Mercer

Government Human Services Consulting

Delaware External Quality Review

2024 Technical Report

State of Delaware
Division of Medicaid and Medical Assistance

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Contents

Section 1

Introduction

The State of Delaware (Delaware or State) Division of Medicaid and Medical Assistance (DMMA), within the Department of Health and Social Services(DHSS), has provided 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 (DSAAPD), 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 (RFQ) to solicit innovative approaches to drive improvements in the delivery system and quality of services offered to DSHP and DSHP Plus members. DMMA provided formal notification to United Healthcare Community Plan of Delaware (UHCP), one of its incumbent MCOs, of its intent to not exercise the 2018 contract option year. DMMA opted to contract with AmeriHealth Caritas Delaware (ACDE) with a planned go-live date of January 1, 2018. Transition and continuity of care activities with UHCP occurred through December 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 (RFP) 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).

Additionally, 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. 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.
- Network Adequacy Focus Study.
- Readiness Review for Integration of Pediatric Dental Benefit.

Section 2

External Quality Review Overview

External Quality Review Objectives

Mercer's objective for the 2024 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 comprehensive 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 2023.
- 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	
Met	For file reviews, the MCO must have achieved 90.0% compliance or greater.
Partially Met	For file reviews that scored between 75.0% and 89.0% compliance.
Not Met	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 2024 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).

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

Description of the Data Obtained

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

- Policies and procedures (P&Ps), quality, utilization management (UM), and CM program descriptions.
- CC, CM, 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 four of the 14 standards reviewed in the current reporting cycle (disenrollment requirements and limitations, emergency and post-stabilization services, subcontractual relationships and delegation, and practice guidelines). The scores for the 10 standards that

were not fully compliant ranged from 74.0% to 99.0% with ACDE receiving a total compliance score of 93.8% for all 14 standards. DFH was fully compliant in three of the 14 areas (disenrollment requirements and limitations, emergency and post-stabilization services, and practice guidelines). The scores for the 11 standards that were not fully compliant ranged from 76.0% to 97.3% with DFH receiving a total compliance score of 92.8% for all 14 standards. HHO was fully compliant in three of the 14 areas (disenrollment requirements and limitations, emergency and post-stabilization services, and practice guidelines). The scores for the 11 standards that were not fully compliant ranged from 72.0% to 99.0% with HHO receiving a total compliance score of 95.0%. Additionally, the number of items across standards needing a CAP, which is scoring less than "Met," was higher for DFH (91) than ACDE (80) and HHO (60).

Based upon the comprehensive ISCA review, ACDE continues to demonstrate effective partnership and collaboration between the local MCO and the enterprise AmeriHealth Caritas (ACFC) family of companies teams, operations, and systems and, as such, continues to perform well in supporting the systems-related requirements of Delaware's managed Medicaid program. The insights gained from ACDE's comprehensive ISCA desk review and virtual 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. ACDE employed Facets' built in editing tools as well as Strategic National Implementation Process (SNIP) level 4, Optum claims edit system, Optum clinical editing, and Cotiviti pre-payment edits. Staff described the processes for auditing both paid and denied claims processed manually and auto adjudicated. ACDE demonstrated increased oversight of its subcontractors' performance through increased auditing. The desk and on-site reviews of the 2024 ISCA items resulted in 84 of the 88 desk review items (95.5%) receiving a review score of Met for ACDE.

DFH's comprehensive ISCA desk review and discussions confirmed systems in 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. DFH complies with all applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA), including electronic data interchange (EDI) standards for code sets. DFH is structured in a manner such that many major processes such as system configuration and management, claims processing, encounter processing, vendor oversight, and report development are implemented by enterprise level staff members with local staff providing oversight and validation. Although local staff members continue to rely heavily on enterprise resources for assistance with answering questions about routine processes, there is strong evidence of streamline coordination and collaboration between the local health plan and the enterprise Centene teams, operations, and systems. The desk and on-site reviews of the 2024 ISCA items resulted in 79 of the 88 desk review items (89.8%) receiving a review score of Met for DFH.

HHO's comprehensive ISCA desk review and discussions confirmed systems in 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. HHO complied with all applicable provisions of HIPAA, including EDI standards for code sets. HHO implemented the Healthtrio Authorized Representative Inbound Single Sign-On (SSO) Member Portal on July 14, 2023. Additionally, HHO upgraded the GuidingCare platform on July 31, 2023, providing enhanced features related to authorization portal, prior authorization (PA) list, Population Health, Health Model, and LTSS. HHO demonstrated their continued efforts to improve their claims processing operations and submission of encounter data to effectively support Delaware's Medicaid managed care program. At the same time, HHO has made substantial progress in claims remediation and audit

activities. HHO showed improvement in procedures for coordinating benefits with third parties. HHO made notable progress in their vendor oversight capabilities including enhanced processes, value added dashboards, and collaborative meetings. As implied through their well-organized and thoughtful RFI response, HHO continued to exhibit strong process orientation, comprehensive understanding of DMMA requirements, and well-organized internal partnership. The desk and on-site reviews of the 2024 ISCA items resulted in 81 of the 88 desk review items (92.0%) receiving a review score of Met for HHO.

All three MCOs continue to demonstrate an ongoing collaboration with DMMA and Gainwell to identify and remediate encounter data submission issues which has been beneficial to stakeholders.

The MCOs have processes in place to generate standardized PMs (e.g., HEDIS and CAHPS) to fulfill contractual obligations. However, the validation of PM results indicated room for improvement for one of the MCOs in State-specific reporting. The EQRO reported high confidence in all six State-specific measures for ACDE and HHO, and high confidence in five State-specific measures, with one measure unable to be validated for DFH. A full description of the validation of PM results is in Section 5 of the report.

There is a significant opportunity for improvement in HEDIS results for all three MCOs. Of the 39 reported measures for ACDE, three inpatient utilization measures (surgery average length of stay [ALOS], surgery days/1,000, and total inpatient ALOS) were at or above the 90th percentile. Twenty-two measures were reported to be at or above the 50th percentile with 11 of those measures being at or above the 75th percentile. ACDE reported 19 measures where the HEDIS rate improved by one percentage point or greater, nine measures where the HEDIS rate did not change by more than one percentage point, and 11 measures where the HEDIS rate declined by one percentage point or greater from 2023 to 2024. Fourteen of ACDE's HEDIS results for these 39 measures (36%) were below the 50th percentile. Of the 39 reported measures for DFH, four measures (breast cancer screening, cardiac rehabilitation — achievement [total], inpatient utilization — surgery ALOS, and well-child visits in the first 30 months of life (first 15 months) were at or above the 90th percentile. Three measures, lead screening in children, inpatient utilization measures (maternity ALOS and total inpatient ALOS), were reported to be at or above the 75th percentile. Six measures, appropriate treatment for upper respiratory infection (total), inpatient utilization measures (medicine ALOS, medicine days/1,000, medicine discharges/1,000, surgery days/1,000, and total in patient days/1,000) were at or above the 50th percentile. Twenty-six of DFH's HEDIS results for these 39 measures (66%) were below the 50th percentile. Of the 39 reported measures for HHO, six measures, timeliness of prenatal care, lead screening, inpatient utilization measures (maternity ALOS, surgery ALOS, surgery days/1,000, and total inpatient ALOS) were at or above the 90th percentile. Eighteen measures were reported to be at or above the 50th percentile with nine of those measures being at or above the 75th percentile. HHO reported 17 measures where the HEDIS rate improved by one percentage point or greater, seven measures where the HEDIS rate did not change by more than one percentage point, and 15 measure where the HEDIS rate had declined by one percentage point or greater from 2023 to 2024. Fifteen of HHO's HEDIS results for these 34 measures (38.0%) 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

is providing 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 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. With DFH being new to the Delaware market as of January 1, 2023, DFH was not required to complete a CAHPS survey for 2024. The first year of DFH's CAHPS results will be available in 2025. Both ACDE's and HHO's performance from 2023 to 2024 has improved. ACDE's members gave the highest scoring of at or above the 90th percentile for the measures: adult rating of all healthcare, adult customer service, adult ease of filling out forms, and children rating of health plan. ACDE's members gave the lowest scoring of below the 50th percentile for the following measures: adult rating of personal doctor, adult getting care quickly, adult coordination of care, children getting needed care, children how well doctors communicate, children coordination of care, and children ease of filling out forms. Out of the 20 categories surveyed, ACDE improved its performance year-over-year in 10 categories, was stagnant in one category, and declined its performance in nine categories. HHO's members gave the highest scoring, at or above the 90th percentile, for the measures: adult rating of health plan, adult ease of filling out forms, children rating of all healthcare, and children rating of personal doctor. HHO's members gave the lowest rating, below the 50th percentile, for the following measures: adult rating of personal doctor, adult rating of specialist, adult getting care quickly, adult getting needed care, adult customer service, children rating of health plan, children getting care quickly, children getting needed care and children ease of filling out forms. Out of the 20 categories surveyed, HHO improved its performance year-over-year in 12 categories 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 2024 compliance review cycle, the EQRO validated the 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 planning stage, the majority of the on-site discussion focused on the initial interventions developed, the barrier analysis completed to date, and baseline 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, the Aim Statements lack specificity and measurability. A well-developed Aim Statement includes the PIP intervention, defines the population and time period, and specifies the measurable impact. The MCOs should review CMS guidelines on Aim Statement development to identify missing required elements before submitting their PIPs for State review and EQRO validation.

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
Access and Availability	§438.56 Disenrollment Requirements and Limitations	100.0%	100.0%	100.0%	Review Cycle 2024
	§438.100 Enrollee Rights Requirements	93.8%	96.3%	91.3%	Review Cycle 2024
	§438.206 Availability of Services	100.0%	100.0%	100.0%	Review Cycle 2024
	§438.207 Assurances of Adequate Capacity of Services	91.0%	95.7%	96.2%	Review Cycle 2024
Care Management	§438.208 Coordination and Continuity of Care	74.0%	76.0%	72.0%	Review Cycle 2024
UM	§438.114 Emergency and Post-Stabilization Services	86.9%	94.6%	97.4%	Review Cycle 2024
	§438.210 Coverage and Authorization of Services	93.5%	95.9%	98.8%	Review Cycle 2024
Provider Network	§438.214 Provider Selection	90.7%	92.7%	92.0%	Review Cycle 2024
	§438.224 Confidentiality	96.8%	91.6%	97.9%	Review Cycle 2024
	§438.230 Subcontractual Relationships and Delegation	89.4%	90.6%	96.5%	Review Cycle 2024
Grievance and Appeals	§438.228 G&A Systems	100.0%	90.0%	92.0%	Review Cycle 2024
Quality Improvement and Assessment	§438.236 Practice Guidelines	100.0%	100.0%	100.0%	Review Cycle 2024
	§438.242 Health Information Systems	98.8%	97.3%	97.0%	Review Cycle 2024
	§438.330 QAPI	99.0%	78.5%	99.0%	Review Cycle 2024
	Total	***92.8%***	***93.8%***	***95.0%***	

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 kick-off the EQR, Mercer developed and distributed to MCO staff a timeline that chronologically summarized the EQR deliverables and their due dates for 2024. The 2024 comprehensive review encompassed the MCO's calendar year 2023 operations and specifically focused the file review on the period of January 1, 2023 through March 31, 2023. The 2024 EQR process began on April 15, 2024 and April 29, 2024, when Mercer delivered the RFI to DFH, ACDE, and HHO, respectively. Mercer used a HIPAA compliant secure file transfer protocol site, Mercer Connect SharePoint, to allow a secure exchange of information among Mercer, DMMA, and the MCOs. DFH materials were uploaded to the SharePoint site by May 13, 2024, while ACDE and HHO materials were uploaded to the SharePoint site by May 29, 2024. The desk review was a comprehensive analysis of P&Ps and supporting documents related to FRMMC, CHIPRA, and State contract standards. In addition, Mercer reviewed the CC, MCC, CM, G&A, provider and facility credentialing, provider termination, and pharmacy 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 June 11, 2024 to June 13, 2024, for DFH; from July 15, 2024 to July 18, 2024, for HHO; and from July 23, 2024 to July 25, 2024, for ACDE. 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 enrollees.

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 Comprehensive Review				
EQRO Review Sections	Number of Items Reviewed in 2024	ACDE	DFH	HHO
		Number of CAP Items Identified in 2024	Number of CAP Items Identified in 2024	Number of CAP Items Identified in 2024
Administration and Organization	45	14	10	12
CC	63	20	13	6
Delegation	10	0	3	3
G&A	34	11	8	3
LTSS CM	77	8	17	12
Pharmacy	18	0	1	1
Provider Network	48	18	20	18
Quality	47	1	13	2
UM	66	8	6	3
Total	**408**	**80**	**91**	**60**

2024 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 2024 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 the following areas for improvement: • Confirmation of addressing and resolving health-related social needs (HRSNs) are not always documented. • A consistent process for timely identification and elevation from low-risk to high-risk MCC is not evident. • Documentation does not always reflect referral and follow-up from positive screens. • Members who were assigned a Resource Coordinator as their care coordinator did not receive complete initial assessments.	The State should continue to review contractually required quarterly clinical reports, and when needed conduct file reviews, to assess level of care evaluations and member assessments are being completed and documented. As part of ongoing oversight and monitoring, DMMA should continue monitoring MCC files through ongoing case file review to ensure all contractual requirements are met, appropriate assessments have been completed timely, follow-up documentation has been updated to include all referrals, and members are receiving the appropriate level of care.

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**
Prenatal and Postpartum Care — Timeliness of Prenatal Care	**ACDE**: 83.07%	**DFH**: 81.00%	**HHO**: 93.67%	The State should ensure MCOs are engaging in best practices (e.g., addressing social determinants of health, ensuring timely and equitable access to care, including BH support and culturally competent services, etc.) and working collaboratively with community partners to educate members to improve the quality of maternal and infant care.
Prenatal and Postpartum Care — Postpartum Care	**ACDE**: 76.68%	**DFH**: 72.76%	**HHO**: 83.70%	The State should ensure MCOs are engaging in best practices (e.g., addressing social determinants of health, ensuring timely and equitable access to care, including BH support and culturally competent services, etc.) and working collaboratively with community partners to educate members to improve the quality of maternal and infant care.
Well-Child Visits in the First 30 Months of Life (15 Months–30 Months)	**ACDE**: 73.82%	**DFH**: 50.00%	**HHO**: 73.09%	The State should ensure MCOs are engaging in best practices (e.g., addressing social determinants of health, ensuring timely and equitable access to care, including BH support and culturally competent services, etc.) and working collaboratively with community partners to educate members to improve the quality of maternal and infant 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**
Hemoglobin A1c Control for Patients with Diabetes — HbA1c Control (<8%)	**ACDE**: 55.96%	**DFH**: 51.09%	**HHO**: 59.12%	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., Delaware Diabetes Coalition, Inc.) to drive improved quality of comprehensive diabetes care
Statin Therapy for Patients with Diabetes — Received Statin Therapy	**ACDE**: 65.83%	**DFH**: 33.33%	**HHO**: 63.89%	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, etc.) to drive improved quality of comprehensive cardiovascular care.
Statin Therapy for Patients with Diabetes — Statin Adherence 80%	**ACDE**: 64.96%	**DFH**: 0.00%	**HHO**: 65.74%	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, etc.) to drive improved quality of comprehensive cardiovascular care.
Controlling High Blood Pressure	**ACDE**: 60.25%	**DFH**: 60.83%	**HHO**: 69.83%	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, etc.) to drive improved quality of comprehensive cardiovascular care.
Statin Therapy for Patients with Cardiovascular Disease — Received Statin Therapy	**ACDE**: F 40–75: 79.64% M 21–75: 84.05% Total: 82.31%	**DFH**: F 40–75: 0.00% M 21–75: 0.00% Total: 0.00%	**HHO**: F 40–75: 82.77% M 21–75: 83.75% Total: 83.33%	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, 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 Cardiovascular Disease — Statin Adherence 80%	**ACDE**: F 40–75: 75.94% M 21–75: 66.20% Total: 69.91%	**DFH**: F 40–75: 0.00% M 21–75: 0.00% Total: 0.00%	**HHO**: F 40–75: 73.30% M 21–75: 66.78% Total: 69.52%	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, etc.) to drive improved quality of comprehensive cardiovascular care.

Information from the 2023 QS Goal: 3. To reduce communicable diseases				
QS Expectations	**EQRO Finding or HEDIS Rates**			**EQRO Suggestions for the State**
Chlamydia Screening in Women Ages 21 to 24	**ACDE**: 68.3%	**DFH**: 61.2%	**HHO**: 66.1%	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.
Appropriate Treatment for Upper Respiratory Infection	**ACDE**: 3–17: 80.08% 18–64: 59.72% 65+: 0.00% Total: 72.81%	**DFH**: 3–17: 95.60% 18–64: 78.35% 65+: 100.00% Total: 90.90%	**HHO**: 3–17: 94.06% 18–64: 81.94% 65+: 75.00% Total: 90.86%	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, etc.) to drive the reduction in communicable diseases.
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	**ACDE**: 3–17: 78.45% 18–64: 34.15% 65+: 100.00% Total: 65.73%	**DFH**: 3–17: 56.18% 18–64: 29.41% 65+: 75.00% Total: 45.34%	**HHO**: 3–17: 73.49% 18–64: 32.41% 65+: 100.00% Total: 57.86%	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, 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**
HIV Viral Load Suppression	**ACDE**: 18–64: 27.10% 65+: 25.00%	**DFH**: 18–64: 19.00% 65+: 7.10%	**HHO**: 18–64: 14.00% 65+: 5.00%	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., Delaware HIV Consortium, etc.) to drive the reduction in communicable diseases.
Immunizations for Adolescents — Human Papillomavirus (HPV)	**ACDE**: 38.55%	**DFH**: 37.80%	**HHO**: 50.26%	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, 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 — Initiation Phase	**ACDE**: 42.08%	**DFH**: 0.00%	**HHO**: 34.18%	The State should ensure MCOs are engaging in best practices (e.g., educating members on importance of medication adherence, educational materials for providers, etc.) and with community partners and programs (e.g., Children and Adults with Attention-Deficit/Hyperactivity Disorder [CHADD] of Delaware, Nemours Children's, 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 Care for Children Prescribed ADHD Medication — Continuation and Maintenance Phase	**ACDE**: 53.95%	**DFH**: 0.00%	**HHO**: 37.10%	The State should ensure MCOs are engaging in best practices (e.g., educating members on importance of medication adherence, educational materials for providers, etc.) and with community partners and programs (e.g., CHADD of Delaware, Nemours Children's, etc.) to drive improved quality of BH care.
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment — Initiation Total	**ACDE**: 18–64: 53.90% 65+: 66.67%	**DFH**: 18–64: 52.10% 65+: 0.00%	**HHO**: 18–64: 55.30% 65+: 50.00%	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 AOD Abuse or Dependence Treatment — Engagement Total	**ACDE**: 18–64: 28.20% 65+: 33.30%	**DFH**: 18–64: 22.90% 65+: 0.00%	**HHO**: 18–64: 22.70% 65+: 25.00%	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.
Follow-up After Hospitalization for Mental Illness — Age 18 and Older (within 30 days after discharge) Total	**ACDE**: 18–64: 45.96% 65+: 50.00%	**DFH**: 18–64: 39.80% 65+: 0.00%	**HHO**: 18–64: 36.80% 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.

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 (within 7 days after discharge) Total	**ACDE**: 18–64: 27.37% 65+: 50.00%	**DFH**: 18–64: 27.00% 65+: 0.00%	**HHO**: 18–64: 22.30% 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 Emergency Department (ED) Visit for Mental Illness — Age 18 and Older (within 30 days of the ED visit) Total	**ACDE**: 18–64: 49.30% 65+: 50.00%	**DFH**: 18–64: 34.20% 65+: 14.30%	**HHO**: 18–64: 49.20% 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 (within 7 days of the ED visit) Total	**ACDE**: 18–64: 38.50% 65+: 50.00%	**DFH**: 18–64: 23.30% 65+: 0.00%	**HHO**: 18–64: 36.20% 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.

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 Needed Care Composite	**ACDE:** Adult: 84.70% Child: 81.20%	**HHO:** Adult: 80.80% Child: 81.40%	Monitor grievance reports to identify opportunities for improved member satisfaction with timely access to high-quality 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 Getting Care Quickly Composite	**ACDE:** Adult: 80.80% Child: 90.20%	**HHO:** Adult: 78.20% Child: 86.50%	Monitor grievance reports to identify opportunities for improved member satisfaction with timely access to high-quality care.
CAHPS Customer Service Composite	**ACDE:** Adult: 93.70% Child: 89.70%	**HHO:** Adult: 84.40% Child: 89.40%	Monitor grievance reports to identify opportunities to ensure a continued level of high member satisfaction with care by providers.
CAHPS Rating of Health Plan Composite	**ACDE:** Adult: 67.00% Child: 83.80%	**HHO:** Adult: 69.90% Child: 69.40%	Monitor grievance reports to identify opportunities to ensure a continued level of high member satisfaction with care by providers.

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
PIP Validation			
ACDE	ACDE has met the requirements for PIPs based on the Delaware QS and the EQRO has a moderate-level of confidence in the reported results for all two validated PIPs.	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.	Quality, Access, Timeliness
DFH	DFH has met the requirements for PIPs based on the Delaware QS and the EQRO has a moderate-level of confidence in the reported results for all two validated PIPs.	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.	Quality, Access, Timeliness

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
PIP Validation			
HHO	HHO has met the requirements for PIPs based on the Delaware QS and the EQRO has a moderate-level of confidence in the reported results for all two validated PIPs.	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.	Quality, Access, Timeliness

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
PM Validation			
ACDE	The EQRO has a high-level of confidence in the validity of the PMs generated using NCQA-certified HEDIS software.	None.	Quality, Timeliness, Access
DFH	The EQRO has a high-level of confidence in the validity of the PMs generated using NCQA-certified HEDIS software.	The EQRO could not validate DFH's BH Acute Care Admissions/1,000 Rate PM.	Quality, Timeliness, Access
HHO	The EQRO has a high-level of confidence in the validity of the PMs generated using NCQA-certified HEDIS software.	None.	Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Network Adequacy Validation			
ACDE	The EQRO has a high-level of confidence for Pharmacy and Hospital/ED Time and Distance standards and a moderate-level of confidence for Panel Size standards.	The EQRO has a low- to moderate-level of confidence for overall Time and Distance standards, a low-level of confidence for LTSS Personal Care Attendant standards, and no to low-level of confidence for Appointment Wait Time standards.	Timeliness, Access
DFH	The EQRO has a high-level of confidence for Pharmacy and Hospital/ED Time and Distance standards, and a moderate-level of confidence for overall Time and Distance standards and Panel Size standards.	The EQRO has a low-level of confidence for LTSS Personal Care Attendant standards and Appointment Wait Time standards.	Timeliness, Access
HHO	The EQRO has a high-level of confidence for Pharmacy and Hospital/ED Time and Distance standards, and a moderate-level of confidence for overall Time and Distance standards and Panel Size standards.	The EQRO has a low-level of confidence for LTSS Personal Care Attendant standards, and no to low-level of confidence for Appointment Wait Time standards.	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.	There is a need for a comprehensive Staff Training and Education Plan that outlines all training activities, their frequency, and topics, as required by the Master Service Agreement (MSA). Additionally, a training program for subcontractors and an evaluation of the compliance of entities responsible for adjudicating grievances are needed to strengthen the overall grievance management system.	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.	The absence of an opportunity for new member orientation via webinar, insufficient evidence of voicemail capabilities in the member call center, and the need for better training and oversight for member service representatives should be addressed.	Quality, Timeliness, Access
	ACDE has a clear structure for handling G&As, with dedicated staff and established protocols for timely acknowledgment, investigation, and resolution.	Better alignment of P&Ps with State and federal requirements is needed, particularly regarding written consent when grievances are filed on behalf of members, as well as timelines for grievance investigations and member notifications.	Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance Review			
	ACDE's CM program has an established infrastructure, featuring effective staffing models, compliance with member caseload ratios, and a commitment to detailed auditing and oversight processes. Additionally, ACDE's CC program reflects timely member outreach, consistent contact in facilities by embedded care coordinators, and the provision of resources such as breast pumps and other services to members.	There is a need for better alignment of some CM P&Ps with MSA requirements, enhanced training materials to ensure all topics are covered, and improved documentation standards to meet compliance rates. Additionally, the CC program can enhance the effectiveness of member engagement by using clearer communication about the benefits of the program, ensuring a reliable process for timely identification and elevation from low-risk to high-risk MCC, and addressing the lack of complete initial assessments for members assigned to Resource Coordinators.	Quality, Timeliness, Access
	ACDE's Quality Management (QM)/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.	Although the Quality Assessment and Performance Improvement program is well understood by staff, there are elements within the member handbook and related policies that require updates to meet contractual obligations.	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's PIPs can be enhanced by incorporating more specific and measurable Aim Statements to ensure that all required components from CMS guidelines are included, such as defining the population, the time period, and specifying measurable impacts.	Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance Review			
		Several UM delegates had CAPs that remained open for longer than six months. Although ACDE regularly meets with delegates, it should consider enhancing the frequency and oversight of monitoring delegate performance to ensure that individual and team trends are identified promptly and that interventions are in place to mitigate future corrective actions.	Quality, Timeliness, Access
DFH	DFH has strong and stable leadership in senior and key personnel positions. This leadership fosters a member-first mindset, builds trust among team members, and promotes a continuous QI culture across the organization.	There are training opportunities across multiple program areas, including for subcontractors and delegates, to ensure understanding of and compliance with Delaware-specific services, standards, and requirements. For example, there is a need for specific training for subcontractors on QM concepts and methodologies, as no such training is currently provided.	Quality
	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.	Member access to information can be enhanced by updating the member handbook to ensure it reflects current information, improving distribution practices for the handbook, and enhancing the website's user experience for better navigation.	Quality, Timeliness, Access
	DFH has established multiple reporting channels for Fraud, Waste, and Abuse (FWA) concerns, promoting transparency and accountability. The program incorporates ongoing checks of network providers against federal exclusion lists and requires ownership disclosure, ensuring thorough vetting of service providers.	There are gaps in the FWA compliance plan, including the need to identify Delaware-specific timelines and requirements.	Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance Review			
	DFH has a robust committee structure with multiple subcommittees reporting to the QI committee, which oversees clinical quality and service functions. The organization is committed to health equity, implementing training on cultural sensitivity, and increasing accessibility to healthcare services. Regular Joint Operations Committee meetings and ongoing monitoring activities, including audits and CAPs, demonstrate a commitment to compliance and continuous improvement. Additionally, DFH has a comprehensive quality training program for staff, ensuring ongoing education on QM topics.	DFH lacks a process to evaluate the effectiveness of the delegated entity's QM/QI program, which is essential for ensuring alignment with State expectations.	Quality, Timeliness, Access
	The grievance files reviewed were well-organized and included timely documentation of member correspondence and grievance details, demonstrating effective management of grievances. Additionally, grievances are tracked, trended, and reported to identify opportunities for improved care and service, indicating a proactive approach to QI.	An evaluation process for the compliance of the entity responsible for adjudicating BH and pharmacy appeals should be established. Additionally, there is a need for enhanced training for member customer service representatives and subcontractors to ensure familiarity with G&A processes and federal regulatory requirements.	Quality, Timeliness, Access
	DFH LTSS CM demonstrates a commitment to member outreach, assessment, and engagement through community-based activities and has developed a clear care plan template that captures member strengths. MCO staff described a high-touch, member-focused approach, providing strong examples of meeting members where they are, whether in the community or a correctional facility, to assess and address healthcare needs. Additionally, DFH has a well-structured CC and MCC system with dedicated staff, effective caseload management, and integration of BH training.	DFH's LTSS CM program has demonstrated a need for timely and accurate documentation processes, particularly regarding HIPAA compliance and follow-up after member hospitalizations or service needs. DFH's CC program should also enhance documentation and engagement strategies to effectively reach members, especially during the initial outreach phase. Additionally, there are gaps in the Health Risk Assessment (HRA) screening tool concerning HRSNs that should be addressed.	Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance Review			
	DFH's pharmacy program review process demonstrates a solid understanding of regulatory and contractual provisions and acknowledges identified issues, indicating a commitment to continuous improvement.	DFH's pharmacy program needs to update its quarterly pharmacy transparency reporting to ensure it meets all elements outlined in the MSA.	Quality, Timeliness, Access
	DFH's PIP design and implementation reflect a strong understanding of the process, the use of workgroups for continuous QI, and well-written, detailed PIPs that align with population health concerns. Additionally, DFH's validation of PMs includes robust processes that ensure data accuracy and completeness before reporting, and the MCO has established effective monitoring and reporting mechanisms for discrepancies.	DFH's PIPs can be improved by ensuring that the specificity and measurability of the Aim Statements, as well as enhanced documentation practices, are included when submitting PIP information for validation.	Quality, Timeliness, Access
	DFH's UM program utilizes a shared services model, allowing flexibility in staffing to meet service demands and maintain turnaround times. It also has a Quality Improvement and Utilization Management Committee (QIUMC) that includes diverse stakeholders, facilitating interdepartmental coordination and oversight of UM functions.	There is a need for additional oversight, documentation, and formal processes to enhance the overall effectiveness of the UM program, including delegated entities for services such as In Lieu of Services and Coordination of State Benefits. Additionally, delegation audits need to be specific to the Delaware Medicaid market, vendor management policies must align with the MSA, and monitoring P&Ps need to reflect full compliance.	Quality, Timeliness, Access
HHO	HHO's organizational structure demonstrates leadership from the corporate entity to the local health plan, which is essential for effective governance and reflects a strong commitment to service excellence. Additionally, the use of technology to enhance service delivery and member outcomes is evident.	HHO should develop an organizational chart that aligns with the MSA requirements for key positions and outlines communication and coordination between departments.	Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance Review			
	The integration of quality practices is evident throughout the organization, with ongoing training programs and a focus on continuous improvement. The addition of the Learning Advisor position has further enhanced the development of a comprehensive learning and education plan.	HHO should produce documentation and policies related to provider training and outreach, as well as develop a more comprehensive Provider Network Development and Management Plan (PNDMP) that meets all MSA requirements.	Quality, Timeliness, Access
	HHO conducts orientation sessions for new members and has trained staff on enrollee rights, aligning with federal nondiscrimination provisions. Additionally, the member handbook is comprehensive, detailing enrollee rights, available benefits, and definitions of emergency care.	HHO's organization lacks options for in-person or webinar new member orientation, limiting accessibility for some members. Additionally, the provider directory and member handbook do not fully comply with MSA requirements, particularly regarding Spanish translations and the development of a single member handbook.	Quality, Timeliness, Access
	The use of the GuidingCare system for tracking G&As enhances organization and facilitates timely communication among departments. This is reflected in the appeal file review, which demonstrated 100% compliance with required elements, indicating strong adherence to regulations and internal policies.	HHO should consider opportunities to ensure that all screening questions are answered, enhance the clarity of documentation regarding HRSNs and care gap follow-ups, and address the vagueness noted in some care plans.	Quality, Timeliness, Access
	HHO provides multiple reporting channels for suspected FWA, ensuring non-retaliation for good faith reporting. The organization has well-documented policies, a dedicated Compliance Officer (CO) with direct reporting to the Board, and comprehensive training for staff on compliance, confidentiality, and privacy.	HHO should ensure consistent language across member and provider materials, particularly regarding grievance filing processes and timeframes. This need is evidenced by gaps in the member handbook and provider directory content concerning the notification process when the appeals timeframe is extended, which does not align with regulatory requirements.	Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance Review			
	HHO has an established infrastructure for LTSS CM, inclusive of P&Ps and job aids. The MCO has an effective staffing model dedicated to CM and has implemented co-management between the assigned case manager and the Transition of Care case manager, which involves outreach and follow-up for every member admission. The care plan template is comprehensive and person-centered, with mechanisms for coordination across disciplines and programs. Additionally, enhancements were made to the Risk Stratification process, and new stratification cohorts were created for their BH and substance use disorder (SUD) members, including self-harm, serious and persistent mental illness, polypharmacy, and SUD, to ensure that the member population identifies all potential members who would benefit from CC.	HHO has established internal processes for LTSS CM, but these should be consistently outlined in defined reference documents. The current training monitoring process tracks training completion dates, but there is an opportunity to enhance it to clearly identify the completion of all contract-mandated training topics for new hires and annual training. CM file reviews reflect ongoing opportunities to ensure consistency in timely follow-up after ED visits and hospital admissions. Additionally, the files revealed a need for further training on the care plan template for CM staff to better capture documentation of member strengths in care plans.	Quality, Timeliness, Access
	HHO's pharmacy program has shown no significant quality concerns during compliance reviews, and a new Balance on Hand program has been implemented to reduce medication waste and save costs.	HHO has exhibited persistent data issues following changes in pharmacy claims payment methodology, including duplicate encounters and inconsistencies in the language regarding medical necessity in approval and denial letters.	Quality, Timeliness, Access
	HHO contracted with a quality vendor, Reciprocity, to reach out to members under the age of 21 with care gaps for well visits. The outreach includes interactive voice response, short message service (SMS), and email. Members are encouraged to participate to receive incentives based on the completion of addressing their care gap.	HHO's contract templates and provider participation agreements should be updated to align with the MSA. Specific issues include discrepancies in the retention period for medical records and the lack of language regarding provider enrollment with the Delaware Medical Assistance Portal for Providers. Addressing these gaps will enhance compliance with contractual requirements and improve overall program integrity.	Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance Review			
	HHO has a comprehensive approach to performance measurement that integrates technology, processes, and personnel, ensuring accurate data validation and quality reporting, along with a strong understanding of PIP design.	HHO should ensure consistent documentation and completeness related to PM reporting, and that PIPs have specific and measurable Aim Statements, which include the intervention, defined population, time period, and measurable impact.	Quality, Timeliness, Access
	HHO has a comprehensive training plan for both the UM department and the delegated entity, EviCore. The HHO Clinical Training and Development team includes a dedicated UM trainer who is a certified InterQual® trainer. In 2023, the trainers completed one-on-one mentoring for team members regarding the UM Review job duties and processes.		Quality, Timeliness, Access

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

ACDE 2024 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 (TTY), 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. However, the online directory does not contain a disclaimer with the frequency that it is updated. For Spanish translations, members can access the online provider directory; however, ACDE does not have a written provider directory available in Spanish. The MSA requires the provider directory be available in Spanish; ACDE's current practice does not comply with MSA requirements.

Member Communication Requirements

Member call center operations are operated out of Philadelphia, Pennsylvania and Jacksonville, Florida. The call center works 24 hours a day, seven days a week, 365 days a year (24/7/365). At the 2024 on-site review, ACDE did not provide evidence of voicemail capabilities. The MSA requires MCOs to ensure there is an option within their automated system to leave a message and that the system have capacity to receive messages. All relevant policies should include requirements surrounding voicemail messages. The member call center is overseen by the Workforce Management team, who uses historical data and operational insights of member contact rates, average call handling times, staff shrinkage, and contact center occupancy to determine staff levels and agent schedules.

During the 2024 on-site review, Mercer and DMMA staff listened to three member calls. The member calls demonstrated a heavy reliance on supervisors to assist in member service responses. There were multiple situations noted in which member service representatives did not have strong call management, did not address member care gaps, transferring of the call was inappropriate, and notifications regarding G&As were unclear. Although the calls were challenging in nature and follow-up with supervisors is a good step, it appeared training and other oversight remains an area for improvement. ACDE did not demonstrate that an analysis of historical data is used to inform staffing or that the current approach ensures adequate staff to meet quality performance standards.

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. ACDE indicated there is a plan to redesign their website in 2024 to improve overall user experience and enhance marketing.

ACDE's approach to development and distribution of marketing materials includes quality control processes ensuring materials are accurate and do not mislead, confuse, or defraud a member or the State. The State requires ACDE to disclose events and activities they plan to sponsor and/or participate in during the year and to ensure their annual sponsorship budget does not exceed a pre-determined threshold set by the State. Member and marketing materials are sent to the State for approval. In the review of materials shared it was discovered that many do not include the DHSS logo, which is a MSA requirement.

During the comprehensive compliance 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. However, there were elements within member materials, the provider directory, the member website, and the call center for which required documentation was incomplete or inconsistent with practice.

Regulation/Contract Standard Not Fully Compliant	2024 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	All video or print marketing materials should carry the DHSS logo. Some marketing materials submitted by ACDE are not in compliance.	Update all materials to ensure they carry the DHSS logo, as appropriate.
The provider directory is available in English, Spanish, and any additional prevalent non-English language in Delaware. (3.14.2.5)	Substantially Met	All written member materials, including the provider directory, shall be available in English and Spanish. ACDE states they do not have a written provider directory in Spanish and evidence of on-site demonstration showed inability to ensure Spanish is available to access online.	Develop a provider directory in Spanish to ensure all written materials are compliant with the MSA.
The provider directory is updated to ensure compliance with contract. (3.14.9, 3.9.5.1.1)	Substantially Met	The online version of the provider directory shall contain a disclaimer that the online provider directory is updated more frequently than the printed directory. ACDE does not include this disclaimer in the online version of their provider directory.	Update the online provider directory to include disclaimer.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has a member website that is available to all members and the general public without any log-in restrictions and provides accurate, up-to-date information about the MCO. (3.14.11.1)	Substantially Met	The member website does not include ACDE's formulary and the State's preferred drug list (PDL) nor does it inform members that they are able to request a hard copy of the member newsletters.	Update the member website to include ACDE's formulary, the State's PDL, and information that members are able to request hard copies of the member newsletters.
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)	Substantially Met	ACDE does not provide options for members to complete new member orientation via webinar. Documentation was only provided to support orientation sessions for new members in-person and welcome calls via phone.	Ensure members have the option to participate in new member orientation in-person, via webinar, and by phone.
The MCO has adequate staff for the member services information line required to meet performance standards. (3.14.16)	Substantially Met	Documentation provided did not demonstrate the MCO analysis of historical data to inform member services information line staffing. It was not clear the current approach ensures the MCO has adequate staff for the member services information line required to meet performance standards.	Develop policies and processes to ensure the MCO has adequate staff for the member services information line required to meet performance standards.
The MCO has an automated system available during non-business hours, including weekends and State holidays. This automated system provides callers with operating instructions on what to do in case of an emergency, the option to speak directly to a nurse, and, at a minimum, includes a voice mailbox for callers to leave messages. (3.14.16.1.14)	Partially Met	ACDE did not provide evidence of voicemail capabilities.	Ensure there is an option within an automated system to leave a message; ensure the system has capacity to receive messages. Update policies to include requirements surrounding voicemail messages as required by the MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO measures and monitor the accuracy of responses and take corrective action as necessary to ensure the accuracy of responses by staff. (3.14.16.1.13, 3.14.16.2.2)	Minimally Met	There were multiple situations during the Member Call Review session when member service representatives did not have strong call management, did not address member care gaps, care coordinators transferred a call to member services that should have remained with the care coordinator, unclear notification regarding G&As, and a reliance on supervisors to assist in member services response. Although calls were challenging in nature and follow-up to supervisors is a good step, it appeared training and other oversight remain areas for performance improvement.	Develop policies, processes, and training to ensure MCO measures and monitor the accuracy of responses and take corrective action as necessary to ensure the accuracy of responses by staff.

DFH 2024 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. 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. Upon enrollment, members are mailed a new member enrollment packet that includes identification card, welcome letter, member handbook, and HIPAA privacy notice.

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 policy globally addresses member rights and member requests for access to health records and the right to change information, including instances in which access to and the right to change are denied, along with due process and grievance pathways. Delegates, through contract, are required to follow all Delaware MSA requirements. When necessary and appropriate DFH works with its delegates to provide training on key topics pertinent to the MSA.

Information regarding member rights and protections, available benefits, and how to access emergency versus urgent care are all contained within the member handbook, which is made available in English and Spanish. Alternative formats of the member handbook, including braille, audio tapes, TTY, and language translation services (including American Sign Language) are available to members at no cost. Members are advised, via the member handbook and DFH website, to contact Member Services via DFH's toll-free number to request translation assistance.

A full list of covered benefits is available within the member handbook, which is accessible online via DFH's website. Information on the types of conditions that constitute an emergency and how to access emergency services versus when to use urgent or primary care is also shared via the member handbook and posted online. DFH was unable to provide evidence reflecting that the member handbook was updated in the year 2023. Additionally, the member handbook policy does not include information regarding the distribution practice to members.

The member website is available to all members and the public without any log-in restrictions and addresses most requirements outlined in the contract with the State. However, it did not include a BH parity analysis or attestation on their website. The website was also difficult to navigate. DFH plans to improve the website user experience to focus on the member journey.

Member call center operations continue to be remote. During the on-site review, Mercer and DMMA staff listened to three member calls. Member Services operations were smooth and evidenced happy, customer-centric staff dedicated to assisting members to the best of their ability.

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 are defined in member materials. Policies authorizing payment for post-stabilization services reflect federal definitions and include care provided in-network and OON.

Marketing

DFH maintains a Delaware-specific policy governing the development of marketing materials for members, which meets federal requirements pertaining to member communications. Additionally, DFH creates an annual marketing plan, in accordance with its contract requirements with the State. The DFH marketing plan in 2022 focused on signage; in 2023 the plan focused on increasing brand awareness to ensure providers, communities, and members were aware of DFH specifically and not just Centene. DFH meets regularly with providers to continuously improve brand awareness. DFH plans to focus on health and wellness in 2024.

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 sent to the State for approval. However, some materials included the DHSS logo in the wrong colors. DHSS requires the logo be displayed in maroon and grey. All DFH materials are reviewed to ensure the format can be easily understood and is worded at a sixth-grade reading level.

During the comprehensive compliance 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. However, there were elements within member materials, the member handbook, and the member website where required documentation was incomplete or inconsistent with practice.

Regulation/Contract Standard Not Fully Compliant	2024 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	All video or print marketing materials should carry the DHSS logo in the specified colors. Some marketing materials submitted by DFH are not in compliance.	Update all marketing materials to ensure they carry the DHSS logo, as appropriate.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The member handbook contains all required contract items and is available in Spanish and any additional prevalent non-English language in Delaware. (3.14.6) The online version of the MCO's member handbook should include a version in English and a version in the top three prevalent non-English languages. (3.14.11.1)	Substantially Met	DFH submitted the AO_21_DFH_Member Handbook Policy and Procedure, which includes procedures and instructions on what is to be included in the member handbook. However, the policy does not include the requirement that the handbook must be updated at least annually, nor does it include the requirement that the handbook must be distributed to all members within 10 business days of the member's enrollment date to align with the MSA.	Update policy AO_21_DFH_Member Handbook Policy and Procedure to include information on the requirement that the handbook must be updated at least annually, as well as the requirement that the handbook must be distributed to all members within 10 business days of the member's enrollment date to align with the MSA.
The MCO has a member website that is available to all members and the general public without any log-in restrictions and provides accurate, up-to-date information about the MCO. (3.14.11.1)	Substantially Met	DFH does not include BH parity analysis or attestation on their website.	Update the member website to include information about BH parity analysis or attestation.

