for coordinating benefits for members with other insurance. Additionally, DFH staff members reported no system changes since the 2024 review.

DFH’s RFI response was comprehensive, and the appropriate personnel were available during the on-site interviews to address follow-up questions. Staff members responded to inquiries with minimal hesitation and provided ample detail, demonstrating a strong and thorough knowledge of processes and procedures. Presentations prepared by DFH staff facilitated discussions and offered

valuable insights into processes. Diagrams clearly illustrated processes and data flows. DFH continued to exhibit a strong process orientation and mature systems capabilities, along with a deep understanding of DMMA requirements.

Implementation of Prior Recommendations

As a result of the 2025 CAP review, DFH was found to have successfully addressed seven of the previous year's nine outstanding CAP items:

- During the 2024 comprehensive review, DFH referenced four to five instances each month of unauthorized system changes or changes that lacked appropriate approvals. At the 2025 CAP review, DFH clarified that the flow and documentation for these system changes were not consistent with standard procedures. However, further investigation confirmed that the system changes were emergency updates. Although the system changes did not align with standard procedures, they were fully and appropriately authorized.
- DFH and its vendors provided lists of denial reason codes and descriptions. During the 2024 claims review, one claim was listed with the denial reason as "lack of medical necessity"; however, DFH later clarified that the actual reason for the denial was "lack of supporting documentation." To address this discrepancy, DFH implemented a quarterly process in which the claims director and vice president of operations query all denials from the previous quarter and review the denial codes and descriptions for reasonableness and accuracy in the Delaware market and among providers. If issues are identified or more accurate descriptions become available, DFH revises them as needed.
- Prior to 2025, DFH had no effective way to collect, store, and share available third-party liability (TPL) data with subcontractors consistently to ensure that Medicaid was the payer of last resort. Since the 2024 comprehensive review, DFH has developed and implemented an automated software application (BOT) designed to process claims with TPL. DFH's BOT audited 819 claims that required coordination of benefits (COB) between July 2024 and November 2024, achieving an accuracy rate of 99.93%. DFH reviewed 2023 claims and identified 3,507 COB claims that required reprocessing, which was underway at the time of the 2025 on site review. Additionally, DFH enhanced system logic to prevent systemic overpayments, provided all COB support staff with refresher training in February 2025, and implemented a process to audit COB claims prior to payment.
- The dental claims file submitted for the 2024 comprehensive ISCA review presented multiple issues. The file included incorrect data, which limited the scope of the EQRO's planned review, as the submitted data did not match the information in the MCO's claims system. As a result of the 2024 review, DFH enhanced subcontractor oversight and reporting, including a review of claim denial details. Data submitted for the 2025 CAP review was improved.
- In 2024, DFH's website was not fully 508 compliant. During the 2025 CAP review, DFH staff reported that they were working with Deque to run weekly checks of the website to confirm ongoing adherence to both transport layer security and 508 compliance.

- Previously, DFH reported known gaps with the Application Programming Interface (API), including formulary data and provider organization affiliations. In 2025, DFH attested to full compliance with API requirements; however, staff reported that, to date, no Delaware members have opted to use the API.

DFH Opportunities

Two outstanding CAP items from the previous 2024 comprehensive review, as well as two new items, were identified as areas in which DFH could strengthen its commitment to excellence:

