Mercer

Delaware External Quality Review

2020 Summary Report

Delaware Division of Medicaid & Medical Assistance
April 23, 2021

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Contents

1 Introduction

The State of Delaware (Delaware or State) Division of Medicaid & Medical Assistance (DMMA), within the Department of Health and Social Services (DHSS), has provided health care services to its Medicaid population, including individuals with disabilities, through the Diamond State Health Plan (DSHP) and the Delaware Healthy Children's Program, 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 and Medicaid Services (CMS), sister agencies, such as the Division of Services for Aging and Adults with Physical Disabilities, providers, such as nursing facilities and Home- and Community-Based Services (HCBS) providers, and community stakeholders, including nursing facilities, patient advocates, members and others, amended their Section 1115 waiver to include a Managed Long-Term Services and Support (MLTSS) program. The program serves individuals eligible for MLTSS (institutional and HCBS) and individuals living in the community who are dually eligible for Medicaid and Medicare; this program is referred to as DSHP Plus. DSHP Plus does not include individuals with developmental disabilities receiving institutional or community-based Long-Term Services and Supports (LTSS).

On January 1, 2015, the DSHP Plus Medicaid Managed Long-Term Care program was launched. In 2015, the DSHP program continued to evolve and, in addition to integration of acute and LTSS services, the pharmacy benefit was "carved in" and DMMA integrated a new MCO, Highmark Health Options (HHO), into the Delaware market. In response to these changes, DMMA, with CMS approval, took an innovative approach to its quality review activities in 2015 including 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 topics, continued activities supporting compliance with the HCBS final rule, and an analysis of each MCOs compliance with existing network adequacy standards.

In 2016, DMMA focused on the three mandatory External Quality Review (EQR) activities and expanded the scope of work to include optional activities including assessment of network adequacy, technical assistance in selecting a standardized MLTSS comprehensive assessment tool, continued support for ensuring compliance with the HCBS settings requirements in the Medicaid Managed Care Final Rule, and technical assistance to enhance the capacity of the State's Quality Care Management and Measurement Report (QCMMR). Follow-up on MCO progress toward full compliance with the Balanced Budget Act Compliance and Information Systems Capabilities Assessment (ISCA) was also evaluated.

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

In 2018, Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, the State's External Quality Review Organization (EQRO), conducted a post-implementation assessment of ACDE. The purpose of this review was to ensure that ACDE was stabilizing operations, moving toward full compliance with contract expectations, and would be on sound footing for a comprehensive compliance review in 2019. Mercer also conducted a corrective action plan (CAP) review of HHO in 2018. During 2019, Mercer completed a comprehensive compliance review of ACDE and HHO that encompassed the three mandatory activities, compliance review, validation of Performance Measures (PMs), and validation of Performance Improvement Projects (PIPs) for both MCOs; Mercer also completed a comprehensive ISCA.

In 2020, Mercer completed a corrective action plan (CAP) review of ACDE and HHO that encompassed the three mandatory activities, CAP items review, validation of PMs, and validation of PIPs for both MCOs; Mercer also completed a CAP ISCA. In addition to completion of mandatory activities, the EQRO conducted the following activities, detailed throughout the report:

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

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External Quality Review

EQR Objectives

Mercer's objective for the 2020 EQR was to assess Delaware MCO performance toward achieving the Delaware Quality Strategy goals, which are:

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

To achieve this objective, Mercer performed the mandatory EQR activities for year two of the annual compliance cycle and this report presents the results as required by 42 CFR 438.364. The objectives of this review included:

- Assessing implementation of CAP activities by the MCOs for those items that scored less than "Met" in 2019.
- Assessing the quality of services provided, the timeliness of services provided, and access to care and recommendations to the MCOs and DMMA for continued improvement.
- Comparison of MCO PM results with national benchmarks.
- Evaluation of PIPs.

Technical Methods for Data Collection and Analysis

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

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

Request for Information

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

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

File Review Protocol

Similar to the RFI, Mercer developed a file request Excel template containing the specific date range and data fields required for each of the file review areas. Additionally, Mercer provided the detail file formats and content expected for each file review type. These templates were shared with ACDE via the SharePoint site.

In selecting the files to be evaluated, Mercer utilized the National Committee for Quality Assurance's (NCQA's) "8/30" rule for evaluation of health care organization file reviews. The rule states that of a sample of 30 files, if the initial eight pass the review, the entire sample of 30 can be cleared. The additional 22 files are reviewed if and only if issues are discovered in the first eight. The NCQA has evaluated this method to be "a cost effective and statistically appropriate method of gathering data about the overall performance" of a health care organization. After discussion with DMMA for the purpose of all file reviews, Mercer employed a variant of the "8/30" rule, and chose to review 10 files selected from a sample of 30. For file reviews in which there was not enough volume to reach the 10 or 30 file denominator, Mercer reviewed all files for that category.

After receiving the universe file listing for the specified time period, Mercer selected a targeted random sample of files for review. The final file selection was distributed to the MCO via the SharePoint site, and the MCO was provided three weeks to upload the file contents to the SharePoint site. Mercer reviewed the files and posted the preliminary file findings prior to the virtual onsite review to allow the MCO an opportunity to collect additional information to address file findings. Outstanding file findings were discussed during the virtual onsite review, additional supporting documentation was requested and provided as available.

For scoring the file review, Mercer has retained a 3-tiered system. This approach for quantitative scoring was determined as more appropriate than the 5-tiered system used for regulatory and contractual compliance activities due to predictive constraints of the denominator size.

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

Analysis and Reporting

Information from all phases of the review process was gathered, and a comprehensive analysis was completed. The 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 2020 review (i.e., substantially met, partially met, minimally met, not met). Results of the analysis make up this report and are written in a format consistent with federal protocols to easily identify compliance with BBA standards as written in the Federal Register, June 14, 2002. The table below outlines the 5-tiered system utilized to determine compliance findings.

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

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

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

Description of the Data Obtained

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

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

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

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

Conclusions Based on the Data Analysis

DMMA continues to work collaboratively with the MCOs as they implement activities towards continuous quality improvement. The summary results of the EQR indicate that the MCOs in Delaware have opportunities to improve timely access to care, to improve the QOC, while ensuring members are satisfied with services as outlined in the Quality Strategy (QS).

The MCOs have shown strong performance in compliance with federal regulations. However, as evidenced by the HEDIS results, both MCOs have room for improvement in timely access to primary and preventive services, access to maternal and pregnancy services, quality of early life and early detection services, quality of weight and nutrition management, and diabetes management.

While members for one MCO shared a relatively high level of satisfaction with five of the 14 CAHPS adult or child measures, they have opportunity for improvement in the remaining nine measures. The second MCO has significant opportunity to improve member satisfaction in all CAHPS adult and child measures.

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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 CAP of Delaware's MCOs, ACDE and HHO assessing compliance with the following federal regulations:

42 CFR 438.206 Availability of services	42 CFR 438.224 Confidentiality
42 CFR 438.207 Assurances of adequate capacity and services	42 CFR 438.228 Grievance and appeal systems
42 CFR 438.208 Coordination and continuity of care	42 CFR 438.230 Sub-contractual relationships and delegation
42 CFR 438.210 Coverage and authorization of services	42 CFR 438.236 Practice guidelines
42 CFR 438.214 Provider selection	42 CFR 438.242 Health information systems
	42 CFR 438.330 Quality assessment and performance improvement program

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

- Review of MCO compliance with Federal Regulations for Medicaid Managed Care (FRMMC), with the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), and State standards.
- Review of compliance with contract standards for:

  - DSHP and DSHP Plus CM
  - DSHP All Member Level Coordination, Level I Resource Coordination, and Level II Clinical Care Coordination (CCC)
- PIP validation
- PM validation

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

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

To kick off the EQR, Mercer developed a timeline that chronologically summarized the EQR deliverables and their due dates for 2020 and distributed it to MCO staff. The 2020 EQR process began on August 8, 2020, when Mercer delivered the RFI to both MCOs. Mercer used a Health Insurance Portability & Accountability Act (HIPAA) compliant secure file transfer protocol site, SharePoint, to allow a secure exchange of information among Mercer, DMMA, and the MCO. MCO materials were uploaded to the SharePoint site by September 2, 2020. The review assessed calendar year 2019 operations with a focus on CAP implementation subsequent to the 2019 comprehensive compliance review. In addition, Mercer reviewed files for CC, CM, pharmacy PA, provider and organizational provider credentialing/recredentialing, provider terminations and grievances, and appeals then submitted preliminary findings to MCO to prepare for the virtual onsite review.

Due to the public health emergency (PHE) declared January 31, 2020 (i.e., the Novel Coronavirus Disease [COVID-19]) the onsite portion of the annual compliance review was conducted virtually via video conference and teleconference. The annual virtual onsite reviews were conducted by Mercer, with DMMA staff in attendance, on September 29, 2020–October 1, 2020 for ACDE and October 6–8, 2020 for HHO. The documentation reviews and staff interviews were conducted to gain a more complete and accurate understanding of CAP implementation, the operations of MCO and how those operations contribute to its compliance with federal and State regulations and requirements, consistency with internal P&Ps and processes, and adherence to contractual standards in the provision of health care services to its enrollees.

Compliance Review

This review was conducted based on information submitted by ACDE and HHO through the RFI and through virtual onsite meetings. ACDE had 112 CAP items across all eight EQRO review sections identified in 2019. During the 2020 EQR, 67 of the 112 outstanding CAP were deemed closed. HHO had 137 CAP items across all eight EQRO review sections identified in 2019. During the 2020 EQR, 76 of the 137 outstanding CAP were deemed closed.

The table below provides a sense of the MCO's progress toward full compliance with expectations by review area.

ACDE Corrective Action Plan						
EQRO Review Sections	**ACDE**			**HHO**		
	Number of CAP Items Identified in 2019	**Number of CAP Items Closed in 2020**	**Items Needing CAP from 2020 EQR**	**Number of CAP Items Identified in 2019**	**Number of CAP Items Closed in 2020**	**Items Needing CAP from 2020 EQR**
Administration & Organization	8	8	0	9	8	1
CC	39	14	25	30	10	20
Grievances & Appeals	5	5	0	3	2	3–1 from 2019 & 2 new in 2020
LTSS CM	16	11	5	19	11	8
Pharmacy	1	1	0	2	2	0
Provider Network	21	14	9:7 from 2019 & 2 new in 2020	27	23	4
Quality	4	3	1	24	7	17
UM	18	11	8:7 from 2019 & 1 new in 2020	23	13	10
Total	**112**	**67**	**49**	**137**	**76**	**63**

ACDE 2020 Quality, Timeliness, and Access to Care Strengths

- In 2019, their second full year in the Delaware Medicaid program, ACDE focused on initiatives to enhance medical management programs, expand use of reporting tools and technology, and streamline administrative processes. Also, in 2019 ACDE attained the NCQA "Interim" health plan accreditation and opened the Wellness Center. These accomplishments exemplify ACDE's mission to "help people get care, stay well and build healthy communities."

- The 2019 Quality Improvement Program Evaluation analysis included evaluation of service indicators, provider satisfaction, clinical care, LTSS program, and audit activities. The annual evaluation included a number of data analyses with conclusions and recommendations for improvement in 2020.

- ACDE is led by capable and invested executives at the local level who care for their members and staff. Key Staff positions were relatively stable with little turnover; ACDE has begun to scale staffing as necessary to meet program requirements and member needs and has made impressive progress in further developing training content, coordinating, and tracking progress.

- Mercer finds ACDE's pharmacy program and staff is strong and very closely managed by the onsite MCO pharmacy staff who are involved with member-level decisions and closely connected to PerformRx and DMMA staff. ACDE's Delaware Market Pharmacist is fully engaged across internal departments and provided a detailed overview on pharmacy program initiatives, clinical observations, and upcoming challenges.

- ACDE's significant improvements were noted in the current Provider Network and Development Plan (PNDMP); cultural needs and preference information was added, access and availability standards, member/provider ratios, panel status and panel size standards, and benchmarks are examples of the updates made to the PNDMP.

- The MCO's Behavioral Health (BH) Chief Medical Officer (CMO) has been exploring the use of certified peer specialists to enhance outreach to members with BH conditions, including substance use disorders. The BH CMO is also in the process of meeting with hospital/inpatient facility Chief Executive Officers to discuss how discharge and transition planning can be enhanced for members with BH challenges.

ACDE 2020 Quality, Timeliness, and Access to Care Opportunities

- The MCO submitted final revisions to the Risk Stratification Plan to DMMA on October 14, 2020. In order to close out the risk stratification CAP items, it will be important for the MCO to provide evidence of ongoing validation testing to confirm the revised risk stratification algorithm is producing valid and reliable results.

- ACDE made a strategic move to have one director oversee both UM and CC departments. Having a senior leader focused on both units dilutes the ability to implement and monitor the key initiatives for UM and CC. Each of these departments should have a senior leader who is dedicated to overseeing the services of the department for the Delaware membership.

- DMMA has mandated that each MCO conduct a minimum of five PIPs covering specific topics; ACDE has not met the minimum requirements for PIPs based on the Delaware QS. Based in EQR results there are a number of areas where a PIP could be developed and implemented to improve MCO performance.

- In 2019, the MCO filled a number of CC staff vacancies, provided training to resource coordinators (RCs) regarding managing members with low acuity non-emergent (LANE) emergency department (ED) visits and developed a LANE analysis report and workflow. Despite training and policy development efforts, file reviews indicate there is a need to continue to evaluate the extent to which resource coordination supports are effective in assisting members to avoid LANE ED visits and redirecting these members to primary care supports.

- The MCO has made progress promoting inter-departmental coordination through the development of P&Ps, audit processes, and staff training. The results of audits are tracked and trended and are used to educate staff on areas where improvements are needed. File reviews indicate that despite the progress made, there is opportunity for greater interdepartmental (UM, CC, CM) coordination. A lack of coordination was noted for members who were being/had recently been discharged from an inpatient stay, AIDS waiver members, and high-risk pregnancies.

- Several opportunities exist in provider data management for full CAP implementation and process improvements to ensure all required data elements are present, data is accurate, and quarterly provider directory data validation is conducted for the Provider Directory.

- To enhance both UM and delegate oversight, ACDE and National Imaging Associates (NIA), the vendor to whom UM decision making for certain radiology requests (e.g., MRI, PET, CT, etc.) has been delegated, should conduct inter-rater reliability on a sample of authorization requests to ensure the MCO agrees with the service denial.

HHO 2020 Quality, Timeliness, and Access to Care Strengths

- In the last quarter of 2019 and through 2020, HHO successfully transitioned a number of responsibilities from their delegate Gateway. This transition required adding key personnel as well as a significant number of frontline staff. HHO used this transition as an opportunity to address a key CAP item related to training and in January 2020 implemented its Annual Staff Training Plan and a Training, Evaluation, Innovation and Oversight project plan. This significant transition created very little member and provider disruption. HHO’s commitment to the Delaware membership is evident from the highest level of the management team to the front-line staff.

- Mercer finds HHO's grievance and appeal systems functioning well. The unit has done a good job of integrating past EQRO recommendations into standard practice. The unit has a strong leadership team in place and has shown the ability to identify issues within their system and work to change processes to rectify them.

- While more fully addressed in the ISCA report, HHO has a robust system for conducting audits, including payment integrity audits, as well as, P&Ps for protection of confidentiality and protected health information. Corporate policies clearly outline what constitutes personal health information (PHI) and personal identifiable information (PII) and provide members with a formalized process by which access to health records for review and revision including instances where such information would not be shared; all appear in compliance with federal regulatory requirements. Member newsletter articles reinforce information by including topics such as fraud, waste, and abuse, as well as educating members on how to access and correct information in their medical records.

- Mercer noted significant improvements in the current PNDMP, including: the addition of HHO's provider recruitment and retention philosophy, staffing, and organization structure, access and availability standards, provider directory maintenance, and reporting requirements. In support of these efforts, the Provider Network Management Team has employed a multi-pronged approach to capturing provider demographic data in order to maintain the integrity of the information contained in the Provider Directory.

- HHO has updated and modernized its website and has dedicated a team to monitor website content and functionality. As more and more members access benefit and provider information via the website the improvements and maintenance of these efforts will be key to continued member satisfaction.

- HHO's UM program highlights include an overall team structure redesign that clearly delineates the distinction of the clinical departments and promotes enhancements for communication and collaboration across the clinical departments. UM key initiatives include a focus on discharge planning and the implementation of interdisciplinary rounds that include staff from UM, CM, and CC as well as resource coordination. HHO has developed a comprehensive training plan to ensure that the UM staff are aware of the updated enhancements.

- HHO addressed and resolved issues related to timely processing workbooks and LTSS service initiation. The MCO has provided additional training to case managers on integrated care, medical management of LTSS members, and care planning; progress in these areas is evident.

HHO 2020 Quality, Timeliness, and Access to Care Opportunities

- There have been ongoing concerns around training and staff development and the impact of turnover within the Quality Management (QM)/Quality Improvement (QI) department. A significant portion of the QI department has been replaced since the last review. At the time of the review in July 2019 into the first quarter of 2020, the QM/QI department did not have a permanent Director and the Quality Manager position as well as the four Clinical Quality Management Analyst positions were staffed with temporary staff. The lack of an adequate continuity plan to ensure that QI initiatives continue when there is turn-over within the QI department as well as the lack of a fully developed

and implemented training program that covers fundamental QM concepts and QI methodologies have presented challenges to a strong QI program, integration of quality concepts throughout the organization, and implementation of innovative interventions aimed at improving the health and wellbeing of the Medicaid members.

- The lack of leadership and direction in the QM/QI department lead to PIPs that lacked a strong design, did not have lead and lag measures that were well-defined, interventions that were not highly effective, and results that did not demonstrate improvement.
- The use of the term “medically necessary” on Notice of Adverse Benefit Determination (NOABD) letters when denying pharmacy medication due to needed PA as well as when the medication was not on the preferred drug list is not accurate. Medically necessary is defined as the essential need for health care or services delivered by or through authorized and qualified providers. PA and medications listed on the State’s approved preferred drug list do not determine whether it is deemed medically necessary.
- Opportunities exist in the area of quality control in the grievance and appeal system. Appeals quality control processes were ineffective and resulted in incorrect information being sent to members during the recent transition from Gateway.
- Tools used to capture and collect provider data do not contain the appropriate level of detail to allow HHO to successfully capture information pertaining to accommodations for individuals with physical, mental, or cognitive disabilities. This accessibility information is critical for the most vulnerable members to be able to access services. Additionally, HHO has an opportunity to ensure greater consistency in following defined processes for requesting Primary Care Provider (PCP) and Specialty Care Provider panel and open UM authorization information during the provider termination process.
- There continues to be an opportunity for case managers to ensure that not only are LTSS/HCBS needs met for the DSHP Plus population, but that medical management and disease management needs are met. Examples of opportunities include:
  - Documentation of follow up to member identified needs and needs identified via assessment.
  - Measurement of plan of care (POC) goal achievement.
  - Evidence of discharge and transition planning following inpatient admissions and follow up to ED admissions.
- The CC member outreach processes continues to involve multiple staff and multiple handoffs. There is a continued opportunity to evaluate these processes and assess the impact on the member engagement process. Areas of particular concern include:
  - Following up with members with LANE ED visits and linking members to their PCP for appointments and timely follow up.

  - An immediate need to address the standards of practice through which pregnancy CC is being provided and the level of resource/CC provided to pregnant members, particularly those who are at high risk for adverse outcomes.
  - Inconsistency with follow up to needs identified during assessment.

- There continues to be a need to address coordination of care between the MCO and AIDS waiver case managers and ongoing medical management of AIDS Waiver members. The MCO is required to have a process to conduct Health Risk Assessments (HRA) of new members within 60 days of enrollment with at least 50% completion rate. The MCO provided the end-to-end process and gap analysis conducted to evaluate the HRA completion process. However, the MCO has not been successful in meeting the contractually required minimum completion rate for HRAs.

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

The following federal regulations are addressed in this section: 438.100(a)(1–2).

The intent of these regulations is to ensure the MCO has written policies related to enrollee rights and ensure the MCO complies and holds staff and affiliated providers accountable to comply with enrollee rights and applicable State and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100(b), 438.10(d), and 438.102.

The intent of these regulations is to ensure the MCO provides appropriate information to enrollees and potential enrollees in a language and format that is easily understood. The MCO must inform enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific enrollee rights and protections is identified and communicated to members, staff, and providers acting on behalf of the MCO, including member's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.10(f), 431.51, 438.10 (g)(3),438.10(h), 438.106, and 438.108.

The intent of these regulations is to ensure the MCO informs enrollees of their right to receive information and to receive that information in a timely manner. The MCO provides the enrollee with information, including enrollee rights, scope of benefits, changes to member benefits, provider terminations, limitations of freedom of choice of providers, and financial considerations.

The following federal regulations are addressed in this section: 438.10(f6)(viii–ix), 438.114, and 422.113(c).

The intent of these regulations is to ensure the MCO assists the member to understand when and how to access emergency and post stabilization services, including after hours.

The following federal regulations are addressed in this section: 438.104.

The intent of these regulations is to ensure the MCO obtains State approval for all marketing materials, distributes materials to its entire service area, does not seek to influence enrollment in conjunction with the offer of any private insurance, and does not engage in cold call marketing or other contractually restricted marketing techniques.

ACDE 2020 Findings and Recommendations

This section of the review focused on six CAP items identified during the 2019 EQR. These items included: streamlining training on member rights and responsibilities with delegates; updates to delegation oversight tools and processes; inclusion of pharmacy co-pay information on the member ID card; minor tweaks and updates to various P&Ps.

One topic that generated a number of CAP items in 2019 was the Provider Directory. Specifically, the process to ensure all required data elements are present, data is accurate, and quarterly provider directory data validation is conducted. ACDE has made a number of improvements in this area including the capture and sharing of race, ethnicity and language (REL) information of its provider network with its

member services call center so they may aid members in identifying providers who meet their cultural needs and preferences. Additionally, ACDE had engaged its provider account executives to use the provider visit form to capture and validate provider information including REL data. Communication pathways to update provider data received during recredentialing are in place. However, several opportunities for full CAP implementation and process improvements still exist.

From an improvement perspective, while ACDE has engaged its provider account executives to assist in provider data collection and validation, the site visit tool does not provide the necessary detail to capture information pertaining to all Americans with Disabilities Act (ADA) requirements and Federal Medicaid requirements pertaining to accommodations available for members with physical, mental, or cognitive disabilities. During the interview, ACDE indicated that providers were difficult to engage, were not always responsive to outreach efforts, and there was concern around provider abrasion. These are valid concerns and there may be opportunity for collaboration between DMMA and its managed care contractors to improve the process to capture the required level of detail for the provider directory.

ACDE successfully cleared four of the six CAP items from the 2019 review. However, two items linger and two new CAP items were identified. The two lingering items are related to ACDE's provider data validation policy addressing how the Provider Directory is updated, the frequency of updates and validation of information in its provider directory and the process used to perform a quarterly review and validation of the data for each provider type represented in the directory, as required by DMMA. The policy for Provider Information Validation was submitted with two different policy numbers (159-009-002 and 159-009-006) and each policy did not evidence the quarterly provider directory validation required by DMMA. The two new CAP items include necessary revisions to the provider termination letter template and updates to how non-PCP providers are referenced in the Provider Termination Process policy, as well as adding triggers for when the policy would not be followed.

Metric Description	2019 Score	2020 Score
The MCO has a defined process to educate staff and the staff of subcontractors and delegates regarding Member Rights and monitors to ensure Member Rights are respected and that any breaches are referred through the grievance and/or QOC/quality of service (QOS) processes.	Substantially Met	Met

Metric Description	2019 Score	2020 Score
The member identification card meets all requirements and is not different than non-Medicaid line of business identification cards. Card must include: • MCO name • Key telephone numbers (e.g., member services, nurse advice line, pharmacy services) • Emergency services procedures • Identification number • Member name • Date of birth • Effective date of enrollment • Copayment • PCP name • LTSS front and back (if applicable)	Substantially Met	Met
The provider directory contains all required contract items and is available in Spanish.	Partially Met	Met
The MCO has P&Ps describing how the Provider Directory is updated, frequency of updates, and validation of information in its provider directory, including the data elements listed in Section 3.14.1.6.1 of the contract (e.g., open/closed panel, languages, ADA compliance, etc.).	Substantially Met	Substantially Met
The MCO has a P&P to perform a quarterly review and validation of the data for each provider type represented in the directory (i.e., physicians and specialists, hospitals, pharmacies, BH providers, and LTSS providers). In addition to the quarterly review, the Contractor shall review the accuracy of these data elements during recredentialing.	Substantially Met	Substantially Met
The MCO's P&Ps include effective and member-centric mechanisms for assisting members in locating a new non-PCP provider within seven business days after provider termination.	Substantially Met	Substantially Met
The MCO's P&Ps include effective and member-centric mechanisms for assisting members in locating a new non-PCP provider within seven business days after provider termination.	New Finding for 2020	Substantially Met

HHO 2020 Findings and Recommendations

Member call center operations represent the face of HHO to its membership; HHO has always had an enthusiastic team eager to help members resolve issues and connect them to services. With a membership illiteracy rate of approximately 14% there was an opportunity to enhance call center operations through training and process improvements to help identify and provide supports for members who may be illiterate. Updates to desk level procedures and training were provided to call center staff to help identify individuals who may need assistance due to illiteracy. Additionally, in its efforts to provide best in class services, complex calls with multiple issues were often dealt with in a

piecemeal way; that is call center staff addressed some items, as appropriate, and sometimes the member was then transferred to the next area. Given DMMA's focus on CC, HHO had an opportunity to streamline call flow processes and educate call center representatives on when to transfer the entire issue to the CC team, Member Advocate, or the urgent response team. Through training and partnership with other business units, call center staff have been trained and workflows updated to ensure a more holistic approach to issue resolution

Mercer's 2019 review yielded two CAP items:

- Update P&P: MK 101 MD DE Marketing and Member Material Oversight to include reference for oral interpretation services for individuals who may have English as a Second Language or who are illiterate. Update associated P&Ps, internal workflow documents, and training for staff to address Delaware's high instance of illiteracy to allow all member facing staff to be aware of how to identify and assist members, who may be illiterate, to receive oral (or audio) interpretation services, or other supports necessary to help a member navigate through the HHO processes and navigate the health care delivery system.