HHO 2024 Findings and Recommendations

Member Rights, Responsibilities, and Member Communication Requirements

HHO has policies in place to ensure member rights, including availability of materials in both English and Spanish. 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 are mailed a new member welcome letter, which includes a "Welcome Kit" and a quick-response (QR) code that will link the member to the handbook and member website. The MCO conducts orientation sessions for all new members. However, HHO did not demonstrate that options were provided for members to complete new member orientation in-person or via webinar. Documentation was only provided to support orientation sessions for new members by phone.

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, are included within the member handbook. The member handbook is made available in English and Spanish, and online. There is an opportunity to provide the member handbook in additional languages, per the MSA requirement to provide materials in the three prevalent non-English languages. Alternative formats of the member handbook, including braille, audio tapes, TTY, and language translation services (including American Sign Language) are available to members at no cost. The member handbook includes a full list of covered benefits, including those not covered by HHO. However, the member handbook and other documentation does not clearly demonstrate the process for obtaining interpretive services and provider access to the language line. HHO currently has two member handbooks: one for DSHP Plus LTSS members and a separate handbook for DHSP DHCP members; this does not comply with the MSA, which requires a single member handbook.

The provider directory allows members to search by type and distance, and to filter by accessibility. For hard copies of the directory, members can request a hard copy from the Member Services department. Only the cover pages of the provider directory printout are translated into Spanish. Provider names and address information are not translated. It was noted that members have the ability to change the display language on their desktop or smartphone; however, there is no guidance on the website to assist members in making this change on their desktop or smartphone. The MSA requires the provider directory to be available in Spanish, including an online version. HHO’s current practice does not comply with MSA requirements.

Member call center operations continue to be handled out of Pittsburgh, Pennsylvania, with agents remote to this location. The dental call center is located in Camp Hill, Pennsylvania, with agents remote to this location. The nurse advise line operates 24/7/365 and is operated by the subcontractor Health Dialog. Staffing for the member call center is calculated using Delaware membership and program needs; forecasting and performance trends are also utilized to ensure adequate staffing. During the 2024 on-site review, Mercer and DMMA staff listened to three member calls. Member Services operations were smooth and evidenced happy, customer-centric staff dedicated to assisting members to the best of their ability. HHO has the ability to look at care gaps within the system and has implemented a positive introductory line to their menu reminding members to bring their ID card to appointments.

Emergency and Post-Stabilization Services

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

Marketing

HHO 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, HHO 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. HHO continues to address the public health emergency that occurred in 2020 by including notes within their marketing plan and continuing to offer virtual events.

HHO's approach to development and distribution of marketing materials includes quality control processes ensuring material is accurate and does not mislead, confuse, or defraud a member or the State. The State requires HHO to disclose events and activities they plan to sponsor and/or participate in during the year and to ensure their annual sponsorship budget does not exceed a pre-determined threshold set by the State. Member and marketing materials are sent to the State for approval. In review of materials shared as part of this review it was discovered that many do not include the DHSS logo, which is an MSA requirement.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed further with MCO staff. In assessment of Member Rights and Protections, MCO staff demonstrated understanding of regulatory and contractual provisions. However, there were elements within member materials, the member handbook, and the call center in which required documentation was incomplete or inconsistent with practice.

Regulation/Contract Standard Not Fully Compliant	2024 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	All video or print marketing materials should carry the DHSS logo. Some marketing materials submitted by HHO are not in compliance.	Update all marketing materials to ensure they carry the DHSS logo, as appropriate.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has P&Ps in place to ensure member rights. (§ 438.100 and 3.9.6.1)	Substantially Met	HHO Attachment "AO_19_Member Rights and Responsibilities" states that the member handbook is mailed within 10 calendar days instead of 10 business days as required by the MSA. Information should align with MSA requirements.	Ensure language is consistent across all P&Ps by updating to align with MSA timeframe verbiage.
The MCO ensures language requirements are met: • Oral interpretation services are available. • A monitoring process exists for oral interpretation services. • Oral interpretation services are free of charge and are available in all non-English languages, not just the prevalent ones the State identified. • Enrollees and potential enrollees are notified of the availability of oral interpretation services in any language and how to access them. (42 CFR 438.10 and 3.14.2.6, 3.14.7)	Substantially Met	Documentation does not clearly demonstrate process for interpretive services and provider access to language line.	Develop policies and materials regarding oral interpretation. Documentation should include the process by which the provision of oral interpretation services by providers and subcontractors is monitored and actions taken if providers/subcontractors are not compliant with interpretation or requirements.
The provider directory is available **in English, Spanish, and any additional prevalent non-English language in Delaware. (3.14.2.5)**	Substantially Met	All written member materials, including the provider directory, shall be available in English and Spanish. HHO states they do not have a written provider directory in Spanish and evidence of on-site discussion showed inability to ensure Spanish is available to access online.	Develop a provider directory in Spanish to ensure all written materials are compliant with the MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
• The Member Handbook contains all required contract items and is available in Spanish and any additional prevalent non-English language in Delaware. (3.14.6) • The online version of the MCO's member handbook should include a version in English and a version in the top three prevalent non-English languages. (3.14.11.1)	Substantially Met	The MSA states that the MCO shall develop a member handbook using the State-developed model member handbook and update the member handbook at least annually. HHO currently has two member handbooks.	Develop one member handbook to meet the MSA requirements.
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)	Partially Met	HHO does not provide options for members to complete new member orientation in-person, by phone, or via webinar. Documentation was only provided to support orientation sessions for new members by phone.	Ensure members have the option to participate in new member orientation in-person and via webinar, in addition to by phone.
The MCO has P&Ps that cover call center staffing, training, hours of operation, access and response standards, transfers, call monitoring, translation, and quality. The call center P&Ps are applicable to DSHP, DHCP, and DSHP Plus member. (3.14.16)	Partially Met	A policy on general call center operations was not submitted.	Develop a policy for general call center operations.

Advance Directives

ACDE 2024 Findings and Recommendations

ACDE meets the federal regulations and contract requirements for notification to adult members regarding their rights under State law relative to advance directives (ADs). In addition to new member materials and the member handbook, the ACDE website provides the appropriate link to the Delaware-approved AD form, retrievable from the DSAAPD website. ACDE encourages members to contact member services for AD forms, recommends members discuss ADs with their doctor, and ensures AD is on file within the member's

medical record. Case managers and care coordinators have been trained to assist members, families, and caregivers with questions concerning ADs.

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 is present, MCO staff provided responses that are 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 2024 Findings and Recommendations

DFH meets the federal regulations and contract requirements for notification to adult members regarding their rights under State law relative to ADs. DFH's website lists the three ways to make a formal AD, which include a living will, healthcare power of attorney, and advance instruction for mental health treatment. The website page then provides the appropriate link to the Delaware-approved AD form, retrievable from the DSAAPD website. The member handbook encourages members who are interested in or who need assistance with completing AD paperwork to contact the Member Services call center for further assistance; call center representatives have been trained to access online help, which contains standard instructions on how to work with members who may call inquiring about ADs. The member handbook additionally provides contact information for DSAAPD if more information is sought or to file a complaint if member wishes are not being followed.

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

HHO 2024 Findings and Recommendations

HHO meets the federal regulations and contract requirements for notification to adult members regarding their rights under State law relative to ADs. In addition to new member materials and the member handbook, the HHO website provides the appropriate link to the Delaware-approved AD form, retrievable from the DSAAPD website. HHO encourages members to contact Member Services for AD forms, recommends members discuss ADs with their doctor, and ensures AD is on file within the member's medical record. Case managers and care coordinators have been trained to assist members, families, and caregivers with questions concerning ADs.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed further with MCO staff. In assessment of ADs, MCO staff demonstrated understanding of regulatory and contractual provisions. 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.

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 PNDMP. The PNDMP acts as the Network Management program description, outlining the different populations served, goals, objectives, outcomes, and action steps taken to develop, monitor, and maintain ACDE's network of providers. Although the expectation is that ACDE use the PNDMP as a living document, updating it as the year unfolds, annually the State requires an evaluation of the effectiveness of the PNDMP; the results of the evaluation should be used as the basis for the next year's plan. ACDE spoke to their capabilities to utilizes geo-spatial analytics, grievance, 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. ACDE AEs completed 810 site visits to participating providers during 2023; the site visits were a combination of both virtual and in-person visits based on the provider preference. During a visit, AEs provide a high-level claim summary, plan updates concerning P&Ps, claim dispute process, wellness program overview, Quality Enhancement program, electronic funds transfer (EFT)/electronic remittance advice (ERA) set up, demographic requirements, provider education, and training opportunities. During site visits the AEs may also distribute the provider tool kit for new providers.

In 2023, ACDE continued to develop provider alerts, highlighting ACDE health education programs and activities. Alerts were posted monthly and designed to highlight important topics to support providers on best practices, claims issues, initiatives, and programs. 2023 alert topics included: Coronavirus Disease 2019 (COVID-19), lead screening and Respiratory Syncytial Virus (RSV) flyer, PPP with OUD survey, balance billing of ACDE members, maternal health and SUD stigma and bias, and updated NaviNet® training materials.

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. An overview of the ACDE network follows.

Provider Types	Number of Providers
Primary Care Provider (PCP)	1,049
Specialty Care Physician	1,452
BH	1,765

ACDE operates a provider website and contracts with NaviNet for its online provider portal. The NaviNet portal allows for claims status check, eligibility verification, and PA submission and response, as well as provider complaint submission. ACDE has several cross-functional workgroups that review NaviNet trends, weekly denied claim reports, and provider complaints. The workgroups proactively engage with Provider Network Management (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.

PNM utilizes 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 utilized to initiate outreach and begin contracting efforts with any identified OON provider that members utilize. PNM also monitors access and availability reports and member grievances to help determine whether a geographic location requires additional specialty types. Through the use of 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 2023, PNM provided monthly Provider Post bulletins to highlight programs and process to providers. A variety of topics were highlighted, including the Bright Start App, Cultural Competency training, and the Provider Authorization Lookup tool. Additionally, provider bulletins provided a spotlight on select policies or a change in process.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed availability of services further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. However, the annual Staff Training evaluation, Provider Training and Outreach plan, PNDMP, and Workforce Analysis and Development plan did not address many components required in the contract and multiple policies 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 nondiscrimination language and providers are also required to practice nondiscrimination in their approach to patient selection and treatment planning. Recredentialing follows a three-year cycle except for HCBS provider types who are recredentialed 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 ChristianaCare Health System (CCHS), Delaware Chiropractic Services Network, and Nemours. Delegation oversight of these credentialing entities includes review of standards and review of credentialing/recredentialing files. ACFC and ACDE also delegate credentialing to national partners Avēsis and SKYGEN USA, LLC; 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 organizational providers and 30 from independent providers were selected, including HCBS provider types. In total, 10 independent provider and 10 organizational provider files were selected for initial review, with files split between initial and recredentialing. Although no CAP is required as a result of the file review, there are three opportunities (detailed below) for ACDE to consider addressing in advance of the 2025 EQR Compliance Review. 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 (OIG) queries
- List of Excluded Individuals and Entities (LEIE), System of Award Management (SAMS), Excluded Parties List System (EPLS), and Social Security Administration Death Master File (SSA DMF)
- 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

As noted above, there are opportunities for ACDE. DMMA requires a 45-day turnaround time (TAT) to process initial applications; receipt of a complete application begins the countdown, and it ends when the credentialed provider is added to the MCO's system. Several of the initial credentialing files reviewed did not include evidence of when the provider was added to ACDE's system. As a follow-up to on-site interviews, ACDE shared screenshots that satisfied the requirements. To streamline the process for file reviews and on-site interviews and minimize undue scrutiny, it is recommended that ACDE carefully consider the EQRO's data and file request when compiling provider file documentation. Additionally, two files reviewed contained provider letters stating that provisional credentialing was approved but did not include the appropriate timeline of six months for recredentialing. It is recommended ACDE review its process for ensuring provider notifications accurately reflect the credentialing requirements.

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

Provider Terminations and the Provider Termination File Review Process

When a provider is terminated from an MCO network, members who had an established relationship 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 2023. A total of 300 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 and open authorizations or visit history in the past 12 months for specialists. Overall, the files reviewed were found to have greater than 90% compliance in the required elements.

Regulation/Contract Standard Not Fully Compliant	2024 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)	Substantially Met	The provided organizational charts did not clearly outline coordination and communication between departments for all key positions and business units from the corporate board of directors to the local MCO business units, including all subcontractors, downstream entities, and delegates. Titles on the organizational charts did not always align with key personnel titles as outlined in the MSA.	Develop one overarching organizational chart that clearly outlines all key positions and business units from the corporate board of directors to the local MCO business units, including all subcontractors, downstream entities, and delegates. The organizational chart should list staff titles as outlined in the MSA. Gain State-approved exception documentation for those reporting structures that do not align with the MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO conducts provider training in compliance with contract requirements. (3.9.7.5.1)	Partially Met	Documentation was provided that outlined some provider training, but it did not include most of the requirements for the Provider Training and Outreach plan. Provider Training and Outreach plan evaluation was mentioned in the Provider Training and Outreach plan. It did not include the location of trainings/events, funds expended, number and types of attendees, or a narrative summary of efforts to train providers to implement health and wellness programs, including the number of new health and wellness programs identified or started and added to the Contractor's Resource registry.	Develop a Provider Training and Outreach plan, including minimum requirements as outlined in the MSA. Provide a Provider Training and Outreach Evaluation report as outlined in the MSA.
The MCO has training materials to ensure participating providers comply with contract requirements. (3.9.7.5)	Substantially Met	Some of the required trainings were provided and/or discussed with MCO staff. However, not all required training topics were included in trainings.	Develop training materials for all trainings listed in the Provider Training and Outreach plan.
The MCO has developed and implemented training that outlines accepted telehealth practice. (3.9.17.4.1)	Substantially Met	A one-page document was provided regarding MDLIVE. There was no other documentation demonstrating how the MCO has implemented training that outlines accepted telehealth practice.	Develop training materials that outline accepted telehealth practice. Materials should educate members and providers about telehealth, considerations for using telehealth versus in-person visits, applicable requirements, and how to access telehealth options.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has policies and processes to ensure all participating providers accept members for treatment and do not intentionally segregate members in any way from other individual receiving services. (3.9.4)	Substantially Met	Documentation was provided that included a one-page nondiscrimination notice and a letter to providers dated May 2024, that included anti-discrimination and linked to the provider manual.	The MCO has policies and processes to ensure all participating providers accept members for treatment and do not intentionally segregate members in any way from other individual receiving services.
The MCO has P&P in place for maintaining an appropriate network of providers. (3.9.1.2.4)	Substantially Met	P&Ps for maintaining an appropriate network of providers. However, details were not provided on how membership is taking into consideration when assessing number and type of providers and providers with closed panels.	Develop P&Ps for maintaining an appropriate network of providers with consideration of membership impact on the number and type of providers and providers with closed panels.
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)	Minimally Met	Documentation submitted did not provide enough detail to determine whether provider recruitment P&Ps include effective strategies to ensure adequate access to all covered services.	Develop P&Ps for provider recruitment that includes effective strategies to ensure adequate access to all covered services with the State's access standards.
The MCO's provider recruitment P&Ps describe effective responses to a change in the network that affects access and the MCO's ability to deliver services in a timely manner. (3.9.1.2.5)	Minimally Met	Documentation was not submitted that described how the Contractor responds to a change in the network that affects access and its ability to deliver services in a timely manner.	Develop written P&Ps that describe how the Contractor responds to a change in the network that affects access and its ability to deliver services in a timely manner.
The MCO's remediation activities are effective to address identified network capacity issues or network deficiencies. (3.9.15.3)	Partially Met	ACDE's submitted policy does not require participating providers to maintain a master history of appointments for monitoring and investigation of grievances related to scheduling which is required per the MSA.	Develop policies that demonstrate ACDE monitors and ensures compliance with appointment standards per the MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has a PNDMP that at minimum includes: • Summary of participating providers, by type and geographic location in the State. • Demonstration of monitoring activities to ensure access standards are met and 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	The PNDMP report does not fully address the minimum requirements outlined in the MSA. In particular, there, is a high-level summary of participating providers by type and geographic location in the State, but no geo-access information is provided. The summary of participating provider capacity issues by service and county is not provided and is instead referenced as an activity conducted. The Contractor's remediation and QM/QI activities and the targeted and actual completion dates for those activities are not listed. Network deficiencies by service and by county and interventions to address the deficiencies are not addressed, as it is implied there are none. Ongoing activities for provider network development and expansion, taking into consideration identified participating provider capacity, network deficiencies, service delivery issues, and future needs are not included.	Develop a PNDMP that addresses minimum requirements as outlined in the MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has developed and implemented a measurable workforce development strategy to promote and maintain a qualified, competent, and sufficient workforce to support provider network adequacy and member access to care, with an emphasis on development of community-based providers and direct service workers, including self-directed employees. (3.9.2.1)	Minimally Met	A Workforce Analysis and Development plan was not submitted for 2023.	Develop a Workforce Analysis and Development plan that includes minimum components as outlined in the MSA.
The MCO provides access to home visiting services, Nurse Family Partnership, and Health Family America for eligible members. (3.4.6.7)	Partially Met	The home visiting provider network is still being developed.	Develop P&Ps for home visiting services. Monitor utilization of program and enrolled Nurse Family Partnership and Healthy Families America providers.
The MCO has adequate methods to verify compliance with State-determined network adequacy standards and produces quarterly geospatial analysis reports. (3.9.3)	Minimally Met	The Network Development plan submitted did not include an evaluation providing a list of actions taken and lessons learned in 2023.	Develop a PNDMP Evaluation plan that describes outcomes of the PNDMP and lessons learned. Develop P&Ps demonstrating how the MCO will verify compliance with all State-determined network adequacy standards.
The ongoing provider network development activities effectively address any existing network capacity issues, network deficiencies, or service delivery issues. Ongoing activities are aligned with future needs.	Substantially Met	Documentation and data submitted does not demonstrate the ACDE is able to identify all network capacity issues, network deficiencies, or service delivery issues. An understanding of the issues will be crucial to inform activities designed to address issues.	Ensure provider network development activities effectively address any existing network capacity issues, network deficiencies, or service delivery issues. Develop ongoing activities aligned with future needs.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
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	Documentation and data submitted does not demonstrate that ACDE is able to assess member access to care in terms of provider-to-member ratios, distance requirements, appointment standards, and office waiting times. An understanding of the issues will be crucial to ensure ACDE has capacity to provider covered services.	Ensure 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.
The MCO has a template for the MCO's provider participation agreements, including agreements with NFs and HCBS providers that has been approved by the State and adheres to contract requirements. (3.10)	Substantially Met	Provider agreement template incorrectly lists retainment policy of seven years.	Update provider agreement to list retainment policy of 10 years to align with the MSA.
The MCO's provider complaint system includes P&Ps, a designated staff person, and outlines the timeframes and notification processes required by the contract. (3.9.7.7)	Partially Met	ACDE's submitted documentation did not include timelines to address and/or acknowledge complaint. ACDE has been out of compliance with the provider complaint turnaround time.	Ensure ACDE's provider complaint system includes P&Ps and a designated staff person, and outlines the timeframes and notification processes required by the MSA.
The MCO contract templates are compliant with contract requirements. (3.22.2.3.5)	Partially Met	Contract templates noted records should be retained for seven years, but MSA requirements state records should be retained for 10 years.	Update contract templates to state that records should be retained for 10 years to align with the MSA.

DFH 2024 Findings and Recommendations

Contractually, DFH is required to develop and maintain a PNDMP. The PNDMP is the Network Management plan outlining the different populations served, goals, objectives, outcomes, and action steps taken to develop, monitor, and maintain DFH's network of providers. Although the expectation is that DFH uses the PNDMP as a living document, updating it as the year unfolds, the State requires an annual evaluation of the effectiveness of the PNDMP; the results of the evaluation should be used as the basis for the next year's plan. DFH has a strong process to update and monitor the PNDMP, utilizing geo-access reports, monthly network adequacy reports, daily team huddles, provider feedback, grievances, and provider engagement meetings. However, the report did not include much of the detail required per the contract. In particular, it does not include providers by geographic location, a summary

of provider capacity by service/county, network deficiencies by county, or a summary of participating provider capacity issues by service and county. It also does not include the Contractor's remediation requirements, required QM/QI activities, or the targeted and actual completion dates for those activities.

There are six Provider Engagement Administrators (PEAs) who provide external support for participating providers and three internal Provider Network Support specialists who provide support to the PEAs. PEAs play a critical role in facilitating provider education, driving provider performance, and driving resolution for operational issues. DFH has a dedicated PEA assigned to support HCBS providers, assisting with the recruitment, contracting, and credentialing process. Much of the work done by the PEAs involves direct interactions with network providers. These interactions can be completed in-person, virtually, or in a hybrid modality. These tasks can be segmented into three visit types: educational, performance, and transactional.

DFH contracts with various provider types, engaging independent providers, and focusing on key providers, including hospital systems, BH facilities, federally qualified health centers, and Medicaid accountable care organizations. DFH reported that they started out in 2023 with 3,343 unique National Provider Identifiers (NPIs) for the specialties required to be tracked per the MSA and 13 gaps. By December 2023, DFH reported they had added an additional 1,167 providers in 10 of these specialties for a total of 4,510 providers. An overview of the DFH network follows in the table below.

Provider Type	Number of Providers	Provider Type	Number of Providers
Hospital	10	Pharmacy	655
Adult PCP	883	Adult Specialists	863
Pediatric PCP	950	Pediatric Specialists	76
BH Inpatient (IP)	4	BH Outpatient OP	931
SUD	43	Adult Day	8
Assisted Living	7	NF	37
Personal Care Attendant (PCA) Services	43		

DFH operates a provider website and online provider portal. The portal allows for claims status check, eligibility verification, and PA submission and response, as well as provider complaint submission. The Provider Engagement team provides targeted, proactive outreach based on operational trends and provides one-on-one assistance to help providers submit clean and accurate claims and minimize claim denials. The Provider Engagement team also facilitates risk adjustment and performance-based discussions with identified PCPs.

DFH offers providers virtual training options, including recorded sessions, and offers in-person training when appropriate. Providers have access to training and education materials through the portal, monthly trainings, and ad hoc training as needed. Provider

training materials focused on the Cures Act and the Secure Provider Portal Overview. Portal training provides administration detail for billing and claims but no other detail.

Network monitoring activities outlined in the PNDMP are conducted primarily through ad hoc reports and discussions with different departments. More formal meetings devoted to network adequacy are in development. DFH accessed the adequacy and accessibility of their network by: (1) reviewing the number and type of members; (2) assessing compliance with time and distance standards; (3) auditing providers' compliance with office wait times standards; (4) reviewing panel status; (5) reviewing member grievances relating to adequacy; (6) collaborating with other departments to identify gaps; (7) continuous recruitment and contracting; and (8) ongoing provider data and directory audits and cleanup efforts.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed availability of services further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. It was also noted that many areas of concerns had been identified by DFH and enhancements were being planned. However, an annual Staff Training evaluation was not provided, the Provider Training and Outreach plan and the PNDMP did not address many components required in the contract, a Workforce Analysis and Development plan was not developed, multiple policies are needed to better demonstrate compliance with the contract, the provider website was missing required information, and the Provider Advisory Council did not meet in 2023. It was noted that the role of the Dental Services liaison had been filled, but it was not clear that the liaison role aligned with requirements of the contract.

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, recredentialing, 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. Recredentialing is performed at least every 36 months (HCBS performed annually), and the recredentialing 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.

Delegated Provider Network Development: Credentialing

DFH delegates credentialing to CCHS, Tidal Health Nanticoke, Tidal Health, and Delaware Chiropractic Network. 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. The file review encompassed initial credentialing activities for organizational providers and independent providers. No recredentialing files were submitted due to the MCO being added to the Delaware Medicaid program as of January 1, 2023. A sample of 30 credentialing files were selected, including HCBS provider types. In total, 10 individual providers and 10 organizational provider files were selected for initial review.

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 OIG queries
- LEIE, SAMS, EPLS, and SSA DMF
- Signed and dated provider attestation
- Date of previous credentialing for 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

Overall, the individual and organizational provider files reviewed demonstrated compliance with DMMA’s required 45-day TAT for all initial applications. Evidence of sanction and debarment checks, Social Security Death Master File review, collection of Clinical Laboratory Improvement Amendments waivers, and provider disclosure forms were all evidenced in the file review or supported by P&P. Interview sessions dedicated to file review demonstrated consistency with DFH’s submitted written response. Overall, the files reviewed were found to have less than 70% compliance in the required elements.

Provider Terminations and the Provider Termination File Review Process

When a provider is terminated from an MCO network, members who had an established relationship or who had an ongoing 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 individual and organizational providers representing DFH and delegated credentialing entities. There are two opportunities (detailed below) for DFH to consider in advance of the 2025 EQR Compliance Review. 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. A total of 261 terminated providers were identified. Overall, the files reviewed were found to have greater than 90% compliance in the required elements. Termination reasons appeared primarily voluntary in nature due to providers leaving practice or due to location closings.

As noted above, there are opportunities for DFH. Issues with DFH's process for notifying members of provider terminations was not addressed until March 2024. As a result of DFH not tracking claims appropriately, no member notifications were made during the review period. It remains unclear whether and how delegated entities notify members of provider terminations. DFH acknowledged a need to improve the process. DFH has an opportunity to solidify process ownership for termination notices to be sent timely by the MCO and its delegates.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed provider selection, credentialing, and termination further with MCO staff. It was identified as part of the File Review Process that a Provider Termination letter was not provided for review.

Regulation/Contract Standard Not Fully Compliant	2024 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)	Substantially Met	The provided organizational charts did not clearly outline coordination and communication between departments for all key positions and business units from the corporate board of director to the local MCO business units, including all subcontractors, downstream entities, and delegates. Titles on the organizational charts did not always align with key personnel titles as outlined in the MSA.	Develop one overarching organizational chart that clearly outlines all key positions and business units from the corporate board of director to the local MCO business units, including all subcontractors, downstream entities, and delegates. The organizational chart should list staff titles as outlined in the MSA. Gain State-approved exception documentation for reporting structures that do not align with the MSA.
Administration and staffing structure appears sufficient to successfully implement contract requirements. (3.20)	Substantially Met	The Dental Services liaison is an employee of Envolve and not DFH. It was not clear that the Dental Services liaison serves as the main point of contact for DMMA regarding dental services.	Develop a Dental Services liaison job description that documents communication with DMMA.
The MCO conducts provider training in compliance with contract requirements. (3.9.7.5.1)	Partially Met	Documentation was provided that outlined some provider training, but it did not include most of the requirements for the Provider Training and Outreach plan.	Develop a Provider Training and Outreach plan including minimum requirements as outlined in the MSA. Provide a Provider Training and Outreach Evaluation report as outlined in the MSA.
The MCO has training materials to ensure participating providers comply with contract requirements. (3.9.7.5)	Substantially Met	The majority of required trainings were provided and/or discussed with DFH staff. However, it was not clear all required training topics were included in trainings.	Develop training materials for all trainings listed in the Provider Training and Outreach plan.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has developed and implemented training that outlines accepted telehealth practice. (3.9.17.4.1)	Substantially Met	Documentation was not provided demonstrating that DFH has developed and implemented training that outlines accepted telehealth practice.	Develop training materials that outline accepted telehealth practice. Materials should educate members and providers about telehealth, considerations for using telehealth versus in-person visits, applicable requirements, and how to access telehealth options.
The MCO has policies and processes to ensure all participating providers accept members for treatment and do not intentionally segregate members in any way from other individual receiving services. (3.9.4)	Substantially Met	DFH's submitted nondiscrimination policy does not include written procedures for language services or any of the requirements for the written plan.	Develop a nondiscrimination policy that includes details on language services.
The MCO has P&Ps in place for maintaining an appropriate network of providers. (3.9.1.2.4)	Substantially Met	DFH has P&Ps for maintaining an appropriate network of providers; however, details were not provided on how membership is taken into consideration when assessing number and type of providers and providers with closed panels.	Develop P&Ps for maintaining an appropriate network of providers with consideration of membership impact on the number and type of providers and providers with closed panels.
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	DFH's submitted dental policies are not Delaware-specific and do not align with the MSA.	Develop dental policies that address requirements as outlined in the MSA.
The MCO's provider recruitment P&Ps describe effective responses to a change in the network that affects access and the MCO's ability to deliver services in a timely manner. (3.9.1.2.5)	Substantially Met	DFH submitted policies that outline activities and procedures that have not yet taken place. In particular, the provider engagement survey was not conducted in 2023.	Develop an annual and monthly provider satisfaction survey including target response rate.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO's remediation activities are effective to address identified network capacity issues or network deficiencies. (3.9.15.3)	Partially Met	DFH's submitted P&Ps did not demonstrate that appointment standards are consistently monitored and the results utilized to ensure adequate appointment availability. Additionally, the provided policies do not require participating providers to maintain a master history of appointments for monitoring and for the investigation of grievances related to scheduling which is required per the MSA.	Develop P&Ps that demonstrate DFH monitors and ensure compliance with appointment standards that align with the MSA.
The MCO has established a Provider Advisory Council and has P&Ps, membership, and example agendas. (3.9.7.8)	Minimally Met	DFH did not hold any Provider Advisory Council meetings in 2023.	Develop P&Ps, membership, and agendas for the Provider Advisory Council to ensure meetings will be held going forward.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has a PNDMP that at minimum includes: • Summary of participating providers, by type and geographic location in the State. • Demonstration of monitoring activities to ensure 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 considering 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	The revised PNDMP does not include the minimum information required in the MSA. In particular, it does not include providers by geographic location, a summary of provider capacity by service/county, network deficiencies by county, and a summary of participating provider capacity issues by service and county. It also does not include the Contractor's remediation requirements, required QM/QI activities, and the targeted and actual completion dates for those activities.	Develop a PNDMP that addresses minimum requirements as outlined in the MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has developed and implemented a measurable workforce development strategy to promote and maintain a qualified, competent, and sufficient workforce to support provider network adequacy and member access to care, with an emphasis on development of community-based providers and direct service workers, including self-directed employees. (3.9.2.1)	Minimally Met	A Workforce Analysis and Development plan was not developed in 2023.	Develop a Workforce Analysis and Development plan.
The MCO provides access to home visiting services, Nurse Family Partnership, and Health Family America for eligible members. (3.4.6.7)	Partially Met	The home visiting provider network is still being developed.	Develop P&Ps for home visiting services. Monitor utilization of the program and enrolled Nurse Family Partnership and Healthy Families America providers.
The MCO has adequate methods to verify compliance with State-determined network adequacy standards and produces quarterly geospatial analysis reports. (3.9.3)	Substantially Met	The PNDMP Evaluation report does not demonstrate that the MCO has adequate methods to verify compliance with State-determined network adequacy standards per the MSA. Current processes to assess appointment wait times and PCP panel requirements are not sufficient.	Develop P&Ps demonstrating how the MCO will verify compliance with all State-determined network adequacy standards.
The ongoing provider network development activities effectively address any existing network capacity issues, network deficiencies, or service delivery issues. Ongoing activities are aligned with future needs.	Substantially Met	The PNDMP Evaluation report does not demonstrate that DFH has adequate methods to verify compliance with State-determined network adequacy standards per the MSA. Current processes to assess appointment wait times and PCP panel requirements are not sufficient.	Develop P&Ps demonstrating how the MCO will verify compliance with all State-determined network adequacy standards.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO can 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	Documentation and data submitted does not demonstrate the MCO is able to assess member access to care in terms of provider-to-member ratios, distance requirements, appointment standards, and office waiting times, an understanding of the issues will be crucial to ensure DFH has capacity to provider covered services.	Ensure 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.
The MCO has a secure provider portal that includes functionality as required by the contract. (3.9.7.4.2)	Substantially Met	The provider website is not easy to navigate and does not appear to include all pertinent information as outlined in the MSA.	Update the provider website so it includes all information required as part of the MSA.
The MCO notifies the State when the MCO has denied a provider credentialing/recredentialing application for program integrity-related reasons. (3.9.9.12, 3.16)	Substantially Met	Credentialing policy does not include Delaware-specific timeframe requirements in the MSA.	Develop Credentialing policy (Disciplinary Actions and Reporting) that includes Delaware-specific timeframe requirements.
The MCO has a provider termination process in accordance with the contract. (3.9.16.4)	Substantially Met	An example Provider Termination letter was not provided.	Develop a Provider Termination Letter template.

HHO 2024 Findings and Recommendations

In Delaware, by contract, HHO is required to develop and maintain a PNDMP. The PNDMP acts as the Network Management program description outlining the different populations served, goals, objectives, outcomes, and action steps taken to develop, monitor, and maintain HHO's network of providers. Although the expectation is that HHO use the PNDMP as a living document, updating it as the year unfolds, the State requires an annual evaluation of the effectiveness of the PNDMP, and the results are to be used as the basis for the next year's plan. Provider Network collaborates with Member Experience and CC teams to develop a responsive network. They work closely with Provider Relations and Claims teams to address and prevent barriers to caring for members and providers.

The Provider Account Liaison (PAL) conducts an extensive orientation within 45 days of a new provider group becoming active in the network. Each provider is given a presentation to welcome them to the health plan. This presentation encompasses an overview of Medicaid, HHO and its P&Ps, and provider/member rights and responsibilities. In 2023, the PALs conducted goal visits to providers (virtual and in-person), per their individualized plan, to engage their assigned providers.

Delegation of network development and management activities occurs nationally with Davis Vision (Versant Health), EviCore, Health Dialog, Icaro, United Concordia Dental (UCD), American Well, and CVS/Caremark, and locally with CCHS, Matrix Medical Network, and Nemours as credentialing delegates. The Provider Network team met with the Vendor Management Organization team to assess training needs, track training requirements, and update policies for vendors. Vendor subcontractor employees and downstream entities will receive training upon hire/assessment followed by annual refresher training.

HHO maintains a large network of providers and offers a Health Library, powered by Healthwise. An overview of the HHO network is as follows.

Provider Type	Number of Providers	Provider Types	Number of Providers
PCP	2,073	Day Habilitation	3
Specialty Care Provider	6,539	Home Delivered Meals	5
BH	1,653	Homemaker Chore Services	24
Hospital	15	Home Health	21
HCBS	91	Adult Day Care	11
Urgent Care	8	In-Home Respite Care	23
NF	41	IP Respite	0
Dental	22	Attendant Care	41
Vision	181	Personal Emergency Response System	9
Assisted Living Facility	12	Support for Self-Directed Attendant Care (SDAC) Service	2
Minor Home Modifications	4		

HHO maintains a provider directory, which contains all contractually required elements. HHO has created separate directories for different provider types, including one specific to HCBS providers. A third-party vendor, Atlas Systems, sends questionnaires to providers and engages in telephonic outreach every 90 days to confirm the accuracy of provider data. In addition, each HHO PAL has an individualized plan to engage in ongoing provider education to their assigned providers. PALs educated providers on cultural competency training options and the cultural competency toolkit to increase provider completion of cultural competence training. During annual goal visits with providers, PALs also verify practice demographics, panel status, age limits, and caseloads. HHO conducted multiple trainings in 2023 to educate providers on appropriate and inappropriate billing practices. 2024 goals include hosting monthly provider forums, collaborating with other MCOs to educate providers on new doula benefit, and continuing to collaborate internally to ensure the Provider Network is informed of HHO initiatives.

Providers have access to training and education materials through the NaviNet provider portal and receive new provider orientation when entering the network. Provider forum webinars were hosted monthly in 2023, with attendance and participation monitored based on provider registration and sign-in. Providers complete electronic attestations for participation in training that is available through Brainshark. In addition, HHO implemented a Provider Forum and Training workgroup to review the needs for upcoming forums, trainings, and other provider-facing education plans. This interdepartmental workgroup focuses on planning for provider education and content creation. This group is comprised of business subject matter experts (SMEs) from across HHO, as well as the Learning Advisor. Although processes are in place to develop a thorough training plan, the MCO did not demonstrate it conducts provider training in compliance with contract requirements.

Network monitoring activities are outlined in the PNDMP. HHO incorporates multiple elements of network monitoring into a coordinated analysis with the intent of being able to determine network capacity to provide covered services both in aggregate and for any identified special populations, such as children with special healthcare needs. HHO conducts a monthly internal review of network changes. The HHO Network Adequacy workgroup, led by Provider Network, meets monthly to review, and monitor reports. Grievance and critical incident information is reviewed and, when necessary, providers are brought to the Peer Review Committee (PRC) for further evaluation and consideration of continued participation in the network. Although the PNDMP provided some detail on the HHO PNDMP, many of the minimum components required by the MSA were not outlined.

Provider satisfaction is monitored through annual surveys and through review of trends related to provider complaints. A Provider Satisfaction workgroup supports the development of the annual provider satisfaction survey, analyzes results, and develops a CAP focused on improving provider satisfaction.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed availability of services further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. However, the annual Staff Training evaluation, the Provider Training and Outreach plan, the PNDMP, and the Workforce Analysis and Development plan did not address all components required in the contract, including but not limited to, additional training details, funds expended, and new health and wellness programs. Additionally, multiple policies are needed to effectively demonstrate compliance with the contract.

Provider Selection and the Credentialing File Review Process

Credentialing support is provided by Highmark Shared Services and is conducted in accordance with NCQA standards and modified as necessary for Delaware-specific requirements. Highmark Shared Services is responsible for coordinating the National Credentialing committee, while the HHO CMO is responsible for chairing the 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 nondiscrimination language and providers are also required to practice nondiscrimination in their approach to patient selection and treatment planning. However, although the documents submitted meet general credentialing and recredentialing requirements, they often need Delaware specificity. For example, CRP-004 Ongoing Monitoring, Interventions and Reporting policy, lacks specificity related to checking the SSA DMF, which should be monitored monthly. The MSA requires written P&Ps that demonstrate compliance with DMMA's provider selection requirements; many of the submitted documents lack specificity. Recredentialing follows a three-year cycle except for 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.

Delegated Provider Network Development: Credentialing

HHO currently delegates credentialing and recredentialing of practitioners, in the local market, to CCHS, Matrix Medical Network, and Nemours. Delegation oversight of these credentialing entities includes review of standards and review of (re)credentialing files.

The credentialing file review was performed using the File Review Protocol methodology outlined in Section 3. File review encompassed initial credentialing activities for organizational providers and independent practitioners. A sample of 30 credentialing files from organizational providers and 30 from independent providers were selected, including HCBS provider types. 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 OIG queries:
- LEIE, SAMS, EPLS, and SSA DMF
- Signed and dated provider attestation
- Date of previous credentialing for 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

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

There are opportunities for HHO to improve its credentialing process. DMMA does not specify a required timeframe for notifying newly credentialed providers; however, HHO's policy (CRD-002) states that providers will be informed of the Highmark Network Quality and Credentials committee decision of initial approval within 60 calendar days. Six of the files reviewed did not meet HHO's P&P standard, with some provider notifications being sent more than a year after the committee's decision.

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 individual and organizational 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 of all terminated providers. Termination reasons appeared primarily voluntary in nature due to provider leaving practice, or due to location closure. Overall, the files reviewed were found to have greater than 90% compliance in the required elements.