- A claim reviewed in 2024 was denied for a missing or invalid present on admission indicator when it should have been denied for “inappropriate indicator.” The indicator used was a valid value for this field but was not appropriate for this case. DFH should review denial explanations and ensure claims denied for an inappropriate indicator clearly specify “inappropriate” rather than “invalid.”
- It was evident during the 2024 comprehensive review that DFH’s vendors were not familiar with the Delaware contractual standards. To address this finding, DFH staff reported reviewing vendor policies to ensure the processes described align with the contractual standards specific to Delaware. During the 2025 claims review, DFH explained that its dental vendor had been subtracting member copayment liability from the MCO’s liability. Although DMMA has no explicit instruction prohibiting this practice, standard practice and DMMA’s expectation is that the member’s liability should not reduce the member’s benefit limits or the MCO’s liability. DFH should revise its P&Ps to ensure the payment of the full annual maximum dental benefit of \$2,500 (\$1,000 standard plus \$1,500 emergency benefit) is not reduced by the member’s copayment liability.
- In response to the 2025 RFI, DFH submitted several documents containing PHI. The Health Insurance Portability and Accountability Act requires covered entities to disclose only the minimum amount necessary to achieve the intended purpose, such as treatment, payment, or healthcare operations. Since no member level details were requested or required to demonstrate evidence of compliance, this disclosure constitutes a violation of the minimum necessary rule. DFH should review the minimum necessary rule and update training materials as needed to ensure a comprehensive understanding of the rule.
- During the 2025 vision claims review, Mercer found one record for pediatric services that was denied due to other insurance. The master service agreement and 42 CFR § 433.139 require MCOs to pay claims for preventive pediatric care (including EPSDT services) at the time they are presented for payment by the provider, and the MCO shall bill the responsible third party. DFH should develop P&Ps to ensure EPSDT services are paid at the time they are presented, which should include processes for the MCO to bill the responsible third party.

DFH ISCA Findings Requiring Corrective Action

The desk review in combination with detailed interviews resulted in four items receiving a review score of “Not Fully Met.” All items that were not marked as “Fully Met” require DFH to submit a CAP detailing their plans and timeframes for achieving full compliance. Review items that require a CAP are below

Regulation/Contract/Systems Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO’s systems and IT staff and operations must have P&Ps for prioritizing the required IT changes, fixes, and enhancements required to meet the State’s contractual and performance expectations. If these functions are supported at the enterprise level, the MCO must ensure that required IT changes, fixes, and enhancements are managed independent of other business lines and markets the enterprise IT function must support to ensure the State’s requirements are met in a timely manner. (3.19.3.15) For subsequent fixes/enhancements, the MCO must have P&Ps that document a description of system changes, the business case, timeframe, and a summary of testing results, including any corresponding mitigation plans for the State’s review and approval prior to implementation. (3.19.3.17)	Substantially Met		All documentation is present, MCO staff responses are consistent with supporting documentation and provide evidence of compliance.	None.

Regulation/Contract/Systems Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
The MCO shall put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network within the MCO's span of control. This includes but is not limited to no provider or member service applications shall be directly accessible over the Internet and shall be appropriately isolated to ensure appropriate access. (3.19.3.10) The MCO's systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information. (3.19.3.1)	New findings for 2025	Partially Met	intended purpose, such as treatment, payment, or healthcare operations. As no member level details were requested or required to demonstrate evidence of compliance, this disclosure is a violation of the minimum necessary rule.	Review minimum necessary rule and update training materials as needed to ensure comprehensive understanding of the rule.

Regulation/Contract/Systems Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
	Substantially Met	Substantially Met		Review denial explanations and verify that claims denied for inappropriate indicator clearly indicate inappropriate as opposed to invalid.
The MCO has appropriate denial reason codes and descriptions at the claim and claim line level.	Substantially Met	Met	All documentation is present, MCO staff responses are consistent with supporting documentation and provide evidence of compliance.	None.

Regulation/Contract/Systems Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
	Partially Met	Met	All documentation is present, MCO staff responses are consistent with supporting documentation and provide evidence of compliance.	None.
	New finding for 2025			