- Evaluate Member Services Call Center resolution actions and transfer processes to develop greater consistency in member issue resolution and clear triggers for when callers with complex issues should be transferred to another unit for more integrated and holistic issue resolution.

Mercer's 2020 CAP review cycle finds both of these items fully resolved and staff trained to better handle member contacts in both instances. All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

Metric Description	2019 Score	2020 Score
The MCO assures that language requirements are met: • Oral interpretation services are available. (438.10(c)(4)) • 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. (438.10(c)(5)) • Enrollees and potential enrollees are notified of the availability of oral interpretation services in any language and how to access them (438.10(c)(5)(1) and (2))	Substantially Met	Met

Metric Description	2019 Score	2020 Score
The call center: • Has the capacity to monitor calls remotely. • Can receive calls from limited English proficiency and hearing impaired callers. • Has bilingual Spanish (and other prevalent language) representatives. • Must allow members to first choose their preferred language on the phone line. • Is staffed at least Monday through Friday, 8 am to 7 pm Eastern, except for holidays, and has an automatic system to handle calls outside of business hours. • Staff must be trained to respond to member questions on DSHP and DSHP Plus as described in 3.14.2.3.8. • Has procedures to transfer calls appropriately and warm transfer when required. • Has access to electronic documentation from previous calls from the member services line, nurse triage/advice line, pharmacy service information line, CC, and CM. • Has the ability to access the wellness registry to help link members to covered and non-covered services.	Substantially Met	Met

Grievance System

The following federal regulations are addressed in this section: 438.10(f)(6)(iv) and 438.10(g).

The intent of these regulations is to inform members of their rights under grievance, appeal and State Fair Hearing (SFH) processes. The MCO must inform members of how to access the grievance system, the availability of the MCO to assist in the process, and the timeliness for application and completion of each process step.

ACDE 2020 Findings and Recommendations

ACDE meets the federal regulations and contract requirements to inform members of their rights under grievance, appeal, and SFH processes. The MCO informs members of how to access the grievance system, the availability of the MCO to assist in the process, and the timeliness for application and completion of each process step. There were no CAP items for review in 2020; Mercer reviewed information on the grievance system to the extent needed to conduct the grievance and appeal file review.

HHO 2020 Findings and Recommendations

HHO meets the federal regulations and contract requirements to inform members of their rights under grievance, appeal, and SFH processes. The MCO informs members of how to access the grievance system, the availability of the MCO to assist in the process, and the timeliness for application and completion of each process step. There were no CAP items for review in 2020; Mercer reviewed information on the grievance system to the extent needed to conduct the grievance and appeal file review.

Advance Directives

The following federal regulations are addressed in this section: 438.100(b)(2)(iv), 438.6(i), 422.128, and 417.436(d).

The intent of these regulations is to ensure the MCO maintains P&Ps related to advance directives, including their rights under State law, and must contain clear and concise language on the limitation if the MCO cannot implement an advance directive as a matter of conscience. The MCO is responsible for providing enrollees with periodic written information regarding advance directives and their rights under the State laws. The MCO is expected to provide education for staff, providers, and the community regarding advance directives.

ACDE 2020 Findings and Recommendations

Mercer's 2019 review yielded a single CAP item pertaining to the resource used to convey advance directive information to members. ACDE updated the desk level procedure and hyperlink to the appropriate DHSS sub-domain for Advanced Directive/Living Wills.

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

Metric Description	2019 Score	2020 Score
The MCO has advance directive P&Ps that comply with the following: • State and federal law. • Written information to all adult members concerning their rights. • Contractor policies for implementing member rights include any limitations. • Documentation in the member medical record and POC. • Prohibition of execution of an advance directive as a provision of care. • How to file a complaint regarding non-compliance with advance directives. • Education on advance directives for providers and staff. (438.6(i)(2) and 422.128)	Substantially Met	Met

HHO 2020 Findings and Recommendations

There were no CAP items for review in 2020. HHO meets the federal regulations and contract requirements to inform members of their rights related to advance directives, including their rights under State law, as well as the limitation if the MCO cannot implement an advance directive as a matter of conscience. The MCO provides members with written information regarding advance directives and their rights under the State laws as well as education for staff, providers, and the community regarding advance directives.

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

The following federal regulation is addressed in this section: 438.206(e)(2).

The intent of this regulation is to ensure the MCO participates in the State's efforts to deliver services in a culturally competent manner.

The following federal regulation is addressed in this section: 438.6(m), 438.206(d)(1–8), and 438.207.

The intent of this regulation is to ensure the MCO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MCO's member demographics, needs, and geographic location when developing the network.

The following federal regulations are addressed in this section: 438.214 (a–e) and 438.12 (a–b).

The intent of these regulations is to ensure the MCO has written P&Ps for the selection and retention of providers and a documented process for the initial and recredentialing of providers. Regulation 438.214(c) and 438.12 (a–b) prohibits discrimination against providers that deliver services to high-risk or high-cost members. 438.214(d) prohibits the MCO from contracting with providers that are excluded from participation in Medicare and State health care programs.

The following federal regulation is addressed in this section: 438.206(e)(1)(i–vi).

The intent of this regulation is to ensure access to care is compliant with State requirements. The MCO is required to meet, and expects affiliated providers to meet, standards for access to care and services in or out of network.

ACDE 2020 Findings and Recommendations

The PNDMP is a critical document and acts as the program description outlining the philosophy, analytic approach, standards, and activities related to the development and maintenance of ACDE's provider network. In 2019, ACDE's PNDMP was rudimentary and did not evidence the expected rigor necessary to document ACDE's network development and management strategy. Significant improvements were noted in the current PNDMP; cultural needs and preference information was added, access and availability standards, member/provider ratios, panel status and panel size standards, and benchmarks are examples of the updates made to the PNDMP. One item that remains absent from this document is the incorporation of information pertaining to the capacity of the MLTSS providers, particularly HCBS providers, to service members. ACDE is encouraged to, at a minimum, incorporate data from the Missed and Late Visit report, which captures HCBS service inconsistencies.

Several CAP items from 2019 were related to provider services, network management training and P&Ps. Significant work has been done to refine the training program; necessary updates to P&Ps helped to clear a number of CAP items. Policy PNM 103 Network Sufficiency, Access and Availability is a comprehensive policy that outlines both NCQA and DMMA requirements. However, as ACDE has adopted NCQA's

definition of high impact and high volume providers, not all DMMA pediatric specialties required by DMMA have been incorporated into the geo-spatial analytic reports.

In 2019 ACDE's telehealth program, while documented, was very basic. However, in early in 2020, the COVID-19 PHE had the effect of requiring rapid scaling and deployment of telehealth. ACDE worked quickly and collaboratively with DMMA to waive barriers related to telehealth including: State-based originating site restrictions, established relationship requirement, recognized Federal waiver of HIPAA violations for good-faith efforts relative to video services (e.g., Facebook messenger, FaceTime, Skype, etc.), and distributed detailed billing and HIPAA specific guidance.

Credentialing File Review

The credentialing file review was performed using the File Review Protocol methodology outlined in Section 2. File review encompassed initial credentialing and recredentialing activities for organization and independent practitioners. A sample of 30 credentialing files (15 initial and 15 recredential) were selected, including LTSS provider types. The files were assessed for compliance with BBA regulations, State contract requirements, and ACDE internal policy standards. The following elements were included in the review:

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

Files evidenced timeliness with the initial file 45-day turn-around-time requirement for ACDE processed files and delegation oversight tools demonstrate delegates are being held to the 45-day requirement for initial credentialing files. However, there is an opportunity to enhance delegate oversight tools to ensure that the provider complaint process is evaluated initially and annually thereafter for all entities delegated

provider network and development activities. Additionally, ACDE has an opportunity to capture provider complaint data from delegates and integrate this information into ACDE's provider complaint reporting.

Provider Termination File Review Process

The provider termination file review was performed using the File Review Protocol methodology outlined in Section 2. A sample of 30 provider termination files was selected for review; sampling was pulled from both 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.

There were a limited number of terminations throughout 2019, 89 in total, encompassing 88 discreet providers. In general, review of the termination files demonstrated improved documentation from the previous review. ACDE experienced difficulties in pulling the Universe file listing for provider terminations as some providers have practice locations credentialed by ACDE and other locations that fall under a delegate's purview. When data was pulled from the ACDE provider data system, differentiation at a detailed level resulted in mismatches between data in the Universe file and the actual provider termination file submitted for review. ACDE is encouraged to add a check to the credentialing delegate oversight tools to examine provider termination workflows. It is noteworthy that ACDE has improved the process to exchange data between credentialing delegates and ACDE's credentialing department to ensure compliance with initial credentialing application timeliness and provider directory data updates. ACDE self-diagnosed inconsistencies in the process to conduct panel checks and is working on a solution.

Metric Description	2019 Score	2020 Score
The MCO has developed and implemented training that outlines accepted telemedicine practice.	Minimally Met	Met

Metric Description	2019 Score	2020 Score
The MCO completes the initial credentialing process with a provider before the effective date of the provider participation agreement. The MCO completely processes credentialing applications within 45 calendar days of receipt of a completed application. Completely process means: receive, approve, load into provider files in claims processing system, **or** deny, notify provider, and ensure provider is not used for services.	Substantially Met	Met
The MCO has established P&Ps on provider recruitment, retention, and termination and describes how the MCO responds to changes in the network that affect access and availability of covered services.	Substantially Met	Met
The MCO's P&Ps include effective strategies for contracting with providers from different cultures and offering training to providers on how to provide culturally appropriate care to members. (42 CFR 438.204(b)(3) and 42 CFR 438.206(c)(2))	Minimally Met	Substantially Met
The P&Ps include timeframes (15 days for non-duals and auto-assignment within 30 calendar days) for outreach and notification regarding PCP selection and/or assignment, documents the methodology used to auto-assign the member to a PCP (e.g., individual or family relationship, age, language, geographic proximity), ensures members are not assigned to a closed PCP, and outlines the process to notify the member and the Health Benefits Manager (HBM) of the PCP assignment.	Substantially Met	Met
The MCO's P&P definition of a PCP include the following provider types advanced practice registered nurses, nurse midwives, family practice, general practice, geriatricians, pediatricians, and OB/GYN or internist and allows nephrologists for members on dialysis and outlines how the MCO seeks State approval on a case by case basis to allow specialists as the member's PCP.	Substantially Met	Met
The MCO's P&P outlines circumstances under which a PCP lock-in may be requested, processes should outline due process through the grievance system and include ongoing monitoring to determine if utilization problems have been resolved; tracking and reporting to the State on lock-ins is also addressed.	Minimally Met	Met
The MCO conducts new hire and ongoing training and education of its provider services and network management staff and when appropriate staff of its subcontractors and delegates. Training materials and attendance demonstrate topics are relevant, focused on continuous quality improvement, and address any identified need.	Partially Met	Met
The MCO has written P&Ps outlining instances where a PCP reassignment may occur including PCP termination from the network (within 15 days of termination), resolution to a formal grievance, member requires specialized care, current PCP termination or member behavior is disruptive and PCP has made reasonable efforts to accommodate (three attempts within 90 calendar days), the member has taken legal action against the PCP.	Partially Met	Met
The MCO has a clear P&P to evaluate a delegate, subcontractor, or sister entities' compliance with State contract and federal requirements including pre-delegation, ongoing monitoring and oversight and annual audits. The policy should indicate the ability to terminate delegated arrangements including requests from the State for termination.	Substantially Met	Substantially Met

Metric Description	2019 Score	2020 Score
The MCO's Provider Network Development and Management Plan includes the following components: (1) summary of participating providers, by type and geographic location in the State, (2) demonstration of monitoring activities to ensure that access standards are met and that members have timely access to services, (3) a summary of participating provider capacity issues by service and county, the contractor's remediation and QM/QI activities, and the targeted and actual completion dates for those activities, (4) network deficiencies by service and by county, and interventions to address the deficiencies, and (5) ongoing activities for provider network development and expansion, taking into consideration identified participating provider capacity, network deficiencies, service delivery issues and future needs. (42 CFR 438.207)	Partially Met	Met
The MCO has adequate methods to verify compliance with State determined network adequacy standards and produces quarterly geo-spatial analysis reports. Methods to detect network adequacy should include at a minimum geo-spatial reports, tracking PCP open/closed panels, appointment availability within defined State standards, and assessment of LTSS gaps in care.	Substantially Met	Substantially Met
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.	Partially Met	Met
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.	Partially Met	Met
The MCO's provider recruitment strategies do not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment, or against any provider acting within the scope of the provider's license or certification under applicable State law. Written plan must include consideration of: • Anticipated Medicaid enrollment • Expected utilization of services and population demographics • Number of closed panels • Geographic location (time/distance) (42 CFR 438.12)	Substantially Met	Met
The MCO's provider retention P&Ps accurately describe retention issues of importance to providers and include effective and provider-centered strategies to address these issues and encourage provider retention.	Substantially Met	Substantially Met

Metric Description	2019 Score	2020 Score
The MCO's provider complaint system includes P&Ps, a designated staff person, and outlines the timeframes and notification processes required by the contract. • Allows providers 45 calendar days to file a written complaint for issues that are not about claims and no later than 12 months from the date of service, or 60 calendar days from payment, denial, or recoupment for issues about claims, whichever is latest. • Notification within three business days of receipt of complaint and the expected date of resolution. • Resolves all complaints within 90 calendar days of receipt and provides written notice of the resolution and the basis for the resolution to the provider within three business days of resolution. • Documents why a complaint is unresolved after 30 calendar days of receipt and provides written notice of the status to the provider every 30 calendar days thereafter.	Substantially Met	Substantially Met

HHO 2020 Findings and Recommendations

HHO's Provider Network, Provider Information Management, and Provider Services Call Center work together to address issues and concerns regarding HHO's provider network. The PNDMP is a critical document and acts as the program description outlining the philosophy, analytic approach, standards, and activities related to the development and maintenance of HHO's provider network. At the time of the 2019 EQR, HHO's PNDMP was basic and did not evidence the expected rigor necessary to document HHO's network development and management strategy. Mercer noted significant improvements in the current PNDMP, including: the addition of HHO's provider recruitment and retention philosophy, staffing and organization structure, access and availability standards, provider directory maintenance, and reporting requirements. One item that remains absent from this document is the incorporation of information pertaining to the capacity of the MLTSS providers, particularly HCBS providers, to service member. HHO is encouraged to, at a minimum, incorporate data from the Missed and Late Visit report, which captures HCBS service inconsistencies. While not specific to the PNDMP, geo-spatial analysis specifications to run the time-distance reports for pediatric specialists does not use the contract guidance to define pediatric specialist; this should be updated as soon as possible and geo-spatial analysis should be re-run and reviewed for gaps.

In order to maintain the integrity of the information contained in the Provider Directory, HHO employs a multi-pronged approach to capturing provider demographic data. Provider account executives and associated site visit forms capture and validate data during onsite office visits. Information received as part of (re)credentialing activities is given to Provider Information Management for updates to the provider file; additionally, Atlas Systems conducts quarterly provider data validation surveys. It was noted that tools used to capture and collect provider data do not contain the appropriate level of detail to allow HHO to successfully capture information pertaining to accommodations for individuals with physical, mental, or cognitive disabilities. During interviews with HHO, DMMA relayed instances when a member who arrived by stretcher was declined service upon arrival to the office because the office does not have the capacity or capability to accept a patient on a

stretcher. This accessibility information is critical for the most vulnerable members to be able to access services. HHO expressed concerns regarding provider abrasion relative to all the outreach to collect the provider demographic data elements required by Federal rule and data regarding PCP panel size required by DMMA. These are valid concerns and the EQRO encourages a collaborative solution to reduce redundancy, improve operational efficiency, and reduce provider abrasion.

In 2019, HHO's telehealth program was well documented; HHO had partnered with American Well for telehealth services. However, the COVID-19 PHE resulted in the need to rapidly scale telehealth options. HHO worked with its vendor American Well, with the other Medicaid managed care vendor, and DMMA, to quickly and collaboratively ensure telehealth options were available to providers and members. Some of the actions taken to rapidly scale included: waiving barriers related to telehealth such as easing State-based originating site restrictions and the established relationship requirement, recognizing Federal waiver of HIPAA violations for good-faith efforts relative to video services (e.g., Facebook messenger, FaceTime, Skype, etc.), and distributing detailed billing and HIPAA specific guidance.

Other CAP items in 2019 included submission of missing information and minor revisions to policies and desk level procedures. These items were quickly resolved and all CAP items have been satisfied.

Credentialing File Review

The credentialing file review was performed using the File Review Protocol methodology outlined in Section 2. File review encompassed initial credentialing and recredentialing activities for organization and independent practitioners. A sample of 30 credentialing files (15 initial and 15 re-credential) was selected, including LTSS provider types. The files were assessed for compliance with BBA regulations, State contract requirements, and HHO internal policy standards. The following elements were included in the review:

- Credentialing entity
- Verification of medical licensure, board certification, Drug Enforcement Administration licensure (if applicable), and malpractice insurance coverage
- Documentation of National Practitioner Data Bank and/or Office of Inspector General queries:
  - List of Excluded Individuals and Entities, System of Award Management, Excluded Parties List System, and Social Security Administration Death Master File
- 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

Turn-around-times of 45 days for initial credentialing files was present and in one of the credentialing files, collection of Clinical Laboratory Improvement Amendment (CLIA) waiver documentation was present. Delegate oversight tools are robust and evidence consistency with DMMA specific requirements.

Provider Termination File Review

The provider termination file review was performed using the File Review Protocol methodology outlined in Section 2. A sample of 30 provider termination files was selected for review; sampling was pulled from both 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

Improvements to the provider termination process were noted especially as it relates to integration of credentialing delegate data.

Metric Description	2019 Score	2020 Score
The MCO's provider services staffing plan, including description of number of full-time equivalents (FTEs) and staff experience and expertise, are sufficient to perform all provider services responsibilities: assisting providers with questions concerning covered services and member enrollment, assisting providers with physician assistants and referrals, assisting providers with claims payment procedures, handling provider claim disputes, and providing/offering/encouraging provider training.	Substantially Met	Met
The MCO's provider complaint system includes P&Ps, a designated staff person, and outlines the timeframes and notification processes required by the contract. • Allows providers 45 calendar days to file a written complaint for issues that are not about claims and no later than 12 months from the date of service, or 60 calendar days from payment, denial or recoupment for issues about claims, whichever is latest. • Notification within three business days of receipt of complaint and the expected date of resolution. • Resolves all complaints within 90 calendar days of receipt and provides written notice of the resolution and the basis for the resolution to the provider within three business days of resolution. • Documents why a complaint is unresolved after 30 calendar days of receipt and provides written notice of the status to the provider every 30 calendar days thereafter.	Substantially Met	Met
The P&Ps include timeframes (15 days for non-duals and auto-assignment within 30 calendar days) for outreach and notification regarding PCP selection and/or assignment, documents the methodology used to auto-assign the member to a PCP (e.g., individual or family relationship, age, language, geographic proximity), ensures members are not assigned to a closed PCP, and outlines the process to notify the member and the HBM of the PCP assignment.	Substantially Met	Met
The MCO conducts new hire and ongoing training and education of its provider services and network management staff and when appropriate staff of its subcontractors and delegates. Training materials and attendance demonstrate topics are relevant, focused on continuous quality improvement, and address any identified need.	Substantially Met	Met
The Provider Call Center staffing plan and those of delegated entities appear adequate to meet the contractual requirements and key performance indicators (e.g., ASA, AHT, etc.)	Substantially Met	Met
The MCO's provider services call center is sufficiently staffed to take calls from 8:00 am to 5:00 pm, Monday through Friday, except State holidays, and to respond to UM requests for inpatient hospitalization 24 hours a day, 7 days a week. The MCO's provider services call center has an automated system during non-business hours with information on how to obtain after-hours UM requests and a voice mailbox for callers to leave messages. The MCO's provider services call center returns messages on the next business day.	Substantially Met	Met
The MCO's provider services call center staffing is sufficient to meet the call center performance standards specified in the contract: less than 5% abandonment rate, 80% of calls answered within 30 seconds, and average wait time does not exceed 60 seconds.	Substantially Met	Met

Metric Description	2019 Score	2020 Score
The MCO has established P&Ps on provider recruitment, retention, and termination and describes how the MCO responds to changes in the network that affect access and availability of covered services.	Substantially Met	Met
The MCO's P&Ps include effective strategies for contracting with providers from different cultures and offering training to providers on how to provide culturally appropriate care to members. (42 CFR 438.204(b)(3) and 42 CFR 438.206(c)(2))	Substantially Met	Met
The MCO's PNDMP includes the following components: (1) summary of participating providers, by type and geographic location in the State, (2) demonstration of monitoring activities to ensure that access standards are met and that members have timely access to services, (3) a summary of participating provider capacity issues by service and county, the contractor's remediation and QM/QI activities, and the targeted and actual completion dates for those activities, (4) network deficiencies by service and by county, and interventions to address the deficiencies, and (5) ongoing activities for provider network development and expansion, taking into consideration identified participating provider capacity, network deficiencies, service delivery issues, and future needs. (42 CFR 438.207)	Substantially Met	Met
The MCO has adequate methods to verify compliance with State determined network adequacy standards and produces quarterly geo-spatial analysis reports. Methods to detect network adequacy should include at a minimum geo-spatial reports, tracking PCP open/closed panels, appointment availability within defined State standards, and assessment of LTSS gaps in care.	Substantially Met	Substantially Met
The MCO 's remediation activities are effective to address identified network capacity issues or network deficiencies.	Substantially Met	Met
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	Substantially Met
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.	Partially Met	Met
The MCO's provider recruitment P&Ps include effective strategies to ensure adequate access to all covered services in accordance with the State's access standards that includes the following: • Considers State standards for timely access, consistent with the needs of the member • Ensures network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees • Makes services in the contract available 24 hours a day, seven days a week, when medically necessary • Established mechanism to ensure compliance by providers • Regular process to monitor compliance • Process to take corrective action when providers fail to comply. (42 CFR 438.206(c)(1))	Substantially Met	Met

Metric Description	2019 Score	2020 Score
The MCO's provider recruitment strategies do not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment, or against any provider acting within the scope of the provider's license or certification under applicable State law. Written plan must include consideration of: • Anticipated Medicaid enrollment • Expected utilization of services and population demographics • Number of closed panels • Geographic location (time/distance) (42 CFR 438.12)	Substantially Met	Met
The MCO's provider retention P&Ps accurately describe retention issues of importance to providers and include effective and provider-centered strategies to address these issues and encourage provider retention.	Substantially Met	Met
The MCO's P&Ps for its provider portal include effective strategies for ensuring that content is updated and accurate.	Not Met	Met
The MCO has P&Ps describing how the Provider Directory is updated, frequency of updates, and validation of information in its Provider Directory, including the data elements listed in Section 3.14.1.6.1 (e.g., open/closed panel, languages, ADA compliance, etc.).	Partially Met	Substantially Met
The MCO has a P&P to perform a quarterly review and validation of the data for each provider type represented in the directory (i.e., physicians and specialists, hospitals, pharmacies, BH providers, and LTSS providers). In addition to the quarterly review, the Contractor shall review the accuracy of these data elements during recredentialing.	Not Met	Met
The MCO has developed and implemented training that outlines accepted telemedicine practice.	Partially Met	Met
The MCO ensures that all participating laboratory sites have CLIA certification or waiver of certification with a CLIA ID number and that waiver laboratories only provider CLIA-waived tests.	Not Met	Met
The MCO's recredentialing process takes into consideration provider performance data, including member grievances and appeals, provider audits, and QOC issues.	Partially Met	Met
The MCO's P&Ps include that the MCO provides written notice to members no less than 30 calendar days prior to the effective date of the termination of a PCP and no more than 15 calendar days after receipt or issuance of the termination notice.	Substantially Met	Met
The MCO's P&Ps include effective and member-centric mechanisms for assisting members in locating a new non-PCP provider within seven business days after provider termination.	Substantially Met	Substantially Met
The MCO provides written notice of termination to the providers including: (1) the reason for the proposed termination, (2) notice that the provider has a right to request a hearing or review by the MCO, (3) a time limit of not less than 30 calendar days for requesting a hearing, and (4) a time limit for completion of hearing or review of not more than 30 calendar days.	Partially Met	Met

Program Integrity Requirements and Confidentiality, Prohibited Affiliations with Individuals Debarred by Federal Agencies

The following federal regulation is addressed in this section: 438.608 (a–b).

The intent of this regulation is to ensure appropriate safeguards for the MCO to guard against fraud and abuse. The MCO must have administrative and management arrangements or procedures, including a mandatory compliance plan, designed to guard against fraud and abuse. The MCO must have a designated compliance officer and compliance committee accountable to senior management, written P&Ps that accurately spell out the compliance process, effective training and lines of communication, enforcement standards, disciplinary guidelines and provisions for internal monitoring, reporting and corrective actions.

The following federal regulation is addressed in this section: 438.224.

The intent of this regulation is to ensure the MCO has processes to protect medical records and any other health and enrollment information that identifies a particular enrollee and ensures that the uses and disclosure of such individually identifiable health information is in accordance with federal privacy requirements to the extent that these requirements are applicable.

The following federal regulation is addressed in this section: 438.610 (a–d).

The intent of this regulation is to ensure the MCO has processes in place to guard against knowingly entering into a relationship with an individual or an affiliate of an individual who is debarred, suspended, or otherwise excluded by federal regulation from participating in federal procurement or certain non-procurement activities.

ACDE 2020 Findings and Recommendations

Mercer's 2019 comprehensive review yielded one CAP items that required the development of a formal P&P to notify DMMA of Key Personnel changes. While ACDE clearly understood the process, should key leadership change, without formal documentation this process could easily become broken. The submitted policy was compliant with all required elements.

Mercer's 2020 review finds these issues resolved. 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.

There were no CAP items regarding prohibiting affiliation with individual debarred by federal agencies for review in 2020. ACDE meets the federal regulations and contract requirements to guard against knowingly entering into a relationship with an individual or an affiliate of an individual who is debarred, suspended, or otherwise excluded by federal regulation from participating in federal procurement or certain non-procurement activities.

