State of Delaware

Managed Care Quality Strategy Evaluation

Division of Medicaid & Medical Assistance
December 30, 2025

Contents

1 Introduction

Background

The State of Delaware (Delaware or the State) Division of Medicaid & Medical Assistance (DMMA), within the Department of Health and Social Services (DHSS), serves the vast majority of all Medicaid and Children's Health Insurance Program (CHIP) recipients through the State's Medicaid managed care program, comprised of Diamond State Health Plan (DSHP) and DSHP Plus. It operates under the authority of a Section 1115(a) Demonstration and provides integrated physical, behavioral health, and long-term services and support (LTSS) to eligible Medicaid members through contracted managed care organizations (MCOs). DMMA's mission is to improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost-effective manner.

DMMA strives to meet the diverse needs of Delawareans through innovation and a quality structure. The Managed Care (MC) Quality Strategy (QS) provides a framework for implementing DMMA's mission. The MC QS identifies the State's monitoring and oversight activities, focusing on quality improvement. The monitoring activities allow DMMA to identify and address compliance issues and report variances from expected results and represent the State's ongoing actions to ensure compliance with federal and State contract standards and promote an environment focused on performance improvement. The MC QS also aims to identify trends and opportunities for quality improvement related to Medicaid programs, waivers, policy and procedure development, and system change initiatives.

Purpose: The framework of the Managed Care Quality Strategy (MC QS) has been designed to accomplish its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Delaware Medicaid MC health ecosystem.

To demonstrate compliance with the Centers for Medicare & Medicaid Services' (CMS') managed care quality strategy evaluation requirements set forth in 42 CFR §438.340(c)(i), the State has evaluated its MC QS to measure its effectiveness and usefulness in shaping healthcare delivery and policy for the DMMA MC QS moving forward. That evaluation is summarized in this report and will provide an overview of monitoring activities and achievement of improvement initiatives from 2021 through 2023.

Managed Care Environment

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

Highmark Health Options (HHO) has been contracted by DMMA since January 1, 2015, to provide Medicaid managed care services in Delaware. The State contracted with AmeriHealth Caritas Delaware (ACDE) to provide Medicaid managed care services effective January 1, 2018. Beginning January 1, 2023, Delaware First Health (DFH) was contracted as a third Medicaid MCO. Prior to DFH implementation, the State's External Quality Review Organization (EQRO), in conjunction with DMMA staff, completes a targeted Readiness Review. The review confirms the MCO has adequate and appropriate processes to address continuity of care, ensure member health and safety, pay claims, and ensure an adequate network composition.

2
Compliance Oversight

Monitoring Infrastructure

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

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

Members of the QII Task Force include representatives from DMMA, the Division of Public Health (DPH), DSAMH, EQRO, and Medicaid MCOs. Effective July 9, 2025, information from the QII Task Force may be shared with the Medicaid Advisory Committee (MAC), formerly known as the Medical Care Advisory Committee (MCAC) oversight committee, as necessary.

DMMA's Chief Medical Officer (CMO) provides executive and clinical oversight of the Quality unit and is the Chair of the QII Task Force. The QII Task Force provides a forum for the review of quality performance, identification of improvement opportunities, and coordination of statewide quality initiatives across programs and stakeholder partners.

The DMMA Quality Director provides operational leadership for the State's Medicaid quality oversight infrastructure and is responsible for the day-to-day management and coordination of quality monitoring activities across DSHP, DSHP Plus, and CHIP. Under the direction of the CMO, the Quality Director oversees implementation of the QS, including Core Set (Adult and Child) and Managed Care Program Annual Reports (MCPARs), Performance Improvement Projects (clinical and non-clinical), Consumer Assessment of Healthcare Providers & Systems (CAHPS) administration and review, Critical Incident Management, and quality-related audit activities. The Quality Director co-leads the QII Task Force with

the Chief Medical Officer to advance statewide quality priorities. The Quality Director also leads cross-agency collaboration with internal partners (e.g., DPH, DSAMH, Division of Developmental Disabilities Services [DDDS]) and external entities, including MCOs, the EQRO, and data vendors, to support data quality, performance monitoring, and continuous quality improvement. The DMMA Compliance Officer position is responsible for monitoring contract compliance and developing and enforcing appropriate sanctions for vendors, which do not meet contractual standards. The Compliance Officer works closely with the Quality Director to assist with the management of the MCO's quality performance requirements.

Health Information Technology

As part of DMMA's Medicaid Managed Care Quality Strategy, contracted MCOs participate in statewide health information exchange and data submission activities through the Delaware Health Information Network (DHIN). These activities support timely care coordination, data-driven decision-making, and comprehensive oversight of managed care quality.

DMMA MCOs provide member roster information to DHIN on a regular basis to enable identification of the Medicaid members they serve. This information allows DHIN to associate members with the appropriate MCO and facilitates the secure delivery of Admission, Discharge, and Transfer (ADT) notifications generated by participating healthcare facilities. MCOs use ADT notifications to support timely care coordination, care transitions, and follow-up activities.

In addition to receiving ADT notifications, MCO care coordinators are granted DHIN access to review available clinical information for Medicaid members. Access to DHIN supports Medicaid by allowing care coordinators to view relevant clinical data across providers and care settings, strengthening their ability to assess member needs, support continuity of care, and address gaps in services.

Under state requirements, DMMA and the contracted MCOs submit Medicaid claims data to the Health Care Claims Database (HCCD) operated by DHIN. DHIN serves as the administrator and operator of the HCCD, ensuring standardized collection, maintenance, and governance of claims data across payers. DMMA provides financial support for the ongoing development, enhancement, and operation of the HCCD through Advanced Planning Document (APD) funding, supporting system sustainability and expanded analytic capabilities.

DMMA retrieves comprehensive HCCD data from DHIN and uses this information to develop dashboards and analytic tools that support managed care quality oversight. These dashboards inform policy and programmatic decisions, monitor performance trends, identify opportunities for quality improvement, and assess MCO compliance with Medicaid managed care quality requirements.

In addition, DMMA leverages data infrastructure supported by DHIN to inform the development and monitoring of statewide healthcare quality benchmarks. Although DHIN does not establish quality

benchmarks or performance goals, its role as the operator of the HCCD and statewide health information exchange enables DMMA to consistently measure utilization, outcomes, and quality across the Medicaid population.

Through this integrated approach — combining health information exchange, claims data aggregation, financial investment in data infrastructure, and analytic oversight — DMMA leverages DHIN as a centralized statewide resource to strengthen care coordination, enhance transparency, and promote continuous quality improvement across the Medicaid managed care program.

Feedback Cycle

DMMA strives to employ a process of ongoing, continuous feedback to facilitate changes and improve the quality of care to members. Within this process, opportunities are identified to develop collaborative quality activities that span across the DSHP, DSHP Plus, PROMISE Medicaid, and CHIP programs. Ongoing communications between the DMMA Office of the Chief Medical Officer, the DMMA Quality Unit and the QII Task Force creates a feedback loop that facilitates quality of care improvements for DSHP, DSHP Plus, PROMISE Medicaid, and CHIP members.

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

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

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

EQRO Monitoring and Improvement Activities

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

The EQRO completes a comprehensive compliance review of DMMA contracted MCOs based on 42 CFR §438.320 for analysis and evaluation of quality, timeliness, and access to care using CMS EQR

required and optional protocols as chosen by DMMA. Master Service Agreement (MSA) contractual requirements and state requirements are included in the comprehensive compliance review.

3
Quality Metric and Performance Targets

EQRO Compliance Evaluation

In 2021, Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, 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 Programs (PIPs) for both MCOs. Mercer also completed a comprehensive Information Systems Capabilities Assessment (ISCA).

Below is a crosswalk of the standards reviewed by the State's EQRO against the Subpart D, Quality Assurance and Performance Improvement (QAPI) Standards, and MCO scores for the 2021 comprehensive review cycle.

Standard Reviewed by the EQRO	Subpart D and QAPI Standard	ACDE	HHO
Access and Availability	§438.206 Availability of Services	100.0%	100.0%
	§438.207 Assurances of Adequate Capacity of Services	100.0%	100.0%
Care Management	§438.208 Coordination and Continuity of Care	84.4%	100.0%
Utilization Management (UM)	§438.210 Coverage and Authorization of Services	94.1%	100.0%
Provider Network	§438.214 Provider Selection	100.0%	100.0%
	§438.224 Confidentiality	100.0%	100.0%
	§438.230 Subcontractual Relationships and Delegation	100.0%	90.0%
Grievance and Appeals	§438.228 Grievance and Appeal (G&A) Systems	100.0%	98.9%
Quality Improvement and Assessment	§438.236 Practice Guidelines	84.0%	100.0%
	§438.242 Health Information Systems	97.4%	97.4%
	§438.330 QAPI	98.5%	87.8%

National Core Indicators-Aging and Disabilities

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

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

CAHPS, HEDIS, and Child and Adult Core Set Data

DMMA annually reviews Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Healthcare Effectiveness Data and Information Set (HEDIS®), and Child and Adult Core Sets. The CAHPS survey captures information from consumers about their experiences with healthcare. It focuses on quality aspects, such as communication skills of providers and ease of access to healthcare services. There are separate versions of the survey for adult and pediatric members (administered to parents or guardians). The CAHPS survey data is presented for reporting years 2022, 2023, and 2024 and corresponds to data collected during the measurement years 2021, 2022, and 2023, respectively. HEDIS data provides standardized, nationally comparable quality measures that are reported by MCOs. Child and Adult Core Set measures are designed by CMS to assess access, preventative services, behavioral health, and chronic condition management for Medicaid and CHIP beneficiaries.

Results for CAHPS and HEDIS are compiled, and comparative results among MCOs relative to the Quality Compass® (QC) national benchmarks are reviewed by DMMA. The State requires its MCOs to address all measures that fall below the established benchmark of the 75th percentile. This Quality Systems Evaluation (QSE) assessed CAHPS data, HEDIS data, and Adult and Child Core Set data for

measurement years (MYs) 2021 to 2023. Core Set data was only utilized to assess one measure (rate of babies born with low birth weight).

CAHPS surveys were conducted on several different groups that varied by MCO. No survey findings were available for a LTSS population for DFH, as such, Adult LTSS CAHPS findings presented in this QSE are limited to ACDE and HHO.

Findings from these three data sources are organized by QS goal in the subsequent sections in Table 1 below.

Table 1:

MCO	2022 (MY 2021)	2023 (MY 2022)	2024 (MY 2023)
AmeriHealth Caritas Delaware (ACDE)	Adult Adult LTSS Child — Medicaid Child — CHIP	Adult Adult LTSS Child — Medicaid Child — CHIP	Adult Adult LTSS Child — Medicaid Child — CHIP
Highmark Health Options (HHO)	Adult Adult LTSS Child — Medicaid Child — CHIP	Adult Adult LTSS Child — Medicaid Child — CHIP	Adult Adult LTSS Child — Medicaid Child — CHIP
Delaware First Health (DFH)	NA	NA	Adult Child — Medicaid Child — CHIP

Goal 1: Improve Maternal and Infant Health

The first goal of Delaware's QS was to improve maternal and infant health with several subgoals as follows:

1.1 Increase the timeliness of prenatal care.

1.2 Increase the rate of postpartum depression screening and follow-up.

1.3 Increase well-child visits in the first 30 months of life.

1.4 Decrease the rate of babies born with low birth weight.

Table 2 below provides a summary of the findings associated with Goal 1. ACDE reached the 75th percentile solely in 2022, while HHO surpassed the 75th percentile in each of the three years and exceeded the 90th percentile in 2022 (see Figures 1–7) below.

Table 2:

Goal 1: Improve Maternal and Infant Health							
MCO and Measurement Year		ACDE			HHO		
		2021	2022	2023	2021	2022	2023
1.1	Increase the timeliness of prenatal care	<75th	75th	<75th	75th	90th	75th
1.2	**Increase the rate of postpartum depression screening and follow-up**						
	Postpartum Care	75th	75th	<75th	<75th	<75th	<75th
1.2a	Increase postpartum depression screening	NB	75th	75th	NR	NR	<75th
1.2b	Increase the rate of follow-up after a positive postpartum depression screen	NB	<75th	<75th	NR	NR	<75th
1.3	Increase well-child visits in the first 30 months of life						
	Well-Child Visits in the First 30 Months of Life (15 Months–30 Months)	<75th	<75th	75th	75th	75th	75th
	Well-Child Visits in the First 30 Months of Life (First 15 Months)	90th	75th	<75th	75th	75th	75th
1.4	Decrease the rate of babies born with low-birth weight*	NR	NR	NR	NR	NR	NR
Note: An asterisk (*) indicates that this measure was not reported by the MCOs separately, but the Adult or Child Core Set data provided related data. NB indicates that no QC benchmark was available. NR indicates that no data was reported.							

Figure 1:

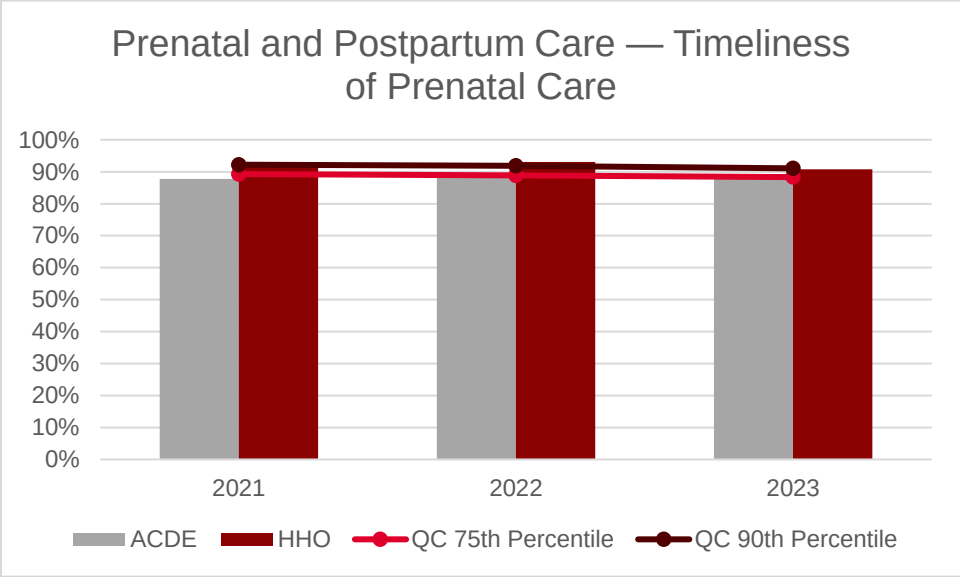


Figure 2:

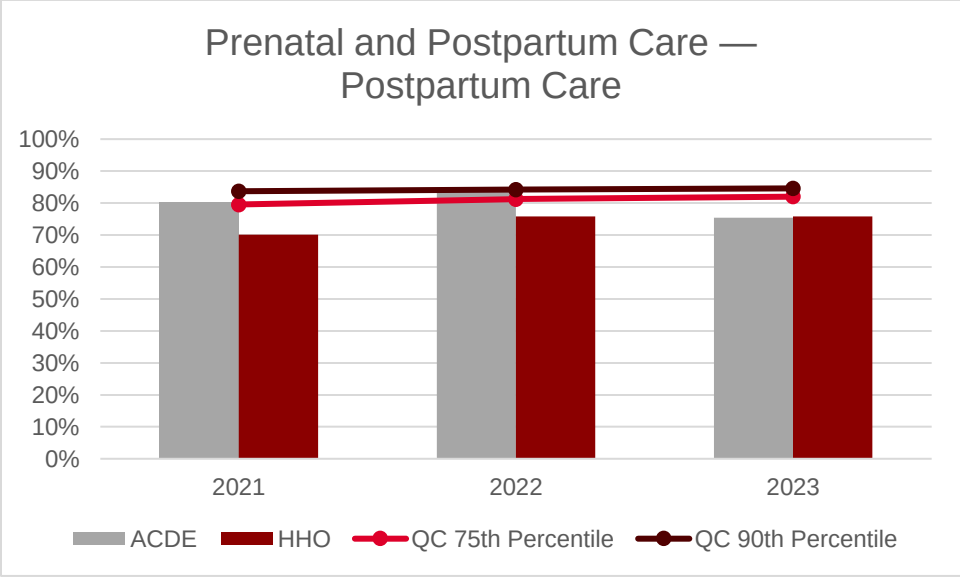
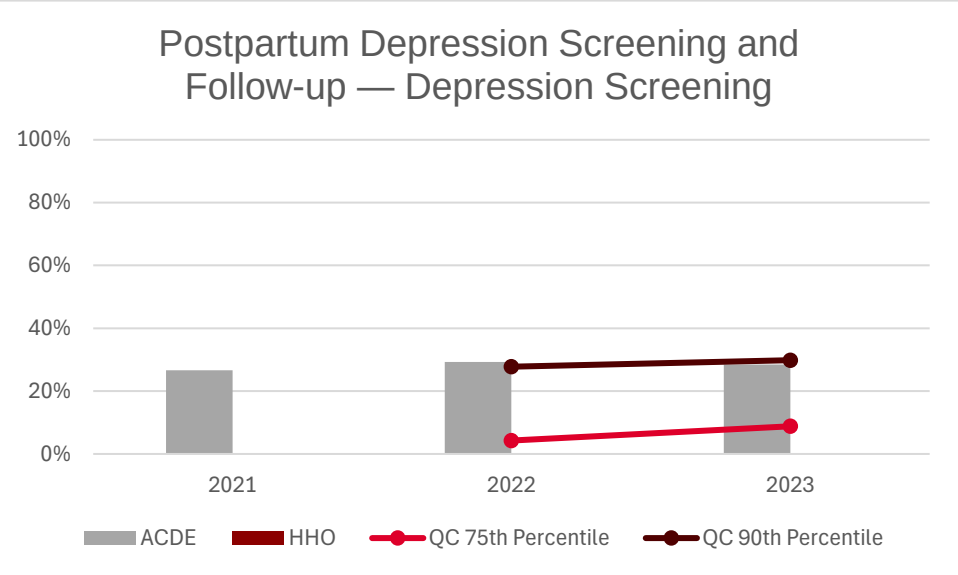
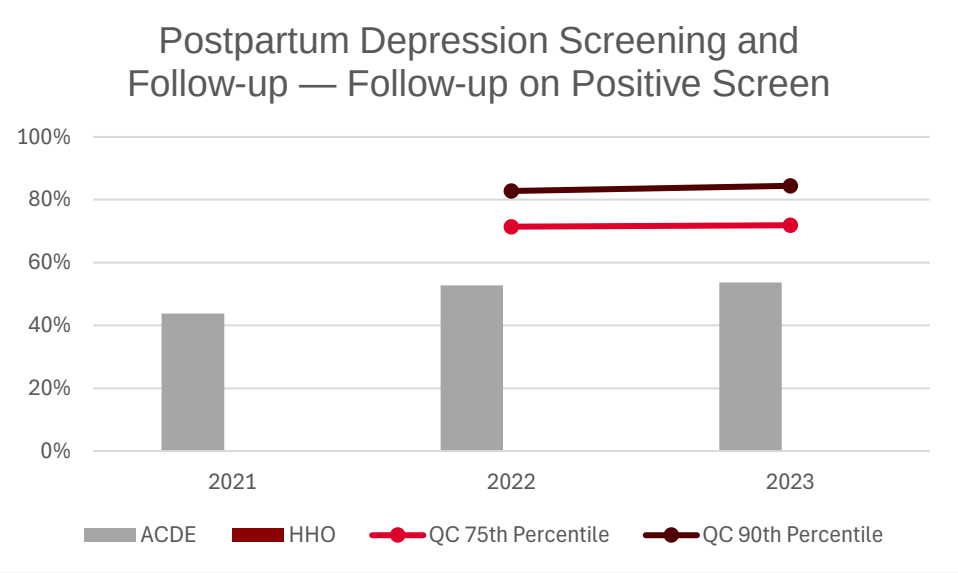


Figure 3:



Note: HHO did not start reporting this measure until 2023, and reported 0% for this measure in 2023. Quality compass benchmarks were not available for this measure for 2021.

Figure 4:



Note: HHO did not start reporting this measure until 2023, and reported 0% for this measure in 2023. Quality compass benchmarks were not available for this measure for 2021.

Figure 5:

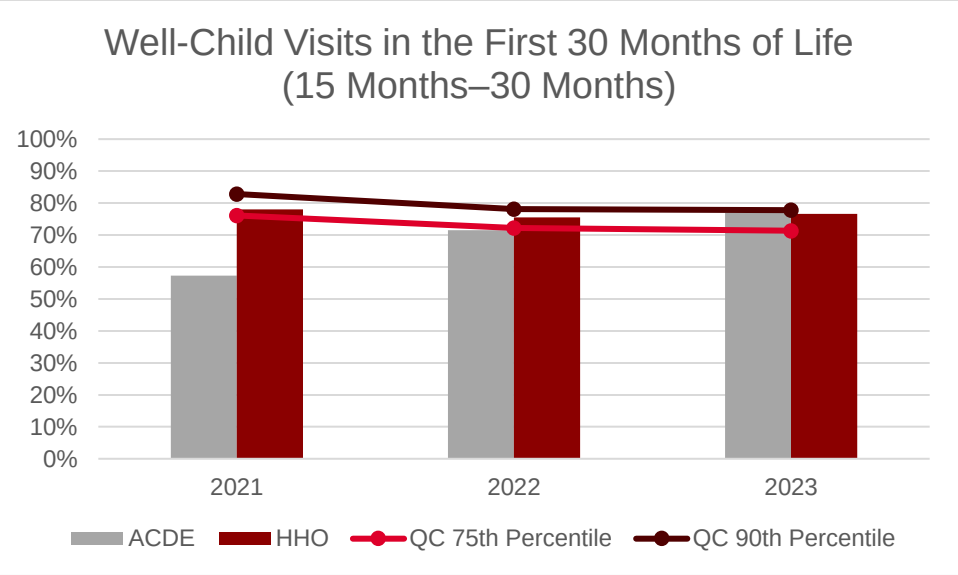
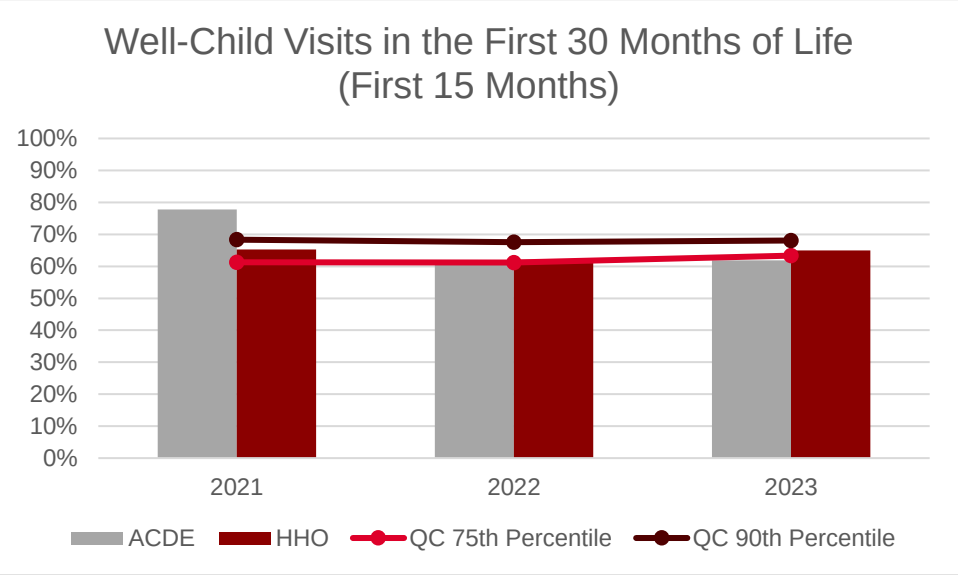


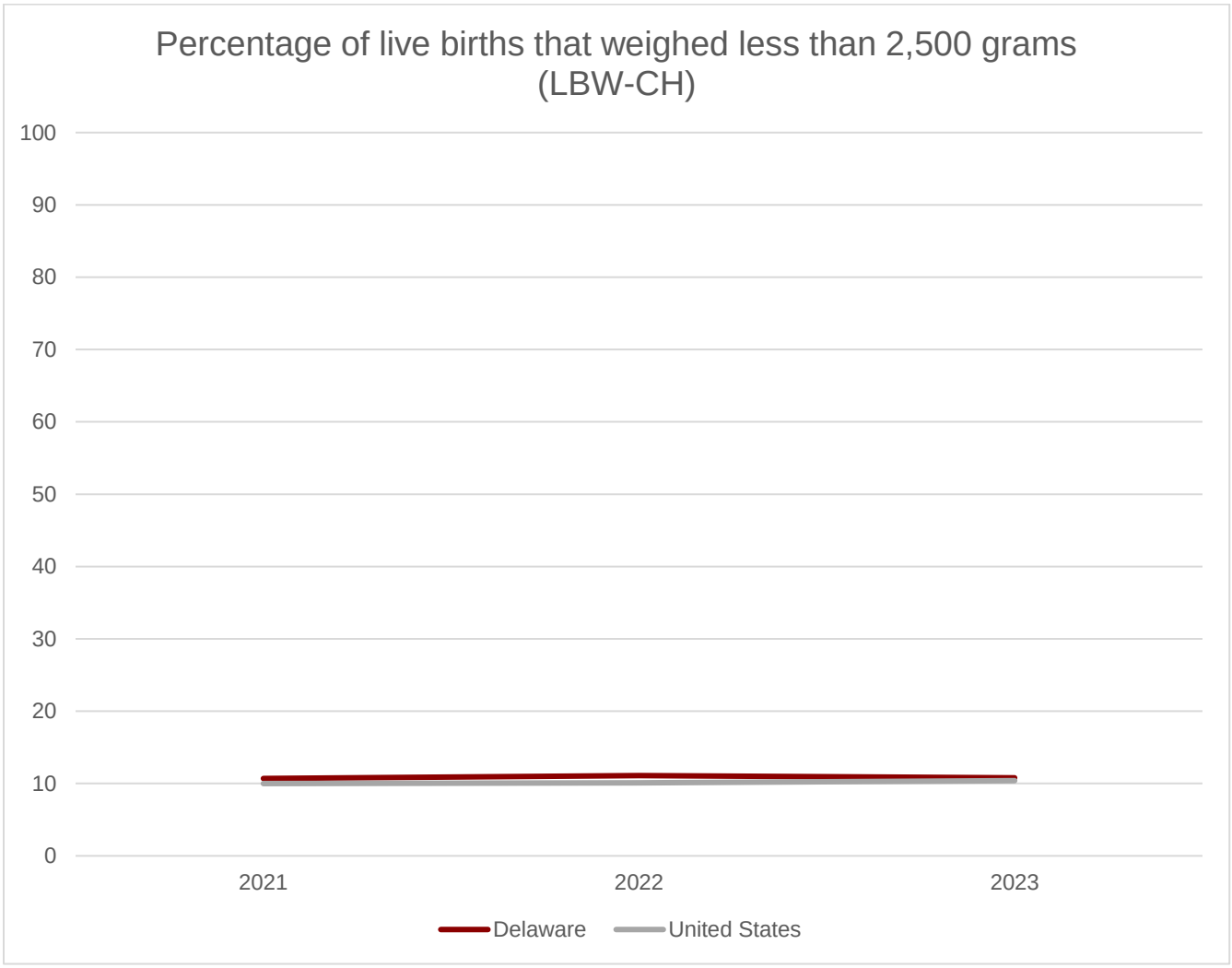
Figure 6:



Between 2021 and 2023, the rate of postpartum depression screening for ACDE ranged from 27–29%. In 2022 and 2023, when QC benchmarks were available, ACDE exceeded the 75th percentile in both years. ACDE exceeded the 95th percentile in 2022 but missed the 95th percentile marginally in 2023. HHO did not report on postpartum depression screening rates until 2023, but reported 0% for 2023, indicating an opportunity for future improvement. For follow-up rates on a positive postpartum depression screen, ACDE missed the 75th percentile in both years in which QC benchmarks were available (2022 and 2023). HHO again reported 0% in 2023, the year it started reporting. Taken together, this highlights an opportunity for improvement for both MCOs related to follow-up rates when after a positive screen. A related metric reported by the MCOs through the Adult Core Set is the “Postpartum Care” measure, which evaluates the percentage of deliveries with a postpartum visit occurring between 7 and 84 days after delivery. ACDE met the 75th percentile benchmark in 2021 and 2022 but failed to do so in 2023. HHO did not meet the 75th percentile benchmark in any of the three years. This indicates a need for improvement in postpartum care for both MCOs.