Regulation/Contract Standard Not Fully Compliant	2024 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)	Substantially Met	The provided organizational charts did not clearly outline coordination and communication between departments for all key positions and business units from the corporate board of directors to the local MCO business units, including all subcontractors, downstream entities, and delegates. Titles on the organizational charts did not always align with key personnel titles as outlined in the MSA.	Develop one overarching organizational chart that clearly outlines all key positions and business units from the corporate board of directors to the local MCO business units, including all subcontractors, downstream entities, and delegates. The organizational chart should list staff titles as outlined in the MSA. Gain State-approved exception documentation for those reporting structures that do not align with the MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO conducts provider training in compliance with contract requirements. (3.9.7.5.1)	Partially Met	Documentation was provided that outlined some provider training, but it did not include most of the requirements for the Provider Training and Outreach plan. A Provider Training and Outreach plan evaluation was provided, but it did not include the location of trainings/events, funds expended, number and types of attendees, or a narrative summary of efforts to train providers to implement health and wellness programs, including the number of new health and wellness programs identified or started and added to the Contractor's Resource registry.	Develop a Provider Training and Outreach plan, including minimum requirements as outlined in the MSA. Provide a Provider Training and Outreach Evaluation report as outlined in the MSA.
The MCO has training materials to ensure participating providers comply with contract requirements. (3.9.7.5)	Substantially Met	The majority of required trainings were provided and/or discussed with HHO staff. However, it was not clear all required training topics were included in trainings.	Develop training materials for all trainings listed in the Provider Training and Outreach plan.
The MCO has developed and implemented training that outlines accepted telehealth practice. (3.9.17.4.1)	Substantially Met	Documentation was not provided demonstrating HHO has developed and implemented training that outlines accepted telehealth practice.	Develop training materials that outline accepted telehealth practice. Materials should educate members and providers about telehealth, considerations for using telehealth versus in-person visits, applicable requirements, and how to access telehealth options.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has P&P in place for maintaining an appropriate network of providers. (3.9.1.2.4)	Substantially Met	HHO has P&Ps for maintaining an appropriate network of providers. However, details were not provided on how membership is taking into consideration when assessing number and type of providers and providers with closed panels.	Develop P&Ps for maintaining an appropriate network of providers with consideration of membership impact on the number and type of providers and providers with closed panels.
The MCO's provider recruitment P&Ps describe effective responses to a change in the network that affects access and the MCO's ability to deliver services in a timely manner. (3.9.1.2.5)	Minimally Met	Documentation was not submitted that described how the Contractor responds to a change in the network that affects access and its ability to deliver services in a timely manner.	Develop written P&Ps that describe how the Contractor responds to a change in the network that affects access and its ability to deliver services in a timely manner.
The MCO's remediation activities are effective to address identified network capacity issues or network deficiencies. (3.9.15.3)	Partially Met	Provider Appointment Standard policy submitted does not require participating providers to maintain a master history of appointments for monitoring and investigation of grievances related to scheduling which is required per the MSA.	Enhance existing policy to include language requiring participating providers maintain a master history of appointments for monitoring and compliance with appointment standards per the MSA.
MCO has P&Ps regarding provider preventable conditions, including reporting and reimbursement. (3.18.4.9.3)	Partially Met	Documentation does not appear to be a complete policy. Does not reference self-reporting and does not include payment policies for provider preventable conditions.	Develop P&Ps regarding preventable conditions, including reporting and reimbursement.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has a PNDMP that at minimum includes: • Summary of participating providers, by type and geographic location in the State. • Demonstration of monitoring activities to ensure access standards are met and 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	The PNDMP report does not include minimum requirements outlined in the MSA. In particular, its 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; and ongoing activities for provider network development and expansion, taking into consideration identified participating provider capacity, network deficiencies, service delivery issues, and future needs.	Develop a PNDMP that addresses minimum requirements as outlined in the MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has developed and implemented a measurable workforce development strategy to promote and maintain a qualified, competent, and sufficient workforce to support provider network adequacy and member access to care, with an emphasis on development of community-based providers and direct service workers, including self-directed employees. (3.9.2.1)	Minimally Met	The Workforce Development plan and evaluation was submitted but does not include a capacity assessment, analysis, and description of the methodologies utilized to assess the Contractor's current and future provider workforce capacity, competency, and workforce needs. It did identify workforce strengths and deficits and outlines some actions taken to address some of those deficits. It does not provide a description of long-term planning strategies that address future workforce initiatives and account for future projected workforce needs or describe stakeholder engagement and collaboration efforts to develop and implement the workforce development plan.	Develop a Workforce Analysis and Development plan that includes minimum components as outlined in the MSA.
The MCO provides access to home visiting services, Nurse Family Partnership, and Health Family America, for eligible members. (3.4.6.7)	Partially Met	The home visiting provider network is still being developed.	Develop P&Ps for home visiting services. Monitor utilization of program and enrolled Nurse Family Partnership and Healthy Families America providers.
The MCO has adequate methods to verify compliance with State-determined network adequacy standards and produces quarterly geospatial analysis reports. (3.9.3)	Substantially Met	The PNDMP Evaluation report does not describe outcomes of the PNDMP and lessons learned. The report does not demonstrate that HHO has adequate methods to verify compliance with State-determined network adequacy standards. Current processes to assess appointment wait times and PCP panel requirements are not sufficient.	Develop a PNDMP Evaluation plan that describes outcomes of the PNDMP and lessons learned. Develop P&Ps demonstrating how the MCO will verify compliance with all State-determined network adequacy standards.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The ongoing provider network development activities effectively address any existing network capacity issues, network deficiencies, or service delivery issues. Ongoing activities are aligned with future needs.	Substantially Met	Documentation and data submitted does not demonstrate that HHO is able to identify all network capacity issues, network deficiencies, or service delivery issues. An understanding of the issues will be crucial to inform activities designed to address issues.	Ensure provider network development activities effectively address any existing network capacity issues, network deficiencies, or service delivery issues. Develop ongoing activities aligned with future needs.
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)	Minimally Met	LTSS Alternate Service Wait Times and Access standards were not included in the PNDMP Evaluation report as required by the MSA. Documentation and data submitted does not demonstrate that HHO is able to assess member access to care in terms of provider-to-member ratios, distance requirements, appointment standards, and office wait times. An understanding of the issues will be crucial to ensure that HHO has capacity to provider-covered services.	Develop documentation demonstrating how HHO ensures LTSS Alternate Service Wait Times as outlined in the MSA. Ensure 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 wait times.
The MCO has a template for the MCO's provider participation agreements, including agreements with NFs and HCBS providers that has been approved by the State and adheres to contract requirements. (3.10)	Substantially Met	Provider Participation agreement templates incorrectly list retainment policy of five years.	Update Provider Participation agreement to retainment policy of 10 years as stated in the MSA.
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	During the file review, files showed provider licenses expired three months to six months prior to HHO learning of expired license.	Review and update processes for monitoring providers for compliance with credentialing standards.

Program Integrity Requirements and Confidentiality

ACDE 2024 Findings and Recommendations

As a wholly owned subsidiary of ACFC, ACDE is committed to the policy guidance and directives found 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 and elicit collaborative participation at all levels across the organization and to foster a culture of compliance. The administration of ACDE's Compliance program includes maintaining a full capacity of Compliance and Special Investigations Unit staffing, as well as conducting daily departmental operations. ACDE has well-documented compliance activities consisting of an annual written Compliance Program Work plan and management of ACDE P&Ps. The ACDE Regulatory Compliance committee meets at least quarterly. The CO reports on the Compliance program to ACDE's Executive Management team and the ACDE Board of Directors. The Regulatory Compliance committee assists the Market CO with the implementation and oversight of the Compliance program.

ACDE utilizes 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 the multiple tracking and analysis methods for monitoring FWA.

ACDE's website, 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 provided and include telephone and links to the Office of the Inspector General; all allow anonymous reporting. Internally, ACDE staff can report suspected cases via an email box or tip line, or by bringing an issue to a manager; non-retaliation policies for good faith reporting are in place.

All ACDE staff and contractors are assigned training during their onboarding to ensure they are trained on 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, which includes education and guidance on ethics and legal compliance policies, code of conduct and ethics, FWA issues, and procedures for reporting and the investigation of compliance issues. This includes education on the available reporting mechanisms that associates and contractors may use to report issues of non-compliance, privacy, or FWA. Additionally, the ACFC Corporate Compliance department and the ACDE Compliance department collaborate to host an Annual Compliance and Ethics Week event 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 outline what constitutes Protected Health Information (PHI) and personally identifying information and provide members with a formalized process to access health records for both review and revision, including instances when the requested information would not typically be shared; all appear in compliance with federal regulatory requirements. ACDE uses the

State-required file format to report breaches in confidentiality to the State and has adopted a Delaware-specific policy for reporting, which reflects the required timeframes for reporting to the State.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed program integrity further with MCO staff. MCO staff provided responses consistent with each other and with the documentation regarding FWA. However, no documentation was provided demonstrating the MCO has a process to notify the State regarding changes in member or provider eligibility.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has a process to notify the State regarding changes in member or provider eligibility. (42 CFR 438.608 and 3.16.1.9)	Partially Met	No documentation was provided demonstrating that ACDE has a process to notify the State regarding changes in member or provider eligibility.	Develop P&Ps for notification when a member or participating provider's circumstances change.

DFH 2024 Findings and Recommendations

DFH has compliance and program integrity programs consisting of: an annual written Compliance program and work plan; a 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 training on compliance and program integrity. DFH's website, 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 provided and include telephone numbers and links to the DHSS and DFH Abuse hotlines. Internally, FWA can be reported anonymously and confidentially by anyone through multiple channels, including the referral mailbox, the Special Investigations Unit Fraud hotline, and direct contact with the Vice President (VP) of Compliance at DFH.

The Compliance program is managed by the CO for DFH. The CO, with support and direction of 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 PD is completed annually. The Compliance program and annual work plans are designed to adjust to new regulatory and legal developments, and to implement needed changes identified by audits or investigations. DFH has a dedicated CO who is the Chair of 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 (e.g., 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 outline what constitutes PHI and personally identifying information and provide members with a formalized process by which access to health records for review and revision, including instances in which such information would not be shared; all appear in compliance with federal regulatory requirements. DFH uses the State-required file format to report breaches in confidentiality to the State and has adopted a Delaware-specific policy for reporting, which reflects the required timeframes for reporting to the State.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed certifications and program integrity further with MCO staff. It was identified that the FWA Compliance plan does not address all components outlined in the MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has a FWA Compliance plan and procedures to implement the compliance plan. (3.16)	Partially Met	DFH's FWA Compliance plan does not address all components outlined in the MSA.	Develop a FWA Compliance plan that addresses all components outlined in the MSA.
The MCO has a process for notifying the program integrity unit and Medicaid Fraud Control Unit (MFCU) of all cases of suspected FWA within two days of discovery of the suspected incident. Subsequently, the MCO promptly begins a preliminary investigation (concluded within 10 days) to determine whether a full investigation is warranted. (3.16.4)	Partially Met	DFH's submitted documents do not include Delaware-specific timelines and requirements. An Addendum WW was provided with Delaware-specific information, but there is no reference to this Addendum in the FWA plan. (CC.COMP.16)	Develop a FWA plan that includes Delaware-specific detail per the MSA.

HHO 2024 Findings and Recommendations

HHO has well-documented compliance and program integrity programs consisting of an annual written Compliance program and work plan, a defined audit approach, and other data mining activities, as well as a corporate Code of Conduct and required annual training on compliance, confidentiality and privacy, and 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 provided and include telephone and links to the Office of the Inspector General; all allow anonymous reporting. Internally, HHO staff can report suspected cases via an email box, tip line, or by bringing an issue to a manager; non-retaliation policies for good faith reporting are in place.

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

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

Program integrity activities occur within the local HHO MCO with linkages to the HHO CO. Staff work closely with local HHO leadership and the State to identify and share information pertaining to potential instances of FWA. Training on what constitutes FWA is given upon hire and annually thereafter. Tracking compliance follows a similar process as that described for Privacy and Confidentiality training above.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed further with MCO staff. MCO staff provided responses that were consistent with each other and with the documentation regarding FWA. However, contract templates and provider participation agreements require updates to align with the MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO contract templates are compliant with contract requirements. (3.22.2.3.5)	Substantially Met	HHO contract templates are not compliant with contract requirements. For example, contract templates state that notes and medical records should be retained for five years; however, MSA states medical records need to be retained for 10 years. Contract template states that in event of termination, providers may still provide services for 120 days; does not include any language that the provider must be enrolled with the Delaware Medical Assistance Program (DMAP) first; and the HCBS contract template does not include electronic visit verification, which is a requirement in the MSA.	Update contract templates so they align with the MSA.
The MCO Provider Participation agreements comply with the contract, including the process to ensure prior approval by the State. (3.10)	Substantially Met	HHO's Provider Participation Agreement policy does not include a step to confirm providers are enrolled with DMAP per the MSA.	Update policy to include requirement that providers be enrolled with DMAP as stated in the MSA.

Prohibited Affiliations with Individuals Debarred by Federal Agencies

ACDE 2024 Findings and Recommendations

ACFC and ACDE retain the responsibility and accountability for Delegated Credentialing and Recredentialing activities. At a minimum, ACFC and ACDE conduct a pre-delegation assessment and a formal annual audit of each credentialing delegate's performance and compliance with the Delegation of Credentialing agreement. The Delegation Oversight Coordinator is responsible for performing initial and ongoing (monthly) checks of all network providers. By contract, the State requires the MCOs to perform monthly checks against LEIE, SAMS/EPLS, and the SSA DMF. Additionally, ownership disclosure information is collected at the time of credentialing and annually thereafter, and those entities who hit the threshold are shared with DMMA for further review and follow-up. The Credentialing committee reviews the Executive summary and any applicable recommendations submitted by the

Delegation Oversight Coordinator, and delivers decisions regarding corrective actions for deficiencies identified in the Pre-Delegation audit. The Credentialing committee reports to the QAPI committee/QI committee on a quarterly basis or more often (if applicable).

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed the Provision of Prohibited Affiliations with Individuals Debarred by Federal Agencies further with MCO staff. All required documentation was present and provided evidence of compliance with regulatory or contractual provisions. MCO staff provided responses that were consistent with each other and with the documentation.

DFH 2024 Findings and Recommendations

The DFH Compliance program incorporates monitoring of its implementation and regular reporting to the CO and the Compliance committee. Compliance reports created by this ongoing monitoring, including reports of suspected noncompliance, are maintained by the CO and shared with the DFH directors, senior management, and the Compliance committee. DFH refrains from the execution of contracts with service providers that have been recently convicted of a criminal offense related to healthcare or that are listed by a federal agency as debarred, excluded, or otherwise ineligible for participation in federal healthcare programs.

Corporate and DFH credentialing are responsible for performing initial and ongoing (monthly) checks of all network providers. By contract, the State requires the MCOs perform monthly checks against the LEIE, EPLS, and the SSA DMF. Additionally, ownership disclosure information is collected at the time of credentialing and annually thereafter, and those entities who hit the threshold are shared with DMMA for further review and follow-up. Findings are reported to DFH and Provider Data management to implement appropriate action up to and including termination.

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 is present, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, providing evidence of compliance with regulatory or contractual provisions.

HHO 2024 Findings and Recommendations

On a monthly basis, Integrated Risk operations ensures all entities and individuals who are performing any activity on behalf of Highmark are being screened against the federal OIG and General Services Administration (GSA) exclusion lists. Enterprise Risk and Governance (ER&G) reviews the third parties' P&P(s) to ensure the frequency, mechanism for monitoring, and escalation process for federal exclusion screenings is documented. ER&G may also perform detailed employee testing to evidence that employees performing functions on behalf of Highmark are being screened against the federal OIG and GSA exclusion lists prior to contract or hire and monthly thereafter.

Additionally, ownership disclosure information is collected at the time of credentialing and annually thereafter, and those entities who hit the threshold are shared with DMMA for further review and follow-up. There are clear processes to terminate network providers, vendors, and employees who are flagged as part of HHO's systematic evaluation process.

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

Grievance and Appeal Systems

ACDE 2024 Findings and Recommendations

The grievance system follows standard processes. Grievances can be received from members, member representatives, providers, verbally through Member Services, or through an ACDE staff member (e.g., the member advocate) or be written (i.e., by filling out a form on the ACDE website or through the mobile application). When a grievance is received, the Grievance Team lead conducts a review of the completed Service Forms in the EXP MACESS system by generating an Employee Production report; this system is a repository for all member grievances received. In the event a Service Form is not properly handled or documented, the Grievance Team lead will notify the Grievance associate and the Grievance supervisor for feedback and coaching. There are currently 10 full-time equivalents (FTEs) dedicated to the Delaware line of business for Grievance management.

Grievance staff facilitate the Grievance investigation, sending acknowledgement letters to members, and coordinating investigations with other impacted business units. Any information that is sent to other units of ACDE for investigation is returned to the grievance team along with the investigatory findings. EXP MACESS is used for housing all grievance documentation, which includes tracking the timeliness of resolution. The Quality of Care (QOC) issues and other clinical issues are sent to the QM program, in which a Clinical Quality Performance Specialist (QPS) will perform further investigation, and resolution. The Clinical QPS will send an outcome letter to the provider (within one week of determination) and the QOC Grievance Member Resolution letter to the member (within two business days of the resolution). The Clinical QPS then uploads the QOC Grievance Member Resolution letter and documents that the letter was sent in EXP MACESS (within two business days of the resolution of the grievance).

In instances in which a pharmacy-related grievance is received via phone, the member is warm transferred to the MCO's Pharmacy Benefits Manager (PBM), PerformRx. PerformRx appears to adjudicate these grievances, and it is unclear how the MCO is identifying and capturing these member grievances according to the MCO's policies. The MCO should have a process in place to evaluate the compliance of PerformRx and the adjudication of grievances to ensure all pharmacy-related grievances are appropriately accounted for and represented in continuous QI activities.

Similar to grievances, standard appeals are accepted both verbally (through Member Services) and in writing (the appeals form can be found on the ACDE website or on the last page of the member's Notice of Adverse Benefit Determination [NOABD] letter) and sent to ACDE via US mail, fax, or email. Appeals are handled out of the local ACDE office, using the Jiva™ medical management documentation system; there are four FTEs dedicated to appeal adjudication. At the time of review, all positions were filled. If an appeal is filed by a member, written consent is not required. Appeals filed by a provider or member representative, on behalf of the 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 written), or the date member written consent is received, if the appeal was filed on a member's behalf. If member's written consent is not received as part of the initial written appeal filed on their behalf, the appeals analyst calls the member to inform them an appeal has been filed on their behalf and asks if they would like to proceed with the appeal. If the member responds in the affirmative, ACDE transitions it to a member appeal; however, this erroneously bypasses the need for written consent.

ACDE's P&Ps clearly identify that a member or authorized representative acting on behalf of the member can file a G&A or request a State Fair Hearing either verbally or in writing. However, the file review evidenced instances when grievances were submitted on a member's behalf and written consent from the member was missing. During the on-site discussion ACDE reported that they were instructed not to request written consent from the member when a grievance was filed on the member's behalf. Per federal regulation §438.402(c)(ii), "If State law permits and with the written consent of the member, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of a member." Written consent from a member is a mandatory requirement when G&A or request for a State Fair Hearing is requested on the member's behalf.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed the grievance system further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. However, there were elements within the member handbook and related policies that were missing contractual requirements.

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 the grievance files consisted of a review of the member's original grievance, internal notes and documents, letters produced by ACDE, and other documents supporting the investigation. Overall, the EQRO continues to see an increase in the number of member grievances captured and investigated by the MCO. One file reviewed did not include written consent when the grievance was filed on the member's behalf. All grievances that are filed on the member's behalf have a mandatory requirement of obtaining written consent, and all policies, processes, and trainings should support this. Overall, the files reviewed were found to have greater than 90% compliance in the required elements.

Appeal File Review

The appeal file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 appeals files was selected for review, representing Medicaid, CHIP, and DSHP Plus membership. The sample contained appeals that were upheld, overturned, and withdrawn following or prior to the Appeals committee meeting. 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	Findings	Recommendations
P&Ps clearly identify that a member can file a G&A 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)	Substantially Met	ACDE's P&Ps clearly identify that a member can file a G&A 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. However, during the on-site discussion it was discovered that ACDE was instructed not to request written consent from the member when a grievance was filed on the member's behalf. Per federal regulation §438.402(c)(ii), "If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee." Written consent from a member is a mandatory requirement when G&A or request for a State Fair Hearing is requested on the member's behalf.	Revise policies, processes, and trainings to incorporate the mandatory requirement of obtaining written consent from the member when a G&A or State Fair Hearing is requested on the member's behalf.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
Policies demonstrate the appropriate definitions for: • Adverse Benefit Determination (ABD): Denial or limited authorization of a requested service, reduction, suspension, or termination of a previously authorized service, failure to provide services in a timely manner, and so on. • Appeal: Review of an ABD. • Grievance: Expression of dissatisfaction about any matter other than an ABD (QOC, quality of service (QOS), and so on). • G&A System: Processes the MCO implements to handle G&As of an ABD; process to collect and track information about G&As. • State Fair Hearing: Process set forth in 42 CFR 431, Subpart E and Title 16 DE Admin Code 5000. (42 CFR 438.400 and 3.15)	Substantially Met	All submitted P&Ps are consistent and reflect contract requirements; however, the provider manual states that a State Fair Hearing must be requested within 120 calendar days, which does not align with the MSA requirement of 90 calendar days.	Update the provider manual to align with the MSA requirement, which states that a State Fair Hearing must be requested within 90 calendar days.
The MCO has a clearly defined policy and process for organizing and conducting the Appeals committee that ensures compliance with voting members; including one State representative, one physician employed by the MCO, and a nurse employed by the MCO. (3.15.3.2.8)	Substantially Met	ACDE stated during the on-site session that a nurse is included in the Appeals committee as required by the MSA; however, policy “GA 10 131.001 Handling of Member Appeals and Access to the State Fair Hearing System” does not include this information.	Revise policy “GA 10 131.001 Handling of Member Appeals and Access to the State Fair Hearing System” to state inclusion of a nurse employed by the Contractor in attendance in the Appeals committee process.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO and its subcontractors have a training program that covers fundamental G&A 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 G&A training program. (3.20.3)	Substantially Met	ACDE has a robust G&A training program for staff. However, lack of evidence has been provided to demonstrate a training program for subcontractors that covers all of the fundamental G&A concepts, DMMA-specific contract standards, and federal regulatory requirements.	Develop training for subcontractors on fundamental G&A concepts, DMMA-specific contract standards, and federal regulatory requirements, as well as ACDE's G&A 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	ACDE did not provide evidence of a training program for subcontractors. As such, there is no documented process in place to evaluate the effectiveness and outcomes of the training provided.	Develop a process and tools to evaluate the effectiveness and outcomes of the training on fundamental G&A concepts for subcontractors.
The MCO has a process to evaluate the compliance of its delegates responsible for adjudication of G&As. Delegation oversight tools and file review clearly demonstrate evaluation of the delegate's grievances system for compliance with federal requirements, including: grievance system structure, accurate definitions, rural exceptions, ABD language, resolution timeframes, expedited appeal processes, how information is shared with provider, continuation of benefits, and effectuation of reversed appeals. (42 CFR 438.400, Sub-part F, and 3.22.2.2)	Not Met	Although ACDE states that it does not delegate G&A activities, ACDE's grievances are adjudicated by PerformRx. ACDE should have a process in place to evaluate the compliance of the entity responsible for adjudication of these grievances. This evaluation process should clearly demonstrate an evaluation of the delegate's grievance system for compliance with federal and MSA requirements.	Develop a process to evaluate the compliance of delegates responsible for the adjudication of grievances that clearly demonstrates evaluation of the delegates' grievance system for compliance with federal and MSA requirements.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
Samples of grievance acknowledgement, resolution, and extension templates are available in alternative languages and formats (i.e., Braille), including how to obtain oral interpretation services for those who require it. Member handbook, MCO website, provider manual, and any additional new member/provider orientation materials should have consistent language on this topic. (42 CFR 438.10(c)(d) and 3.14.7.1.1.3)	Substantially Met	The ACDE GA 13E Extension letter states that the MCO is allowed 30 days from the date of receipt to review a grievance, instead of 30 calendar days as required by the MSA. Additionally, the letter states that the QM department is requesting an extra 14 days to investigate further, instead of 14 calendar days as required. It is important for the information to align with the MSA requirements.	Ensure language is consistent across all grievance materials by updating ACDE GA 13E Extension letter to align with MSA timeframe verbiage.
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 3.15.1.7)	Substantially Met	Member handbook states MCO research time can be extended by 14 business days rather than 14 calendar days. Information should align with MSA requirements.	Ensure language is consistent across all grievance materials by updating member handbook to align with MSA timeframe verbiage.
Samples of appeal acknowledgement, resolution, and extension templates are available in alternative languages and formats (i.e., Braille), including how to obtain oral interpretation services for those who require it. Member handbook, MCO website, provider manual, and any additional new member/provider orientation materials should have consistent language on this topic. (42 CFR 438.10(c)(d) and 3.14.7.1.1.3)	Substantially Met	Samples of appeal acknowledgement and resolution letters, member handbook, provider manual, and website state availability in alternative languages and formats (i.e., Braille) when requested and include how to obtain oral interpretation services for those who require it. However, extension letter template did not include information regarding availability in alternate languages/formats or how to obtain oral interpretation services.	Revise appeals extension letter template to include availability in alternative languages and formats (i.e., Braille) when requested and include how to obtain oral interpretation services for those who require it.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
Content of the ABD must include explanations of the following: • The ABD the MCO has made or intends to make and reasons for the ABD, including the right to be provided to copies of all documents, records, and other relevant information. • The right to request an appeal, right to request a State Fair Hearing, and circumstances in under which an appeal can be expedited. • The right to benefits pending resolution, how to request benefit continuation, and under which the member may be required to pay the costs of services. (438.404(b) and 3.15.2.3)	Substantially Met	ACDE's NOABD letters include all of the required elements, with the exception of informing the member of their right to be provided, upon request and free of charge, copies of all documents, records, and other relevant information.	Revise NOABD letters to include the right of the member to be provided upon request and free of charge, copies of all documents, records, and other relevant information to align with MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
P&Ps, file review, manuals, and handbooks: • Provide that oral inquiries seeking to appeal are treated as appeals, unless the member or the provider requests expedited resolution. • Provide the member a reasonable opportunity to present evidence, and make legal and factual arguments, in-person as well as in writing. • Provide the member and their representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process. • Provide a copy of the member's case file, including medical records, within five business days of the State's request. • Include, as parties to the appeal: The member and their representative; or the legal representative of a deceased member's estate. (42 CFR 438.406(b) and 3.15.3.2)	Partially Met	Overall, ACDE's P&Ps and provider manual evidence compliance by outlining the general process for handling appeals. However, the member handbook is missing important information regarding the member's opportunity to present evidence and testimony, access to the case file, receiving medical records free of charge and in a timely manner, providing the State with a copy of the member's case file within five days, and including all required information to all parties involved in the appeal, as required by the MSA.	Revise the member handbook to include and align with MSA citation 3.15.3.2.2–3.15.3.2.5 requirements.

DFH 2024 Findings and Recommendations

The DFH grievance system follows standard processes. Grievances can be received from a member, a member representative, or a provider, or through the Member Customer Service department. A grievance can also be received through a DFH staff member (e.g., member advocate) or in written format (e.g., fax, US mail, email, and web portal). The Member Customer Service department serves as the primary intake point for any grievance received verbally, via US mail, or in-person. If a grievance is received, the Member Customer Service department documents the grievance in the Online Member Network Interface (OMNI) on the same day

and then immediately routes to PRIME for processing by the Grievance department. The PRIME system is used for retention and MicroStrategy reporting. There are four FTEs dedicated to the Delaware line of business for grievance management.

Grievance staff facilitate the grievance investigation, sending acknowledgement letters to members and documenting the substance of the grievance. Grievance staff will route the grievance to the appropriate department for investigation, including any grievances that may involve urgent clinical issues. Once a resolution is received, grievance staff will review for completeness, and, upon completion, the staff will notify the member of the resolution. If a response is incomplete, it is forwarded back to the appropriate department for additional information. Grievances are tracked, trended, and reported, both internally and to the appropriate State regulators to identify opportunities for improved care and/or service to providers. QOC issues are documented via referral in TruCare and are processed as a standard grievance prior to being referred to the QI department for investigation. If a grievance is determined to be a QOC issue, QI clinical staff are directly responsible for the initial review of the grievance, referrals, and identifying need for further investigation. QOC incident investigations are to be completed within 30 calendar days.

Although DFH states that it does not delegate G&A activities, DFH's BH and pharmacy appeals are adjudicated by Shared Services. DFH should have a process in place to evaluate the compliance of the entity responsible for adjudication of these appeals. This evaluation process should clearly demonstrate an evaluation of the delegate's appeals system for compliance with federal and MSA requirements. In instances in which a BH or pharmacy-related appeal is received, it is unclear how the MCO is evaluating the compliance of the entity responsible for the adjudication of these appeals.

Similar to grievances, standard appeals are accepted both verbally (through Member Services or in-person) or in writing (appeal information can be found on the DFH website, the DFH member portal, or on the last page of the member's NOABD letter) and can be sent to DFH via US mail, fax, or email. If an appeal is filed by a member, written consent is not required. Appeals filed by a provider or member representative on behalf of the 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 written), or the date the member's written consent is received if the appeal was filed on a member's behalf. DFH's process is to have the appeals analyst call the member to inform them if an appeal has been filed on their behalf and asks whether they would like to proceed with the appeal if a member's written consent is not received as part of the initial written appeal filed on their behalf. If the member responds in the affirmative, the appeal is transitioned to a member appeal; however, the need for written consent is not satisfied. Reviewed appeals files contained notes that indicate there were instances in which member verbal consent was received and show the provider (or representative) initiated the appeal, creating confusion on the resolution timeline. The MCO's intention in this process is to minimize unnecessary burden for the member by not requiring written consent for an appeal filed on their behalf. There is an opportunity for the MCO to improve these processes by updating the language on its website and member handbook to align with its provider manual.

The MCO uses a robust training program that covers the fundamental G&A concepts to train internal staff. During the on-site review of member calls, one of the calls included a missed opportunity for the member customer service representative to advise a member on the timeline for grievance resolution. Representatives are required to look at past interactions and calls and grievances entered

into the system; however, a representative should also be aware of the general G&A processes. DFH acknowledged there is opportunity to train the representatives to be more familiar with the grievance process. Additionally, training has not been developed for subcontractors and, as such, there is not a way to evaluate the effectiveness and outcomes of training on fundamental G&A concepts for subcontractors. This demonstrates an opportunity for the MCO to enhance training for any staff and/or subcontractors that may interact with members, as all should be aware of the federal regulatory requirements and have familiarity with the G&A process.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed the grievance system further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. However, there were elements within the P&Ps that were missing contractual requirements.

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 the grievance files consisted of a review of the member’s original grievance, internal notes and documents, letters produced by DFH, and other documents supporting the investigation. Overall, the files reviewed were well-organized, timely, and included all federally and contractually required items, and it is evident that member grievances are being captured and investigated by the MCO. However, the file review identified that grievance resolution letters and acknowledgement letters contain errors, including

grammatical and spelling errors and non-specific language surrounding timelines. Overall, the files reviewed were found to have greater than 80% compliance in the required elements.

Appeal File Review

The appeal file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 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 consisted of a review of NOABD letters, internal notes and documents, letters produced by DFH, and other documents supporting the appeal investigation. Overall, the files reviewed were found to have scored less than 75% compliance in the required elements. The files were well-organized and included all federally and contractually required items; however, there were a few notable issues. Out of 30 files reviewed, nine did not include an appeal acknowledgement letter, three did not have written member consent when the appeal was submitted on the member's behalf, three did not have resolution letters addressed or cc'd to all affected parties, and one did not meet timeliness standards. Out of 30 files reviewed, 13 were overturned (43%), three were withdrawn (10%), six were upheld (20%), and eight were dismissed (27%).

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO and its subcontractors have a training program that covers fundamental G&A 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 G&A training program. (3.20.3)	Substantially Met	DFH has a robust G&A training program for staff. However, there is no specific training for subcontractors that covers fundamental G&A concepts, DMMA-specific contract standards, and federal regulatory requirements regarding G&As.	Develop training for subcontractors on fundamental G&A concepts, DMMA-specific contract standards, federal regulatory requirements, and DFH's G&A 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	DFH states that there is no specific training provided to subcontractors on G&A concepts. As a result, there is currently no process in place to evaluate the effectiveness and outcomes of the training provided.	Develop a process and tools to evaluate the effectiveness and outcomes of the training on fundamental G&A concepts for subcontractors.
The MCO has a process to evaluate the compliance of its delegates responsible for adjudication of G&As. Delegation oversight tools and file review clearly demonstrate evaluation of the delegate's grievances system for compliance with federal requirements, including grievance system structure, accurate definitions, rural exceptions, ABD language, resolution timeframes, expedited appeal processes, how information is shared with provider, continuation of benefits, and effectuation of reversed appeals. (42 CFR 438.400 [Subpart F] and 3.22.2.2)	Not Met	Although DFH states that it does not delegate G&A activities, DFH's BH and pharmacy appeals are adjudicated by Shared Services. DFH should have a process in place to evaluate the compliance of the entity responsible for adjudication of these appeals. This evaluation process should clearly demonstrate an evaluation of the delegate's appeals system for compliance with federal and MSA requirements.	Develop a process to evaluate the compliance of delegates responsible for the adjudication of appeals that clearly demonstrates evaluation of the delegates' appeals system for compliance with federal and MSA requirements.

Regulation/Contract Standard Not Fully Compliant	2024 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 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 3.15.1.7)	Substantially Met	The terminology regarding the process for filing a grievance is inconsistent between the provider manual, the member handbook, and the website. For example, the provider manual states that the form to use to file a grievance on behalf of a member is called an “Authorized Representative Designation Form,” while the member handbook refers to it as a “Release of Information.” Additionally, the website does not provide any information about a specific form for filing a grievance.	Update the verbiage in the provider manual, member handbook, and website to ensure consistent language and terminology are used to describe the process for filing a grievance.
File review and letter templates contain the following information: • Result of the grievance and any actions taken, including process steps. • Process and date of resolution and contact information should there be follow-up questions. (42 CFR 438.408 and 3.15.4.9)	Partially Met	The submitted letter templates and file review evidence all required information. However, file review evidences that grievance resolution and acknowledgement letters contain errors (e.g., grammatical and spelling). Additionally, acknowledgement letters state that a decision will be made within 30 days, rather than specifying 30 calendar days.	Update the auditing procedures and tools to ensure that adequate sample sizes are being evaluated to reflect error-free grievance resolution and acknowledgement letters. Adjust staff training and protocols to address new audit findings. Additionally, update the acknowledgement letter template to state that a decision will be made within 30 calendar days.

Regulation/Contract Standard Not Fully Compliant	2024 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 QS. • Quality committee meetings evidence grievance reporting. • Process to identify trends and take action is in place, including when there are high or low grievance numbers. • There is a process to performance barrier analysis and continuous QI based on findings. (42 CFR 438.416 and 3.15.7.1, 3.15.7.2)	Substantially Met	DFH's Quality committee meeting minutes include the MCO's grievance reporting, identification of grievance trends, actions taken, performance barrier analysis, and continuous QI conducted. However, no formal policy was submitted to capture this process.	Develop a process and system to capture all grievance information, including PBM and subcontractors, investigation findings, actions taken, decisions made, timeframes, provider education regarding the grievance, and the review of the information as part of the State's QS.
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 ABD by an MCO, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (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 3.15.1.6.8)	Substantially Met	The provider manual contains appropriate language regarding the process for filing an appeal. However, the member handbook and website do not specify what triggers an appeal or provide information on the timeline for filing an appeal.	Update the member handbook and website to include verbiage on what triggers an appeal as well as the timeline for filing an appeal.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
P&Ps and file review indicate that the MCO provides any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/Telecommunications Device for the Deaf (TTD) and interpreter capability. Acknowledge receipt of each appeal in writing to the member within five business days of receipt. Ensure the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making and who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease. An appeal of a denial that is based on lack of medical necessity. An appeal that involves clinical issues. (42 CFR 438.406(b) and 3.15.3.1)	Partially Met	All submitted P&Ps are consistent and reflect contract requirements. However, during the file review, it was found that appeal acknowledgement letters were not consistently sent out. The percentage of files that did not fully meet expectations resulted in a file review score of not met (below 75% compliant).	Enhance the existing appeal monitoring and audit tools to ensure that adequate sample sizes are being evaluated to reflect the required appeal requirements. Additionally, adjust staff training and protocols to address new audit findings.

HHO 2024 Findings and Recommendations

The grievance system follows standard processes. Grievances can be received from members, member representatives, or a provider acting on a member's behalf; orally through the Member Services call center; or through another HHO staff member (i.e., a member advocate). A grievance can also be received in writing, via fax, or via a web portal (i.e., filling out a form on the HHO website). If a grievance is received orally, a grievance analyst begins the data collection process in GuidingCare, which includes categorizing by grievance type to allow for identification of trends and related root-cause analyses. The GuidingCare platform captures all member information, including G&As' file documentation and progress notes in a centralized spot accessible by any MCO staff member.

When a grievance is received, the intake coordinator assigns the case to a grievance analyst to begin and facilitate an investigation. The intake coordinator also forwards the grievance to a G&A nurse to perform a clinical review and determine whether a QOC concern is present. The grievance analyst provides an acknowledgement to the member and then begins the data collection process by categorizing the grievance by type and involving any other departments that may need to be involved in the investigation and resolution (e.g., Provider Relations, Quality department, CC, and vendors/delegates). The GuidingCare system is used to house all G&A information, and the grievance analyst can prompt other departments for investigation through this system. If a member calls HHO specifically regarding the receipt of a bill for covered services, the representative attempts to resolve the issue at the time of the call. If the member is satisfied with the results during the initial call, the grievance is noted as "telephonically resolved" and included in tracking and trending reports to identify providers that continue to balance bill members; based on a pattern of balance billing members, a provider may be referred to FWA. The practice of telephonically resolved grievances appears to be effective in providing members a more immediate and satisfactory resolution.

Similar to grievances, standard appeals are accepted orally, in writing, via fax, or through the HHO web portal. All appeal data is stored through the clinical platform GuidingCare. The appeal filing limit is 60 calendar days from the NOABD for a standard appeal. HHO only requires written consent for appeals filed on behalf of the member. The appeal will be acknowledged within five business days of receipt of the appeal. The appeal process start date is the date the appeal is received from the member, or the date the written member consent is received for appeals filed on their behalf. Appeals analysts are responsible for sending out member correspondence, including the initial acknowledgement letter, letters requesting additional information, and the resolution letter, as well as calling and/or faxing providers. If continuation of current services is requested by the member, the appeals analyst verifies the member request is within the required timeframe. If an appeal hearing is requested, the member or member representative is invited to attend in-person or by phone to present the appeal and respond to questions. The member advocate also attends, along with the standing Appeals committee. The case is deliberated, and a decision is made and communicated to the member within two business days.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed the grievance system further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. However, there were elements within the member handbook, provider manual, and P&Ps that did not align with the MSA or were missing contractual requirements.

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 the grievance files consisted of a review of the member's original grievance, internal notes and documents, letters produced by HHO, and other documents supporting the investigation and resolution. One file reviewed did not meet the timeliness standard for acknowledgement, one did not have a resolution within the expected timeframe, and one was missing member consent. Overall, the files reviewed were found to have 90% compliance in the required elements.

Appeal File Review

The appeal file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 appeals files was selected for review, representing Medicaid, CHIP, and DSHP Plus membership. The sample contained appeals that were upheld, overturned, and withdrawn following or prior to the Appeals committee meeting. 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%), one was upheld (10%), one was withdrawn (10%), and one was dismissed (10%).

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has a clearly defined policy and process for organizing and conducting the Appeals committee that ensures compliance with voting members, including one State representative, one physician employed by the MCO, and a nurse employed by the MCO. (3.15.3.2.8)	Substantially Met	HHO stated during the on-site session that a nurse is included in the Appeals committee as required by the MSA; however, policy GA_11_MBU-AGR-POL-1003, Standard Appeals Policy, does not include this information.	Revise policy GA_11_MBU-AGR-POL-1003, Standard Appeals Policy, to state inclusion of a nurse employed by the Contractor in attendance in the Appeals committee process.
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 3.15.1.7)	Substantially Met	HHO's provider manual states, "If a provider files a grievance on behalf of a patient, the patient cannot file a separate grievance," which is not included in the member handbook. Additionally, the provider manual includes a fax number not included in the member handbook. Furthermore, the timeframes listed in the provider manual state "30 days" instead of "30 calendar days" and "14 days" instead of "14 calendar days". It is important for the information to align across member and provider materials, as well as with MSA requirements.	Ensure consistent language across all grievance materials by updating member handbook to align with grievance information stated in the provider manual and updating grievance timeframe verbiage in the provider manual to align with the MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
P&Ps, file reviews, and so on ensure that if the MCO extends the timeframe not at the request of the member for appeal of a denial decision, it must make reasonable efforts to give prompt oral notice of the delay; within two calendar days, give written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if they disagrees with that decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the extension expires. (42 CFR 438.408(c) and 3.15.4.6)	Not Met	HHO's member handbook and provider manual do not mention that when an MCO extends the appeals timeframe, not at the request of the member, the MCO will give the member written notice within two calendar days. This notice should include the reason for the decision to extend the timeframe and inform the member of their right to file a grievance if they disagree with that decision.	Update the verbiage in the member handbook and provider manual to align with the MSA requirements regarding the responsibilities of the MCO when the MCO extends the appeals timeframe, not at the request of the member.

Subcontractual Relations and Delegation

ACDE 2024 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 (National Imaging. Associates Inc [NIA]) — Radiology Benefit Manager, PerformRx — PBM, and SKYGEN USA, LLC — Dental Benefit. The Delegation Oversight department conducts audits of these entities, including follow-ups as appropriate. This department also provides Delaware-specific training on an ongoing basis.

Corporate ensures all delegates undergo a pre-delegation audit; the MCO also ensures routine reporting and that an annual delegation audit occur within the required timeframes. Annually, Corporate Clinical and Delegate auditing conducts an assessment to ensure delegates remain able to provide delegated functions. This assessment may be conducted on the desktop, on-site, or both. The assessment 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. File reviews are conducted as appropriate. If a delegate does not pass the annual assessment, Corporate Clinical and Delegate auditing may recommend to ACDE that it consider termination of parts or all of the Delegation agreement. If ACDE chooses to continue with 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 USA, LLC	Claims Adjudication, PNM, Provider Services, Credentialing, Provider Contact Center, UM
Evolent Health	Radiology UM
Carenet Health Solutions	Member Triage/Advice Line
CCHS	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
MDLive Provider Services, LLC	Credentialing, Recredentialing, Primary Source Verification, Credentialing Committee

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed subcontractual relationships and delegation further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. All required documentation is 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 2024 Findings and Recommendations

The DFH vendor oversight program is a multi-pronged collaborative and risk-based model. Contracts are constructed to include expectations of performance, risk allocation, and emphasize regulatory requirements. The Vendor Management team then ensures subcontractors abide by contractual obligations and provide best in class service to members. As part of this oversight, continual

monitoring of vendors is implemented including regularly scheduled Joint Operations Committee meetings, review of metrics, capacity and forecasting planning, and day-to-day issue resolution. Finally, the compliance teams assess subcontractor compliance with managed care obligations through audits, ongoing monitoring activities, remediation activities, and reports on CAPs.

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

Entity	Responsibilities
Modivcare	Value-Add Transportation: Non-Emergency Transportation providing customer service, claims/payment, credentialing, network management, complaints, and grievances
NIA	UM and Provider Customer Service
Envolve Benefit Options: Dental	Dental Benefit Manager (DBM): Providing account management, credentialing, customer service, network management, provider services, provider relations, and UM
Envolve Benefit Options: Vision	Vision Benefit Manager: Providing account management, credentialing, customer service, network management, provider services, and provider relations
CVS Caremark	Pharmacy Benefit Manager (PBM): Providing claim adjudication, pharmacy network, and drug rebate information
SKYGEN USA, LLC	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 (COB), and medication therapy management
Tidal Health Nanticoke	Credentialing
Tidal Health	Credentialing
Delaware Chiropractic Network	Credentialing
CCHS	Credentialing

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed subcontractual relationships and delegation further with MCO staff. It was identified that audits were not specific to the Delaware Medicaid market, the Vendor Management policies did not align with the contract, and monitoring P&Ps were not sufficient to demonstrate compliance.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO organizational structure demonstrates leadership from the corporate entity to the local health plan and includes relationships with sister entities, subcontractors, and delegates. (3.20.1.3). Administration and staffing structure appears sufficient to successfully implement contract requirements. (3.22.2.1.7)	Partially Met	Audit reports provided for each delegated entity combined information at a national level and for all lines of business.	Develop audits of delegated entities that apply specifically to the Delaware Medicaid market.
The MCO subcontracting responses, policies, and contracts reflect that MCO is wholly responsible for entire contract. (3.22.1.1, 3.22.2.3.4)	Partially Met	Vendor Management policy does not include processes to ensure professional quality, technical accuracy, timely completion, and coordination of all services furnished by subcontractor.	Develop a Vendor Management policy that includes processes to ensure professional quality, technical accuracy, timely completion, and coordination of all services furnished by subcontractor.
The MCO has procedures to ensure delegated entities are in compliance with State and federal requirements. (3.22.2)	Substantially Met	Documentation provided is contract text input into policy. Not clear that DFH has procedures, including timelines and tools, to monitor subcontractors' and downstream entities' performance.	Develop P&Ps, including timelines and tools, to monitor subcontractors' and downstream entities' performance.