Regulation/Contract/Systems Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
	Partially Met	Substantially Met	DFH staff reported reviewing vendor policies to confirm processes described align with contractual standards specific to Delaware. During the on-site claims review, DFH explained its dental vendor has been subtracting member copayment liability from the MCO's liability. Although DMMA has no explicit instruction prohibiting this practice, standard practice and DMMA's expectation is that the member's liability should in no way reduce the member's benefit limits or the MCO's liability.	Revise P&Ps to ensure payment of the full annual maximum of \$2,500 of the dental benefit (\$1,000 standard plus \$1,500 emergency benefit) is not reduced by the member's copayment liability.
	Partially Met	Met	All documentation is present, MCO staff responses are consistent with supporting documentation and provide evidence of compliance.	None.
Ensure that its website meets DTI's minimum transport layer security and 508 compliance standards. (3.19.1.1.5)	Partially Met		All documentation is present, MCO staff responses are consistent with supporting documentation and provide evidence of compliance.	None.
Comply with the requirements in 42 CFR 438.242 regarding APIs. (3.19.1.1.10)	Substantially Met		All documentation is present, MCO staff responses are consistent with supporting documentation and provide evidence of compliance.	None.

Regulation/Contract/Systems Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
Vision Claim Record Review	Not Met		All documentation is present, MCO staff responses are consistent with supporting documentation and provide evidence of compliance.	None.

HHO Overall Assessment

HHO continues to demonstrate effective partnership and collaboration between the local HHO and the enterprise teams, operations, and systems. As a result, HHO continues to perform well in supporting the system related requirements of Delaware's managed Medicaid program. The insights gained from HHO's comprehensive ISCA desk review and on-site discussions confirmed compliance with 42 CFR § 438.242, section 6504(a) of the Affordable Care Act, and section 1903(r)(1)(F) of the Social Security Act.

On January 1, 2024, HHO's encounter data storage transitioned from the Highmark Enterprise Encounter Management System to the Veradigm Comprehensive Submissions Platform. The new platform is configured to apply business rules as outlined in the companion guides. HHO's subcontracted dental vendor, United Concordia, also transitioned to the Veradigm platform in April 2024. Additionally, HHO successfully implemented its business continuity plan to respond quickly and effectively to the Change Healthcare cyber event. As a result of the cyber event in February 2024, HHO discontinued its use of Change Healthcare and transitioned to Availity. Recognizing providers' challenges in quickly adapting to this abrupt change in the clearinghouse, HHO implemented a program to offer providers advance payments while they transitioned to the new clearinghouse. This gesture of goodwill was reportedly well received and appreciated.

Throughout 2024, HHO staff continued extensive collaboration with DMMA and other MCOs to ensure all providers are appropriately registered with the Delaware Enterprise Medicaid System and to further implement the electronic visit verification system. HHO worked closely with DMMA and Gainwell to plan and test the new pediatric dental program, as well as the new postpartum and doula benefits, which were implemented on January 1, 2025.

HHO's RFI response was comprehensive, and the appropriate personnel were available during the on-site interviews to address follow-up questions. Staff members responded to inquiries with minimal hesitation and provided ample detail, demonstrating a strong and thorough knowledge of processes and procedures. Presentations prepared by HHO staff facilitated discussions and offered valuable insights into processes. Diagrams clearly illustrated processes and data flows. HHO continued to exhibit a strong process orientation and mature systems capabilities, along with a deep understanding of DMMA requirements.

Implementation of Prior Recommendations

As a result of the 2025 CAP review, HHO was found to have successfully addressed five of the previous year's seven outstanding CAP items:

- In 2024, HHO attested to having a Business Continuity and Disaster Recovery plan and reported the results of its disaster recovery and business continuity testing; however, no plan was submitted. In 2025, HHO submitted its 2025 Business Continuity Corporate Plan, which included the required content and with the results of testing performed in September 2024.
- During the claims review in 2024, claims were identified where the COB was not correctly applied. In response to this finding, HHO reviewed and revised its COB desk level procedures to provide clearer direction on appropriate processing. HHO also conducted an in-depth analysis of historical COB processing errors and used the results to design an automated audit program. HHO retroactively reviewed all COB claims from 2024 and readjudicated those with identified errors. Moving forward, all COB claims will be analyzed, with particular attention to areas identified as most prone to mistakes. Any claim identified as having a potential issue will be suspended for further review. HHO staff reported significant improvements in the short time the program has been in production.
- HHO had no edit in place for school-based wellness center (SBWC) claims to deny payments for members older than the expected age for a high school student. To address this, HHO developed a process to query the system in January and July of each year to identify paid SBWC claims for members over 22 years old. Any identified claims will be reprocessed appropriately. The initial report was run in January 2025. HHO reported that, in addition to reprocessing the few claims identified, it reached out to the providers to educate them on appropriate billing practices.
- HHO verified that the system changes described by the dental benefit manager during the 2024 reviews did not impact Delaware Medicaid claims. HHO confirmed with its subcontractors that no system changes affecting Delaware Medicaid claims processes can be implemented without HHO approval. Additionally, HHO strengthened oversight of subcontractor processes to include a 100% review of all fields with known issues.
- Finally, HHO confirmed that members have access to laboratory and imaging results via the Application Programming Interface. DMMA also confirmed that there is no requirement for HHO to make laboratory and imaging results available to members through the member portal.

HHO Opportunities

Two outstanding CAP items from the previous 2024 comprehensive review were identified as an area where HHO could strengthen its commitment to excellence:

- HHO staff members reported improvements in the timeliness of encounter data submissions since transitioning to the Veradigm encounter platform; however, HHO did not meet the State Encounter Data timeliness requirement of submitting 100% of encounter data within 60 days of adjudication. HHO should implement processes and procedures to ensure 100% of encounters are submitted within the required 60-day timeframe.
- HHO's website migration to a new ecosystem was completed in March 2025. This transition was expected to resolve the 508 compliance issues identified during the 2024 ISCA. Staff reported that HHO will be conducting evaluations throughout April 2025 to confirm all issues have been resolved. HHO should continue to evaluate its website and provide evidence of compliance with 508 requirements.

HHO ISCA Findings Requiring Corrective Action

The desk review in combination with detailed interviews resulted in two items receiving a review score of "Not Fully Met." All items that were not marked as "Fully Met" require HHO to submit a CAP detailing their plans and timeframes for achieving full compliance. Review items that require a CAP are below.

Regulation/Contract/Systems Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
	Not Met	Met	All documentation is present, MCO staff responses are consistent with supporting documentation and provide evidence of compliance.	
	Substantially Met	Met	All documentation is present, MCO staff responses are consistent with supporting documentation and provide evidence of compliance.	None.

Regulation/Contract/Systems Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
If the MCO has not negotiated a different payment arrangement with a particular SBWC, the MCO shall pay the SBWC using the Medicaid FFS payment methodology and fee schedule. (3.11.3.3.1)	Substantially Met	Met	All documentation is present, MCO staff responses are consistent with supporting documentation and provide evidence of compliance.	None.
The MCO and any of its Subcontractors, Downstream Entities, or participating providers paying claims shall maintain claims processing capabilities. (3.18.1.1) The MCO has appropriate oversight processes for ensuring that subcontracted claims processing are performed accurately and timely. The MCO subcontractors have appropriate resources, including benefits configuration, to ensure that DMMA claims are processed in accordance with the MCO's contractual requirements.	Substantially Met	Met	All documentation is present, MCO staff responses are consistent with supporting documentation and provide evidence of compliance.	None.
The MCO shall meet the State Encounter Data timeliness requirements by submitting to the State at least 90% of its non-pharmacy claims, originals, adjustments, and corrections, within 30 calendar days of the date of adjudication, and 100% within 60 calendar days of the date of adjudication in accord with the specifications included in the HIPAA Technical Review Guides. (3.18.4.8.3)	Substantially Met	Substantially Met		Implement processes and procedures to ensure 100% of encounters are submitted within 60 days of adjudication.