The results for well-child visits within the first 30 months of life were mixed for ACDE. There was a steady decline in well-child visits during the first 15 months compared to the national benchmark, with ACDE exceeding the 90th percentile in 2022, dropping to exceeding the 75th percentile in 2023, and missing the 75th percentile in 2024. For the 15–30 months period, ACDE missed the 75th percentile in 2022 and 2023 but showed improvement by meeting the 75th percentile in 2024. In contrast, HHO exceeded the 75th percentile for both measures across all three years. Statewide Core Set data indicated that the percentage of live births weighing less than 2,500 grams ranged from 10.7% to 11.1% in Delaware during 2021 to 2023, consistently exceeding the US average of 10% to 10.4% for those years.

Figure 7:



Note: Data presented as United States represents the CMS-published national median for the Child Core Set LBW-CH measure.

Goal 2: Improve Chronic Condition Management

Table 3 provides a summary of the findings associated with Goal 2, to improve chronic condition management. The subgoals of Goal 2 are as follows:

2.1 Improve diabetes.

2.1b Increase the use of and adherence to statin therapy.

2.2 Improve utilization of statin therapy to improve cardiovascular outcomes.

2.2b Improve the use of and adherence to statin therapy.

Table 3:

Goal 2: Improve Chronic Condition Management							
MCO and Measurement Year		ACDE			HHO		
		2021	2022	2023	2021	2022	2023
2.1	**Improve diabetes**						
2.1a	Increase hemoglobin A1c control for patients with diabetes	<75th	<75th	<75th	75th	75th	90th
2.1b	**Increase the use of an adherence to statin therapy**						
2.1b.1	Increase the use of statin therapy	<75th	<75th	<75th	<75th	<75th	<75th
2.1b.2	Increase the statin adherence to 80%	<75th	<75th	<75th	<75th	<75th	<75th
2.2	**Improve utilization of statin therapy to improve cardiovascular outcomes**						
2.2a	Increase control of high blood pressure	<75th	<75th	<75th	<75th	<75th	<75th
2.2b	**Improve the use of and adherence to stain therapy**						
2.2b.1	Increase the use of statin therapy	<75th	<75th	<75th	<75th	<75th	90th
2.2b.2	Increase the statin adherence to 80%	<75th	<75th	<75th	<75th	<75th	<75th

Diabetes Care

Hemoglobin A1c control for patients with diabetes who were part of HHO was consistently above the 75th percentile. Furthermore, in 2023, HHO exceeded the 90th percentile. ACDE showed improvement from 2021 to 2023, however, its performance missed the 75th percentile in all three years. Furthermore, both measures for statin use and adherence to statin therapy among patients with diabetes was below the 75th percentile benchmark for both MCOs across all three years. Taken together, these results suggest opportunities for improvement for both MCOs.

Figure 8:

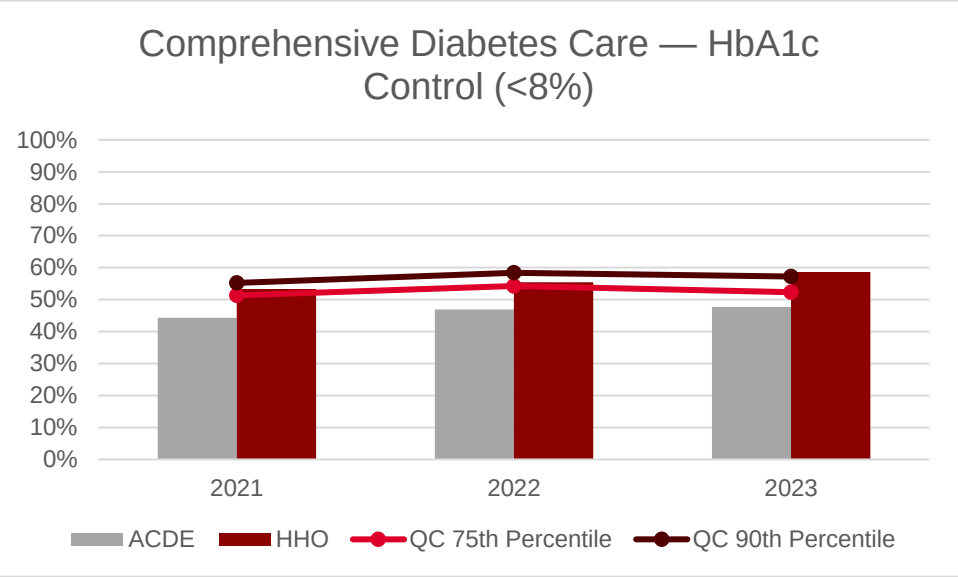


Figure 9:

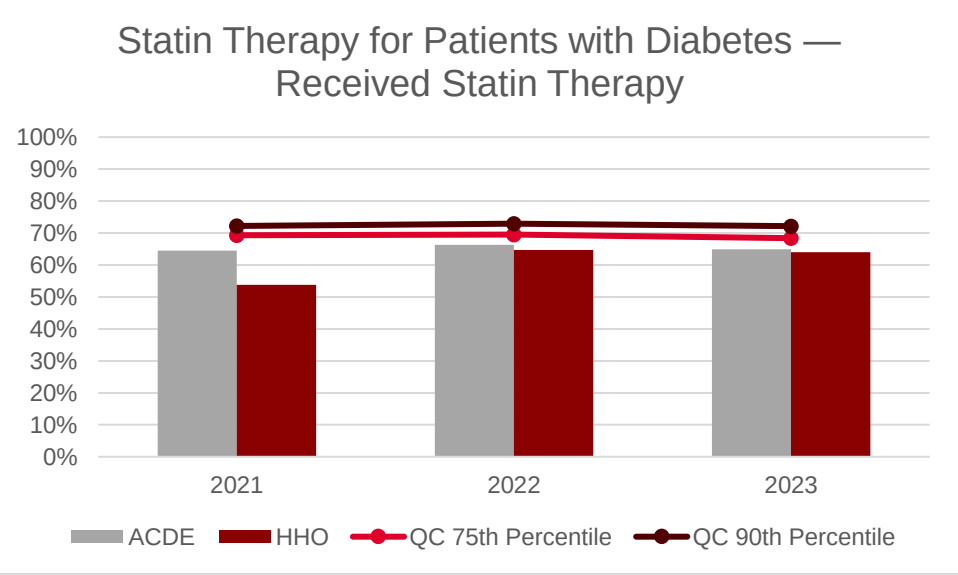
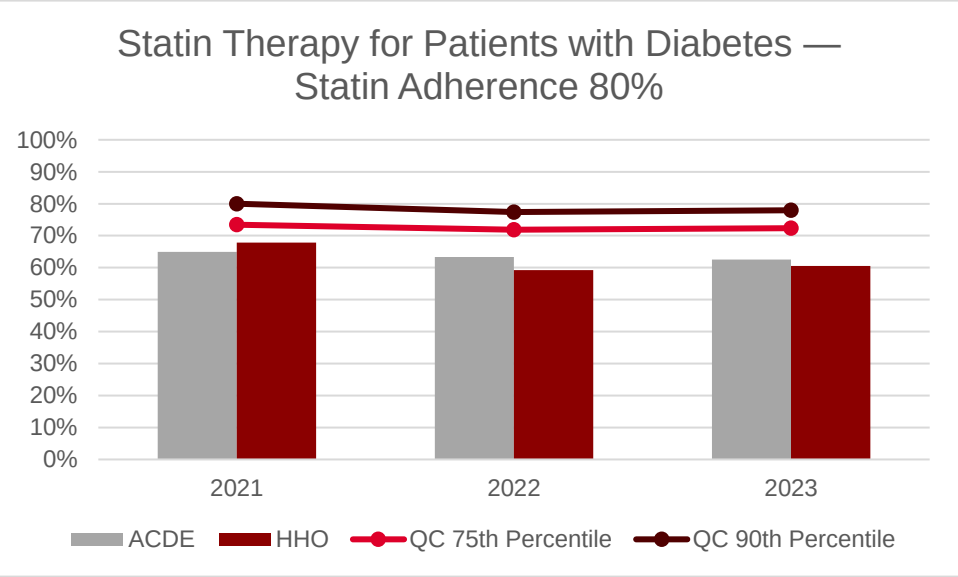


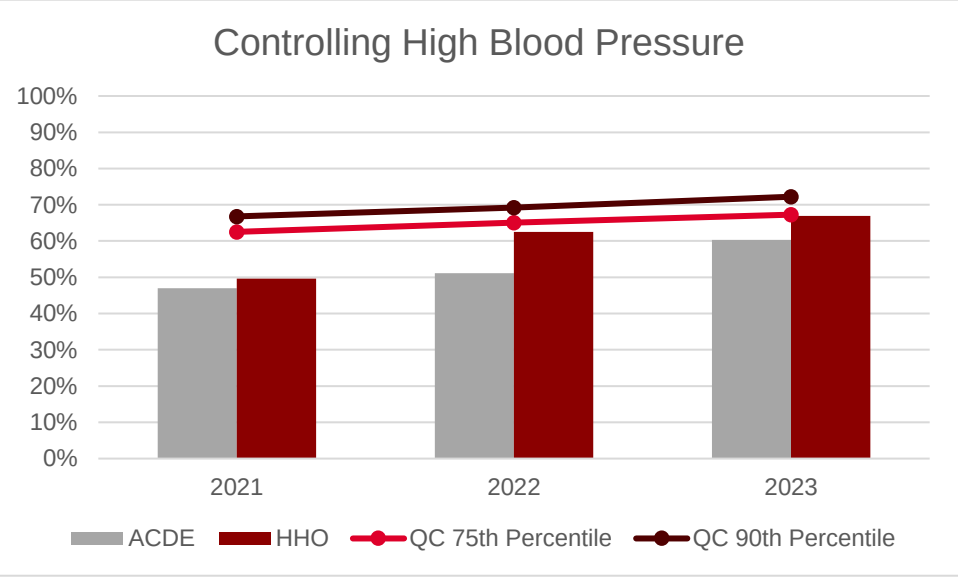
Figure 10:



Cardiovascular Disease

Similar to the Diabetes outcomes, results for hypertension highlight an area for improvement for both ACDE and HHO. Both MCOs missed the 75th percentile benchmark for all three years, across all three measures for cardiovascular disease.

Figure 11:



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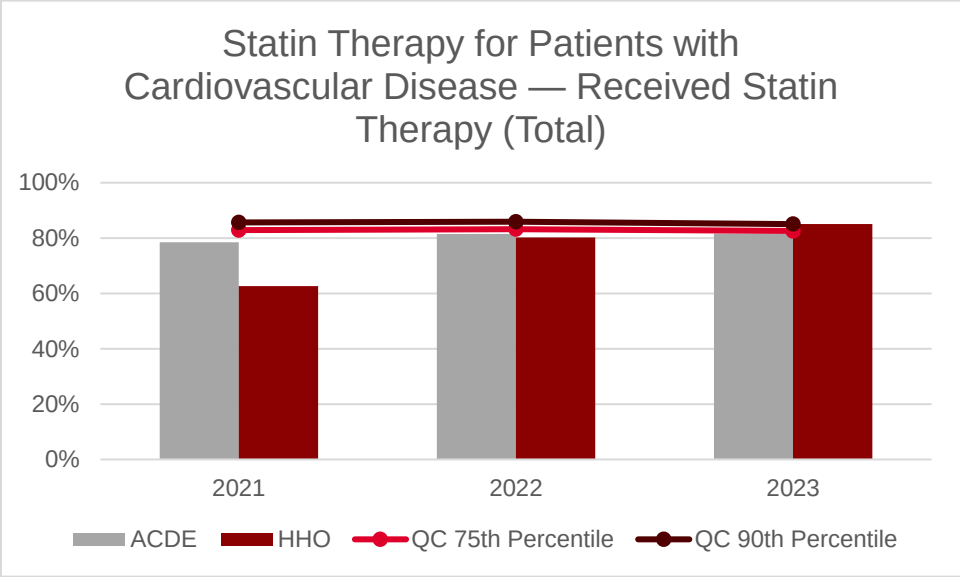
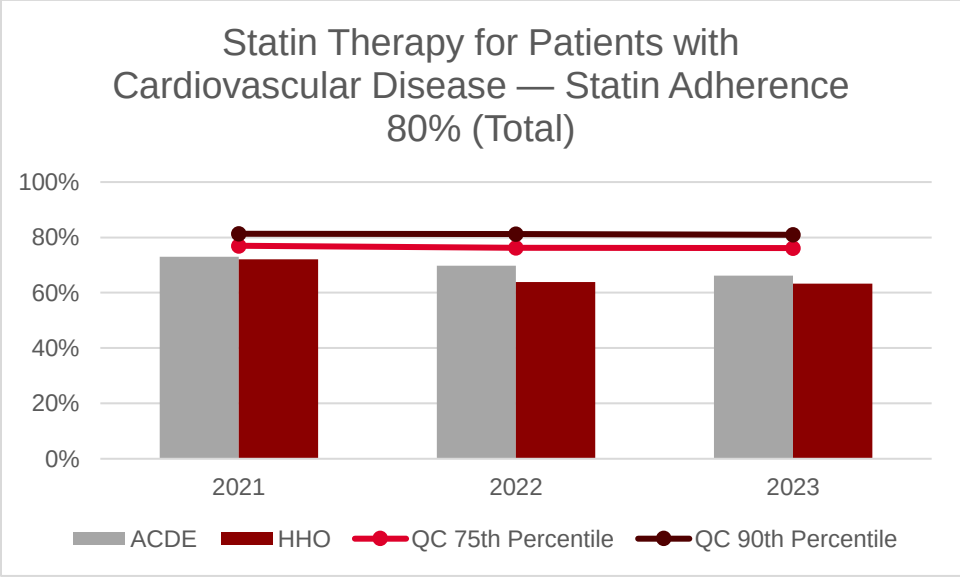


Figure 13:



Goal 3: Reduce Communicable Diseases

The third goal of Delaware's QS has the following subgoals:

3.1 Increase Chlamydia screening.

3.2 Increase rate of adult influenza immunization.

3.3 Increase childhood immunizations.

3.4 Increase the frequency of appropriate treatment of upper respiratory infections.

3.5 Increase avoidance of antibiotic treatment for acute bronchitis/bronchiolitis.

3.6 Reduce HIV disease progression.

Table 4: Communicable Disease Outcomes by MCO (2021–2023)

Goal 3: Reduce Communicable Diseases							
MCO and Measurement Year		ACDE			HHO		
		MY 2021	MY 2022	MY 2023	MY 2021	MY 2022	MY 2023
3.1	Increase Chlamydia screening	75th	90th	75th	<75th	<75th	<75th
3.2	Increase rate of adult influenza immunization[1]	NB	<75th	<75th	NR	NR	<75th
3.3	Increase childhood immunizations	<75th	<75th	<75th	<75th	<75th	75th
3.4	Increase the frequency of appropriate treatment of upper respiratory infections	<75th	<75th	<75th	<75th	<75th	<75th
3.5	Increase avoidance of antibiotic treatment for acute bronchitis/bronchiolitis	75th	<75th	<75th	<75th	<75th	<75th
3.6	Reduce HIV disease progression	NR	NR	NR	NR	NR	NR

Note: NB indicates that no QC benchmark was available. NR indicates that no data was reported.
[1]For the adult influenza immunization measure, for MY 2022, the measures reported are the rate among adults aged 19–65, whereas, for MY 2023, the rate reported is for all adults aged 19 and above. QC benchmarks used for comparisons utilize the appropriate populations for each MY.

Table 4 above presents an overview of findings related to each of the aforementioned subgoals. The two MCOs did not provide data on subgoals 3.2 and 3.6.

The figures 14–18 below depict the subgoals with reported findings.

Figure 14:

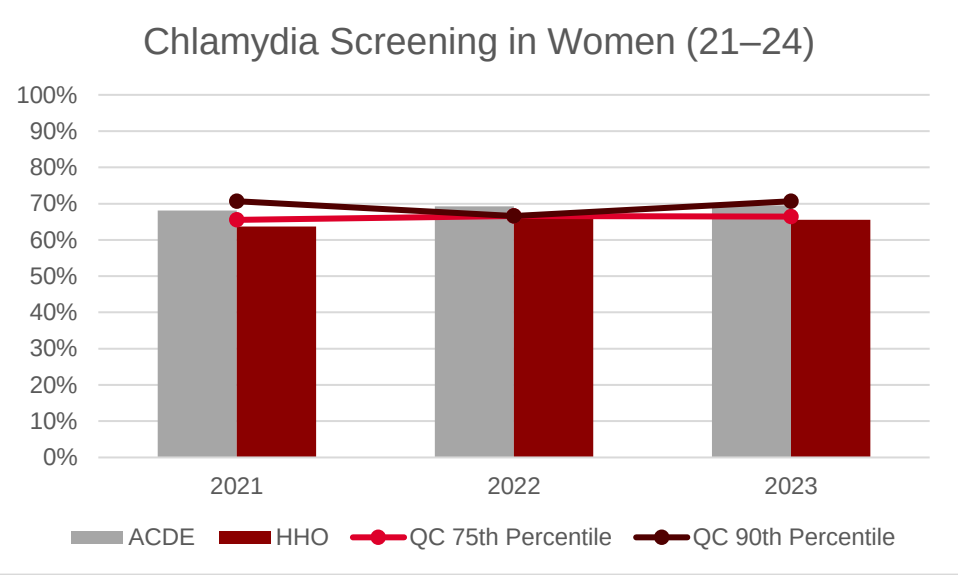
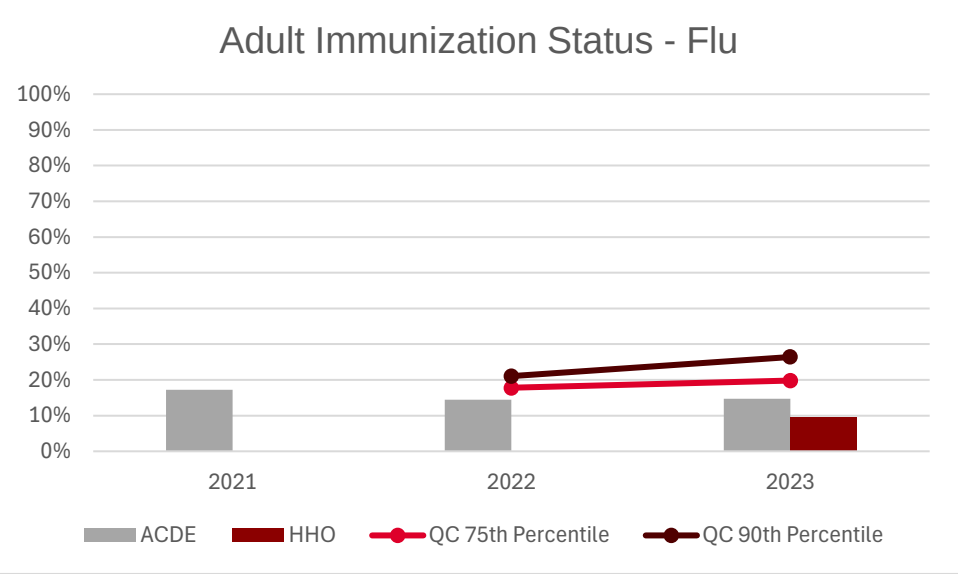


Figure 15:



Notes: For the adult influenza immunization measure, for MY 2022, the measures reported are the rate among adults aged 19–65, whereas, for MY 2021 and MY 2023, the rate reported is for all adults aged 19 and above. QC benchmarks used for comparisons utilize the appropriate populations for each measurement year.

Figure 16:

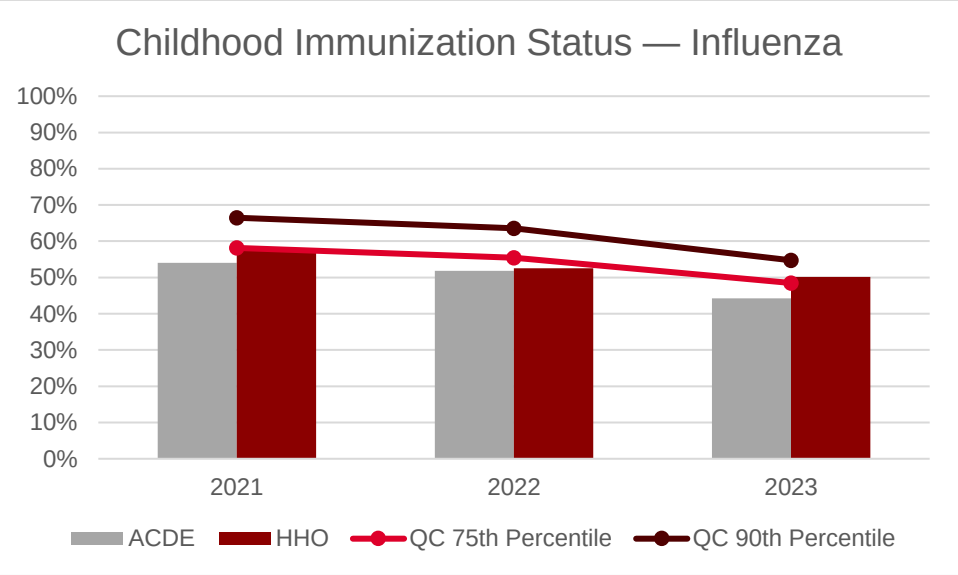


Figure 17:

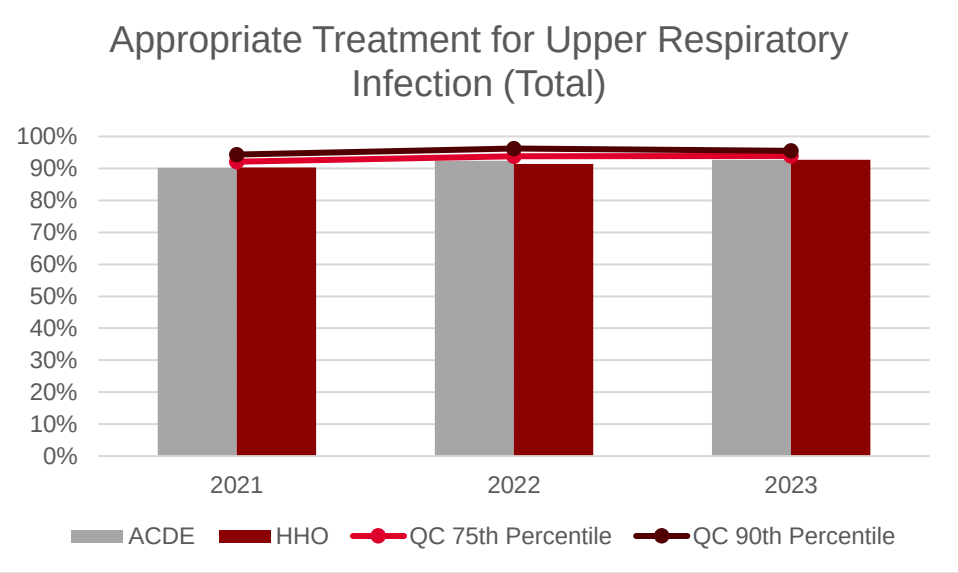
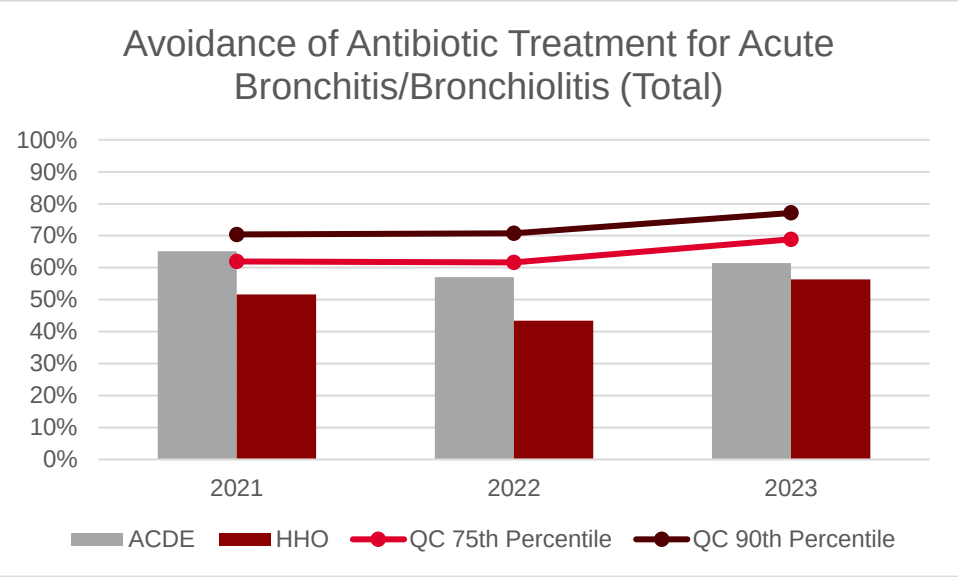


Figure 18:



The rate of chlamydia screening among women aged 21–24 for ACDE and HHO ranged from 68–70% and 64–66%, respectively, during the period from 2021 to 2023. ACDE met the 75th percentile benchmark in all three years and exceeded the 90th percentile in 2022, while HHO fell short of the benchmark by less than two percentage points in each of the three years. Flu immunizations among adults decreased among ACDE members from 17% to 15% from 2021 to 2023; furthermore, ACDE missed the 75th percentile benchmark for all three years. HHO only reported the adult immunization measure in 2023, and similarly, missed the 75th percentile benchmark. This highlights an opportunity for improvement. Although HHO reached the 75th percentile benchmark in 2023, immunization rates for influenza among children declined over time for both MCOs. This decline aligns with a broader downward trend observed in national benchmarks for this measure, indicating an opportunity for improvement not only for these two MCOs but also more broadly across the United States. Regarding the “appropriate treatment for upper respiratory infection” measure, ACDE and HHO performed similarly, both showing modest increases over time. Despite these upward trends, both MCOs still fell short of the 75th percentile benchmark in all three years. Lastly, for the “avoidance of antibiotic treatment for acute bronchitis/bronchiolitis” measure, ACDE, despite achieving the 75th percentile in 2021, missed the benchmark in 2022 and 2023; HHO missed the benchmark in all three years.

Goal 4: Improve Behavioral Health Condition Identification and Management

The fourth goal of Delaware’s MC QS is to improve the identification and management of behavioral health conditions. As part of this goal, Delaware identified the following subgoals:

4.1 Increase follow-up care for children prescribed ADHD medication.

4.2 Increase rate of depression screening and follow-up for adolescents and adults.

4.3 Increase the rate of initiation and engagement of alcohol and other drugs (AOD) abuse or dependence treatment.

4.4 Increase rate of follow-up after hospitalization for mental illness.

4.5 Increase rate of follow-up after emergency department visit for mental illness.

Table 5 below presents an overview of the QSE's findings for each of the aforementioned subgoals.