HHO 2024 Findings and Recommendations

HHO uses a three-pronged oversight team for subcontractor oversight: the Vendor Management Oversight (VMO), the Functional Business Owners (FBOs), and the ER&G team. Delegate oversight occurs in a matrixed fashion involving the VMO, compliance, quality, and FBOs (e.g., UM and credentialing). The VMO acts as the liaison with the delegate from an oversight perspective and works with the Compliance unit to ensure the VMO framework is compatible with the contract. FBOs are identified within each business unit and aligned with the delegate's scope of services. FBOs are responsible for the day-to-day operations and overall delegate relationship management, including performing operational oversight, training, and audits. Results of delegate oversight activities are shared through the Quality committee structure (QI/UM committee). All delegated activities follow NCQA standards and

consist of a signed agreement documenting the delegated responsibilities and other pertinent contract elements, including any flow-downs from the MSA HHO has signed with DMMA.

The process starts with capturing all relevant regulations from different governing bodies (e.g., Delaware, specifically DMMA, CMS, Blue Cross Blue Shield Association, and NCQA). During this initial sourcing and contracting exercises, HHO ensures vendors can fulfill all regulatory requirements, and their MSA includes all required contract terms and service level agreements (SLAs). HHO's Vendor Management policy governs vendors providing goods and services to Highmark Medicaid (including HHO) in compliance with all applicable CMS Federal, DMMA State, and NCQA organization regulations. HHO ensures its subcontractors, downstream entities, and high-risk vendors comply with all regulatory requirements. The responsibility for the quality and completion of all work performed by the vendors falls on HHO, who will monitor the vendors' performance going forward. The approach includes a focus on vendor onboarding and education, vendor monitoring, vendor contract maintenance, and an onboarding assessment. Delegation oversight audit tools have been developed to capture both NCQA and Delaware-specific requirements. Audit results are reported out at the NCQA and Delaware-specific requirement levels and CAPs are requested when results fall below established thresholds. CAP oversight is shared between the FBO and VMO; however, HHO retains the final determination on decisions affecting delegated relationships.

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

Entity	Responsibilities
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
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

Entity	Responsibilities
Nemours Children's Health	Provider Credentialing
UCD	Adult Dental Benefit Services

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed further with MCO staff. In assessment of subcontractual relationships and delegation, it was identified that audits were not specific to the Delaware Medicaid market, the Vendor Management policies did not align with the contract, and monitoring P&Ps were not sufficient to demonstrate compliance.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has a defined process to evaluate prospective subcontractors, monitor for and identify breaches of contract, and implement CAPs when necessary. (3.22.2.2.1, 3.22.2.3.4)	Partially Met	Vendor Score cards provided did not identify Delaware-specific data. It is unclear how HHO evaluates prospective subcontractors, monitors for and identifies breaches of contract, and implements CAPs specific to Delaware Medicaid members.	Develop assessments and other documentation that demonstrates how HHO evaluates prospective subcontractors, monitors for and identifies breaches of contract, and implements CAPs specific to Delaware Medicaid members.
The MCO has clear P&Ps to evaluate a subcontractor and downstream entities' compliance with State contract and federal requirements including pre-delegation, ongoing monitoring, and oversight and annual audits. The policy should include information provided to subcontractors and downstream entities in compliance with contract. (3.22.2)	Substantially Met	The Vendor Oversight and Monitoring policy was not submitted.	Develop a Vendor Oversight and Monitoring policy.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO's credentialing and recredentialing P&Ps: • Follow State guidelines for recredentialing, every three years for non-HCBS providers and annually for HCBS. • Include nondiscrimination. • Do not employ or contract with providers precluded from participation. • Comply with NCQA standards for the credentialing and recredentialing of providers. • Include all types of participating providers, including licensed independent practitioners, licensed organizational providers, and non-licensed independent and organizational providers, such as certain HCBS providers and BH providers. • MCO provides a process for providers to be credentialed online. (3.9.9)	Substantially Met	Documentation was not provided with the required basic information regarding HCBS credentialing requirements per the MSA.	Develop credentialing and recredentialing P&Ps for HCBS following MSA guidelines.

Clinical Practice Guidelines and Coverage, and Authorization of Services

ACDE 2024 Findings and Recommendations

The ACDE UM organizational chart illustrates that all UM positions are currently filled, apart from the UM Operations Oversight Manager, a key personnel position. At the time of this review, ACDE had identified a candidate and was in the process of curating an offer. The UM program consists of staff dedicated to Delaware Medicaid, as well as staff functioning within corporate shared services. ACDE and each delegate provided a staffing plan and methodology to assess staffing needs.

The ACDE CMO has direct oversight of the UM department for both shared services and those specific to Delaware Medicaid. The UM Operations Oversight Manager reports directly to the CMO and serves as a SME to achieve regulatory standards while acting as the UM liaison for plan providers, delegates, and healthcare vendors.

Delaware-specific delegates include:

- Avēsis Third Party Administrators, Inc.: UM of vision services.
- Evolent [formerly NIA]: Radiology UM.
- Perform Rx: PBM.
- SKYGEN USA, LLC: Management of the Adult Dental Benefit Administration. **The SKYGEN USA, LLC contract will terminate July 31, 2024.**

There is a separate section of this report for Pharmacy that will review PerformRx. This UM section provides a review of Avēsis, Evolent, and SKYGEN USA, LLC.

ACDE provided corporate UM P&Ps and Delaware Medicaid-specific addendums to guide the UM process. The corporate policies do not have State-specific addendums, which could lead to confusion and non-compliance with Delaware contractual requirements for UM team members. ACDE may want to consider adopting a process to ensure staff are aware of State-specific addendums or incorporate State-specific contractual requirements into corporate policies. In review of the ACDE P&Ps, there were areas that did not address Delaware contractual requirements. ACDE did not provide a P&P that is fully compliant with the contractual requirements for reimbursement of non-participating providers for family planning services. In addition, ACDE did not provide a formal process that outlines notification to the State when there is a request to extend the timeframe for a service authorization decision. This process requires ACDE to send a written member notification with the rationale for extending the timeframe, including the right to file a grievance if the member disagrees. Although ACDE submitted NOABD policies, the policies did not include a description of the process to render administrative denial determinations, or the staff who are able to make administrative denial determinations. In addition, the ACDE documentation through P&Ps and processes did not include a formal process to identify LTSS service utilization for DSHP Plus LTSS members. There was no indication of the requirements to capture LTSS member service needs, the timeframe required to do so, or the process to notify the State, as required by the Delaware Medicaid contract.

The UM PD, work plan, and evaluation are specific to ACDE. The UM work plan detailed UM deliverables and the associated requirement in addition to the frequency, responsible party, and department for completing each deliverable. Within the work plan there is a column to provide a narrative note, but at times the narrative is blank. ACDE is encouraged to provide a narrative for each deliverable to ensure decision points and barriers are captured. The UM evaluation provides an overview of the UM program, performance, and areas of focus for 2024. The UM PD includes the majority of the MSA requirements, with the exception of a

description of administrative denials, administrative denial types, or the staff who are able to make administrative denial determinations.

ACDE described the importance of internal coordination of care for member treatment and discharge planning. Coordination across disciplines occurs through weekly interdisciplinary rounds with participation from UM, CC, LTSS CM, and market Medical Directors to coordinate ongoing discharge planning activities with the goal of reducing the length of stay for members with complex cases. ACDE provided a narrative in the PD, standing operating procedures (SOP), and policies to describe the UM staff role in discharge planning. At times, the guidance within the UM PD did not appear to be in alignment with the "LOB 7100 UM Referral Triage and Coordination to Population Health Management (PHM)" SOP. For example, the UM PD indicates discharge begins upon admission and a Discharge Planning assessment will be completed. Within the SOP, there is no indication of a requirement to request discharge planning information upon admission. It is also not clear whether there is a process to request discharge planning for continued stay reviews. The SOP language suggests the UM team member should input specific discharge planning data only "when available" and references initiation of the "Discharge Management Checklist." ACDE should create alignment of discharge planning language within the PD and SOPs to provide clear direction and eliminate staff confusion in roles and responsibilities. In addition, there is no quantitative or qualitative process to ensure **all** IP admissions are receiving discharge planning. ACDE does run a Daily Assessment report, but it does not clearly indicate how many of the total admissions found had a Discharge Management Checklist completed. Furthermore, the monthly audit tools do not currently capture compliance with discharge planning requirements.

To monitor the performance of UM staff for contractual MSA compliance, there is a structured process in place. Daily, the UM managers and supervisors oversee case volume, UM worklists and call center volume, average speed of answer, and abandonment rates. This assists with identification of cases that are close to timeliness non-compliance and allows the UM supervisors to adjust caseloads accordingly. Reports are reviewed weekly, and supervisors will provide individual or team coaching as opportunities are identified. Audits are conducted on a monthly basis, and identified team trends are escalated to leadership for additional action. The yearly audit average for 2023, was 99%, a 2% increase from the previous year. Team meetings are held monthly and used as a forum to provide coaching or share information pertinent to the UM role. Leadership meets on a regular cadence internally and across disciplines to share information pertinent to the UM role. ACDE's efforts to monitor staff performance are reflected in their 2023 TAT compliance, maintaining above 95% compliance for all service authorization request types. Inter-rater reliability (IRR) is conducted quarterly at a minimum and coaching or corrective action is provided as needed.

In 2023, ACDE and delegates did not conduct Delaware-specific UM training. Part of the UM Operations Oversight Manager's role is to develop Delaware-specific content to orient and train ACDE staff and delegates. During the review, ACDE indicated a key focus of 2024, is to develop Delaware-specific UM training for ACDE staff and delegates.

ACDE uses InterQual Level of Care criteria, American Society of Addiction Medicine (ASAM) criteria, clinical policy, and/or community-developed evidence-based criteria for issuing coverage determinations related to medical services. Criteria are reviewed

annually, updated as applicable, and posted to the provider website. The Corporate Clinical Policy committee develops, reviews, updates, and approves clinical policies and clinical practice guidelines.

The ACDE QAPI committee is in place to meet the MSA requirements for an UM committee and evaluates the effectiveness of multiple aspects of the UM program. This includes the UM PD, UM Program evaluation, UM reports (i.e., Decision Timeliness, IRR, IP Readmissions, and Over- and Under-Utilization), medical necessity criteria review, and oversight of UM P&Ps. The committee is chaired by the ACDE CMO. The committee meets at a minimum every quarter and attendees include the CMO, BH CMO and leadership from QM, LTSS CM, UM, PNM, PHM, HEDIS, Appeals, Member Services, Member Engagement, Pharmacy, Compliance, and Delegation. Selected in-network providers attend each QAPI committee meeting. Fifty percent of the voting membership constitutes a quorum, including a minimum of two practicing physicians. The committee chair has the tie-breaking vote. Committee minutes are recorded at each meeting and reflect key discussion points, decisions, rationale, planned actions, responsible persons, and follow-up from prior recommendations. The meeting minutes are submitted to DMMA quarterly.

ACDE has a robust EPSDT program with a designated EPSDT coordinator to ensure members younger than 21 years old are receiving necessary screenings and services. Providers are supplied periodicity schedules with screenings by age and associated bill codes to track screening types and due dates. ACDE utilizes NaviNet to interface with providers, where care gap query reports are available to review overdue screenings. ACDE reported that provider reporting rates for members who received a treatment within 90 days of the initial screening are currently low (4.98%–10.36%), likely due to billing practices. ACDE plans to coordinate with providers to ensure there is a method to accurately track treatment following screening with the timeframe to evaluate compliance to be provided within 90 calendar days from the initial screening. The EPSDT team partners with the quality program to collaborate on HEDIS initiatives, specifically, lead screening, Human Papillomavirus (HPV) member outreach, birthday card mailings, and one-way texting campaigns. Recently, the EPSDT team launched a dashboard to track immunizations, lead screening, periodic visits, and sick visits.

At the time of review, multiple delegates remained on CAPs. Specifically, Avēsis was placed on a CAP in June 2023 for non-compliance with a call center service level metric of at least 80% of calls answered by a live voice in 60 seconds or fewer. On the Monthly Delegation Oversight reports for June 2023, Avēsis reported meeting 70.59% of calls in 60 seconds or fewer. Avēsis implemented the following strategies to improve the CAP: implementation of mandatory overtime, coaching sessions, leadership support during peak call times, and partnering with the Human Resources department to increase recruitment efforts.

In addition, Avēsis did not meet the requirement that non-urgent written notification of decisions be sent to members and providers within seven calendar days. As of January 1, 2023, Delaware changed the standard service authorization decision TAT requirement from 10 calendar days to seven calendar days. The 2023 Annual Delegation review conducted in October 2023 indicated that Avēsis' policies and processes were not in line with the updated Delaware contract standards. Since the CAP was implemented in June 2023, Avēsis has been out of compliance with the standard service authorization written notification requirement for July 2023, September 2023, November 2023, December 2023, February 2024, March 2024, and April 2024. Avēsis is required to remain on the

CAP until the metric is met for three consecutive months. To mitigate delayed letters, Avēsis has implemented a Failed Letter report to prompt staff to generate a manual letter.

SKYGEN USA, LLC was placed on a CAP in July 2022, due to missing policy language regarding written member notification of the decision to extend the timeframe for decisions and the members' right to file a grievance if they disagree with the extension, missing contents from the NOABD identifying the criteria on which the decision was based, and using language exceeding a sixth grade reading level within the denial letters. As of May 2024, SKYGEN USA, LLC continues to remain on all three corrective actions until the metrics are met for three consecutive months. SKYGEN USA, LLC's contract will terminate at the end of July 2024 and DentaQuest will be the new Dental Benefit administrator effective August 1, 2024.

Although ACDE meets with delegates on a routine basis and reviews monthly performance and audit metrics with ACDE's Quality committee, increasing the frequency of review and meetings may be warranted to oversee the corrective action. The delegates should be showing timely objective improvement in CAPs and ensure individual performance data is routinely monitored, tracked, and trended as warranted so proactive opportunities for corrective action and coaching are not missed.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed UM further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. However, there were elements within P&Ps that were missing contractual requirements.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has a P&P that allows for reimbursement of non-participating providers for family planning services rendered to members as long as the following conditions are met: provider is qualified to provide family planning services based on licensed scope of practice and is a DMAP-enrolled provider; electronic claims are submitted using HIPAA standard transactions; medical records sufficient for MCO CC activities are provided and if a member refuses the release of medical information the non-participating provider must submit documentation of such refusal; and informed consent is obtained for all contraceptive methods including sterilization consistent with requirements of 42 CFR 441.257 and 42 CFR 258. **DHCP members may not utilize OON family planning providers. (3.4.1.4.2.3)**	Partially Met	ACDE indicated the contract requirements in section 3.11.3.9 of the MSA are fulfilled in the "UM 14–UM.401.DE Direct Access to Providers (Addendum)" and "UM 14–UM.401 — Direct Access to Providers" policies. The policies submitted do not fulfill the requirements in section 3.11.3.9 of the MSA. The missing criteria includes: • Electronic claims are submitted using HIPAA standard transactions. • The family planning provider provides medical records sufficient to allow the Contractor to meet its CC responsibilities; if a member refuses the release of medical information, the non-participating provider must submit documentation of such refusal. • The family planning provider obtains informed consent for all contraceptive methods, including sterilization, consistent with requirements of 42 CFR 441.257 and 42 CFR 441.258.	Develop a P&P that outlines the requirements in section 3.11.3.9 of the MSA explaining the following: • Electronic claims are submitted using HIPAA standard transactions. • The family planning provider provides medical records sufficient to allow the Contractor to meet its CC responsibilities; if a member refuses the release of medical information, the non-participating provider must submit documentation of such refusal. • The family planning provider obtains informed consent for all contraceptive methods, including sterilization, consistent with requirements of 42 CFR 441.257 and 42 CFR 441.258.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has training materials specific to UM that reflect Medicaid managed care federal requirements and DMMA-specific contractual standards. This includes a roster of staff who completed the trainings in the year under review. (3.20.3)	Not Met	The annual training indicated for Avēsis, Evolent, PerformRx, and SKYGEN USA, LLC includes "Utilization Management Key Information Annual Training" (follow-up: 2024 Subcontractor UM Training). There were no routine State-specific trainings provided in 2023.	Develop and distribute UM training materials that reflect DMMA-specific contract standards that will be used for both internal ACDE team members and delegated entities. Include the roster of staff that have completed the trainings, including those within the delegated entities.
The MCO's P&Ps and/or SOPs appropriately categorize service requests as standard and expedited; all requests are adjudicated in an expeditious fashion with standard requests completed within seven business days of receipt and within 72 hours for expedited requests; extensions up to 14 days are allowed with clear documentation of requester and reason. (42 CFR 438.210 and 3.12.8.5.2.1, 3.12.8.5.2.4)	Partially Met	ACDE must (1) detail the process to notify the State of a request to extend the timeframe for a service authorization decision, and (2) provide a copy of the written notice distributed to members with the rationale for expending the timeframe and right to file a grievance if they disagree.	Develop a guiding document that includes the process to notify the State of a request to extend the timeframe for a service authorization decision and provide a copy of the written notice distributed to members with the rationale for extending the timeframe and right to file a grievance if they disagree.
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	After further review of the UM PD, page 13 indicates: "Only a Medical Director may issue an adverse benefit determination." The PD does not define an administrative denial or the staff able to make an administrative denial determination.	Include in the UM PD language defining the staff who are able to make administrative denial decisions and types of administrative denials.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has a formal process for ABDs 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)	Partially Met	ACDE has a NOABD corporate policy with an associated Delaware-specific addendum. The policy does not differentiate the difference between a medical necessity denial and administrative denial, indicate types of administrative denials, or indicate the staff who can make adverse determinations.	Develop language within the NOABD policy, including for delegates, the definition of an administrative denial and include the types and staff able to complete an administrative denial decision.
The MCO demonstrates, through chart reviews, tracer scenarios, and other activities that UM and Transition and Discharge planning staff work together to support the members needs during the hospitalization and post-discharge. (3.12.2.1.13)	Partially Met	The UM PD outlines the UM clinician's role in working with facility discharge planners to review and update the discharge plan and complete the "Discharge Planning Assessment;" the "LOB 7100 UM Referral Triage and Coordination to PHM" SOP outlines in step five the "UM" (not associate) requirements for documentation but does not outline the process to complete the Discharge Planning assessment. In addition, these requirements are not captured in ACDE's auditing tools provided. ACDE may want to consider creating SOP alignment with the verbiage in the UM PD, in addition to capturing the requirement in the audit tool to track compliance.	Develop documentation through a P&P, SOP, or other process document that aligns with the verbiage in the UM PD and include evidence of discharge planning in the UM audit tool or other mechanism to track compliance.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO operates an EPSDT program compliant with federal regulations and State contract standards. (42 CFR 441.56(e) 3.4.6.3) • Service timeframes. • Provider notification. • Member and family notification. • Process to track and report compliance and outreach to members to encourage compliance with EPSDT screening.	Partially Met	ACDE must develop a formal process to comprehensively track whether treatment is provided to members no later than 90 calendar days from the date of the EPSDT screening if a need was identified as indicated in section 3.4.6.3.2 of the MSA.	Develop a formal process to accurately track whether treatment is provided to members no later than 90 calendar days from the date of the EPSDT screening if a need was identified as indicated in section 3.4.6.3.2 of the MSA.
The MCO has a formal process or mechanism by which to monitor LTSS service utilization of DSHP Plus LTSS members and to be able to identify members who have not received such services within a 30-calendar day period of time and notify the State of these members. (3.12.7)	Not Met	ACDE provided what appears to be a CC SOP that outlines the process for clinically appropriate referrals and timely linkage and coordination of services from the IP level of care. There is no indication of the requirements to capture an LTSS member service need, or the timeline required to do so. This process does not meet the requirement to (1) identify LTSS service utilization of DSHP Plus LTSS, (2) identify members who have not received such services within a 30-calendar day period of time, and (3) notify the State of these members. Examples of service utilization could include receiving home healthcare after an admission or receiving a request for durable medical equipment (DME).	Develop a documented process to (1) identify LTSS service utilization of DSHP Plus LTSS, (2) identify members who have not received such services within a 30-calendar day period of time, and (3) notify the State of these members.

DFH 2024 Findings and Recommendations

DFH submitted an organizational chart for the UM program that includes the names of UM team members and their positions. All UM positions were filled at the time of the submission. DFH uses a shared services approach for UM functions, with specific team members reviewing Delaware Medicaid and a calculated percentage of the team members' time attributed to Delaware Medicaid. Those that are assigned to review Delaware Medicaid are licensed in the State.

The organizational chart indicates that the UM manager reports directly to the VP, PHCO, which is a corporate position and is 100% dedicated to Delaware Medicaid. The VP, PHCO, reports to the CMO. The MSA requires that the UM manager report directly to the CMO. The initial documentation and the follow-up documentation provided by DFH was inconsistent. The MCO referenced prior discussions with DMMA related to the reporting structure; however, formal approval was not obtained.

DFH and delegated entities determine staffing needs based on membership, volume of service requests, and TAT requirements for physical health (PH), BH, and LTSS. DFH UM leadership monitors daily caseloads, as well as authorization aging reports, to ensure sufficient staff is in place to maintain TATs, rebalancing workloads as needed. As DFH uses a shared services model, additional staff can be assigned to assist with DFH UM tasks.

DFH subcontracts with four UM delegated entities. The CMO has oversight of these delegated entities:

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

In addition to oversight of the delegated entities, the CMO oversees all UM, CC, CM, quality, and pharmacy functions. DFH has several standing meetings in place to facilitate interdepartmental coordination and provide an avenue to bring complex cases for discussion. These include BH rounds, case conferences, UM (PAs/concurrent review) Medical Director Touchpoint, PHCO/UM/Provider/Operations meeting, UM performance and BH collaboration calls, and a DFH morning huddle that is held twice weekly. As an example, of coordination with delegated entities, DFH refers Evolent denials to CC for follow-up. The member handbook lists benefits that are provided by the Delaware Medicaid State plan; however, there is not a documented process in place to inform and direct the UM team members on coordination of these State-provided benefits.

Oversight of the DFH UM program is incorporated into the QIUMC for which the DFH board of directors has oversight and operating authority. The QIUMC is chaired by DFH CMO. The QIUMC composition includes Executive Leadership, LTSS, and BH Medical

Directors, designated PHCO staff, QI staff, network practitioners who represent a range of specialties within the network and across the service area, and other operational staff as requested, including Networking/Contracting, Member/Provider Services, Compliance/Regulatory, and Pharmacy. QIUMC meetings are scheduled quarterly, with additional meetings scheduled as needed. Fifty percent of committee member attendance is required for a quorum. A minimum of two health plan staff and two external practitioners must be present for a quorum. Minutes are taken by a delegated committee designee. The QIUMC minutes are completed within 30 days of the meeting and stored in a secure location. Committee minutes are submitted to the board of directors quarterly.

DFH has a comprehensive suite of UM P&Ps to guide the UM process for Delaware Medicaid management. For example, there is a specific policy explaining coverage of family planning services by any qualified provider whether or not the provider is in-network, with the exception of DHCP members. The P&P includes the conditions, as identified in the MSA, for coverage by a non-participating provider. DFH demonstrated the use of multiple avenues to provide information to both members and providers on covered services, including the DFH website, the member handbook, and the provider manual. Key to addressing health inequities and encouraging adherence to discharge and treatment planning is the inclusion and auditing of cultural considerations in trainings. However, DFH did not demonstrate that there is a process in place to ensure cultural preferences are included when reviewing cases and discharge planning. DFH communicated that cultural preferences will be incorporated into member communications with UM/CM collaboration. Questions will be added to the UM team workflow regarding cultural considerations and outcomes will be documented in the Discharge Planning note. If cultural considerations exist, UM staff will coordinate with provider staff, as applicable, to address and a task will be sent to notify CC.

DFH submitted a comprehensive list of the trainings provided to DFH UM team members. The documents included training provided to Envolve, Evolent, and MRIoA. The trainings met Medicaid- and DMMA-specific requirements. DFH has a corporate program, “Centene University,” where trainings and post-tests are housed. This program provides dashboarding for trainings allowing the Business Standards Performance (BPS) team to track audit results. The process to oversee delegated entities included auditing. The MRIoA Annual training from April 8, 2024, included the redacted names of the reviewers with their scores. The average score was approximately 34%; one review scored 100%. The MRIoA Staff Development and Training document requires a score of 80% or higher. For those that score lower, a re-read of the policies is required, along with a re-take of the quiz. The 2024 plan has increased scores; however, 17 are scores below 80% (30%’s). The NIA 2023 Third-Party Risk Management Office (TPRMO) Combined Audit Results Summary document dated December 7, 2023, states that the audit was announced on July 13, 2023. The audit scores ranged from 64%–100%, with three identified opportunities for improvement and three CAPs. The three CAPs were regarding: (1) Offer of Peer-to-Peer for Medical Necessity Adverse Determinations; (2) Denial Rationale in Laymen Terms and Understandable to the Member; and (3) AZ Licensed Medical Director for PA Decision. The report does not include the number of files that were reviewed overall, and it does not include the number of files for each state and/or line of business.

Review of PAs and the rate of denials and appeals provides insights into service or provider trends where intervention may be required. For Evolent, the medical necessity denial rate ranged from 21.4%–34.8%, with a total of 936 denials for 2023. The number

of appeals was exceptionally low (eight appeals). DFH had not drilled down on this data to evaluate the services or providers that are driving the number of denials and to ensure that the members with a denial are receiving appropriate alternative care. If a member is enrolled in either CM or CC and there is a denial determination by Evolent, then the CC or CM will follow-up with the member. There is not a process in place to monitor member needs if a denial is determined and an appropriate alternative is recommended. For Envolve Dental, the total number of denials in 2023 was 120, with the number of appeals at five. Forty-one percent of the denials were administrative, leaving 59% of the denials based on medical necessity.

To service inbound UM phone requests, the daily call center hours are 8:00 am–5:30 pm ET, with after-hours coverage available outside of these times. The member handbook provides the phone numbers to reach DFH; this number is used by the member, whether it is during or after business hours. The leadership team meets weekly to discuss key performance indicators (KPIs). KPIs monitored are average handle time, average hold time, abandonment rate, average speed of answer, quality, and service levels, calls offered, and calls handled. The team analyzes and addresses any failed KPIs with remediations if needed.

The UM PD and UM work plan are both specific to DFH. The UM PD includes the required MSA elements: UM decision criteria, organizational structure, concurrent review process, medical necessity evaluations and determinations, mechanisms to detect over- and under-utilization, qualifications of staff making UM determinations, denial and appeals process, protocols for denials, discharge planning and retrospective review of claims, UM committee structure and functions, and IRR activities to ensure consistent application of review criteria. UM activities are structured to ensure incentives are not provided for denial, limitation, or discontinuation of medically necessary services. DFH submitted the Envolve UM PD, which described the UM structure and process. The UM work plan is detailed and includes the following fields: requirement/authoritative source, scope, objective, activity, responsible department, responsible party, and completion dates and comments. The 2023 UM Program evaluation analyzed 2022 utilization activities and identified opportunities for process improvement. Examples of findings are as follows (this is not inclusive of all categories): staffing, program scope and goals, NCQA UM standards, audits, and under- and over-utilization.

InterQual and ASAM medical necessity criteria are used to determine medical necessity. DFH utilizes clinical medical necessity criteria and Medical Director guidance for special conditions. The DFH Medical Directors are available for review of special conditions, as well as review of case consultation through rounds. Requests for transplant evaluation are reviewed by the Centene Transplant unit and a recommended decision is submitted to the DFH Medical Director. The final determination is made by the Plan Medical Director. For LTSS home modification requests, DFH has a process to track home modifications for LTSS members, including cumulative spend.

DFH has an established table of clinical practice guidelines that are adopted and published. These are typically established at the corporate level. To encourage practitioner adherence, new provider orientations include reference to practice guidelines with discussion of health plan expectations; measures of compliance are shared in provider newsletter articles available on the provider web site; targeted mail outs that include guidelines relevant to specific provider types underscore the importance of compliance; and provider incentives. DFH uses applicable HEDIS measures to monitor practitioner compliance with adopted guidelines. If performance

measurement rates fall below DFH/State/accreditation goals, DFH implements interventions for improvement as applicable. The clinical and preventive health guidelines are updated upon significant new scientific evidence or change in national standards, or at least every two years. Guidelines are distributed to providers via the provider manual, the DFH website, and/or provider newsletters and are available to all members or potential members upon request.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed UM further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. However, there were elements within the organizational structure, as well as P&Ps, which were missing contractual requirements.

Regulation/Contract Standard Not Fully Compliant	2024 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 the 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. (3.12.2.2, 3.20.2.1.10)	Substantially Met	DFH provided an organizational chart for the UM program that included the names of senior and departmental management, the number of FTEs per department/position, and the staff supporting Delaware population; there were no open positions. The reporting structure for the UM manager has the position reporting directly to the VP, PHCO. The readiness review organizational chart includes a dotted line to the CMO. DFH stated that DMMA approved the MSA variance for the UM manager to report to VP, PHCO. This approval was provided verbally at the DFH Readiness Review in November 2022 and confirmed during the post-implementation review in March 2023 and EQR in June 2023. Presentations with organizational charts from readiness review, post-implementation review, and EQR attached. Clarification is needed on the reporting structure for the UM manager and DMMA approval.	Develop an updated organizational chart and reporting structure for the UM manager, such that this position report directly to the CMO as contractually required, or, alternatively, evidence of an approved exception from DMMA for the current reporting structure.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
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)	Partially Met	The MRIoA Annual training score submission was approximately 34%. The MRIoA Staff Development and Training document requires a score of 80% or higher. An explanation of this submission did not appear to take place as part of delegation oversight.	Develop a process to review and intervene on delegated entity audit scores to ensure timely review and feedback to delegates.
The MCO has a process to evaluate the compliance of its delegates responsible for UM decision-making. Delegation oversight tools and file review should clearly demonstrate evaluation of the delegate's UM program for compliance with requirements set forth under 42 CFR 438.210 and Delaware contract standards. (42 CFR 438.210 and 3.22.2.3.1)	Partially Met	The NIA 2023 TPRMO Combined Audit Results Summary document dated December 7, 2023, states that the audit was announced on July 13, 2023. The report does not include the number of files that are reviewed overall, and it does not include the number of files for each state and line of business.	Develop a process to ensure only delegated entities audit Delaware cases.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has a formal process for ABDs 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)	Partially Met	For Evolent, the medical necessity denial rate ranged from 21.4%–34.8%, with a total of 936 denials for 2023. The number of appeals were exceptionally low, at eight appeals. DFH had not drilled down on this data to evaluate the services or providers that are driving the number of denials and to ensure the members with a denial are receiving appropriate alternative care. If a member is enrolled in either CM or CC and there is a denial determination by Evolent, then the CC or CM will follow-up with the member. There is not a process in place to monitor member needs if a denial is determined and an appropriate alternative is recommended. For Envolve Dental, the total number of denials in 2023 was 120, with the number of appeals at five. Forty-nine (41%) of the denials were administrative, leaving 59% of the denials based on medical necessity. Five appeals were submitted.	Develop a process to track and trend providers and services for delegated entities based on denials and appeals for delegation oversight and assurance that members have plan in place for appropriate care.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has a process to coordinate benefits provided by the State, such as dental services for children, prescribed pediatric extended care, day habilitation, non-emergency transport, specialized services as identified through Pre-Admission Screening and Resident Review (PASRR) assessments, pathways employment services, and BH services (children and adult). The process also provides a means for COB with Medicare, and with other State payment guidelines. (3.4.10)	Partially Met	DFH does not have a documented process or workflow to provide guidance on coordination for State-provided benefits.	Develop a training document and SOP to assist the UM team members, including State-provided benefits for members.
If the MCO provides optional or additional services, beyond the required benefits packages, these services are clearly communicated to eligible member and to providers. (3.4.8)	Substantially Met	DFH does not have a current process for providing DMMA with in lieu of service requests, with the rationale.	Develop an in lieu of service form that will be used for communicating with DMMA for requests of in lieu of services

HHO 2024 Findings and Recommendations

HHO submitted an organizational chart dated December 31, 2023, which includes the team members supporting UM by title, as well as the number of team members. At the time of the review, there were no vacancies within the UM department. All UM staff are 100% dedicated to Delaware Medicaid; there are no shared services within HHO. Due to decreasing membership, the former UM director, as well as a program manager, were transitioned to a role supporting new growth opportunities within the Corporate Highmark entity. The new UM director started in January 2024 and reports directly to the Interim CMO. However, this relationship is not clear within the HHO Organizational Structure document that was submitted for the Administration and Organization section. The HHO Organizational Structure document depicts the UM director within the Service Operations section, but without a line indicating a direct reporting arrangement.

HHO provided a detailed description of the process to determine staffing needs for the UM department using several tools, including membership numbers, activity reports, call center SLAs, TATs, UM decision-making standards, productivity metrics, authorization volume, inbound fax volume, and provider portal activity. All metrics are tracked and trended. UM activities are monitored daily, weekly, monthly, quarterly, and annually. Using this process, ratios are used for HHO staffing within the following categories:

- Leadership Team: 7 FTEs
- IP PH and BH UM: 1 FTE clinician/7,500 (1:20)
- OP PH and BH UM: 1 FTE clinician/15,000 (1:25)
- UM Call Center Staff: 1 FTE non-clinician/25,000
- Other Non-clinical Staff: 1 FTE/20,000
- The Private Duty Nursing (PDN) team transitioned to CC effective October 1, 2023.

The HHO 2023 UM Staffing model is dated January 17, 2023, and was approved through the QIUMC.

UM for radiology, cardiology, and musculoskeletal medical services is delegated to EviCore. HHO provided the methodology used by EviCore to determine staffing needs. EviCore staff that support the Delaware HHO business are non-clinical, clinical, and physicians. A forecasted trend of case initiations to calculate a percentage for caller rates from historical data is calculated, then an Erlang-C, a traffic modeling formula, approach uses this data to determine FTE requirements. EviCore forecasts calls for a single entity, as well as at a national level. HHO uses the Delaware TAT report to monitor performance and as assurance that the staff model is meeting the Delaware Medicaid member needs.

Through numerous avenues, HHO provided evidence for coordination of care across departments. The A&O organizational chart demonstrates alignment of the LTSS, PH, and BH Medical Directors, as well as the Director of Care Management and the Director of LTSS; however, as noted, the UM director is not included within the clinical teams but rather within Service Operations. Effective linkages are accomplished through discussion and activities, such as weekly Interdisciplinary rounds, which are hosted by UM. The Interdisciplinary rounds promote opportunities to collaborate on complex care needs for members, including members with barriers to discharge. Participants include Medical Directors, directors, managers, supervisors, CC, LTSS, pharmacy, and staff from other departments, as needed. Medical Directors attend weekly BH, PH, Neonatal Intensive Care unit, and Maternal Child Health Weekly rounds and offer recommendations and provide feedback. GuidingCare is the documentation platform used by UM, CC, and CM, which allows team members to have a comprehensive view of the member. EviCore uses their own internal documentation platform; however, authorizations entered are reflected through a portal that can be used by the UM team. There is a requirement for the UM team member to log in to the portal to view the authorizations, and all nurses have access to the portal. HHO prioritizes discharge planning upon admission. There are different approaches for members depending on whether or not they are assigned to CC/CM. If the member has an assigned care coordinator or case manager, the UM team member enters an alert into GuidingCare informing them of the member’s admission. The care coordinator/case manager is accountable for discharge planning. If the member does not have an assigned care coordinator (all LTSS members should have a case manager), and meets CC criteria, the UM team member will request that a care coordinator be assigned and can indicate whether the request is urgent. HHO policies outline the process to

integrate care for co-morbid conditions as well as coordination with the Division of Substance Abuse and Mental Health (DSAMH). The integrated rounds support review of comprehensive approach for members with co-morbidity and complexity.

EviCore is delegated for UM and adverse determinations, including sending denial letters. Any appeal for services managed by EviCore is reviewed and processed by HHO. To ensure member care is in place, all members that receive a denial for an EviCore service is assigned to a member advocate if not assigned to CC or CM. This process is in place to assist the member in understanding the rationale for the denial, if additional steps are needed for the service to be covered, or if there is an alternative service recommended, providing the linkage. EviCore and HHO representatives meet to discuss topics, including specific clinical issues; review the radiology, cardiology, and musculoskeletal programs; and discuss trends, observations, efficiencies, effectiveness, and any matters identified. This is accomplished during the monthly scorecard meetings, biweekly operations touch point meetings, semiannual Joint Oversight Committee meetings, and ad hoc meetings as needed. Both HHO's VMO and FBO are engaged with EviCore with ongoing oversight of delegated functions.

Davis Vision (Versant Health) and UCD are delegated to manage vision and adult dental benefits, respectively. These entities are not included as delegated for UM, as the task is to manage to the benefits versus the use of clinical decision-making. If a service is requested that is not covered per the benefits, an administrative denial may be rendered.

The HHO QIUMC is a collaborative committee with the QI and UM departments focusing on continuous QI of prevalent chronic healthcare conditions, preventive healthcare, and clinical and service indicators, and is chaired by the CMO. Voting members include HHO network-participating PCPs and specialists. Non-voting members include HHO team members. A majority of voting members (i.e., 50% plus one) constitutes a quorum. The HHO QI/UM meetings are held 12 times per year with UM reports (over- and under-utilization patterns, policies, trilogy documents, new technology, IRR, denial audits, delegate performance, guidelines, and utilization patterns) reviewed on, at a minimum, a quarterly basis.

HHO has developed and maintains a work plan that includes both QI and UM activities. The work plan is designed to be a fluid document that can be updated and changed as needed based on evaluation of tasks and objectives. The HHO UM PD states that the UM program has oversight in the development of the UM work plan, which would include the PH CMO, BH CMO, LTSS CMO, Health Services Director, UM coordinator, and the QM/QI coordinator, who are all involved with developing the annual work plan. HHO has a documented process to evaluate the UM PD through an annual UM program evaluation. HHO submitted the 2023 UM evaluation that provides an analysis of the UM program.

HHO has State-specific UM P&Ps that are clearly written and detailed. The P&Ps submitted include those that outline the processes in place for UM decision-making, timeframes, timeliness, tracking, and trending of UM denials and a holistic process to integrate UM decision-making across all entities, business units, and subcontractors. HHO submitted EviCore P&Ps that also outline the UM decision-making process, timeframes, and timeliness.

HHO provided a robust training plan for both UM department and the delegated entity, EviCore. The HHO Clinical Training and Development team has one dedicated UM trainer who is also a certified InterQual trainer. The trainers provided orientation for all new hires within the UM department and provided ongoing education for all existing staff. Additionally, in 2023, the trainers completed one-to-one mentoring around the Utilization Management Review (UMR) job duties and processes. Various training modalities continue to be utilized for staff education, including instructor-led courses, PowerPoint presentations, webinars, guest speakers, and self-directed study through the myLearning platform. The UM Tip of the Week emails provided education on department updates, community resources, and opportunities for improvement identified by leadership and through the completion of focused and supervisory audits. HHO includes Cultural Competency in the annual trainings and Cultural Considerations in the new hire training; EviCore includes Cultural Diversity in the annual trainings.

The member handbook provides the phone number for 24/7 healthcare needs and the provider manual provides a phone number for PH PA Monday–Friday 8:00 am–5:00 pm ET, BH PA 8:00 am–8:00 pm ET, and voicemail availability after-hours. Providers may fax authorization requests after-hours; those for post-stabilization services as part of transition from a medical or behavioral admission are approved the next business day. An HHO utilization reviewer will contact the facility's authorization staff during the next business day to render an authorization. If the after-hours authorization request is for any other type or form of authorization, an HHO utilization reviewer will contact the facility or provider authorization staff during the next business day to review the request. Requests for acute IP admissions need to be submitted 24 hours after the date and time of the admission order or next business day (during the holidays or weekends). All requests are required to be submitted during that timeframe. Authorizations from HHO are not required for observation services performed on an OP basis, as part of an ED visit, or as a result of false labor. IP care shorter than 24 hours is considered observation.

HHO monitors call quality and accuracy through call monitoring and recording. UM call center activities are monitored in real time, on a daily, weekly, monthly, quarterly, and annual basis. Real-time call center metrics provide the ability to monitor ongoing calls, average speed to answer, agent availability, shrinkage (i.e., a measure of how much time is lost in the call center to things like vacation, breaks, lunch, holidays, sick time, training, meetings, etc.), and other metrics. Analyzing the metrics provides a useful way to benchmark performance, identify opportunities for improvement, and evaluate staffing needs.

HHO uses InterQual or ASAM criteria for guiding medical necessity reviews. If the condition and member presentation is outside of these criteria sets, HHO has a listing of Medical policies that are used. The UM team members would refer the case to the Medical Director, who would reference the Medical policies for guidance. The Medical policies are available on the HHO website. Examples of the Medical policies for guidance include Organ Transplant, Management of Chronic Conditions, and Other Transplant Services. There are 167 Medical policies available on the website. HHO has a documented process within the Request for Criteria policy to guide team members on providing criteria specific to decision-making upon request. This policy is applicable to Member Services, Provider Services, Medical Management, and G&As. The QIUMC reviews and approves all criteria used, both in-house and by delegated entities. The Application of UM Criteria policy outlines that criteria are reviewed by appropriate practitioners (voting members of the QIUMC) at least annually and more frequently as needed and as updates are made.

HHO lists covered services within the Medicaid/CHIP and LTSS member handbooks and the provider manual. This includes SUD services for Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) members, transplant criteria, and HIV/AIDS oral nutrition requirements. The LTSS provider manual and LTSS member handbook include the benefits with limits for minor home modifications. HHO has a Minor Home Modification report that is used to track services.

HHO has numerous processes in place to monitor under- and over-utilization. Specific metrics include PCP visits, ED visits/1000, EPSDT, pharmacy prescriptions, provider utilization, top clinical conditions, IP and OP trends, admissions/1000, discharges/1000, readmissions, IP utilization (total discharges/1000), and average length of stay. HHO uses a process that allows PCPs to compare their performance against their peer group in alignment to the MSA requirements. This program allows for monitoring of provider performance to track and trend. The report includes key claim utilization, preventative care service, pharmacy data, QOC, and QOS.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed UM further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. However, there were elements within the organizational structure, as well as processes and policies that were missing required elements.