Regulation/Contract/Systems Standard Not Fully Compliant	2024 Review Score	2025 Review Score	Findings	Recommendations
Ensure that its website meets DTI's minimum transport layer security and 508 compliance standards. (3.19.1.1.5)	Partially Met	Substantially Met		- Continue evaluation of HHO website to verify 508 compliance. - Provide evidence of compliance with 508 requirements.
for member identification cards, and requests to change PCPs and receive a response, giving the member the option of requesting a response by return email or phone call in addition to or in lieu of a letter. (3.14.11.4) The MCO shall respond to questions or comments received from members via the MCO's website or member portal within one business day from receipt. (3.14.11.5) The MCO's member services information line staff shall have access to the MCO's website and member portal to provide assistance to members with navigating the site and locating information. (3.14.11.6)	Partially Met	Met	All documentation is present, MCO staff responses are consistent with supporting documentation and provide evidence of compliance.	None.

Section 8

Encounter Data Validation

Comparative Summary for Quarter 4 2023 — Quarter 3 2024

Purpose

The United States Department of Health and Human Services, OIG, has published multiple reports with adverse findings on the quality of data that the CMS receives from state Medicaid agencies. OIG's report from March 2021¹⁶ emphasized the importance of high-quality encounter data for rate setting and CMS' responsibilities for overseeing state Medicaid programs, identifying trends to drive policy-making, and detecting FWA. CMS is also monitoring the quality of the encounter data submitted using the [DQ \(Data Quality\) Atlas](#).¹⁷ Additionally, on May 28, 2025,¹⁸ CMS issued the letter regarding the Data Reporting Compliance for the Transformed-Medicaid Statistical Information System (T-MSIS) and compliance considerations. CMS will resume data assessment in September 2025 and will start enforcing compliance based on CMS DQ assessments of more than 500 critical and high-priority measures that check for data integrity, accuracy, and completeness issues that may impact the data's usability and usefulness for program monitoring and research purposes.

The State of Delaware (Delaware or State) DMMA relies on the quality of encounter data submitted by or on behalf of MCOs to accurately and effectively monitor and improve the program's QOC, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. DMMA contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to conduct a review of DMMA's Medicaid encounters.

¹⁶ United States Department of Health and Human Services, OIG Data Brief OEI-02-19-00180. March 2021. Available at: [Data on Medicaid Managed Care Payments to Providers Are Incomplete and Inaccurate OEI-02-19-00180 03-26-2021 \(hhs.gov\)](#)

¹⁷ [Resources About View - DQ Atlas](#)

¹⁸ [Data Reporting Compliance for the Transformed-Medicaid Statistical Information System \(T-MSIS\)](#)

Approach

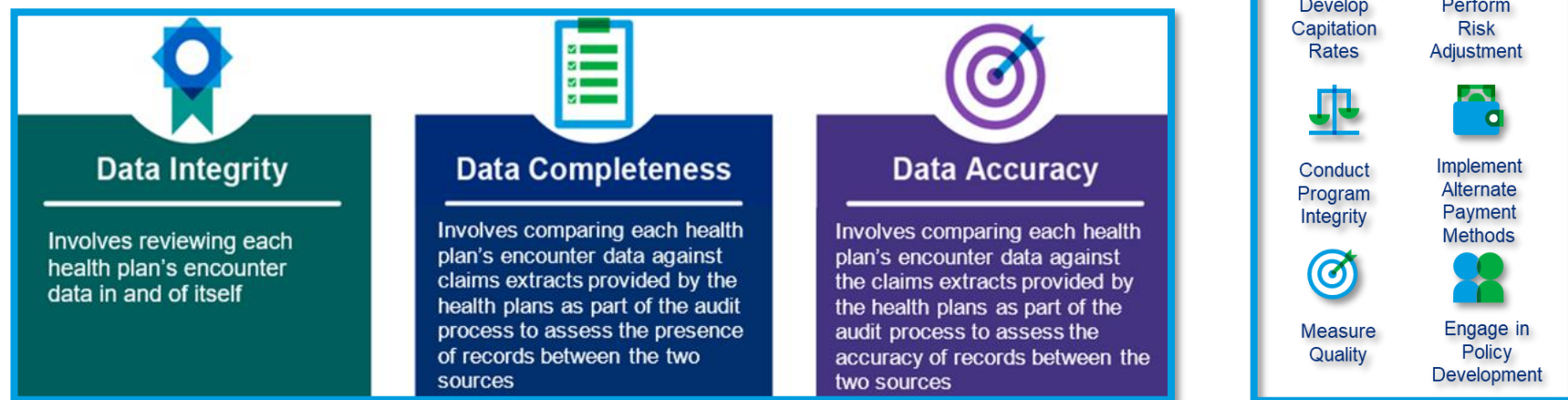
Mercer leveraged CMS' External Quality Review Protocol 5. Validation of Encounter Data Reported by the Medicaid and Children's Health Insurance Program Managed Care Plan¹⁹ (Encounter Data Validation [EDV] Protocol) Activity 3: Analyze electronic encounter data to complete the work.