Table 5:

Goal 4: Improve Behavioral Health Condition Identification and Management								
MCO and Measurement Year		ACDE			HHO			
		MY 2021	MY 2022	MY 2023	MY 2021	MY 2022	MY 2023
4.1	**Increase follow-up care for children prescribed ADHD medication**						
4.1a	Increase follow-up care for children initially prescribed ADHD medication	<75th	<75th	<75th	<75th	<75th	<75th
4.1b	Increase follow-up care for children prescribed ADHD medication on an ongoing basis	<75th	<75th	<75th	<75th	<75th	<75th
4.2	**Increase rate of depression screening and follow-up for adolescents and adults**						
4.2a	Increase rate of depression screening for adolescents and adults	NR	NR	NR	NR	NR	NR
4.2b	Increase rate of follow-up for adolescents and adults after a positive depression screen	NR	NR	NR	NR	NR	NR
4.3	Increase rate of initiation and engagement of AOD abuse or dependence treatment						
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment — Engagement of AOD — Alcohol Abuse or Dependence (Total)	75th	75th	90th	<75th	<75th	75th
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment — Engagement of AOD — Opioid Abuse or Dependence (Total)	90th	<75th	90th	75th	75th	75th
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment — Engagement of AOD — Other Drug Abuse or Dependence (Total)	75th	75th	90th	<75th	<75th	<75th
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment — Engagement of AOD — Total (Total)	90th	90th	90th	75th	90th	75th
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment — Initiation of AOD — Alcohol Abuse or Dependence (Total)	<75th	<75th	75th	<75th	<75th	<75th

Goal 4: Improve Behavioral Health Condition Identification and Management							
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment — Initiation of AOD — Opioid Abuse or Dependence (Total)	90th	<75th	<75th	<75th	75th	90th
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment — Initiation of AOD — Other Drug Abuse or Dependence (Total)	75th	<75th	90th	<75th	<75th	75th
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment — Initiation of AOD — Total (Total)	90th	<75th	90th	75th	75th	75th
4.4	Increase rate of follow-up after hospitalization for mental illness						
	Follow-Up After Hospitalization For Mental Illness — 30 days (18–64)	<75th	<75th	<75th	<75th	<75th	<75th
	Follow-Up After Hospitalization For Mental Illness — 7 days (18–64)	<75th	<75th	<75th	<75th	<75th	<75th
4.5	Increase rate of follow-up after emergency department visit for mental illness						
	Follow-Up After Emergency Department Visit for Mental Illness — 30 days (18–64)	<75th	<75th	<75th	<75th	<75th	<75th
	Follow-Up After Emergency Department Visit for Mental Illness — 7 days (18–64)	<75th	<75th	<75th	<75th	<75th	<75th
Note: NR indicates that no data was reported.							

Data reported from 2021 to 2023 by ACDE and HHO highlighted the need for improvements in follow-up care for children who are initially prescribed ADHD medications, as well as for those receiving ADHD medications continuously. The MCOs did not provide data concerning depression screenings or follow-up rates for either adolescents or adults.

Figure 19:

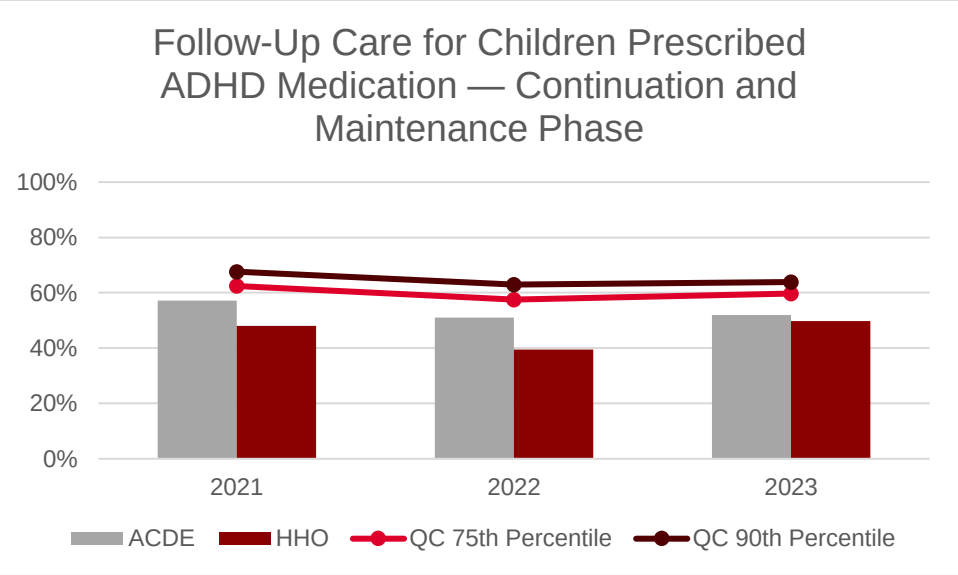
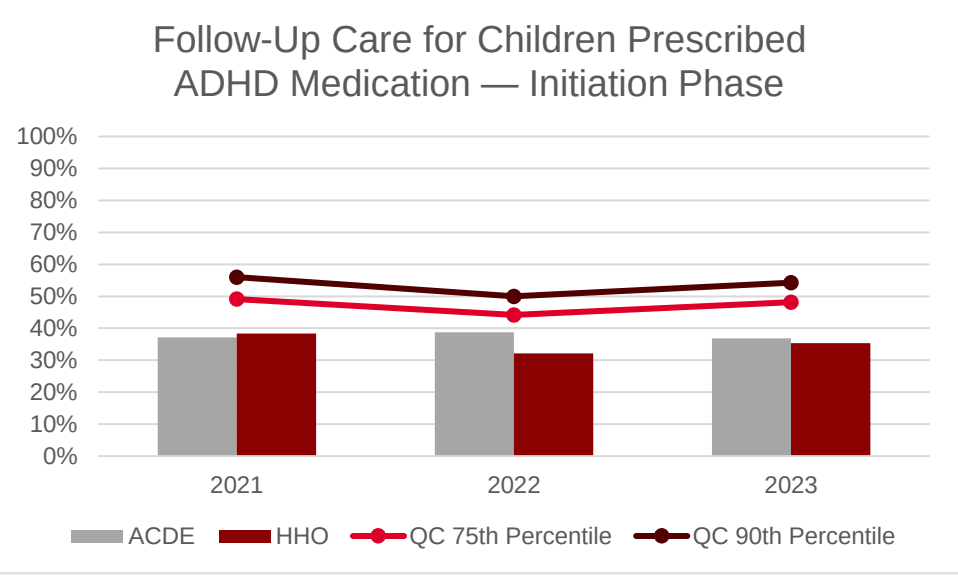


Figure 20:



This section presents findings on the engagement rates in treatment for AOD abuse or dependence. Regarding engagement in alcohol abuse treatment, ACDE consistently reached the 75th percentile benchmark across all three years and surpassed the 90th percentile in 2023. Conversely, HHO did not meet the benchmark in 2021 and 2022 but showed progress in 2023 by exceeding it. In terms of treatment engagement for opioid abuse or dependence, ACDE surpassed the 90th percentile in 2021 and 2023, although it fell short of the 75th percentile in 2022. HHO consistently met the 75th percentile for all three years. For other drug abuse or dependence treatments, ACDE consistently attained the 75th percentile benchmark and exceeded the 90th percentile in 2023, while HHO failed to meet the 75th percentile in any of the three years. When combining all types of AOD treatment engagement, both ACDE and HHO achieved at least the 75th percentile across the three years. Notably, ACDE maintained performance above the 90th percentile during the entire period, and HHO surpassed the 90th percentile in 2022.

Figure 21:

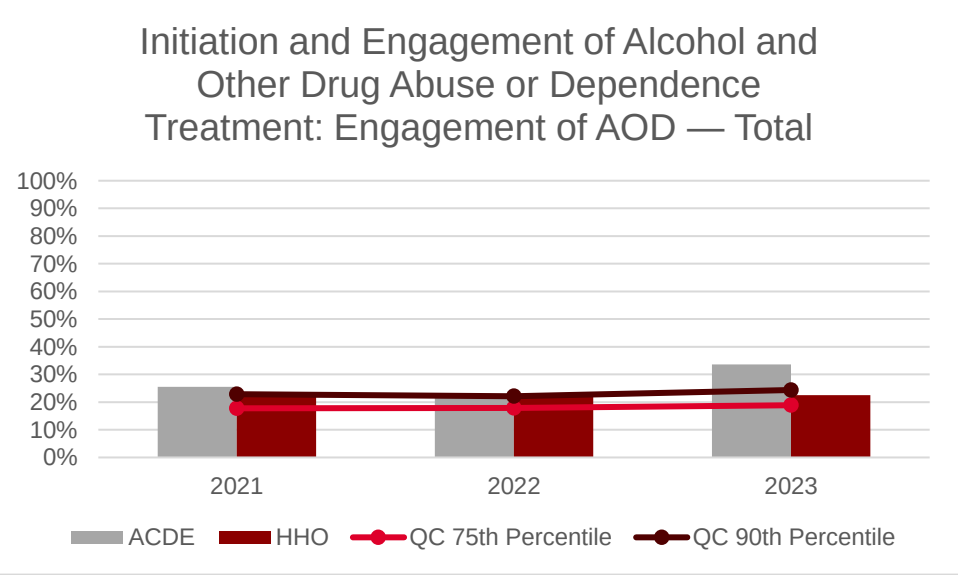


Figure 22:

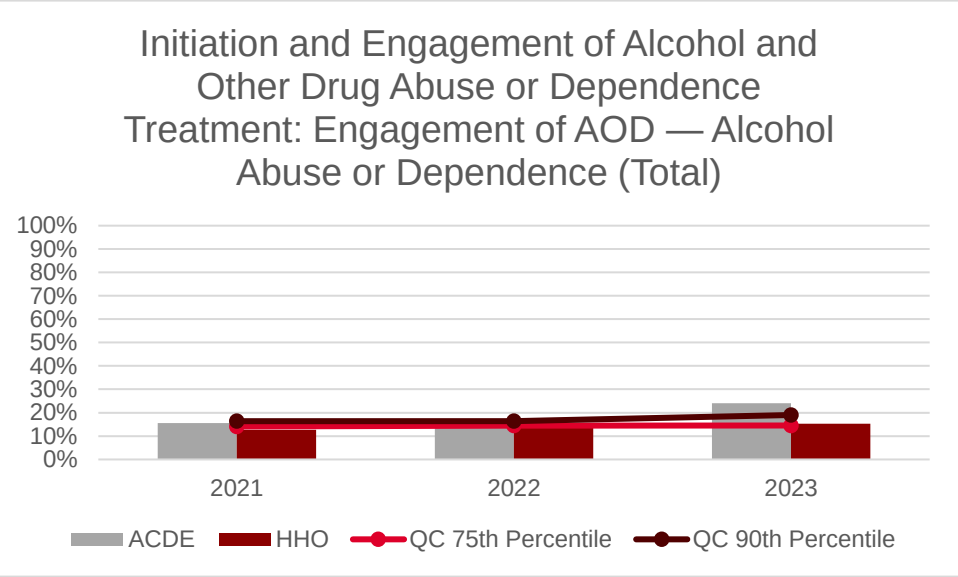


Figure 23:

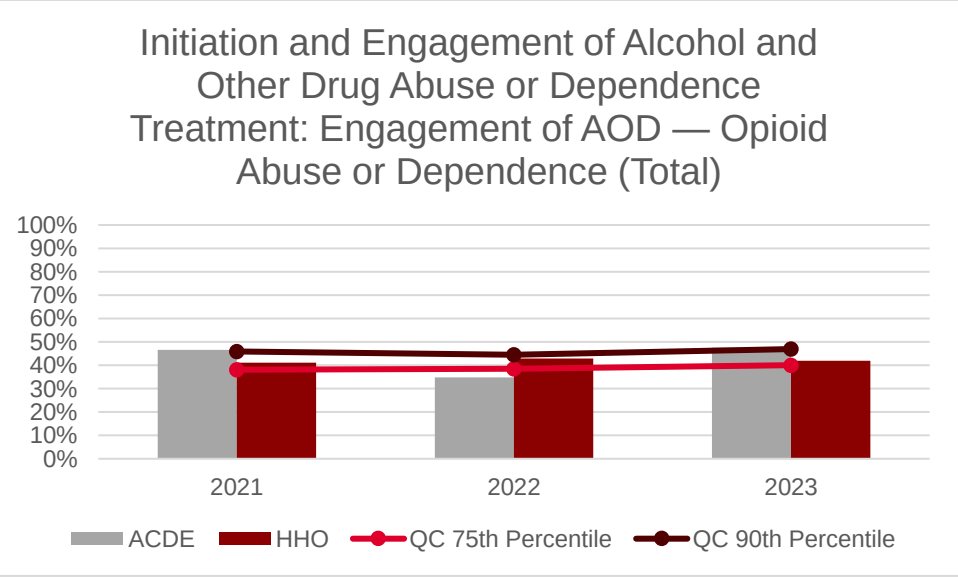
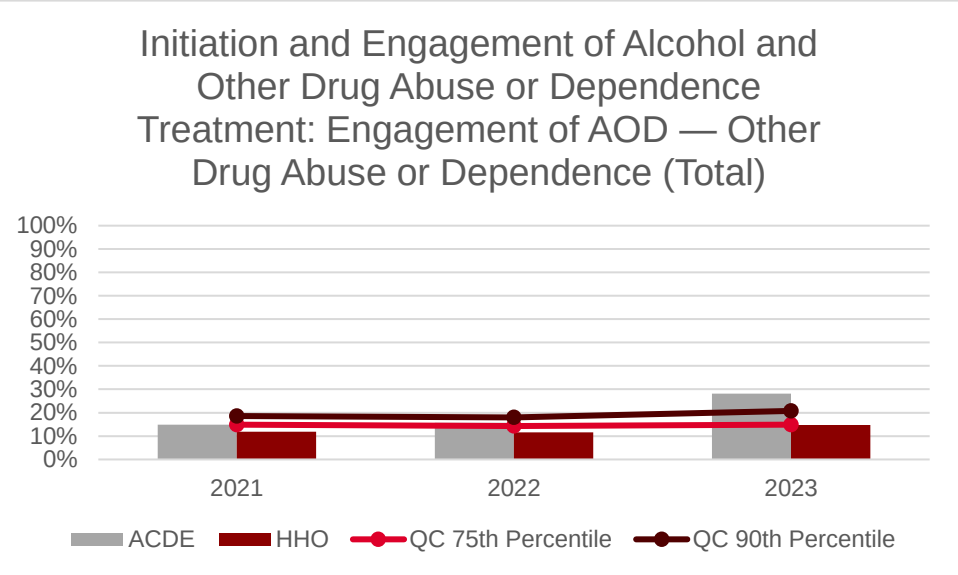


Figure 24:



Regarding initiation rates for treatment of AOD abuse or dependence across all AOD types, ACDE surpassed the 90th percentile in 2021 and 2023 but did not reach the 75th percentile in 2022. HHO consistently achieved the 75th percentile in all three years. However, when initiation rates were further broken down by alcohol, opioid, and other drug abuse or dependence, the outcomes were more varied. For alcohol abuse or dependence, ACDE failed to meet the benchmark in 2021 and 2022, only achieving it in 2023, whereas HHO did not meet the benchmark in any of the three years. Concerning opioid abuse or dependence, although ACDE reached the 90th percentile in 2021, it fell below the 75th percentile in 2022 and 2023. In contrast, HHO showed steady improvement, progressing from below the 75th percentile in 2021 to achieving the 75th percentile in 2022 and exceeding the 90th percentile in 2023. Lastly, for other types of drug abuse or dependence, ACDE attained the 75th percentile in 2021, dropped below it in 2022, and then surpassed the 90th percentile in 2023. HHO did not meet the benchmark in 2021 and 2022 but exceeded it in 2023.

Figure 25:

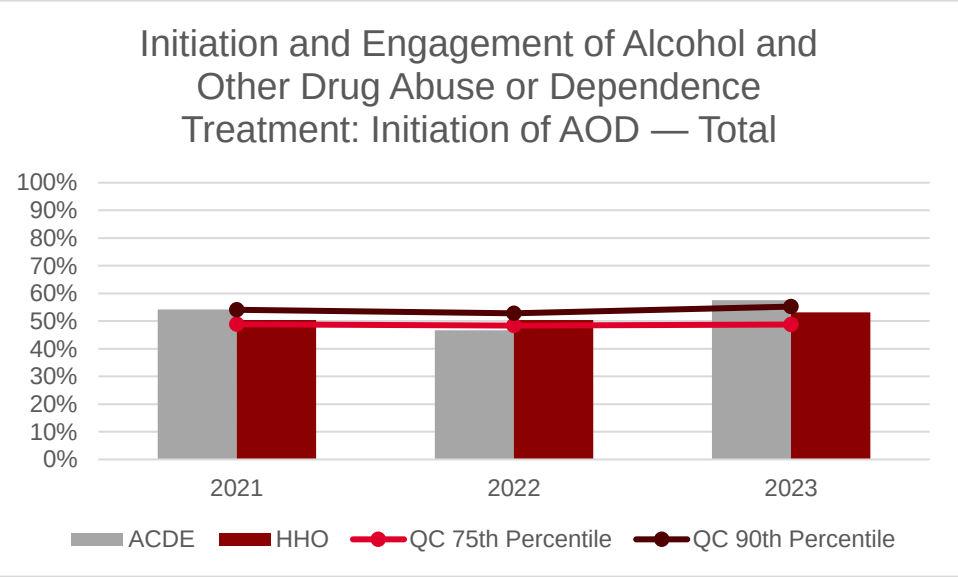


Figure 26:

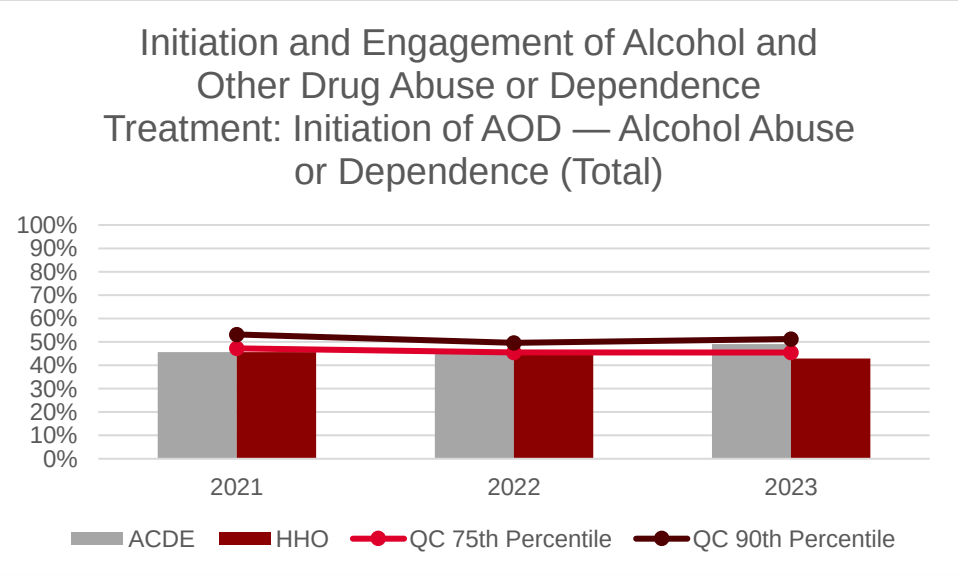


Figure 27:

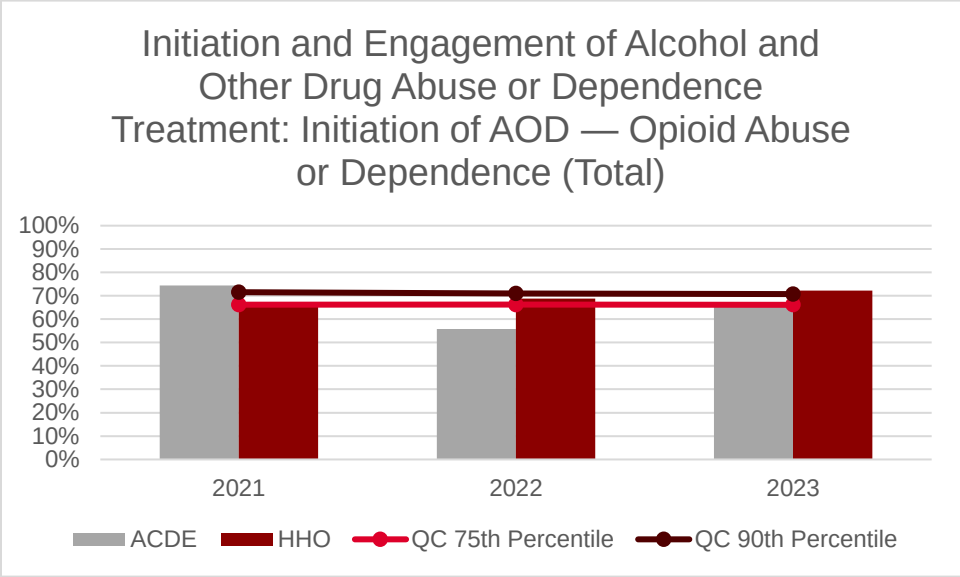
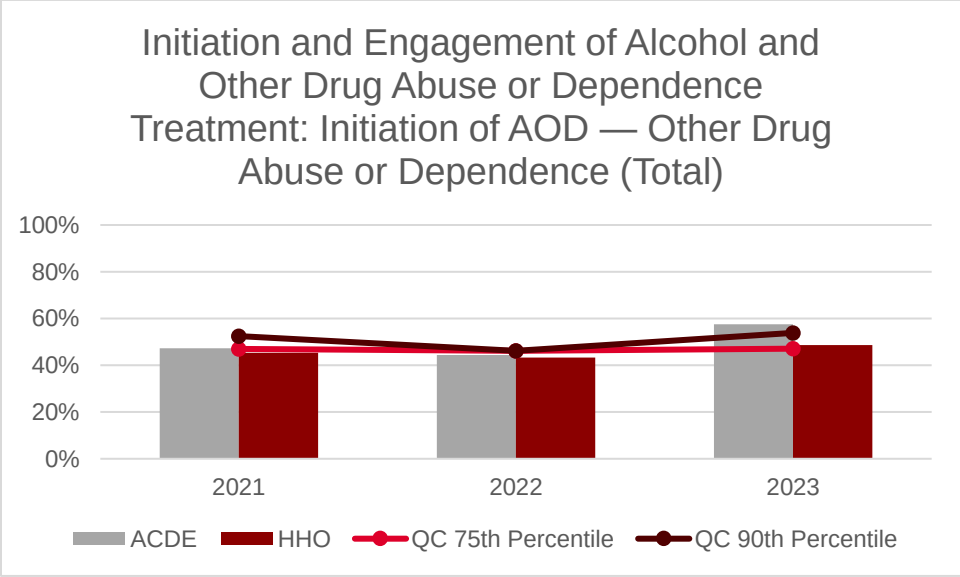


Figure 28:



Among ACDE and HHO members, all four measures related to follow-up after hospitalization or an emergency department visit for mental illness fell short of the 75th percentile benchmark across all three years, representing a significant opportunity for improvement for both MCOs.

Figure 29:

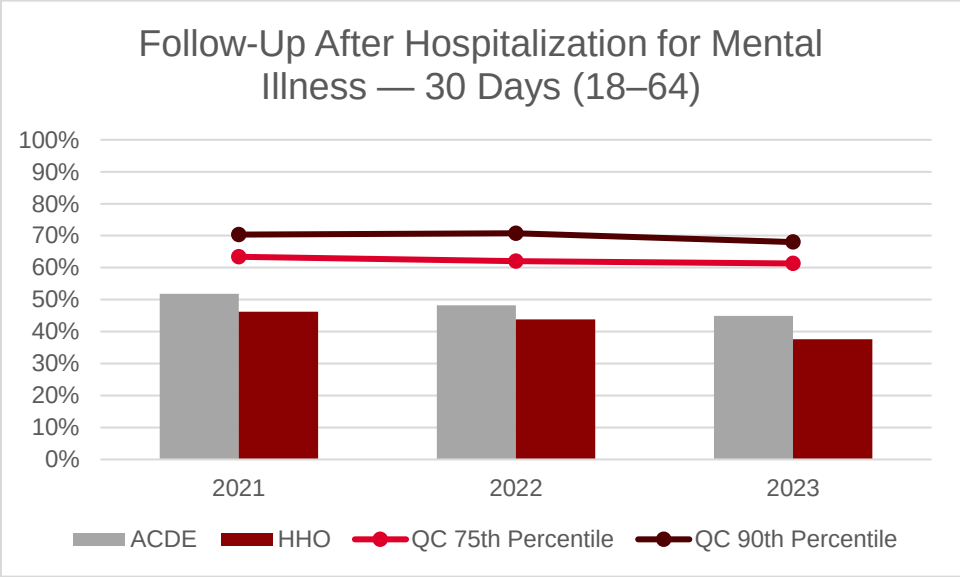


Figure 30:

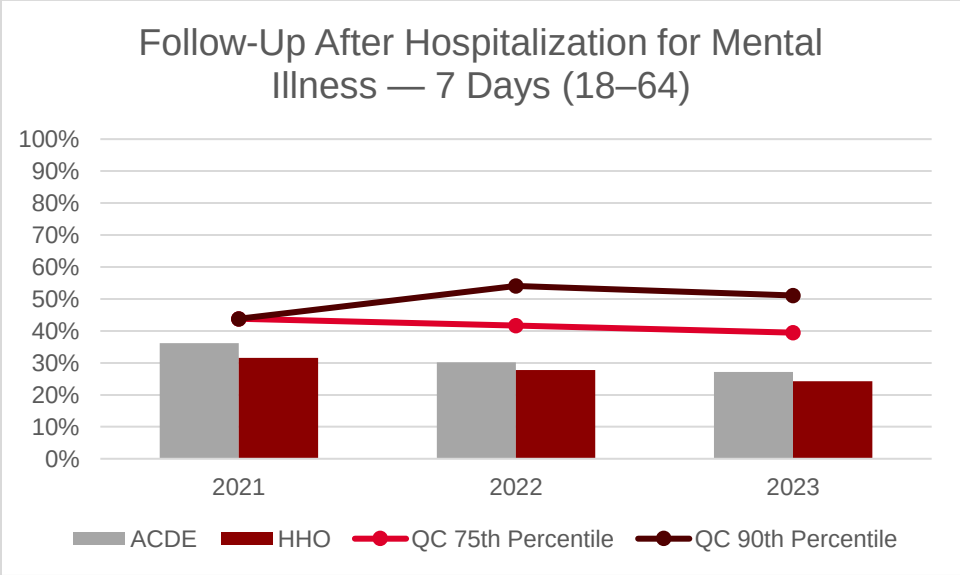


Figure 31:

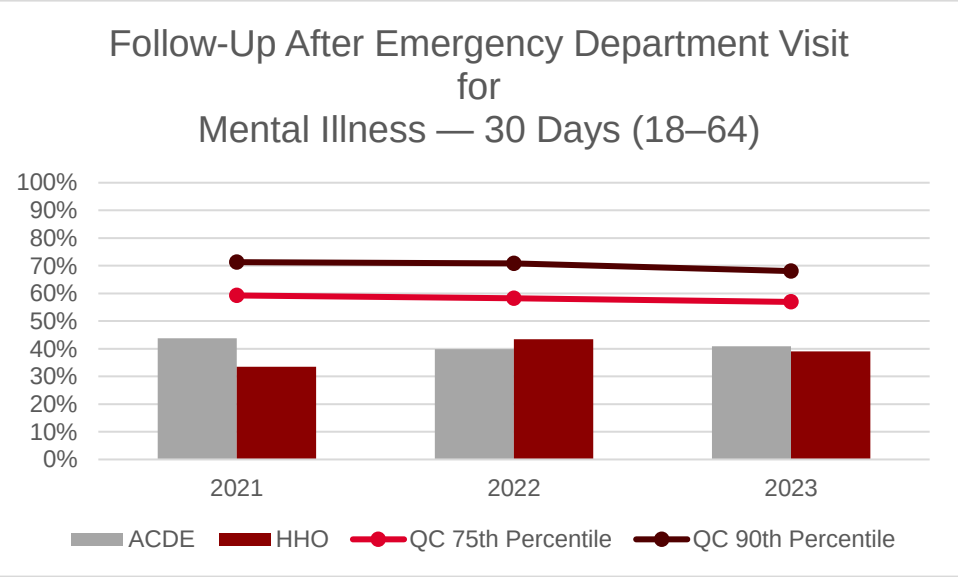
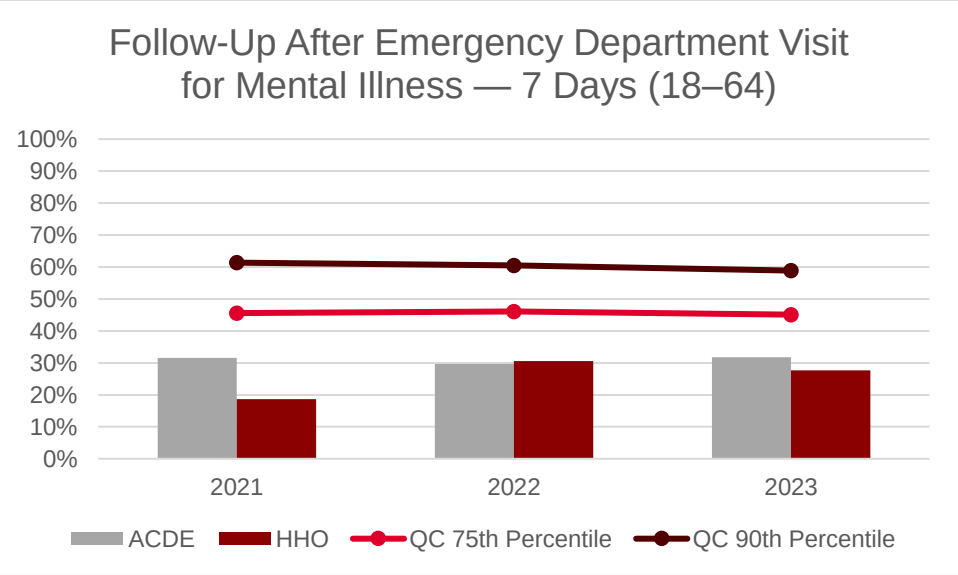