Metric Description	2019 Score	2020 Score
The MCO has a process to notify the State in the event of breaches of PHI without unreasonable delay.	Substantially Met	Met

HHO 2020 Findings and Recommendations

HHO has a corporate code of conduct that includes information on fraud and abuse, investigations, HIPAA, resources, and guidance for reporting violations. The MCO has a designated corporate compliance officer who is supported by compliance staff. The compliance and privacy committee reports to the HHO board of directors. Minutes from the 2019 HHO Compliance Committee were submitted and reviewed as was the annual compliance work plan. There is a host of required compliance trainings for all new hires and existing staff are refreshed annually; compliance is tracked through the learning management system and employees face disciplinary action up to and including termination for non-compliance.

While more fully addressed in the ISCA report, HHO has a robust system for conducting audits, including payment integrity audits, as well as, P&Ps for protection of confidentiality and protected health information. Corporate policies clearly outline what constitutes PHI and PII and provide members with a formalized process by which access to health records for review and revision including instances where such information would not be shared; all appear in compliance with federal regulatory requirements. Member newsletter articles reinforce information by including topics such as fraud, waste, and abuse, as well as educating members on how to access and correct information in their medical records.

The one opportunity identified during the 2019 review was related to the HHO website and placement of the fraud, waste, and abuse hyperlink. HHO's updated website has the hyperlink clearly displayed at the top of the webpage in an easy to see, easy to find location. Mercer's 2020 CAP review cycle finds this issue fully resolved. 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.

There were no CAP items regarding prohibiting affiliation with individual debarred by federal agencies for review in 2020. HHO meets the federal regulations and contract requirements to guard against knowingly entering into a relationship with an individual or an affiliate of an individual who is debarred, suspended, or otherwise excluded by federal regulation from participating in federal procurement or certain non-procurement activities.

Metric Description	2019 Score	2020 Score
The MCO has a process to ensure enrollees aren't held liable for inappropriate costs, payments and balance billing. (438.106 and 438.108)	Substantially Met	Met

Grievance and Appeal Systems

The following federal regulations are addressed in this section: 438.10(f)(6)(iv), 438.10(g), and 438.228.

The intent of these regulations is to inform members of their rights under grievance, appeal, and SFH processes. The MCO must inform members of how to access the grievance system, the availability of the MCO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulation is addressed in this section: 438.400 and 402.

The intent of these regulations is to ensure the MCO operates a grievance system that includes processes to adjudicate grievances, appeals, and SFHs, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulation is addressed in this section: 438.404, 438.408 and 438.10, 431.211, 431.213, and 431.214.

The intent of these regulations is to ensure the MCO provides NOABD letters that are compliant with language, content and format as required by enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MCO provides enrollees with assistance, if requested, to complete processes within the grievance system. The MCO has processes in place ensuring enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulation is addressed in this section: 438.414, 438.416, 438.420 and 438.424.

The intent of this regulation is to ensure the MCO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MCO must keep a log of all grievances and appeals filed. The MCO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

ACDE 2020 Findings and Recommendations

The grievance system follows standard processes. Grievances can be received from members, member representatives, or providers orally through Member Services or through an ACDE staff member (e.g., the member advocate), or be written (i.e., filling out a form on the ACDE website and submitting it). If a grievance is received orally, the grievance coordinator completes the Contact Center Grievance & Appeals

Service Form and begins documenting the process using the EXP MACESS system. This system is a repository for all Member Grievances received via Member Services, Member Advocates, LTSS Case Managers, and the Pharmacy Department.

Grievance staff facilitate the grievance investigation, sending acknowledgement letters to members and coordinating investigations with other impacted business units. For instance, the Provider Network Management team is sent QOS grievances; CM may be engaged due to member concerns about the assigned case manager. QOC issues and other clinical issues are sent to the QM department for further investigation and resolution. Any information that is sent to other areas of ACDE for investigation is returned to the grievance unit along with the investigatory findings. EXP MACESS is considered the “source of truth” for grievance resolution and is used for tracking the timeliness of resolution and housing all grievance documentation. The QM Department is responsible for uploading the resolution letter to EXP MACESS and routing the letter back to the grievance unit.

Similar to grievances, standard appeals are accepted both orally (through Member Services) and in writing (through a form on the ACDE website or through the form on the last page of the member’s NOABD letter) and sent to ACDE. Oral appeals or appeals filed by providers are required to have written member consent. The appeal start date is the date the written appeal is received or the date the oral appeal is received, if written member consent is received within 10 calendar days from initial filing.

Appeals staff are responsible for sending out member correspondence including the initial acknowledgement letter, letters requesting additional information, and the resolution letter, as well as calling and/or faxing providers. If continuity of care is requested, the analyst checks to ensure the proper steps have occurred and timelines are met. If an appeal hearing is requested, the member or member representative is invited to attend in person or by phone along with the member advocate and the standing committee members. Appeal hearings are held weekly. The member or member representative presents the case and answers questions, the case is deliberated, and a decision is made and communicated to the member within two business days.

ACDE meets the required BBA and contract standards based on review of policies, procedures, member handbooks, and the provider manual. In general, the grievance and appeal systems appear to function well. Both units have done an exemplary job of integrating past EQRO recommendations into standard practice. These units have strong leadership teams in place and have shown great ability to identify issues within their system and change processes to rectify them.

Mercer’s 2019 comprehensive review yielded five CAP items. Items included grievance timelines not being met, grievance resolution letters not being member-centric, and including details of actions taken as part of the QOC investigation, member handbook not stating accurate timeline for filing an appeal, appeal letters not indicating a physician reviewer denied the benefit as well as inconsistent and inaccurate content

demonstrated in the appeals file review. These items have been satisfactorily resolved and have been scored as “Met”. Mercer did not identify new CAP items in 2020.

Grievance File Review

The grievance file review was performed using the File Review Protocol methodology outlined in Section 2. A sample of 30 grievance files was selected for review, representing Medicaid, CHIP, and DSHP Plus membership. Grievance subjects included categories such as access/availability of care, communication/relationships, transportation, QOC, and others. The files were assessed for compliance with BBA regulations, State contract requirements, and 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
- 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 ACDE, and other documents supporting the investigation. Overall, the files reviewed were found to have greater than 90% compliance in the required elements. Files reviewed demonstrated a strong focus on members, as evidenced by outreach calls from Grievance Coordinators to ensure satisfaction with grievance resolutions, as well as strong documentation of investigative notes and timely acknowledgement letters sent to members. Previous concerns surrounding QM resolution letters not being timely or containing information about the investigation or resolutions have been fully resolved.

Appeal File Review

The appeal file review was performed using the File Review Protocol methodology outlined in Section 2. A sample of 30 appeals files was selected for review, representing Medicaid, CHIP, and DSHP Plus membership. The sample contained appeals that were upheld, overturned, and withdrawn following or prior to the appeals committee meeting. One expedited appeal was reviewed. The files were assessed for compliance with BBA regulations, State contract requirements, and ACDE internal policy standards. The following elements were included in the review:

- Documentation of NOABD, member appeal, member consent, and supplemental information submitted by the member or the 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. Files reviewed demonstrated that documents and timelines were met according to BBA and contract regulations. Previous concerns surrounding inconsistencies in messaging provided to the members as well as missing signatures or references to physician review have been fully resolved.

Metric Description	2019 Score	2020 Score
Basic rule — the MCO/BHMCO must dispose of each grievance and provide notice, as expeditiously as the enrollee's health condition requires. Standard disposition of grievances — 30 calendar days from the day the MCO receives the grievance. Extension of timeframes — the above timeframes may be extended by up to 14 calendar days if the enrollee requests the extension or there is need for additional information that is in the enrollee's interest. (42 CRF 438.408)	Partially Met	Met

Metric Description	2019 Score	2020 Score
File review and letter templates must contain the following information: • Result of the Grievance and any actions taken. • Date of Resolution and contact information should there be follow up questions. (42 CFR 438.408€)	Partially Met	Met
Content of the adverse benefit determination must include explanations of the following: • Action the MCO has taken or intends to take, reasons for the action, right and process to appeal MCO decision, direct access to SFH, availability of expedited resolution. • Right to benefits pending resolution, how to request benefit continuation, enrollee may be required to pay the costs of services. (438.404(b))	Partially Met	Met
Policies, procedures, SOPs, and manuals/handbooks clearly define the timelines for filing an appeal: • Following the receipt of a notification of an adverse benefit determination by the Contractor, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan. (42 CFR 438.402(c))	Substantially Met	Met
File review and letter templates must contain the following information: • Result of the Appeal. • Date of Resolution. • For Appeals not resolved wholly in favor of the member (partial denial) right to access a SFH and how to do so, right to request and receive Covered Services while the SFH is pending and how to make the request, and information that the enrollee may be held liable for costs of those services if the SFH decision upholds the MCOs/BHMCO's decision. (42 CFR 438.408(e))	Partially Met	Met

HHO 2020 Findings and Recommendations

The grievance system follows standard processes. Grievances can be received from members, member representatives, or providers orally through Member Services or through an HHO staff member (e.g., the member advocate), or be written (i.e., filling out a form on the HHO website and sending it in). If a grievance is received orally, the grievance coordinator completes a member grievance form and begins documenting the process. In the fourth quarter of 2016, the Appeals and Grievance Department began using a system called MedHOK to track, trend and to store all data for grievances. MedHOK is maintained and updated as needed to assure all regulatory and business reporting requirements are satisfied. Write-access to MedHOK is limited to grievance analysts and department management and support staff. Related departments are provided with read-only access to promote transparency and knowledge of a full member experience.

Grievance staff take the lead on investigations, sending acknowledgement letters to members and sending letters and faxes and/or making calls to providers to obtain information regarding the grievance. Depending upon the nature of the grievance, other HHO departments may be

involved in the investigation and resolution process. For instance, Provider Relations is sent QOS grievances, Provider Contracting is sent vision grievances, and QI is sent QOC issues and other clinical issues. As needed, additional consultation and input is received from a medical director, care/CM supervisors, pharmacy staff, and claims processing supervisors. Any information that is sent to other areas of HHO for investigation is returned to the grievance unit along with the investigatory findings. This information is used by the grievance unit to address the member's grievance and to craft a resolution letter; the grievance analyst then closes out the case.

Similar to grievances, standard appeals are accepted both orally (through Member Services) and in writing (through a form on the HHO website or through the form on the last page of the member's NOABD letter) and sent to HHO. Oral appeals, or appeals filed by providers, are required to have written member consent to move forward with the appeal process. The appeal process start date is the date the written appeal is received or the date the oral appeal is received, if written member consent is received within 10 calendar days from initial filing.

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

HHO meets most of the required BBA and contract standards based on review of policies, procedures, member handbooks, and the provider manual. In general, the grievance and appeal systems appear to function well. The unit has done a good job of integrating past EQRO recommendations into standard practice. The unit has a strong leadership team in place and has shown the ability to identify issues within their system and work to change processes to rectify them.

Mercer's 2019 comprehensive review yielded three CAP items. Items included NOABD language that was inconsistent with the contract regarding medical necessity, appeal timelines not being met, and not having a formal policy and/or procedure on governing recoupment of payment from members when the original denial was upheld and the member chose to receive services during the appeal. Two of these items have been satisfactorily resolved and have been scored as "Met". However, one item lingers and two new CAP items were identified. The one lingering item is related to the use of the term "medically necessary" used on pharmacy NOABD letters and the two new CAP items include inconsistent quality control processes as evidenced by incorrect information being sent to members and a lack of integration of QOC and QOS grievances in regards to tracking, trending, and reporting findings to all business unit. During the virtual session, it was discovered that HHO process for tracking, trending, and reporting QOC and QOS grievances was not integrated throughout all of the business units. The importance

of making other areas in the organization (such as Provider Network, UM, etc.) aware of these trends to be able to rectify issues accordingly was discussed during the session.

Grievance File Review

The grievance file review was performed using the File Review Protocol methodology outlined in Section 2. A sample of 30 grievance files was selected for review, representing Medicaid and DSHP Plus membership. Grievance subjects included categories such as access/availability of care, communication/relationships, transportation, QOC, and others. The files were assessed for compliance with BBA regulations, State contract requirements and HHO internal policy standards. The 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 HHO, and other documents supporting the investigation. The grievance file review demonstrated that documents and timelines were met according to BBA and contract regulations. The grievance files were found to have achieved 90% or greater compliance.

Appeal File Review

The appeal file review was performed using the File Review Protocol methodology outlined in Section 2. A sample of 30 appeals files was selected for review, representing Medicaid and DSHP Plus membership. The sample contained appeals that were overturned, partially overturned, withdrawn, and dismissed prior to the appeals committee meeting. Two expedited appeals were reviewed. The files were assessed

for compliance with BBA 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

Overall, 24 of 30 appeals files were found to have improper use of the term "medically necessary" on NOABD letters when denying pharmacy medication due to needed PA as well as when the medication was not on the preferred drug list. Medically necessary is defined as the essential need for health care or services delivered by or through authorized and qualified providers. PA and medications listed on the State's approved preferred drug list do not determine whether it is deemed medically necessary. During the virtual session, it was discovered that during the recent transition from Gateway the appeals quality control process was ineffective and resulted in incorrect information being sent to members. HHO stated that starting in September 2020, HHO began a quality control process, which encompasses 100% review of all appeal items being sent to members. While this should rectify the situation, further staff training fine-tuning of processes are recommended.

Metric Description	2019 Score	2020 Score
Basic rule — the MCO/BHMCO must dispose of each grievance and provide notice, as expeditiously as the enrollee's health condition requires. Standard disposition of grievances — 30 calendar days from the day the MCO receives the grievance. Extension of timeframes — the above timeframes may be extended by up to 14 calendar days if the enrollee requests the extension or there is need for additional information that is in the enrollee's interest. (42 CRF 438.408)	Met	Partially Met
Content of the adverse benefit determination must include explanations of the following: • Action the MCO has taken or intends to take, reasons for the action, right and process to appeal MCO decision, direct access to SFH, availability of expedited resolution. • Right to benefits pending resolution, how to request benefit continuation, enrollee may be required to pay the costs of services. (438.404(b))	Substantially Met	Substantially Met

Metric Description	2019 Score	2020 Score
Basic rule — the MCO/BHMCO must resolve each appeal and provide notice, as expeditiously as the enrollee's health condition requires. Standard disposition of appeals — for resolution of an appeal and notice to the affected parties, no longer than 30 calendar days from the day the MCO/BHMCO receives the appeal. Expedited resolution of appeals — no longer than three business days after the MCO/BHMCO receives the appeal. Extension of timeframes — the above timeframes may be extended by up to 14 calendar days if the enrollee requests the extension or there is need for additional information that is in the enrollee's interest. (42 CRF 438.408)	Partially Met	Substantially Met
The MCO policy, procedure, file review etc. has a policy to recoup the cost of services if the final resolution of the appeal is adverse to the enrollee and the enrollee has continued to receive services during the appeal, to the extent that services were furnished solely as a result of the appeal. (42 CFR 438.420(d))	Substantially Met	Met

Sub-contractual Relations and Delegation

The following federal regulation is addressed in this section: 438.230(a–b).

The intent of this regulation is to ensure the MCO has P&Ps in place which guarantee the MCO retains full accountability for any activities under the contract that are delegated to a subcontractor and that the MCO has processes in place to provide ongoing monitoring of contractors and the ability to take corrective action, if necessary.

ACDE 2020 Findings and Recommendations

ACFC provides support to ACDE for oversight of national subcontractors and delegates via its Delegated Vendor Audit Department; tools, processes and results appear robust and systematized. Results of the Delegated Vendor Audit Department activities are shared with ACDE via its quality committee structure. ACDE is responsible for delegation oversight at the local level, which includes credentialing oversight of Christiana and Nemours which is conducted with assistance from the national credentialing department. All delegated activities follow NCQA standards and consist of a pre-delegation audit, routine reporting, and an annual delegation audit. CAP oversight is shared between ACFC and ACDE. ACDE retains the final determination on decisions affecting delegated relationships. The biggest opportunity relative to subcontractors who are delegated network development and management is the Delaware contract requirements relative to operating a provider complaint system. There is no evidence that ACDE requires PerformRX, Avēsis, and Skygen to operate a provider complaint system consistent with the requirements outlined in its contract with the State.

HHO 2020 Findings and Recommendations

Each section contained within this report addresses specific details related to delegation and subcontractual relationships for that review area, as appropriate. The intent of this section of the report is to provide a broader overview of how each of the related entities oversees its various subcontractors and/or the internally delegated MCO operational areas. All delegated activities follow NCQA standards and consist of a pre-delegation audit, routine reporting, and an annual delegation audit; CAP oversight is shared between Corporate and HHO. HHO retains the final authority for decisions affecting delegated relationships.

HHO was formed via partnership between Highmark Blue Cross Blue Shield Delaware, Highmark Health Inc., its parent company, and related entity, Gateway Health. As such, each entity comprising this partnership has some level of delegation arrangement and delegation oversight responsibility.

Delegation oversight processes and tools have been enhanced over the years. However, the greatest opportunity that exists within the delegation oversight arena is HHO's oversight of its parent, Highmark Health, Inc. and of functions remaining at Gateway Health. For example, during the review, HHO indicated that NIA, the vendor used to for medical necessity decision making for high dollar radiology procedures, had not been transitioned to a HHO contract, the contract was still under Gateway Health. Oversight of NIA was being conducted directly by Gateway with involvement by HHO and any CAPs are managed directly by HHO: this is a concern.

Vendor scorecards have been developed that integrate financial, operational, service level agreement, and annual audit data. Vendors are reviewed based on a three-tier system which is predicated on the level of PHI or PII the vendor receives. While the Vendor Management Oversight team is responsible for national delegates, local delegates, such as those delegated credentialing are reviewed through the credentialing department.

Clinical Practice Guidelines and Coverage, and Authorization of Services

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MCO, with input from providers, has clinical practice guidelines in place that reflect the needs of enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210(a–f).

The intent of this regulation is to ensure services offered to members are clearly identified and that the MCO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

ACDE 2020 Findings and Recommendations

The updates made within the UM program demonstrate a comprehensive approach for improvement and incorporate findings and recommendations from the 2019 EQRO review and feedback. The highlights include a focus on linkage to other departments and discharge planning.

In 2019, ACDE made a strategic move to have one director oversee both UM and CC to improve coordination between the CC and UM departments. After assessing this move, ACDE has determined that having a senior leader focused on both units dilutes the ability to implement and monitor the key initiatives for UM and CC. Thus, ACDE communicated a planned change to the staffing organization, which designates a Director for UM and a separate Director for CC. ACDE will follow-up with DMMA on the time frame for this planned staffing change.

The MCO has improved processes that focus on discharging planning and coordination with CC and CM. Improvement shall be confirmed through ongoing file audits to demonstrate the application of the processes presented during this review. The discharge and service approval process does not include a process to assess and ensure cultural considerations when determining approval of services. ACDE also presented a preliminary PCP profiling plan that requires completion and DMMA approval. This plan will assist with coordination of care with PCPs to improve member outcomes and improved quality metrics.

The PARC list is intended to provide information for members or providers about services that are covered and those that require a PA. It is unclear how this is used by the internal ACDE staff to identify and communicate services that are covered, non-covered and require a PA for

both member and provider inquiries. It appears that the ACDE staff member would require the specific CPT code to verify the covered service protocol. Typically the caller would not have this level of detail, thus clarification on the utility of this list is needed.

ACDE delegates UM decision making to Magellan NIA for certain radiology requests (i.e., MRIs, PET, CTs). During the 2019 EQR, NIA had a high number of denials and subsequent appeals associated with those denials. ACDE submitted the executive summary for the annual delegation review, which included a high level summary of documents reviewed and accompanying assessments. The oversight plan did not include a process for ACDE and NIA to conduct inter-rater reliability to ensure the MCO agrees with the service denial. An assessment and confirmation of the accuracy of the decision process is vital to ensuring that the Delaware membership has access to appropriate services. Given previous findings this process should be integrated into the delegation oversight.

Metric Description	2019 Score	2020 Score
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.	Substantially Met	Not Met
The organizational chart and other program documents indicate staff making UM decisions have appropriate access to the medical director, and clinical staff with experience in BH and LTSS for service decision questions and consultations.	Substantially Met	Met
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; if a member refuses the release of medical information the non-participating provider must submit documentation of such refusal; informed consent is obtained for all contraceptive methods including sterilization consistent with requirements of 42 CFR 441.257 and 42 CFR 258. **Note**: DHCP members may not utilize Out-of-Network Family Planning Providers	Partially Met	Met
The MCO has a process to evaluate the training program of its delegates responsible for UM decision making, this may include results of delegation oversight audits and/or agendas, minutes or reports presented at a joint operating/delegation oversight committee.	Minimally Met	Minimally Met
The MCO has a process to evaluate a delegated entity's compliance with federal requirements set forth under 42 CFR 438.210 which includes: UM, program structure, coverage, authorization of service, notice of adverse benefit determination (standard authorization and expedited), and the compensation for utilization activities.	Partially Met	Partially Met

Metric Description	2019 Score	2020 Score
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.	Partially Met	Partially Met
The MCO UM department is available by phone 8 am–5 pm Eastern Time, Monday–Friday, except for State holidays, to render UM decisions for providers and available by telephone 24 hours a day, seven days a week to respond to authorization requests for inpatient hospitalization, or P&Ps that allow for emergency admissions with authorization the next business day. Information on how to access the UM department is found, at a minimum, in the Member Handbook, the Provider Manual, and the online website.	Partially Met	Met
The MCO has a completed UM Program Description approved by DMMA, that includes all of the required elements, including: 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, inter-rater reliability activities to ensure consistent application of review criteria. UM activities are not structured to provide incentives to deny, limit, or discontinue medically necessary services. The UM Trilogy documents are specific to Delaware Medicaid without documentation from other product lines. (42 CFR 438.210(e))	Substantially Met	Met
The MCO has a process to conduct PCP profiling to identify PCPs who appear to be operating outside peer norms and identify utilization, prescribing patterns, and/or QOC/QOS issues; information about patterns, trends or quality are documented and reported to the appropriate committee and steps are taken to address trends and variances.	Not Met	Partially Met
The MCO has a process to identify emergency and post stabilization services such that these services are not denied or members are denied access to such services. P&Ps and/or SOPs ensure requests for post-stabilization services are responded to within one-hour or they are considered "approved" by the State. (42 CFR 422.113(c), 42 CFR 438.114)	Substantially Met	Met
The MCO has a process to track minor home modification authorizations against service cost caps and has a process to share cost/cap information for members who change MCOs. There is a policy that allows the Contractor’s case manager may authorize service request exceptions above this limit when it determines the expense to be cost-effective.	Substantially Met	Met
Notices of Adverse Benefit Determination (member and provider) are completed and have been approved for use by DMMA; including those used by any delegates and/or sister entities.	Partially Met	Met
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.	Minimally Met	Partially Met
The MCO has a process to ensure that federally excluded services and certain services (OON family planning and NEMT) to DHCP members are excluded from coverage per Contract.	Partially Met	Met

Metric Description	2019 Score	2020 Score
The MCO has an integrated process for ensuring that member cost caps for the job ($6,000), the year ($10,000), and the lifetime maximum ($20,000) are not exceeded. This process includes how information is transmitted or received from other MCO when a member leaves or joins.	Partially Met	Met
The MCO has a process that ensures UM and clinical staff are trained and have access to Delaware membership-specific member benefits package information.	Not Met	Partially Met
The MCO has a process to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. (42 CFR 438.206(c)(2))	Not Met	Not Met
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.	Not Met	Met

HHO 2020 Findings and Recommendations

The structure and the vision of the UM department is described within the UM program description and led by the CMO, the Vice President of Care Management and the Director of UM (UM Care Coordinator). The updates made within the UM program took a comprehensive approach for improvement and incorporated findings and recommendations from the 2019 EQRO review. The highlights include an overall team structure redesign that clearly delineates the distinction of the clinical departments and promotes enhancements for communication and collaboration across the clinical departments. Additional work completed for UM key initiatives include a focus on discharge planning and the implementation of interdisciplinary rounds that include staff from UM, CM, and CC as well as resource coordination. HHO developed a comprehensive training plan to ensure that the UM staff are aware of the updated enhancements.

HHO delegates UM decision making to NIA for certain radiology requests (i.e., MRI, PET, CTs). During the 2019 EQR, Mercer noted that NIA had a high number of denials and subsequent appeals associated with those denials. HHO developed and implemented a comprehensive delegation oversight plan that identifies areas of opportunity and the steps needed for process improvement. The oversight plan includes the creation of the Joint Operating Committee (JOC) that meets monthly. The JOC offers the opportunity for HHO to review specific cases, targeting those where a denial has been rendered. The plan includes a process for HHO to review denials to determine inter-rater reliability. The tracking and trending of denials and appeal overturns demonstrate a decrease in cases denied and those overturned as well.

The initiatives resulted in the ability to close several CAP items for UM and many that remain open are on track for completion, only needing outcome reporting and review to validate the new processes put in place.