Results

A major component of Activity 3 involves comparing the claims data extracts submitted to Mercer by the MCOs (MCO claims) to encounter data from the Delaware Medicaid Enterprise System (DMES).

Mercer analyzed the MCO claims and DMES encounter data to assess data integrity, data completeness, and data accuracy in accordance with the data test plan, focusing on select data fields that inform or influence capitation rate development and other uses of the encounter data, and performed separate analyses for the following claim types: institutional, professional, pharmacy, dental, and vision claims.

Analytics performed during this activity were organized into three categories based on recommendations included in the EDV Protocol. These included the following.



¹⁹ CMS External Quality Review Protocols. February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on June 27, 2024.

Based on the validation performed during the data integrity analysis, Mercer determined that all MCOs presented acceptable levels of population and validity, with many critical fields being populated at 100% with valid values based on the healthcare standards. Although the majority of the data elements were populated and presented the values in alignment with the national standards, some data elements, especially in the financial category, were populated sparsely or with a value of \$0.

During the completeness analysis at the Internal Control Number level, Mercer identified that professional data (including dental and vision) shows the lowest level of completeness with the Statewide average at 84.5% and with all MCOs having relatively low level of shared records, but a substantial number of records classified as missing or surplus. For institutional records, one MCO had a much higher rate of surplus records at 11% versus the other MCOs at 4%–6% surplus.

In the last step, Mercer determined that although some values on the claims and encounter data match at 100%, in some instances it appears that not all data are submitted as part of the encounter submission. Contrarily, there are also values present in the encounter data files that were not found in the claims data submitted.

Key Recommendations

Based on the validation results described above, Mercer provides the following key recommendations for DMMA to consider.

- Mercer recommends DMMA strengthen its master service agreement language by adding detailed information regarding how DMMA assesses completeness, accuracy, and consistency of encounter data and consistently monitors the DQ, including each individual field, to ensure the data submitted by the MCOs can be successfully ingested by the State systems and subsequently submitted to CMS based on the T-MSIS specifications.
- Mercer recommends DMMA perform research and investigation into the root cause of discrepancies identified for specific data elements, including allowed amounts, POA indicators, provider data, modifiers, and tooth surface. Mercer included specific recommendations based on the analyzed data in the body of the report under specific sections (e.g., data integrity, data completeness, data accuracy).

Overall Impressions

Mercer's qualitative and quantitative findings from the MCOs' EDV suggest that, overall, DMMA has systems and processes in place to appropriately monitor and ensure the quality of encounter data. Additionally, each MCO has the appropriate systems and capabilities to generate encounter data. The results of our assessment of the encounter and claims data provided for this validation were variable and, in some cases, required additional analysis and research. Although some assessment areas, such as Population Integrity and Reasonableness Integrity, showed strong results, Mercer recommends that DMMA conduct further investigation to identify how the DMES system can be enhanced to support accurate encounter acceptance. This would enable DMMA to fully assess

whether all required encounter data are being submitted. Currently, system limitations hinder precise assessment and determination of the completeness, timeliness, and accuracy of the encounter data.