Figure 32:



Goal 5: Improve Member Experience of Care

CAHPS Composite Scores

Table 6:

Goal 5: Improve Member Experience of Care										
MCO and Measurement Year		ACDE			HHO			DFH		
		MY 2021	MY 2022	MY 2023	MY 2021	MY 2022	MY 2023	MY 2021	MY 2022	MY 2023
5.1	**Increase CAHPS composite measures**									
5.1a	**Increase member ability of getting needed care**									
5.1a.1	Increase adult members' ability of getting needed care									
	Adult	<75th	<75th	75th	<75th	<75th	75th	NA	NA	<75th
	LTSS	75th	<75th	90th	<75th	<75th	<75th	NA	NA	ND
5.1a.2	Increase pediatric members' ability of getting needed care									
	Child	<75th	<75th	<75th	<75th	<75th	<75th	NA	NA	<75th
	CHIP	<75th	<75th	<75th	75th	<75th	<75th	NA	NA	<75th
5.1b	**Increase member ability of getting needed care**									
5.1b.1	Increase adult members' ability of getting care quickly									
	Adult	<75th	<75th	<75th	<75th	<75th	75th	NA	NA	<75th
	LTSS	90th	90th	90th	75th	75th	75th	NA	NA	ND
5.1b.2	Increase pediatric members' ability of getting care quickly									
	Child	<75th	<75th	75th	<75th	<75th	<75th	NA	NA	<75th
	CHIP	<75th	<75th	<75th	<75th	<75th	<75th	NA	NA	<75th

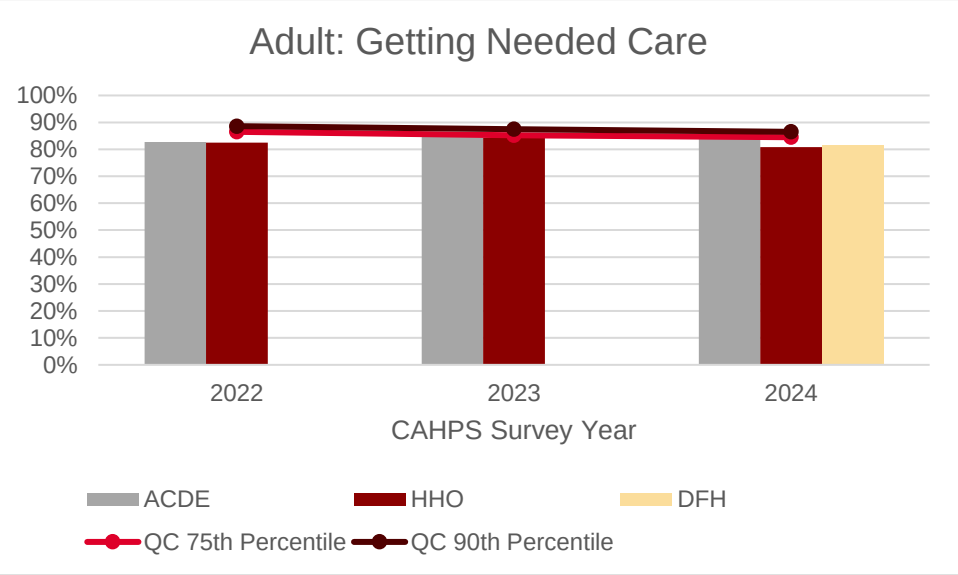
Goal 5: Improve Member Experience of Care										
MCO and Measurement Year		ACDE			HHO			DFH		
		MY 2021	MY 2022	MY 2023	MY 2021	MY 2022	MY 2023	MY 2021	MY 2022	MY 2023
5.1c	**Increase members' rating on health plan customer services**									
5.1c.1	Increase adult members' rating on health plan customer services									
	Adult	<75th	75th	90th	<75th	90th	<75th	NA	NA	<75th
	LTSS	90th	90th	90th	<75th	90th	<75th	NA	NA	ND
5.1c.2	Increase pediatric members' rating on health plan customer services									
	Child	<75th	<75th	75th	<75th	75th	<75th	NA	NA	<75th
	CHIP	<75th	<75th	90th	<75th	90th	<75th	NA	NA	<75th
5.1d	**Increase members' rating on health plan**									
5.1d.1	Increase adult members' rating on health plan									
	Adult	<75th	90th	75th	75th	75th	90th	NA	NA	<75th
	LTSS	75th	75th	90th	90th	75th	90th	NA	NA	ND
5.1d.2	Increase pediatric members' rating on health plan									
	Child	90th	90th	90th	90th	75th	<75th	NA	NA	<75th
	CHIP	75th	90th	90th	75th	90th	<75th	NA	NA	<75th

Note: The measurement year data presented for 2021, 2022, and 2023 correspond to data that are reported in CAHPS years 2022, 2023, and 2024, respectively. NA indicates that reporting was not applicable. ND indicates no data was available.

Adult CAHPS

Getting Needed Care

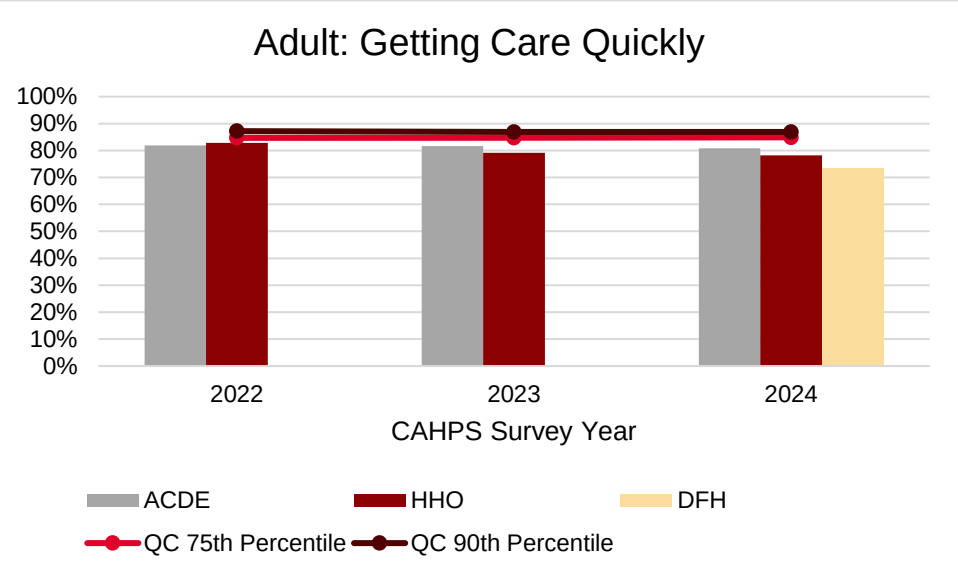
Figure 33:



The percentage of individuals reporting that they usually or always receive the necessary care exceeded 80% across all years. Nevertheless, when compared to the national benchmark, ACDE and HHO both fell below the 75th percentile in 2022 and 2023, while DFH was below the 75th percentile in 2024. Notably, ACDE surpassed the 75th percentile in 2024.

Getting Care Quickly

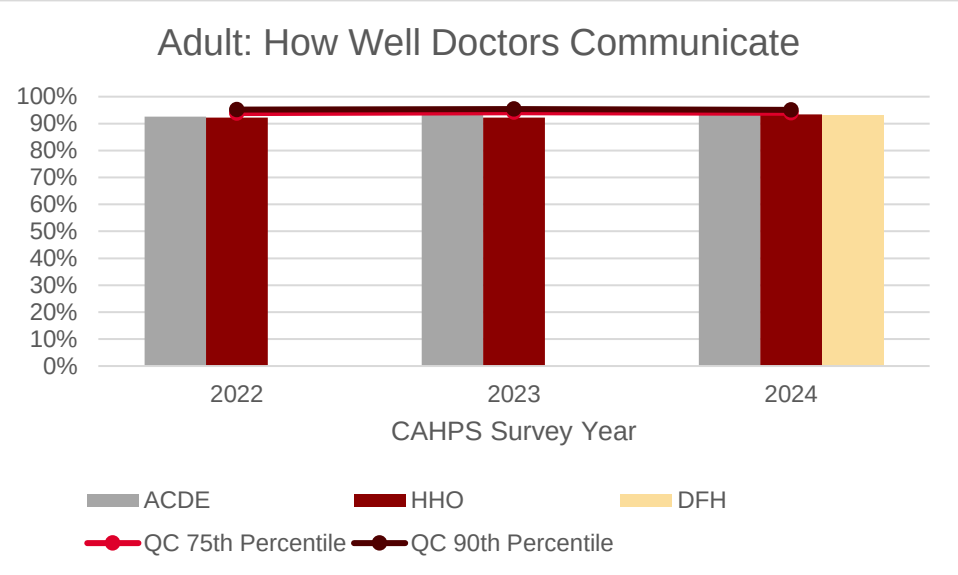
Figure 34:



Findings presented in the figure above highlights an area for improvement for all three MCOs. The percentage of individuals reporting that they usually or always get care quickly fell below the 75th percentile for all years in which data was available for the three MCOs. ACDE consistently maintained between 81–82% of individuals reporting that they usually or always get care quickly between 2022 to 2024. HHO presented a slight downward trend going from 83% in 2022 to 78% in 2024. In 2024, 73% of DFH beneficiaries reported that they usually or always get care quickly.

How Well Doctors Communicate

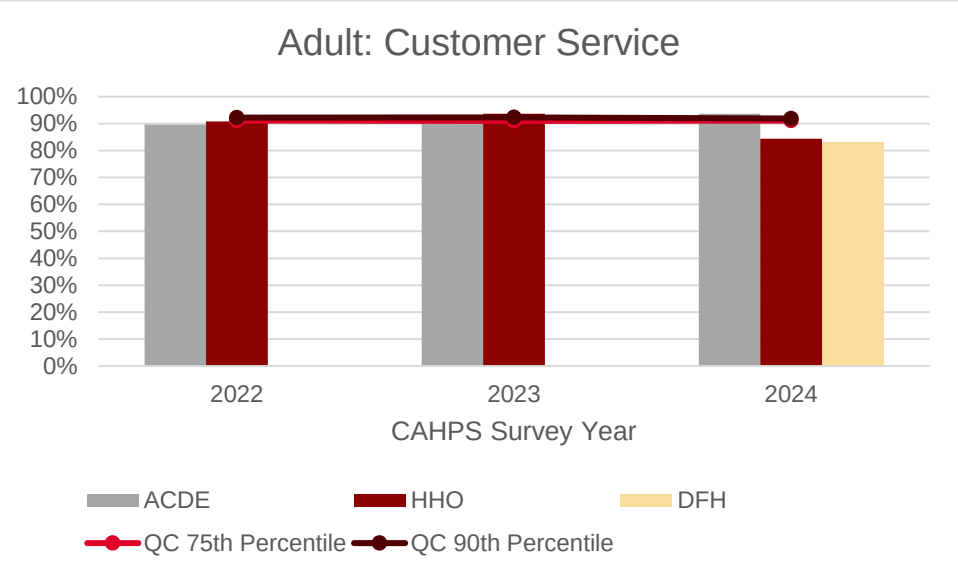
Figure 35:



Overall, across the three MCOs, more than 90% of individuals reported that their doctors usually or always communicated well. Compared to national standards, ACDE ranked below the 75th percentile in 2022, reached the 75th percentile in 2023, and surpassed the 90th percentile in 2024, indicating steady progress over time. Although HHO did not achieve the 75th percentile in any of the three years, it consistently had over 92% of members indicating that their doctors usually or always communicated well. Similarly, DFH fell short of the 75th percentile in 2024 but was within less than one percentage point of meeting the benchmark.

Health Plan Customer Service

Figure 36:

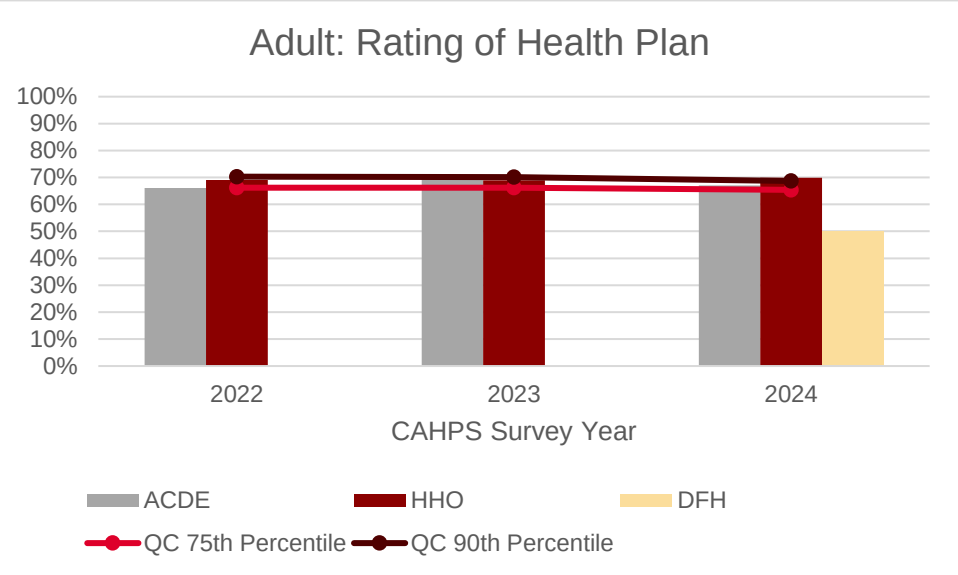


Notes: The CAHPS survey year data presented for 2022, 2023, and 2024 correspond to data collected during the 2021, 2022, and 2023 measurement years, respectively.

ACDE demonstrated improvement in customer service from 2022 to 2024, with the percentage of individuals reporting they were usually or always satisfied with the customer service they received increasing from 90% to 94%. Relative to the national benchmark, ACDE was below the 75th percentile in 2022, reached the 75th percentile in 2023, and achieved the 90th percentile in 2024. HHO improved between 2022 and 2023 but experienced a decline in satisfaction in 2024, indicating an area needing improvement for the plan. DFH, in its first year of reporting, performed below the 75th percentile.

Rating of Health Plan

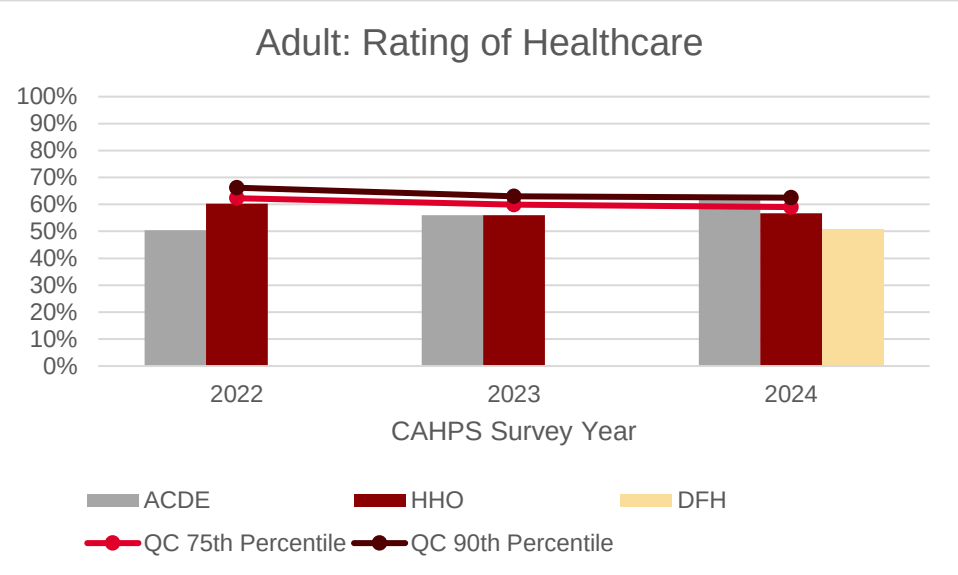
Figure 37:



In 2022, 66% of individuals rated their health plan in ACDE as either 9 or 10, falling below the national benchmark. ACDE showed progress in the following years, surpassing the 90th percentile in 2023. However, a minor decline in 2024 placed ACDE's performance above the 75th percentile, narrowly missing the 90th percentile by less than two percentage points. HHO consistently improved, exceeding the 75th percentile in both 2022 and 2023, and surpassing the 90th percentile in 2024. DFH, in its first reporting year, ranked below the 75th percentile, indicating an area with an opportunity for improvement.

Rating of Healthcare

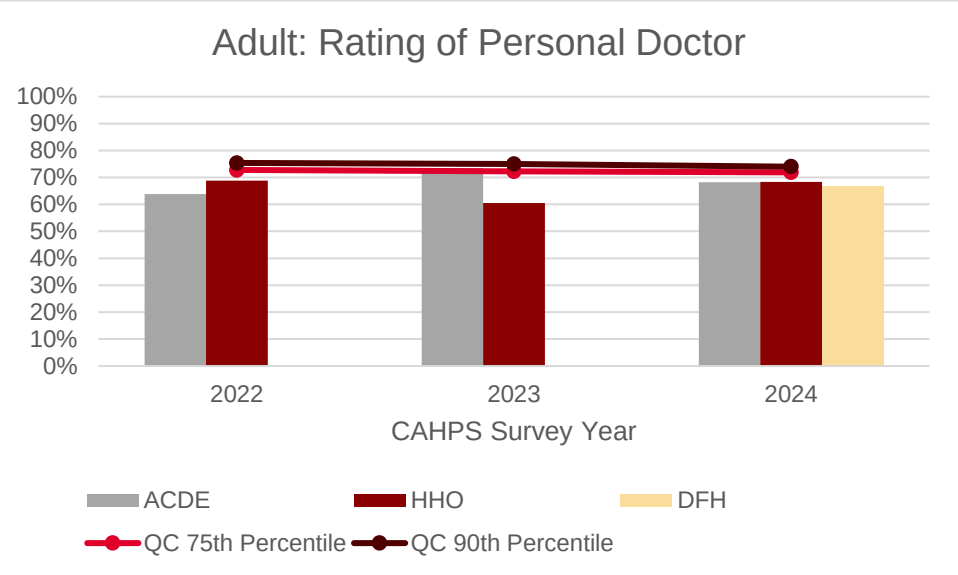
Figure 38:



ACDE performed below the 75th percentile in the healthcare rating measure in 2022 and 2023; however, in 2024, the plan demonstrated notable improvement, surpassing the 90th percentile. HHO remained below the 75th percentile, with data showing a steady decline in its healthcare rating between 2022 and 2024, highlighting an opportunity for improvement. Similarly, DFH also ranked below the 75th percentile in 2024.

Rating of Personal Doctor

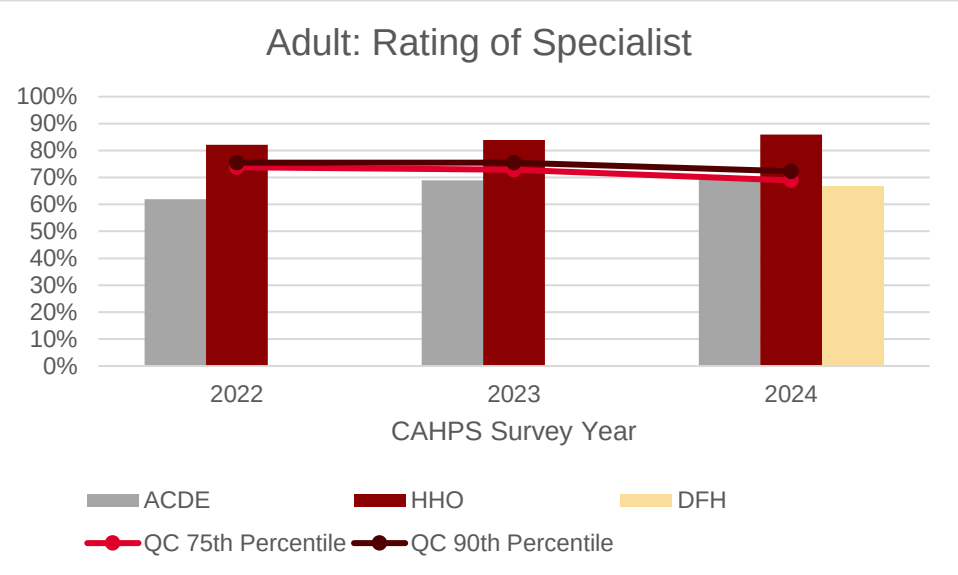
Figure 39:



Across all three MCOs, the rating of personal doctor measure results highlight opportunities for improvement. ACDE scored below the 75th percentile in 2022 and 2024, although it showed progress in 2023 by surpassing the 75th percentile. Both HHO and DFH consistently scored below the 75th percentile throughout all reported years.

Rating of Specialist

Figure 40:

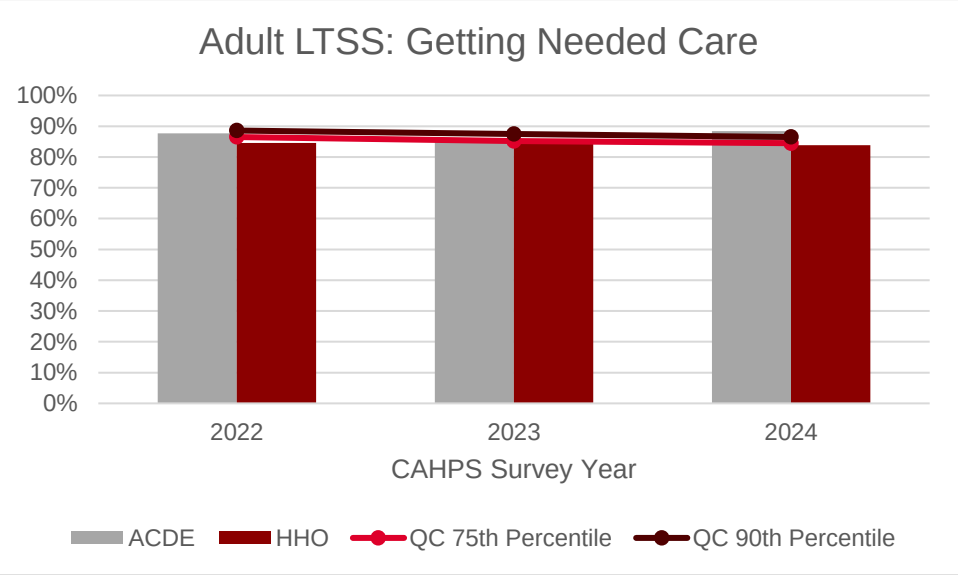


For specialist ratings, ACDE demonstrated improvement between 2022 to 2024; the plan performed below the 75th percentile for the initial two measurement years assessed and reached the 75th percentile in 2024. HHO performed below the 75th percentile for all three years, although by 2024, HHO was only three percentage points away from reaching the benchmark, indicating that despite being an area for improvement, the plan is not far from reaching the benchmark. Similarly, DFH, despite missing the 75th percentile in 2024, was only about three percentage points away.

Adult LTSS CAHPS

Getting Needed Care

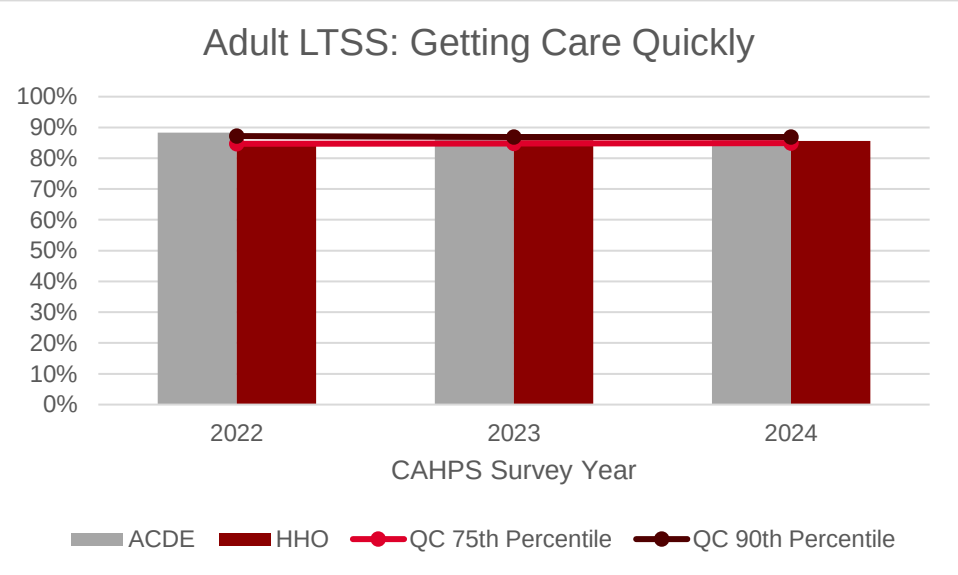
Figure 41:



The percentage of individuals reporting that they usually or always receive the necessary care exceeded 80% across all years, with ACDE consistently out performing HHO across all three years. ACDE in 2022 met the 75th percentile, in 2023 missed the 75th percentile, and in 2024 exceeded the 90th percentile. HHO, across all three years, narrowly missed the 75th percentile benchmark.

Getting Care Quickly

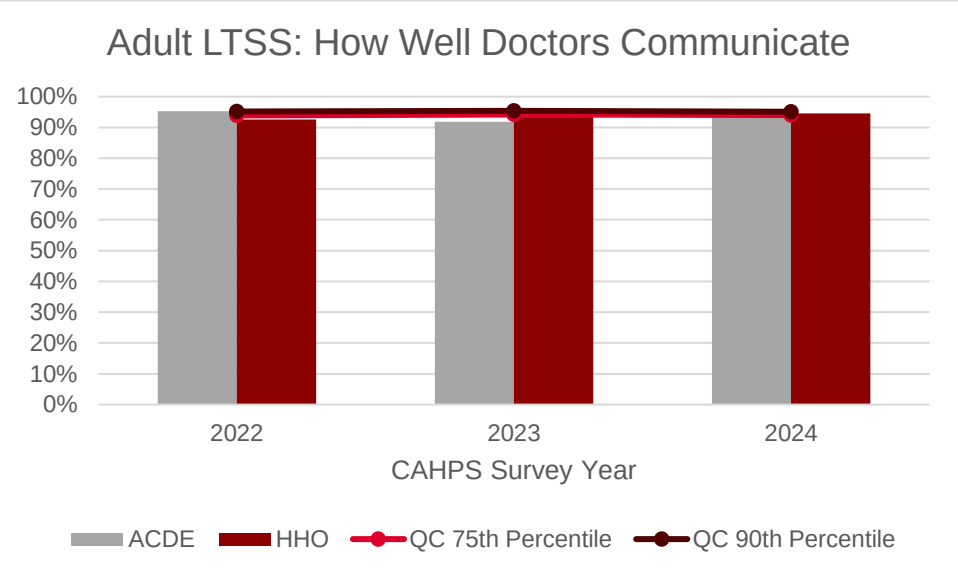
Figure 42:



Similar to the previous measure, ACDE consistently outperformed HHO across all three years. ACDE exceeded the 90th percentile for the “Getting Care Quickly” measure across all three years. HHO also consistently exceeded the 75th percentile across all three years.