Metric Description	2019 Score	2020 Score
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 DE 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.	Partially Met	Met
UM staffing plan complete and submitted to DMMA for approval.	Substantially Met	Substantially Met
Organizational chart demonstrates how BH and LTSS UM functions are managed and coordinated within the MCO and across any delegates and/or sister entities.	Partially Met	Partially Met
Staff making UM decisions have required qualifications, including physical health (PH), BH and LTSS determinations. The UM Coordinator meets requirements in 3.20 and duties of UM Coordinator.	Substantially Met	Met
The MCO provided all policies and procedures specific to UM. Those policies clearly 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 delegates.	Substantially Met	Met
The MCO and its delegates have a training program that covers fundamental UM concepts, contractually required topics and addresses federal regulatory requirements as well as a process for identifying and addressing ad hoc training needs based on audit or other self-evaluation activities.	Substantially Met	Substantially Met
The MCO has a process to evaluate the training program of its delegates responsible for UM decision making, this may include results of delegation oversight audits and/or agendas, minutes, or reports presented at a joint operating/delegation oversight committee.	Minimally Met	Met
The MCO has a process to evaluate a delegated entity's compliance with federal requirements set forth under 42 CFR 438.210 which includes: UM, program structure, coverage, authorization of service, notice of adverse benefit determination (standard authorization and expedited), and the compensation for utilization activities.	Minimally Met	Partially Met
The MCO has a process to evaluate the compliance of its delegates responsible for UM decision making. Delegation oversight tools and file review should clearly demonstrate evaluation of the delegate's UM program for compliance with requirements set forth under 42 CFR 438.210 and Delaware contract standards.	Not Met	Met

Metric Description	2019 Score	2020 Score
The MCO has a completed UM Program Description approved by DMMA, that includes all of the required elements, including: 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, inter-rater reliability activities to ensure consistent application of review criteria. UM activities are not structured to provide incentives to deny, limit, or discontinue medically necessary services. The UM Trilogy documents are specific to Delaware Medicaid without documentation from other product lines. (42 CFR 438.210(e))	Partially Met	Met
The MCO provided an overview of their UM committee that includes: reporting structure, membership, responsibilities, meeting frequency, quorum and voting membership, how the UM committee review UM activities, BH utilization (including BH inpatient), PCP UM reports, and UM operational processes. The UM Committee is chaired by the CMO, or designee.	Minimally Met	Met
The MCO has a process to coordinate benefits provided by the State, such as dental services for children, prescribed pediatric extended care, day habilitation, non-emergency transport, specialized services as identified through PASRR assessments, Pathways employment services, BH services (children and adult). The process also provides a means for coordination of benefits (COBs) with Medicare, and with other State payment guidelines.	Partially Met	Met
The MCO's medical necessity definition is consistent with the State's definition in the contract and when appropriate uses the Delaware American Society for Addiction Medicine (DE-ASAM) criteria for BH services.	Partially Met	Met
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.	Partially Met	Met
The MCO has a formal process to ensure that staff are appropriately trained to use clinical decision support tools, and there is a process to evaluate the effectiveness and accuracy (i.e., inter-rater reliability) of UM decision making for all staff members.	Partially Met	Substantially Met
The MCO has a process to ensure that decisions for UM, member education, coverage of services ,and other areas to which the practice guidelines apply are consistent with the guidelines. (42 CFR 438.236(d))	Partially Met	Met
Notices of Adverse Benefit Determination (member and provider) are completed and have been approved for use by DMMA; including those used by any delegates and/or sister entities.	Partially Met	Substantially Met
The MCO has a process that articulates the policy and process as well as, roles and responsibilities relative to authorizations out-of-network services and single case agreements and pay out-of-network and single case agreement claims.	Substantially Met	Substantially Met

Metric Description	2019 Score	2020 Score
The MCO has a formal approach to ensure a successful transition of care such that the P&P to identify, authorize, and ensure discharge planning needs are fully addressed identifies the roles, responsibilities of all individuals who may be taking part in the discharge planning process (i.e., PROMISE members, those with comprehensive needs, or those at-risk for readmission.)	Partially Met	Substantially Met
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.	Partially Met	Substantially Met
The MCO has a process to ensure that federally excluded services and certain services (OON family planning and NEMT) to DHCP members are excluded from coverage per Contract.	Not Met	Partially Met
The MCO has a process to track BH admissions, readmissions, and monitor lengths of stay.	Substantially Met	Met
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.	Substantially Met	Met

Enrollment and Disenrollment

The following federal regulations are addressed in this section: 438.226 and 438.56(b–e).

The intent of these regulations is to ensure the MCO complies with the State enrollment and disenrollment requirements and limitations.

ACDE 2020 Findings and Recommendations

Mercer's 2019 comprehensive review yielded two CAP items. One item focused on staff training on contractually defined terms of disenrollment and transfer and to update all policies, procedures, and desk level procedures to reflect these terms. The other item focused on ACDE's P&P that would trigger instances where ACDE may request a member transfer to another MCO. Updated policies met contract requirements.

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

Metric Description	2019 Score	2020 Score
The MCO has a process for monitoring and notifying the State when a member meets a condition for disenrollment. (42 CFR 438.56(b)) • Loss of eligibility • Placement in an ICF/MR for more than 30 calendar days • Enrolled in error • Death • Move out of state • Inmate of a public institution. • Contract criteria for exclusion • MCO does not cover a service the member wants because of religious reasons. • Member requires related services to be provided at the same time and the services are not available • Other reasons such as lack of services covered under the contract, poor QOC, and lack of providers. (42 CFR 438.56(d)(ii)(2))	Substantially Met	Met
The MCO may request to transfer members for the following reasons: • Member consistently refuses to follow prescribed treatments or comply with MCO requirements. • Abusive or threatening member conduct. • MCO inability to safely and effectively care for DSHP LTSS member in the community. • The MCO follows procedures in 3.2.7.5.3-5 to first resolve difficulties leading to the request for transfer, notify the member in writing, and allow the member the right to grievance and to appeal the transfer.	Partially Met	Met

HHO 2020 Findings and Recommendations

In 2019, standards related to this area of review were compliant except for a small opportunity related to training internal HHO staff on use of contractually defined terms for disenrollment and transition. Training was conducted and this CAP item was addressed.

Mercer's 2020 CAP review cycle finds this issue fully resolved. All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

Metric Description	2019 Score	2020 Score
The MCO has a process for monitoring and notifying the State when a member meets a condition for disenrollment. (42 CFR 438.56(b)) • Loss of eligibility • Placement in an ICF/MR for more than 30 calendar days • Enrolled in error • Death • Move out of state • Inmate of a public institution. • Contract criteria for exclusion • MCO does not cover a service the member wants because of religious reasons. • Member requires related services to be provided at the same time and the services are not available • Other reasons such as lack of services covered under the contract, poor QOC, and lack of providers. (42 CFR 438.56(d)(ii)(2)	Substantially Met	Met

Quality Assessment and Performance Improvement Program

The following federal regulations are addressed in this section: 438.330.

The intent of these regulations is to ensure the MCO has an ongoing quality assessment and PIP for the services it furnishes to its enrollees. The assessment must include the following elements: performance improvement projects; collection and submission of performance measurement data; mechanisms to detect both under-utilization and over-utilization of services; mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs and enrollees using LTSS; prevention, detection, and remediation of CI.

ACDE 2020 Findings and Recommendations

There continues to be strong leadership in the QM/QI department that is supported by senior leadership within ACDE. The 2019 Quality Assessment Performance Improvement Evaluation includes a description of the QI and UM activities and initiatives that were defined in the 2019 QI Program Description toward improved quality and safety of CC and QOS. The analysis included an assessment of provider satisfaction, evaluation of service indicators, evaluation of clinical care, evaluation of the LTSS program, and related audit activities. The annual evaluation included a number of data analyses with conclusions and recommendations for improvement in 2020.

As ACDE considers those areas identified for improvement in the annual quality program evaluation, the Quality Assessment Performance Improvement Committee should explore the array of possible PIP topics, but at a minimum implement PIPs that meet the QS requirements. The service PIP that was in place in 2019 and is now retired has not been replaced.

As a result of the 2019 review, there were four CAP items to be addressed; during this review three were scored as "Met." The one outstanding item will be addressed in conjunction with the provider relations team to audit provider compliance with the requirement to supply a copy of a member medical record within 10 days and implement a process for corrective action if the provider was not compliant with the requirement.

Metric Description	2019 Score	2020 Score
The MCO and its delegates have a training program that covers fundamental quality management concepts and QI methodologies.	Substantially Met	Met
The MCO has a process to evaluate the training program of its delegates 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.	Substantially Met	Met
The MCO has a process to evaluate a delegated entity's QM/QI program to ensure alignment with the Delaware QS.	Partially Met	Met
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.	Partially Met	Partially Met

HHO 2020 Findings and Recommendations

The QM/QI department of HHO has faced significant challenges throughout the past four years. In 2017, the department did not evidence the anticipated maturation of the department expected since the MCO started operations in 2015. At the time of the 2018 EQR, the QM/QI department of HHO had added nine staff members: one Quality Manager, four additional Clinical Quality Management Associates, two Community Health Workers, and two additional Member Advocates. These positions were added to support expanded management of the QM/QI unit and program and to provide greater coordination of QM/QI activities, including PIPs. Early in 2019, it was determined that the department leadership and supporting staff were not meeting the need for improvement in the QM/QI department. At that time HHO leadership worked with its delegate, Gateway, to install an Acting Director of Quality, who stepped in to assess existing team members, QM/QI initiatives, and overall approach to QM and improvement throughout HHO. At the time of the review in July 2019 the QM/QI department did not have a permanent Director, and the Quality Manager position as well as the four Clinical Quality Management Analyst positions were staffed with temporary (to hire) staff.

In March 2020, HHO hired a full-time Director, QI; throughout 2020 the following positions were staffed with new HHO personnel:

- Quality Improvement Manager (May 2020)
- Clinical Project Manager (March 2020)
- Strategy Program Manager (September 2020)
- Senior Decision Support Analyst (August 2020)
- Clinical Quality Management Analysts (five positions, three new staff added since April 2020)
- Community Health Workers (three positions, one new staff added in 2020)

As noted in previous EQRO reports, there have been ongoing concerns around training and staff development and the impact of turnover within the QM/QI department. As seen in the bullets above, a significant portion of the QI department was new to HHO in 2020. The lack of an adequate continuity plan to ensure that QI initiatives continue when there is turnover within the QI department as well as the lack of a fully developed and implemented training program that covers fundamental QM concepts and QI methodologies have presented challenges to a strong QI program, integration of quality concepts throughout the organization and implementation of innovative interventions aimed at improving the health and wellbeing of the Medicaid members.

The 2020 Quality Program Description contains appropriate goals and objectives and the annual work plan; the document describes the committee structure and the roles and responsibilities of the various subcommittees that report to the HHO QI/UM Committee. The Annual Evaluation of the Quality Improvement and Utilization Management Program for 2019 includes a description of the QI and UM activities and initiatives throughout 2019. The analysis included evaluation of service indicators, consumer and provider satisfaction, evaluation of clinical care, evaluation of the LTSS program, audit activities, and recommendations for 2020. The annual evaluation included a number of data analyses with conclusions and recommendations for improvement noted. HHO conducts studies specifically to test the DSHP Plus LTSS program effectiveness. Three metrics are chosen for study: quarterly reporting of private duty nursing (PDN) missed hours, quarterly reporting of specialized services (most utilized services), and alternative service wait time reporting. It does not appear that HHO conducts the same utilization and readmission analysis for the DSHP Plus population as for the Medicaid and CHIP populations; this lack of analysis may result in missed opportunities to identify opportunities for improvement in this population.

Metric Description	2019 Score	2020 Score
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.	Partially Met	Met
Staffing for QM/QI is adequate to support continuous QI and all QI requirements for the Delaware population.	Minimally Met	Met
There is an adequate continuity plan to ensure that QI initiatives continue when there is turnover within the QI department.	Partially Met	Partially Met
The MCO organization chart indicates that QM/QI processes are integrated throughout all areas of the organization and the QM/QI department has ultimate responsibility for all QM/QI activities.	Partially Met	Partially Met
Departmental leads demonstrate active roles within PIPs and other QI initiatives.	Partially Met	Partially Met
The MCO and its delegates have a training program that covers fundamental QM concepts and QI methodologies.	Not Met	Minimally Met
The MCO has a process to evaluate the training program of its delegates 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.	Not Met	Partially Met
The MCO has a process to evaluate a delegated entity's QM/QI program to ensure alignment with the Delaware QS.	Not Met	Partially Met
The MCO QM/QI annual program description presents the quality performance and improvement goals and objectives of the MCO, as well as the quality monitoring and QI activities of the MCO and any delegates for the year. (42 CFR 438.330 (b))	Substantially Met	Met
The MCO has a process to assess the quality and appropriateness of care provided to DSHP Plus LTSS members and members with special health care needs. (42 CFR 438.330(b))	Substantially Met	Substantially Met
The MCO participates in efforts to prevent, detect, and remediate critical incidents. (42 CFR 438.330(b))	Substantially Met	Substantially Met
The MCO participates in efforts to improve health disparities identified through data collection.	Partially Met	Substantially Met
The MCO QM/QI annual program description explains how performance measurement data (including UM information and data from any delegates) are used to develop quality initiatives and PIPs. The program description also presents the process for reporting the required PMs to the State. This includes how the data are gathered, validated, reported, and who the responsible individuals/committees are for attesting to the accuracy and completeness of the submissions (QCMMR and CMS core measures). (42 CFR 438.330(c) and (d))	Partially Met	Met

Metric Description	2019 Score	2020 Score
The MCO UM program description explains how data (including UM information) are reported to the QM/QI department and are used to develop quality initiatives and PIPs. (42 CFR 438.330(b))	Partially Met	Met
The MCO ensures prompt transfer of medical records to both participating and non-participating providers. If a member changes PCPs, medical records (or copies) are forwarded to the new PCP within 10 business days of request.	Substantially Met	Substantially Met
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.	Substantially Met	Substantially Met
The MCO P&Ps require any MCO staff member or staff member of a subcontractor to report when they have reasonable cause to believe that a member has been abused, mistreated, neglected, or financially exploited or experienced any other type of critical incident (as defined in State policy).	Substantially Met	Met
The MCO P&Ps require the MCO to report to DMMA and the appropriate investigative agency all information known about a critical incident. The MCO telephones DMMA and the investigative agency immediately and follows up in writing within eight hours.	Substantially Met	Met
The MCO provider practice analysis includes review of a provider's practice methods and patterns, including quality outcomes, prescribing patterns, morbidity/mortality rates, and all grievances filed against the provider related to medical treatment.	Minimally Met	Minimally Met
The MCO provider practice analysis includes evaluation of the appropriateness of care rendered.	Minimally Met	Minimally Met
The MCO provider practice analysis includes implementation of a CAP, if necessary.	Not Met	Minimally Met
The MCO provider practice analysis includes development of policy recommendations to maintain or enhance the QOC provided to members.	Not Met	Partially Met
The MCO provider practice analysis includes a review of the appropriateness of diagnosis and subsequent treatment, maintenance of provider medical/case records, adherence to generally accepted standards in terms of outcome and care.	Not Met	Partially Met
The MCO peer review process includes receipt and review of all written and oral allegations of inappropriate or aberrant service by a provider.	Partially Met	Substantially Met

Coordination and Continuity — Primary Care and Special Health Care Needs

The following federal regulation is addressed in this section: 438.208(h)(1–7).

The intent of this regulation is specify how care is provided in order to promote coordination and continuity of care to ensure the MCO has procedures to deliver primary care appropriate to a member's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208(d–g).

The intent of this regulation to address services provided to enrollees with special health care needs, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care.

The contractor shall develop and implement an integrated CC program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize quality of care and member health outcomes.

All member level CC: For the contractor's entire member population, the contractor shall provide appointment assistance and linkage to covered services and non-covered services with the objective of facilitating member access to medically necessary services and identifying members who could benefit from wellness programs. In addition, with the objective of engaging members in wellness and healthy behaviors, the contractor shall maintain an up-to-date registry of all wellness, health education, disease management, and self-management programs and activities available to members and accepting new members.

Level 1 Resource Coordination (RC): Members eligible to participate at this level shall be determined by predictive modeling to meet any of the following conditions: pregnancy, one or more chronic conditions, gaps in preventive care (shown by HEDIS or other outcome measures), comorbid PH and BH conditions, high inpatient hospital utilization, polypharmacy, overutilization of prescription drugs, or high rate of LANE visits to the emergency room. The contractor is required to actively assist providers in discharge planning for Level 1 members following acute episodes of care involving, at a minimum, one of the following services: inpatient psychiatric stay, ambulatory surgery, hospital inpatient stay, and rehabilitation facility services. In addition, the contractor shall actively engage members with LANE use of the ED back to their PCP and identify barriers and coordinate the member's linkage back to primary care services.

Level 2 CCC: Members determined eligible for Level 2 may include those members who have multiple chronic conditions including substance use disorder or comorbid PH and BH conditions, complex health conditions, complex service needs requiring supported coordination of care, history of poor outcomes, utilization patterns that suggest inadequate linkage to primary and preventive care, or other indicators of high risk or potential for poor health outcomes. For all Level 2 members, the contractor shall provide CCC. Members shall have the right to participate or decline participation in CCC.

ACDE 2020 Findings and Recommendations

The MCO began operations in Delaware in 2018. Although some progress has been made with regard to the development of an effective CC program, the MCO continues to struggle in this area. The Director of Population Health is responsible for both the CC and the UM units. While this is not specifically prohibited in the contract, it does not appear that this is a manageable approach, particularly given the extent of improvements needed in order to address ongoing issues identified in the MCOs CC program. The MCO has developed standards of practice and a program description that describes an integrated CC program. However, file reviews conducted show little improvement in this area and do not demonstrate the provision of integrated and coordinated care.

On October 14, 2020, the MCO submitted final revisions to the Risk Stratification Plan to DMMA, which includes the Delaware specific requirements for Level 1 and Level 2 Risk Stratification. In order to close out the risk stratification CAP items, it will be important for the MCO to provide evidence of ongoing validation testing to confirm the revised risk stratification algorithm is producing valid and reliable results.

The MCO has made progress with regard to appropriate staffing levels. In 2019, the MCO filled a number of staff vacancies, provided training to RC regarding managing members with LANE ED visits and developed a LANE analysis report and workflow. Despite training and policy development efforts, file reviews indicate there is a need to continue to evaluate the extent to which RC supports are effective in assisting members to avoid LANE ED visits and redirecting these members to primary care supports.

Emerging Best Practice

The MCO's BH CMO has been exploring the use of certified peer specialists to enhance outreach to members with BH conditions, including substance use disorders; the use of technology such as telehealth and zoom conferencing is being explored. The BH CMO is also in the process of meeting with hospital/inpatient facility Chief Executive Officers to discuss how discharge and transition planning can be enhanced for members with BH challenges.

All Member Level Coordination

The MCO has taken steps to address completion of HRAs to meet the contract requirement for completion of an HRA with at least 50% of new members within 60 days of enrollment. The MCO put a member incentive program in place to support HRA completion. Because the program did not provide the outcomes the MCO had hoped for, alternative interventions are being considered moving forward. Meeting the contract requirements for HRA completion continues to be a challenge for the MCO.

Level I Resource Coordination

Although some progress has been made with regard to the development of an effective Level I RC program, the MCO continues to struggle in this area. The MCO has a detailed standard operating procedure for transitions of care and has placed RC in key inpatient facilities. This is intended to bolster the extent to which discharge and transition activities are occurring prior to member discharges; however, based on file reviews, it appears RC do not have the requisite experience or expertise to fully appreciate member discharge/transition needs or the need for ongoing RC.

While the MCO has continued to work on tools and auditing processes for RC oversight, there continues to be little evidence, based on file reviews, that the audits are effective in identifying or addressing qualitative aspects of RC such as follow up on member issues/concerns and assistance with discharge planning activities.

The MCO provided information about how it addresses outreach to members experiencing an acute episode of care, including P&Ps for embedded CC staff. However, file review findings and discussions during the virtual onsite review highlighted concerns regarding the overall effectiveness of the processes in place.

Level 1 Resource Coordination File Review

The Level 1 RC file review was performed using the File Review Protocol methodology outlined in Section 2. A sample of 15 files was selected for review, including children and adults, pregnant members, and members with BH conditions. The files were assessed for compliance with BBA regulations, State contract requirements, and ACDE internal policy standards. The following elements were included in the review:

- Documentation of timely outreach and engagement
- Evidence of HRA completion
- Evidence of follow up after hospitalizations and ED visits to link members with their PCP
- Documentation of coordination with PCPs or other providers

The general findings of the Level 1 RC file review are listed below:

- RCs would benefit from registered nurse clinical assistance to ensure members are appropriately supported to address medical needs and appropriately stratified and referred for additional/ongoing RC supports. This was particularly evident for RC who are embedded in hospitals and other inpatient facilities.
- There is a need to ensure internal auditing processes capture both qualitative and quantitative aspects of the delivery of discharge planning and other supports.
- The documentation found in the files lacked sufficient detail to conceptualize or determine the RC supports provided to the member. Most files showed a lack of timely and consistent outreach and engagement.
- Members with substance use disorders are not consistently identified or referred for RC or after care services following inpatient admissions.
- There is an opportunity for improvement in managing members with LANE ED utilization.

Level 2 Clinical Care Coordination

The MCO has P&Ps for outreach and engagement that align with contract requirements for Level II CCC; however, several file reviews revealed weak outreach attempts without active pursuit of new/valid contact information when members could not be reached.

While the MCO has continued to work on tools and auditing processes for CCC oversight, there continues to be little evidence, based on file reviews, that the audits are effective in identifying or addressing qualitative aspects of Level II CCC such as follow up on member issues/concerns and member centric care planning.

The MCO continues to have an open CAP item related to the provision of CCC for members receiving eight hours or more of PDN. To date, the MCO has not been assigning both a nurse and social work care coordinator to these members, but rather has been assigning a nurse as the member's single clinical care coordinator and providing a social worker for consultative purposes. Following the virtual onsite review, the MCO provided follow up information indicating these members will "receive an offer" for co-management with a nurse and social worker. In order to close out this CAP item, the MCO needs to submit the process that describes how the MCO will assign a nurse and a social worker for members with more than eight hours of PDN and describe how the activities of the nurse and social worker will be coordinated by the MCO to provide maximum benefit and support to the member/family caregiver.

Level 2 Clinical Care Coordination File Review

The Level 2 CCC file review was performed using the File Review Protocol methodology outlined in Section 2. A sample of 15 files was selected for review, including children and adults, pregnant members, members receiving PDN, and members with BH conditions, including substance use disorders. The files were assessed for compliance with BBA regulations, State contract requirements, and ACDE internal policy standards. The following elements were included in the review:

- Documentation of timely outreach, engagement, and face-to-face visits
- Evidence of follow up after hospitalizations and ED visits to link members with their PCP
- Follow up to assessment findings and issues/concerns cited by members
- Documentation of coordination with PCPs or other providers
- Evidence of follow up on achievement of care plan goals and objectives

The general findings of the Level 2 CCC file review are listed below:

- The EQRO observed improved documentation in some CCC files during this review as compared to the previous review. For example, the files included more consistent assessment and POC completion; however, this was not consistent across the files reviewed.
- Files continue to demonstrate inconsistency with follow up to needs identified during assessment and confirmation that follow up services were delivered. Most files lacked evidence of consistent coordination with providers and other supports.
- The MCO needs to ensure internal auditing processes capture both qualitative and quantitative aspects of the delivery of Level II CCC. There is also a need to develop a process for tracking and trending audit findings.

Metric Description	2019 Score	2020 Score
The MCO has an organizational chart for the CC program that includes the names of senior and departmental management, the number of FTEs per department/position, the staff supporting Delaware population, including those shared across other State programs (if applicable), and notes staff situated in Delaware and identifies any open positions. (Note: Assess organizational chart for all three levels of CC.)	Partially Met	Met
The MCO and its delegates have a process for assessing its staffing needs relative to mandated caseload requirements and CC decision making. (Note: Assess staffing approach and caseloads to address all three levels of CC.)	Partially Met	Met
The MCO has a process to ensure that staff who require supervision, including clinical care coordinators, are provided adequate supervision by qualified staff. Supervisor to clinical care coordinator should not exceed 1:15. (Note: Assess for all three levels of CC.)	Minimally Met	Met
The MCO has field based staff allocated by county and can adjust based on membership thresholds to support appointment referral and linkage requirements. Clinical care coordinator caseloads should not exceed a ratio of 1:50. The job responsibilities and qualifications by position are appropriate and certification standards are met where appropriate. Staffing should reflect assignment of a nurse and social worker as care coordinators to any member receiving more than eight hours of PDN.	Minimally Met	Met
The MCO has designated, qualified BH Specialists to support the needs of members with BH and substance use treatment needs.	Minimally Met	Met
If the MCO delegates CC activities to persons or entities other than the MCO’s CC staff, there is evidence the State has approved the delegation arrangement and oversight plan.	Partially Met	Met
The MCO has a process to conduct HRAs on all new members within 60 days of enrollment. The process is designed to ensure at least 50% of those member's received a HRA and to identify and refer high-risk members for further CC services.	Minimally Met	Partially Met

Metric Description	2019 Score	2020 Score
The MCO provided data regarding HRA completion, evidences compliance with 60-day outreach standard and demonstrates active outreach and engagement within the first 30 days.	Minimally Met	Met
The MCO has an integrated CC program that eliminates fragmentation in care and promotes education, communication, and access to health information for members and providers to optimize QOC and member health outcomes. The CC program is based on risk stratification and rooted in a population health model, touches members across the entire care continuum, promotes healthy behaviors, provides face-to-face care coordination as needed, and is supported by evidence based medicine and national best practices.	Partially Met	Partially Met
The MCO has a well-defined process to ensure comprehensive CC to all members based on member's risk level. CC efforts incorporate pharmacy, BH providers, DSAMH, and other community-based entities including school-based wellness centers. The process should address coordination of physical and BH conditions and social determinants of health needs.	Minimally Met	Partially Met
The MCO has a process to coordinate care for members with BH needs with DSAMH and referrals for members who may be eligible for PROMISE.	Minimally Met	Partially Met
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.	Minimally Met	Substantially Met
The MCO has a State approved predictive modeling algorithm, which includes, at a minimum, the following data: claims, pharmacy, lab results, supplemental information from providers, referral and utilization patterns, and/or HRA results.	Minimally Met	Substantially Met
The MCO has a process to identify pregnant members using 834 enrollment data, claims, referrals, or other methods identified by the MCO.	Partially Met	Partially Met
The MCO provided data, regarding CC stratification and outreach, demonstrates successful activities for engaging members in appropriate levels of CC.	Minimally Met	Substantially Met
The MCO has a process to effectively identify children with special needs, children in need of EPSDT services, and pregnant members.	Partially Met	Partially Met
The MCO's predictive model identifies eligible Level 1 members and includes the following conditions/factors: pregnancy, one or more chronic conditions, gaps in preventive care, comorbid PH-BH conditions, high inpatient utilization, polypharmacy, high rates of LANE ED utilization.	Minimally Met	Met
The MCO's predictive model identifies eligible Level 2 members and includes the following conditions/factors; multiple chronic conditions, complex service needs, history of poor outcomes, utilization patterns that suggest linkage to primary and preventative care or other indicators of high risk or potential for poor outcomes.	Minimally Met	Substantially Met
The MCO's CC program incorporates clinical practice guidelines, cultural, and linguistic needs and demonstrates coordination between PH and BH providers.	Partially Met	Met