Limitations and Use

This EDV has been informed, designed, and conducted in accordance with the EDV Protocol to provide DMMA with reasonable assurance that encounter data received from the MCOs are complete, accurate, and timely. While this validation meets certain compliance requirements and contributes to improved data quality and increased program transparency, there are inherent limitations that DMMA should be aware of when reviewing this report and considering the implementation of the recommended actions. Mercer has detailed these limitations within the body of this report.

This report has been prepared on behalf of DMMA and is intended to be relied upon by DMMA.

The MCOs, as suppliers of data, are solely responsible for its validity and completeness. Mercer has reviewed the data and information for internal consistency and reasonableness utilizing CMS' EDV Protocols and guidance, but validation of each encounter and data element against source systems and medical records was not within the scope and timing of the review objectives. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates.

Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

Section 9

National Core Indicators Aging and Disabilities Adult Consumer Survey

DMMA, in partnership with ADvancing States and Human Services Research Institute (HSRI), implemented the 2024–2025 National Core Indicators Aging and Disabilities (NCI-AD) Adult Consumer survey in Delaware. DMMA recognizes the need for an independent assessment of HCBS, as well as all services provided under MLTSS. Delaware uses data from the survey to strengthen MLTSS policy, inform quality assurance activities, evaluate managed care performance and compliance, and improve the quality of life of MLTSS participants. To allow for year-to-year comparison of the data, Delaware plans to continue to implement NCI-AD in future years.

NCI-AD Survey Overview

The NCI-AD Adult Consumer survey is designed to measure outcomes across 19 important domains comprised of approximately 80 core indicators. Indicators are the standard measures used across states to assess the progress or performance of services provided to individuals, including respect and rights, service coordination, CC, employment, health, safety, person-centered planning, etc. An example of an indicator in the Service Coordination domain is the “Percentage of people whose services meet their needs and goals”.

While most indicators correspond to a single survey question, a few refer to clusters of related questions. For example, the indicator “Percentage of people who have needed home modifications” in the Access to Needed Equipment domain is addressed by several survey questions that ask about the person’s need for various types of home modifications.

NCI-AD Sample

The total number of NCI-AD Adult Consumer surveys conducted in Delaware for DSHP Plus members in 2025 and included for analysis was 969 (Total N=969).

DSHP Plus: Delaware’s Medicaid managed care program, comprised of DSHP and DSHP Plus, is authorized under the authority of a Section 1115 Demonstration waiver. This program provides improved access to community-based long-term care services and increased flexibility to address individual needs more effectively, and to better control rising long-term care costs significantly

impacting Medicaid. Two types of service settings were included in the sample strategy: facility-based (i.e., NF) and HCBS. All service recipients were enrolled in one of three MCOs: ACDE, DFH, and HHO.

Survey Process in Delaware

Mercer contracted with Vital Research, a national survey group, to hire and manage local interviewers to conduct the NCI-AD Adult Consumer survey. Along with Vital Research, Mercer worked with the State to identify individuals to be NCI-AD interviewers and have them appropriately trained. DMMA, Mercer, and Vital Research staff conducted a mandatory three-day in-person training with these interviewers on February 4–6, 2025. The training consisted of a detailed review of the NCI-AD Survey tool, an overview of the NCI-AD project, general, and population-specific surveying techniques; procedures for scheduling interviews and obtaining written consent; guidance for follow-up in cases of unmet needs and/or abuse, neglect, or exploitation; mock interviewing practice sessions; and data entry procedures. Delaware used NCI-AD's optional module on person-centered planning and chose to add four additional State-specific questions to the standard NCI-AD survey. Interviews began on February 10, 2025, and Vital Research sent the final data from the interviews to HSRI on June 27, 2025.

Survey Findings

At the time of this report, HSRI has not released findings from the 2024–2025 survey cycle.



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