Regulation/Contract Standard Not Fully Compliant	2024 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. (3.12.2.2, 3.20.2.1.10)	Substantially Met	The organizational charts submitted for various track teams do not align with the organization chart submitted for UM. HHO submitted an organization chart dated December 31, 2023, which includes the team members supporting UM by title, as well as the number of team members, in which the Director of UM (UM manager) reports directly to the interim CMO. This differs from the reporting structure provided in the organizational chart submitted for A&O.	Develop clarifying documentation within all organizational charts that are consistent and meet the MSA requirements, which include alignment of the UM organization structure.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
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)	Substantially Met	HHO provided State-specific training materials that are used for UM delegated entities. IRR is a tool used to evaluate consistent decision-making for the Delaware Medicaid population. EviCore IRR scores averaged as follows: Q1 2023 — 99.36%, Q2 2023 — 99.69%, Q3 2023 — 99.68%, Q4 2023 — 99.57%, and Q1 2024 — 100%. The results are stratified by type of review and type of reviewer. However, the IRR exercise is enterprise-wide; therefore, it is unknown whether any of the cases chosen for IRR were Delaware Medicaid.	Develop the oversight process to determine whether EviCore IRR evaluations and auditing of performance is applicable to Delaware Medicaid and, if not, to include Delaware Medicaid.
The MCO has a process that articulates the policy and process, as well as roles and responsibilities relative to authorizations of OON services and single case agreements and pay OON and single case agreement claims. (3.10.1.11)	Substantially Met	HHO has a draft policy (UM_30_MBU-PC-POL-0610-Single Case Agreement Policy_DRAFT) with a next review date of September 1, 2022. The Provider Contracting team advised they are working on the finalized single case agreement policy and do not have an updated policy at this time.	Finalize the single case agreement policy.

Enrollment and Disenrollment

ACDE 2024 Findings and Recommendations

ACDE has a well-defined process to onboard new members that includes new member welcome calls, new member welcome kits, completion of an HRA, and new member orientation meetings. New members coming into ACDE are subject to a continuity period for any services and/or treatment plans that were in effect at the time of entry into managed care, regardless of whether the member

transitioned from the fee-for-service system or another Medicaid MCO. ACDE's transition of care (TOC) policies are consistent with regulatory requirements.

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

Per federal regulation, members are able to switch to another MCO without cause within the first 90 days of enrollment, during the open enrollment period, or re-enroll with the same MCO under automatic re-enrollment after a short period of ineligibility. For cause termination, P&Ps are consistent with regulatory requirements and apply to instances such as lack of specialty provider(s) or service availability, loss of a network direct service or other long-term services providers that may impact a member's housing situation (for members receiving DSHP Plus benefits), or for moral and religious objections over the services the member seeks. The MCO's internal P&Ps evidence compliance with the federal requirements; although the MCO is afforded a right to request disenrollment of a member under certain circumstances, ACDE has not requested relief under this provision.

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

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

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 is present, MCO staff provided responses that are 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 2024 Findings and Recommendations

DFH has a well-defined process to onboard new members, providing options for members to participate in-person, by phone, or via webinar. Information is provided on the DSHP benefit package; COB; how to make appointments and utilize services; Medicaid

benefits provided by the State; the Member Services information line, nurse triage/nurse advice line and pharmacy services information line; availability of service coordination services; what to do in an emergency, urgent medical situation, or BH crisis; how to register a grievance or file an appeal, including the State Fair Hearing process; information about member advocates, including, but not limited to, the role of a member advocate and how to contact a member advocate for assistance; the importance of providing information requested by the State to renew their Medicaid/DHCP eligibility; and members' rights and responsibilities. New members coming into DFH are subject to a continuity of care period for any services and/or treatment plans that were in effect at the time of entry into managed care, regardless of whether the member transitioned from the fee-for-service system or another Medicaid MCO. DFH transition of care policies are consistent with regulatory requirements.

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

Per federal regulation, members are able to switch to another MCO without cause within the first 90 days of enrollment or during the open enrollment period, or to re-enroll with the same MCO under automatic re-enrollment after a short period of ineligibility. For cause termination, P&Ps are consistent with regulatory requirements and apply to instances such as lack of provider specialty or service availability, loss of a network direct service or other long-term services providers that may impact a member's housing situation (for members receiving DSHP Plus benefits), or for moral and religious objections over the services the member seeks. The MCO's internal P&Ps evidence compliance with the federal requirements; while the MCO is afforded a right to request disenrollment of a member under certain circumstances, DFH has not requested relief under this provision.

Should a member request disenrollment from the Medicaid program or request a transfer from DFH to another MCO, DFH directs those members to the State's HBM for additional assistance.

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

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

HHO 2024 Findings and Recommendations

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

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

Per federal regulation, members are able to switch to another MCO without cause within the first 90-days of enrollment during the open enrollment period or re-enroll with the same MCO under automatic re-enrollment after a short period of ineligibility. For cause termination, P&Ps are consistent with regulatory requirements and apply to instances such as lack of provider specialty or service availability, loss of a network direct service or other long-term services providers that may impact a member's housing situation (for members receiving DSHP Plus benefits), or for moral and religious objections over the services the member seeks. Although the MCO is afforded a right to request disenrollment of a member under certain circumstances and given the MCO's internal P&Ps evidence compliance with the federal requirements, HHO has not requested relief under this provision.

Should a member request disenrollment from the Medicaid program or request a transfer from HHO to another MCO, HHO directs those members to the State's HBM for additional assistance. Mechanisms to identify and notify the State of members whose circumstances may support disenrollment from HHO and/or the Medicaid program are in place and are communicated to the State via the Weekly Issues spreadsheet; associated P&Ps are consistent with requirements. Reports submitted evidence compliance with requirements.

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 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.

Quality Assessment and Performance Improvement Program

ACDE 2024 Findings and Recommendations

ACDE has a strong QM/QI program that is supported by senior leadership within ACDE. The QM/QI program has continued to demonstrate progress in their quality initiatives, resulting in strong performance in each of the quality areas assessed during the 2024 review. There is evidence of integration of quality throughout the organization as evidenced by the QIUMC meeting minutes. The 2023 Quality Improvement Program evaluation includes a description of the QI activities and initiatives throughout 2023, including, but not limited to, the quality and safety of clinical care, the QOS activities, and regulatory and accreditation activities. The evaluation includes a summary of overall QI program effectiveness. The analysis included evaluation of accessibility and availability of services, evaluation of clinical care, provider satisfaction, evaluation of clinical care, medical record reviews (MRRs), and audit activities. The annual evaluation included a number of data analyses with conclusions and recommendations for improvement in 2024.

ACDE held seven QAPI committee meetings in 2023. The meetings included oversight of approved policies and program documents for QM, CC, UM, and LTSS CM. Additionally, quality of clinical care reports, QOS report, safety reports, and member experience reports were reviewed. Monthly Provider forums continued in 2023 with topics, including but not limited to, third-party liability (TPL) and COB, balance billing members, access and availability, and provider satisfaction. There were four Member Advisory Council (MAC) meetings held in 2023. The MAC meetings were all held in-person/virtual with guest speakers from Supporting Kids, Christiana Care Behavioral Health, Delaware Perinatal Collaborative, Delaware Quit Smoking, and the Christina School District.

ACDE has a robust quality training program for staff. Quality training topics include State-specific Quality program, Critical Incidents, Wellness programs, and the Resource registry. Trainings are offered within six months of hire and then on an annual basis. ACDE has also developed a detailed training program for its delegates and subcontractors. The training program focuses on State-specific QM topics, as well as critical incidents. Each training deck has a corresponding attestation document to be completed by the delegate organization once training has been completed. The 2023 QM training overview includes information on healthcare quality; national QS goals; Delaware QS goals; ACDE’s QM PD, objectives, and program goals; ACDE’s UM work plan; QOC issues; grievances; and peer review oversight and processes. The 2023 Critical Incident Training gives an overview of the end-to-end process of ACDE’s critical incident process, including example scenarios. These trainings are a great way to bring ACDE’s delegates up to speed with the Delaware Medicaid program.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed the QAPI program further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. However, there were elements within the member handbook and related policies that were missing contractual requirements.

Regulation/Contract Standard Not Fully Compliant	2024 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	Member handbook includes verbiage stating that a member has the right to request and receive a copy of the member's medical record. However, the handbook states that the MCO will provide a copy within 30 days of the request, which does not align with the MSA requirement of furnishing the record within 10 calendar days of the member's request. Additionally, the member handbook does not state that the member is entitled to one free copy of their medical records.	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.

DFH 2024 Findings and Recommendations

DFH has developed a 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 QIUMC meeting minutes. The 2023 QI Program evaluation includes a description of the QI initiatives throughout 2023, including but not limited to, improving wellness and preventative care, chronic disease management, BH, and satisfaction/access to care. The evaluation includes a summary of overall QI program effectiveness, including the evaluation of patient safety, access and availability of services, member satisfaction, clinical practice guidelines, and care management, including continuity and coordination of care. The evaluation also includes data analysis and the opportunities for improvement identified in 2023.

DFH has a strong committee structure with 12 subcommittees reporting up to the QM/QI committee, which is accountable to the board of directors. The QM/QI committee is supported by the senior leadership committee that reviews and monitors all clinical quality and service functions of the health plan and provides oversight of all subcommittees. The Performance Improvement Team (PIT) is an internal, cross-functional QI team that facilitates the integration of a culture of QI throughout the organization. Results from performance improvement efforts and activities planned to improve member outcomes are compared with expected results. Findings are evaluated by the PIT team using industry-recognized methodology for analyzing data. In addition, the PIT team will review, categorize, track, and trend grievances, administrative reviews, and requests for external reviews, in order to determine appropriate

action and follow-up. The Provider Advisory and Member Advisory committees are subcommittees that report up to the PIT team. There were four Member Advisory committee meetings held in 2023; however, there were no DFH members in attendance.

DFH is committed to health equity and works to enhance its approach by sustaining a strong QM/QI organizational structure. DFH has adopted core components for its health equity approach, which include training and advocacy on cultural sensitivity, increasing accessibility to all forms of healthcare service choices, addressing health inequities, advancing the provision of culturally tailored services, assessing the causes of disparities within DFH, and monitoring all grievances, which are aggregated by type and category to identify underlying reasons.

DFH has a robust quality training program for staff. Quality training topics include QM, Quality reporting, HEDIS, Performance scorecards, and PIPs. Training sessions are provided at the time of hire and on an annual basis. Although DFH has a comprehensive quality training program, there was no Delaware-specific information included in the training, and there was no training developed for delegates and subcontractors to understand the nuances of the Delaware Medicaid program. During the on-site visit, it was discussed that DFH has held Lunch ‘n’ Learns to educate staff on these areas.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed QAPI program further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. However, there were elements within P&Ps that were missing contractual requirements.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The QM/QI director job responsibilities include: • Developing the annual QM/QI PD. • Leading the QM/QI committee. • Development and implementation of the QM/QI program and monitoring QOC members received. • Reviewing all potential QOC problems. • Development and implementation of continuous assessment and improvement of QOC provided to members. • Specifying use of quality indicators. • Attending Quality Improvement Initiative (QII) taskforce meetings. • Attending G&A committee meetings when necessary. (3.13.1.2.3, 3.13.1.3)	Not Met	Although DFH submitted Job Profile: "210481 — VP, QI" job description, which includes the minimum key personnel requirements for the QM/QI director listed in the MSA, the job description does not include the specific duties listed under MSA citation 3.13.1.3.	Revise the Job Profile: "210481 — VP, QI" job description to include the specific QM/QI director duties outlined under MSA citation 3.13.1.3.
The MCO and its subcontractors have a training program that covers fundamental QM concepts and QI methodologies. (3.20.3.1)	Substantially Met	DFH has a robust quality training program for staff. However, there is currently no specific training for subcontractors that covers fundamental QM concepts and QI methodologies.	Develop training for subcontractors on fundamental QM concepts and QI methodologies.
The MCO has a process to evaluate the training program of its subcontractors responsible for QM/QI; 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	DFH states that there is no specific training provided to subcontractors on QM concepts and QI methodologies. As a result, there is currently no process in place to evaluate the effectiveness and outcomes of the training provided.	Develop a process and tools to evaluate the effectiveness and outcomes of the training on fundamental QM concepts and QI methodologies for subcontractors.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has a process to evaluate a delegated entity's QM/QI program to ensure alignment with the Delaware QS. (3.13.1.1.1)	Not Met	DFH did not provide a process to evaluate a delegated entity's QM/QI program to ensure alignment with the Delaware QS. DFH should have a process to evaluate the effectiveness of the delegate's quality program (i.e., training and processes, QM P&Ps, PDs, and workplan) to ensure its alignment with the State's expectations and requirements for quality activities.	Develop a process to evaluate a delegated entity's QM/QI program to ensure alignment with the Delaware QS.
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	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 2023, which is a requirement of the MSA.	Revise strategies for engaging members in the QM/QI committee meetings to ensure participation in 2024.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
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	DFH has a Peer Review subcommittee that is part of the QM/QI committee structure; the CMO chairs the committee and includes participating providers. However, the Peer Review subcommittee meets quarterly, not bi-monthly 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.
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	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 routine reviews of a provider's practice methods and patterns, including quality outcomes, prescribing patterns, morbidity/mortality rates, and all grievances filed against the provider related to medical treatment. (3.13.7.1.2.2.1)	Not Met	DFH does not have a policy or SOP outlining the MCO's routine provider practice review including routine reviews of a provider's practice methods and patterns, including quality outcomes, prescribing patterns, morbidity/mortality rates, and all grievances filed against the provider related to medical treatment.	Develop a policy and process outlining the MCO's routine provider practice review, which includes routine reviews of a provider's practice methods and patterns, including quality outcomes, prescribing patterns, morbidity/mortality rates, and all grievances filed against the provider related to medical treatment.
The MCO provider practice review includes routine evaluation of the appropriateness of care rendered by participating providers. (3.13.7.1.2.2.2)	Not Met	DFH does not have a policy or SOP outlining the MCO's routine provider practice review including the routine evaluation of the appropriateness of care rendered by participating providers.	Develop a policy and process outlining the MCO's routine provider practice review that includes the routine evaluation of the appropriateness of care rendered by participating providers.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO provider practice review includes a review of the appropriateness of diagnosis and subsequent treatment, maintenance of provider medical/case records, and adherence to generally accepted standards in terms of outcome and care. (3.13.7.1.2.2.3)	Not Met	DFH does not have a policy or SOP outlining the MCO's routine provider practice review including the review of the appropriateness of diagnosis and subsequent treatment, maintenance of provider medical/case records, and adherence to generally accepted standards in terms of outcome and care.	Develop a policy and process outlining the MCO's routine provider practice review that includes the review of the appropriateness of diagnosis and subsequent treatment, maintenance of provider medical/case records, and adherence to generally accepted standards in terms of outcome and care.
The MCO provider practice review includes referral for peer review as determined necessary by the MCO. (3.13.7.1.2.2.4)	Not Met	DFH does not have a policy or SOP outlining the MCO's routine provider practice review including the referral for peer review as determined necessary by the MCO.	Develop a policy and process outlining the MCO's routine provider practice review which includes the referral for peer review as determined necessary by the MCO.
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	DFH does not have a policy or SOP outlining the MCO's routine provider practice review including the development of policy recommendations to maintain or enhance the QOC provided to members.	Develop a policy and process outlining the MCO's routine provider practice review which 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	DFH does not have a policy or SOP to educate 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.	Develop a policy and process to educate 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 2024 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 2024 review. Integration of quality is seen throughout the organization, as evidenced by QIUMC meeting minutes. The 2023 QI/UM Annual Program evaluation included: a description of the QI activities and initiatives throughout 2023, 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 2024.

Since the addition of the Learning Advisor position in 2022, many of the Quality department's methods have been treated as best practice in the development of an overall learning and education plan for the organization. The QM/QI department management continues to participate in meetings with the Learning Advisor and other trainers in the organization to strategize on improvements and streamlining. The QI Medicaid 101 series, created in 2021 and continued through 2023, allows for SMEs within the organization to present each of the key areas within the scope of the QI program to all new QI staff and to staff outside the Quality department on a semi-annual basis. Additionally, HHO offers an internal training and certification program for employees to become educated on Lean Six Sigma concepts and practices, at the Yellow Belt level. All new staff must undergo this education (unless otherwise certified) as a best practice requirement to ensure there is a baseline level of knowledge of QI concepts.

The training module for vendors and subcontractors was redesigned in 2023 to provide more relevant material for external entities. The training module is documented on a vendors' scorecard and included in overall assessment of compliance. The QM/QI team is working closely with the Learning Advisor to update training material and simplify the process for vendors to access training, via the BrainShark platform. The Quality, Vendor Management teams, and Learning Advisor continue to collaborate and streamline the distribution of training to vendors and subcontractors.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed quality assessment and the PIP further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. However, there were elements within the organizational structure, as well as the member handbook and related policies, which were missing contractual requirements.

Regulation/Contract Standard Not Fully Compliant	2024 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 coordinator 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	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 organizational chart illustrates the QM/QI director reporting directly to the VP, Government Quality, instead of the CMO, as required by the MSA. Revise the organizational structure to have the QM/QI director report directly to the CMO to align with the MSA or gain State-approved exception documentation for this deviation from the MSA.	Revise HHO's organizational chart to depict the QM/QI director report directly to the CMO to align with the MSA or gain State-approved exception documentation for this deviation from the MSA.
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)	Substantially Met	HHO's provider manual and member handbook include the contract-required language for when a member requests their medical records. However, the member handbook does not explicitly state that the member is entitled to one free copy of their medical record.	Update the member handbook and any related policies to state that members are entitled to one free copy of their medical records to align with the requirements outlined in the MSA.

Coordination and Continuity — Primary Care and Special Health Care Needs

ACDE 2024 Findings and Recommendations

ACDE submitted a CC PD that uses a PHM framework and strategy matching members to the level of support needed to meet their medical, BH, and social needs. The goal of this approach is person-centered, and to identify members with conditions for which, without appropriate and needed intervention, potential avoidable healthcare services are utilized. Identification of these higher-risk members allows them to receive interventions that would improve healthcare outcomes and decrease unnecessary or preventable

services. Through this person-centered approach, a focus on empowerment of the at-risk members is key to regaining optimal health. The CC team includes nurses, BH clinicians, non-clinical care connectors, community health navigators, pharmacists, medical directors, and community agencies to provide a multidisciplinary approach. CC services are typically performed telephonically and face-to-face. The 2023 Delaware DSHP MSA includes specific contractually required elements for CC. There is not an inclusion of CC stratification into different levels of CC. The ACDE CC risk stratification has been approved and designed to identify members in need of CC and those identified are to receive, at a minimum, the interventions included within the MSA. The ACDE CC PD includes stratification of CC members into either Level 1 or Level 2 CC. This is not in alignment with the MSA contractual requirements. In addition, the CC PD and supporting documents use corporate nomenclature that is not congruent with the 2023 Delaware DSHP MSA. For example, the PD refers to complex case managers and care managers, which ACDE reports are clinical care coordinators. ACDE should align the submitted job descriptions with the CC staffing descriptions within the 2023 Delaware DSHP MSA. Similar discrepancies were noted with job descriptions being misaligned with the contract language. ACDE uses corporate job descriptions and titles that do not always align with the contractual positions required by DMMA.

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

- The manager of complex adult CC oversees four supervisors responsible for four separate teams.
  - A supervisor that leads the Interdisciplinary Care Team (ICT) for members with chronic PH and/or BH conditions in Kent/Sussex Counties staffed by clinical care coordinator positions.
  - A supervisor that leads the ICT for members with chronic PH 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/Community Response Team (CRT) with three supervisors:

  - A supervisor of the CRT north team 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 Special Health Care Needs (SHCN), SDAC, 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. All the CC teams report to the director of CC who reports to the CMO. The director of maternal child health provides clinical support to the Maternity/Pediatrics team but does not have direct reports on that team. Two housing managers are shared with CC and LTSS and report to the CMO. The positions on the CC team include three care connectors, 20 resource coordinators, and two senior resource coordinators, 85 clinical care coordinators, four senior clinical care coordinators, 11 CC supervisors, four CC managers, one director of CC, and 32 community health navigators. The team is fully staffed, but as of the time of this review, there were three care coordinator resignations. ACDE previously used temporary care coordinator positions to meet the new contractual requirements, but these were all closed in early 2023, with some of the temporary staff hired as permanent staff. ACDE does not delegate CC tasks or activities. ACDE reports that community health navigators focus on the population who do not qualify for or refuse CC. They primarily work with SUD members but also do low-acuity non-emergent (LANE) ED follow-up and are in the community.

The teams utilize a variety of positions, including clinical care coordinators, resource coordinators, and community health navigators, and the roles of the staff are not always clearly documented. CC team members with BH expertise are known by the managers but not noted on the organizational chart. ACDE reports that both clinical care coordinators and resource coordinators provide CC. The role of the resource coordinator is to provide CC to emerging and moderate-risk members, including members who do not need or are refusing CC. This level of intervention is not in alignment with the State DSHP MSA, specifically the stratification for “emerging” and/or “moderate”-risk members as a separate level of CC. The job description of the Resource Coordinator II position indicates that developing a POC is a job responsibility; however, file reviews did not demonstrate the completion of assessments or POCs for the members assigned to resource coordinators. ACDE indicates that the resource coordinators were trained on development and maintenance of care plans in 2023. Additional discrepancies within the CC program were noted in the 156.215 CC SHCN policy, which includes language that says when a member is identified and outreached, they are offered resource coordinator/clinical care

coordinator intervention. It was unclear why they would be offered either resource coordinator or clinical care coordinator services as separate and distinct categories, and whether the CC activities were aligned with the contractual requirements.

ACDE assesses staffing needs through the use of membership data and predictive modeling stratification data, plus data from providers, referrals, UM, HRA, and caseload reports. Reductions in membership occurred because of Medicaid redetermination and a third MCO entering the market. Caseload reports are reviewed daily/weekly by senior care coordinators, supervisors, and managers for appropriate ratio balance. ACDE reports an increase in SDAC and requests for respite care; otherwise, they have not observed any major changes in the CC population and the caseloads have remained in compliance with the MSA. ACDE submitted documents that indicated supervisory ratios of 1:15 for clinical staff and 1:12 for non-clinical staff, but some teams included both clinical and non-clinical staff and it was unclear how the ratios were determined. Staff caseloads were shown to be within 1:50 for clinical care coordinators and 1:40 for the Bright Start program, although documents did not consistently reflect the 1:40 requirement for MCC. CC caseloads are maintained by consistent application of criteria for ending CC and/or closing a case. Supervisors can take cases as necessary and senior care coordinators also carry a smaller caseload.

ACDE has a comprehensive CC training program for staff. However, some materials do not accurately reflect the core CC responsibilities and are corporate enterprise documents, and not specific to Delaware Medicaid. Monthly audits are completed by the Corporate Audit team of two random cases and are reviewed with CC team members during monthly supervision. A score of 95% is required for passing. Although ACDE reports overall rates within the goal range, certain individual indicators are well below the goal and are opportunities for improvement, such as communication of the plan with the provider and medication reconciliation. CC also performs a self-audit. In addition to auditing, weekly team meetings are held, and most teams have a daily huddle, to provide both real-time case discussion and guidance. Leadership support and consultation is always available. Quarterly IRR exercises are completed by the supervisors, as well as a monthly phone audit and a “ride along” for new staff or as warranted. In 2023, there was a continued emphasis on care planning enhancement with a “Connecting the Dots” interactive training, aimed at linking interventions with problems identified, and the development of a POC playbook which was implemented in May 2024.

The Bright Start program materials were incomplete. The PD does not include outreach timeframes or the process to monitor members lost to follow-up. ACDE submitted a Bright Start checklist that includes the requirements for assessment and interventions; however, this is a job aid and there is no formal approved policy to reference. The materials also do not reflect the requirement that an assessment for HRSN is required for members identified as low-risk.

ACDE views service coordination as a function and not a unique job position. Service coordination activities are handled by multiple departments, including Member Services, member engagement, Rapid Response and Outreach Team (RROT), housing transition team, LTSS, and CC, namely the TOC, DOC, outreach and coordination, and PROMISE teams. ACDE continues to use a service coordination checklist that describes when a clinical case consult is required and the process; however, the document does not specifically reference discharge planning.

ACDE utilizes a risk stratification plan that was approved by DMMA in Q4 2022 and implemented in January 2023. The stratification 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 of low-risk, moderate/emerging-risk, and high-risk to assign members to the appropriate staff. It is unclear how this is determined as the outreach team makes the initial contact. The documents did not clearly identify the criteria for the each of these categories. The CC PD includes a description of the Predicting Impact of Care Coordination Success system that assigns a score for each member. Those with risk scores in the top 1% are placed in CC and those with a high-risk score in the top 2%–5% are placed into service coordination. It is unclear what this means, given the previous description of service coordination. Any member stratified into CC should receive CC activities and interventions in compliance with the MSA, and this is not demonstrated in the documents or file review. The risk stratification also does not include a methodology for stratifying low-risk pregnant individuals; ACDE reports that any pregnant person who is not high-risk is captured within low-risk MCC. Previously, ACDE indicated that a Jiva enhancement was being explored to auto-assign cases from the month, but this has not occurred.

Referrals for the CC and the MCC program 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 other sources generally reflect individuals who would not have been identified by the risk stratification and do not have current plans to update the risk stratification plan. Although outreach was generally noted to be timely, the rate of members engaged in CC or MCC who are assessed and with a complete POC is low. The table below provides CC statistics.

Quarter	Number of Members Identified as Eligible for CC	Number of Members Declining CC	Number of Members Successfully Assessed with Treatment Plan Developed	Average Number of Successful CC Contacts	Number of CC Face-to-Face Contacts
Q1 2023	9,927	382	1,680	7,599	2,382
Q2 2023	10,179	149	1,554	6,446	2,009
Q3 2023	10,041	121	1,971	7,311	2,738
Q4 2023	9,195	102	2,093	8,550	2,018

Quarter	Number of Members Identified as Eligible for High-Risk MCC	Number of Members Declining MCC	Number of Members Successfully Assessed with Treatment Plan Developed	Average Number of Successful MCC Contacts	Number of MCC Face-to-Face Contacts
Q1 2023	1,029	69	213	663	135
Q2 2023	1,014	95	264	770	144

Quarter	Number of Members Identified as Eligible for High-Risk MCC	Number of Members Declining MCC	Number of Members Successfully Assessed with Treatment Plan Developed	Average Number of Successful MCC Contacts	Number of MCC Face-to-Face Contacts
Q3 2023	1,019	73	259	749	159
Q4 2023	991	58	259	744	163

Quarter	Number of Members Identified as Eligible for Low-Risk MCC	Number of Members Declining MCC	Average Number of Successful MCC Contacts
Q1 2023	599	8	420
Q2 2023	593	7	393
Q3 2023	460	10	324
Q4 2023	490	10	321

ACDE provides multiple ways for a member to complete a HRA, including the member web portal, kiosks, by mail, and by phone. Members who complete the HRA within 60 days receive an incentive. New members receive a copy of the HRA in their welcome packet, as well as instructions on other ways to complete the HRA. The ACDE Welcome team uses texts and phone calls to outreach the member to complete an orientation that includes the HRA. The RROT texts and calls members. The RROT is a shared service with other departments and is a remote, corporate managed team, although the Delaware team members reside in Delaware. All member-facing associates are trained to check whether a member needs a HRA to be completed during any contact. If ACDE is unable to complete the HRA within 20 days of enrollment, ACDE uses a vendor. The vendor provides routine reports on outreach attempts and completed the HRAs. ACDE also monitors completion through the HRA BITS Dashboard, HRA summary report, HRA assessment, outreach, and dashboard. ACDE provided results, which demonstrate compliance with the contractual requirement of completing 80% or greater of HRAs for members who were successfully contacted.

Quarter	Discrete Number of all Outreach Calls Made	Number of Calls Made within 60 Days	Number of Calls Made Past 60 Days	Number of HRAs Completed Within 60 Days of New Enrolment	Percentage of All HRAs Completed Within 60 Days of New Enrolment
Q1 2023	4,201	3,155	1,046	1,286	93%
Q2 2023	4,183	3,582	601	1,729	92%

Quarter	Discrete Number of all Outreach Calls Made	Number of Calls Made within 60 Days	Number of Calls Made Past 60 Days	Number of HRAs Completed Within 60 Days of New Enrolment	Percentage of All HRAs Completed Within 60 Days of New Enrolment
Q3 2023	2,890	2,457	433	1,468	95%
Q4 2023	3,131	2,705	426	1,579	94%

ACDE maintains a wellness registry that includes wellness, heath education, disease management, and self-management programs that members and providers can access. ACDE staff have access to the registry, but documentation did not explain how members in need were referred and identified to programs. ACDE did not submit a DMMA-approved wellness provider training plan.

ACDE continues efforts to comply with contractual standards to identify and outreach individuals with LANE ED utilization. Members are identified daily using the top 25 LANE diagnoses and a weekly report is generated as a safeguard to capture members who did not trigger the admission, discharge, and transfer list. The goal is to conduct outreach within 48 hours of the ED visit and perform a diversion survey and coordinate appropriate follow-up. For members not assigned to a CC or MCC, LANE outreach is conducted by the RROT. Community health navigators also assist with follow-up and care coordinators and maternity care coordinators are alerted when their assigned members have been in the ED. ACDE has developed an ED LANE Visit Activity report for review with providers during the Accountable Care Organizations (ACOs) meeting. These reports showed the top utilizing members in the ACO and their attributed PCP. The ACO reviews this data with the PCP. Still, the rate of PCP follow-up remains relatively low and unchanged.

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 2023	8,036	607	3,747	2,397	36.99%
Q2 2023	8,243	612	4,805	2,323	34.68%
Q3 2023	7,853	625	5,088	2,172	35.99%
Q4 2023	8,044	633	5,868	2,351	36.28%

Please note: If the MCO reports this information utilizing varied thresholds, please provide that reporting information in lieu of the thresholds used here and indicate the thresholds used.

The ACDE RFI submission and slide presentation included language that aligns with contract requirements and incorporates findings from the previous EQR. However, some documents contain outdated language from previous contract years, or corporate enterprise

language that is not applicable to the Delaware population. Additionally, ACDE continues to struggle to demonstrate operationalizing the CC and MCC programs.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed CC further with MCO staff. MCO staff demonstrated an understanding of regulatory and contractual provisions. However, there were elements of the P&Ps that did not align with the MSA or were missing contractual requirements.

Care Coordination File Review

Mercer completed a review of 10 clinical care coordination (CCC) files, 11 low-risk MCC, and nine high-risk MCC files using the File Review Protocol outlined in Section 3. Mercer requested that ACDE choose a sample of these files that they felt demonstrated excellent CC in accordance with the MSA standards.

Many files reflected individuals with high PH/BH/SUD needs and significant HRSNs, including homelessness or unstable housing, food insecurity, and financial strain. Resources and referrals were consistently given follow-up to determine whether the need addressed was typically lacking. Some files contained conflicting information, some of which is related to the job title of resource coordinator being used for CC. Files also referred to “low-risk” and “Level 1” identification, which are not CC categories in the MSA requirements. Other files assigned to a resource coordinator for CC did not include a comprehensive assessment, quarterly reassessment, or POC. Some MCC files identified as low-risk appeared to have more complex needs, including a member with a history of suicidal ideation, depression, and pre-eclampsia. Although the resource coordinator outreached consistently and provided linkages to the Special Supplemental Nutrition Program for Women, Infants, and Children, home visiting, and equipment (breast pump), there is no documentation that the case was ever escalated even for consultation. Another low-risk MCC case was 42 years old, which meets the criteria for high-risk MCC, but the referral was not made.

One file involved a pediatric member with complex medical needs who had an order for over eight hours per day of PDN. The case was assigned to both a nurse and social worker as required, and consistent outreach was made to local agencies, but the case went unstaffed for over a year until a SDAC request was submitted. There was no documentation of case escalation or coordination with primary insurance.

The EQR file reviews did reflect consistent and generally timely outreach, and even when members declined CC, the program monitoring continued, and outreach was attempted if there was an ED visit or IP admission. As noted, maintaining engagement with members appears to be a continued challenge. Cases that included assessments and POCs were largely comprehensive and member-centric. Members and providers were provided with copies of the POCs, though there was limited actual collaboration with providers.

Some files submitted by ACDE could not be scored completely. Three CC files, five low-risk MCC files, and two high-risk MCC files were unable to be scored due to members being unable to reach, lost to follow-up, or declining CC. Of the seven CC files reviewed,

two files scored above 90% compliance, two files scored between 75%–89% compliance, and three files scored less than 75% compliance in the required elements. Of the six low-risk MCC files reviewed, two files scored over 90% compliance, three files scored between 75%–89% compliance, and one file scored below 75% compliance in the required elements. Of the seven high-risk MCC files, two charts scored over 90% compliance and five scored between 75%–89% compliance in the required elements.

The following table displays the strengths and opportunities broken down by domains. Please consider that not all sections of the case files could be scored, as the number of file reviews was small and several cases could not be fully scored.

Review Area	Strengths	Opportunities
Outreach and Engagement (for all levels)	Member outreach is generally timely. File reviews demonstrate contact in facilities by embedded care coordinators.	Some file documentation reflects language that may not engage members effectively, such as reading the Bill of Rights or leaving a message that an assessment is due, instead of clearly identifying and communicating the benefits of the ACDE CC program. Call monitoring is recommended to evaluate program offering. Engagement for DOC members post-release is poor.
Screening (for low-risk MCC)	Members were routinely provided with resources to receive a breast pump and other services.	Ensure a reliable and consistent process for timely identification and elevation from low-risk to high-risk MCC.
Assessment (for CCC and high-risk MCC)	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.	Members who were assigned a resource coordinator as their care coordinator, did not receive complete initial assessments.
POC (for CCC and high-risk MCC)	The high-risk MCC files overall demonstrated member-centric, comprehensive POCs with consistent delivery of the plan to the member and the provider.	Members who were assigned a resource coordinator as their care coordinator, did not receive care planning.
CC Activities (for all levels)	Housing coordinators are routinely involved and document consistent outreach and efforts. Members who opted out continue to be followed/monitored.	LANE ED PCP visit rate remains low. Follow-up to assess whether referrals and resources were obtained is not consistently documented.

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	Findings	Recommendations
The MCO has field-based staff allocated by county and can adjust based on membership thresholds to support appointment referral and linkage requirements. Clinical care coordinator caseloads should not exceed a ratio of 1:50. Maternity care coordinator caseloads should not exceed a ratio of 1:40. The job responsibilities and qualifications by position are appropriate and certification standards are met where appropriate. Staffing should reflect assignment of a nurse and social worker as care coordinators to any member receiving more than eight hours of PDN. (3.6.5.1.3, 3.6.5.1.4, 3.6.7.4.2)	Partially Met	The submitted ACDE policies do not include the required MCC caseload ratios.	Update all policies and documents to reflect caseload requirements for CCC and MCC as required by the MSA. Ensure the policy is implemented in practice with corresponding training and monitoring.
The MCO has designated, qualified BH specialists to support the needs of members with BH and substance use treatment needs. (3.6.5.2.1.2)	Substantially Met	The organizational charts and staff rosters do not clearly identify which staff have BH experience.	Develop a staff listing and/or update the organizational chart to identify staff with BH experience and any specialty areas.
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	ACDE has a robust CC training program for staff; however, some materials do not accurately reflect the core care coordinator responsibilities.	Ensure the new hire training is accurate in materials and practice related to roles and responsibilities required by the MSA.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has an integrated CC program that eliminates fragmentation in care and promotes education, communication, and access to health information for members and providers to optimize QOC and member health outcomes. The CC program is based on risk stratification and rooted in a population health model, touches members across the entire care continuum, promotes healthy behaviors, provides face-to-face (or virtual) CC as needed, and is supported by evidence-based medicine and national best practices. (42 CFR 438.208(b) and 3.6.1.1)	Minimally Met	ACDE has a CC program based on a PHM framework. The 2023 PD includes stratification language that is no longer in compliance with the MSA. For example, resource coordinator job responsibilities do not align with the responsibilities of CC or service coordination, ACDE has multi-tier levels for CC where the MSA does not, and the CC PD references development of “mini care plans,” which does not align with MSA verbiage.	Ensure the CC PD and all CC supporting documents are accurate in language and practice related to CC program MSA requirements.
The MCO has a process to identify enrollees with SHCNs consistent with the definition in the State’s QS. The CC system, file review/scenario responses identify the SHCNs and evidence a member-centric CC plan. (3.8.11.1.1)	Partially Met	ACDE submitted a CC SHCN policy that states members can be offered resource coordinator/clinical care coordinator intervention; however, the policy does not identify how a member would be assigned to either category.	Review the policy and protocol to ensure all persons identified as having SHCN are receiving CC activities and intervention in compliance with the MSA, including a POC.
The MCO has a process to identify and refer members who could benefit from community services, including health and wellness education, disease management, and self-management activities, as well as organizations and programs that address HRSN. (3.8.2.9.1.7)	Partially Met	ACDE described resources for members, but it was unclear how members in need were identified and referred.	Ensure a clear process is in place to identify members who could benefit from the resources offered through the registry or other community services and connect them to services.
The MCO has full-time discharge planning staff. Non-clinical discharge planning staff are supervised by a registered nurse (RN) or other clinical staff at a ratio no greater than 1:12. (3.8.2.11.4.1)	Partially Met	ACDE reports that supervisory ratios are no greater than 1:12 for non-clinical staff but did not identify which staff are designated as non-clinical.	Ensure non-clinical staff are supervised by an RN with a ratio no greater than 1:12. Review staffing and job descriptions to ensure staff are appropriately identified as clinical or non-clinical.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
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	ACDE uses a service coordination checklist that describes when a clinical case consult is required and the process; however, the document does not specifically reference discharge planning.	Develop or revise any training materials or job aides to describe the escalation process for the Discharge Planning team.
The MCO has a process to utilize stratification results and other referral sources to identify members most appropriate for CCC and such a process includes monthly re-stratification of the entire population. (3.6.3.7)	Substantially Met	ACDE submitted a PD and SOP describing how the MCO utilizes stratification results; however, the documents included the term “complex CM” which is an enterprise term and not applicable to the MSA.	Revise documents to align verbiage and terms with the MSA.
The MCO has P&Ps that indicate all initial outreach occurs within 15 days of member being identified as eligible, with a minimum of five attempts made within the first 90 days, including at least one documented face-to-face (or virtual) attempt. If after 90 days or member declines participation, the CCC notes all outreach attempts and can close the case. If the member is identified as high-risk, BH, or SUD, the MCO outreaches to DMMA, DSAMH, DDDS, or other agencies or providers prior to closing the case. (3.6.6.1.1)	Partially Met	ACDE has P&Ps that incorporate outreach standards. However, the policy states that the member “may” receive a face-to-face visit, which does not align with the requirements outlined in the MSA. Member files reviewed typically show timely outreach. However, some documentation reflects language that may not engage members effectively, such as reading the Bill of Rights or leaving a message that an assessment is due, instead of clearly identifying and communicating the benefits of the ACDE CC program.	Update policy to be consistent with the MSA CC requirements in language and practice. Demonstrate fidelity of the CC program alignment with the MSA CC requirements through file review audits and reporting. Ensure training and ongoing support is provided to CC team members on best practices to inform and engage members to the benefits of CC enrollment.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO's P&Ps require clinical care coordinators to outreach to eligible members within 30 calendar days to complete a comprehensive assessment (i.e., PH, BH, social, environmental, cultural, and psychological needs), including input from the member's caregivers, family, PCP, and other providers as appropriate. All outreach and coordination efforts are documented within the member's file and demonstrate active and good faith efforts to incorporate provider involvement in CC activities. (3.6.6.2.1)	Partially Met	ACDE has P&Ps and processes that outline the requirements for completing an assessment within 30 days. ACDE submitted audit results that demonstrate timely completion of assessments but also improvement opportunities, as the initial assessment particular to the medication form was as follows: September 2023 — 16%, October 2023 — 27%, November 2023 — 23%, and December 2023 — 40%.	Review the CC assessment list and ensure the required assessments are completed per MSA requirements. Develop trainings and desk-level procedures to support CC team members in improving metrics that fall below audit goals.
The MCO's P&Ps require reassessment at a minimum of quarterly for all members identified for CCC, including members receiving more than eight hours of PDN a day. All PDN recipients will have an assigned nurse and social worker to coordinate care. (3.6.6.2.4)	Partially Met	ACDE has P&Ps that outline the reassessment requirements. Member files evidenced only a few cases included quarterly reassessments; however, this was largely due to loss of engagement in the program. ACDE submitted audit results that demonstrate improvement opportunities, as the rate for quarterly assessment of member needs was as follows: September 2023 — 75%, October 2023 — 82%, November 2023 — 78%, and December 2023 — 83%.	Develop trainings and desk-level procedures to support CC team members in improving metrics that fall below audit goals.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO's P&Ps, file reviews, and/or tracer scenarios evidence person-centered planning processes. All POCs include, at a minimum, prioritized goals and actions, effective and comprehensive TOC plan, communication plan with PCP and other providers, list of providers delivering services to the member, listing of other services received by programs other than those provided by the MCO (to avoid duplication), evidence of referral to community or social support services, HRSNs, frequency of ongoing member contacts, and identification and plans to close gaps in care. Documentation demonstrates that a member receives a copy of their POC. (3.6.6.3)	Not Met	ACDE is utilizing staff in resource coordinator positions to provide CC; however, those staff were not completing care planning activities during the review period.	Ensure all positions providing CC are trained in completing care planning activities as outlined in the MSA. Develop and implement a monitoring plan to ensure POCs include all MSA requirements.
The MCO has a process to monitor care plans and initiate updates and revisions to member's POC, as necessary. This includes a minimum of one face-to-face/virtual contact every six months with members enrolled in CCC and requires documentation of all outreach attempts. (3.6.6.4.3)	Partially Met	ACDE submitted audit results that demonstrate improvement opportunities for development and revision of CM plans.	Develop training and provide ongoing support provided to CC team members to improve metrics below goal and demonstrate fidelity of the CC program.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has P&Ps that indicate initial outreach occurs within 10 days of member being identified as eligible, with a minimum of five attempts made within the first 30 days, including at least one documented face-to-face (or virtual) attempt. Members who decline or are lost to follow-up continue to be eligible for MCC. The MCO will monitor for any changes in member status and offer supports, as appropriate. (3.6.7.7.1, 3.6.7.3.2)	Minimally Met	The Bright Start PD includes a section on member outreach, but it does not include the contract citation language for 3.6.7.7.1, 3.6.7.3.2 related to the outreach timeframes, methods, or the process to continue to monitor members lost to follow-up.	Develop a policy consistent with the MSA MCC requirements in language and practice. Demonstrate fidelity of the CC program alignment with the MSA CC requirements through file review audits and reporting.
The MCO has P&Ps that identify high-risk maternity interventions that include assessment, POC development, and monitoring and ongoing CC activities. (3.6.7.8)	Minimally Met	ACDE submitted a Bright Start Checklist that includes the high-risk interventions, including assessment, developing a POC, and providing ongoing support and intervention. However, there is no P&P.	Develop MCC polices or revise existing CC policies to include contract requirements specific to MCC. Demonstrate fidelity of the MCC program alignment with the MSA MCC requirements through file review audits and reporting.
The MCO's P&Ps require that the member assessment is completed within 10 calendar days of making contact with an eligible high-risk MCC member. The assessment includes specific needs related to pregnancy and postpartum and coordination with obstetric and other providers. (3.6.7.8.2)	Minimally Met	ACDE submitted a Bright Start Checklist that includes language that the initial assessment must be completed within 10 days. However, there is no P&P.	Develop MCC polices or revise existing CC policies to include contract requirements specific to MCC. Demonstrate fidelity of the MCC program alignment with the MSA MCC requirements through file review audits and reporting.
The MCO has a process to monitor care plans and initiate updates and revisions to member's POC, as necessary. This includes a minimum of one in-person interaction and a minimum of a monthly contact to reassess need, in addition to monitoring the POC and providing additional CC service. (3.6.7.8.4)	Partially Met	ACDE has documented care planning protocols; however, the file review sample offered limited opportunities to demonstrate updating and revising POCs.	Demonstrate fidelity of the MCC program alignment with the MSA MCC requirements through file review audits and reporting.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO's P&Ps require that the member screening for engagement in prenatal care, risk factors, and HRSN is completed within 10 calendar days of making contact with an eligible low-risk MCC member. (3.6.7.9)	Minimally Met	ACDE provided a CC Assessment list that outlines the assessments expected to be completed when engaging members in CC. For members identified as low-risk maternity, an assessment for HRSN is not required, which is not in compliance with MSA citation 3.6.7.9.	Update the workflow, assessment guide, or policy to be consistent with the MSA CC requirements. Demonstrate fidelity of the MCC program alignment with the MSA MCC requirements through file review audits and reporting. Develop and implement training and ongoing support for MCC team members.
The MCO has tools and processes to conduct IRR and Level 2 CCC file audits, taking action on identified gaps in knowledge and variance from approved processes. The file audit tool assesses completeness of the POC, addressing member needs and personal goals. The goals must be specific and measurable with achievement timeframes and desired outcomes. (3.6.10.1)	Partially Met	ACDE conducts monthly audits and IRR audits for clinical and non-clinical staff. Results are reviewed during routine supervision. Submitted audit results demonstrate high POC scores, but there are significant opportunities for improvement for specific indicators.	Ensure training, education, and monitoring of these indicators is designed to improve performance.