Metric Description	2019 Score	2020 Score
The MCO has a process to identify enrollees with special health care needs consistent with the definition in the states' QS. The CC system, file review/scenario responses identify the special health care needs and evidence a member centric CC plan.	Minimally Met	Met
The MCO has a documented process to identify and track gaps in care inclusive of all elements of EPSDT services and applicable HEDIS measures.	Minimally Met	Met
The MCO has a process to link members to needed community resources, including BH and substance use treatment.	Partially Met	Met
The MCO has developed a comprehensive wellness registry that is accessible online by members, providers, and MCO staff and contains up to date information on all wellness, health education, disease management, and self-management programs available to members and that are accepting new participants. The registry is searchable by type of activity, location, price, indicates if the program is a covered service, and any additional eligibility requirements.	Substantially Met	Met
The MCO has a process to utilize stratification results to identify members most appropriate for Level 1 RC CC and such a process includes the ability to re-stratify a member to a higher level.	Minimally Met	Substantially Met
The MCO has created a threshold for high rates of LANE ED utilization, which determines the members identified for outreach and engagement into the primary care setting.	Minimally Met	Met
The MCO has a process to actively outreach and engage members who have reached the threshold of having LANE ED utilization and has taken steps to identify and remove barriers as well as coordinate linkage to primary care services to mitigate further LANE ED utilization.	Minimally Met	Partially Met
The MCO has a process to actively engage PCPs whose members have reached the established threshold for LANE ED utilization that incorporates other business units such as quality and/or provider services to identify barriers and influence PCP behavior, as appropriate.	Minimally Met	Met
The MCO uses continuous QI activities to reduce LANE ED utilization and address identified barriers to primary care.	Partially Met	Partially Met
The MCO has a process for outreaching to members experiencing an acute episode of care (i.e., acute inpatient, psych inpatient, ambulatory surgery, inpatient rehabilitation) to assist with identification and coordination of discharge planning needs (e.g., appointments, referrals and linkages to services, coordination of DME, PA).	Minimally Met	Partially Met
The MCO has a process to assist providers (e.g. hospital case managers, social workers) in discharge planning activities for Level 1 members to ensure all services are authorized and equipment delivered to support the transition of care.	Minimally Met	Partially Met
The MCO engages continuous QI efforts to enhance transition and discharge planning, reduce readmissions, improve member experience, and outcomes of care.	Minimally Met	Met
The MCO has a process to monitor and oversee non-clinical resource coordinators, including appropriate supervisor to staff ratios, conducting inter-rater reliability and file audits, taking action on identified gaps in knowledge and variance from approved processes.	Minimally Met	Partially Met

Metric Description	2019 Score	2020 Score
The MCO has a process to evaluate the success of the RC Program, which includes metrics and benchmarks for performance, activities to close identified gaps or variances, and incorporates continuous QI activities.	Not Met	Partially Met
The MCO has a process to utilize stratification results and other referral sources to identify members most appropriate for Level 2 CCC and such a process includes the ability to re-stratify a member to a lower level.	Minimally Met	Substantially Met
The MCO has P&Ps that indicate all initial outreach occurs within 15 days of member being identified as eligible; with a minimum of five attempts made within the first 90 days, including at least one documented face-to-face 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 substance use disorder, the MCO outreaches to DMMA, DSAMH, or other agencies or providers prior to closing the case.	Partially Met	Partially Met
The MCO's P&Ps require CCCs to outreach to eligible members within 30 calendar days to complete a comprehensive assessment (e.g., PH, BH, social, environmental, cultural, psychological needs) including input from the member's caregivers, family, PCP, and other providers as appropriate. All outreach and coordination efforts are documented within the member's file and demonstrate active and good faith efforts to incorporate provider involvement in CC activities.	Minimally Met	Partially Met
The MCO's P&Ps, file reviews, and/or tracer scenarios evidence person-centered planning processes. All plans of care include at a minimum prioritized goals and actions, effective and comprehensive transition of care plan, a communication plan with PCP and other providers, list of providers delivering services to the member, listing of other services received by programs other than those provided by the MCO (to avoid duplication), evidence of referral to community or social support services, frequency of ongoing member contacts, identification, and plans to close gaps in care. Documentation demonstrates that a member receives a copy of their POC.	Minimally Met	Partially Met
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 contact every six months with members enrolled in Level 2 CCC and requires documentation of all outreach attempts.	Minimally Met	Partially Met
The MCO has tools and processes to conduct inter-rater reliability 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.	Minimally Met	Partially Met
The MCO has a process to evaluate the success of the Level 2 CCC Program, which includes metrics and benchmarks for performance, activities to close identified gaps or variances, and incorporates continuous QI activities.	Not Met	Partially Met

HHO 2020 Findings and Recommendations

The MCO addressed many of the areas identified through the 2019 comprehensive EQR review and subsequent CAP items. As a result, a number of CAP items were closed.

The MCO provided information about the development of a standard governance process for all vendors and subcontractors, indicating that all vendors are held to similar standards based on DMMA requirements. However, the MCO did not provide information clarifying whether or not Envolve People Care or Eliza are considered to be formal delegates or subcontractors.

The MCO is required to have a process to conduct HRAs of new members within 60 days of enrollment with at least 50% completion rate. The MCO provided the end-to-end process and gap analysis conducted to evaluate the HRA completion process. However, the MCO has not been successful in meeting the contractually required minimum completion rate for HRAs.

The MCO developed a workgroup to implement a standardized process and staff training to promote integrated care. File reviews indicate there continues to be an opportunity to strengthen the extent to which care coordinators are providing integrated CC supports.

Although the MCO provided information about the policies, procedures, and workflows in place for identification of pregnant members, file reviews of pregnant members indicate there is a significant and immediate need to address the standards of practice through which pregnancy CC is being provided and the level of resource/CC provided to pregnant members, particularly those who are at high risk for adverse outcomes.

Emerging Best Practices

The MCO has secured a vendor to address integrated CC with integration of health related social needs (HSRNs) and the Delaware Health Information Network (DHIN). The first phase of implementation is projected for April 2021.

Level 1 Resource Coordination

The MCO provided information about enhancements and improvements to the outreach process within the Triage and Outreach Pod (TOP) for members identified as having LANE ED visits, including a newly approved LANE ED Utilization policy, a plan to utilize IVR for outreach to members with LANE ED visits, and a revised file audit tool. File reviews indicate there is an opportunity to strengthen the extent to which care coordinators are following the outreach process and policy, following up with members with LANE ED visits and linking members to their PCP for appointments and timely follow up.

The MCO described efforts intended to address discharge and transition planning. The need for this was highlighted via file reviews that indicated there continues to be an opportunity to strengthen the discharge and transition supports provided to members.

Emerging Best Practices

The MCO described efforts to bring together a team of cross-departmental subject matter experts from CC, UM, LTSS, and quality to address discharge planning and efforts to understand, align, and integrate the processes, policies, workflows, roles, and responsibilities of all stakeholders in the discharge process. Target completion date for this activity is by the end of 2020.

The MCO provided information about the development of the Clinical Services Audit Team, which will conduct targeted audits and use the results of the audits to provide coaching and training to care coordinators. This is important as there continues to be an opportunity, based on file review findings, to apply an auditing process that considers both the qualitative and quantitative elements of service provision in order to ensure member records reflect the provision of timely, effective, and comprehensive CC supports.

The MCO formed a committee to identify quality measures for the purpose of evaluating the success of the RC program. The work of this group is expected to be complete in January 2021.

Level 1 Resource Coordination File Review

The Level 1 RC file review was performed using the File Review Protocol methodology outlined in Section 2. A sample of 15 files was selected for review, including children and adults, pregnant members, and members with BH conditions. The files were assessed for compliance with BBA regulations, State contract requirements, and HHO internal policy standards. The following elements were included in the review:

- Documentation of timely outreach and engagement
- Evidence of HRA completion
- Evidence of follow up after hospitalizations and ED visits to link members with their PCP
- Documentation of coordination with PCPs or other providers

The general findings of the Level 1 RC file review are listed below:

- File reviews for pregnant members indicate an immediate need to address the standards of practice through which pregnancy CC is being provided and the level of resource/CC provided to pregnant members, particularly those who are at high risk for adverse outcomes.
- HRAs are consistently included in the CC files but are not necessarily completed within 60 days

- Files continue to demonstrate inconsistency with follow up to needs identified during assessment.
- File documentation appears to indicate that members are receiving calls from a number of different CC staff as opposed to having a single point of contact. It is unclear if as many member needs are being met as possible during each outreach/encounter.
- Documentation indicates an improvement in outreach to pharmacies and PCPs to request updated contact information for members who cannot be reached using the contact information on file at the MCO.
- Evidence of effective discharge and transition planning supports were not consistently found in the files reviewed.
- File reviews indicate there is an opportunity to strengthen the extent to which care coordinators are providing integrated CC supports.
- One member file included information about a member's dissatisfaction with non-emergent medical transportation services. There was no evidence in the file that the grievance process was followed.

Level 2 Clinical Care Coordination

The MCO continues to struggle with collecting and reporting valid and reliable Level II CCC data.

File review findings indicate a continued need to develop audit tools that evaluate the extent to which care plans are member centric and address PH, BH, and HSRNs. File review findings also reflect a need for staff training regarding comprehensive care planning.

The MCO does not currently have a process for identifying quality measures or processes for tracking and trending audit results to evaluate overall CC program performance.

Emerging Best Practices

The MCO has secured a vendor to address the lack of integration between the CC system/platform and other systems. Expected start date for the integration initiative is October 2020 and the first phase of implementation is projected for April 2021.

According to the MCO, the CC unit is working with the analytics unit to ensure accurate, valid, and reliable data collection for CC provided to Level II members. The target date for completion of this initiative is December 2020.

The MCO has developed revised audit tools to evaluate the extent to which care plans are member centric and address members' needs for integrated CC supports. In addition, training is planned for 2020 to address improvements needed in the care planning process.

A committee has been formed and has been charged with identifying quality measures and processes for reviewing action plans, tracking and trending audit results, and developing efforts to support continuous improvement. The work of this committee is projected to be completed in January 2021.

Level 2 Clinical Care Coordination File Review

The Level 2 CCC file review was performed using the File Review Protocol methodology outlined in Section 2. A sample of 15 files was selected for review, including children and adults, pregnant members, members receiving PDN, and members with BH conditions, including substance use disorders. The files were assessed for compliance with BBA regulations, State contract requirements, and HHO internal policy standards. The following elements were included in the review:

- Documentation of timely outreach, engagement, and face-to-face visits
- Evidence of follow up after hospitalizations and ED visits to link members with their PCP
- Follow up to assessment findings and issues/concerns cited by members
- Documentation of coordination with PCPs or other providers
- Evidence of follow up on achievement of care plan goals and objectives

The general findings of the Level 2 CCC file review are listed below:

- As noted in the Level 1 file review section, there is an immediate need to address the standards of practice through which pregnancy CC is being provided and the level of resource/CC provided to pregnant members, particularly those who are at high risk for adverse outcomes.
- File reviews indicate there is an opportunity to strengthen the extent to which care coordinators are providing integrated CC supports and supports for members with LANE ED visits.
- Files continue to demonstrate inconsistency with follow up to needs identified during assessment

Metric Description	2019 Score	2020 Score
The MCO has designated, qualified BH Specialists to support the needs of members with BH and substance use treatment needs.	Partially Met	Met

Metric Description	2019 Score	2020 Score
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.	Partially Met	Met
If the MCO delegates CC activities to persons or entities other than the MCOs CC staff, there is evidence the State has approved the delegation arrangement and oversight plan.	Partially Met	Partially Met
The MCO has a process to conduct HRAs on all new members within 60 days of enrollment. The process is designed to ensure at least 50% of those member's received a HRA and to identify and refer high-risk members for further CC services.	Minimally Met	Partially Met
The MCO provided data regarding HRA completion, evidences compliance with 60-day outreach standard, and demonstrates active outreach and engagement within the first 30 days.	Minimally Met	Partially Met
The MCO has a well-defined process to ensure comprehensive CC to all members based on member's risk level. CC efforts incorporate pharmacy, BH providers, DSAMH, and other community-based entities including school-based wellness centers. The process should address coordination of physical and BH conditions and social determinants of health needs.	Partially Met	Substantially Met
The MCO has a process to identify pregnant members using 834 enrollment data, claims, referrals, or other methods identified by the MCO.	Partially Met	Minimally Met
The MCO has a process to effectively identify children with special needs, children in need of EPSDT services, and pregnant members.	Partially Met	Met
The MCO has an effective process to provide members telephonic access to CC supports after hours, holidays, and weekends for members with CC needs. Note: Assess how the members are educated about how to access CC and the use of nurse triage lines if appropriate.	Substantially Met	Met
The MCO's CC program has a documented process to coordinate services for members who may have other primary insurance (i.e., duals) and file review/scenario responses evidences such coordination.	Substantially Met	Met
The MCO has a process to identify enrollees with special health care needs consistent with the definition in the states' QS. The CC system, file review/scenario responses identify the special health care needs and evidence a member centric CC plan.	Partially Met	Met
The CC system(s) provide a single comprehensive member record that documents member interactions, outreach attempts, member refusal, assessment information, and clinical conceptualization appropriate for assigned care coordination level.	Minimally Met	Partially Met
The MCO has a documented process to track EPSDT service utilization. This process shall include notification to PCPs about screening due dates, outreach to members to coordinate services, and a process to track necessary referrals and completion of identified treatment plan in accordance with EPSDT guidelines.	Substantially Met	Met

Metric Description	2019 Score	2020 Score
The MCO has created a threshold for high rates of LANE ED utilization, which determines the members identified for outreach and engagement into the primary care setting.	Partially Met	Substantially Met
The MCO has a process to actively outreach and engage members who have reached the threshold of having LANE ED utilization and has taken steps to identify and remove barriers as well as coordinate linkage to primary care services to mitigate further LANE ED utilization.	Partially Met	Substantially Met
The MCO has a process to actively engage PCPs whose members have reached the established threshold for LANE ED utilization that incorporates other business units such as quality and/or provider services to identify barriers and influence PCP behavior, as appropriate.	Partially Met	Substantially Met
The MCO uses continuous QI activities to reduce LANE ED utilization and address identified barriers to primary care.	Partially Met	Substantially Met
The MCO has a process to identify hospitalized members experiencing an acute episode of care (i.e., acute inpatient, psych inpatient, ambulatory surgery, inpatient rehabilitation) in a timely manner. The process should include how discharge planning activities (e.g., appointments, referrals and linkages to services, coordination of DME, PA) are conducted after-hours, weekends, and holidays.	Partially Met	Substantially Met
The MCO has a process for outreaching to members experiencing an acute episode of care (i.e., acute inpatient, psych inpatient, ambulatory surgery, inpatient rehabilitation) to assist with identification and coordination of discharge planning needs (e.g., appointments, referrals and linkages to services, coordination of DME, PA).	Partially Met	Substantially Met
The MCO has a process to assist providers (e.g. hospital case managers, social workers) in discharge planning activities for Level 1 members to ensure all services are authorized and equipment delivered to support the transition of care.	Partially Met	Substantially Met
The MCO has a process to monitor and oversee non-clinical resource coordinators, including appropriate supervisor to staff ratios, conducting inter-rater reliability and file audits, taking action on identified gaps in knowledge, and variance from approved processes.	Partially Met	Substantially Met
The MCO has a process to evaluate the success of the RC Program, which includes metrics and benchmarks for performance, activities to close identified gaps or variances, and incorporates continuous QI activities.	Partially Met	Substantially Met
The MCO has P&Ps that indicate all initial outreach occurs within 15 days of member being identified as eligible; with a minimum of five attempts made within the first 90 days, including at least one documented face-to-face 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 substance use disorder, the MCO outreaches to DMMA, DSAMH, or other agencies or providers prior to closing the case.	Partially Met	Met
The MCO has a process to educate and share information with the members on how to reach the CCC and member services including in cases of emergency, after hours, weekends, and holidays. The process includes a system to identify the backup CCC and ensures CCC respond to all messages from the member within one business day.	Partially Met	Met

Metric Description	2019 Score	2020 Score
The MCO's P&Ps require reassessment at a minimum of quarterly for all members identified for Level 2 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.	Minimally Met	Partially Met
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 transition of care plan, a communication plan with PCP and other providers, list of providers delivering services to the member, listing of other services received by programs other than those provided by the MCO (to avoid duplication), evidence of referral to community or social support services, frequency of ongoing member contacts, identification, and plans to close gaps in care. Documentation demonstrates that a member receives a copy of their POC.	Partially Met	Substantially Met
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 contact every six months with members enrolled in Level 2 CCC and requires documentation of all outreach attempts.	Partially Met	Substantially Met
Supervisors and Level 2 CCC staff receive reports to monitor timeliness of outreach efforts and consistency with outreach and contact timeframes and develop staff and/or departmental corrective actions if necessary.	Partially Met	Substantially Met
The MCO has tools and processes to conduct inter-rater reliability 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.	Partially Met	Substantially Met
The MCO has a process to evaluate the success of the Level 2 CCC Program, which includes metrics and benchmarks for performance, activities to close identified gaps or variances, and incorporates continuous QI activities.	Partially Met	Substantially Met

4

Validation of Performance Measures

The following federal regulation is addressed in this section: 438.330 (c).

The intent of this regulation is to ensure MCO annually measure and report to the State on its performance, using the standard measures required by the State.

Objective: Validate the accuracy of Medicaid, CHIP, and DSHP Plus PMs reported by the MCO.

The PM review process included application of the CMS protocol entitled “Validating Performance Measures” aimed at assessing the compliance with identified specifications applicable to each PM. The measures reviewed for 2019 were selected by DMMA and included a combination of CMS adult and pediatric core measures, as well as QCMMR measures.

ACDE Performance Measures Overall Assessment

Overall Assessment

The Director of Contract Performance manages the development of data reports and/or products that enhance the overall performance of the business, manages, and leads a team in performing quantitative and qualitative analyses of utilization and cost data, establishes estimates and forecasts, and ultimately reports on business and statistical findings and recommendations throughout the organization. The MCO's reporting policy defines the process for the Regulatory Reporting team to create and modify contractually required reports. Recognizing that fulfillment of the reporting requirements is dependent upon sources of data beyond their immediate control, Regulatory Reporting adheres to the due dates for submission of reports as strictly as possible. If changes or unforeseen circumstances appear to jeopardize the ability to meet these dates, Regulatory Reporting notifies the MCO, State, or other regulatory agencies and requests an extension providing as much advanced notice as possible.

All reporting generated by Regulatory Reporting is reviewed for data integrity. The review process includes verifying that all requested data elements are provided, data is within the reporting period requested, and that all data fits specific criteria requested. If summary and detailed files are available, the two reports will be reconciled to each other. Where possible, reports will be checked for reasonableness through benchmarking and/or trend analysis. The Regulatory Reporting Department follows a multi-step process for each report completed within the

unit. The Director/Manager of the Department works with the associate responsible for the completion of the report to assist in addressing issues identified during the completion phase. A review session is then held with the Manager/Director and Specialist/Analyst to review in detail a final draft of the report. During this review, the report is checked for accuracy and reasonableness of the data. As appropriate, a report may be reviewed with other internal department management.

The ACFC utilizes the NCQA certified HEDIS software, Quality Spectrum Insight by Inovolon, for calculating all HEDIS PMs and non-HEDIS Core Measures; this source code is considered fully compliant. ACFC engages Inovolon, who uses the base HEDIS proprietary source code, to program and calculate the non-HEDIS based core measures as well. The sampling process, tools, and inter-rater reliability testing for generating hybrid measure results appear appropriate. The final audit statement from HealthcareData, the HEDIS Compliance Auditor, did not identify any findings or anomalies

The processes for generating the QCMMR measure for maternity third trimester timely access was submitted. ACDE submitted the script used to assess appointment availability as well as the tool used for data collection. The numerator and denominator specifications were followed and the data reported appear accurate and complete.

The source code and processes for generating the QCMMR measure for the rate of institutional and HCBS reassessments completed within 30 days of the due date and the maternity third trimester timely access were submitted. There have been ongoing concerns with the accuracy of the rate of institutional and HCBS reassessments completed within 30 days of the due date. After discussing the process of data collection and data entry into the JIVA system by the case managers and reviewing the source code for generating measure results, it is evident that the source code for generating the measure is accurate, but the data for reassessment entered by the case managers was inaccurate. There are significant concerns that stem from this inaccurate data collection. One concern is, given that this is a date-driven reassessment, if the data entry is inaccurate there may be related concerns in the timeliness of notification (or the “trigger”) for the next reassessment. A second concern is that this appears to be a training issue for the case managers that has not been addressed. The final concern is that the QCMMR data have appeared inaccurate over an extended period of time; this calls into question the regulatory review process detailed above.

The EQRO has a high level of confidence in the validity of the PMs generated using NCQA certified HEDIS software and nationally recognized specifications. While the data collection and reporting for third trimester maternity access appears accurate and complete, the EQRO does not have the same level of confidence in the State-defined QCMMR measure rate of institutional and HCBS reassessments completed within 30 days of the due date.

Compliance Findings

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

Overall Results

PM	Confidence in Reported Results
Chlamydia Screening in Women	High
Prenatal and postpartum care (timeliness of prenatal care)	High
HIV Viral Load Suppression	High
Developmental Screening in the First 3 Years of Life	High
Access — timely appointments Maternity 3rd trimester	Moderate
Case Management Reassessments	Low

Chlamydia Screening in Women

1. Overview of Performance Measure
Managed Care Plan (MCP) name: Highmark Health Options

1. Overview of Performance Measure
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) Claims ☐ Medical records (describe) ☐ Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): Women ages 16-20 who were identified as sexually active who were continuously enrolled during the measurement year (no more than one gap in continuous enrollment of up to 45 days). Women ages 21-24 who were identified as sexually active who were continuously enrolled during the measurement year (no more than one gap in continuous enrollment of up to 45 days).
Definition of numerator (describe): At least one chlamydia test during the measurement year.
Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☒ CHIP (Title XXI) only ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2019 – December 31, 2019

2. Performance Measure Results (If measure contains more than one rate, add columns to the table)		
Performance measure	Women ages 16-20	Women ages 21-24
Numerator	2127	2096
Denominator	3510	1369
Rate	60.60%	65.31%

3. Performance Measure Validation Status

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

AmeriHealth Caritas was compliant with the HEDIS® Information System Standards and HEDIS® Determination Standards, and continues to use NCQA-certified software vendors for HEDIS® measure production.

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

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

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

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

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.

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

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

EQRO recommendations for improvement of performance measure calculation:

None.

Prenatal and Postpartum Care (timeliness of prenatal care)

1. Overview of Performance Measure

Managed Care Plan (MCP) name: AmeriHealth Caritas of Delaware

1. Overview of Performance Measure
Performance measure name: Prenatal and postpartum care (timeliness of prenatal care)
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) MCO claims_____ ☒ Medical records (describe) Member medical records_____ ☐ Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: The minimum required sample size was selected with an oversample rate of 5%. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): Deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year who were continuously enrolled 43 days prior to delivery through 56 days after delivery.
Definition of numerator (describe): Received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in Medicaid/CHIP.
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date) November 6, 2018 - November 5, 2019

2. Performance Measure Results (If measure contains more than one rate, add columns to the table)	
Performance measure	Timeliness of Prenatal Care
Numerator	411
Denominator	359
Rate	87.35%

3. Performance Measure Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). AmeriHealth Caritas was compliant with the HEDIS® Information System Standards and HEDIS® Determination Standards, and continues to use NCQA-certified software vendors for HEDIS® measure production.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results. There were no findings from the ISCA that affected the reliability or validity of the performance measure results. ☐ Not applicable (ISCA not reviewed)
Describe any findings from medical record review that affected the reliability or validity of the performance measure results. There were no findings from the medical record review that affected the reliability or validity of the performance measure results. ☐ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the performance measure calculation. 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.
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence “Validation rating” refers to the EQRO’s overall confidence that the calculation of the performance measure adhered to acceptable methodology.
EQRO recommendations for improvement of performance measure calculation: None.

HIV Viral Load Suppression

1. Overview of Performance Measure
Managed Care Plan (MCP) name: AmeriHealth Caritas of Delaware
Performance measure name: HIV Viral Load Suppression
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☐ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☒ Other measure steward (specify) Health Resources and Services Administration
Is the performance measure part of an existing measure set? (check all that apply) ☐ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) MCO claims ☐ Medical records (describe) _____ ☐ Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of beneficiaries age 18 and older with both a diagnosis of HIV in the measurement year and at least one medical visit in the measurement year.
Definition of numerator (describe): The number of beneficiaries in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date) January 1, 2019–December 31, 2019

2. Performance Measure Results (If measure contains more than one rate, add columns to the table)		
Performance measure	HIV Viral Load Suppression ages 18-64	HIV Viral Load Suppression ages 65 and older
Numerator	85	0
Denominator	277	3
Rate	30.69%	0.00%

3. Performance Measure Validation Status

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

AmeriHealth Caritas was compliant with the CMS Adult Core Set technical specifications, and continues to use NCQA-certified software vendors for Adult Core Set measure production.

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

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

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

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

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

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

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

EQRO recommendations for improvement of performance measure calculation:

None

Developmental Screening in the First 3 Years of Life

1. Overview of Performance Measure

Managed Care Plan (MCP) name: AmeriHealth Caritas of Delaware

1. Overview of Performance Measure
Performance measure name: Developmental Screening in the First 3 Years of Life
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☐ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☒ Other measure steward (specify) Oregon Health and Sciences University _____
Is the performance measure part of an existing measure set? (check all that apply) ☐ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) MCO claims ☒ Medical records (describe) Member medical records ☐ Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: Eligible members was only 260, so the entire population was sampled. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): Denominator 1: The children in the eligible population who turned 1 during the measurement year and were continuously enrolled. Denominator 2: The children in the eligible population who turned 2 during the measurement year and were continuously enrolled. Denominator 3: The children in the eligible population who turned 3 during the measurement year and were continuously enrolled. Denominator 4: All children in the eligible population who turned 1, 2, or 3 during the measurement year, i.e., the sum of denominators 1, 2, and 3.

1. Overview of Performance Measure

Definition of numerator (describe):

The numerators identify children who were screened for risk of developmental, behavioral, and social delays using a standardized tool. National recommendations call for children to be screened three times in the first three years of life. This measure is based on three, age-specific indicators.

Numerator 1: Children in Denominator 1 who had a claim with CPT code 96110 before or on their first birthday.

Numerator 2: Children in Denominator 2 who had a claim with CPT code 96110 after their first and before or on their second birthdays.

Numerator 3: Children in Denominator 3 who had a claim with CPT code 96110 after their second and before or on their third birthdays.