How Well Doctors Communicate

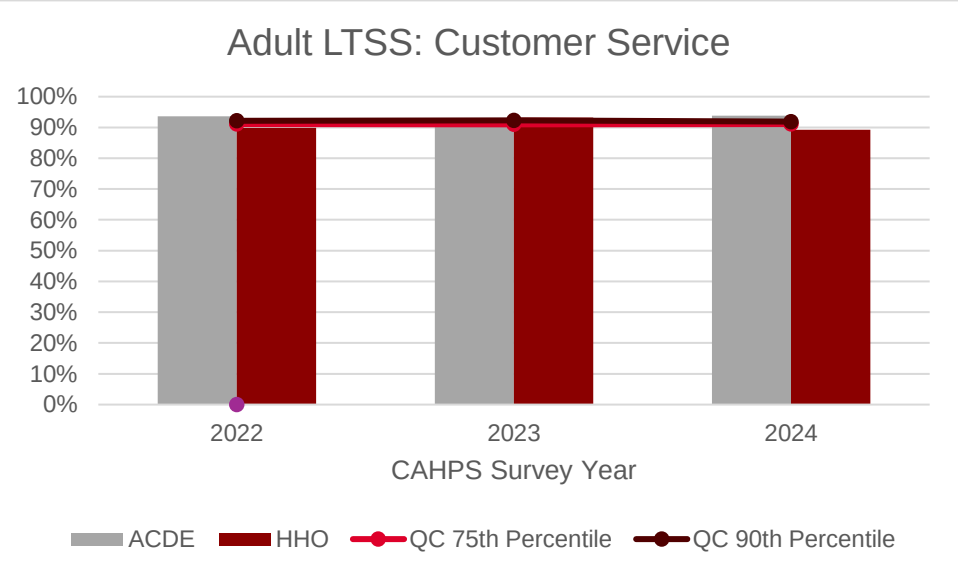
Figure 43:



Overall, across the three MCOs, more than 90% of their LTSS population reported that their doctors usually or always communicated well. Compared to national standards, ACDE ranked above the 90th percentile in 2022, missed the 75th percentile in 2023, and then met the 75th percentile in 2024. HHO, in 2022 missed the 75th percentile by less than two percentage points and improved in 2023 and 2024, exceeding the 75th percentile benchmark.

Health Plan Customer Service

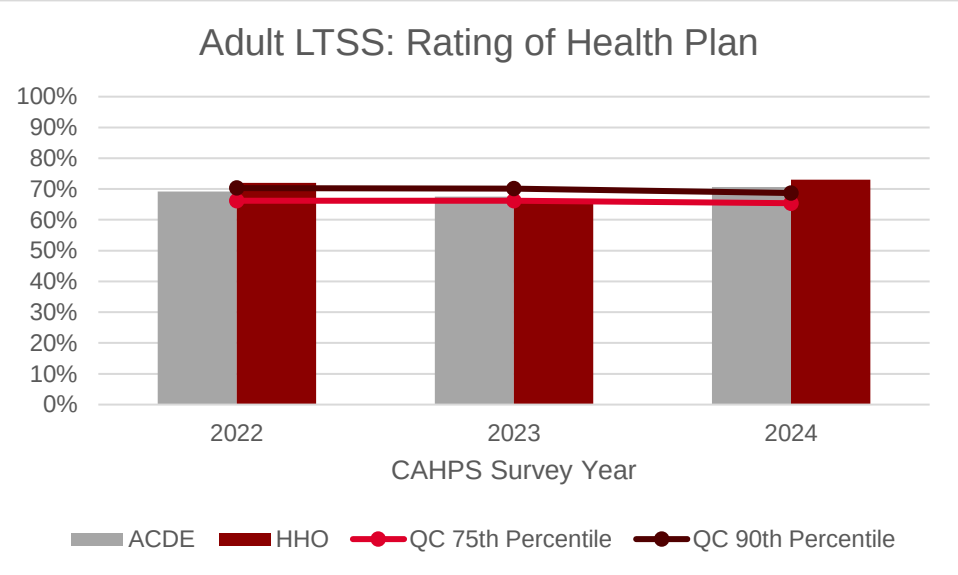
Figure 44:



ACDE exceeded the 90th percentile for all three measurement years among its LTSS population for customer service. HHO missed the 75th percentile in 2022 and 2024, but exceeded the 90th percentile in 2023. However, in the years HHO missed the target benchmark, it was consistently less than two percentage points away.

Rating of Health Plan

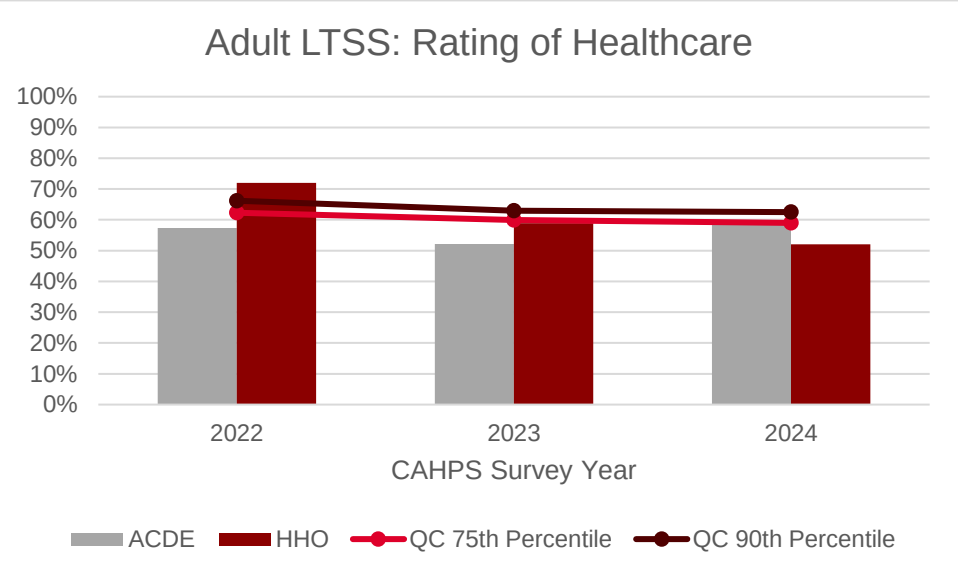
Figure 45:



Both MCOs that reported data on their LTSS population, exceeded the 75th percentile in all three years for the health plan rating measure. In 2024, both MCOs also exceeded the 90th percentile.

Rating of Healthcare

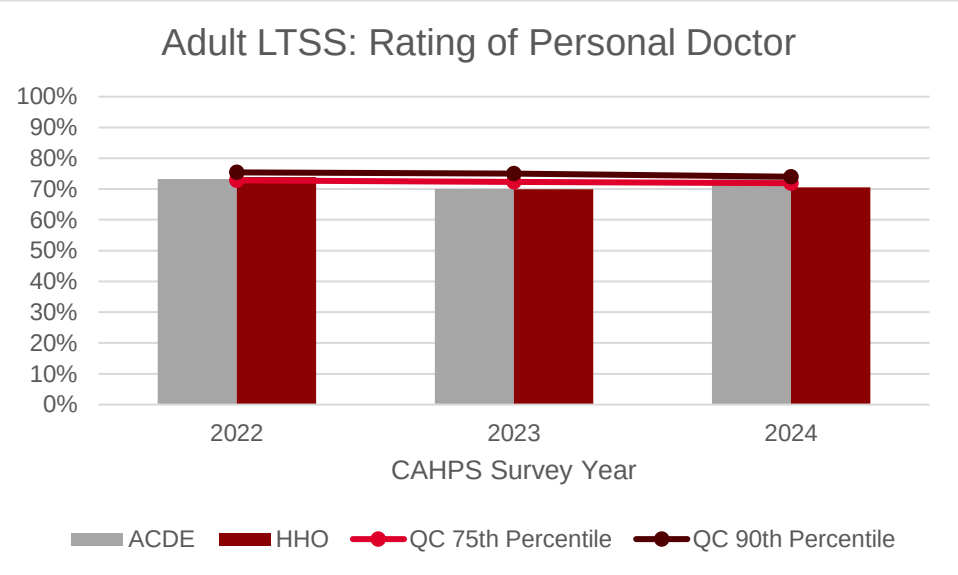
Figure 46:



For the healthcare rating measure, ACDE performed below the 75th percentile in 2022 and 2023, however, they demonstrated improvement in 2024 such that it performed above the 75th percentile. Although exceeding the 90th percentile in 2022, HHO demonstrated a consistent decline in this measure in the subsequent years, highlighting an opportunity for future improvement.

Rating of Personal Doctor

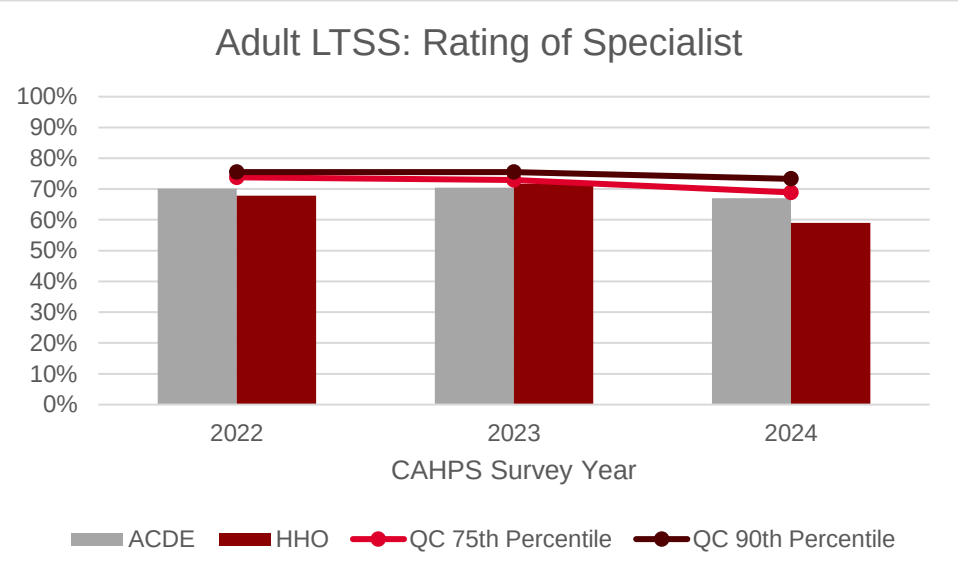
Figure 47:



The rating of personal doctors among ACDE's LTSS population attained the 75th percentile in 2022, dropped below the 75th percentile in 2023, but then exceeded the 90th percentile in 2024. This measure declined across time among HHO's LTSS population. Despite meeting the 75th percentile benchmark in 2022, HHO missed the target benchmark in both 2023 and 2024, highlighting an opportunity for improvement.

Rating of Specialist

Figure 48:

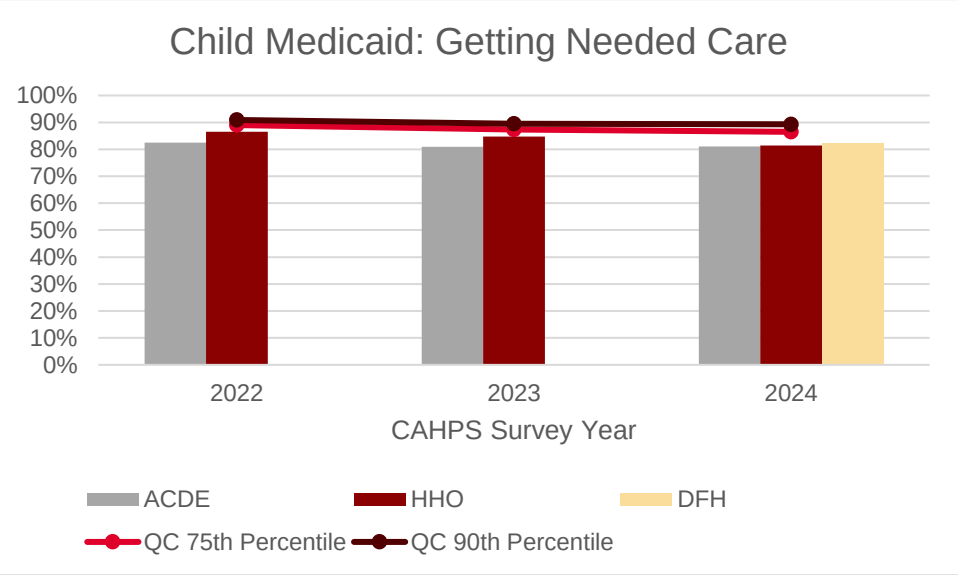


ACDE and HHO both missed the 75th percentile benchmark for all three years. Although modest improvements were observed for both MCOs between 2022 to 2023, both observed declines in 2024. As such, ACDE and HHO should consider efforts to improve its members' experiences with specialist providers.

Child Medicaid CAHPS

Getting Needed Care

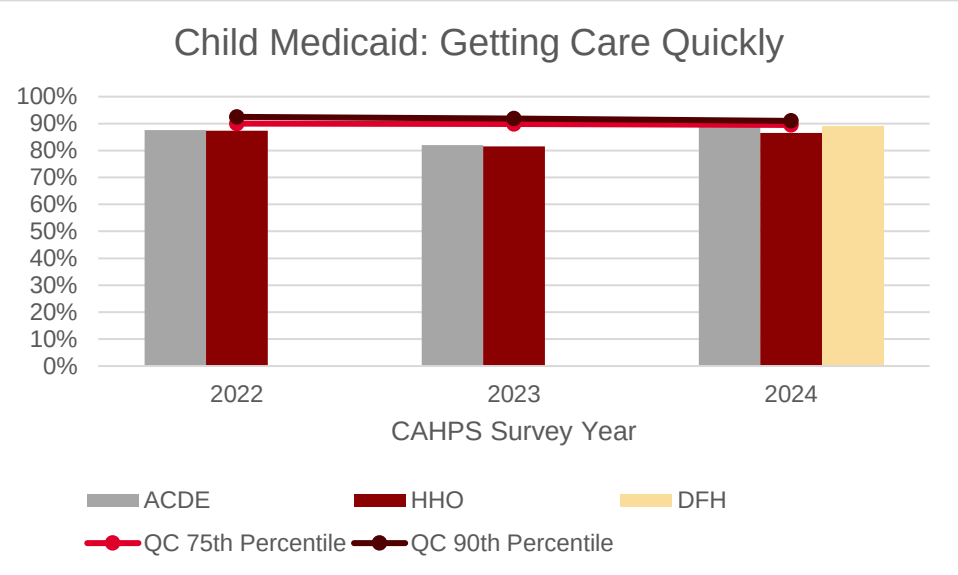
Figure 49:



All three MCOs serving Medicaid children failed to meet the 75th percentile benchmark across all measurement years for the “getting needed care” measure, underscoring an opportunity for improvement.

Getting Care Quickly

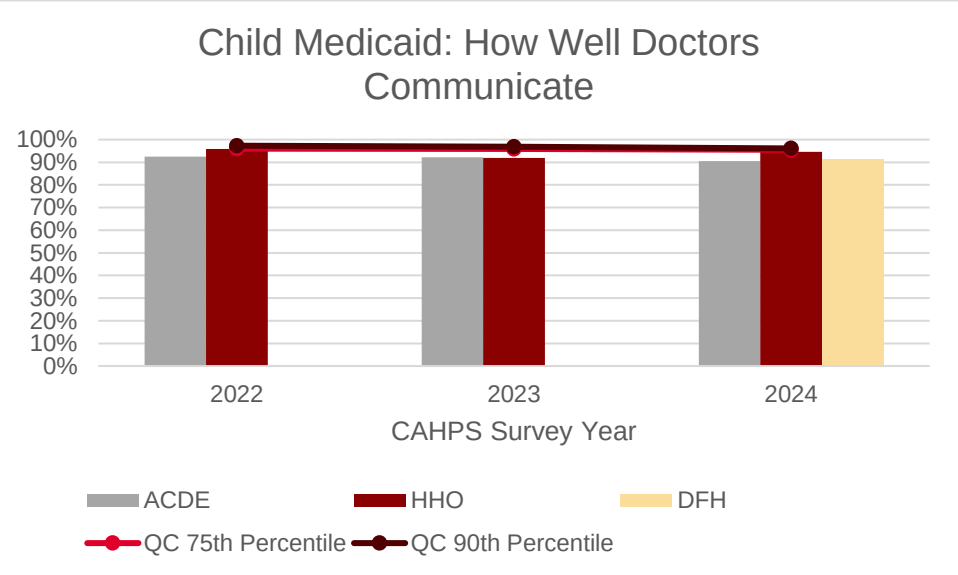
Figure 50:



The percentage of Medicaid children who received care quickly in ACDE performed below the 75th percentile in 2022 and 2023, however improvements in 2024 put ACDE above the national benchmark. HHO on the other hand, performed below the national benchmark for all three years. DFH also performed below the national benchmark in 2024, however they were less than one percentage point away from meeting it.

How Well Doctors Communicate

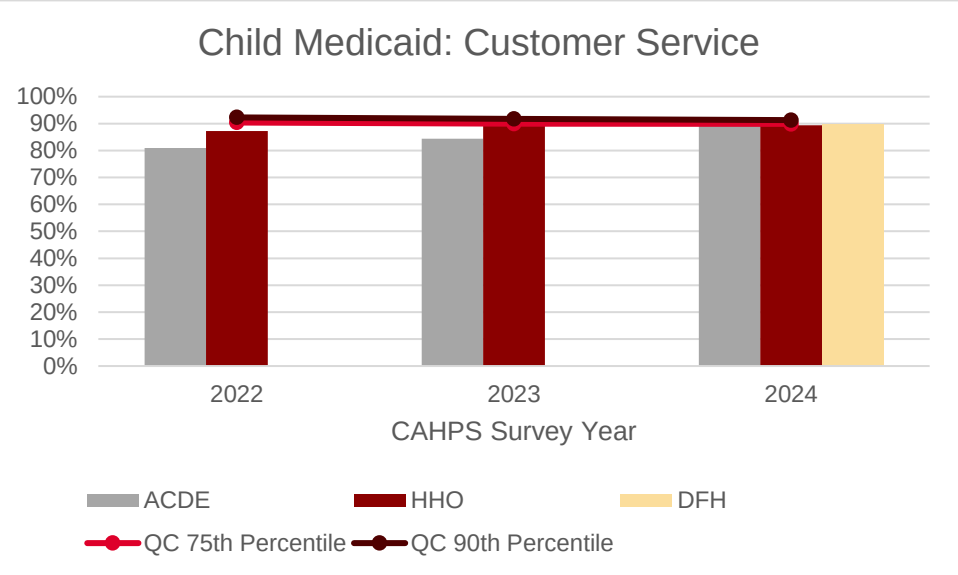
Figure 51:



Overall, across the three MCOs, more than 90% of their Medicaid children population reported that their doctors usually or always communicated well. However, when compared to national benchmarks, all three MCOs failed to meet the 75th percentile benchmark across all measurement years.

Health Plan Customer Service

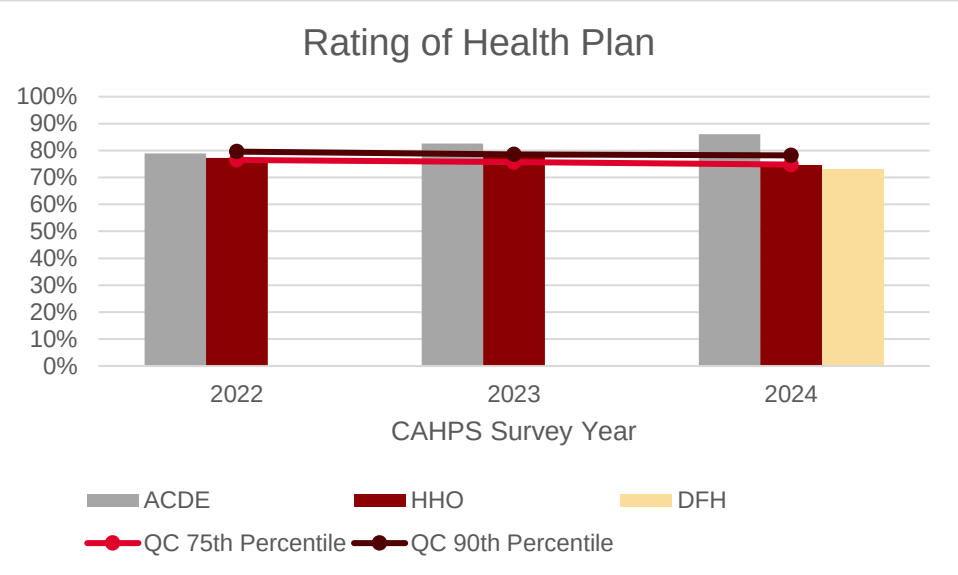
Figure 52:



ACDE ranked below the 75th percentile in 2022 and 2023, but exceeded the 75th percentile in 2024. HHO, on the other hand, performed below the 75th percentile for all three years. DFH in 2024 also ranked below the 75th percentile.

Rating of Health Plan

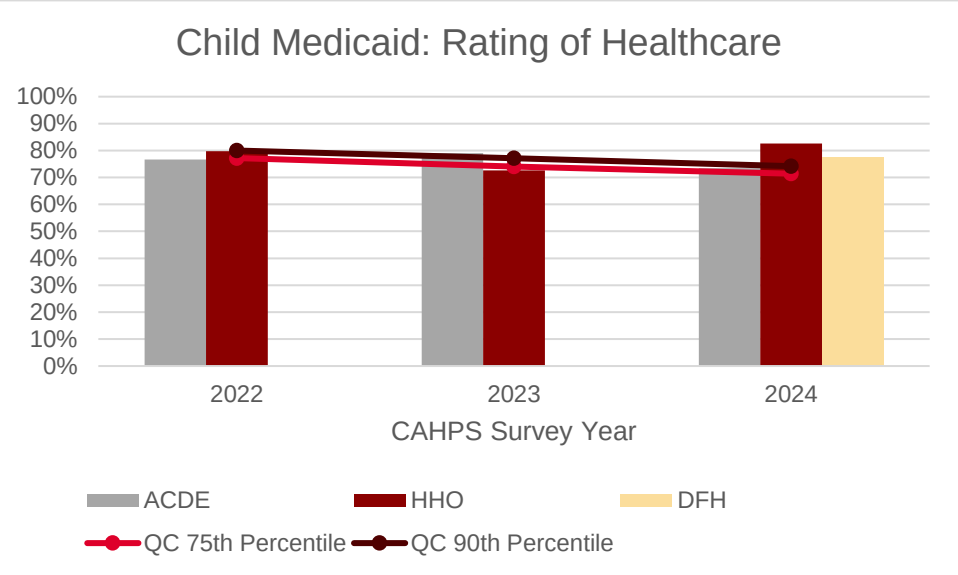
Figure 53:



ACDE exceeded the 90th percentile in the health plan rating measure in 2023 and 2024, marginally missing it in 2022. 85% of HHO Medicaid children members gave the plan a score of 9 or 10, however, that percentage dropped to 76% in 2023, and 69% in 2024, highlighting that there is opportunity for improvement. Consistent findings were observed when HHO was compared to the national benchmarks. In 2021, HHO exceeded the 90th percentile, in 2022, HHO missed the 90th percentile but still performed above the 75th percentile, and in 2023, HHO missed the 75th percentile. In 2024, DFH also missed the 75th percentile in this measure.

Rating of Healthcare

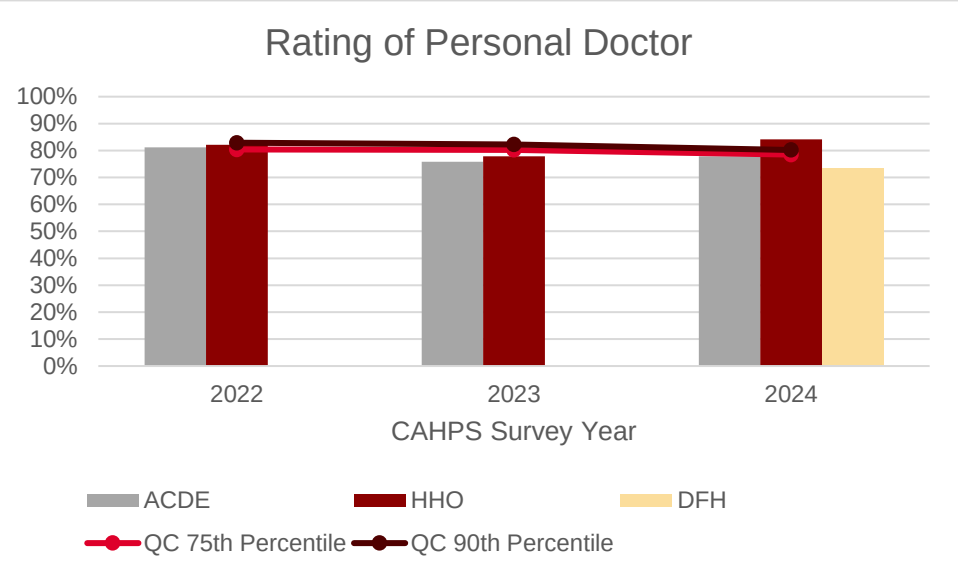
Figure 54:



For the healthcare rating measure, ACDE performed below the 75th percentile in 2022, exceeded the 90th percentile in 2023, but then only met the 75th percentile in 2024. HHO in 2022 exceeded the 75th percentile, in 2023 fell below the 75th percentile, and in 2024 exceeded the 90th percentile. DFH in its first year of reporting (2024) exceeded the 90th percentile.

Rating of Personal Doctor

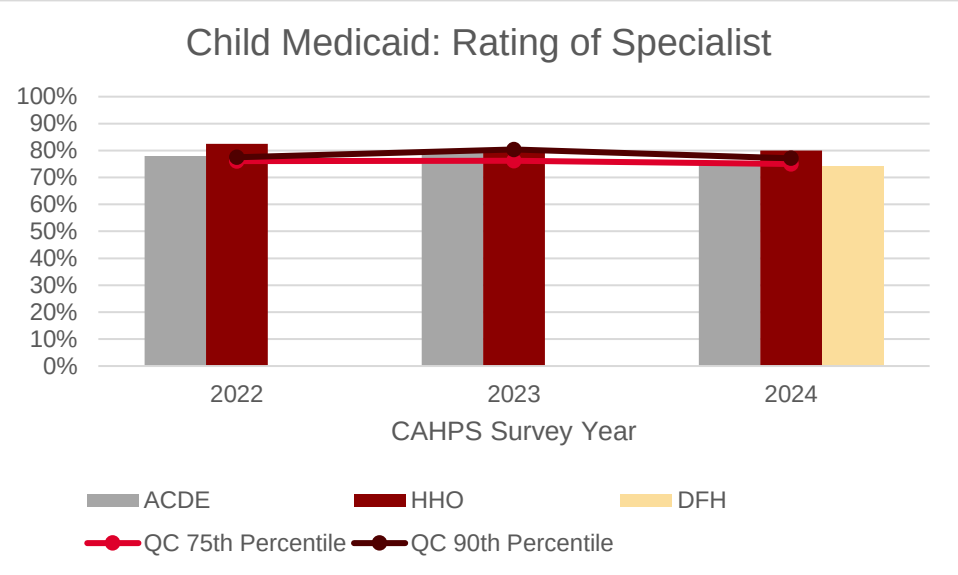
Figure 55:



The rating of personal doctors among ACDE's Medicaid children population attained the 75th percentile in 2022 but dropped below the 75th percentile in 2023 and 2024. HHO exceeded the 75th percentile in 2022, was below the 75th percentile in 2023, and performed over the 90th percentile in 2024. DFH in 2024 failed to meet the 75th percentile benchmark, highlighting that there is opportunity for improvement for DFH in this area.