DFH 2024 Findings and Recommendations

DFH has developed an integrated CC program with specified goals of keeping members healthy, managing members with emerging risk, and supporting members with chronic illness and complex health conditions. DFH also offers a MCC program, Smart Start for Your Baby, for PPP up through 90 days post-delivery. Both the MCC and CC programs report to the Director of Medical Management Operations, who reports to the VP of PHCO, who reports to the CMO, which is not in compliance with the MSA. The programs share the same CMO and BH Medical Director. The CC program does not use any delegates.

All DFH care coordinator positions are full-time and dedicated solely to Delaware Medicaid. DFH CC managers and supervisors assign referrals based on identified need and member location. Caseloads are monitored daily, and submitted documents demonstrate average caseloads ranging from 11 to 33, which are well within the required ratio of 1:50. Caseloads are lower as DFH works to increase membership and, as a result, case assignments have included a primary and secondary care coordinator. Care coordinators are assigned by county and are field-based, and 13 of the 20 care coordinators have extensive BH experience. DFH has established a weekly collaborative meeting with the DSAMH PROMISE team. DFH takes an integrated approach to BH, including training all staff on BH and SUD, incorporating screening tools such as the Patient Health Questionnaire-9 (PHQ-9) and the

Edinburgh Depression Scale, and conducting interdisciplinary team huddles. The current structure shows two care coordinators manage most of the PDN cases, and, in cases in which the member is receiving more than eight hours of PDN per day, a social worker is also assigned. Three team members are dedicated to providing CC to high-risk DOC members who are within 90 days of release, and two housing specialists also support the program. The field-based discharge planning team was moved from the service coordination program in September 2023 to align more closely with the care coordinators.

The MCC program has 10 dedicated full-time staff members, including four care coordinators, four program coordinators, one program coordinator II, and a community health worker (CHW), and although none of them have specific BH or SUD experience, they are supported by the BH team. Low-risk MCC members are managed by the new program coordinator II position. The MCC also has a program coordinator who follows members who have declined the MCC program or were unable to be reached and monitors them for increased utilization of services and hospitalizations, including deliveries. At any time, outreach can be attempted again. The MCC program has a dedicated CHW who will provide outreach in the community. One of the new full-time program coordinator positions is assigned to manage the new maternity nutrition benefit implemented in June 2024. The MCC caseloads are monitored daily, and submitted documents demonstrate average caseloads range from 28 to 34, meeting the requirement of the 1:40 ratio. DFH did not have a Delaware-specific policy for the Start Smart program in 2023.

Leadership staff for both CC and MCC have access in the system to real-time monitoring of caseloads, assigned tasks, and due dates. Weekly rounds offer the opportunity to discuss cases, and the supervisors and Medical Director are available to review cases or seek consultation.

DFH became operational January 1, 2023. The strategy for CC in the first quarter was to use the MCO transfer forms and a CM prioritization report to outreach members. In Q2, the Delaware risk stratification criteria was integrated. The entire DFH population is stratified on a monthly basis, with a lookback period of six months. The methodology includes claims and encounter data; laboratory data; provider-driven data such as the electronic health record and the health information exchange; HRA data and referrals from providers, service coordinators, UM staff, or other internal sources; and members themselves. DFH uses ImpactPro, a predictive modeling analytic tool to define conditions such as complex PH or BH conditions, pregnant and postpartum members, children with SHCN, members with significant HRSNs, and members with high utilization of ED and IP services. The ImpactPro tool also identifies care gaps and missed visits. The MCO reports that LTSS members are not included in the stratification, but this was not documented in any materials. Pregnant and postpartum members are also identified by the 834 enrollment data and notice of pregnancy reports in addition to the other sources, and are further stratified by the MCC supervisor into high- and low-risk categories based on the MCC criteria. Monthly, PHCO prioritizes members for outreach and assigns them to the appropriate team. A weekly leadership meeting also reviews referrals from service coordination and assignment.

The Service Coordination team includes 21 program coordinators, four CHWs, three supervisors, a manager, and a director. The program coordinators in the Service Coordination program complete outreach for HRA completion, LANE ED utilization, care gap closure, and risk stratification for CC. The Service Coordination and CC teams work closely together, including weekly leadership

touchpoints and monthly meetings including LTSS and customer service. The teams document in the same system so referrals can be electronically routed. The program coordinators within the Service Coordination team outreach members to complete the HRA. Target populations include newly enrolled individuals, persons identified through risk stratification, and those with serious mental illness/SUD. At least three attempts are made to reach the member and alternative numbers are researched. CHWs can also make face-to-face attempts in the community. DFH reported challenges in outreaching members and completing HRAs during Q1 2023, as a new plan with 35,000 transitioning members. HRA completion rates increased in Q3 2023 and Q4 2023, as depicted in the table below. DFH also submitted an HRA report demonstrating that the rate of completion for members who had a successful contact met the goal of 80%. DFH has continued to provide training for staff, as well as developing member engagement strategies, including having live agents make the phone calls and offering a $15 value-added benefit for completion. Members can also complete HRAs in other ways, including by mail, in-person, and online. However, the HRA screening tool that was provided did not include questions related to 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 2023	2,092	884	2%
Q2 2023	4,265	144	6%
Q3 2023	18,062	639	49%
Q4 2023	19,374	776	46%

DFH created a job aid for Centene Clinical Action (CCA), a software tool that updates HEDIS care gaps on a weekly basis and allows users to identify care gaps with alerts indicating whether the status is compliant, overdue, or failed. The “overdue” category is actionable. HEDIS care gaps are also pulled monthly, and rates are reviewed in the PIT meeting.

DFH focused efforts on tracking and addressing LANE ED utilization in Q4 2023. In October 2023, DFH worked with the Delaware Health Information Network (DHIN) to provide ED utilization alerts. The Service Coordination team launched an ED diversion initiative in December 2023, which reports all members who utilized the ED, were outreached, screened for appropriate usage of ED, linked to PCPs when needed, and provided education on alternative care options, such as urgent care. No documents were submitted to provide an overview of the ED diversion program. Members are also screened for HRSNs and referred to CC, if needed. Leadership tracks the outreach, which has increased throughout 2023; however, the rate of PCP follow-up has remained about the same. The submitted materials address the outreach process to PCPs, but do not include information related to the identification and engagement of PCPs, who exceed the threshold for LANE utilization, or the work with other departments to address the PCPs’ behavior.

Quarter	Percentage 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 2023	2,855	129	127	2,052	29%
Q2 2023	2,671	138	267	2,019	27%
Q3 2023	2,643	145	466	1,956	28%
Q4 2023	2,836	147	529	2,170	24%

The discharge planning team outreaches members within 48 hours of an IP admission and 72 hours of a known ED visit. Discharge planners can follow members for up to 30 days post-admission to assist with post-discharge appointments, helping members understand the treatment plan, obtaining medications, and addressing barriers that could lead to readmission. Those members who require a high-level of coordination are referred to a care coordinator.

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 2023	579	43	220	32%
Q2 2023	571	34	75	29%
Q3 2023	578	36	245	25%
Q4 2023	603	19	294	24%

DFH has P&Ps and workflows for both the CC and MCC programs. The plan reports efforts in 2023 to monitor the program to train and retrain staff, evaluate initial processes and procedures post-implementation, and to determine whether changes or enhancements were necessary to improve the programs.

CC supervisors are assigned to no more than 15 clinical staff. Documents submitted demonstrated compliance with the 1:15 ratio. Supervisors meet with all reports monthly to review challenging cases, caseload size, and review audits. Call audits are completed monthly. DMMA selects files for joint visits and corporate Business Performance and Standards conducts case file audits that monitor required elements such as HIPAA verification, outreach timeliness, assessment and POC completion, and PCP and obstetrics and gynecology (OB/GYN) coordination. The tool is used for other lines of business but includes all required elements for Delaware. “Soft” case file auditing began in February 2023 without recording scores, as the program was in early implementation. DFH reports that support is always available to CC and MCC staff through supervisors, managers, and the Medical Directors.

CARE COORDINATION AVERAGE AUDIT SCORES 2023											
	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
2023 AUDIT SCORES	*Soft audits began*	64%	69%	71%	75%	79%	78%	81%	83%	89%	90%

Leadership provided coaching and retraining to the team, with a focus on identifying and addressing member needs while also meeting the requirements of the audit. Scores steadily improved throughout the year. The number of members identified as eligible for CC is low, and DFH reports the outreach data may have been underreported due to a system limitation, which has since been resolved. Care planning has been a major focus of the training, and the audit tool includes nine elements related to the care plan. Data from 2023 shows small numbers of members being successfully assessed with a treatment plan developed for both CC and MCC. DFH should assess outreach and how the program is being offered to members to emphasize the many benefits of the program. For example, maternity care coordinator evaluates access to prenatal care and assists members with securing appointments if they are not with a practice and offers a financial contribution to the MyHealth Pays rewards for timely prenatal care. The maternity care coordinator can also connect members with home visiting programs and doula services and can educate on other value-added benefits, such as post-discharge meals and supplies like diapers and wipes. The maternity care coordinators also attend community events related to maternal and child health and hosted three community baby showers in 2023.

Quarter	Number of Members Identified as Eligible for CC	Number of Members Declining CC	Number of Members Successfully Assessed with Treatment Plan Developed	Average Number of Successful CC Contacts	Number of CC Face-to-Face Contacts
Q1 2023	387	169	136	8	113
Q2 2023	496	0	45	5	40
Q3 2023	272	4	81	4	54
Q4 2023	172	6	44	2	17

Quarter	Number of Members Identified as Eligible for High-Risk MCC	Number of Members Declining MCC	Number of Members Successfully Assessed with Treatment Plan Developed	Average Number of Successful MCC Contacts	Number of MCC Face-to-Face Contacts
Q1 2023	193	0	32	8	179
Q2 2023	147	9	32	8	133
Q3 2023	123	5	38	5	98
Q4 2023	107	12	26	2	39

The CC and MCC programs continued to develop operations over 2023. The 2023 Program evaluation assesses the successful implementation of a CC program and the future plans for program enhancement. DFH has convened workgroups to identify opportunities, barriers, and interventions to improve quality measures. An analyst is being hired who will be dedicated to CC to assist in developing and refining data reporting from TruCare for performance monitoring. Efforts should be made to ensure and demonstrate P&Ps and workflows are being followed as written, and to promote the benefits of the CC programs to members, providers, and community partners.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed CC further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. However, there were elements within the organizational structure, as well as the P&Ps, which did not align with the MSA or were missing contractual requirements.

Care Coordination File Reviews

Mercer completed a review of 10 CCC files, 10 low-risk MCC files, and 10 high-risk MCC files using the File Review Protocol outlined in Section 3. Many files demonstrated significant BH and SUD, either as a primary or co-occurring condition.

Only one CC, one low-risk MCC, and one high-risk MCC chart could not be fully scored due to lack of successful outreach and engagement. The remaining CC files had three cases that scored above 90%, three cases that scored between 75%–89%, and three that scored below 75%. One low-risk MCC chart scored above 90%, four scored between 75%–80%, and four scored below 75%. Three high-risk MCC files scored above 90%, five scored between 75%–89%, and one scored below 70%. The EQR file review audits demonstrated timely outreach, but challenges were noted in reaching members initially, due to incorrect phone numbers, full voicemail, or no call backs, as well as with maintaining engagement after the initial contact. In cases in which the member remained engaged, there was evidence of face-to-face (in the home or virtual) meetings and comprehensive assessments and member-centric POCs. Documentation did not always demonstrate follow-up to provider and community linkages.

Several cases included documentation that demonstrated significant efforts to holistically address member needs. One high-risk MCC file involved a 13-year-old; the maternity care coordinator coordinated transportation and appointments to accommodate her school schedule, collaborated with the provider office to ensure they would not turn her away if she arrived late, and provided trimester-specific education verbally and in writing. Another file demonstrated the assignment of an RN and social worker for a complicated pediatric case requiring extensive PDN hours. The parent of the member was often unreachable; however, the care coordinator maintained outreach attempts and continued communication with the provider team, eventually reconnecting with the parent.

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)	Cases are being assigned in a timely manner and initial telephonic outreach is timely and consistent. Maintain caseload of members who have declined and unable to reach and attempted contact once postpartum.	Explore opportunities to outreach members while hospitalized or in other treatment settings to improve reach rate. Call monitoring is recommended to evaluate program offering of the benefits of the programs to engage members and reduce “lost to follow-up” cases after initial contact.
Screening (for low-risk MCC)	Members were routinely screened for HRSNs. Benefits such as breast pumps, home visiting, and doula services were offered routinely.	Confirmation of addressing and resolving HRSNs are not always documented.
Assessment (for CCC and high-risk MCC)	Assessments were thorough and included multiple screening tools.	Documentation does not always reflect referral and follow-up from positive screens.
POC (for CCC and high-risk MCC)	Members are included in the POC development and receive a copy, as do providers.	POCs may not include certain indicators or risk factors if member did not prioritize them. Some files appeared to use standardized and not individualized language. POCs were shared with providers, but little evidence of true collaboration.
CC Activities (for all levels)	Files demonstrated collaboration with PROMISE program.	Continued engagement will allow for more opportunities to assist with needs and evaluate program effectiveness.

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.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has an organizational chart for the CC program (including CCC, 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 the Delaware population (including those shared across other State programs [if applicable]), notes staff situated in Delaware, and identifies any open positions. (3.6.5)	Substantially Met	The MCC, CCC, and service coordination charts depict position titles, key personnel, positions dedicated to Delaware by county, corporate positions, and persons with BH experience. The submitted organization charts do not meet the requirement of the MSA, as the director positions report to the VP of Population Health and not directly to the CMO.	Gain State-approved exception documentation for the reporting structure that does not align with the MSA.
The MCO's HRA includes screening for PH needs, BH needs, and HRSNs (at a minimum housing, food, and transportation needs, as well as documented race, ethnicity, and preferred language), and identifies members needs for resources, referrals, wellness programs, and community supports. Wherever possible, the MCO uses questions from validated, nationally recognized questionnaires and tools. The MCO provided evidence of DMMA approval of the HRA. (3.8.1.1)	Partially Met	DFH provided a copy of the HRA, which included screening for PH and BH needs, but no HRSN questions were included.	Ensure the HRA tool includes all of the required elements as outlined in the contract citation. Gain approval from DMMA for use of the tool.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has an integrated CC program that eliminates fragmentation in care and promotes education, communication, and access to health information for members and providers to optimize QOC and member health outcomes. The CC program is based on risk stratification and rooted in a population health model, touches members across the entire care continuum, promotes healthy behaviors, provides face-to-face (or virtual) CC as needed and is supported by evidence-based medicine and national best practices. (42 CFR 438.208(b) and 3.6.1.1)	Substantially Met	The submitted policy “Start Smart for Your Baby CC.PHCO.CM.01” is effective June 3, 2024, and is a corporate policy that does not include Delaware-specific language about position titles or stratification. DFH indicates a Delaware-specific addendum will be introduced.	Develop a Delaware-specific addendum for the Bright Start program. Ensure staff are trained on the program requirements.
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)	Substantially Met	The number of identified members is low, and the outreach data may have been underreported due to a system limitation which has since been resolved.	Review the staff documentation and the quarterly data tables to ensure data is being captured and reported accurately.
The MCO has a process to identify and exclude LTSS Plus members and active PROMISE members from CC. (3.6.3.4)	Partially Met	DFH reports that LTSS members are not included in the stratification, but this was not documented in any materials. Members enrolled in PROMISE are followed by a care coordinator and there are weekly meetings with the PROMISE team.	Update the risk stratification policy and other relevant documents to clearly explain how LTSS Plus members and active PROMISE members are excluded from CC.
The MCO has a documented process to identify and track gaps in care, inclusive of all elements of EPSDT services and applicable HEDIS measures. (3.6.6.5.1.7)	Partially Met	The content of the CCA job aid is comprehensive and meets the MSA requirement. The job aid was created February 1, 2024.	Ensure staff are fully trained on the job aid and develop an implementation plan. Evaluate opportunities to obtain data from the tool.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
The MCO has a process to actively engage PCPs whose members have reached the established threshold for LANE ED utilization that incorporates other business units such as quality and/or provider services to identify barriers and influence PCP behavior, as appropriate. (3.8.2.9.1.8, 3.6.6.5.1.10)	Partially Met	The submitted materials address the outreach process to PCPs, but do not include information on identifying and engaging PCPs who exceed the threshold for LANE utilization and working with other departments to address the PCP behavior.	Develop a process to identify PCPs who exceed the LANE ED threshold and ensure there is a process for addressing the utilization with the provider. Identify and implement documentation and reporting opportunities to ensure the process is being followed.
The MCO uses continuous QI activities to reduce LANE ED utilization and address identified barriers to primary care. (3.8.2.9.1.8)	Substantially Met	DFH implemented an ED diversion program in December 2023 and included a structured note to document the attempts to connect member with an existing PCP or to select and schedule with a PCP.	Develop an overview of the ED diversion program. Ensure staff have been trained on the implementation of the structured note and develop a method to monitor effectiveness, including the process of completing the note and any outcomes for scheduling/reaching PCP. Ensure interdepartmental activities involving reducing LANE ED are included in the monitoring.
The MCO engages continuous QI efforts to enhance transition and discharge planning, reduce readmissions and improve member experience and outcomes of care. (3.8.2.11, 3.6.6.5.1.9)	Substantially Met	DFH has convened workgroups to identify opportunities, barriers, and interventions to improve quality measures.	Develop a monitoring plan to evaluate progress towards these QI activities.
The MCO has P&Ps that identify high-risk maternity interventions that include assessment, POC development, and monitoring and ongoing CC activities. (3.6.7.8)	Partially Met	The submitted policy “Start Smart for Your Baby CC.PHCO.CM.01” is effective June 3, 2024, and is a corporate policy that does not include Delaware-specific language about position titles or stratification. DFH indicates a Delaware-specific addendum will be introduced.	Develop a Delaware-specific program overview for MCC that includes all of the required interventions as per the MSA. Once program overview is developed, ensure staff are trained appropriately.

Regulation/Contract Standard Not Fully Compliant	2024 Review Score	Findings	Recommendations
Supervisors and CCC staff receive reports to monitor timeliness of outreach efforts and consistency with outreach and contact timeframes and develop staff and/or departmental corrective actions, if necessary. (3.6.6.4.1)	Substantially Met	DFH has implemented a structured supervision process to review performance requirements.	Ensure any areas of deficiencies are addressed through supervision and trainings.
The MCO has tools and processes to conduct IRR and Level 2 CCC file audits, taking action on identified gaps in knowledge and variance from approved processes. The file audit tool assesses completeness of the POC addressing member needs and personal goals. The goals must be specific and measurable with achievement timeframes and desired outcomes. (3.6.10.1)	Substantially Met	DFH has a structured audit process to evaluate CC performance.	Ensure audit tools are evaluated routinely to accurately monitor contractual requirements.
The MCO has a process to evaluate the success of the Level 2 CCC program, which includes metrics and benchmarks for performance, activities to close identified gaps or variances, and incorporates continuous QI activities. (3.21.6.7)	Substantially Met	DFH has a program evaluation, and in 2023 the focus was to successfully implement a CC program. DFH reports that an analyst was hired to assist with refining and developing performance monitoring.	Ensure the report development includes all of the required metrics and benchmarks. Develop a plan to utilize results to revise the program and implement additional staff training.

HHO 2024 Findings and Recommendations

The HHO CC department continues to demonstrate success with its CC program with updates to the risk stratification model, additional cohorts to identify members, a dedicated team of service coordinators to assist with appointments, and new positions created for the maternity population. The organizational hierarchy illustrates the CC Director reporting to the Senior VP rather than to the CEO, which is a MSA requirement, providing oversight to managers, supervisors, care coordinators, and service coordinators, as well as housing coordinators. Due to the increasing number of members with PDN needs in 2023, two new positions for PDN care coordinators were added. The Care Coordinator Director reports to the Senior VP before the CEO, which is not in compliance with the MSA requirements.

The department has a Triage and Outreach pod designed to increase outreach and engagement, and other pods, which include BH, TOC, PDN/DDDS, and maternity/pediatrics/EPSDT. All pods include both care coordinators and service coordinators. The discharge planning team coverage is assigned by county. After-hours coverage, including weekends and holidays, is staffed by departmental managers and supervisors, which allows members consistent access to CC. HHO has a plan for additional backup staff to cover when the care coordinator is on leave.

All positions are full-time and dedicated to Delaware. At the time of the on-site review, there were no open positions for CC or service coordination, and staffing met the required ratios to not exceed 1:50 for CCC and 1:40 for MCC. Caseload volumes are assessed daily by supervisors. Additionally, the Triage and Outreach pod assesses members from risk stratification and daily caseload reports. CC supervisory ratios complied with the requirement to not exceed 1:15.

The MCC program now has dedicated staff. There is one supervisor, for both high- and low-risk maternity care coordinators and service coordinators. The maternity care coordinators (high- and low-risk) are licensed RN or practical nurses with qualifying experience of maternal care. They provide monthly outreach to the members and providers, assessing needs, providing education, and developing care plans. Escalation to a high-risk maternity care coordinator is done when a member is at a risk of negative maternal outcomes. The service coordinators do not directly manage low-risk maternity cases, but they assist with screenings, benefit education, and assessment of equipment needs for members (e.g., breast pumps).

The MCO did not provide any P&Ps detailing or other evidence of CC assisting members with securing a PCP or access to a specialist. No documentation was provided that addressed the workflow for identifying and reporting issues with the primary care panel status or correcting inaccurate information.

During 2023, HHO used a hybrid model to complete the HRA. The model consisted of utilizing a vendor, Icario, and the internal HHO Outreach representative as the primary approach to completing an HRA with all new members within 60 days of enrollment. Other HHO staff that support completion include the service and care coordinators who complete the HRA during their member interactions if one is not showing as completed in the GuidingCare system. The data reports showed Q1 2023 results for completion of HRAs within 60 days as 74% and Q2 2023 results as 65%, which reflects that HHO missed the target rate of 80%. However, in Q3 2023 and Q4 2023, HHO met the target rate with increased rates of 80% and 93%, respectively. Icario had deficiencies, including not mailing “thank you” incentives and sending numerous text messages and emails per day due to staffing shortages of live agents. Icario was put on a formal CAP, and ultimately HHO terminated their contract at the end of 2023 and transitioned to a fully in-house outreach model beginning January 1, 2024. Reporting results were provided by quarter, and not monthly as requested.

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 2023	10,865	2,132	74%
Q2 2023	7,790	1,478	65%
Q3 2023	8,345	1,579	80%
Q4 2023	7,049	1,326	93%

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

- In 2023, HHO built a team of service coordinators for appointment assistance, access to wellness and community resources, and discharge planning following acute episodes of care. However, HHO did not have a Delaware-specific policy that demonstrated training to providers regarding access to wellness programs and activities.
- HHO made changes to the CC program evaluating cases using a holistic approach and incorporating it into the care of the member. This included the creation of an audit team that centers on in-depth, focused audits with feedback and recommendations, Death Investigation Alert case reviews, and completion of NCQA complex audits. HHO supervisors began conducting joint field visits and care coordinators began attending rounds at IP facilities for BH and SUD members and following up with Wayspring coordinators. HHO began operational and compliance reporting, and created a clinical compliance coordinator position.
- HHO created further stratification cohorts for their BH and SUD members. Self-harm, serious and persistent mental illness, polypharmacy, and SUD were added. The John Hopkins ACG® system has been incorporated to identify members. Screenings have been added into GuidingCare. The BH specialists can also reach out to coordinate with other care coordinators.
- HHO made changes to their Risk Stratification process to ensure their member population is identifying all potential members who would benefit from CC. This was approved by DMMA in 2024. The 2023 additions included an edit of the predictive model to give a more accurate description of the models utilized. The models are now the BH Readmission model, the HRSN model, and population health risk scores. The decision was made to no longer receive risk scores from the vendor Lucina and to remove the Makena® cohort, as the drug is no longer approved by the US Food and Drug Administration. HHO added the following cohorts to the risk stratification: polypharmacy, high IP and ED utilization, those with significant HRSNs, and those released from federal prison residing at a State Recovery Response center. In 2024, the maternity stratification reports are now run daily and monthly, from being run weekly. The Risk Stratification model data is run on a daily and monthly basis; however, it was unclear which reports are run on the monthly SAS/Pythin system versus the daily Risk Stratification model. The submission did not include a

clear definition of how the reports are utilized. The reports submitted were quarterly results and not monthly, though HHO reported in the RFI that audits are conducted monthly.

- In addition to risk stratification, members are identified through the HRA, provider referrals, and interdepartmental referrals, including self-referrals through Member Services.
- Maternity and postpartum 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. In 2023, the highest number of members identified for MCC were those in their second trimester.
- In 2023, HHO contracted with the quality vendor Reciprocity to outreach with members under ages 21 years with care gaps for well visits. This resulted in an increase of members outreached for appointment assistance in Q4 2023.
- In 2023, HHO created new benefits for members, including SDAC, pediatric respite, and post-discharge meals.
- Audit score benchmarks are set internally at 90%. The HHO Clinical Audit team works closely with department managers and supervisors to develop focused audits. Focused audits were conducted and reviewed care planning, ED follow-up, discharge planning, maternity, and referrals. Results ranged from 83%–96%. The care plan focused audits were suspended in March 2024 due to high scores; however, they resumed in Q4 2023 due to decreased performance. The Clinical Services Audit team is comprised of a manager and four Clinical Quality & Regulatory specialists who are licensed healthcare professionals. Audited items include outreach timeliness, PDN assignment, member assessment timeliness, face-to-face visit timeliness, and staffing and caseload ratios. Audit scores ranged from 97.1% to 100.0% each quarter. This information is taken from trends in chart deficiencies and newly implemented processes. Once the audited scores are obtained, they are presented to the leadership team to follow-up with staff and provide re-education, if necessary. Discharge planning audit results were provided as quarterly results, and not monthly as requested after the on-site review.

Quarter	Care Plan Audit	Discharge Planning Audit	ED Follow-Up Audit	Maternity Audit
Q1 2023	95%	90%	84%	N/A
Q2 2023	N/A	N/A	N/A	85%
Q3 2023	N/A	N/A	N/A	92%
Q4 2023	83%	N/A	N/A	N/A

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed CC further with MCO staff. MCO staff demonstrated understanding of regulatory and contractual provisions. However, there were elements within the

organizational structure, as well as HRA results, auditing results, and documentation that were not fully aligned with MSA requirements.

Care Coordination File Reviews

Mercer completed a review of 10 CCC files, 10 low-risk MCC files, and 10 high-risk MCC files using the File Review Protocol outlined in Section 3. Mercer requested that HHO also submit files they felt demonstrated excellent CC in accordance with the MSA standards. The preliminary findings were reviewed with DMMA and HHO at the on-site interview and member records from each group were reviewed in the HHO electronic CC system.

Overall, the files demonstrated detailed member assessment and progress notes. The care plans were member-centric, the care coordinators maintained consistent contact with members and the files were well organized and easy to follow. HIPAA verification was completed in every case, there was consistency with education about benefits, and education materials were provided to all members. For members who were reachable, the outreach and engagement were consistent and timely. There was evidence in multiple cases when the care coordinators made the appropriate referrals and worked diligently with other coordinators, providers, and caregivers. The limitations of the flat file created some difficulties with following the clinical pathway of care. For example, the clinical interventions and referrals were not always easy to follow, primarily due to the function of the dropdown selections in GuidingCare, and the reviewer was unable select dropdowns to see where the task was completed in the flat file. One case involved a member with Hepatitis C and the infant was exposed during the perinatal period, and due to the limitations of the file, it did not show if the infant was discharged home with the mother. The case was further discussed during the on-site review, and missed opportunities regarding follow-up for the infant were found. HHO continues to share care plans with member providers through the provider portal. The providers can add input, and it allows the care coordinator to receive alerts when the provider responds, although the files showed limited responses from the providers.

There were some discrepancies regarding members with English as a second language. Education materials were provided in the members' native language; however, provision of care plans in the members' primary language could not be confirmed. Care gaps were pulled from HEDIS measures to address specific needs for each member, including vision and dental visits. The maternity case files did not always reflect recommended trimester-specific interventions, such as the Tdap vaccine being recommended at 28 weeks.

Of the 10 CCC files reviewed, six files scored above 90% compliance and four files scored between 75%–89% compliance in the required elements. Of the 10 low-risk MCC files reviewed, two files scored above 90% compliance, six files were scored between 75%–89% compliance, and two files scored below 75% compliance in the required elements. Of the 10 high-risk MCC files reviewed, one file scored above 90% compliance, six files scored between 75%–89% compliance, two files scored below 75% compliance in the required elements, and one file was not scored as the member was unreachable.

The following table displays high-level strengths and opportunities in the file reviews, broken down by domain.

Review Area	Strengths	Opportunities
Outreach and Engagement (for all levels)	Member outreach is generally timely. Community visits are attempted when phone outreach is unsuccessful.	None noted in file sample.
Screening (for low-risk MCC)	Numerous screenings are available for completion.	Some screening questions were not answered.
Assessment (for CCC and high-risk MCC)	The notes demonstrate detailed and comprehensive assessments.	None noted in file sample.
POC (for CCC and high-risk MCC)	Many files demonstrated member-centric, comprehensive POCs, with consistent delivery of the plan to the member and the provider.	Some care plans were not member-centric and included vague or generic opportunities.
CC Activities (for all levels)	Members are consistently educated on benefits and resources. Excellent coordination with a housing specialist in one case.	HRSN and care gap follow-up and completion are not always clearly documented to determine whether referrals and resources were obtained.

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	Findings	Recommendations
The MCO has an organizational chart for the CC program (including CCC, 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 the Delaware population (including those shared across other State programs [if applicable]), notes staff situated in Delaware, and identifies any open positions. (3.6.5)	Partially Met	The organizational chart shows the Director reporting to the Senior VP before the CEO, not complying with the MSA requirements. The organizational chart displayed during the on-site, shows two housing coordinator positions, while the chart submitted for the RFI only shows one position.	Revise the organizational chart to reflect the updated positions and direct reporting structure. Gain State-approved exception documentation for those reporting structures that do not align with the MSA.
The MCO provided data regarding HRA completion and evidence of compliance with 60-day outreach standard, and demonstrates active outreach and engagement within the first 30 days. (3.8.1.6)	Partially Met	HHO used an outside vendor to complete member HRAs through December 2023; however, metric scores remained low during Q1 2023 and Q2 2023. HHO then created an outreach team to complete HRAs.	Review reporting results for the past three months to demonstrate compliance with the HRA outreach requirements as defined in the MSA. In reviewing, revise any specific trainings or updates to the job aides that apply.
The MCO's Risk Stratification plan outlines the contractually defined frequency of stratification (new membership a minimum of monthly and the rest of the population a minimum of quarterly) and delineates the various data inputs that feed the predictive modeling algorithm. The MCO's Risk Stratification plan and predictive modeling algorithm include, at a minimum, the following sources of data: claims, pharmacy, lab results, supplemental information from providers, referral and utilization patterns, and/or HRA results and HRSNs data. (3.6.3)	Substantially Met	HHO has an approved risk stratification that was updated in 2024 to include updates for MCC. The data is run on a daily and monthly basis.	Ensure risk stratification has corresponding explanation describing the difference between what is run monthly with SAS/Pythin versus the Risk Stratification model that is run daily as well as how these reports are utilized.

Regulation/Contract Standard Not Fully Compliant	2024 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)	Substantially Met	HHO has an outreach process that is monitored through supervisor auditing and compliance reporting, which is completed monthly. HHO submitted quarterly audit scores.	Ensure reporting audited results are provided monthly to demonstrate compliance with the outreach process requirements as defined in the MSA.
The MCO engages continuous QI efforts to enhance transition and discharge planning, reduce readmissions, and improve member experience and outcomes of care. (3.8.2.11, 3.6.6.5.1.9)	Substantially Met	HHO has a process to monitor discharge planning and TOC compliance that includes monthly chart audits. HHO provided quarterly audit scores.	Ensure monthly audit reports demonstrate compliance with discharge planning and TOC process requirements as defined in the MSA
Supervisors and CCC staff receive reports to monitor timeliness of outreach efforts and consistency with outreach and contact timeframes and develop staff and/or departmental corrective actions, if necessary. (3.6.6.4.1)	Substantially Met	HHO has P&Ps that define the outreach processes and audit tools to monitor compliance with the MSA timelines. HHO submitted quarterly audits scores. File reviews generally demonstrated timely outreach.	Ensure reporting audited results are provided monthly to demonstrate compliance with outreach process requirements as defined in 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 PPPs with OUD PIP is in the planning stage, the majority of the on-site discussion focused on the initial interventions developed, the barrier analysis completed to date, and baseline results. The evaluation demonstrated a high degree of confidence in the foundational steps. Although the PIPs are clearly written, the Aim Statements lack specificity and measurability. ACDE should review CMS guidelines on Aim Statement development to identify missing required elements. A well-developed Aim Statement includes the PIP intervention, defines the population and time period, and specifies the measurable impact.

PIP Name	Confidence PIP Adhered to Acceptable Methodology for All Phases
PIP 1: PPPs with OUD	Moderate Confidence
PIP 2: ED LANE	Moderate Confidence

PIP Name	Confidence PIP Produced Evidence of Significant Improvement
PIP 1: PPPs with OUD	N/A — PIP in Planning Phase
PIP 2: ED LANE	High Confidence

Pregnant and Postpartum Persons with Opioid Use Disorder PIP

1. General PIP Information
Managed Care Plan (MCP) Name: ACDE
PIP Title: PPPs with OUD.
PIP Aim Statement: Improve the rate of PPPs with OUD who utilize pharmacotherapy (methadone or buprenorphine) for treatment.
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 prepaid inpatient health plans [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 female children of childbearing age.
Target population description, such as duals, LTSS, or pregnant people (please specify): All PPP 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 (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- Quarter 1 2023:
  - Bright Start care coordinators continued to outreach to members for engagement in Bright Start program. CC also has staff who are bilingual in Spanish and utilize the language line when appropriate to engage members in their preferred language.
- Quarter 2 2023:
  - Bright Start care coordinators continued to outreach to members for engagement in Bright Start program. CC also has staff who are bilingual in Spanish and utilize the language line when appropriate to engage members in their preferred language.
- Quarter 3 2023
  - Bright Start care coordinators continued to outreach to members for engagement in Bright Start program. CC also has staff who are bilingual in Spanish and utilize the language line when appropriate to engage members in their preferred language.
- Quarter 4 2023
  - Bright Start care coordinators continued to outreach to members for engagement in Bright Start program. CC also has staff who are bilingual in Spanish and utilize the language line when appropriate to engage members in their preferred language.

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 2023:
  - Tracked response to Provider survey regarding SUD. Reviewed and revised survey due to no responses received. Fax blast notifications distributed weekly to provider offices requesting survey completion.
- Quarter 2 2023
  - Continued tracking response to Provider survey regarding SUD. Discussed strategies to improve provider response (discuss with ACOs, AEs reviewing at office visits, and provider newsletter article). Fax blast notifications distributed weekly to provider offices requesting survey completion.
- Quarter 3 2023
  - Continued tracking response to Provider survey regarding SUD. Article posted in Summer Issue of Connections Provider Newsletter educating providers on PPPs with OUD and requesting survey to be completed. Fax blast notifications distributed weekly to provider offices requesting survey completion.
- Quarter 4 2023
  - Continued tracking response to Provider survey regarding SUD. Discussed strategies to improve provider response (discuss with ACOs, AEs reviewing at office visits, and provider newsletter article). Fax blast notifications distributed weekly to provider offices requesting survey completion. Provider Network AEs to distribute notifications for survey during on-site visits.

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

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

- Quarter 1 2023:
  - Completed analysis of internal survey on SUD bias. Outcomes were reviewed with ACDE leadership and DMMA.
  - Implemented Bias training for ACDE staff. In March 2023, West Virginia University in collaboration with the University of Delaware and Rural Opioid Technical Assistance Regional (ROTA-R) presented webinar on Substance Use Education. Topics included key theories of addiction, stigma, and the effect on individual and families, and strategies for supporting those impacted by addiction. Approximately 80 staff attended.
- Quarter 2 2023:
  - Continued Bias training for ACDE staff. Trainings were recorded when possible and made available to additional staff on request.
  - In April 2023, Dr. Mishka Terplan presented a webinar on Identification and Consequences of Stigmatizing Language on Pregnant and Parenting People Living with SUDs. Approximately 70 staff attended the session.
  - In June 2023, Dr. Meena presented on The Intersection of Risk: Substance Misuse and Maternal Morbidity and Mortality. One hundred and fifty staff attended virtually and in-person.
- Quarter 3 2023
  - Continued Bias training for ACDE staff. Trainings were recorded when possible and made available to additional staff on request.
  - In July 2023, Brandywine Counseling presented training on priority admission's perinatal CM, collaboration for early identification of pregnancies, peer support sessions, data collections, barriers to treatment, medication-assisted treatment, member-reported bias from OB/GYNs, and ACDE resources. Approximately 100 staff attended the session virtually and in-person.
  - In August 2023, Dr. Meena presented a webinar on "Lessons from Fetal and Infant Mortality Review". One hundred and eighty-five staff attended virtually and in-person.
  - In August 2023, Representative Melissa Minor-Brown, MSN, RN, discussed her history with the PPP with OUD population, including those within the DOC, her bills sponsored within this space (specifically for those incarcerated pregnant persons), and the pilot for housing unstable and pregnant people, which included a robust question and answer session followed the presentation. One hundred and seventy-eight staff attended the session virtual.
  - In August 2023, Kimberly D. Williams, MPH, provided training specific to opioids versus opiates and tolerance; dependence versus addiction; medication OUD treatment during pregnancy; neonatal abstinence syndrome; impact on infants and breastfeeding; stigma concepts, including experiential and action-oriented stigmas, sources of stigma, and effects of stigma on individuals and pregnant individuals with SUD; inclusive, person-first language; reasons why pregnant individuals with SUD may not seek medical care or breastfeed; relayed anecdotal life experiences from maternal interviews, such as receiving care for a SUD and pregnancy and the perceived biases encountered; and actions staff can take. Approximately 160 staff attended the session virtually.
- Quarter 4 2023
  - Continued Bias training for ACDE staff. Trainings were recorded when possible and made available to additional staff on request.
  - In October 2023, Joelle Puccio, BSN, RN, from the Academy for Perinatal Harm Reduction lead a discussion around the framework of perinatal harm reduction, including case studies.

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

- Objectives included define perinatal harm reduction, review examples of harm reduction principles, identify how to implement harm reduction principles in practice. Approximately 250 staff attended.