Numerator 4: Children in the entire eligible population who had claim with CPT code 96110 in the 12 months preceding or on their 1st, 2nd, or 3rd birthday (the sum of numerators 1, 2 and 3).

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

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

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

Performance measure	Developmental Screening in Year 1	Developmental Screening in Year 2	Developmental Screening in Year 3	Developmental Screening in Year 1, 2, 3 Total
Numerator	56	40	23	119
Denominator	103	81	76	260
Rate	54.37%	49.38%	30.26%	45.77%

3. Performance Measure Validation Status

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

AmeriHealth Caritas was compliant with the CMS Child Core Set technical specifications, and continues to use NCQA-certified software vendors for Child Core Set measure production.

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

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

☐ Not applicable (ISCA not reviewed)

3. Performance Measure Validation Status
Describe any findings from medical record review that affected the reliability or validity of the performance measure results. There were no findings from the medical record review that affected the reliability or validity of the performance measure results. ☐ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the performance measure calculation. NCQA-Certified HEDIS® Compliance Auditor examined ACDE's submitted measures for conformity with the technical specifications for FFY 2019 for the Child Core Set. The audit followed the NCQA HEDIS® Compliance Audit standards and policies and procedures.
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the calculation of the performance measure adhered to acceptable methodology.
EQRO recommendations for improvement of performance measure calculation: None

Access — Timely Appointments Maternity 3rd trimester

1. Overview of Performance Measure
Managed Care Plan (MCP) name: AmeriHealth Caritas of Delaware
Performance measure name: Access – timely appointments maternity 3rd trimester
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☐ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☒ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☐ HEDIS® ☐ CMS Child or Adult Core Set ☐ Other (specify) _____

1. Overview of Performance Measure
What data source(s) was used to calculate the measure? (check all that apply) ☐ Administrative data (describe) _____ ☐ Medical records (describe) _____ ☒ Other (specify) Mystery Shopper Survey
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of test calls per month to schedule an initial prenatal care appointment for a member in the third trimester of pregnancy.
Definition of numerator (describe): The number of test calls that could result in a third trimester appointment within three calendar days of request.
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date) January 1, 2019–December 31, 2019

2. Performance Measure Results (If measure contains more than one rate, add columns to the table)	
Performance measure	Maternity — third trimester access
Numerator	N/A
Denominator	N/A
Rate	49.0%

3. Performance Measure Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). AmeriHealth Caritas was compliant with the QCMMR technical specifications.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results. There were no findings from the ISCA that affected the reliability or validity of the performance measure results. ☐ Not applicable (ISCA not reviewed)

3. Performance Measure Validation Status
Describe any findings from medical record review that affected the reliability or validity of the performance measure results. ☒ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the performance measure calculation. AmeriHealth Caritas was compliant with the QCMMR technical specifications and is reporting the data accurately, however the nonstandard approach to data collection (i.e. not recording data for the numerator and denominator) may lead to inaccurate rate calculation.
Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the calculation of the performance measure adhered to acceptable methodology.
EQRO recommendations for improvement of performance measure calculation: Develop a standardized means for documenting the numerator and denominator per measure specifications to ensure correct rate calculation.

Case Management Reassessments

1. Overview of Performance Measure
Managed Care Plan (MCP) name: AmeriHealth Caritas of Delaware
Performance measure name: Case Management Reassessments
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☐ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☒ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☐ HEDIS® ☐ CMS Child or Adult Core Set ☐ Other (specify) _____

1. Overview of Performance Measure
What data source(s) was used to calculate the measure? (check all that apply) ☐ Administrative data (describe) MCO claims_____ ☐ Medical records (describe) _____ ☒ Other (specify) Jiva case management system
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of DSHP Plus LTSS reassessments due.
Definition of numerator (describe): The number of DSHP Plus LTSS reassessments completed within 30 days of reassessment start date.
Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2019–December 31, 2019

2. Performance Measure Results (If measure contains more than one rate, add columns to the table)		
Performance measure	Institutional Reassessments completed within 30 days	HCBS Reassessments completed within 30 days
Numerator	1,080	917
Denominator	1,385	51
Rate	128%	6%

3. Performance Measure Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). AmeriHealth Caritas was compliant with the QCMMR technical specifications.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results. There were no findings from the ISCA that affected the reliability or validity of the performance measure results. ☐ Not applicable (ISCA not reviewed)

3. Performance Measure Validation Status
Describe any findings from medical record review that affected the reliability or validity of the performance measure results. ☒ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the performance measure calculation. The source code and processes for generating the QCMMR measure for the rate of institutional and HCBS reassessments completed within 30 days of the due date and the maternity third trimester timely access were submitted. There have been ongoing concerns with the accuracy of the rate of institutional and HCBS reassessments completed within 30 days of the due date. After discussing the process of data collection and data entry into the JIVA system by the case managers and reviewing the source code for generating measure results, it is evident that the source code for generating the measure is accurate, but the data for reassessment entered by the case managers was inaccurate. There are significant concerns that stem from this inaccurate data collection. One concern is, given that this is a date-driven reassessment, if the data entry is inaccurate there may be related concerns in the timeliness of notification (or the "trigger") for the next reassessment. A second concern is that this appears to be a training issue for the case managers that has not been addressed. The final concern is that the QCMMR data have appeared inaccurate over an extended period of time; this calls into question the regulatory review process detailed in the Regulatory Reporting policies and procedures, particularly around review of monthly report results by the business owner.
Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the calculation of the performance measure adhered to acceptable methodology.
EQRO recommendations for improvement of performance measure calculation: Train case managers to ensure correct data entry to document reassessment completion. Develop a process to audit data entry of reassessment completion and conduct remedial training as needed. Assess compliance with internal policies and procedures for review of monthly report results by the business owner.

HHO Performance Measures Overall Assessment

Overall Assessment

Throughout 2019 HHO moved certain functions from Gateway health plan and transitioned them back to HHO or to its parent company Highmark, Inc. This transition, which took place in October of 2019 included significant changes as HHO transitioned claims processing and encounters management from Gateway to HHO. Despite bringing key Gateway personnel over to HHO, HHO experienced difficulties providing accurate and complete data files requested in advance of the ISCA meetings. The ability to generate accurate and complete data based on specifications is key to generating accurate PMs. The ISCA report contained findings and recommendations to be addressed by HHO that were specific to data integration and management.

In addition to the data challenges noted during the ISCA, the data flow diagram for generating PMs submitted with the RFI presenting the integration of data sources did not represent the Delaware process but the Commonwealth of Pennsylvania. This was pointed out by the EQRO to the MCO during the virtual onsite and an updated Delaware workflow was submitted.

HHO utilizes the NCQA certified HEDIS software, Quality Spectrum Insight by Inovolon, for calculating all HEDIS PMs and this source code is considered fully compliant. HHO engages Inovolon, who uses the base HEDIS proprietary source code, to program and calculate the non-HEDIS Core Measures as well. The sampling process, tools, and inter-rater reliability testing for generating hybrid measure results appear appropriate. The EQRO has a high level of confidence in the validity of the PMs generated using NCQA certified HEDIS software and nationally recognized specifications.

The source code and processes for generating the QCMMR measure for the rate of institutional and HCBS reassessments completed within 30 days of the due date and the maternity third trimester timely access were submitted. HHO submitted the script used to assess appointment availability as well as the tool used for data collection. The numerator and denominator specifications were followed and the data reported appears accurate and complete.

Compliance Findings

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

Chlamydia Screening in Women

1. Overview of Performance Measure
Managed Care Plan (MCP) name: Highmark Health Options

1. Overview of Performance Measure

Measure steward:

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

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

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

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

☒ Administrative data (describe) Claims
☐ Medical records (describe)
☐ Other (specify) _____

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

☐ Not applicable (hybrid method not used)

Definition of denominator (describe):

Women ages 16-20 who were identified as sexually active who were continuously enrolled during the measurement year (no more than one gap in continuous enrollment of up to 45 days).

Women ages 21-24 who were identified as sexually active who were continuously enrolled during the measurement year (no more than one gap in continuous enrollment of up to 45 days).

Definition of numerator (describe):

At least one chlamydia test during the measurement year.

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

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

2. Performance Measure Results (If measure contains more than one rate, add columns to the table)		
Performance measure	Women ages 16–20	Women ages 21–24
Numerator	2127	2096
Denominator	3510	1369
Rate	60.60%	65.31%

3. Performance Measure Validation Status

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

HHO was compliant with the HEDIS® Information System Standards and HEDIS® Determination Standards, and continues to use NCQA-certified software vendors for HEDIS® measure production.

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

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

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

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

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.

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

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

EQRO recommendations for improvement of performance measure calculation:

None.

Prenatal and Postpartum Care (timeliness of prenatal care)

1. Overview of Performance Measure

Managed Care Plan (MCP) name: Highmark Health Options

Performance measure name: Prenatal and postpartum care (timeliness of prenatal care)

1. Overview of Performance Measure

Measure steward:

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

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

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

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

☒ Administrative data (describe) MCO claims
☒ Medical records (describe) Member medical records
☐ Other (specify) _____

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

The minimum required sample size was selected with an oversample rate of 5%.
☐ Not applicable (hybrid method not used)

Definition of denominator (describe):

Deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year who were continuously enrolled 43 days prior to delivery through 56 days after delivery.

Definition of numerator (describe):

Received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in Medicaid/CHIP.

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

Measurement period (start/end date) November 6, 2018–November 5, 2019

2. Performance Measure Results (If measure contains more than one rate, add columns to the table)	
Performance measure	Timeliness of Prenatal Care
Numerator	343
Denominator	411
Rate	83.45%

3. Performance Measure Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). HHO was compliant with the HEDIS® Information System Standards and HEDIS® Determination Standards, and continues to use NCQA-certified software vendors for HEDIS® measure production.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results. There were no findings from the ISCA that affected the reliability or validity of the performance measure results. ☐ Not applicable (ISCA not reviewed)
Describe any findings from medical record review that affected the reliability or validity of the performance measure results. There were no findings from the medical record review that affected the reliability or validity of the performance measure results. ☐ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the performance measure calculation. 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.
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence “Validation rating” refers to the EQRO’s overall confidence that the calculation of the performance measure adhered to acceptable methodology.
EQRO recommendations for improvement of performance measure calculation: None.

HIV Viral Load Suppression

1. Overview of Performance Measure
Managed Care Plan (MCP) name: Highmark Health Options
Performance measure name: HIV Viral Load Suppression
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☐ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☒ Other measure steward (specify) Health Resources and Services Administration
Is the performance measure part of an existing measure set? (check all that apply) ☐ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) MCO claims ☐ Medical records (describe) _____ ☐ Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of beneficiaries age 18 and older with both a diagnosis of HIV in the measurement year and at least one medical visit in the measurement year.
Definition of numerator (describe): The number of beneficiaries in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date) January 1, 2018–December 31, 2018

2. Performance Measure Results (If measure contains more than one rate, add columns to the table)		
Performance measure	HIV Viral Load Suppression ages 18-64	HIV Viral Load Suppression ages 65 and older
Numerator	213	4
Denominator	865	66
Rate	24.62%	6.06%

3. Performance Measure Validation Status

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

HHO was compliant with the CMS Adult Core Set technical specifications, and continues to use NCQA-certified software vendors for Adult Core Set measure production.

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

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

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

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

NCQA-Certified HEDIS® Compliance Auditor examined HHO's submitted measures for conformity with the technical specifications for FFY 2019 for the Adult Core Set. The audit followed the NCQA HEDIS Compliance Audit standards and policies and procedures.

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

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

EQRO recommendations for improvement of performance measure calculation:

None

Developmental Screening in the First 3 Years of Life

1. Overview of Performance Measure

Managed Care Plan (MCP) name: Highmark Health Options

Performance measure name: Developmental Screening in the First 3 Years of Life

1. Overview of Performance Measure
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☐ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☒ Other measure steward (specify) Oregon Health and Sciences University _____
Is the performance measure part of an existing measure set? (check all that apply) ☐ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) MCO claims ☐ Medical records (describe) Member medical records ☐ Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): Denominator 1: The children in the eligible population who turned 1 during the measurement year and were continuously enrolled. Denominator 2: The children in the eligible population who turned 2 during the measurement year and were continuously enrolled. Denominator 3: The children in the eligible population who turned 3 during the measurement year and were continuously enrolled. Denominator 4: All children in the eligible population who turned 1, 2, or 3 during the measurement year, i.e., the sum of denominators 1, 2, and 3.

1. Overview of Performance Measure

Definition of numerator (describe):

The numerators identify children who were screened for risk of developmental, behavioral, and social delays using a standardized tool. National recommendations call for children to be screened three times in the first three years of life. This measure is based on three, age-specific indicators.

Numerator 1: Children in Denominator 1 who had a claim with CPT code 96110 before or on their first birthday.

Numerator 2: Children in Denominator 2 who had a claim with CPT code 96110 after their first and before or on their second birthdays.

Numerator 3: Children in Denominator 3 who had a claim with CPT code 96110 after their second and before or on their third birthdays.

Numerator 4: Children in the entire eligible population who had claim with CPT code 96110 in the 12 months preceding or on their 1st, 2nd, or 3rd birthday (the sum of numerators 1, 2 and 3).

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

Measurement period (start/end date) January 1, 2018–December 31, 2018

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

Performance measure	Developmental Screening in Year 1	Developmental Screening in Year 2	Developmental Screening in Year 3	Developmental Screening in Year 1, 2, 3 Total
Numerator	292	1,010	1,220	2,522
Denominator	2,618	3,356	3,389	9,356
Rate	11.15%	30.10%	36.07%	26.96%

3. Performance Measure Validation Status

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

HHO was compliant with the CMS Child Core Set technical specifications, and continues to use NCQA-certified software vendors for Child Core Set measure production.

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

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

☐ Not applicable (ISCA not reviewed)

3. Performance Measure Validation Status
Describe any findings from medical record review that affected the reliability or validity of the performance measure results. There were no findings from the medical record review that affected the reliability or validity of the performance measure results. ☐ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the performance measure calculation. NCQA-Certified HEDIS® Compliance Auditor examined HHO's submitted measures for conformity with the technical specifications for FFY 2019 for the Child Core Set. The audit followed the NCQA HEDIS® Compliance Audit standards and policies and procedures.
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the calculation of the performance measure adhered to acceptable methodology.
EQRO recommendations for improvement of performance measure calculation: None

Access — Timely Appointments Maternity 3rd trimester

1. Overview of Performance Measure
Managed Care Plan (MCP) name: Highmark Health Options
Performance measure name: Access — timely appointments maternity 3rd trimester
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☐ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☒ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☐ HEDIS® ☐ CMS Child or Adult Core Set ☐ Other (specify) _____

1. Overview of Performance Measure
What data source(s) was used to calculate the measure? (check all that apply) ☐ Administrative data (describe) _____ ☐ Medical records (describe) _____ ☒ Other (specify) Mystery Shopper Survey
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of test calls per month to schedule an initial prenatal care appointment for a member in the third trimester of pregnancy.
Definition of numerator (describe): The number of test calls that could result in a third trimester appointment within three calendar days of request.
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date) January 1, 2019–December 31, 2019

2. Performance Measure Results (If measure contains more than one rate, add columns to the table)	
Performance measure	Maternity — third trimester access
Numerator	N/A
Denominator	N/A
Rate	65.5%

3. Performance Measure Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). HHO was compliant with the QCMMR technical specifications.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results. There were no findings from the ISCA that affected the reliability or validity of the performance measure results. ☐ Not applicable (ISCA not reviewed)

3. Performance Measure Validation Status
Describe any findings from medical record review that affected the reliability or validity of the performance measure results. ☒ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the performance measure 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 performance measure adhered to acceptable methodology.
EQRO recommendations for improvement of performance measure calculation: HHO was compliant with the QCMMR technical specifications and is reporting the data accurately.

Case Management Reassessments

1. Overview of Performance Measure
Managed Care Plan (MCP) name: Highmark Health Options
Performance measure name: Case Management Reassessments
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☐ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☒ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☐ HEDIS® ☐ CMS Child or Adult Core Set ☐ Other (specify) _____

1. Overview of Performance Measure
What data source(s) was used to calculate the measure? (check all that apply) ☐ Administrative data (describe) MCO claims_____ ☐ Medical records (describe) _____ ☒ Other (specify) EHS case management system
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of DSHP Plus LTSS reassessments due.
Definition of numerator (describe): The number of DSHP Plus LTSS reassessments completed within 30 days of reassessment start date.
Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2019–December 31, 2019

2. Performance Measure Results (If measure contains more than one rate, add columns to the table)		
Performance measure	Institutional Reassessments completed within 30 days	HCBS Reassessments completed within 30 days
Numerator	3,087	16,628
Denominator	3,783	19,297
Rate	81.6%	86.2%

3. Performance Measure Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). HHO was compliant with the QCMMR technical specifications.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results. There were no findings from the ISCA that affected the reliability or validity of the performance measure results. ☐ Not applicable (ISCA not reviewed)

3. Performance Measure Validation Status
Describe any findings from medical record review that affected the reliability or validity of the performance measure results. ☒ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the performance measure 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 performance measure adhered to acceptable methodology.
EQRO recommendations for improvement of performance measure calculation: None.

5

Validation of Performance Improvement Projects

The following federal regulations are addressed in this section: 438.330 (d).

The intent of this regulation is to ensure each PIP is designed to achieve significant improvement as measured by objective quality indicators, to plan and initiate activities for improvement sustained over time in access to and quality of care.

Objective 1:
To assess the methodology applied by the MCO for conducting a PIP.

Objective 2:
To evaluate the overall validity and reliability of PIP results

Objective 3:
To assess compliance with State-required specifications.

PIPs are required by CMS as an essential component of a MCO's quality program and are used to identify, assess, and monitor improvement in processes or outcomes of care. DMMA has mandated that each MCO conduct a minimum of five PIPs; the PIP topics must cover the following:

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

- Non-clinical or service related

The EQRO provides and overall validation rating of the PIP results. The validation rating refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced evidence of significant improvement. Data used to validate PIP results include results from the ISCA, HEDIS results, validation of source code, and medial record review data collection.

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

ACDE PIP Overall Assessment

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

The PIPs and the specifications to be applied included:

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

Review Methodology

The baseline results and recommendations below for the ADHD clinical practice guidelines, medication, and therapy are based on EQR PIP Validation Protocol Steps 1–10. Steps 1–3 include:

- Review the selected PIP study topic

- Review the PIP aim statement
- Review the identified PIP population

The summary results and recommendations presented below for the Oral health for DSHP Plus LTSS members and Benzodiazepines and Opioids concomitant use are based on EQR PIP Validation Protocol Steps 4–10 which include:

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

Overall Results

DMMA has mandated that each MCO conduct a minimum of five PIPs covering specific topics; ACDE has not met the minimum requirements for PIPs based on the Delaware Quality Strategy. As an essential component of a MCO's quality program to identify, assess, and monitor improvement in processes or outcomes of care, ACDE should assess opportunities across the spectrum of the organization and business units to identify and implement PIPs.

PIP	Confidence in Reported Results
Oral health for DSHP Plus LTSS members	Moderate
Benzodiazepines and Opioids concomitant use	High
ADHD clinical practice guidelines, medication, and therapy	High

Oral Health for DSHP Plus LTSS Members

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

2. Improvement Strategies or Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) None conducted in 2019
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) • Q1 2019: HCBS, NF, ALF training done through new and annual provider visit packets to ensure 100% provider education. Tracking is done through the provider relations system, Salesforce. • Q2 2019: The provider toolkit was introduced in conjunction with member educational materials.

2. Improvement Strategies or Interventions (Changes tested in the PIP)
• Q4 2019: From October 15-17, 2019, Provider Forums were held in each of Delaware's 3 counties; information and education was provided at these meetings regarding HHO's benefits and expectations of providers. As of November 12, 2019, the provider toolkit was printed and given to Member Advocates and Community Health Workers to distribute to providers during their events and visits.
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 conducted in 2019

3. Performance Measures and Results (Add rows as necessary)						
Performance measures (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lead 1: Number of HCBS providers educated about the importance of daily oral health care.	2018		2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	0%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 2: Number of SNF providers educated about the importance of oral health care.	2018		2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	0%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 3: Number of DSHP Plus member care plans (community) updated to include daily oral health goal(s).	2018		2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	83.5%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

3. Performance Measures and Results (Add rows as necessary)						
Performance measures (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lead 4: Number of SNF service plans evaluated to ensure daily oral care is documented and included as intervention.	2018		2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	73.6%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lag 1: Percentage of DSHP Plus members in SNF with documented daily oral care.	2018		2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	23.42%	☐ Yes ☒ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 2: Percentage of DSHP Plus members in the community who report a minimum of daily oral care (self-administered or through support services).	2018		2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	91.49%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 3: Percentage of all DSHP Plus plans of care that include meaningful oral health goals.	2018		2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	80.45%	☒ 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 remeasurement ☐ Second remeasurement ☐ Other (specify): Multiple remeasurement periods for lead measures and lag measures that are based on quarterly data. Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: ACDE should evaluate the interventions implemented to date to assess effectiveness particularly related to educating providers about the importance of daily oral health care. As the rate of members in SNF with documented daily oral care has decreased it seems that this is an area for increased education for both providers and members.

Benzodiazepine and Opioid Use

1. General Information
Managed Care Plan (MCP) Name: AmeriHealth Caritas of Delaware
PIP Title: Benzodiazepine and Opioid Use
PIP Aim Statement: Does education of providers and members on the risks of benzodiazepines and opioids decrease the number of members receiving benzodiazepines and decrease ER visits for overdose?
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) ☐ State-mandated (state required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) ☒ Plan choice (state allowed the plan to identify the PIP topic)

1. General Information
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as duals, LTSS or pregnant women (please specify):
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) • 2Q 2019: Updated and mailed member education about danger of combining prescriptions for benzodiazepines and opioids. Member mailing included letter detailing prescription usage from multiple providers if applicable and a member brochure.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) • 2Q 2019: Updated and mailed provider education about concurrent use of benzodiazepines and opioids. Provider mailing included a letter from Pharmacy Director and a survey. If applicable, multiple prescribing providers were included in the member specific details of the letter(s). • 4Q 2019: Presented an overview on opiate-benzodiazepine therapy and opiate guidelines, as well as the PIP to the AmeriHealth Caritas DE Provider Forums (general) held in Delaware's 3 counties to providers and other health care professionals including office staff. PIP overview was presented by Pharmacy Director and QM SME for PIPs. Educational sessions included question and answer format. Presentation by BH-Chief Medical Officer to BH Provider Forums held in Delaware's 3 counties about PIP content of concurrent use of opioids and benzodiazepines.
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) • 1Q 2019: Benzodiazepine, Alprazolam, transitioned to non-preferred drug and denied prescriptions filled.

3. Performance Measures and Results (Add rows as necessary)						
Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Lead 1: Percentage of providers who prescribed opioid(s) and benzodiazepine(s) to the member cohort and who were educated on the risks of benzodiazepine(s) and opioids(s) use together.	Q3 – Q4 2018	46 84.8%	Q2 2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	21 100%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
Lead 2: Percentage of providers who prescribed opioids to the member cohort and who were educated on the risks of benzodiazepine(s) and opioid(s) use together.	Q3 – Q4 2018	117 89.7%	Q2 2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	76 100%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
Lead 3: Percentage of providers who prescribed benzodiazepine(s) to the member cohort and who were educated on the risks of benzodiazepine(s) and opioid(s) use together.	Q3 – Q4 2018	135 88.9%	Q2 2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	86 100%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
Lead 4: Percentage of members in the member cohort that had prescriptions filled for benzodiazepine(s) and opioid(s) that have been educated on the risks of concomitant use.	Q3 – Q4 2018	177 100%	Q2 2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	135 100%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):

3. Performance Measures and Results (Add rows as necessary)						
Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Lag 1: Percentage of members in the member cohort who had prescriptions filled for benzodiazepine(s) and opioid(s) in the quarter following the education.	Q4 2018	177 33.9%	2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	135 34.8%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
Lag 2: Percentage of members in the member cohort who had an ED visit for overdose.	Q4 2018	177 .06%	2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	135 0%	☒ 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 remeasurement ☒ Second remeasurement ☐ Other (specify): Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence “Validation rating” refers to the EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: The PIP has accomplished the goals established by educating providers and members on the risks of concomitant use of benzodiazepines and opioids, decreasing the number of members receiving benzodiazepines and opioids and decreasing ER visits for overdose.