Rating of Specialist

Figure 56:

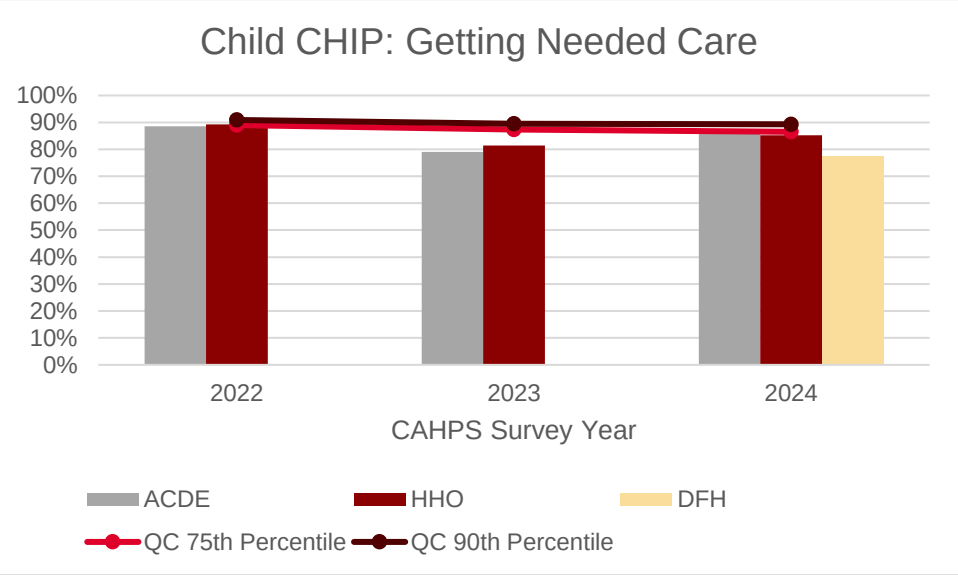


ACDE exceeded the 90th percentile in 2022, but in 2023 it only met the 75th percentile, and in 2024 it missed the 75th percentile, highlighting a consistent decline in performance as compared to national performance. HHO, on the other hand, performed above the 90th percentile for the specialist rating measure across all three years. DFH in 2024 performed below the 75th percentile for this measure but missed it by less than one percentage point.

Child CHIP CAHPS

Getting Needed Care

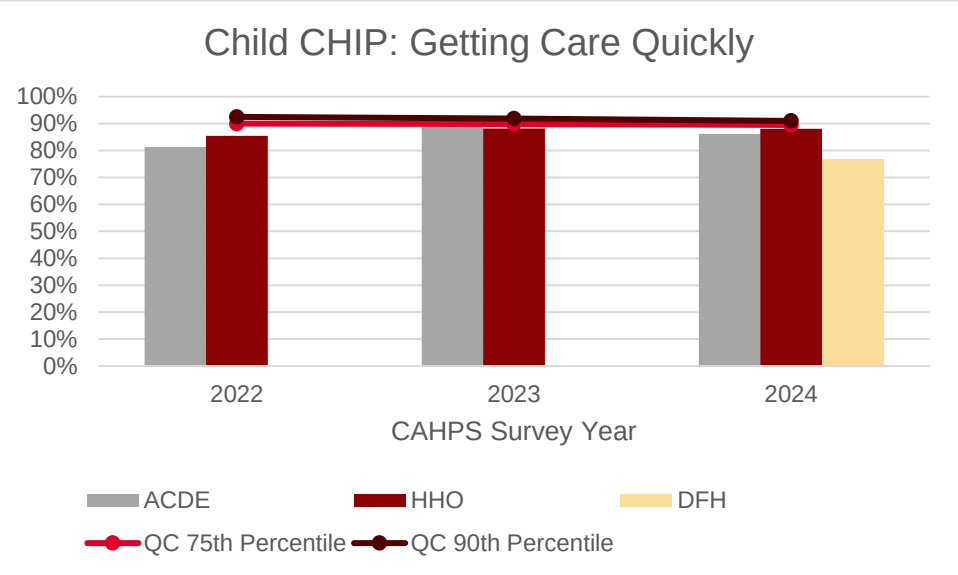
Figure 57:



Across all three years, ACDE missed the 75th percentile for the “getting needed care” measure among its CHIP children population, highlighting an area for improvement. There is similarly an opportunity for improvement for HHO and DFH.

Getting Care Quickly

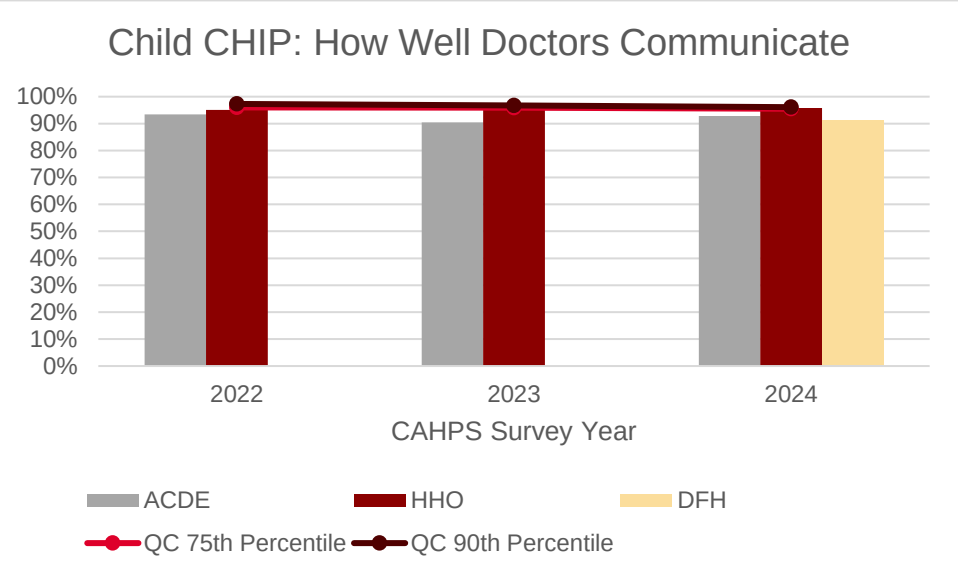
Figure 58:



All three MCOs serving CHIP children failed to meet the 75th percentile benchmark across all measurement years for the “getting needed quickly” measure, highlighting an opportunity for improvement for all three MCOs.

How Well Doctors Communicate

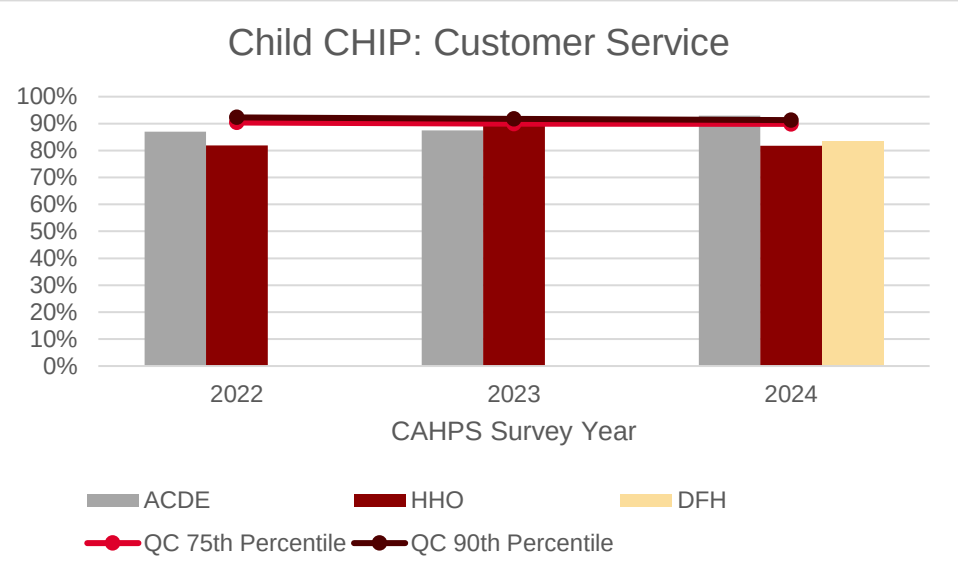
Figure 59:



In 2022 and 2023, ACDE and HHO did not achieve the 75th percentile benchmark for “how well doctors communicate” measure. In 2024, ACDE remained below the 75th percentile, whereas HHO showed progress and surpassed the 75th percentile benchmark. Additionally, DFH's performance in 2024 was below the benchmark.

Health Plan Customer Service

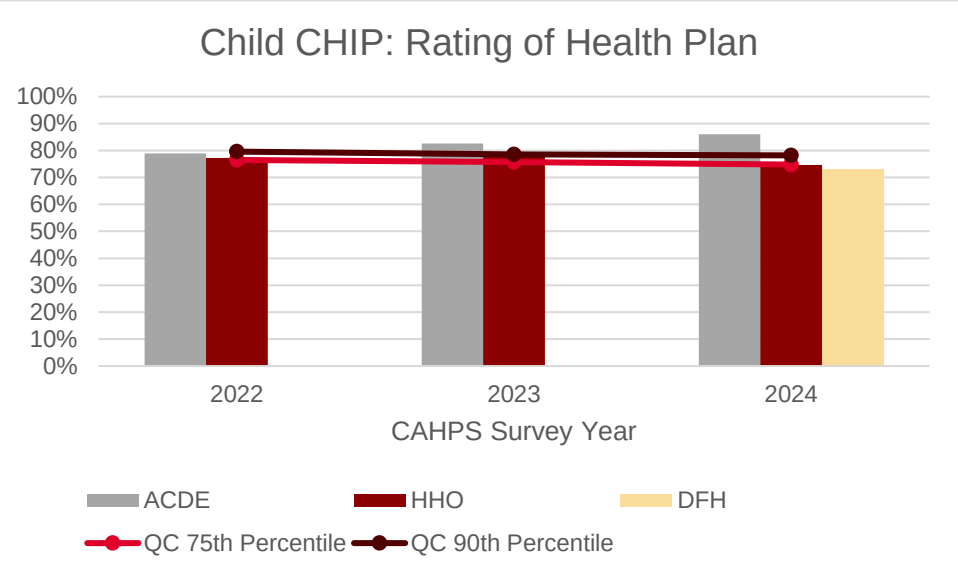
Figure 60:



ACDE fell short of the 75th percentile benchmark for customer service in both 2022 and 2023; however, in 2024, it surpassed the 90th percentile. HHO's performance regarding its CHIP population was inconsistent, missing the 75th percentile in 2022, exceeding the 90th percentile in 2023, but again failing to meet the 75th percentile in 2024. Similarly, DFH did not reach the 75th percentile in 2024. These results underscore the necessity for HHO and DFH to enhance their customer service for the CHIP population.

Rating of Health Plan

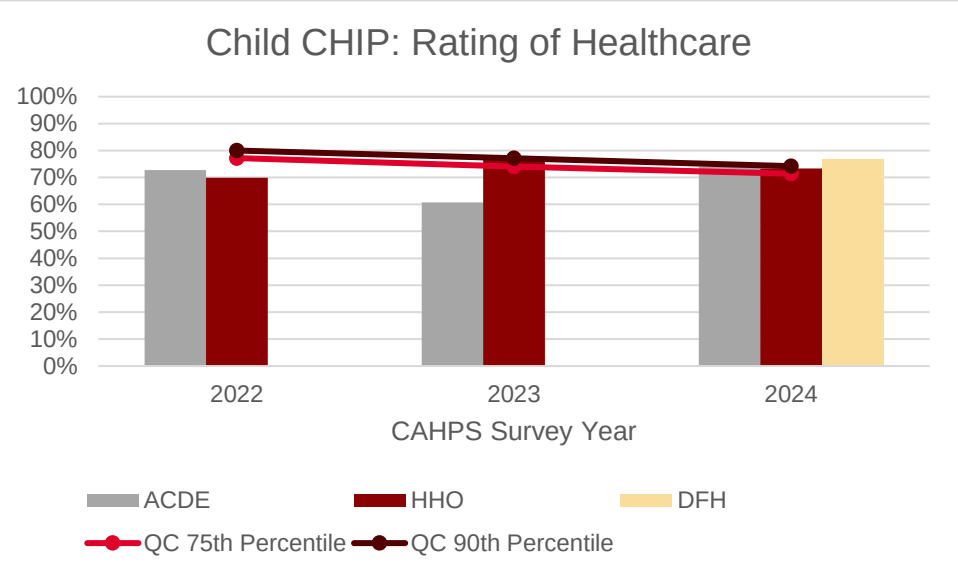
Figure 61:



ACDE surpassed the 75th percentile in the health plan rating measure across all three years and notably also exceeded the 90th percentile in 2022 and 2023. HHO exceeded the 75th percentile in 2022 and the 90th percentile in 2023; however, it did not meet the 75th percentile threshold in 2024. DFH, in its initial reporting year, similarly fell below this threshold. Both HHO and DFH should consider this a chance to enhance their health plan ratings within the CHIP children population.

Rating of Healthcare

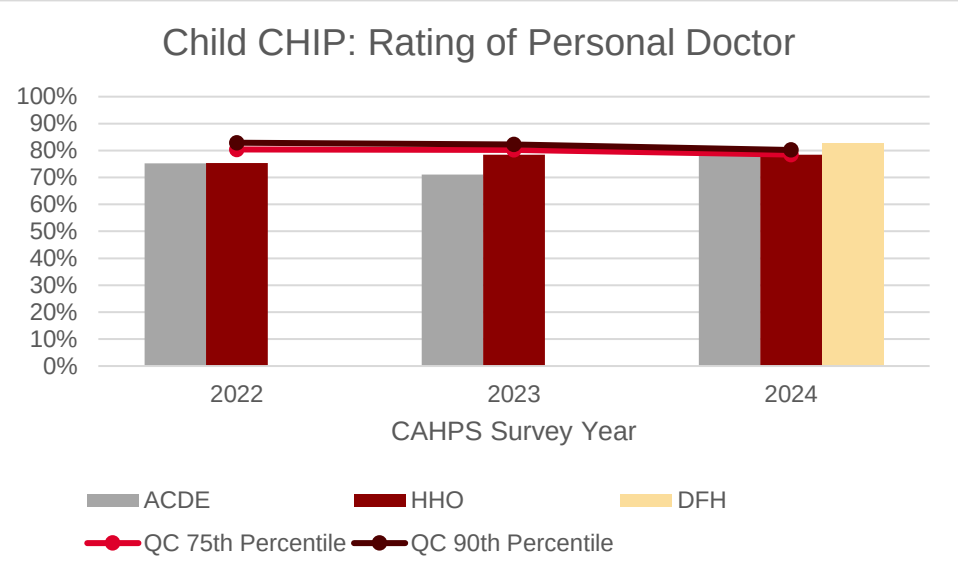
Figure 62:



For the healthcare rating measure, ACDE performed below the 75th percentile in 2022 and 2023 but demonstrated improved performance in 2024 by exceeding the 75th percentile. HHO in 2022 also fell below the 75th percentile. In 2023, HHO exceeded the 90th percentile but missed 90th percentile in 2024 by less than one percentage point. DFH in 2024 exceeded the 90th percentile.

Rating of Personal Doctor

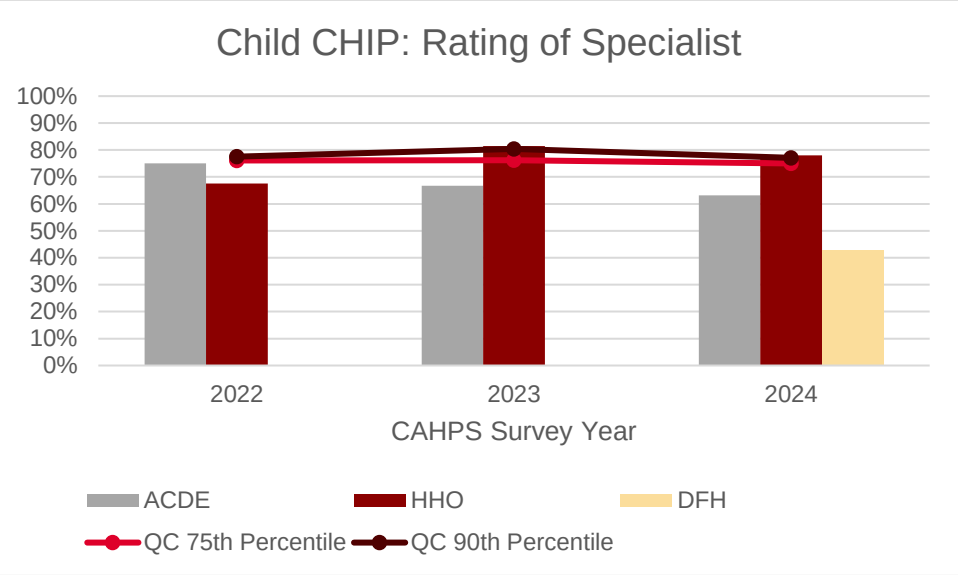
Figure 63:



The rating of personal doctors among ACDE's Medicaid CHIP population was below the 75th percentile in 2022 and 2023, but improvements put ACDE above the 75th percentile in 2024. HHO missed the 75th percentile benchmark for all three years. DFH in 2024 exceeded the 90th percentile in this measure.

Rating of Specialist

Figure 64:



ACDE performed below the 75th percentile benchmark in all three years for the specialist rating measure. It also demonstrated a consistent downward trend in its performance in this measure, highlighting a need for improvement. HHO also missed the 75th percentile in 2022 but exceeded the 90th percentile for both 2023 and 2024. DFH also missed the 75th percentile in 2024, indicating a need for improvement.

National Core Indicators-Aging and Disabilities

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

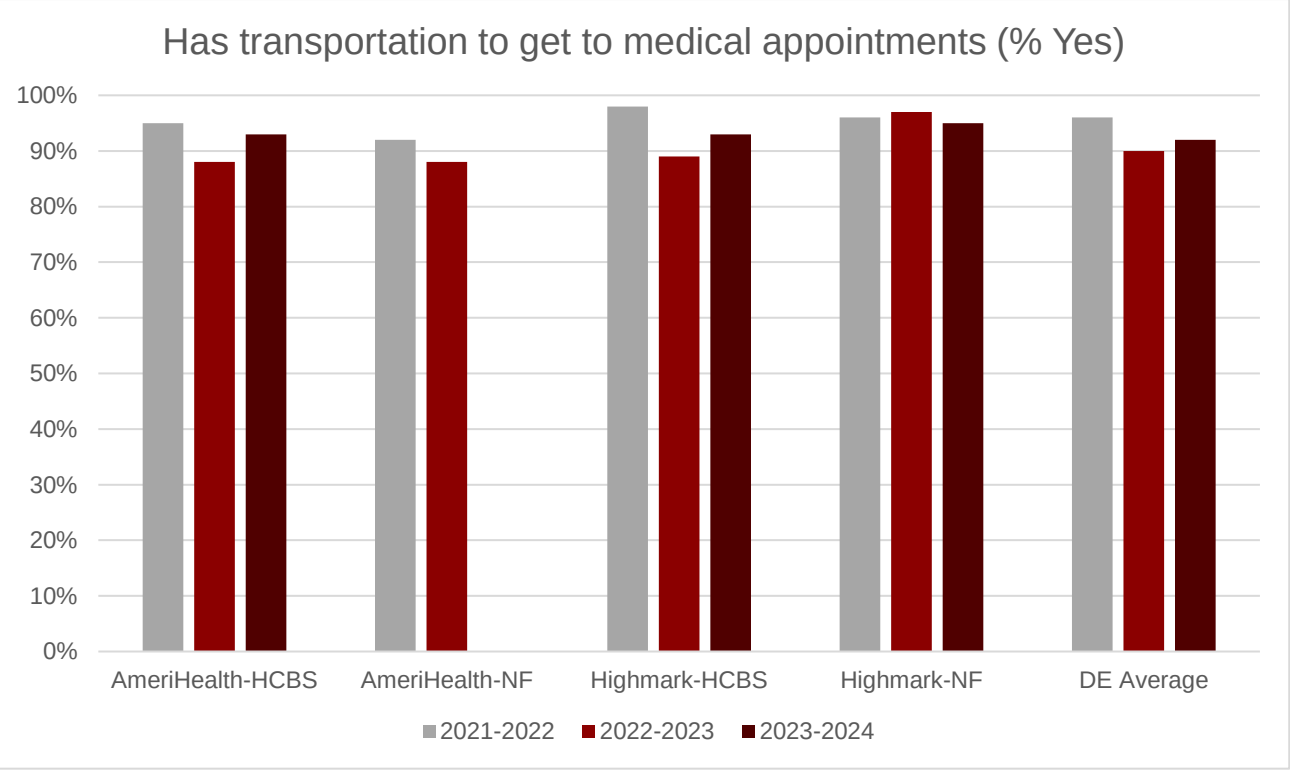
The NCI-AD Adult Consumer Survey measures outcomes across 18 broad domains and key areas of concern. These 18 domains are comprised of approximately 50 core indicators, which are the standard measures used across states to assess experiences and outcomes of services, such as

rights and respect, service coordination, care coordination, health, and safety. DMMA chose to partner with ADvancing States and HSRI to obtain national survey participation and engaged their EQRO (Mercer) to oversee the survey process. The survey process utilized Vital Research, a national social sciences survey group, who conducted the NCI-AD survey face-to-face with members in Delaware. Vital Research then compiled and submitted their survey results to HSRI.

The state of Delaware has been administering the NCI-AD surveys since 2015. Below are the survey results for 2021–2022, 2022–2023, and 2023–2024. This QSE focused on the HCBS and Nursing Facility (NF) populations in ACDE and HHO and compares the results to the State average and the broader US average (also referred to as the NCI-AD Weighted Average). The current QS does not specifically indicate specific goals related to NCI-AD measures. As such, the results presented below represent a small sample of all the questions beneficiaries are asked through the NCI-AD survey.

Transportation to Medical Appointments

Figure 65:

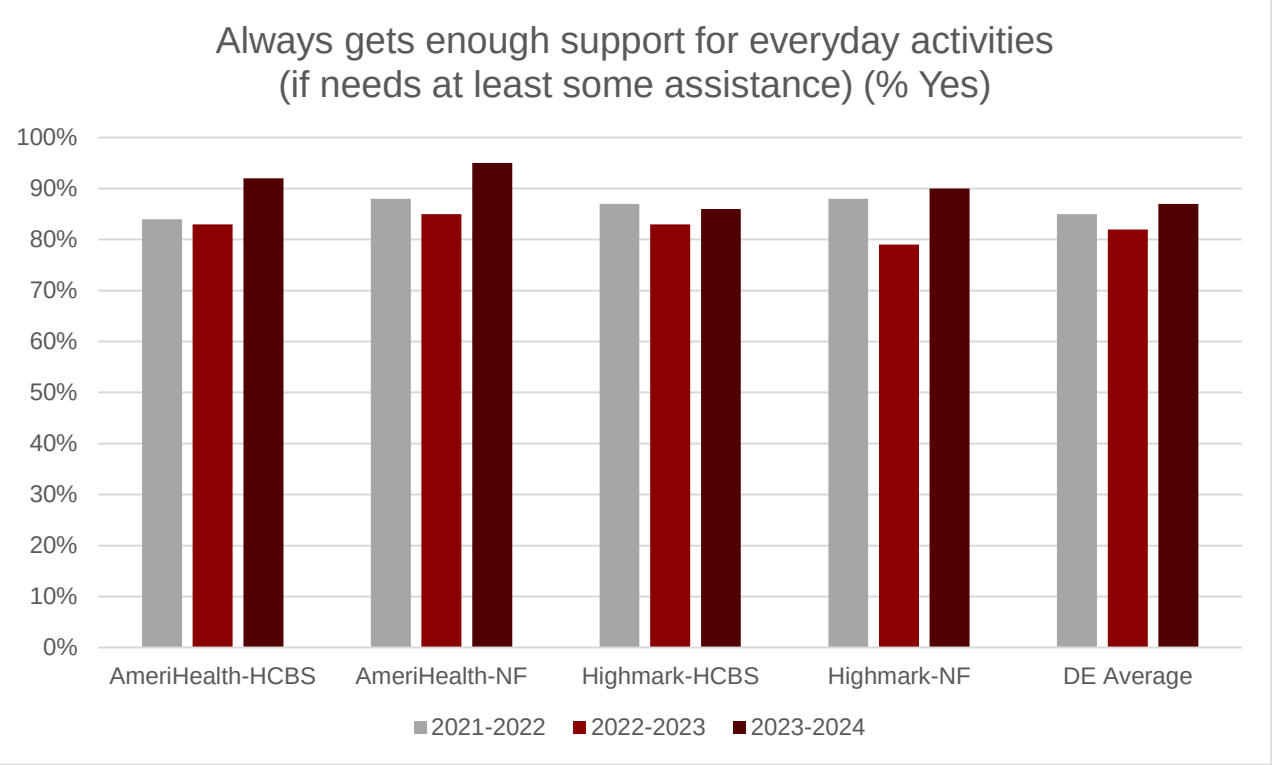


Over the three survey years, Delaware consistently outperformed the NCI-AD average. However, during the 2022–2023 survey period, all groups except for the HHO-NF group experienced a decrease in the percentage of members reporting they had transportation to their medical appointments.

Additionally, all groups with available data for 2023–2024 showed a decline compared to their 2021–2022 performance, with the exception for the ACDE-NF group in which data was not available for 2023–2024. Considering that access to medical appointments is a critical factor influencing health outcomes, Delaware may want to consider setting a quality standard in future evaluations requiring each MCO to perform at or above their 2021–2022 levels, despite currently exceeding the NCI-AD average in 2023–2024.

Support for Everyday Activities

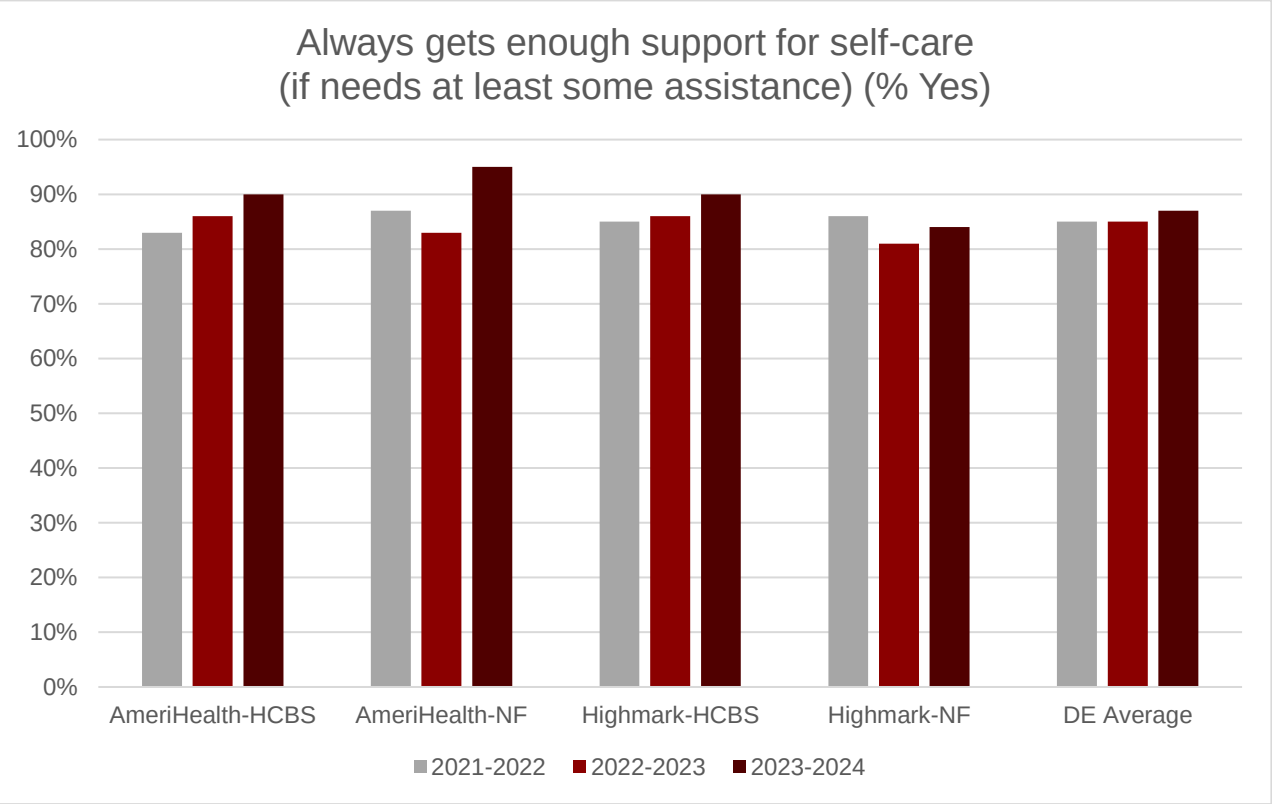
Figure 66:



From the 2021–2022 to 2023–2024 survey years, all four groups observed increases in the percentage of members reporting that they always get enough support for their everyday activities. Furthermore, Delaware on average also performed better than the US average across all three survey years.