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 (MY) (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: Rate of ACDE contracted OB/GYN providers, certified nurse midwives, and nurse midwives within the provider cohort educated about the Substance Abuse and Mental Health Services Administration (SAMHSA) Clinical Guidelines for management of PPP with OUD, specifically prescribing medication-assisted therapy with either methadone or buprenorphine, available CC resources within ACDE, available OUD resources within 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 within the specialties listed above who are identified via credentialing as treating female members of childbearing age for obstetrical care.	2022	Sample Size: 191 Rate: 3.1%	N/A	Sample Size: NA Rate: %	☐ 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 (MY) (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: Rate of pregnant and postpartum members with an OUD diagnosis that are engaged with the Bright Start program through the Enhanced CC Maternity model. Outreach for this PIP is defined as either telephonic/virtual member outreach or home visit by the clinical care coordinator (i.e., RN and social worker). "Engaged" is defined as a completed initial maternity assessment for prenatal and the initial comprehensive assessment plus the initial adult assessment for post-partum.	2022	Sample Size: 179 Rate: 12.8%	2023	Sample Size: 155 Rate: 8.4%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): P = 0.1902
Lag Measure #1: Rate of pregnant persons with an OUD diagnosis receiving buprenorphine or methadone.	2022	Sample Size: 186 Rate: 54.8%	2023	Sample Size: 139 Rate: 55.4%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): P = 0.92034
Lag Measure #2: Rate of postpartum persons with an OUD diagnosis receiving buprenorphine or methadone.	2022	Sample Size: 149 Rate: 64.4%	2023	Sample Size: 86 Rate: 57.0%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): P = 0.92034
Lag Measure #3: Rate of buprenorphine utilization in pregnant persons with OUD.	2022	Sample Size: 186 Rate: 18.3%	2023	Sample Size: 139 Rate: 26.6%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): P = 0.07186

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 (MY) (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 #4: Rate of buprenorphine utilization in postpartum persons with OUD.	2022	Sample Size: 149 Rate: 22.1%	2023	Sample Size: 86 Rate: 24.4%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): P = 0.68916
Lag Measure #5: Rate of methadone utilization in pregnant persons with OUD.	2022	Sample Size: 186 Rate: 39.2%	2023	Sample Size: 139 Rate: 32.4%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): P = 0.20408
Lag Measure #6: Rate of methadone utilization in postpartum persons with OUD.	2022	Sample Size: 149 Rate: 46.3%	2023	Sample Size: 86 Rate: 37.2%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): P = 0.17384

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: 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.

Emergency Department Low-Acuity Non-Emergent PIP

1. General PIP Information
MCP Name: ACDE
PIP Title: 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: Does use of DHIN A08 information increase successful PCP follow-up for members seen in the ED with a LANE diagnosis 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 2023: – RROT and CC utilize interpretive services to facilitate communication in the member's preferred language. RROT and CC also have staff who are bilingual in Spanish and Haitian-Creole. – RROT and CC utilize the Emergency Room (ER) Diversion survey assessment tool for post-ED outreach, which includes assessment of HRSNs. Staff provide education and offer assistance with resolving barriers to care through plan and community resources. • Quarter 2 2023 – RROT and CC utilize interpretive services to facilitate communication in the member's preferred language. RROT and CC also have staff who are bilingual in Spanish and Haitian-Creole. – 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. • Quarter 3 2023 – RROT and CC utilize interpretive services to facilitate communication in the member's preferred language. RROT and CC also have staff who are bilingual in Spanish and Haitian-Creole. – RROT and CC (Level 1) 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. – Implemented two-way texting by ED LANE team to encourage engagement.
• Quarter 4 2023: – RROT and CC utilize interpretive services to facilitate communication in the member's preferred language. RROT and CC also have staff who are bilingual in Spanish and Haitian-Creole. – RROT and CC (Level 1) 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 to improve member communication and engagement.

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)

- Quarter 1 2023:
  - None.
- Quarter 2 2023:
  - None.
- Quarter 3 2023:
  - None.
- Quarter 4 2023:
  - Introduced ED LANE PIP to ACO Quality subcommittee 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 2023:
  - Refined member outreach reports. Reviewed and updated Root Cause analysis. Developed graphs to report outcomes.
- Quarter 2 2023:
  - Began tracking provider calls. Utilized provider calls to confirm member contact number.
- Quarter 3 2023:
  - Deep dive of data by ACO and PCP. Explored collaboration with ACOs regarding ED LANE findings to facilitate focus on interventions. Reviewed reporting cycle and rapid-cycle PIP. Current time lag does not allow for timely analysis. Current data runs one quarter plus one month behind end of measurement period.
- Quarter 4 2023:
  - Reviewed and refined target goals for all measures. Reviewed reporting timeframe for 30-day follow-up visits to determine if 90-day claims lag can be calculated earlier in the month for reporting purposes. Enterprise Information Technology (IT) confirmed that this is not possible.
  - Clarified reporting and education for ED LANE PIP versus ED LANE task force. Discussion of ED LANE utilization at ACO meetings and weekly case rounds support ED LANE task force, whose goal is to reduced ED LANE utilization, which is clinical. The reporting for this PIP is identification of those members for outreach via a new process, and if the increased identification and outreach improved follow-up after an ED visit for a LANE diagnosis.
  - Deep-dive into ED LANE data including visits, diagnoses, ages, and follow-up visits to determine any patterns or trends.

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-MY (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 members seen in the ED with one of the five targeted LANE diagnoses using Admit, Discharge, and Transfer (ADT) and A08 documentation that are not automatically assigned for outreach by CC or RROT through existing/standard ACDE processes.	2022	Sample Size: 497 Rate: 98.4%	2023	Sample Size: 491 Rate: 96.9%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): P = 0.131
Lead Measure #2: The percentage of 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 through existing/standard ACDE processes.	2022	Sample Size: 489 Rate: 88.8%	2023	Sample Size: 476 Rate: 95.4%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lead Measure #3: The percentage of 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 through existing/standard ACDE processes	2022	Sample Size: 489 Rate: 11.2%	2023	Sample Size: 476 Rate: 4.6%	☐ Yes ☒ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag Measure #1: The percentage of 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 ER Outreach Non-Clinical pathway.	2022	Sample Size: 470 Rate: 33.4%	2023	Sample Size: 476 Rate: 50.0%	☒ 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-MY (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 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%	2023	Sample Size: 476 Rate: 42.0%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): P = 0.085
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%	2023	Sample Size: 476 Rate: 34.5%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): P = 0.070

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
EQRO recommendations for improvement of PIP: • Four of the six quantifiable measures demonstrated improvement; two of those four measures of improvement were statistically significant. The PIP 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. The Aim Statement should include the PIP intervention, define the population and time period, and specify the measurable impact.

DFH PIP Overall Assessment

Overall Results

DFH demonstrates a strong understanding of PIP design and implementation. DFH utilizes PIP workgroups for continuous QI, including review and analysis of initiatives and barrier analysis. DFH's PIPs are clearly written, detailed, and align with identified population health concerns. Since the PPPs with OUD PIP is in the planning stage, the majority of the on-site discussion focused on the initial interventions developed, the barrier analysis completed to date, and baseline results. The EQR evaluation demonstrated a high degree of confidence in the foundational steps. Although the PIP is clearly written, the Aim Statement lacked specificity and measurability. DFH should review CMS guidelines on Aim Statement development to identify missing required elements. A well-developed Aim Statement includes the PIP intervention, defines the population and time period, and specifies the measurable impact. Additionally, the Delaware Welcome Call PIP demonstrated success with one of the three quantifiable measures, showing statistically significant improvement. Unfortunately, there was limited documentation submitted to fully collaborate the data collected, the analysis performed, and the interpretation of results. The EQRO recommends ensuring all appropriate documentation is included when submitting PIP information for validation to support PIP results in the future.

PIP Name	Confidence PIP Adhered to Acceptable Methodology for All Phases
PIP 1: PPPs OUD PIP	Moderate Confidence
PIP 2: Delaware Welcome Call PIP	Moderate Confidence

PIP Name	Confidence PIP Produced Evidence of Significant Improvement
PIP 1: PPPs OUD PIP	N/A — PIP in Planning Phase
PIP 2: Delaware Welcome Call PIP	N/A — PIP in Planning Phase

Pregnant and Postpartum Persons with Opioid Use Disorder PIP

1. General PIP Information

MCP Name: DFH

PIP Title: PPPs OUD PIP

PIP Aim Statement: Improve the rate of PPPs with OUD who utilize pharmacotherapy (methadone or buprenorphine) for treatment.

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)

- N/A, PIP interventions will begin in 2024.

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

- N/A, PIP interventions will begin in 2024.

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)

- N/A, PIP interventions will begin in 2024.

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-MY (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: 21 Rate: 62%	☒ Not applicable — PIP is in planning or implementation phase, results not available	Sample Size: N/A Rate: %	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
Lead Measure #2: Number of pregnant and postpartum individuals who received education on harm reduction strategies.	4/1/2023–3/28/2024	Sample Size: N/A Rate: %	☒ Not applicable — PIP is in planning or implementation phase, results not available	Sample Size: N/A Rate: %	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
Lead Measure #3: Percentage of OUD members >90 days–1 year postpartum with an SUD screen.	4/1/2023–3/28/2024	Sample Size: 21 Rate: N/A	☒ Not applicable — PIP is in planning or implementation phase, results not available	Sample Size: N/A Rate: %	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
Lead Measure #4: Percentage of postpartum members with OUD that received postpartum care.	4/1/2023–3/28/2024	Sample Size: 21 Rate: 19%	☒ Not applicable — PIP is in planning or implementation phase, results not available	Sample Size: N/A Rate: %	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
Lead Measure #5: Number of SUD and ED providers engaged to review PPPs with OUD challenges and opportunities to improve the system of care.	4/1/2023–3/28/2024	Sample Size: N/A Rate: %	☒ Not applicable — PIP is in planning or implementation phase, results not available	Sample Size: N/A Rate: %	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
Lag Measure #1: Rate of pregnant persons with an OUD diagnosis receiving buprenorphine or methadone.	4/1/2023–3/28/2024	Sample Size: 21 Rate: 57%	☒ Not applicable — PIP is in planning or implementation phase, results not available	Sample Size: N/A Rate: %	☐ 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 NQF number, if applicable)	**Baseline year**	**Baseline sample size and rate**	**Most recent re-MY (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: Rate of postpartum persons with an OUD diagnosis receiving buprenorphine or methadone.	4/1/2023–3/28/2024	Sample Size: 21 Rate: 62%	☒ Not applicable — PIP is in planning or implementation phase, results not available	Sample Size: N/A Rate: %	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
Lag Measure #3: Rate of buprenorphine utilization in pregnant persons with OUD.	4/1/2023–3/28/2024	Sample Size: 21 Rate: 19%	☒ Not applicable — PIP is in planning or implementation phase, results not available	Sample Size: N/A Rate: %	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
Lag Measure #4: Rate of buprenorphine utilization in postpartum persons with OUD.	4/1/2023–3/28/2024	Sample Size: 21 Rate: 29%	☒ Not applicable — PIP is in planning or implementation phase, results not available	Sample Size: N/A Rate: %	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
Lag Measure #5: Rate of methadone utilization in pregnant persons with OUD.	4/1/2023–3/28/2024	Sample Size: 21 Rate: 38%	☒ Not applicable — PIP is in planning or implementation phase, results not available	Sample Size: N/A Rate: %	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
Lag Measure #6: Rate of methadone utilization in postpartum persons with OUD.	4/1/2023–3/28/2024	Sample Size: 21 Rate: 33%	☒ Not applicable — PIP is in planning or implementation phase, results not available	Sample Size: N/A Rate: %	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A

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 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.

Delaware Welcome Call PIP

1. General PIP Information
MCP Name: DFH
PIP Title: Delaware Welcome Call PIP
PIP Aim Statement: To increase member engagement by 10% in 2024 by converting the outreach method of Welcome Calls from robocalls to live agents and updating the plan caller identification (ID) to reflect the plan name.
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

1. General PIP Information

Target population description, such as duals, LTSS, or pregnant people (please specify):
Newly enrolled DFH members.

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)

- DFH implemented a new member Welcome Call campaign in Q1 2023, utilizing live agents to 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 completion.

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

- N/A, this is a member-focused 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)

- N/A.

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-MY(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%.	2023	Sample Size: Rate: 35%	2024	Sample Size: Rate: 54%	☒ 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-MY(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%.	2023	Sample Size: Rate: 25%	2024	Sample Size: Rate: 22%	☐ 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%.	2023	Sample Size: Rate: 49%	2024	Sample Size: Rate: 48%	☐ 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 one of the three quantifiable measures showing statistically significant improvement, there was limited documentation submitted to fully collaborate the data collected, the analysis performed, and the interpretation of results. Ensure all appropriate 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. HHO utilizes PIP workgroups and ad hoc subgroups for continuous QI, including review and analysis of initiatives, barrier analysis, and identification of variances. HHO's PIPs are clearly written, detailed, and align with identified population health concerns. Since the PPPs with OUD PIP is in the planning stage, the majority of the on-site discussion focused on the initial interventions developed, the barrier analysis completed to date, and baseline results. The EQR evaluation demonstrated a high degree of confidence in the foundational steps. Although the PIPs are clearly written, the Aim Statements lack specificity and measurability. HHO should review CMS guidelines on Aim Statement development to identify missing required elements. A well-developed Aim Statement includes the PIP intervention, defines the population and time period, and specifies the measurable impact.

PIP Name	Confidence PIP Adhered to Acceptable Methodology for All Phases
PIP 1: PPPs with OUD	Moderate Confidence
PIP 2: Prior Authorizations	Moderate Confidence

PIP Name	Confidence PIP Produced Evidence of Significant Improvement
PIP 1: PPPs with OUD	N/A — PIP in Planning Phase
PIP 2: Prior Authorizations	High Confidence

Pregnant and Postpartum Persons with OUD PIP

1. General PIP Information
MCP Name: HHO
PIP Title: PPPs with OUD
PIP Aim Statement: To identify PPPs with an OUD who are receiving medication for OUD (buprenorphine or methadone), consistent with evidence-based standards of care.

1. General PIP Information

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 persons (please specify):

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

- A data file with member identified as pregnant or postpartum with OUD diagnosis is sent to the vendor for outreach and educated on the PPPs with OUD incentive program, which can yield up to $100 for participating and completing at least 14 days of treatment and other various tasks, which include, but not limited to:
  - Initial enrollment with survey
  - First and subsequent clinic visits for methadone
  - Filling a buprenorphine prescription
  - Connecting with a HHO care coordinator
  - Completing at least 14 doses within 30 days
- Members received education regarding the program in the monthly maternity mailers for prenatal and postpartum members. Mailers are in all packets that are sent to prevent stigmatizing those with an OUD diagnosis. It is an educational brochure that gives the member the opportunity to self-identify and self-refer. Members are also informed by resource/care coordinators if they are identified for a referral as a high-risk pregnancy because of opioid use. For those members who agreed to the program and did not respond to the initial contact, an alert is placed in the electronic CM system for the care coordinator to address with their next contact.
  - See attachment PIP-03B_DE_PIP 1 Brochure

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)

- Providers were offered $100 incentive for each referral to medication OUD treatment for pregnant and postpartum members. Education was provided via the provider forum and updates.
  - See Attachment: PIP_03B_PIP1_Quality Provider Forum October 2022 and PIP_03B_PIP1_Quality Provider Forum September 2023
- HHO identified seven facilities that administer methadone and buprenorphine for treatment; individual training was provided to educate them on the process for verifying that members received their medications at the clinic visit, to initiative member incentive payments.
  - See attachment: PIP_03B_PIP1_PPPOUD One-Pager Treatment Facility cheat sheet sample and PIP_03_PIP1_PPPOUD Treatment Facility training sample

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)

- None.

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-MY (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
Rate of pregnant persons with an OUD diagnosis receiving buprenorphine.	April 2023–March 2024	Denominator: 1,134 Rate: 138/1,134 = 12.17%	N/A: PIP is in planning or implementation phase; results not available	N/A	☐ Yes ☐ No N/A	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
Rate of postpartum persons with an OUD diagnosis receiving buprenorphine.	April 2023–March 2024	Denominator: 1,564 Rate: 258/1,564 = 16.50%	N/A: PIP is in planning or implementation phase; results not available	N/A	☐ Yes ☐ No N/A	☐ 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 NQF number, if applicable)	**Baseline year**	**Baseline sample size and rate**	**Most recent re-MY (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**
Rate of methadone utilization in pregnant persons with OUD.	April 2023–March 2024	Denominator: 1,134 Rate: 159/1,134 = 14.02%	N/A: PIP is in planning or implementation phase; results not available	N/A	☐ Yes ☐ No N/A	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
Rate of methadone utilization in postpartum persons with OUD.	April 2023–March 2024	Denominator: 1,564 Rate: 185/1,564=11.83%	N/A: PIP is in planning or implementation phase; results not available	N/A	☐ Yes ☐ No N/A	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
Rate of methadone and/or buprenorphine utilization in pregnant persons with OUD.	April 2023–March 2024	Denominator: 1,134 Rate: 297/1,134 = 36.19%	N/A: PIP is in planning or implementation phase; results not available	N/A	☐ Yes ☐ No N/A	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
Rate of methadone and/or buprenorphine utilization in postpartum persons with OUD.	April 2023–March 2024	Denominator: 1,464 Rate: 443/1,464 = 28.31%	N/A: PIP is in planning or implementation phase; results not available	N/A	☐ Yes ☐ No N/A	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A

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 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.

Prior Authorizations PIP

1. General PIP Information

MCP Name: HHO

PIP Title: PAs PIP

PIP Aim Statement: To decrease the rate of rejections of PAs for opioid and ADHD medications.

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 older) ☐ Both adults and children

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

Target population description, such as duals, LTSS, or pregnant person (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)

- Members are texted through Reciprocity with a message to alert them to get their prescriptions filled in a timely manner. The exact wording of the text message is: *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 prior authorization. A refill on your prescription medicine may be delayed if your pharmacy needs to get prior authorization. Highmark Health Options, your doctor, and your pharmacy need time to communicate when prior authorization is needed.*
- This same message was in the member newsletter as well.
  - See Attachment: PIP_03E_PIP2_member message and PIP_03E_PIP2 _member newsletter

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

- In Q4 2023, a Continuing Medical Education (CME) course was developed to educate providers on the therapeutic uses of ADHD and opioid medications and how to complete their PAs. Pens and a laminated cheat sheet on how to fill out a PA are distributed to provider offices regularly starting in Q4 2023.
  - See Attachments: PIP_03E_PIP2_CME Course, PIP_03E_PIP2 inserts for provider pen packets, PIP_03E_PIP2 Provider Pen, PIP_03E_PIP2 Provider Update, PIP_03E_PIP2 Monthly Provider Forum Slide

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)

- None.

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-MY (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**
The percentage of opioid and ADHD prescribers with two or more and 20% or more rejections who received the education.	2023	Denominator: 1,858 139/1,858 = 7.50%	Q1 2024	Denominator: 5,596 427/5,596 = 7.63%	☒ Yes ☐ No NA	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
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	Denominator: 188 64/188 = 34.00%	Q1 2024	Denominator: 573 203/573 = 35.42%	☒ Yes ☐ No NA	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
The percentage of members with two or more and 20% or more rejections who received the education.	2023	Denominator: 5,867 3547/5,867 = 60.50%	Q1 2024	Denominator: 17,773 12947/17,773 = 72.84%	☒ Yes ☐ No NA	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
The percentage of members who were educated who have a lower rate of rejections in the year following education compared to the year prior to education.	2023	Denominator: 5,694 613/5,694 = 10.77%	Q1 2024	Denominator: 17,707 2435/17,707 = 13.75%	☒ Yes ☐ No NA	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
The percentage of rejections in the MY's month for opioid and ADHD prescriptions.	2023	Subtractor: 13.7% 12.20%–13.7% = −12.8%	Q1 2024	Subtractor: 43.4% 46%–43.4%= 6.66%	☐ Yes ☒ No NA	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A

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:

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 2024 included a combination of CMS adult and child core measures, HEDIS measures, and QCMMR measures. Additionally, the HEDIS roadmap was reviewed for additional details specific to HEDIS reporting.

Compliance Findings

High Confidence	Moderate Confidence	Low Confidence	No Confidence
All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.	After 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.	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 Performance Measures 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 2023, ACDE calculated the HEDIS measures' rates using the NCQA-certified vendor Inovalon, Inc (product Converged Quality, formerly Catalyst Quality Spectrum Insight). During the MY2023, ACDE contracted with HealthcareData Company, LLC, a HEDIS-licensed organization, for completing the HEDIS audit.

ACDE systems include core processing systems which, together with the supplemental data, support the data loading and extraction to and from the Enterprise Data Warehouse (EDW). Before the data enter 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 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, and medical records. 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 did not delegate the MRR function for the hybrid measures but rather developed the necessary skills and competencies internally and successfully completed the review. ACDE uses multiple systems and vendors to support medical records extraction and storage. These include and are referenced in the “Overall Results” section below as other sources supporting PMs:

- Jiva — System storing the data extracted from medical records and used for HEDIS.
- Athena — ACFC has access to and receives continuity of care document data on its members who have been seen by providers using Athena electronic health record software.
- I2I — Population health vendor that contracts with federally qualified health centers and extract and share data with ACFC.
- Nemours — Provider submitting additional records to ACDE based on the eligibility files.
- CCHS — Provider submitting additional records to ACDE based on the eligibility files.
- LabCorp — Provider submitting additional records to ACDE based on the eligibility files.
- DHIN — Health information exchange submitting additional records to ACDE based on the eligibility files.

ACDE has robust processes, policies, and systems to create regulatory reporting, including DMMA-specific reporting. ACDE relies on its parent company to gather the requirements, develop the code, and generate the DMMA-specific reports. The local ACDE role includes monitoring the report production, reviewing the result, and final approval, as some of the reports accuracy depend on the market-specific experience and expertise. All reporting generated by Regulatory Reporting is reviewed by analysts and the business owner, as well as the COO, who provides final sign-off of the reports. The standard review process includes verifying that all requested data elements are provided, data are within the reporting period requested, and that all data fit the specific criteria requested.

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.

Overall Results

PM	Confidence in Reported Results
PM 1: BH acute care admissions/1,000	High Confidence
PM 2: Asthma medication ratio	High Confidence
PM 3: Postpartum depression screening and follow-up — Depression screening	High Confidence
PM 4: Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	High Confidence
PM 5: Well-child visits in the first 30 months of life	High Confidence
PM 6: Controlling high blood pressure	High Confidence

BH Acute Care Admissions/1,000

1. Overview of PM
MCP name: ACDE
PM name: PM 1: BH Acute Care Admissions/1,000
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 and QCMMR PLUS Reporting Requirements
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): Facets is the business operating system for ACFC. EDW is utilized to capture subcontractor claims data.

1. Overview of PM

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

Definition of denominator (describe):
Number of Medicaid/CHIP or DSHP Plus members.

Definition of numerator (describe):
Number of BH acute care admissions for Medicaid/CHIP or DSHP Plus members.

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

Measurement period (start/end date): 1/1/2023–12/31/2023

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

PM	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023
Numerator	247	191	257	214	220	220
Denominator	83,931	85,877	86,862	87,713	88,093	88,287
Rate	2.9	2.2	3.0	2.4	2.5	2.5
PM	**Jul 2023**	**Aug 2023**	**Sep 2023**	**Oct 2023**	**Nov 2023**	**Dec 2023**
Numerator	241	227	229	241	231	214
Denominator	87,913	85,593	83,668	83,281	81,319	80,039
Rate	2.7	2.7	2.7	2.9	2.8	2.7

3. PM Validation Status

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

3. PM 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:
None.

Asthma Medication Ratio

1. Overview of PM

MCP name: ACDE

PM name: PM 2: Asthma medication ratio

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)

1. Overview of PM

Definition of denominator (describe):
Members 5 years–64 years of age who were identified as having persistent asthma during MY and the year prior to the MY. Other elements of denominator compliance are in accordance with HEDIS MY2023 Specifications.

Definition of numerator (describe):
Members 5 years–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of ≥0.50 during the MY. 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): 1/1/2023–12/31/2023

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

PM	5 Years–11 Years	12 Years–18 Years	19 Years–50 Years	51 Years–64 Years	Total
Numerator	71	69	253	132	525
Denominator	132	122	464	225	943
Rate	53.79%	56.56%	54.53%	58.67%	55.67%

3. PM Validation Status

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

3. PM Validation Status

EQRO recommendations for improvement of PM calculation:
None.

Postpartum Depression Screening and Follow-Up — Depression Screening

1. Overview of PM

MCP name: ACDE

PM name: PM 3: Postpartum depression screening and follow-up — Depression screening

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.

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): Jiva, I2I, and Athena

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):
Members who delivered within the period of September 8, 2022 to September 7, 2023, excluding members in hospice or using hospice services at any time during 2023. Other elements of denominator compliance are in accordance with HEDIS MY2023 Specifications.

1. Overview of PM

Definition of numerator (describe):
Numerator 1 — Screening: Members with a documented result for postpartum depression screening, using an age-appropriate standardized instrument, performed during the seven days to 84 days following date of delivery.
Numerator 2 — Follow-Up on Positive Screen: Members who received follow-up care within 30 days of the first positive screen (31 total days).
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): 1/1/2023–12/31/2023

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

PM	Screening Rate	Follow-Up Rate		
Numerator	386	22		
Denominator	1,354	41		
Rate	28.51%	53.66%		

3. PM Validation Status

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

3. PM Validation Status

EQRO recommendations for improvement of PM calculation:
None.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

1. Overview of PM

MCP name: ACDE

PM name: PM 4: Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications

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): I2I, LabCorp, Jiva

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):
Members ages 18 years–64 years with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication in 2023. Other elements of denominator compliance are in accordance with HEDIS MY2023 Specifications.

1. Overview of PM

Definition of numerator (describe):
Members who were screened with a glucose test or an HbA1c test during 2023. 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): 1/1/2023–12/31/2023

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

PM	Schizophrenia or Schizoaffective Disorder	Rate 2	Rate 3	Rate 4
Numerator	936			
Denominator	1,277			
Rate	73.30%			

3. PM Validation Status

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

Well-Child Visits in the First 30 Months of Life

1. Overview of PM

MCP name: ACDE

PM name: PM 5: Well-child visits in the first 30 months of life

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): I2I, Jiva, and Nemours — Delaware

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):
Rate 1: Well-Child Visits in the First 15 Months: Children who turned 15 months in 2023.
Rate 2: Well-Child Visits for Ages 15 Months to 30 Months: Children who turned 30 months old during 2023.
Other elements of denominator compliance are in accordance with HEDIS MY 2023 Specifications.

Definition of numerator (describe):
Rate 1: Well-Child Visits in the First 15 Months: Six or more well-child visits on different dates of service on or before 15-month birthday.
Rate 2: Well-Child Visits for Age 15 Months to 30 Months: Two or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday.
Other elements of numerator compliance are in accordance with HEDIS MY2023 Specifications.

1. Overview of PM
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date): 1/1/2023–12/31/2023

2. PM Results (If measure contains more than one rate, add columns to the table)				
PM	**Age: 0–15 Months**	**Age: 15 Months–30 Months**		
Numerator	1,023	1,263		
Denominator	1,589	1,711		
Rate	64.38%	73.82%		

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

Controlling High Blood Pressure

1. Overview of PM

MCP name: ACDE

PM name: PM 6: Controlling high blood pressure

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): MRR was conducted, as this measure is reported via the hybrid method to find the percentage of members 18 years–85 years old who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the MY.
☒ Other (specify): Jiva, DHIN, I2I, CCHS, and Athena

If the hybrid method was used, describe the sampling approach used to select the medical records:
Systematic sampling was performed per the NCQA HEDIS MY2023 Volume 2 Technical Specifications for Health Plans, Controlling High Blood Pressure measure.
☐ Not applicable (hybrid method not used)

Definition of denominator (describe):
Members 18–85 years of age who had a diagnosis of hypertension. Other elements of denominator compliance are in accordance with HEDIS MY2023 Specifications.

Definition of numerator (describe):
Members whose blood pressure was adequately controlled (<140/90 mm Hg) during the MY. Other elements of numerator compliance are in accordance with HEDIS MY2023 Specifications.

1. Overview of PM
Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP
Measurement period (start/end date): 1/1/2023–12/31/2023

2. PM Results (If measure contains more than one rate, add columns to the table)				
PM	**Controlling High Blood Pressure Rate**			
Numerator	238			
Denominator	395			
Rate	60.25%			

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

DFH Performance Measures 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 2023, DFH calculated the HEDIS measures' rates using the NCQA-certified vendor Inovalon, Inc (product Converged Quality, formerly Catalyst Quality Spectrum Insight). During the MY2023, DFH contracted with Attest Healthcare Advisors (Attest), a HEDIS-licensed organization, for completing the HEDIS audit.

DFH systems include core processing systems, which, along with the supplemental data, support the data loading and extraction to and from the EDW. Before the data enter 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 EDW and loaded into Converged Quality 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, and medical records. 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 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 function for the hybrid measures, but rather developed the necessary skills and competencies internally and successfully completed the review. The organization provided the structure and the chase logic and DFH performed retrieval, abstraction, and overread of medical records.

DFH has robust processes, policies, and systems to create regulatory reporting, including DMMA-specific reporting. DFH relies on its parent company to gather the requirements, develop the code, and generate the DMMA-specific reports. The local DFH role includes monitoring the report production, review of the result, and final approval, as some of the reports accuracy depend 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: BH acute care admissions/1,000	Cannot Be Validated
PM 2: Asthma medication ratio	High Confidence
PM 3: Postpartum depression screening and follow-up — Depression screening	High Confidence
PM 4: Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	High Confidence
PM 5: Well-child visits in the first 30 months of life	High Confidence
PM 6: Controlling high blood pressure	High Confidence

BH Acute Care Admissions/1,000

1. Overview of PM
MCP name: DFH
PM name: PM 1: BH acute care admissions/1,000
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): State QCMMR
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)

1. Overview of PM
Definition of denominator (describe): Number of Medicaid/CHIP or DSHP Plus members.
Definition of numerator (describe): Number of BH acute care admissions for Medicaid/CHIP or DSHP members.
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date): 1/1/2023–12/1/2023

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

PM[3]	DSHP Medicaid/CHIP Rate	DSHP Plus Rate	Rate 3	Rate 4
Numerator	52	0		
Denominator	30,695	1,462		
Rate	1.64	0.00		

3. PM Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (e.g., deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). 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 ☒ Cannot be verified "Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

[3] This measure is required to be reported monthly; however, DFH reported only annual results.

3. PM Validation Status

EQRO recommendations for improvement of PM calculation:
Specification requirements for this PM are to be reported monthly. Numerator and denominator data were not submitted for the months of 2023, so validation could not be conducted.

Asthma Medication Ratio

1. Overview of PM

MCP name: DFH

PM name: PM 2: Asthma medication ratio

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):
Members ages 5 years–64 years who were identified as having persistent asthma during MY and the year prior to the MY. Other elements of denominator compliance are in accordance with HEDIS MY2023 Specifications.

1. Overview of PM

Definition of numerator (describe):
Members ages 5 years–64 years who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of ≥0.50 during the MY. 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): 1/1/2023–12/31/2023

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

PM	5 Years–11 Years	12 Years–18 Years	19 Years–50 Years	51 Years–64 Years	Total
Numerator	-	-	-	-	-
Denominator	-	-	-	-	-
Rate[4]	NA	NA	NA	NA	NA

3. PM Validation Status

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

[4] NA indicates the organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

3. PM Validation Status

EQRO recommendations for improvement of PM calculation:
None.

Postpartum Depression Screening and Follow-up — Depression Screening

1. Overview of PM

MCP name: DFH

PM name: PM 3: Postpartum depression screening and follow-up — Depression screening

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):
Members who delivered within the period of September 8, 2022 to September 7, 2023, excluding members in hospice or using hospice services at any time during 2023. Other elements of denominator compliance are in accordance with HEDIS MY2023 Specifications.

1. Overview of PM

Definition of numerator (describe):
Numerator 1 — Screening: Members with a documented result for postpartum depression screening, using an age-appropriate standardized instrument, performed during the seven days to 84 days following date of delivery.
Numerator 2 — Follow-Up on Positive Screen: Members who received follow-up care within 30 days of the first positive screen (31 total days).
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): 1/1/2023–12/31/2023

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

PM	Depression Screening	Follow-Up	Rate 3	Rate 4
Numerator	0	-		
Denominator	386	-		
Rate	0%	N/A[5]		

3. PM Validation Status

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

[5] NA indicates the organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

3. PM Validation Status

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

EQRO recommendations for improvement of PM calculation:
None.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

1. Overview of PM

MCP name: DFH

PM name: PM 4: Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications

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)

1. Overview of PM

Definition of denominator (describe):
Members ages 18 years–64 years with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication in 2023. Other elements of denominator compliance are in accordance with HEDIS MY2023 Specifications.

Definition of numerator (describe):
Members who were screened with a glucose test or an HbA1c test during 2023. 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): 1/1/2023–12/31/2023

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

PM	Schizophrenia or Schizoaffective Disorder	Rate 2	Rate 3	Rate 4
Numerator	242			
Denominator	342			
Rate	70.76%			

3. PM Validation Status

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

3. PM Validation Status

EQRO recommendations for improvement of PM calculation:
None.

Well-Child Visits in the First 30 Months of Life

1. Overview of PM

MCP name: DFH

PM name: PM 5: Well-child visits in the first 30 months of life

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):
Rate 1: Well-Child Visits in the First 15 Months: Children who turned 15 months in 2023.
Rate 2: Well-Child Visits for Ages 15 Months to 30 Months: Children who turned 30 months old in 2023.
Other elements of denominator compliance are in accordance with HEDIS MY2023 Specifications.

1. Overview of PM

Definition of numerator (describe):
Rate 1: Well-Child Visits in the First 15 Months: Six or more well-child visits on different dates of service on or before the child's 15-month birthday.
Rate 2: Well-Child Visits for Age 15 Months to 30 Months: Two or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday.
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): 1/1/2023–12/31/2023

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

PM	0–15 months	15 months–30 months	Rate 3	Rate 4
Numerator	-	-		
Denominator	-	-		
Rate	NA[6]	NA		

3. PM Validation Status

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

[6] NA indicates the organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

3. PM Validation Status

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

EQRO recommendations for improvement of PM calculation:
None.

Controlling High Blood Pressure

1. Overview of PM

MCP name: DFH

PM name: PM 6: Controlling high blood pressure

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):
Members ages 18 years–85 years who had a diagnosis of hypertension. Other elements of denominator compliance are in accordance with HEDIS MY2023 Specifications.

1. Overview of PM

Definition of numerator (describe):
Members whose blood pressure was adequately controlled (<140/90 mm Hg) during the MY. 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): 1/1/2023–12/31/2023

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

PM	Controlled Blood Pressure	Rate 2	Rate 3	Rate 4
Numerator	228			
Denominator	677			
Rate	33.68%[7]			

3. PM Validation Status

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

[7] The rate reported here was calculated using administrative methods. DFH also calculated a hybrid rate of 60.83%.

3. PM Validation Status
EQRO recommendations for improvement of PM calculation: None.

HHO Performance Measures 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 2023, HHO calculated the HEDIS measures' rates using the NCQA-certified vendor Inovalon, Inc (product Converged Quality, formerly Catalyst Quality Spectrum Insight). During MY2023, HHO contracted with DTS Group (DTS), a HEDIS-licensed organization, for completing the HEDIS Audit.

HHO systems include core processing systems which, paired with the supplemental data, support the data loading and extraction to and from the EDW. Before the data enter 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 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, and medical records. 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 function for the hybrid measures to PalmQuest Inc. PalmQuest has been conducting MRR since MY2020. The HHO clinical staff conducts an over-read of all abstracted charts determined to be compliant along with selected non-compliant charts as deemed appropriate due to their complexity and/or designation as a Quality PM.

HHO has robust processes, policies, and systems to create 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: BH acute care admissions/1,000	High Confidence
PM 2: Asthma medication ratio	High Confidence
PM 3: Postpartum depression screening and follow-up — Depression screening	High Confidence
PM 4: Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	High Confidence
PM 5: Well-child visits in the first 30 months of life	High Confidence
PM 6: Controlling high blood pressure	High Confidence

BH Acute Care Admissions/1,000

1. Overview of PM
MCP name: HHO
PM name: PM 1: BH acute care admissions/1,000
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): State QCMMR
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.

1. Overview of PM

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

Definition of denominator (describe):
Number of Medicaid/CHIP and DSHP Plus members.

Definition of numerator (describe):
Number of BH acute care admissions for Medicaid/CHIP and DSHP Plus members.

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

Measurement period (start/end date): 1/1/2023–12/31/2023

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

PM — Program DSHP	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023
Numerator	160	136	152	151	184	168
Denominator	156,986	141,255	142,855	143,970	144,461	145,369
Rate	1.02	0.96	1.08	1.05	1.27	1.16
PM	**Jul 2023**	**Aug 2023**	**Sep 2023**	**Oct 2023**	**Nov 2023**	**Dec 2023**
Numerator	158	187	148	172	147	155
Denominator	145,284	144,678	141,828	139,388	138,840	135,855
Rate	1.09	1.29	1.04	1.23	1.06	1.14
PM — Program DSHP Plus	**Jan 2023**	**Feb 2023**	**Mar 2023**	**Apr 2023**	**May 2023**	**Jun 2023**
Numerator	24	28	23	22	21	25
Denominator	9,586	8,995	9,089	9,144	9,197	9,398
Rate	2.51	3.11	2.53	2.41	2.28	2.66
PM	**Jul 2023**	**Aug 2023**	**Sep 2023**	**Oct 2023**	**Nov 2023**	**Dec 2023**
Numerator	41	26	20	22	24	29
Denominator	9,447	9,500	9,548	9,557	9,546	9,557
Rate	4.34	2.74	2.09	2.3	2.51	3.03

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

Asthma Medication Ratio

1. Overview of PM
MCP name: HHO
PM name: PM 2: Asthma medication ratio
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

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):

Members 5 years–64 years of age who were identified as having persistent asthma during MY and the year prior to the MY. Other elements of denominator compliance are in accordance with HEDIS MY2023 Specifications.

Definition of numerator (describe):

Members 5 years–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of ≥0.50 during the MY. 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): 1/1/2023–12/31/2023

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

PM	5 Years–11 Years	12 Years–18 Years	19 Years–50 Years	51 Years–64 Years	Total
Numerator	409	382	449	179	1,419
Denominator	562	536	653	261	2,012
Rate	72.78%	71.27%	68.76%	68.58%	70.53%

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

Postpartum Depression Screening and Follow-up — Depression Screening

1. Overview of PM
MCP name: HHO
PM name: PM 3: Postpartum depression screening and follow-up — Depression screening
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

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): Provider electronic medical record (EMR) files.

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):

Members who delivered within the period of September 8, 2022 to September 7, 2023, excluding members in hospice or using hospice services at any time during 2023. Other elements of denominator compliance are in accordance with HEDIS MY2023 Specifications.

Definition of numerator (describe):

Numerator 1 — Screening: Members with a documented result for postpartum depression screening, using an age-appropriate standardized instrument, performed during the seven days to 84 days following date of delivery.

Numerator 2 — Follow-up on Positive Screen: Members who received follow-up care within 30 days of the first positive screen (31 total days).

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): 1/1/2023–12/31/2023

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

PM	Screening	Follow-Up	Rate 3	Rate 4
Numerator	0	0		
Denominator	1,768	0		
Rate	0.00%	N/A[8]		

[8] N/A indicates the organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

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

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

1. Overview of PM
MCP name: HHO
PM name: PM 4: Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications
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

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): EverlyHealth supplemental data source

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

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Members ages 18 years–64 years with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication in 2023. Other elements of denominator compliance are in accordance with HEDIS MY2023 Specifications.

Definition of numerator (describe):

Members who were screened with a glucose test or an HbA1c test during 2023. 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): 1/1/2023–12/31/2023

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

PM	Schizophrenia or Schizoaffective Disorder			
Numerator	1,417			
Denominator	1,850			
Rate	76.59%			

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

Well-Child Visits in the First 30 Months of Life

1. Overview of PM
MCP name: HHO
PM name: PM 5: Well-child visits in the first 30 months of life
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

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): Provider EMR data files and supplemental data (clinical quality feedback loop)

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):

Rate 1: Well-Child Visits in the First 15 Months: Children who turned 15 months old in 2023
Rate 2: Well-Child Visits for Ages 15 Months to 30 Months: Children who turned 30 months old during 2023.
Other elements of denominator compliance are in accordance with HEDIS MY2023 Specifications.

Definition of numerator (describe):

Rate 1: Well-Child Visits in the First 15 Months: Six or more well-child visits on different dates of service on or before 15-month birthday.
Rate 2: Well-Child Visits for Age 15 Months to 30 Months: Two or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday.
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): 1/1/2023–12/31/2023

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

PM	Age: 0–15 Months	Age: 15 Months–30 Months		
Numerator	1,222	1,668		
Denominator	2,219	2,282		
Rate	55.07%	73.09%		

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

Controlling High Blood Pressure

1. Overview of PM
MCP name: HHO
PM name: PM 6: Controlling high blood pressure
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

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): HEDIS hybrid data MRR campaign
☒ Other (specify): Provider EMR data files and supplemental data sources (i.e., clinical quality feedback)

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

Sampling based on HEDIS MY2023 Specifications
☐ Not applicable (hybrid method not used)

Definition of denominator (describe):

Members 18 years–85 years of age who had a diagnosis of hypertension. Other elements of denominator compliance are in accordance with HEDIS MY2023 Specifications.

Definition of numerator (describe):

Members whose blood pressure was adequately controlled (<140/90 mm Hg) during the MY. 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): 1/1/2023–12/31/2023

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

PM	Controlled Blood Pressure			
Numerator	287			
Denominator	411			
Rate	69.83%			

3. PM Validation Status

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

The technical process begins with extracting data from the data warehouse's member and provider tables, followed by cleaning and transforming the data to ensure accuracy and consistency. Geocoding is then applied using Quest Analytics Software to convert addresses into geographic coordinates, facilitating distance and time calculations. This data is integrated into Quest Analytics Software, where algorithms process it to derive insights into time and distance metrics. The software's analysis and visualization tools are utilized to generate reports.

Provider and member address data are pulled, and Quest Analytics software geocodes those addresses with latitude and longitude. The Quest Suite calculates the drive time calculation by determining the starting point and ending point zip codes. Then, the Quest Suite determines if those points are urban, suburban, or rural zip codes. Based on the project preference settings, located in the File menu>Preferences, the miles per hour to those points is applied. The Quest Suite will apply an algorithm to determine the estimated driving distance, and then based on the miles per hour values and zip code classes the route passes through, determines the travel time. This is not a turn-by-turn analysis but an estimated analysis using geographic intelligence.

ACDE completes monthly access and availability calls. Calls are made to PCPs, pediatric PCPs, high-impact specialty practitioners, pediatric high-impact specialty providers, OB/GYNs, and BH practitioners. Fifteen surveys per provider type must be completed

monthly. If the survey identifies a practitioner who fails to adhere to State access standards, they are provided a copy of access standards and resurveyed in 60 days. If the provider continues to provide responses to the survey that do not adhere to State access standards, they will be placed on corrective action.

ACDE PNM monitors access and availability grievances. If issues are reported regarding appointment scheduling, provider education is offered. In addition, the provider will receive calls at random to monitor access and availability. Additionally, the PNM team works closely with member-facing teams. They engage ad hoc and through monthly meetings when there is it is learned that members are unable to obtain appointments

ACDE has secured a vendor to complete secret shopper calls. Secret shopper calls are on track to begin Q4 2024.