ADHD Clinical Practice Guidelines, Medication, and Therapy

General PIP Information
Managed Care Plan (MCP) Name: AmeriHealth Caritas of Delaware
PIP Title: Increase in Compliance to the American Academy of Pediatrics (AAP) Clinical Practice Guidelines for Attention Deficit Hyperactivity Disorder (ADHD)
PIP Aim Statement: Will Pediatric Primary Care Providers, Nurse Practitioners, Psychologists, Psychiatrists, Licensed Professional Counselors and Licensed Clinical Social Workers, and Neurologists educated on the American Academy of Pediatrics' (AAP) Clinical Practice Guidelines for Attention Deficit Hyperactivity Disorder (ADHD) increase member compliance to both stimulant medication and outpatient (OP) BH therapy at least once every four weeks in the 6 to 12 years old population of AmeriHealth Caritas DE membership?
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) ☐ State-mandated (state required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) ☒ Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here: 6 to 12 years old
Target population description, such as duals, LTSS or pregnant women (please specify):
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) • 1Q 2019: Member newsletter articles about ADHD clinical guidelines including ACDE website information about ADHD.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) • 1Q 2019: Provider newsletter articles about ADHD clinical guidelines including ACDE website information about ADHD. Building potential best practices of provider communication to members and caregivers in a way that is understood and acted upon to improve compliance. • 2Q 2019: None

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

- 3Q 2019: Development and consideration of additional provider and/or member education based on article from United States Department of Health and Human Services Office of the Inspector General Report "Many Medicaid-Enrolled Children Who Were Treated for ADHD Did Not Receive Recommended Follow Up Care."
- 4Q 2019: Updated provider education letter. Publish provider newsletter article on ADHD authored by BH Chief Medical Officer 1Q 2020

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

- 1Q 2019: Extend collaboration of PIP content to member facing staff such as Member Services, member advocates, and other departments. Monitor for consideration into the PIP of Telehealth best practices.
- 2Q 2019: Determine length of time for evaluating intervention effectiveness and consideration of additional provider/member education. Refined data analyses to include additional methods for evaluating performance results.
- 3Q 2019: None
- 4Q 2019: None

3. Performance Measures and Results (Add rows as necessary)

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Lead 1: Percentage of AmeriHealth Caritas DE contracted providers* educated about the American Academy of Pediatrics' (AAP) Clinical Practice Guidelines for ADHD, specifically prescribing stimulant medications and OP BH therapy at least once every four weeks.	2019	291 93.8%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

3. Performance Measures and Results (Add rows as necessary)						
Performance measures (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lag 1: Percentage of members diagnosed with ADHD ages 6 to 12 years old that did not receive OP BH therapy at least once every four weeks and were not prescribed stimulants within 45 days after seeing an AmeriHealth Caritas DE contracted provider* who was educated about AAP Clinical Practice Guidelines for ADHD.	2019	756 27.8%	☒ Not applicable—PIP is in planning or implementation phase, results not available	855 21.3%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 2: Percentage of members diagnosed with ADHD ages 6 to 12 years old that did receive OP BH therapy at least once every four weeks and were prescribed stimulants within 45 days after seeing an AmeriHealth Caritas DE contracted provider* that was educated about the importance of the AAP Clinical Practice Guidelines for ADHD.	2019	756 16.7%	☒ Not applicable—PIP is in planning or implementation phase, results not available	855 28.1%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 3: Percentage of members diagnosed with ADHD aged 6 to 12 years	2019	756 46.4%	☒ Not applicable—PIP is in planning or implementation	855 31.0%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value:

3. Performance Measures and Results (Add rows as necessary)						
Performance measures (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
old that were did not receive OP BH therapy at least once every four weeks and were prescribed stimulants within 45 days after seeing an AmeriHealth Caritas DE contracted provider* educated about the importance of the AAP Clinical Practice Guidelines for ADHD.			phase, results not available			☒ <.01 ☐ <.05 Other (specify):
Lag 4: Percentage of members diagnosed with ADHD aged 6 to 12 years old that did receive OP BH therapy at least once every four weeks and were not prescribed stimulants within 45 days after seeing an AmeriHealth Caritas DE contracted provider* educated about the importance of the AAP Clinical Practice Guidelines for ADHD.	2019	756 9.1%	☒ Not applicable—PIP is in planning or implementation phase, results not available	855 19.7%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):

**Providers: Pediatric Primary Care Providers, Nurse Practitioners, Psychiatrists, Psychologists, Licensed Professional Counselors, Licensed Clinical Social Workers, and Neurologists*

4. PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No **"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.**
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☒ Baseline year ☐ First re-measurement ☒ Second re-measurement ☒ Other (specify): Multiple re-measurement periods for lead measures and lag measures that are based on quarterly data. **Validation rating:** ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: The PIP appears to be improving provider adherence to AAP Clinical Practice Guidelines for ADHD. As the interventions have now been in place with providers for approximately a year, ACDE may want to consider a fresh approach for some additional provider education to maintain the improved level of performance.

HHO PIP Overall Assessment

Of the five required PIPs the State required the EQRO to validate three PIPs during the 2020 compliance review cycle. The first PIP was the State-mandated study topic and study question (oral health of the LTSS population). The second PIP was a State-mandated topic but MCO developed study questions (BH and PH integration). The third required PIP allows for a topic selected by the individual MCO that is relevant to its population and approved by DMMA. HHO's selected topic focused on the implementation of EPSDT Resource Coordinator telephonic outreach to pediatric members with incomplete lead screens for members 12 and 24 months of age.

The PIPs and the specifications to be applied included:

- Oral health for DSHP Plus LTSS members — State-developed specifications
- PH and BH CC — MCO-developed specifications
- Pediatric Lead Screening — MCO-developed and HEDIS specifications

Review Methodology

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

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

Overall Results

As noted earlier in this report, the QM/QI department of HHO has faced significant challenges throughout the past four years. At the time of the review in July 2019 into the first quarter of 2020 the QM/QI department did not have a permanent Director and the Quality Manager position as well as the four Clinical Quality Management Analyst positions were staffed with temporary staff. The lack of leadership and direction in the QM/QI department lead to PIPs that lacked a strong design, did not have lead and lag measures that were well-defined, interventions that were not highly effective, and results that did not demonstrate improvement. Throughout 2020 two PIP topics were retired, one PIP topic was redesigned and one new PIP was implemented.

PIP	Confidence in Reported Results
Oral health for DSHP Plus LTSS members	Low
Physical Health and Behavioral Health Care Coordination	Moderate
Pediatric Lead Screening	Moderate

Oral Health for DSHP Plus LTSS Members

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

2. Improvement Strategies or Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) None conducted in 2019
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) • **Q1 2019** — HCBS, NF, ALF training done through new and annual provider visit packets to ensure 100% education. Tracking is done through PR system, Salesforce • **Q2 2019** — Provider toolkit introduced, in conjunction with member educational material

2. Improvement Strategies or Interventions (Changes tested in the PIP)
• **Q4 2019** — From October 15-17, 2019, Provider Forums were held in each of Delaware's 3 counties; information and education was provided at these meetings regarding HHO's benefits and expectations of providers. As of November 12, 2019, the provider toolkit was printed and given to Member Advocates and Community Health Workers to distribute to providers during their events and visits.
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 conducted in 2019

3. Performance Measures and Results (Add rows as necessary)

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Lead 1: Number of HCBS providers educated about the importance of daily oral health care.	2018		2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	0%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 2: Number of SNF providers educated about the importance of oral health care.	2018		2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	0%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 3: Number of DSHP Plus member care plans (community) updated to include daily oral health goal(s).	2018		2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	72.9%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
Lead 4: Number of SNF service plans evaluated to ensure daily oral care is	2018		2019 ☐ Not applicable—PIP is in planning or	88.3%%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):

3. Performance Measures and Results (Add rows as necessary)						
Performance measures (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent remeasurement year (if applicable)**	**Most recent remeasurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
documented and included as intervention.			implementation phase, results not available			
Lag 1: Percentage of DSHP Plus members in SNF with documented daily oral care.	2018		2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	97.3%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
Lag 2: Percentage of DSHP Plus members in the community who report a minimum of daily oral care (self-administered or through support services).	2018		2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	96.1%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
Lag 3: Percentage of all DSHP Plus plans of care that include meaningful oral health goals.	2018		2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	98.6%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):

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

4. PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☒ First remeasurement ☐ Second remeasurement ☐ Other (specify): Multiple remeasurement periods for lead measures and lag measures that are based on quarterly data. **Validation rating:** ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: HHO must adhere to the mandated study question, lead and lag measures. The MCO also should evaluate the interventions implemented to date to assess effectiveness particularly related to educating providers about the importance of daily oral health care and updating care plans to include daily oral health goal(s).

Physical Health and Behavioral Health Care Coordination

1. General PIP Information
Managed Care Plan (MCP) Name: Highmark Health Options
PIP Title: Physical Health and Behavioral Health Care Coordination
PIP Aim Statement: Do the coordination of care interventions for adult members with physical and behavioral health needs help to reduce gaps in care?
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) ☒ State-mandated (state required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) ☐ Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as duals, LTSS or pregnant women (please specify):
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)
• **Q3 2019** — Provided education on medications, treatment options, disease processes. Connected member with resources for Detox, housing, transportation, and other services in the community.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)
• **Q3 2019** — Provided education on medications, treatment options, disease processes. Coordinated care with Primary Care Provider (PCP), specialist, therapists.
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)
• **Q3 2019** — Developed care plans to meet member health and wellness goals. Reviewed gap reports for identified members in this study. The team took a broader look into disease prevalence reports, claims, and HEDIS surveillance data to assess the overall population. Analysis of the data was completed to identify trends/themes in open gaps for these members to focus on. The team collaborated with providers to identify barriers to members closing gaps, optimize patient outcomes, and focus on increasing rates on face to face follow-up from care coordination. Additional investigations will also be completed into options for appointment assistance and referral/linkage to services.

3. Performance Measures and Results (Add rows as necessary)

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Lead 1: Percentage of members with physical and behavioral health needs who have a classification of substance use disorder (SUD) and who receive care	2019	1005 25%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

3. Performance Measures and Results (Add rows as necessary)						
Performance measures (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent remeasurement year (if applicable)**	**Most recent remeasurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
coordinated interventions.						
Lead 2: Percentage of members with Physical and Behavioral health needs that receive 30-day follow-up after ED visit for SUD (substance use disorder).	2019	811 17.3%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lag 1: Percentage of member who had a face-to-face intervention from the care coordinator within 10 days of inpatient admit for substance use disorder.	2019	801 9.6%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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

4. PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): **Validation rating:** ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: The MCO revised the study question but the measure descriptions do not align with the measure numerators and denominators. Define accurately the numerators and denominators to ensure correct data collection and analysis. Lag #1 measure and Lag #2 measure descriptions mention "an intervention" but the intervention is not defined. To correctly measure the intervention, and its effectiveness, the intervention must be specified.

Pediatric Lead Screening

1. General PIP Information
Managed Care Plan (MCP) Name: Highmark Health Options
PIP Title: Pediatric Lead Screening
PIP Aim Statement: Would the Implementation of EPSDT Resource Coordinators Telephonic Outreach to Pediatric Members with Incomplete Lead Screens, Lead to Increased Compliance for members 12 and 24 months of age?
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) ☐ State-mandated (state required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) ☒ Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as duals, LTSS or pregnant women (please specify):
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) Continued Eliza text messaging outreach campaign with incentives. As of July 1, 2020, the EPSDT Outreach team has been redirected and refocused on telephonic contact for Preventive Health screenings. COVID-19 Follow-up has been reassigned to the Triage and Outreach Pod (TOP).
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)
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)

3. Performance Measures and Results (Add rows as necessary)						
Performance measures (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent remeasurement year (if applicable)**	**Most recent remeasurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No)** **Specify P-value**
Lead 1: Percentage of pediatric members age 12 months without a 12 month lead screening, whose guardians were telephonically outreached and educated by a Resource Coordinator on the need to obtain a lead screening by 12 months of age.	2020		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 2: Percentage of pediatric members age	2020		☒ Not applicable—PIP is in planning or		☐ Yes	☐ Yes ☐ No

3. Performance Measures and Results (Add rows as necessary)						
Performance measures (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent remeasurement year (if applicable)**	**Most recent remeasurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
12 months without a 12 month lead screening, whose guardians were telephonically outreached and educated by a Resource Coordinator on the need to obtain a lead screening by 12 months of age.			implementation phase, results not available		☐ No	Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead: Percentage of pediatric members age 12 months, without a 12 month lead screening, whose guardians were telephonically outreached by a Resource Coordinator on the need to obtain a lead screening by 12 months of age, but refused telephonic education.	2020		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 4: Percentage of pediatric members age 24 months, without a 24 month lead screening, whose guardians were	2020		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

3. Performance Measures and Results (Add rows as necessary)						
Performance measures (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent remeasurement year (if applicable)**	**Most recent remeasurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
telephonically outreached by a Resource Coordinator on the need to obtain a lead screening by 24 months of age, but refused education from the Resource Coordinator.						
Lead 5: Percentage of pediatric members age 12 months, without a 12 month lead screening, whose guardians were telephonically outreached by a Resource Coordinator on the need to obtain a lead screening by 12 months of age, but the call was not answered, and the provider left a message.	2020		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 6: Percentage of pediatric members age 24 months, without a 24 month lead screening, whose guardians were	2020		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

3. Performance Measures and Results (Add rows as necessary)						
Performance measures (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent remeasurement year (if applicable)**	**Most recent remeasurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
telephonically outreached by a Resource Coordinator on the need to obtain a lead screening by 24 months of age, but the call was not answered, and the Resource Coordinator left a message.						
Lag 1: Percentage of pediatric members who have completed a lead screening by 12 months of age.	2020		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lag 2: Percentage of pediatric members who have completed a lead screening by 24 months of age.	2020		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lag 3: Percentage of pediatric members who, by 24 months of age, have completed both a 12 month and 24 month lead screen.	2020		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ 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 remeasurement ☐ Second remeasurement ☐ Other (specify): **Validation rating:** ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: The denominators and numerators are not well defined and some lead measures appear to be lag measures. There is opportunity for more precise language throughout the PIP measure descriptions and numerator and denominator definitions. Define accurately the numerators and denominators to ensure correct data collection and analysis. The lag measures are based on the full pediatric population. To assess the effectiveness of the interventions the lag measures should only be based on those who received the interventions. Correct the population defined for lag measures

6

Information Systems Capabilities Assessment

The following federal regulations are addressed in this section: 438.242 and 438.818.

The intent of these regulations are to ensure that each MCO maintains a health information system that collects, analyzes, integrates and reports data, and has a functional infrastructure and demonstrable capabilities to collect, valid, accurate data from which to calculate and report quality improvement data, in addition to meeting CMS' accuracy and completeness reporting requirements for encounter data.

At the request of DMMA Mercer conducted the EQR ISCA CAP of ACDE and HHO for the time period of January 2019–December 2019. This independent review of the managed care organization's information systems was conducted as an enhancement to the EQR mandatory activity outlined in 42 CFR § 438.358. To complete this assessment Mercer utilized the current version of the CMS EQR Protocol 8 — Appendix V, Attachment A, along with comprehensive enhancements to the ISCA to reflect state-specific regulations, standards, and requirements communicated to the MCO through the contract with DMMA. Mercer's EQR ISCA process included review of submitted materials and information, as well as interviews and live systems demonstrations that were conducted virtually due to the PHE declared January 31, 2020 (i.e. the Novel Coronavirus Disease [COVID-19]). The annual ISCA evaluation was conducted by Mercer, with DMMA staff in attendance via video conference on September 15, 2020 through September 17, 2020 for ACDE and September 22, 2020 through September 24, 2020 for HHO. While this was an ISCA CAP review, Mercer supplemented this assessment by focusing on the following:

- Claims systems processing procedures, training, and personnel
- Management of claims information systems
- Claims and encounter data reporting
- Claims systems configuration, claims edits, claims requiring manual intervention
- Claims subcontractor oversight

- Encounters management policies and processes
- In-depth claims data reviews

ACDE Overall Assessment

Based upon the ISCA review, ACDE has successfully maintained the required systems and support services to effectively support Delaware's Medicaid managed care program. ACDE implemented the Delaware line of business effective January 1, 2018, and while systems changes and claims remediation activities were required on occasion, ACDE demonstrated no barriers or delays in identifying the root cause and resolving the issues related to ACDE's systems. The insights gained from ACDE's ISCA desk review and virtual discussions confirmed a strong infrastructure, claims and encounters subject matter expertise, teamwork, and commitment to Delaware. All items requiring a CAP from the 2019 review were scored as Met in 2020. The desk and onsite reviews of the 2020 ISCA items resulted in 37 of the 41 desk review items (90.24%) receiving a review score of Met.

ACDE Strengths

Based on the documentation submitted and virtual onsite review Mercer identified the following strengths in the ACDE operations, leadership approaches, and established processes.

- ACDE exhibits proactive problem solving and team collaboration, as evidenced during the virtual onsite review. Of note was the engagement of the new enterprise data analytics team and ACDE's overall responsiveness to questions throughout the sessions, especially during the claims reviews.
- The MCO understands the value of data and created the new enterprise data analytics department to better serve ACDE's analytic needs. The investment in this department is evidence of the commitment to quality improvement and making data driven decisions.
- ACDE is staffed with subject matter experts for claims systems and operations, and its leadership has shown a commitment to internal training and knowledge expansion.
- The MCO has a performance driven culture as demonstrated by the consistent use of operational performance metrics across job roles and departmental functions.

- Leadership at ACDE is highly engaged as demonstrated by local MCO executives validating that they submitted complete and accurate data in the response for this ISCA. .

ACDE Opportunities

The review also identified areas where ACDE could strengthen its commitment for excellence.

- To minimize the need for mass claims clean-up activities the MCO should develop ongoing internal evaluations of any quality or performance improvement activities using the Plan, Do, Study, Act (PDSA) model[2] to advance outcomes such as more robust testing of any system changes/configuration updates.

- ACDE should ensure that the Delaware Medicaid reporting and analytics needs are appropriately prioritized and supported by the new enterprise data analytics department. ACDE would benefit from establishing enterprise data analytics operational performance benchmarks to ensure ACDE's business and regulatory needs are adequately supported.

- The findings from the vision claims review, indicate that ACDE should re-examine and improve the delegation and oversight and management of the vision benefits and services provided by Avēsis.

- The monthly audit sample size and targeted areas of focus should align with the claims findings identified in this report, in addition to other areas known to have been problematic in the past. An example of this is when manual interventions are employed (e.g., COB identification and calculation).

HHO Overall Assessment

Based upon the ISCA review, HHO demonstrated their continued efforts to improve their claims processing operations to effectively support Delaware's Medicaid managed care program. Since 2017, HHO has evolved their systems and support structure to better align with DMMA's expectations and the needs of DMMA's managed Medicaid populations and providers. In the latter part of 2019, HHO brought the claims operations back in-house from the delegate, Gateway Health, but continued to process claims on the same claims platform, Optimal System for Claims and Reimbursement (OSCAR). The claims remediation activities from this transition are still underway. The insights gained from

[2] Institute for Healthcare Quality Improvement — Plan, Do, Study, Act Framework. Available at: http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx

HHO's ISCA desk review and virtual discussions confirmed HHO's efforts to improve the claims operations and underlying infrastructure to ensure accurate claims processing. The desk and onsite reviews of the 2020 ISCA items resulted in 36 of the 56 desk review items (64.29%) receiving a review score of Met.

HHO Strengths

Based on the documentation submitted and virtual onsite review Mercer identified the following strengths in the HHO operations, leadership approaches, and established processes.

- HHO and Gateway maintained strong collaboration during the transition from delegation of claims processing. HHO has demonstrated the organization's ability not only to develop a comprehensive transition plan, but execute the transition plan well.
- HHO has developed creative approaches to resolving encounter submission issues and collaborated with Gainwell, DMMA's Medicaid Management Information System vendor, to work through the issues together.
- HHO conducted a comprehensive audit of the Davis Vision processes and claims to address requirements for reporting accuracy and timeliness. As a result the recommendation was to migrate from the legacy platform to resolve the discrepancies caused by proprietary code usage in the legacy system.

HHO Opportunities

The review also identified areas where HHO could strengthen its commitment for excellence.

- HHO's internal and external performance monitoring and management mechanisms were insufficient and their efforts to implement core PMs, subcontractor service level agreements, and scorecards are yet to show improved performance and successful subcontractor oversight.
- HHO has taken action to improve issue tracking mechanisms, but co-mingling of operational and systemic issues into one category titled 'remediation' was not beneficial for HHO's ongoing operations improvement activities. There has been inconsistent traceability of issue management and related decisions regarding the resolution of the issues.
- Many of the ongoing claims issues and mass clean-up projects were related to provider information. Recognizing the complexity of HHO's provider database, it appeared that the complexity of setting up provider contracts, negotiated rates, covered services, etc. has been contributing to the paid claims that require mass clean-up. HHO should implement improved processes and quality assurance to ensure the provider contract information is set up correctly at the time of initial contract loading.

- Similar to the complexity of HHO's provider data systems, the OSCAR claims system does not appear to have been designed to accommodate some of the more sophisticated adjudication logic and rules that are often required to support the complexities of managing the Medicaid benefits. While it is understandable that HHO, and previously Gateway, attempted to overcome this with additional desk level procedures, the complexity of the desk level procedures lend themselves to inconsistent interpretation and application of the appropriate processing rules.

- Despite the three previous ISCA recommendations to increase the audits percentages of all Delaware claims processed, HHO's audit percentages in 2019 were consistently below 2%.

- HHO has indicated that additional steps have been taken to introduce service level agreements and performance scorecards for their subcontractors. The subcontractor relationships related to claims would benefit not only from additional oversight, but also HHO's development of a mechanism to measure the subcontractor's ability to meet or exceed expected contractual standards.

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Managed Care Integration of Acute Medical Services for Individuals Receiving Residential Services on the Lifespan Waiver Readiness Review Follow Up

In Delaware, the majority of the LTSS I/DD HCBS Waiver population, with the exception of those receiving provider managed residential habilitation services, is already enrolled with a MCO for their acute medical services. Effective July 1, 2019, DMMA moved a new eligibility group, individuals receiving residential habilitation services on the Division of Developmental Disabilities Services (DDDS) Lifespan Waiver, from fee-for-service (FFS) into the MCO program for their acute medical services. At the request of the DMMA, Mercer conducted a readiness review with both MCOs prior to integration of these services in May 2019.

In 2020, Mercer conducted a readiness review follow up of ACDE and HHO at the request of the DMMA. This review was conducted as a technical assistance activity aimed at assessing compliance with Medicaid Managed Care Regulations and State contract requirements starting on July 1, 2019 when the State began the delivery of acute medical services to individuals with I/DD receiving residential services through the State's Lifespan Waiver.

Readiness review follow up activities included a post-implementation desk review, case file reviews, and an onsite review that included tracer scenarios. The readiness review follow up covered a broad range of MCO operations and specific focus was given to the unique considerations for the CC and medical management of individuals receiving I/DD Waiver supports.

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

- Governance and Administration

- CC
- Grievances and Appeals
- Pharmacy
- Quality
- Network Development and Management
- Reporting
- UM

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 for the period of July 1, 2019 through December 31, 2019.
- Assess the ability of the MCOs to achieve quality outcomes and timely access to health care services for residential Lifespan Waiver 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 individuals with I/DD into the managed care program for acute medical services.

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.

On January 13, 2020, Mercer delivered the RFI to both MCOs. Mercer used a HIPAA compliant secure file transfer protocol site, SharePoint, to allow a secure exchange of information among Mercer, DMMA, and the MCO. MCO materials were uploaded to the SharePoint site on February 3, 2020.

Mercer conducted the onsite evaluation in the presence of DMMA staff and staff representing DDDS at ACDE on February 18, 2020 and HHO on February 19, 2020. The onsite documentation review with management/leadership staff and tracer scenario exercises with front-line/direct staff were conducted to gain a more complete and accurate understanding of the MCOs management of the acute medical services for the Lifespan Waiver residential member population and how MCO 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 acute medical services to these enrollees.

ACDE Strengths

- The MCO transitioned approximately 930 Lifespan Waiver residential members into its CC program utilizing paper files received from DDDS. The MCO demonstrated a strong commitment to the timely transfer of data and other information from the paper files to their electronic system by hiring additional staff to complete this task.
- The MCO demonstrated a strong sense of commitment to meeting the needs of the residential Lifespan Waiver member population and willingness to accept feedback and technical assistance throughout the readiness review follow up process.
- The development of a dedicated resource and CC team to address the needs of the residential Lifespan Waiver member population at go-live and beyond provides for a strong foundation moving forward.
- Collaboration with and between DMMA, DDDS, and ACDE was evident throughout the readiness, go-live and implementation phases. DDDS developed and provided extensive member-specific information for each member to the MCOs, prior to go-live. It was clear that the MCO both appreciated and utilized the information.
- ACDE management attends the Residential Practice Provider Meetings and Nurse Best Practice Meetings hosted by DDDS. These regularly scheduled meetings serve as an opportunity to discuss and resolve issues in real time.
- ACDE was able to identify a BH provider for a member with dual diagnoses and specialty service needs when DDDS had experienced difficulty finding a provider. The MCO has a strong person-centered planning training plan and a commitment to promoting person-centered thinking philosophy.
- MCO recognition of the importance of identifying the “Fatal Four/Fatal Five” diagnoses was evident.
- The MCO has employed information technology solutions that include “widgets” (system flags) for identifying members receiving Lifespan Waiver services.
- The MCO front line staff provided strong and insightful responses to the tracer scenarios used to assess the member’s experience at different integration points across ACDE’s operations.

ACDE Opportunities

- There is a need to develop processes and workflows for members with legal representatives, including how member informing notices, notices of adverse benefit determinations, and other member materials are managed to ensure appropriate distribution/notification.
- There is a need to develop audit and supervisory oversight processes to evaluate the extent to which discharge and transition planning P&Ps are being operationalized by UM clinicians and Care Coordinators and documented in the member record.
- The development of QI strategies is needed to address tracking, trending, and reporting of individuals with “Fatal Four/Fatal Five” diagnoses. This includes updates to the MCOs QM program description, work plan, and inclusion of tracking and trending information into the QS. Consider the possibility of using pharmacy claims to identify members with “Fatal Four/Fatal Five” diagnoses.
- There is an opportunity for DMMA, DDDS, and the MCO to work in partnership to align policies, procedures, workflows, and reporting processes that reflect a shared understanding of abuse, neglect and exploitation (ANE) and critical incident communication/reporting requirements.
- There is an opportunity for DMMA, DDDS, and the MCO to enhance residential staff understanding of the benefits and appropriate use of the nurse triage/nurse advice line.
- There is an opportunity for the MCO to consult with DMMA prior to authorizing unique service requests for members on the Lifespan Waiver.
- Staff training, supervisory oversight, and audit processes are needed to address case file review findings specific to the comprehensiveness of care plans and documentation of follow up and follow through on identified member needs.
- A comprehensive policy with processes and procedures is needed to ensure that members receiving PDN supports in a community residence do not experience gaps in care resulting from nursing call-outs or scheduling challenges.
- Documentation found in member files was not consistent with the depth and breadth of the CC activities and interventions proposed by staff during the tracer scenarios. There is a need for the MCO to conduct more in depth file audits to address this inconsistency and to ensure that all appropriate CC activities and interventions are completed and documented in the member record.

HHO Strengths

- The MCO transitioned approximately 328 Lifespan Waiver residential members into its CC program utilizing paper files received from DDDS. The MCO demonstrated a commitment to the timely transfer of data and other information from the paper files to their electronic system by leveraging existing staff to complete this task.
- The MCO demonstrated a strong sense of commitment to meeting the needs of the residential Lifespan Waiver member population and a willingness to accept feedback and technical assistance throughout the readiness review follow up process.
- The development of the Promoting Independence Now (PIN) pod, a dedicated resource and CC team, to address the needs of the residential Lifespan Waiver member population at go-live and beyond provides for a strong foundation moving forward.
- Collaboration with and between DMMA, DDDS, and HHO was evident throughout the readiness, go-live, and implementation phases. DDDS developed and provided extensive member-specific information for each member to the MCOs, prior to go-live. It was clear that the MCO both appreciated and utilized the information.
- HHO management attends the Residential Practice Provider Meetings and Nurse Best Practice Meetings hosted by DDDS. These regularly scheduled meetings serve as an opportunity to discuss and resolve issues in real time.
- The MCO has a strong person-centered planning training plan and a commitment to promoting person-centered thinking philosophy.
- MCO recognition of the importance of identifying the “Fatal Four/Fatal Five” diagnoses was evident.
- The MCO front line staff provided strong and insightful responses to the tracer scenarios used to assess the member’s experience at different integration points across HHO’s operations.
- The MCO demonstrated efforts to facilitate communication between CC and UM through connectivity in the information technology infrastructure.
- HHO demonstrated a strong understanding of the need to ensure that there are no gaps in the provision of PDN supports to members living in group homes as evidenced by processes in place including the ‘Emergency Backup Plan’ that is created and provided to group homes.