Support for Self-Care

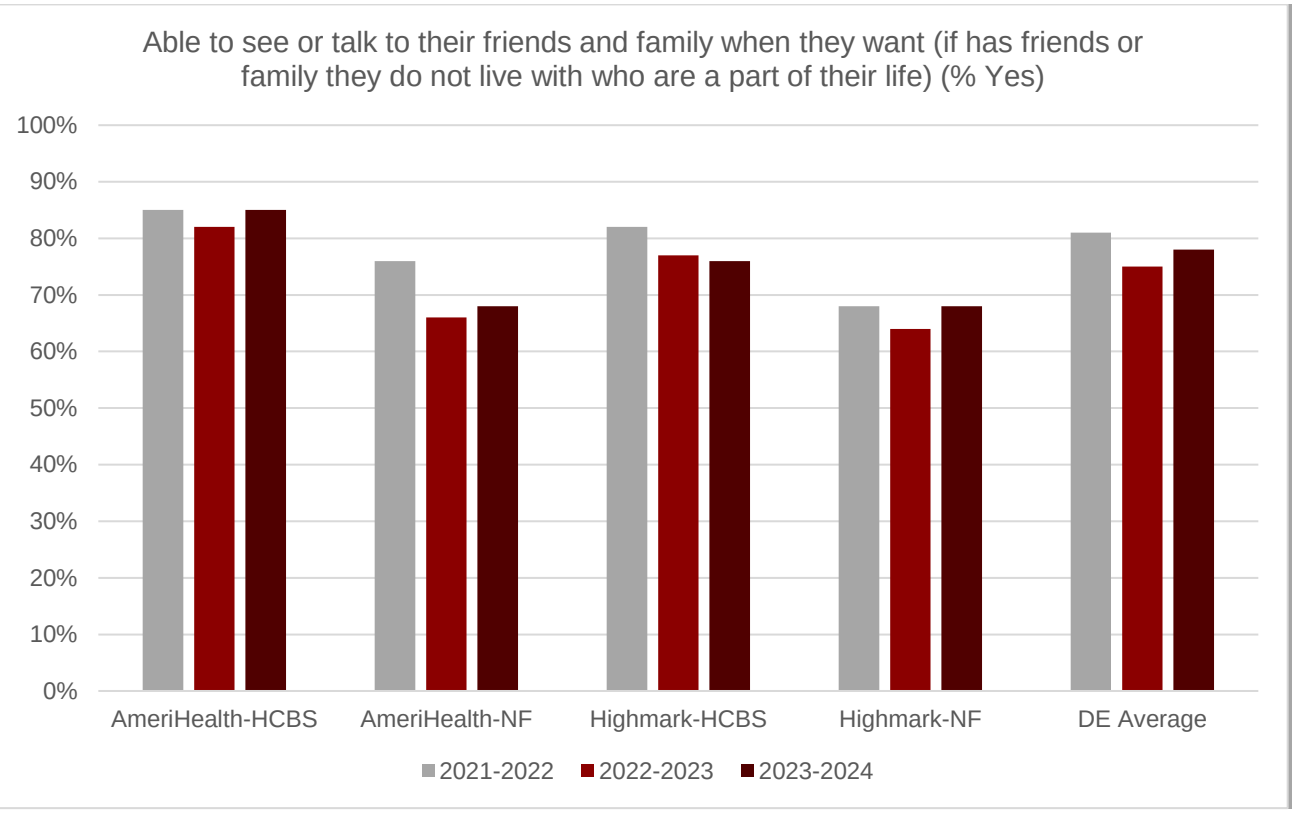
Figure 67:



The percentage of members who report always receiving sufficient support for self-care, when they need at least some assistance, increased for all groups from the 2021–2022 to the 2023–2024 survey period, except for the Highmark-NF group. Additionally, all groups performed better than the national average in every year surveyed, except Highmark-NF, which performed similarly to the national average in both the 2022–2023 and 2023–2024 survey years.

Ability to See or Talk to Friends and Family

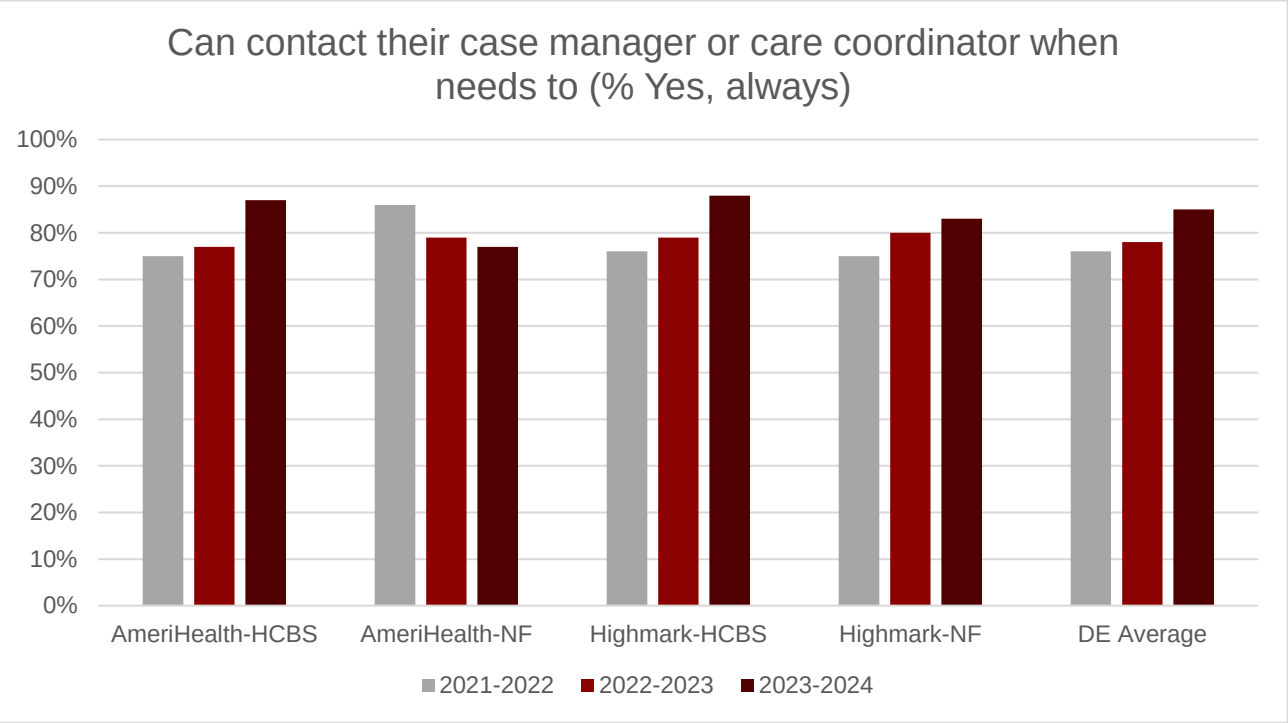
Figure 68:



Three of the four groups (ACDE-NF, HHO-HCBS, and HHO-NF) scored below the national benchmark in all three survey years on the measure of being able to see or talk to their friends and family whenever they want. In contrast, the ACDE-HCBS group consistently met or exceeded the national benchmark. These results highlight a key opportunity for MCOs to enhance their members' quality of life by better supporting their social connections.

Contacting Case Manager or Care Coordinator

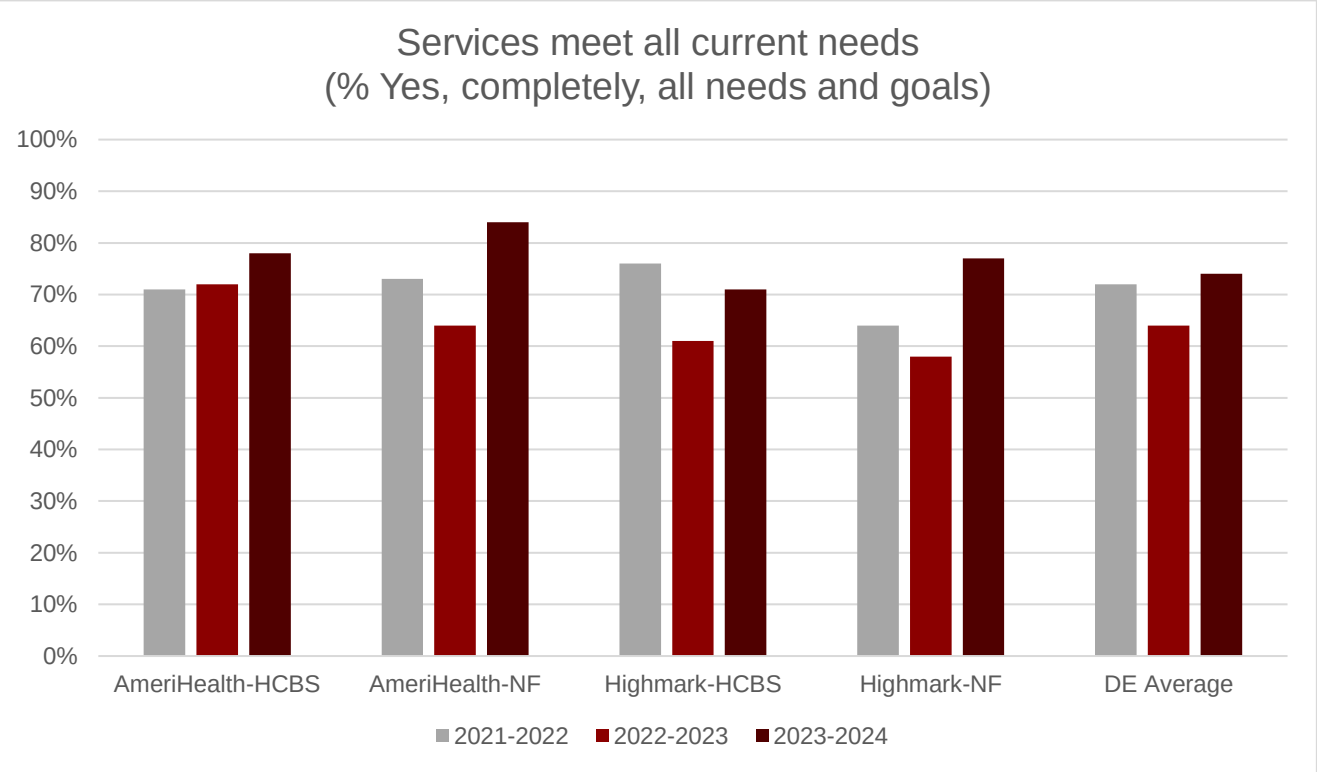
Figure 69:



The percentage of members reporting that they can contact their case manager or care coordinator decreased across the three survey years for the ACDE-NF group. Furthermore, all groups, except for the ACDE-NF group, exceeded the national benchmark by the 2023–2024 survey year. This highlights potential opportunity for ACDE to improve the accessibility of its case managers and care coordinators to its NF population.

Meeting Current Needs

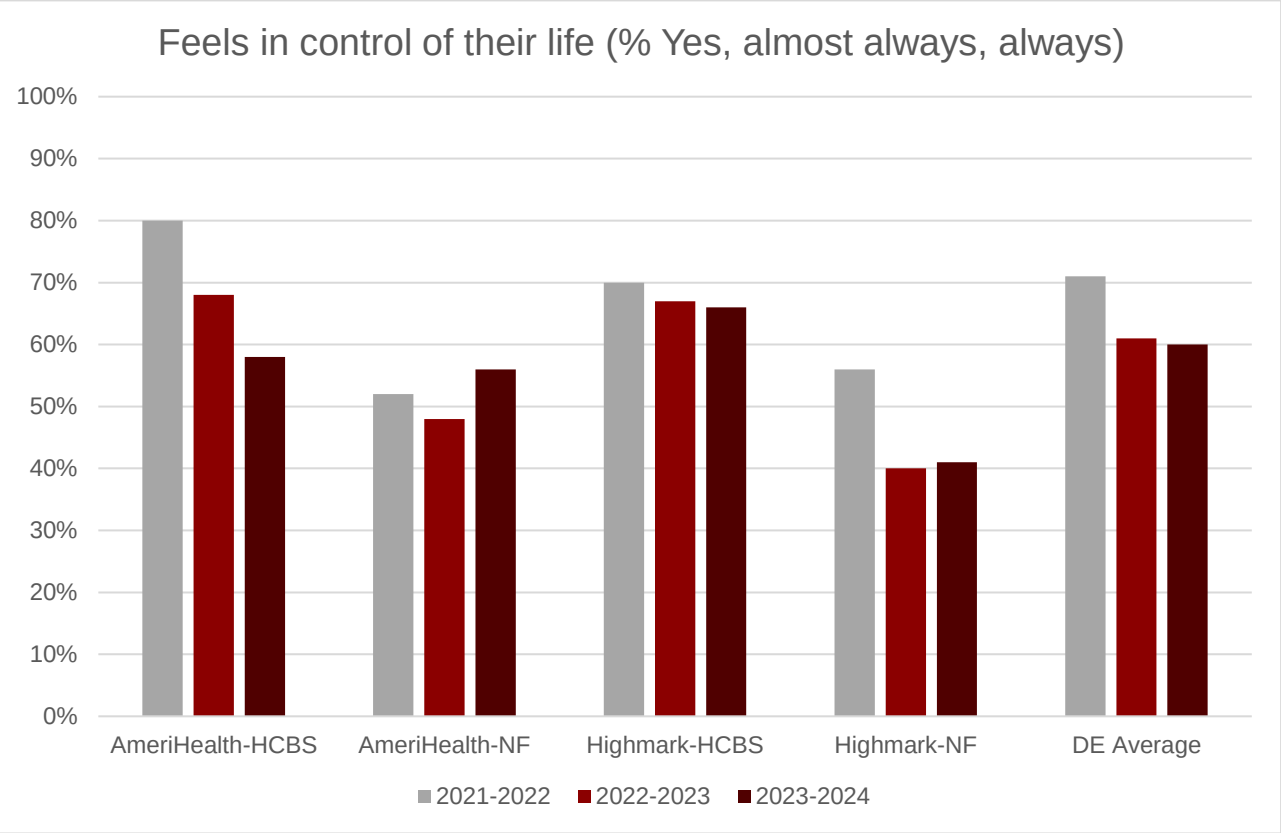
Figure 70:



By the 2023–2024 survey year, all four groups performed at or above the national benchmark for the plan's ability to meet all its members' current needs.

Feeling in Control of Their Life

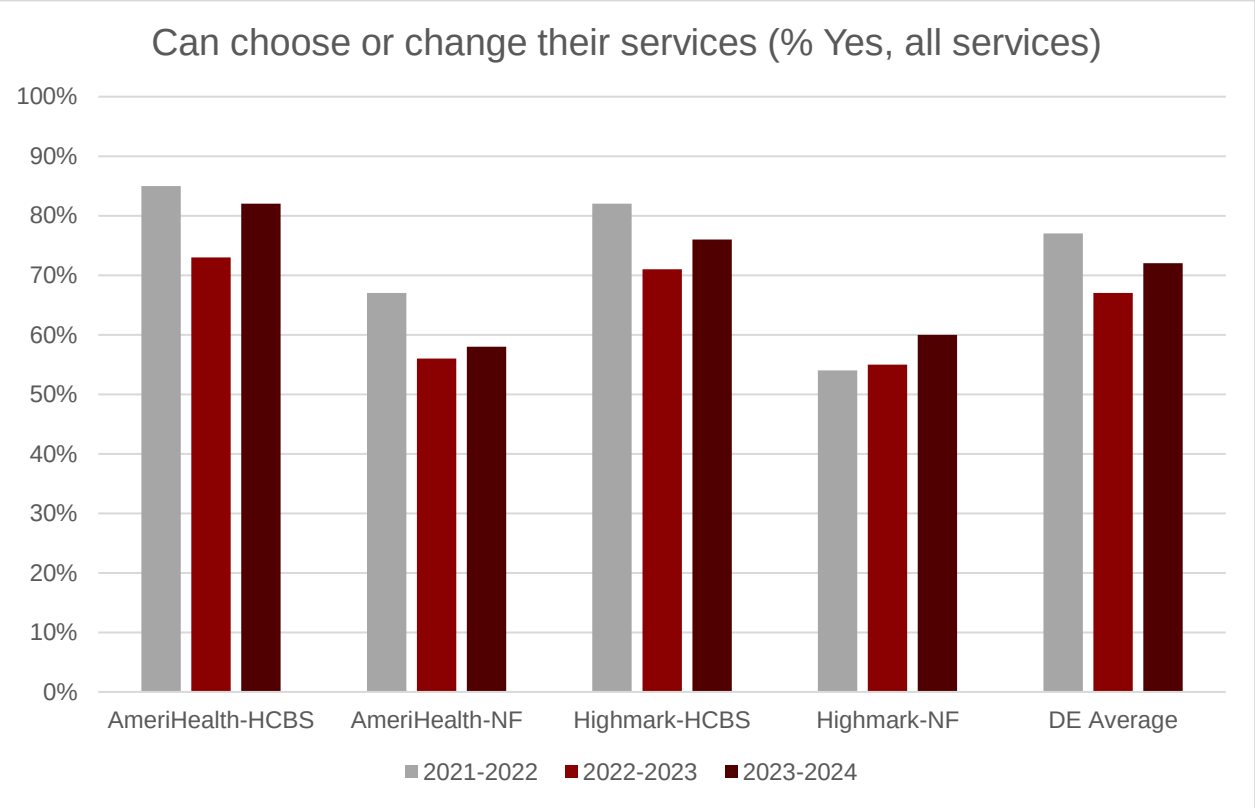
Figure 71:



The ACDE-NF and HHO-NF groups consistently met or exceeded the national benchmark for members' sense of control over their lives across all three survey years. The ACDE-HCBS group only reached the national benchmark in the 2021–2022 survey year. However, subsequent survey results show a steady decline over time. Since members' feelings of autonomy and self-direction are crucial to quality of care and overall care experience, both ACDE and HHO should view this trend as an opportunity to improve their members' experiences.

Choosing or Changing Services

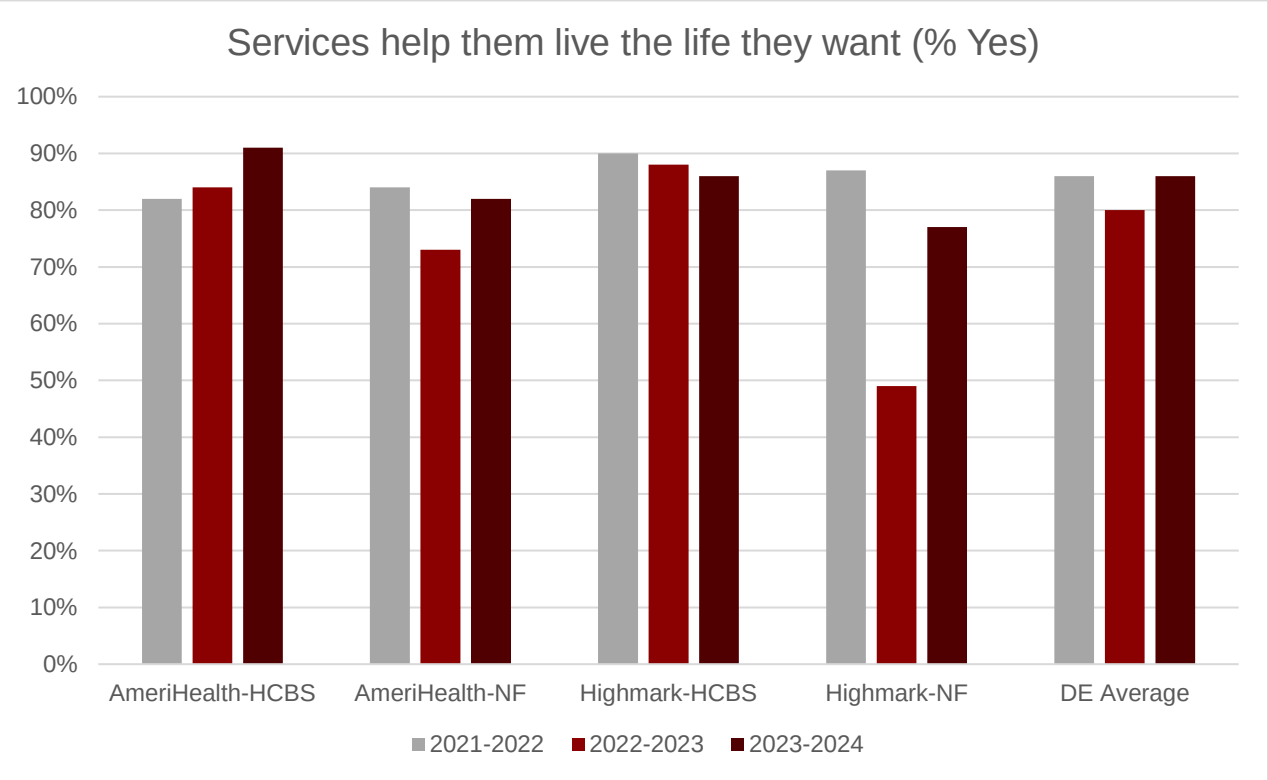
Figure 72:



Members of the ACDE-HCBS group consistently reported their ability to choose or change services above the national benchmark in all years, despite a decline in the 2022–2023 survey. The HHO-HCBS group also exceeded the national benchmark in 2021–2022 and 2023–2024 but fell short by one percentage point in 2022–2023. Both NF groups from ACDE and HHO consistently fell below the national benchmark, indicating an area needing improvement.

Living the Life They Want

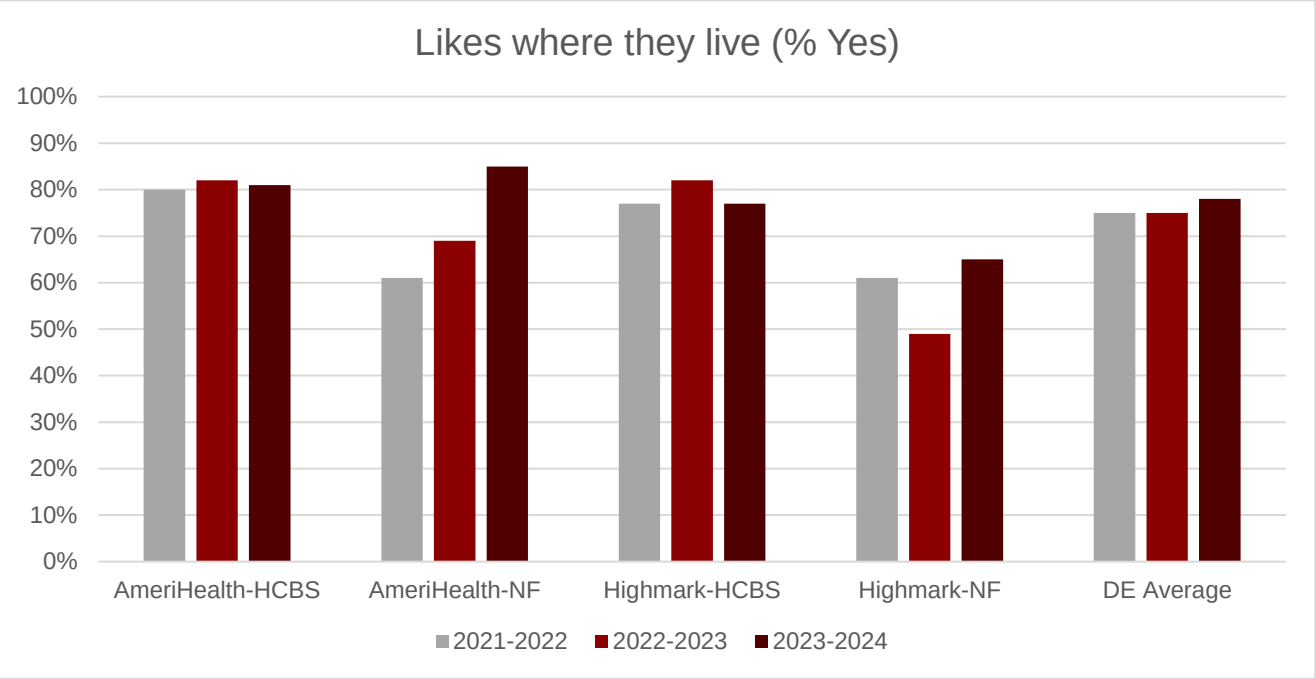
Figure 73:



In general, there are opportunities for ACDE and HHO to improve their members' perception that they can live the life that they want. For the ACDE-HCBS group, only in the 2023–2024 survey year did they perform above the national benchmark. Although the HHO-HCBS met the national benchmark during the first two survey years assessed, a consistent decline across the three years caused it to fall below the national benchmark in the 2023–2024 survey year. Finally, both NF groups consistently performed below the national benchmark across all three years.

Liking Where They Live

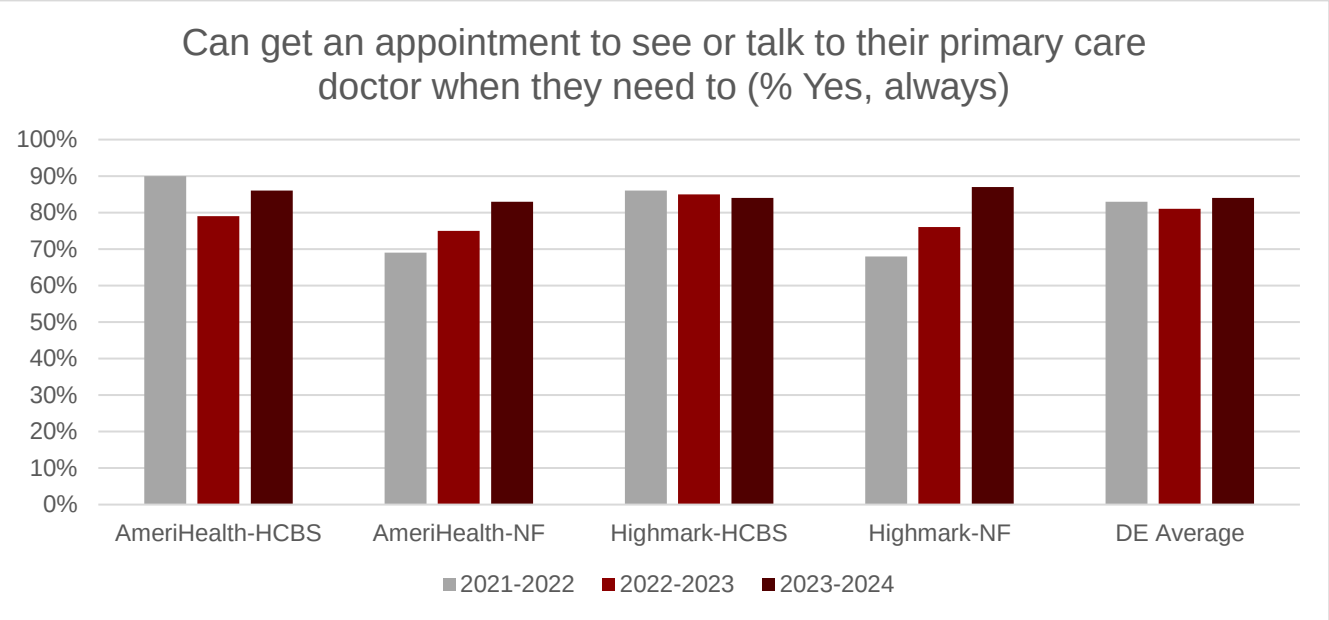
Figure 74:



By the 2023–2024 survey year, the NF and HCBS groups within ACDE surpassed the national benchmark for the measure "likes where they live." In contrast, HHO's NF and HCBS groups consistently fell below the national benchmark.