During the comprehensive compliance review in 2024, 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 moderate confidence.

- Time and Distance Standards: Low to Moderate Confidence (High Confidence noted for Pharmacy and Hospital/ED)
- Appointment Wait Time Standards: No to Low Confidence
- Panel Size Standard: Moderate Confidence
- LTSS PCA Standard: Low Confidence

The 2024 compliance review addressed network validation for the first time. ACDE made a decent effort to provide requested materials and address 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 also plans to implement MCO recommendations to update the RFI and align requests for data 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:** Provider counts inflated — providers counted as full FTE for each of their service locations resulting in one person being counted as multiple providers. Data collection is consistent but not accurate due to overcounting of providers. Provider audit/survey data is not reliable. Many providers were called multiple times, scripts do not align with data captured, and a small sample was audited. The indicator calculation is not listed; it should be a number, not "yes". Numerator does not appear to consider the audit information. Specialties, list of standards, and provider types noted in Geo-Access do not align with the MSA. Provider details should be confirmed more often. In addition, provider FTEs should be considered and allocated appropriately across provider addresses. Currently, providers are counted as a full FTE for each of their practice locations.
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 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 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	

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. Access and availability studies were conducted but not utilized to inform the indicator. No provider data provided to support numerator/denominator. Member engagement is required to assess this indicator. The aim is to determine whether members got an appointment within a certain timeframe. This can only be determined if the MCO is aware when the member called to schedule appointment and dates requested by the member.
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	
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	

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 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	No data provided. The standard is that a member experiencing a BH crisis is ensured immediate referral and warm transfer to crisis providers. ACDE should be, at minimum, tracking these referrals and be able to demonstrate that their network supports this standard.
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	Panel size information provided; noted 1,055 providers have panels under 2,500, with a total of 1,054 PCPs enrolled with ACDE. Number “typo” aside, it is highly unlikely that 100% of enrolled PCPs have open panels. Sampling a subset of members, ensuring geographic and provider diversity, may provide more accurate information on PCP panel size.
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	Data was not supported; ratios of provider to members did not demonstrate the availability of choice of provider. Unclear what FTE count was within the PCA count provided.

Recommendations to Improve Assessment of Network Adequacy	
Prior Recommendation Year:	**N/A**
Current Recommendation Year:	**2024**
EQRO Current Recommendations for ACDE Assessment of Network Adequacy:	• Increase access and availability studies, and address potential roadblocks in identification requirements (i.e., lack of Medicaid ID, etc.). • Provider FTE should be considered and allocated appropriately across provider address. • Align Geo-Access specialties, list of standards, and provider types with the MSA list of specialties. • Determine process to identify prenatal members in first trimester, second trimester, third trimester, and at high-risk. This data will be required in future years' assessments. • Determine process to identify the number of crisis providers enrolled with the MCO. This data will be required in future years' assessments. • Explore utilizing a sampling subset to calculate member wait time standards. Include the sampling frame in future submissions. • Explore utilizing a sampling subset to calculate PCP panel size. Include the sampling frame in future submissions. • Utilize member surveys/outreach to determine wait times. Access encounter data to determine appointment type and follow-up with members directly. • Engage care coordinators to inform high-risk access indicator. • Provider engagement staff should include panel inquiry in their annual visits; bi-annual audits should also be developed. Panel size should include a providers full panel, including members from other plans (Medicaid and Private).

DFH Network Adequacy Validation Overall Assessment

DFH has a clear process to collect and validate network adequacy monitoring data. Corporate runs monthly Network Adequacy reports for DFH. Provider data is stored in Portico, the corporate data management system, which feeds into the EDW, a database used to store historical data. MicroStrategy Reports is used to extract member and provider data from the EDW. That data is outputted to an Excel spreadsheet that feeds into Geo-Access reporting. Criteria is outlined to extract and prepare member data and provider data. Quest Analytics Software is used to calculate Geo-Access based on the time/distance, minimum provider, and

minimum ratio standards set by the State by using member, provider, and service area data. Although the process is clear, DFH has opportunities to improve provider data utilized for the assessment. Provider counts are inflated, as each provider location of service is counted as a whole provider, counting one person as five providers if they work in five locations.

DFH has some methods in place to assess the adequacy of its managed care networks: conducting appointment audits, member surveys, and audits of the provider directory. However, lack of coordination in the appointment audit process resulted in many duplicate calls to providers compromising data. In addition, audit detail did not demonstrate a targeted approach to assess all provider types.

Member surveys were minimal, but 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 access. Provider phone audits often require member detail (e.g., Medicaid ID, date of birth, etc.) making it difficult to conduct as secret shoppers.

DFH performs a quarterly audit of the provider directory by utilizing a data cleanse software, Veda, which validates whether a provider is seeing patients at a particular location. Veda pulls in many sources of data: CMS profiles, National Plan & Provider Enumeration System registrations, State License Boards, board certifications, Drug Enforcement Administration registrations, claims patterns, physician directories, geospatial, National Uniform Claim Committee, sanction records, and network files. When the model identifies that a practitioner is not found at a location, the Corporate Network Operations team hides that provider location so it does not appear in the print provider directory. DFH is then responsible for reviewing the data to identify any gaps and remediate to ensure accurate results to support State Network Adequacy monitoring efforts.

An ISCA review was conducted in 2024, 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. In review of information provided, there are opportunities to improve data so it more accurately portrays network access for Medicaid and CHIP beneficiaries across the continuum of services. Time and distance standards results are well supported through Geo-Access reporting, but require precise provider data. In contrast appointment standards, panel size standards, and LTSS PCA standards are not well supported through Geo-Access and require directed engagement of members and providers to verify access.

During the comprehensive compliance review in 2024, Mercer reviewed documentation and discussed further with MCO staff. DFH’s submission of materials was robust and resulted in a collaborative discussion to improve the process to validate the DFH network. DFH provided provider lists, provider directory audit, audit scripting directory, audit call lists, CAHPS surveys, HEDIS, and panel size determination. With consideration of the data available and provided, standards were assessed in four categories, receiving a validation rating of low to moderate confidence.

- Time and Distance Standards: Moderate Confidence (High Confidence noted for Pharmacy and Hospital/ED)
- Appointment Wait Time Standards: Low Confidence
- Panel Size Standard: Moderate Confidence
- LTSS PCA Standard: Low Confidence

The 2024 compliance review addressed Network Validation for the first time. DFH made a very strong effort to provide requested materials and address 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 also plans to implement MCO recommendations to update the RFI and align requests for data 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:** Provider counts inflated; providers counted as full FTE for each of their service locations resulting in one person being counted as multiple providers. Data collection is consistent but not accurate due to overcounting of providers. Provider audit/survey data is not reliable. Many providers were called multiple times, scripts do not align with data captured, and there was a very small sample audited.
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	Data is sufficient but flagged need for rules for members with PO box and other address information to verify time/distance is not relegated to zip code only. Need to assess how distance is calculated for members that do not have an exact address in analytic software. In case software approximates address versus utilizes exact address (i.e., zip distributed, zip centered, etc.). The indicator calculation does not appear to consider the audit information. Provider details should be confirmed more often. In addition, provider FTE should be considered and allocated appropriately across provider address. Currently, providers are counted as a full FTE for each of their practice locations.
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 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	
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	

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: 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:** There is not a reliable and accurate process to ensure the variable identifying prenatal members in their first, second, and third trimester, or at high-risk. Audits/surveys of providers were small and inconsistent. Results in surveys were not taken into consideration in the data. Access and availability studies were conducted but not utilized to inform the indicator. Member engagement is required to assess this indicator. The aim is to determine whether members got an appointment within a certain timeframe. This can only be determined if the MCO is aware of when the member called to schedule appointments and dates requested by the member. The numerator should grow from first to third trimester. Many people may not report a pregnancy early on, so it is understood there will a higher number of members captured in the third trimester numerator.
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	
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	

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 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	Audit information did not appear to inform indicator. The number of Crisis Providers enrolled with MCO is zero to two, too low to meet needs of members identified in data. Recommend process is developed to accurately capture number of crisis providers enrolled with MCO.
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	Data did not detail full panel size for each PCP, only assessing DFH members attributed to the PCP. Provider panel assessment is only assessed at time of provider enrollment. Sampling a subset of members, ensuring geographic and provider diversity, may provide more accurate information on PCP panel size.
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	Data did not support the indicator; it did not demonstrate accurate data collection supporting DSHP Plus LTSS members had a choice of two providers. The provider list did not identify individual providers, instead incorporating provider groups.

Recommendations to Improve Assessment of Network Adequacy	
Prior Recommendation Year:	**N/A**
Current Recommendation Year:	**2024**
EQRO Current Recommendations for DFH Assessment of Network Adequacy:	• Increase access and availability studies, address potential roadblocks in identification requirements (i.e., lack of Medicaid ID, etc.) • Provider FTEs should be considered and allocated appropriately across provider addresses. • Explore utilizing a sampling subset to calculate member wait time standards. Include the sampling frame in future submissions. • Explore utilizing a sampling subset to calculate PCP panel size. Include the sampling frame in future submissions. • Utilize member surveys/outreach to determine wait times. Access encounter data to determine appointment type and follow-up with members directly. • Engage care coordinators to inform high-risk access indicator. • Provider engagement staff should include panel inquiry in their annual visits; bi-annual audits should also be developed. Panel size should include a providers full panel, including members from other plans (Medicaid and Private).

HHO Network Adequacy Validation Overall Assessment

HHO utilizes three tools to determine adequacy standards: Corporate Provider Repository, End-to-End Database, and Quest Analytics. The network is evaluated in its entirety monthly, based on a point in time for all active members and providers.

Quest Analytics utilizes latitude and longitude coordinates assigned to all providers and members to assess driving time. Coordinates are used to determine the average estimated driving distance in miles from a member's location to the closest provider location. As appropriate, specialty time and distance standards are applied, and adequacy is assessed.

HHO has some methods in place to assess the adequacy of its managed care networks: conducting appointment audits, member surveys, and audits of the provider directory. However, lack of coordination in the appointment audit process resulted in many duplicate calls to providers which compromised data. In addition, audit detail did not demonstrate a targeted approach to assess all provider types.

Member surveys were not conducted but were recommended as an area for further exploration. Member surveys are encouraged, as they will provide HHO important information on appointment wait times and access. Provider phone audits often require member detail (e.g., Medicaid ID, date of birth, etc.) making it difficult to conduct as secret shoppers.

An ISCA review was conducted in 2024, prior to EQR; there are no concerns related to data sources that were used in the Network Adequacy validation.

HHO produced 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 standards, panel size standard, and a PCA choice standard. In review of information provided, there are opportunities to improve data so that it more accurately portrays network access for Medicaid and CHIP beneficiaries across the continuum of services. Time and distance standards results are well supported through Geo-Access reporting, but require precise provider data. In contrast, appointment standards, panel size standards, and LTSS PCA standards are not well supported through Geo-Access and require directed engagement of members and providers to verify access.

During the comprehensive compliance review in 2024, 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 surveys further with MCO staff. With consideration of the data available and provided, standards were assessed in four categories, receiving a validation rating of low to moderate confidence.

- Time and Distance Standards: Moderate Confidence (High Confidence noted for Pharmacy and Hospital/ED)
- Appointment Wait Time Standards: No to Low Confidence
- Panel Size Standard: Moderate Confidence
- LTSS PCA Standard: Low Confidence

The 2024 compliance review addressed Network Validation for the first time. HHO made a strong effort to provide requested materials and address 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 also plans to implement MCO recommendations to update the RFI and align requests for data 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:** Provider counts inflated: providers counted as full FTE for each of their service locations, resulting in one person being counted as multiple providers. Data collection is consistent but not accurate due to overcounting of providers. Provider audit/survey data is not reliable. Many providers were called multiple times, scripts do not align with data captured, and a very small sample was audited. The indicator calculation does not appear to consider the audit information. Provider details should be confirmed more often. In addition, provider FTEs should be considered and allocated appropriately across provider addresses. Currently, providers are counted as a full FTE for each of their practice locations.
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 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	

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:** No data was provided identifying prenatal members in first, second, third trimester, or at high-risk. Audits/surveys of providers were small and inconsistent. Results in surveys were not taken into consideration in the data. Access and availability studies were conducted but not utilized to inform the indicator. Member engagement is required to assess this indicator. The aim is to determine whether members got an appointment within a certain timeframe. This can only be determined if the MCO is aware when the member called to schedule appointment and dates requested by the member.
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	
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	

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 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	Information provided in the table was not supported by data. An indicator was not input. The numerator and denominator would demonstrate a very low indicator, the data input may not be accurate. Crisis provider numbers are missing or very low.
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	It is not clear whether data provided represents an assessment of all PCP panels. As provided, 355 providers have panel sizes under 2,500. Sampling a subset of members, ensuring geographic and provider diversity, may provide more accurate information on PCP panel size.
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	Data was not supported; ratios of provider to members did not demonstrate the availability of choice of provider.

Recommendations to Improve Assessment of Network Adequacy	
Prior Recommendation Year:	**N/A**
Current Recommendation Year:	**2024**
EQRO Current Recommendations for HHO Assessment of Network Adequacy:	• Increase access and availability studies, address potential roadblocks in identification requirements (i.e., lack of Medicaid ID, etc.). • Provider FTEs should be considered and allocated appropriately across provider address. • Determine process to identify prenatal members in first trimester, second trimester, third trimester, and at high-risk. This data will be required in future year's assessments. • Determine the process to identify the number of crisis providers enrolled with the MCO. This data will be required in future year's assessments. • Explore utilizing a sampling subset to calculate member wait time standards. Include the sampling frame in future submissions. • Explore utilizing a sampling subset to calculate PCP panel size. Include the sampling frame in future submissions. • Utilize member surveys/outreach to determine wait times. Access encounter data to determine appointment type and follow-up with members directly. • Engage care coordinators to inform the high-risk access indicator. • Provider engagement staff should include panel inquiry in their annual visits, bi-annual audits should also be developed. Panel size should include a provider's full panel, including members from other plans (Medicaid and Private). • Ensure Geo-Access specialists align with required specialists per the MSA.

Section 7

Information Systems Capabilities Assessment

At the request of the DMMA, Mercer conducted the EQR ISCA comprehensive review of ACDE, DFH, and HHO for the time period of January 2023 through December 2023. 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 via video conference on April 25, 2024 through April 26, 2024 for ACDE, April 9, 2024 through April 10, 2024 for DFH, and April 22, 2024 through April 23, 2024 for HHO, and focused on the core information systems listed below:

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

ACDE Overall Assessment

Based upon the ISCA review, ACDE continues to demonstrate effective partnership and collaboration between the local MCO and the enterprise ACFC teams, operations, and systems and, as such, continues to perform well in supporting the systems-related requirements of Delaware's managed Medicaid program. The insights gained from ACDE's comprehensive ISCA desk review and virtual 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.

ACDE's Business Continuity and Disaster Recovery (BCDR) plan was tested in April 2023. Reports indicate all applications and services included in the scope of the exercises were failed over and validated well within the expected timeframe. ACDE had policies to restrict and monitor access to the premises and information stored in their systems to ensure that only authorized personnel can access. ACDE grants access based on resource evaluation, position requirements, and roles based on the principle of strict need to know basis and least privilege.

ACDE employed Facets' built in editing tools as well as Strategic National Implementation Process (SNIP) level 4, Optum claims edit system, Optum clinical editing, and Cotiviti prepayment edits. Staff described the processes for auditing both paid and denied claims processed manually and auto adjudicated. ACDE demonstrated increased oversight of its subcontractors' performance through increased auditing.

ACDE attested to compliance with and provided additional details on processing daily eligibility files within 24-hours of receipt, and reconciling the file with the member data in their systems, as well as submitting the files to their vendors and verifying timely vendor processing of the daily files. ACDE continues to work closely with DMMA and Gainwell to ensure all providers are appropriately registered in Delaware Medicaid Enterprise System (DMES).

ACDE's RFI response was comprehensive and appropriate persons were available during the virtual interviews to address follow-up questions. Staff members responded to questions with little hesitation and ample detail which demonstrated strong and thorough knowledge of processes and procedures. Presentations prepared by ACDE staff members facilitated discussions and provided valuable insight into processes. Diagrams clearly illustrated processes and data flows. ACDE continued to exhibit strong process orientation and mature systems capabilities, along with a deep understanding of DMMA requirements.

ACDE Strengths

Based on the documentation submitted and the hybrid on-site review, Mercer identified the following strengths in ACDE systems, operations, and leadership capabilities:

- ACDE's systems are strategically designed to ensure seamless operations including provider data management, management of claims, and encounter systems and data.
- ACDE demonstrated strong data security systems, standards, personnel, and policies, and continues to strengthen its data governance program.
- ACDE increased oversight of its subcontractors by implementing claims audits; results are shared with the subcontractor and CAPs are implemented when warranted.

ACDE Opportunities

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

- ACDE has mature processes for data management and governance as well as IT systems operations. However, the architecture and data governance diagrams shared by ACDE did not accurately reflect the systems used. ACDE should ensure that all architecture diagrams are correct and reflect accurate information.
- ACDE has P&Ps in place for claims processing and any necessary overrides. Nevertheless, there are no processes or reports existing to discover inappropriate overrides; solely relying on random audit is not an adequate guarantee for appropriate monitoring of overrides. ACDE should develop processes to ensure the appropriateness of the use of overrides.
- ACDE's dental vendor, SKYGEN USA, LLC, appeared to have inappropriately paid a claim that required a PA and then denied a second claim for no PA, when it appeared that one was on file. ACDE should work with vendors to ensure that systems are appropriately configured for PAs.
- Similarly to prior years, the subcontractors' claim files submitted for the ISCA review had incorrect indicators or data elements. ACDE must implement a robust process to review subcontractor data to confirm data accuracy, quality, and timeliness.

DFH Overall Assessment

DFH's comprehensive ISCA desk review and discussions confirmed systems are in 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. DFH complies with all applicable provisions of HIPAA, including EDI standards for code sets. DFH is structured in a manner such that many major processes such as system configuration and management, claims processing, encounter processing, vendor oversight, and report development are implemented by enterprise level staff members with local staff providing oversight and validation. Although local staff members continue to rely heavily on enterprise resources for assistance with answering questions about routine processes, there is strong evidence of streamline coordination and collaboration between the local health plan and the enterprise Centene teams, operations, and systems.

DFH had a BCDR plan in place with written P&Ps, containing information on system backup and recovery in the event of a disaster. Staff described testing its business continuity plan using tabletop exercises, while disaster recovery testing includes tabletop, simulations, parallel, and interruption testing. DFH had policies to restrict and monitor access to the premises and information stored in their systems to ensure that only authorized personnel can access. DFH grants access based on resource evaluation, position requirements and roles based on the principle of strict need to know and least privilege.

Claims editing is a phase in the claims payment cycle to validate that physician or institution submitted bills are coded appropriately. These edits can be applied at pre-adjudication and post-adjudication levels. DFH applies required Medicaid National Correct Coding Initiative (NCCI)-based edits to prevent improper payment by use of incorrect code combinations, as well as edits to prevent improper payments when services are reported with incorrect units of service.

DFH attested to compliance and provided additional details on processing daily eligibility files within 24-hours of receipt, reconciling the file with the member data in their systems, as well as submitting the files to their vendors and verifying timely vendor processing of the daily files. DFH continues to work closely with DMMA and Gainwell to ensure all providers are appropriately registered in DMES.

DFH staff clearly described processes and had P&Ps in place for creating encounter submissions and for monitoring and resolving all errors. DFH encounters team worked closely with the claims teams to resolve issues and validate submissions.

DFH Strengths

Based on the documentation submitted and the virtual on-site review, Mercer identified the following strengths in DFH systems, operations, and leadership capabilities:

- DFH's systems comply with National Institute of Standards and Technology (NIST) 800-53 R4, Minimal Acceptable Risk Standards for Exchanges (MARS-E) 2.0, and System and Organizational Control (SOC) 2 Type II. DFH maintains a Delaware-specific BCDR plan that is updated and tested at least annually.
- DFH continues to grow its data governance program by developing data dictionaries to identify document location, source, system of record, and documenting the ways data are used to help identify whether a system change could have adverse impacts. DFH has four councils established and anticipated adding a claims council in late 2024. This progress demonstrates DFH's commitment to data quality necessary for reporting, Quality Improvement Initiatives (QIIs), and accurate and timely encounter submissions.

DFH Opportunities

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

- Although DFH has policies for collection and use of TP)/COB data, staff acknowledged that DFH has no effective way to collect, store, and share available COB data with subcontractors. DFH did not use COB consistently to ensure that Medicaid is the payer of last resort. DFH should:
  - Develop a mechanism to collect (through various methods), store, and share the TPL/COB information with subcontractors consistently and correctly.

  - Design DFH processes, training, resources, and system configuration changes needed to ensure that claims received with the COB are processed and paid accurately.
  - Develop report (or ad hoc query) to identify any other instances when COB was not applied correctly and paid as primary.
  - Implement pre-check run reviews and automation opportunities to identify COB claims payments.
- Not all DFH vendors are familiar with the contractual standards (e.g., percentage of required claims for audit). DFH should develop vendor specific dashboards with required contractual standards; train vendors on the standards; and monitor compliance with the standards.
- DFH's contract with DMMA requires that data and reports submitted are of high quality. Dental files submitted for ISCA had not been carefully reviewed before the submission and included incorrect data that limited the planned review. DFH should implement a process to review subcontractor data to confirm data accuracy, quality, and timeliness.
- DFH's website is not fully 508 compliant. DFH should update the website to comply with accessibility standards in Section 508 of the Rehabilitation Act.
- Although, DFH reported compliance with the Application Programming Interface (API) requirements, DFH also identified known gaps with API that included formulary data and provider organization affiliations. DFH should remediate this deficiency to ensure compliance with the federal interoperability rules.
- It is imperative that all claims should be processed and paid based on the CMS regulations including procedure code/diagnosis combination that is acceptable under CMS guidance. DFH should review system configurations to ensure that valid procedure/diagnosis combinations are paid appropriately.

HHO Overall Assessment

HHO's comprehensive ISCA desk review and discussions confirmed systems in 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. HHO complied with all applicable provisions of HIPAA, including EDI standards for code sets.

HHO attested to compliance with MARS-E 2.0, Health Information Trust Alliance (HITRUST), and SOC 2 Type II. Additionally, HHO implemented HITRUST Common Security Framework (CSF) as basis for the information security program and the IT Operational standards. HHO staff reported having passed testing of its BCDR plan in June 2023.

HHO implemented the Healthtrio Authorized Representative Inbound Single Sign-On (SSO) Member Portal on July 14, 2023. Additionally, HHO upgraded the Guiding Care platform on July 31, 2023, providing enhanced features related to authorization portal, PA list, population health, health model, and LTSS.

HHO demonstrated their continued efforts to improve their claims processing operations and submission of encounter data to effectively support Delaware's Medicaid managed care program. At the same time, HHO has made substantial progress in claims remediation and audit activities. HHO showed improvement in procedures for coordinating benefits with third parties.

HHO made notable progress in their vendor oversight capabilities including enhanced processes, value-added dashboards, and collaborative meetings. As implied through their well-organized and thoughtful RFI response, HHO continued to exhibit strong process orientation, comprehensive understanding of DMMA requirements, and well-organized internal partnership.

HHO Strengths

Based on the documentation submitted and the hybrid on-site review, Mercer identified the following strengths in HHO systems, operations, and leadership capabilities:

- HHO's leadership commitment to the *"member first"* approach is evident in the continuous improvements to the organization's systems, policies, and people to strengthen member experience and health quality.
- HHO continues to enhance its oversight of subcontractor processes including audit. HHO requires that its subcontractors audit a minimum of 4% of claims, and HHO is actively involved in the audit review process of the subcontractors' performed audits. HHO's vision subcontractor reported auditing 100% of all claims that require COB.
- HHO's use of the analytics approach allows the organization to monitor any undesirable claims or encounters trends and adjust processes or correct data if necessary.

HHO Opportunities

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

- Although HHO attested to having a BCDR; no plan with projected recovery times and data loss for mission-critical systems in the event of a declared disaster or public health emergency was submitted. HHO leadership should have easy access to the plan and all involved individuals should be trained and ready to assists, if necessary.
- Sporadically, COB claims continue to be paid incorrectly despite the ongoing effort by HHO. HHO should perform a root cause analysis to determine why COB/TPL information is not captured correctly and quantify the volume of claims paid as primary due to

processor errors. HHO must also update processes, provide training, and enhance audit processes to ensure COB claims are paid appropriately and Medicaid is the payer of the last resort.

- Each claim submitted by the provider reflects the services provided, diagnoses, dates, amounts billed, etc. If the claim submitted by a provider is incorrect and it does not pass the logical validation, no payer should make any changes to the claims but rather deny it and require providers to submit correct claims. HHO should ensure that its vendors do not make any changes to the claims but rather deny the claims and require resubmission.
- HHO implemented robust change control processes in its organization; HHO should also develop or enhance processes to fully participate in subcontractor's decision on any system changes related to the claims or processing platform and act as active stakeholder in that process if the change can affect claims or encounter data for the services delivered under the Delaware contract.
- HHO did not meet the State Encounter Data timeliness requirement of 100% of encounter data within 60 days of adjudication. HHO must implement processes and procedures to ensure 100% of encounters are submitted within 60 days of adjudication.
- HHO explained that the website is reviewed twice a year to confirm 508 compliance; however, the WAVE® web accessibility evaluation tool found 37 errors (e.g., missing alternative text and form label), 17 contrast errors, and 90 alerts. HHO must review its website and update deficiencies to ensure full 508 compliance.
- HHO offers members access to their data using the member portal; however, laboratory and imaging results are not available on the member portal. The contract requires that the member portal includes the data specified in 42 CFR 438.242 and 42 CFR 431.60. HHO must develop interfaces, APIs, or processes to ensure members have access to their health information including laboratory and imaging results via the member portal.

Section 8
Encounter Data Validation

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 to conduct a review of DMMA's Medicaid encounters. Mercer worked with DMMA staff to conduct the review of encounter data activities for calendar year (CY) 2022.

Results

The objective for each activity is summarized below, alongside corresponding summary results.

Activity 1: Review DMMA Data Requirements

In the State Toolkit for Validating Medicaid Managed Care Encounter Data[9] (EDV Toolkit), CMS describes the following foundational activities states should undertake to ensure high-quality data:

- Encounter Data Management Staff
- Contractual Requirements
- Encounter Submission Standards and Guidance
- Financial Incentives and Penalties
- Validation and Feedback to MCOs

Mercer evaluated DMMA's capabilities across these five foundational activities to determine whether DMMA provides sufficient support to ensure accurate, complete, and timely encounter data. The following summarizes the overall results of our Activity 1 assessment.

[9] State Toolkit for Validating Medicaid Managed Care Encounter Data. August 2019. Available at: State Toolkit for Validating Medicaid Managed Care Encounter Data.

DMMA's MSA with the MCOs includes required submission standards, timing, attestations, and guidance resources; however, DMMA could strengthen its contract by adding detailed information about how DMMA assesses completeness, accuracy, and consistency of encounter data. DMMA should also consider specifying that a less than 5% error rate is required for all encounter submissions.

Activity 2: Review MCO Data Capability

As the EQRO for Delaware, Mercer conducts annual ISCAs of the MCOs and has a sound understanding of each MCO's processes. As such, Activity 2: Review the MCOs' capabilities, was not included in the scope of this review.

Activity 3: Analyze Electronic Encounter Data

A major component of Activity 3 involves comparing the claims and encounter data extracts submitted to Mercer by the MCOs (MCO claims) and to DMES. Consistent with other review activities, Mercer used the CMS EDV protocol as the framework to complete the data analytics.

Mercer analyzed the 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, and pharmacy claims.

Analytics performed during this activity were organized into three categories based on recommendations included in the CMS EDV protocol. These included the following.

- Data Integrity
- Data Completeness
- Data Accuracy

Based on the validation performed during the data integrity analysis, Mercer determined that ACDE and HHO presented acceptable levels of population and validity with many critical fields being populated at 100% with valid values based on the healthcare standards. In the second step of the analytical review in which Mercer matches the MCO claims to submitted encounters, Mercer identified unexpected variances for the Pharmacy record type, showing a high-level of records missing or surpluses. In the last step, Mercer determined that based on the data submitted, data accuracy analytics may not adequately reflect actual accuracy. Mercer recommends additional research to determine the sources of discrepancy. The initial findings indicate that claim line numbers in the claim systems do not necessarily correspond to the claim line numbers submitted on the claim by the provider or later submitted as encounter data.

Activity 4: Medical Record Review

Activity 4 was not included in the scope of this review. The CMS EDV protocol defers to the State to determine when a MRR is appropriate. Based on the results of Activity 3, DMMA may choose to conduct MRRs to further research root causes of identified issues or to further confirm initial findings.

Activity 5: Submit Findings

This report fulfills the requirement for Activity 5.

Key Recommendations

Based on the validation results described above, Mercer provides the following key recommendations for DMMA to consider.

- Mercer recommends that DMMA expand its staff resources to include at least one person dedicated to encounter data quality and analysis. This person or unit should monitor MCO encounter submissions to verify compliance with contractual requirements and, if warranted, provide feedback and documentation to DMMA leadership to enforce financial penalties.
- Mercer recommends DMMA strengthen its MSA language by adding detailed information regarding how DMMA assesses completeness, accuracy, and consistency of encounter data and by requiring a less than 5% error rate for all encounter submissions.
- Mercer recommends DMMA perform research and investigation to identify the root cause of the Pharmacy record surplus and missing data to determine if it is an error in processing and submission or a data extract issue. Additionally, Mercer advises further assessment of claim lines mismatches between claim data and encounter data to determine if it is a claims processing concern or a data extract issue.

Overall Impressions

Mercer's qualitative and quantitative findings from the MCOs' encounter data validation 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 the encounter and claims data provided for this validation were variable and, in some cases, inconclusive. Although some assessment areas, such as Population Integrity and Reasonableness Integrity, showed strong results, there are several areas in which Mercer recommends DMMA conduct additional investigation to determine whether the results of this analysis are driven by issues associated with the data provided or are representative of larger systemic issues.

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 2023–2024 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 broad domains comprising approximately 80 core indicators. Indicators are the standard measures used across states to assess the outcomes 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 2024 and included for analysis was 1,037 (Total N=1,037).

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 two MCOs: ACDE 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 two-day in-person training with these interviewers on February 6–7, 2024. 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 three additional State-specific questions to the standard NCI-AD survey. Interviews began on February 12, 2024, and Vital Research sent the final data from the interviews to HSRI on June 28, 2024.

Survey Findings

At the time of this report, HSRI has not released findings from the 2023–2024 survey cycle.

Section 10

Network Adequacy Focus Study

DMMA seeks to understand the Delaware Medicaid provider network in order to assess adequacy to provide Medicaid members equitable access to high quality healthcare services. With clearer understanding, DMMA's objective is to enhance strategies, policies, and oversight of MCO Network Adequacy standards to support equitable access to services based on current MCO, industry best practices, and emerging practices. DMMA engaged Mercer to conduct an analysis of access to care for Delaware Medicaid managed care members, research network adequacy best practices nationally, and provide options to improve access to medically necessary services for Delaware Medicaid managed care members. Mercer designed the project to meet three measures of success:

- DMMA will be aware of current Marketplace standards and other State Medicaid agencies' network standards.
- DMMA will have a clear understanding of the Delaware Medicaid managed care Network Adequacy standards, quality, and application.
- DMMA will have a clear understanding of current network development and management strategies of their contracted Medicaid MCOs.

Over approximately four months, Mercer examined national Medicaid and non-Medicaid networks, identified best practices (Medicaid and non-Medicaid), examined the Delaware Medicaid MCO network, and conducted stakeholder interviews. Key takeaways and points of consideration were documented following each task and presented to DMMA for review and feedback. The following summarizes the research, highlights key findings, and outlines possible actions DMMA may want to explore further.

Findings and Recommendations

Delaware current practice meets federal rules; Delaware has established Network Adequacy standards for specific providers, developed time and distance standards, considered the diverse needs of its population in developing those standards, has network standards posted online and, in the QS, monitors the MCOs for compliance, conducts an annual EQR, and has the option to impose penalties for non-compliance. Although minimum standards are met, DMMA wants to improve access to medically necessary services for their Medicaid beneficiaries. In particular, DMMA wants to develop strategies and policies, and to improve reporting and oversight of MCO Network Adequacy standards to support equitable access to services based on current MCO, industry best, and emerging practices. With consideration for current practice and in response to feedback provided by DMMA, listed below are possible actions DMMA may select to improve network adequacy for Delaware Medicaid members. As network adequacy challenges and opportunities may be impacted by State agencies, State legislation, federal legislation, and MCO contracts roles are referenced for

each action to assist in next steps. Additionally, proposed changes to current requirements and proposed new requirements, as outlined in the April 2023 CMS proposed rule, Ensuring access to Medicaid services (Access Notice of Proposed Rulemaking [NPRM]), are included in the themes below, where appropriate.[10]

Quantitative Standards

DMMA

- Define which providers qualify to be counted in quantitative standard (e.g., full-time providers only).
- Utilize QS to encourage quick adoption of initiatives to monitor, assess, and improve access to care, QOC, and member satisfaction.
- Encourage participation in group prenatal care as a means to meet OB/GYN member-provider ratios.
- Define metrics to measure adherence to Network Adequacy standards (i.e., proportion of beneficiaries who have a PCP accepting new Medicaid patients within 30 minutes or 30 miles of their residence, proportion of all licensed and practicing providers in statewide network).

MCO

- Align provider network with claims data. This would remove providers who do not have any Medicaid members claims from time and distance calculations.
- Support development of group prenatal care. Develop incentive payments to support group prenatal care.

Access NPRM Proposed Rule

- Establish national maximum appointment wait time standards for routine primary care, including pediatric primary care, OB/GYN services, OP mental health and SUD — adult and pediatric, and a State-selected service.

[10] CMS "Summary of CMS's Access-Related Notices of Proposed Rulemaking" April 2023. Available at: https://www.cms.gov/newsroom/fact-sheets/summary-cmss-access-related-notices-proposed-rulemaking-ensuring-access-medicaid-services-cms-2442-p

Tools and Data Resources

DMMA

- Develop standardized geo-spatial monitoring and reporting specifications that overlay provider and member demographic data.

MCOs

- Enhance provider network development plan using predictive analytics to forecast population needs and availability of providers.

Evaluation Processes and Monitoring

Delaware

- Develop centralized provider enrollment and provider network process. Providers would provide updated information to one entity. Information could then be shared with Marketplace, Medicaid, and more, as appropriate. This would minimize provider administrative burden and improve directory data.
  - California is currently developing a centralized platform for provider data management.[11]
  - Illinois developed a provider directory to assist medical providers in verifying an actively enrolled ordering/referring/prescribing Medicaid provider.[12]

DMMA

- Assess time and distance ratios across the three plans. Many providers are enrolled with all three plans, possibly distorting provider ratios.

MCO

- Evaluate utilization data to determine actual use of care.

[11] Integrated Healthcare Association "California's centralized platform for provider data management'. Available at: https://www.iha.org/provider-directory-management/symphony-provider-directory/#:~:text=California's%20centralized%20platform%20for%20provider,services%2C%20products%2C%20and%20networks.

[12] Illinois Department of Healthcare and Family Services "Provider Directory". Available at: https://ext2.hfs.illinois.gov/hfsindprovdirectory/

- Monitor average wait time for member appointments.
- Assess proportion of providers accepting new patients.

DMMA/MCO

- Enhance Medical Care Advisory Council input on access. Encourage MCO accountability for engagement/outcomes of MAC meetings.
- Develop the Community Stakeholder Advisory Council to help monitor for member provider access issues. Develop internal processes to document stakeholder feedback on access, ensure feedback is routed to appropriate teams, and document actions taken to address access issues raised.

Access NPRM Proposed Rule

- Require states to use an independent entity to conduct annual secret shopper surveys to validate managed care plan compliance with the appointment wait time standards and provider directory accuracy to help identify errors, as well as network providers that do not offer appointments.
- Require states to conduct an annual enrollee experience survey for each Medicaid managed care plan and post the results on states' websites and report to CMS as part of an existing reporting vehicle.
- Rename and expand the scope and use of states' Medical Care Advisory committees. The renamed Medicaid Advisory committees would advise states on a range of issues, including on medical and non-medical services.
- Require states to establish a Beneficiary Advisory group with crossover membership with the Medicaid Advisory committee.
- Establish minimum requirements for Medicaid beneficiary representation on the Medicaid Advisory committee, membership, meeting materials, and meeting attendance.
- Promote transparency and accountability between the State and its stakeholders by making information on the Medicaid Advisory committee and Beneficiary Advisory group activities publicly available.

Reporting and Enforcement

MCO

- Provide second set of network details for only those providers with agreed upon number of Medicaid claims.

- Include data on providers with lower/higher provider to member ratios.

DMMA

- Determine minimum claim requirement for second set of network details.

Access NPRM Proposed Rule

- Require states to report on waiting lists in section 1915(c) waiver programs; service delivery timeliness for personal care, homemaker and home health aide services; and a standardized set of HCBS quality measures.

Telehealth

DMMA

- Conduct a focus study to determine where, when, and how the Medicaid population uses or could use telehealth services to improve access. Consider potential impacts on health equity, access to care, and QOC.
- Develop telehealth quality policy to ensure member maintains choice in how they receive services.

MCOs

- Monitor whether telehealth services are being utilized appropriately and do not compromise the members' ability to receive quality care.

Health Equity and Cultural Competency

DMMA

- Clearly define what cultural competency means in Delaware and develop a statewide/all payer cultural competency definition.
- Outline how health equity data can be used to inform and develop Network Adequacy standards.
- Include health literacy in Cultural Competency and Health Equity plan.
- Expand peer support specialist/peer wellness specialist benefits.

- Add CHW benefits. CHWs are frontline workers who are meant to come from and represent the communities they service, including cultural background and language.

MCOs

- Develop the Stakeholder council to engage with community leaders/organizations to identify health equity and cultural competency access considerations by population.

Other Network Solutions

- Incentivize directory accuracy.
- Expand non-emergency medical transportation (NEMT) access to cover children accompanying an adult.
- Consider reporting network adequacy by provider race, ethnicity, language, and sexual orientation/gender.

Section 11

Managed Care Integration of Pediatric Dental Benefit Readiness Review

In December 2024, DMMA requested that Mercer complete a readiness review of each MCO for the delivery of pediatric dental benefits prior to the go-live date of January 1, 2025. DMMA asked that the EQRO gather information and facilitate interviews with MCO leadership, supervisory, and management staff engaged in delivering dental benefits and/or overseeing a DBM, as well as evaluate information systems readiness.

The readiness review process began on November 11, 2024, when Mercer delivered the RFI focusing on the key areas for the readiness review to all three MCOs. Mercer used a 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 November 25, 2024.

Mercer reviewed all MCO-submitted documents prior to the virtual on-site review. The information was organized on the SharePoint site into folders and subfolders, coordinating with the RFI. The results of the desk review assisted Mercer in structuring the virtual on-site agenda and focusing interviews on areas in which additional information was still necessary to make a conclusive determination of readiness. During the virtual on-site review phase, additional information was collected, and a small number of outstanding information needs remained. At the close of the virtual on-site review process, the outstanding information needs were summarized and submitted to Mercer for further review and consideration following the virtual on-site visit.

The virtual on-site review took place over a one-day period for each MCO, utilizing web-based video and telephonic technology to connect Mercer, DMMA, MCO, and DBM participants. ACDE's virtual on-site review was held on December 9, 2024; DFH's virtual on-site review was held on December 10, 2024; and HHO's virtual on-site review was held on December 12, 2024. The virtual on-site review began with an introductory session and then moved into specific readiness review topic areas for discussion.

Mercer completed an analysis of the information and supporting documentation submitted by the MCOs and the DBMs following the virtual on-site review. The analysis focused on key operating categories consistent with federal and State rules, regulations, and requirements. The results of the virtual on-site review and the review of supporting documentation have been summarized into strengths and opportunities in readiness for implementing the pediatric dental benefit on January 1, 2025.

The content of the EQR included the assessment of readiness in the following key areas:

- Administration and organization
- Network development and management
- Clinical quality
- Information systems and data

The purpose of this independent review was to:

- Evaluate implementation progress, as well as compliance with all federal regulations pertaining to managed care program readiness and State-defined standards.
- Assess the ability of the MCOs to achieve quality outcomes and timely access to dental care services for pediatric members enrolled in the MCOs and covered under its contract with DMMA.
- Review the appropriateness of the MCOs internal P&Ps and processes.
- Provide technical assistance specific to the integration of dental care services into the managed care program.

To complete this review, Mercer applied standards from the Final Rule, MCO internal P&Ps, and State-defined standards communicated to the MCO through its managed care contract.

ACDE Strengths

- Prior Medicaid dental benefit experience and utilization of the DBM currently responsible for adult dental services, with pediatric dental experience in other states.
- Cross-functional implementation team.
- Key personnel include a Dental Services Liaison position.

ACDE Opportunities

- Incorporation of additional targeted knowledge assessment items.
- Call center report monitoring to inform ongoing training.

- Identification and revision of ACDE and DBM P&Ps, for which edits and/or addendums are needed to reflect compliance with the MSA requirements.

DFH Strengths

- Prior Medicaid dental benefit experience and utilization of the DBM currently responsible for adult dental services.
- The DBM has a Case Management team to assist members with placement for their dental needs.
- Cross-functional oversight team, frequency of meeting cadence (daily post-implementation reports/team meetings for initial 30–45 days), and defined oversight milestones.
- EPSDT knowledge framework documented in P&Ps, workflow, and training.

DFH Opportunities

- Continued monitoring and reporting of call lines and complaints to inform training, in addition to timely response to issues.
- Identification and revision of DFH and the DBM P&Ps, for which edits and/or addendums are needed to reflect compliance with the MSA requirements.

HHO Strengths

- Prior Medicaid dental benefit experience and utilization of the DBM currently responsible for adult dental services.
- Dental subcontractor oversight as detailed in the VMO policy.
- The planned scorecard and performance dashboard metrics are supported by a multi-level oversight approach.

HHO Opportunities

- Identification and revision of HHO and the DBM P&Ps for which edits and/or addendums are needed to reflect compliance with the MSA requirements.
- Validation of the general, pediatric, and specialty provider network that will serve pediatric members, including, updates to the provider directory to clearly note the age range accepted by the dental provider.

- Enhance the dental provider training plan to ensure it is Delaware-specific and addresses PA, process for accessing extended benefits, member eligibility, benefit limits, appointment standards, and claims submission as outlined in the MSA.

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