HHO Opportunities

- There is a need to develop processes and workflows for members with legal representatives including how member informing notices, notices of adverse benefit determinations, and other member materials are managed to ensure appropriate distribution/notification.
- There is a need to develop audit and supervisory oversight processes to evaluate the extent to which discharge and transition planning P&Ps are being operationalized by UM clinicians and Care Coordinators and documented in the member record.
- The development of QI strategies is needed to address tracking, trending, and reporting of individuals with “Fatal Four/Fatal Five” diagnoses. This includes updates to the MCOs QM program description, work plan, and inclusion of tracking and trending information in the Quality Management Committee strategy. Consider the possibility of using pharmacy claims to identify members with “Fatal Four/Fatal Five” diagnoses.
- There is an opportunity for DMMA, DDDS, and the MCO to work in partnership to align policies, procedures, workflows, and reporting processes that reflect a shared understanding of ANE and critical incident communication and reporting requirements.
- There is an opportunity for DMMA, DDDS, and the MCO to enhance residential staff understanding of the benefits and appropriate use of the nurse triage/nurse advice line.
- Staff training, supervisory oversight, and audit processes are needed to address case file review findings specific to the comprehensiveness of care plans and documentation of follow up and follow through on member-identified needs.
- There is a need to develop P&Ps to prevent the authorization of Home Health Aide and Personal Care Services, concurrently, for members living in group homes.
- Documentation found in member files was not consistent with the depth and breadth of the CC activities and interventions proposed by staff during the tracer scenarios. There is a need for the MCO to conduct more in depth file audits to address this inconsistency and to ensure that all appropriate CC activities and interventions are completed and documented in the member record.

Conclusion

Both MCOs are commended for the high level of commitment applied to the integration of Lifespan Waiver members who began to receive acute medical services through the State’s managed care system on July 1, 2019. Initial challenges included recruitment and onboarding of sufficient CC staff, the need to transfer paper information on all new members into the data system and the need to resolve challenges related to incomplete member addresses.

During the onsite review, the MCOs referred to additional accomplishments, which extend past the six-month follow up review timeframe, indicating that member information has been fully incorporated into the data system and that the CC program is actively engaged with Lifespan Waiver members. There is a plan to develop QI activities, focusing on the acute medical needs of members with I/DD, including those identified as having one or more of the “Fatal Four/Five” diagnoses to improve health outcomes.

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Managed Care Integration of Adult Dental Benefit Readiness Review

In July 2020, DMMA requested that Mercer complete a readiness review of each MCO for delivery of adult dental benefits prior to the go-live date of October 1, 2020. DMMA requested that the EQRO gather information and facilitate interviews with MCO leadership, supervisory, and management staff engaged with delivering dental benefits and/or overseeing a dental benefit manager (DBM) as well as evaluate information systems readiness.

A questionnaire focusing on the key areas for the readiness review was prepared and distributed to the MCOs, and then forwarded to their DBMs. Given the abbreviated timeline from program approval to the go-live implementation date, Mercer did not require documentation to be submitted for desk review in advance of the onsite review held September 21, 2020.[3] The results of the virtual interviews and review of supporting documentation have been summarized into strengths and opportunities in readiness for implementing the adult dental benefit on October 1, 2020.

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

[3] *Due to the COVID-19 PHE, the onsite portion of the dental readiness review was conducted virtually.*

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 for the period of October 1, 2020 through December 31, 2020.
- Assess the ability of the MCOs to achieve quality outcomes and timely access to dental care services for adult 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

- The pre-delegation tools used by ACDE were detailed and reviewed key areas of the DBM's operations.
- ACDE and their DBM have fully operational information systems and data exchange functionality; these core functions (eligibility/enrollment, claims, and encounters) have been in place to support ACDE's existing value-added adult dental benefits.
- ACDE's adult dental benefit project plan confirmed that the majority of implementation activities are 100% complete.

ACDE Opportunities

- ACDE should consider extending weekly meetings with their DBM beyond the 30 days after go-live to such time, as program operations are stable.
- ACDE should conduct random checks with customer service staff, lead service representatives, and managers to ensure they have sufficient knowledge to address member and provider questions and concerns.
- ACDE should develop a process for their DBM to report provider satisfaction survey results.

- ACDE and their DBM should develop and deliver Delaware-specific training covering the basic dental benefit, benefit limits, PA, accessing the emergency benefit, member eligibility, appointment standard, and claims submissions.
- ACDE and their DBM should develop the necessary member and provider portal functionality and integration capabilities to display benefit accumulations to the members and providers.
- ACDE's DBM should finalize and implement third-party liability (TPL) policies and procedures regarding member claims and recoupment efforts related to TPL.

HHO Strengths

- HHO training of their DBM on the Delaware adult dental benefit was detailed and comprehensive.
- The assignment of a dedicated dental provider relationship manager to help with education, outreach, contracting, and the credentialing process helps streamline the process for providers.
- P&Ps for handling dental grievances and appeals align with federal regulations and contractual requirements.
- HHO and their DBM have a good understanding of how the emergency benefit can be accessed, and have systems in place to support review and payment of claims submitted.
- HHO's development of an Application Programming Interface (API) to provide real-time information regarding a member's benefit utilization to members and providers will help ensure the appropriate application of the emergency benefit provisions.

HHO Opportunities

- HHO's plan for post-implementation oversight includes cross-functional meetings for 60-days after go-live. As a new benefit, and in the midst of a PHE, there are many unknowns, especially around utilization and access. Therefore, HHO should consider extending the timeline for moving into maintenance mode for program oversight to such time, as program operations are stable. Training materials for HHO staff were incomplete; therefore, it was not clear what was included in the training curriculum. To ensure thorough understanding of the Delaware adult dental benefit, HHO should complete staff training and consider quality checks for call center staff and supervisors.
- DBM manages the provider network and provider call center. However, there will likely be times that HHO receives new or updated provider information. Mercer recommends a written process for how HHO will share this updated provider information with their DBM.

- Member grievances and member appeals for dental services are managed by HHO, while provider complaints and appeals are managed by their DBM. It is important that HHO develop a clear process for tracking and trending appeals and grievances across both members and providers.
- DBM should shorten the timeframe for loading new providers so that both the DBM and HHO are well positioned to meet the CMS requirements for the Provider Directory API in the established compliance timeframes of January 1, 2021.

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National Core Indicators-Aging and Disabilities Adult Consumer Survey

The Delaware DMMA, in partnership with ADvancing States and Human Services Research Institute (HSRI), implemented the 2019–2020 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 75 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: “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 2019–2020 and included for analysis was 361 (Total N=361).

Diamond State Health Plan Plus (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 more effectively address individual needs, 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., nursing facilities [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, Vital Research, ADvancing States, and HSRI staff conducted a mandatory two-day in-person training with these interviewers on January 28-29, 2020. 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 9, 2020 and Vital Research sent final data from the interviews to HSRI on June 25, 2020.

Impact of COVID-19 PHE on 2019-20 Data Collection and Reporting

Due to the COVID-19 PHE the 2019–2020 Adult Consumer Survey (ACS) data collection period was abbreviated with all data collection being stopped in Delaware on March 16, 2020. At the time surveying ended, states were in many different stages of survey administration. Very few states had completed data collection. NCI-AD made the decision to offer to provide state reports to all states that collected data during the 2019–2020 survey year. As states were in various stages of completion, some demographics — including program populations — may not be fully represented. ADvancing States has indicated that results will be for state use only and data should not be used as a comparison between states or within state for previous years.

Highlighted Survey Findings

Results for the 2019–2020 NCI-AD Survey were made available in early 2021. At the time of this report, DMMA is in the process of conducting a comprehensive review of the survey findings. Highlighted survey findings include those found in the Choice and Decision Making Domain specific to the percentage of HCBS members who get up and go to bed when they want (95%) and those who can eat their meals when they want to do so (89%–94%). Additional findings of note are in the Service Coordination Domain, including the percentage of HCBS members who can reach their case manager/service coordinator when they need to (79%–80%) and the percentage whose paid support staff show up and leave when they are supposed to (87%–89%). NF and HCBS members indicated they have an emergency plan in place (NF 85%–89%),

(HCBS 84%–87%). In the CC Domain, HCBS members with chronic conditions reported they know how to manage their conditions (86%–90%). DMMA will finalize its review of survey results and share its analysis with internal and external partners as appropriate.

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Performance Measurement and Reporting Technical Assistance

Strong State monitoring and oversight programs have both prospective and retrospective components. For Delaware, the QCMMR tool is one of the primary means of performance measurement used by DMMA. Additional critical means of oversight and monitoring are the quarterly CC and CM reports. Throughout 2020 the EQRO provided technical assistance to the MCOs to improve the accuracy, completeness, and consistency between MCOs of information submitted in both the QCMMR and the CC/CM reports.

Care Coordination Reports

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

The following tables present data on CCC activities through quarter 4 (Q4) 2020. As described previously in this report, ACDE began operating in Delaware in 2018; the membership distribution between HHO and ACDE was approximately 2:1. While there has been some redistribution of membership, HHO still manages the majority of members. Throughout 2020, ACDE has been assessing its risk stratification algorithm to more accurately align with DMMA expectations and identify appropriate members for each level of CCC.

Resource Coordination (Level 1)	MCO	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Number of members identified as Level 1 during the quarter.	ACDE	30,603	32,998	33,952	19,666
	HHO	2,286	4,773	4,944	4,015
Number of Level 1 members who received assistance from Contractor's resource coordination staff with discharge planning following a PH inpatient stay and/or follow a BH inpatient stay.	ACDE	218	239	207	110
	HHO	311	809	324	159
Number of Level 1 members who received discharge planning assistance following a PH or BH IP visit who were seen by a PCP within 14 calendar days of the MCO being notified of their discharge from the inpatient facility.	ACDE	345	202	240	15
	HHO	71	84	101	45
The number of Level 1 members who received discharge planning assistance following a PH or BH IP visit but were readmitted to an inpatient facility within 30 calendar days.	ACDE	32	27	15	20
	HHO	55	71	47	23

Level 2 Clinical Care Coordination	MCO	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Total number of members identified as Level 2, including members newly identified to Level 2 during the quarter.	ACDE	2,506	2,547	2,672	1,655
	HHO	6,055	7,005	5,345	4,408
Number and percent of Level 2 members who clinical CC staff were unable to contact.	ACDE	14 0.56%	27 1.06%	59 2.21%	11 0.66%
	HHO	1,813 30.00%	712 10.00%	847 15.85%	691 15.68%
Number of newly identified Level 2 members who declined participation in CCC.	ACDE	33	69	56	32
	HHO	1,850	1,595	1,251	956
Number of face-to-face interactions CCC staff had with Level 2 members.	ACDE	976	24	1,107	737
	HHO	1,607	1,604	1,073	629
Number of Level 2 members who were reassessed as eligible to move to a lower level of CC (i.e. Level 1 or All Member level).	ACDE	71	122	102	1
	HHO	62	94	96	83

Quality Care Management and Measurement Reporting

The QCMMR acts as an early alert system to address potential, emerging concerns about the quality, access, and timeliness of care management operations of the State-contracted MCOs. As an early alert system, the report relies on self-reported data from the MCOs, which is submitted monthly via a secure file transfer protocol site using standardized data-submission templates in Microsoft Excel. When variance in expected results occurs, the MCOs are expected to provide a brief description of the corrective action or steps taken to remediate the variance. The EQRO provides technical assistance to the MCOs to ensure the data submitted to DMMA are complete, accurate, and reliable. Trends regarding the data are analyzed quarterly and comparisons are made within each MCO and across MCOs, and when changes in trends are identified, the MCOs are asked to provide a response.

Summary of Diamond State Health Plan QCMMR Findings through Quarter 4 2020

HRA

HRAs serve as a key to identifying and engaging members in need of services early in their experience with an MCO. The DMMA contractors, ACDE and HHO, are contractually required to complete HRAs with at least 50% of their newly enrolled members within 60 days of enrollment. Both MCOs have fallen short of that contractual obligation through 2020; the Year to Date (YTD) average percentage of HRAs completed was 15% for ACDE and 16% for HHO.

Access to Care

Through Q4 2020 for all standards, ACDE reported the following access:

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

Through Q4 2020 for all standards, HHO reported the following access to care:

- Primary care practitioner (Adult) access — routine 93.0%
- Primary care practitioner (Adult) access — urgent 100.0%
- Primary care practitioner (Adult) access — emergency 77.0%
- Primary care practitioner (Pediatric) access — routine 80.0%
- Primary care practitioner (Pediatric) access — urgent 100.0%
- Primary care practitioner (Pediatric) access — emergency 91.5%

Appeals

Appeals are documented in the month in which they are filed, and any appeals resolved are counted in the month during which they have been resolved. The appeals process for both HHO and ACDE needs continued monitoring due to a large percentage of withdrawn appeals at both ACDE and HHO. ACDE had fewer overturned appeals than HHO. Given the difference in membership between the two MCOs more data may be needed before conclusions about differences between the MCOs can be drawn. The following are YTD appeals rates through Q4 2020.

- Appeals were overturned at a higher rate at HHO (42%) verses ACDE (38%)
- Appeals were withdrawn at a higher rate at ACDE (51%) verses HHO (32%)

Grievances

As with the appeals information displayed above, the difference in membership makes comparisons between the MCOs difficult for the topic of grievances. HHO had a slightly higher rate of grievances per 1,000 members (1.14) compared to ACDE (0.52). All data presented below are through Q4 2020.

- Quality of service: The highest percentage of grievances for both MCOs was in this category. The YTD total grievances related to QOC for HHO was 186 and for ACDE was 70.
- Access and availability: ACDE reported a smaller percentage of overall grievances in this category than ACDE.
- Quality of care: ACDE reported 53 and HHO reported 153 grievances in this category.

- Transportation to medical appointment: HHO had a small number (26) of transportation grievances, while ACDE reported four.
- Cultural competency: A small percentage of grievances for both MCOs was related to cultural competency.
- Billing and/or claims: HHO had a much larger percentage of grievances in this category than ACDE. This result was not surprising given the ongoing challenges HHO faced following its claims payment system migration.

Utilization Management — Inpatient

The inpatient utilization (medical, surgical, rehab/SNF) data was similar in comparing the MCOs for all categories, with the exception readmission rates. HHO's readmission rates were higher than ACDE's rates. The average length of stay for medical admissions and the number of days in the hospital were slightly higher at HHO compared to ACDE. The admissions per 1,000 members was lower at ACDE. The average length of stay for surgical admissions was fairly equal at both MCOs but the number of surgical admission and days per 1,000 members were higher at HHO.

Utilization Management — Outpatient

The outpatient utilization data was similar for both MCOs with a few exceptions. ED utilization was essentially equal between the MCOs. HHO reported approximately 167 outpatient BH visits per 1,000 members, while ACDE reported approximately 461 outpatient BH visits per 1,000 members. The same type of large difference is the case for BH physician visits with HHO reporting 426 BH physician visits per 1,000 members and ACDE reported 8.3 per 1,000 members. Additional research into these reporting differences is being considered.

Summary of Diamond State Health Plan Plus QCMMR Findings for 2020

Access and Availability

The number of providers for Home Health, Day Service, and BH for both MCOs are similar with a few exceptions. For HCBS and Atypical Service providers, ACDE has more than double the number of providers than HHO. For HCBS, ACDE has a total of 114 providers while HHO has 52 providers and for Atypical ACDE has 73 providers while HHO has 21 providers.

Case Management

For the DSHP Plus membership through Q4 2020, there are more members active in CM for HHO in comparison to ACDE, which is an expected result given the differences in membership between the MCOs. Comparing the rates, HHO has on average 56% of all Plus

members active in CM and ACDE has 65% active. HHO is averaging 92% of HCBS reassessments being completed within 30 days while ACDE is averaging 67% of HCBS reassessments being completed within 30 days. For institutional reassessments, HHO is averaging 85% while ACDE is averaging 193%.

Safety/Welfare

As anticipated, the distribution of CIs is heavily concentrated on HCBS versus institutional services. The MCOs are responsible for identifying and reporting all potential CIs to DMMA. DMMA works closely with other State agencies and entities to investigate all reported CIs. Each reported incident is thoroughly investigated by the appropriate State agency and CI data is analyzed for trends and when appropriate, performance improvement activities are implemented to address identified issues. The CIs reported by category[4] through Q4 2020 were:

- Unexpected deaths: ACDE reported 2, HHO reported 6
- Physical, mental, sexual abuse or neglect: ACDE reported 12, HHO reported 51
- Theft or exploitation: ACDE reported 9, HHO reported 23
- Severe injury: ACDE reported 1, HHO reported 12
- Medication error: ACDE reported 2, HHO reported 0
- Unprofessional provider: ACDE reported 3, HHO reported 4

Grievances

Through Q4 2020, there were 66 grievances filed by DSHP Plus members in ACDE and 196 in HHO. While a higher number of grievances is not desired as this indicates some level of dissatisfaction, in previous years there was a significant concern that, based on the extremely low numbers reported, grievances were not being appropriately identified, tracked, and trended.

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

Appeals

HHO reported a higher number of appeals than ACDE through Q4 2020. HHO reported 80 appeals and ACDE reported just 47 appeals. While the rate of overturned appeals was not drastically different between the MCOs, HHO (43%) had a higher number of appeals withdrawn than ACDE (38%); ACDE had 6% of appeals upheld while HHO had 14%. A high overturn rate may indicate additional UM review is needed prior to issuing an initial denial to improve member and provider satisfaction and reduce the burden of appeal management for all parties.

Utilization Management — Inpatient

Inpatient utilization (medical and BH) data was similar in comparing the MCOs in the number of admissions per 1,000 members, longer average length of stay and days in the hospital per 1,000. In regards to surgical and rehab/skilled nursing facility, HHO reported a higher number of admissions per 1,000 members, average length of stay and days in the hospital per 1,000.

Utilization Management — Outpatient

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

- Outpatient ED visits: ACDE reported 70.01, HHO reported 72.35
- Outpatient BH services: ACDE reported 294.24, HHO reported 69.30
- Adult physical exam visits: ACDE reported 416.23, HHO reported 5.69
- Physician BH visits: ACDE reported 9.08, HHO reported 762.74

HEDIS and CAHPS Results

HEDIS

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

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

There is significant opportunity for improvement in HEDIS results for both MCOs. Presented below are 43 select HEDIS measures across various domains of care. Please note that results for some measures are 'NR' which is a designation given by NCQA to indicate either the MCO chose not to report the measure or the measure received an 'NR' designation during a NCQA HEDIS Compliance Audit. ACDE reported 42 measures while HHO reported 43.

Of the 40 reported measures for ACDE, two measures, well-child visits in the first 15 months of life (two and four visits), were at or above the 90th percentile. Nine measures, well-child visits in the first 15 months of life (zero, three, and five visits), inpatient utilization (maternity, medicine, surgery, and total average length of stay [ALOS]), and mental health (MH) utilization (inpatient services and intensive outpatient and partial hospitalization), were at or above the 75th percentile. ACDE reported six measures where the HEDIS rate improved by one percentage point or greater, 23 measures where the HEDIS rate did not change by more than one percentage point and two measures where the HEDIS rate declined by one percentage point or greater from 2019 to 2020. Sixteen of ACDE's HEDIS results for these 40 measures (40%) were below the 50th percentile.

Of the 41 reported measures for HHO, 12 measures, well-child visits in the first 15 months of life (zero visits), inpatient utilization (maternity, surgery and total ALOS), medicine, surgery and total days/1,000, medicine, surgery and total discharges/1,000 and MH utilization (outpatient and any services), were at or above the 75th percentile. HHO reported 34 measures where the HEDIS rate was a one percentage point or greater improvement or did not change by more than one percentage point and seven measures where the HEDIS rate had declined by one percentage point or greater. Seventeen of HHO's HEDIS results for these 41 measures (41%) were below the 50th percentile.

2020 HEDIS Measure	2020 ACDE Ratings	2020 HHO Ratings
Access and Availability of Services		
Children and adolescents' access to PCPs — 12 months to 24 months		
Children and adolescents' access to PCPs — 25 months to 6 years		
Children and adolescents' access to PCPs — 7 years to 11 years		

2020 HEDIS Measure	2020 ACDE Ratings	2020 HHO Ratings
Children and adolescents' access to PCPs — 12 years to 19 years		
Adults' access to preventive services — 20 years to 44 years		
Adults' access to preventive services — 45 years to 64 years		
Adults' access to preventive services — 65 years and older		
Timeliness of prenatal care		
Postpartum care		
Prevention and Screening		
Lead screening in children		
Breast cancer screening	NR	
Cervical cancer screening		
Diabetes		
Comprehensive diabetes care — HbA1C screening		
Comprehensive diabetes care — eye exam (retinal)		
Cardiovascular Conditions		
Controlling high blood pressure		
Overuse/Appropriateness		
Appropriate treatment for children with upper respiratory infection		
Behavioral Health		
Antidepressant medication management — acute phase		

2020 HEDIS Measure	2020 ACDE Ratings	2020 HHO Ratings
Antidepressant medication management — continuation phase		
Utilization		
Well-child visits in the first 15 months of life — zero visits		
Well-child visits in the first 15 months of life — one visit		
Well-child visits in the first 15 months of life — two visits		
Well-child visits in the first 15 months of life — three visits		
Well-child visits in the first 15 months of life — four visits		
Well-child visits in the first 15 months of life — five visits		
Well-child visits in the first 15 months of life — six or more visits		
Inpatient utilization — maternity days/1,000		
Inpatient utilization — maternity discharges/1,000		
Inpatient utilization — maternity ALOS		
Inpatient utilization — medicine days/1,000		
Inpatient utilization — medicine discharges/1,000		
Inpatient utilization — medicine ALOS		
Inpatient utilization — surgery days/I,000		
Inpatient utilization — surgery discharges/1,000		

2020 HEDIS Measure	2020 ACDE Ratings	2020 HHO Ratings
Inpatient utilization — surgery ALOS		
Inpatient utilization — total inpatient days/1,000		
Inpatient utilization — total inpatient discharges/1,000		
Inpatient utilization — total inpatient ALOS		
MH utilization — inpatient services		
MH utilization — intensive outpatient and partial hospitalization		
MH utilization — outpatient		
MH utilization — any		

NR: A designation given by NCQA to indicate either the MCO chose not to report the measure or the measure received an NR designation during a NCQA HEDIS Compliance Audit.

** This measure was NR in 2019; therefore, no change in performance reported.*

According to NCQA, "*Discharge rates may be high when a health plan's population is unusually sick, and will be higher when a plan serves an older population. However, high rates are often a sign that access to high-cost inpatient care is not appropriately managed, or that ambulatory care is not used effectively. With mental illness widely under diagnosed, higher rates may mean that more patients with mental illness have been identified and have begun treatment. Lower rates may signal poorer rates of detection or barriers to care for patients with mental illness. However, especially where behavioral health care is carved out, low rates may indicate that necessary data are not available to the health plan. In this case, patients may be receiving care, but without access to the data, there is no assurance of this. It is best to view this statistic in the context of other data that determine utilization of mental health services.*"[5]

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

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

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

2020 HEDIS Measure	2020 ACDE Ratings	2020 HHO Ratings
Utilization		
Ambulatory care — ED Visits/1,000		
MH utilization — ED		

As the table above displays, there is significant opportunity for improvement in the area of ambulatory care — ED visits/1,000. However, the MCOs are performing relatively well in the area of ED utilization for MH.

CAHPS

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

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

ACDE was not required to complete a CAHPS survey for 2019. The first year of CAHPS results for ACDE was in 2020. ACDE's members gave the highest adult score to the rating of the health plan, which fell between the 75th and 90th percentile nationally. Both the adult and child CAHPS surveys highlight significant opportunities for improvement with four of six adult ratings and only one child rating between the 50th and the 75th percentile (adult: rating of specialist, rating of health care, getting care quickly; child: getting care quickly). Respondents gave the lowest scores on the rating of adult personal doctors, adults getting needed care, how well doctors communicate, pediatric personal doctors, pediatric specialists, children's health care, children's health plan, children getting needed care, and how well pediatric doctors communicate.

HHO's performance from 2019 to 2020 demonstrated improvement in three adult and three child areas. One adult and one child area showed a decline in performance while three adult and three child areas saw no change in performance. HHO performed well when rated on adult health plans, adults getting needed care, adults getting care quickly, pediatric personal doctors, and pediatric health plans, which were all above the 90th percentile. Member ratings of adult specialists were also favorable above the 75th percentile. HHO performed at or above the 50th percentile benchmark nationally on all other adult and child measures with the exception of one adult area and three child areas, which scored below the 50th percentile nationally.

Both the adult and child CAHPS surveys highlight significant opportunities for improvement with HHO members scoring two adult ratings and two child ratings between the 50th and the 75th percentile (adult: rating of all health care, how well doctors communicate; child: rating of specialist, rating of all health care). However, respondents gave the lowest scores on the rating of adult personal doctors, children getting care quickly, children getting needed care, and how well pediatric doctors communicate.

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

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

Delaware Medicaid MCO CAHPS Survey Results — Adults

Adult CAHPS Ratings	2020 ACDE Ratings	2020 HHO Ratings
Rating of personal doctor		

Adult CAHPS Ratings	2020 ACDE Ratings	2020 HHO Ratings
Rating of specialist		
Rating of all health care		
Rating of health plan		
Getting needed care		
Getting care quickly		
How well doctors communicate		

Delaware Medicaid MCO CAHPS Survey Results — Children

Child CAHPS Ratings	2020 ACDE Ratings	2020 HHO Ratings
Rating of personal doctor		
Rating of specialist		
Rating of all health care		
Rating of health plan		
Getting needed care		
Getting care quickly		
How well doctors communicate		

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