Appointments to Primary Care Doctor

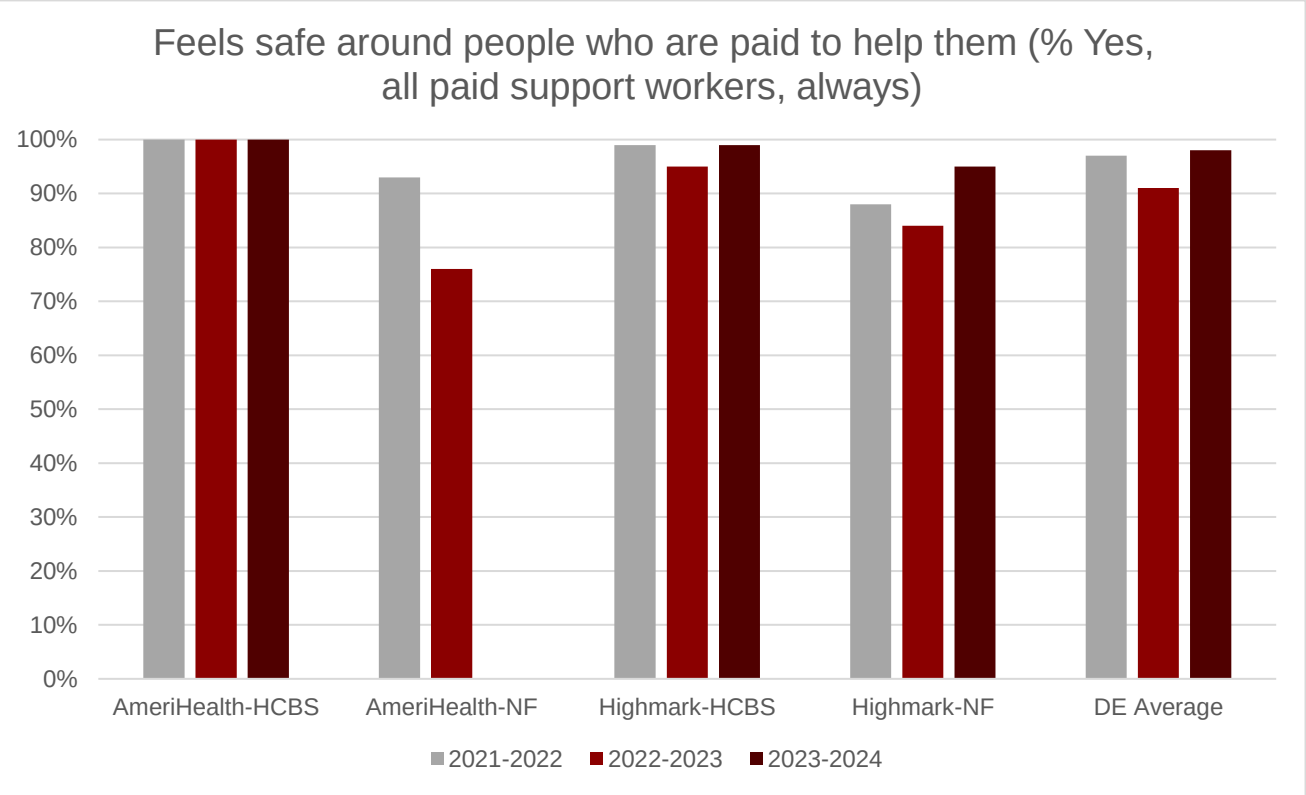
Figure 75:



Each of the four groups met or exceeded the national benchmark in the most recent survey year based on members' reports regarding their ability to secure an appointment to see or speak with their primary care physician (PCP) when necessary. Additionally, the ACDE and HHO NF groups both demonstrated consistent improvement over the observed period.

Feeling Safe Around Paid Support Workers

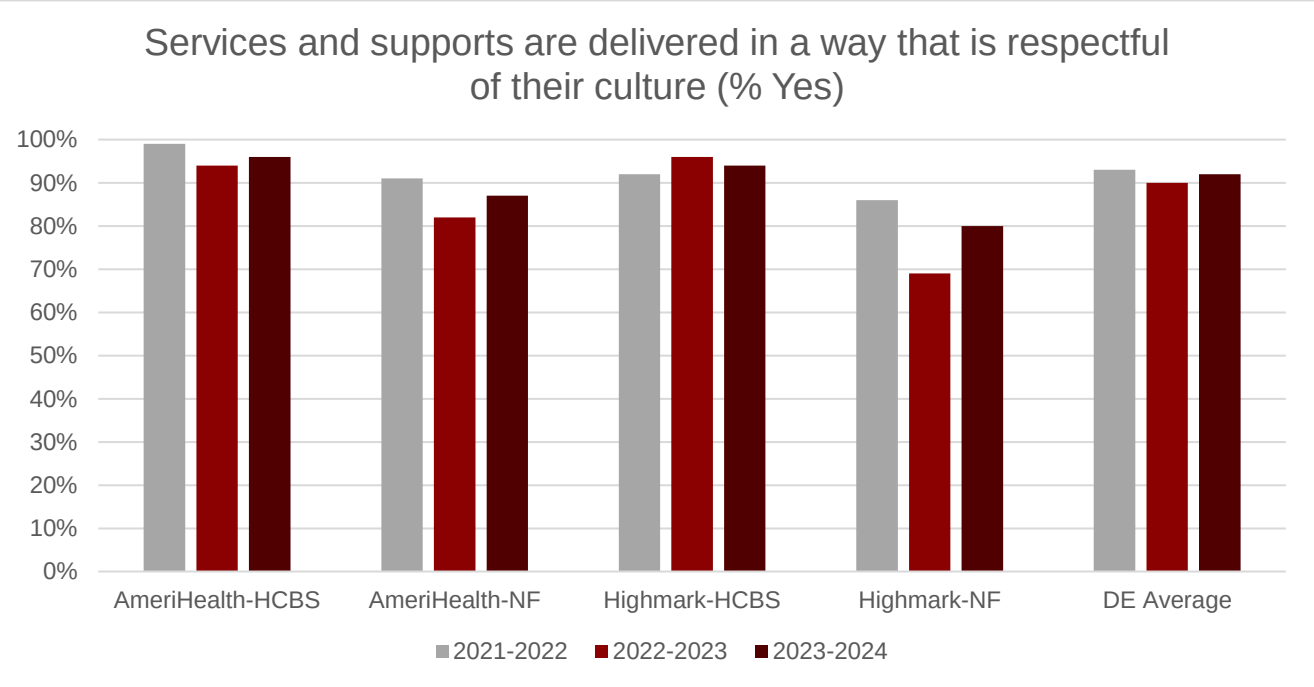
Figure 76:



One hundred percent of members in the ACDE-HCBS group reported that they felt safe around the people who are paid to help them across all three survey years, exceeding the national benchmarks. The ACDE-NF group, on the other hand, missed the national benchmark in the two years for which data was reported (2021–2022 and 2022–2023), signaling a need for improvement. The HHO-HCBS outperformed the national benchmark in the first and third survey years assessed but missed during the second survey year. The HHO-NF group performed below the national benchmark in all three years.

Services Being Respectful of Member's Culture

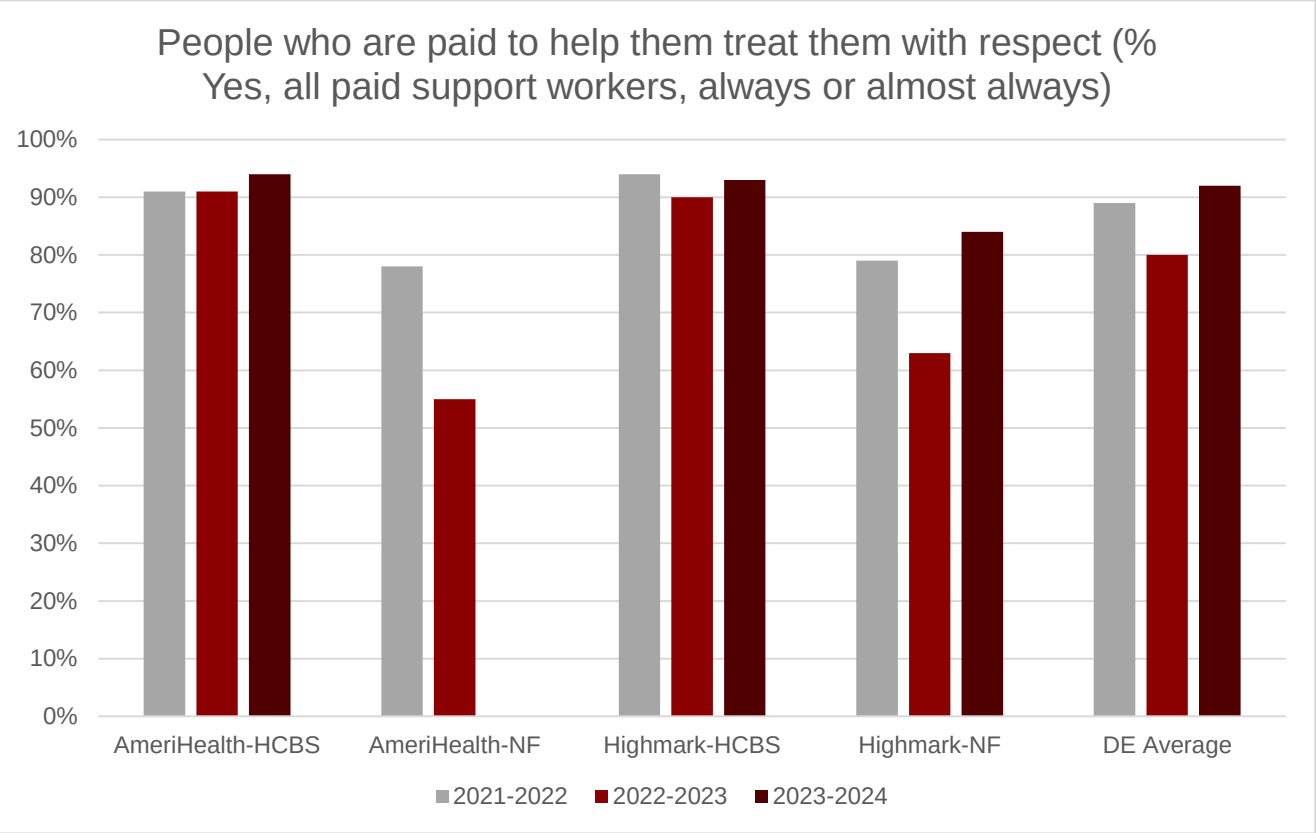
Figure 77:



In general, the NCI-AD survey findings suggest there are opportunities for improvement to ensure that services delivered to their members are done so in a way that is respectful of their culture. ACDE-HCBS performed above the national benchmarks in two of the three survey years. HHO-HCBS only exceeded the national benchmark in one year. Finally, ACDE-NF and HHO-NF both performed below the national benchmark for all three years.

Respectfulness Paid Support Workers

Figure 78:



By the final year of the survey evaluated, both the ACDE-HCBS and HHO-HCBS groups achieved performance levels that met or exceeded the national benchmark. In contrast, the two NF groups consistently fell below the national benchmark throughout all years with available data, highlighting a clear potential for improvement.

Overall Healthcare Delivery Performance

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

Provider Experience

MCOs conduct annual provider satisfaction surveys and each MCO identifies opportunities for improvement based on survey results. This QSE reviewed data from the 2021 to 2023 time period. Survey results are made available to providers via newsletters.

MCOs varied significantly in the specific questions asked in their provider surveys. For instance, while both ACDE and HHO inquire about providers' experiences with pharmacy services, ACDE's questions focus prior authorizations and the ease of access pharmacy information, such as formulary updates. HHO's questions related to pharmacy services primary address the drug formulary itself. This highlights an opportunity to develop standardized survey questions across MCOs, enabling future performance comparisons among ACDE, HHO, and DFH.

After analyzing the questions posed by the two MCOs with data available from 2021 to 2023, this QSE focused on five common measures: (1) overall satisfaction with the plan, (2) timeliness of claims processing, (3) accuracy of claims processing, (4) resolution of claims payment issues or disputes, and (5) the extent to which the plan promotes and encourages preventive care and wellness programs. Between 2021 and 2023, ACDE consistently outperformed HHO on four of these five measures. Provider satisfaction with the plans was generally similar across all three MCOs. Results for the aforementioned measures are presented in the figures below.

Figure 79:

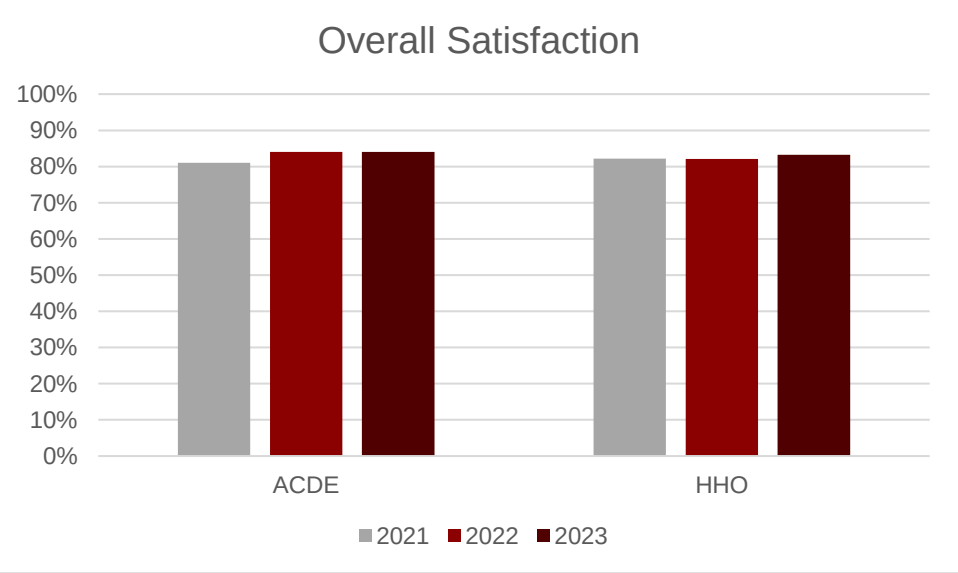


Figure 80:

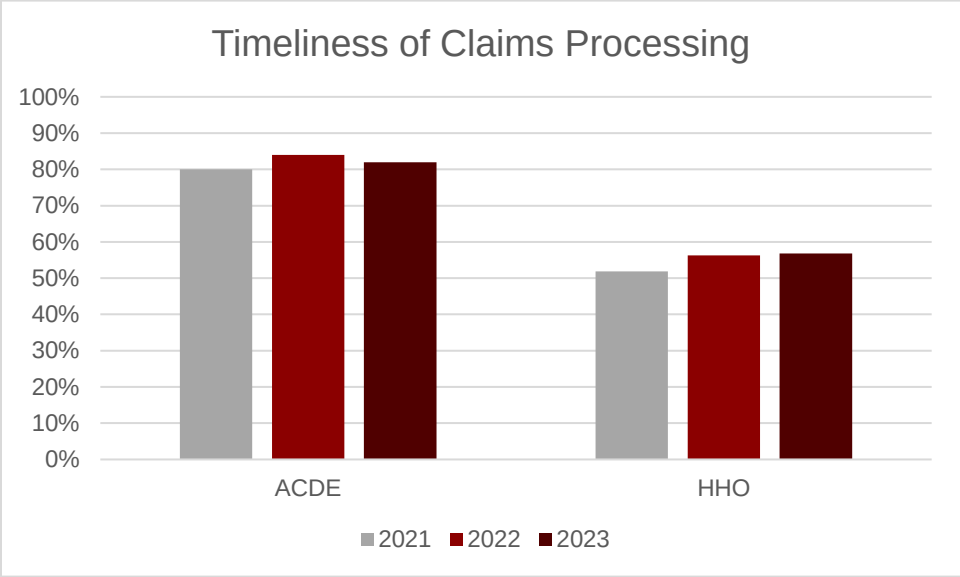


Figure 81:

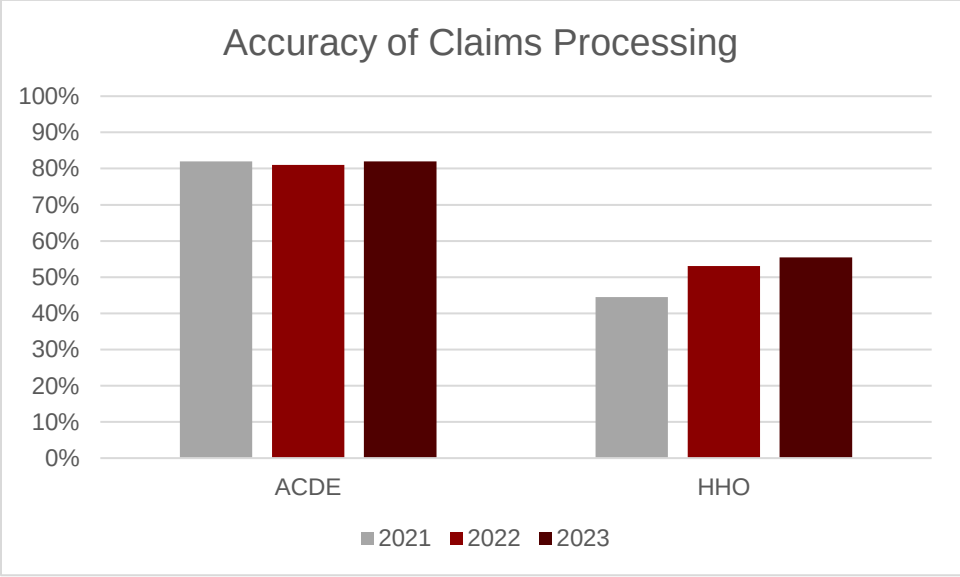


Figure 82:

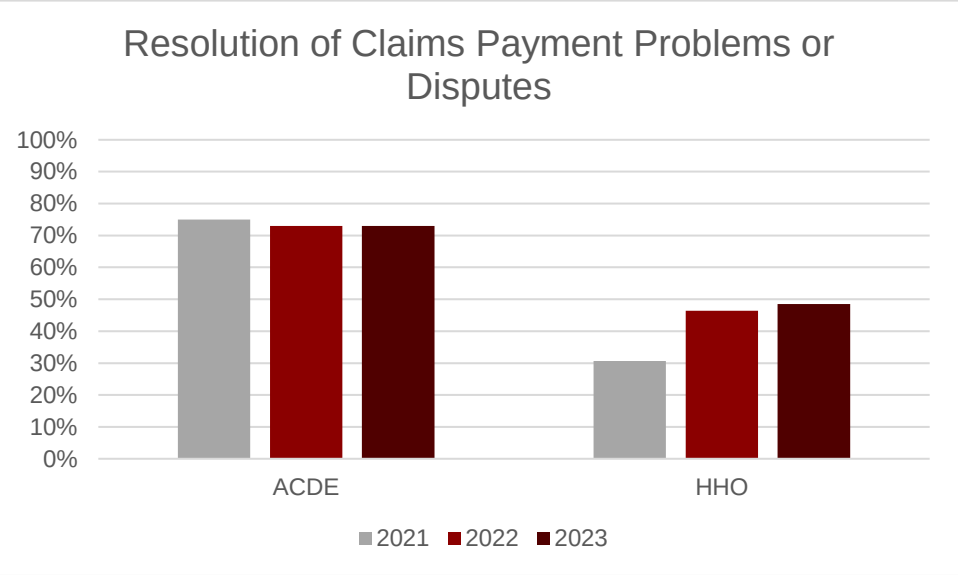
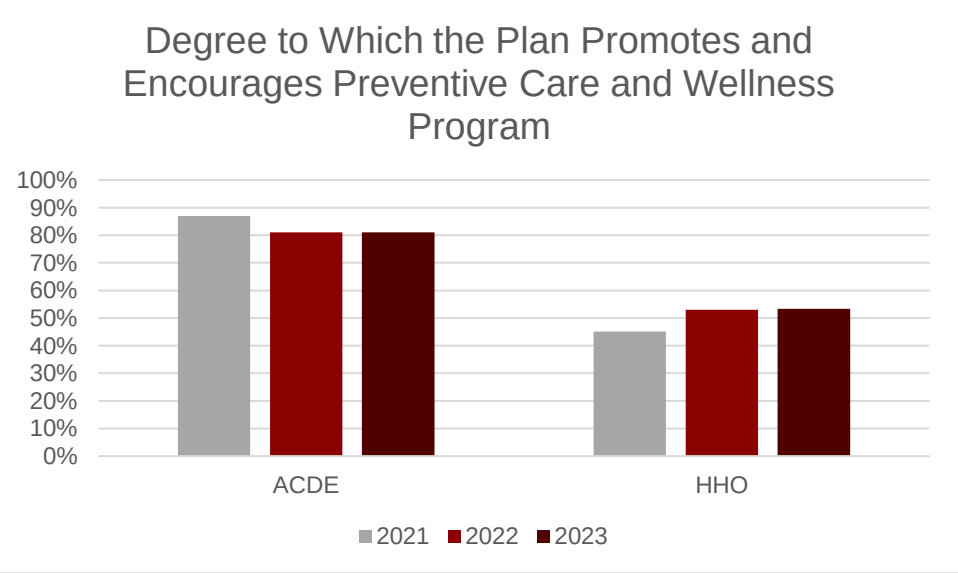


Figure 83:



Additional Performance Measurement

QCMMR and QCMMR Plus Measures and Results

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

Technical specifications for the QCMMR clinical data submission template are reviewed, updated and provided to the MCOs on an annual basis. A separate QCMMR Plus reporting guide for LTSS plan members includes dually eligible members and those in HCBS and institutional settings. QCMMR and QCMMR Plus specifications promote consistent and uniform reporting of performance measures of interest. The purpose of QCMMR reporting is to monitor quality, access, timeliness, and care management aspects of operations of the Medicaid contracted MCOs. The reports are organized to alert DMMA to current or potential areas of underperformance or suspected problems in MCO operations for further investigation. Quarterly feedback with each MCO on QCMMR reporting is provided and includes specific follow-up requests to provide analytical narrative of findings and planned interventions to measure results.

Network Adequacy and Availability

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

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

Demonstration of monitoring activities to ensure that access standards are met and that members have timely access to services, per the requirements of this Contract (ex: appointment availability canvassing, and missed and late visit information for HCBS services).

A summary of participating provider capacity issues by service and county, the Contractor's remediation and QM/QI activities and the targeted and actual completion dates for those activities (ex: grievance data, member experience from CAHPS and NCI-AD surveys).

Network deficiencies by service and by county and interventions to address the deficiencies.

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

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

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

AmeriHealth Caritas Delaware

On a quarterly basis, ACDE assesses its membership access to participating providers. ACDE collects and analyzes geographic distribution and provider to member ratios through use of GeoAccess

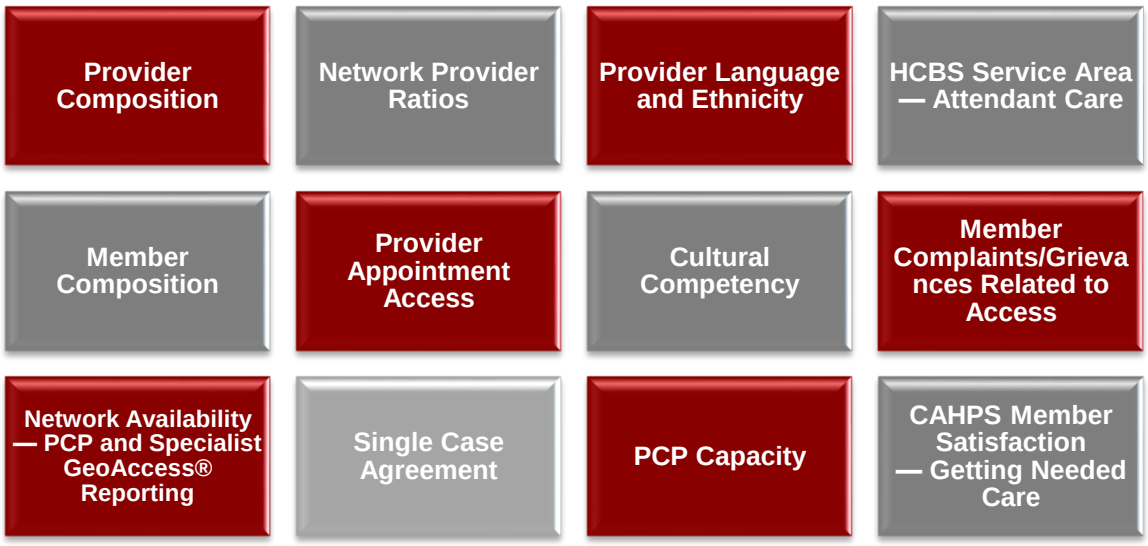
software, a managed care industry's standard instrument for measuring healthcare network access. The software provides maps, graphs, and tabular reports for analyzing member access to network providers. ACDE reviews and assesses availability for practitioners providing primary, specialty, and behavioral healthcare. If and when opportunities are identified for improvement related to practitioner availability, interventions are implemented to ensure adequate member access to practitioners.

Provider network reporting in the PNDMP included:

Highmark Health Options

The HHO PNDMP for 2020 provided a roadmap of next steps to ensure continuous improvement in meeting our members' healthcare needs, meeting State and federal regulatory requirements, and meeting NCQA accreditation standards. 2020 presented several new and complex challenges including logistics of managing and servicing providers during coronavirus disease 2019 (COVID-19) pandemic, transition of network management from a sister entity, Gateway Health, to Highmark, Inc., updating the online provider directory and provider portal, as well as challenges in filling open network management positions.

Provider network reporting in the PNDMP included:



Summary

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

Validation of Performance Measures

The objective of the PM validation in the compliance process is to validate the accuracy of Medicaid, CHIP, and DSHP/DSHP Plus PMs reported by the MCOs to DMMA. The measures reviewed for 2021–2023 were mandated by the State and used technical specifications developed as part of the State's QCMMR and CMS Adult and Pediatric Core Measure reporting. To validate the PMs, Mercer referenced the annual Compliance Review and ISCA and requested information responses with supporting documentation from MCOs. The following table shows a breakdown of validated PMs during 2021–2023 and their compliance rating as met or partially met. In 2020, the compliance rating was changed to high, moderate, or low:

Table 7:

MY 2021–2023 Performance Measure Validation					
2021 Performance Measure Validated	**Compliance Rating/Confidence Level**	**2022 Performance Measure Validated**	**Compliance Rating/Confidence Level**	**2023 Performance Measure Validated**	**Compliance Rating/Confidence Level**
Number of Medicaid members with diabetes who received an oral exam (D0150, D0120, D0180)	**ACDE**: No Confidence **HHO**: Low	Number of Medicaid members with diabetes who received an oral exam (D0150, D0120, D0180)	**ACDE**: High **HHO**: High	Behavioral health (BH) acute care admissions/1,000	**ACDE**: High **HHO**: High **DFH[1]:** No data submitted, no validation
Number of members receiving American Society of Addition Medicine (ASAM) level III (ASAM 3.1, 3.3 & 3.5 included, 3.7 is not covered) residential inpatient substance use disorder (SUD) services	**ACDE**: High **HHO**: High	30-day Hospital Readmission Rate (QPM)	**ACDE**: High **HHO**: No Confidence	Asthma medication ratio	**ACDE**: High **HHO**: High **DFH:** High
Asthma medication ratio	**ACDE**: High **HHO**: High	Controlling High Blood Pressure	**ACDE**: High **HHO**: High	Postpartum depression screening and follow-up — Depression screening	**ACDE**: High **HHO**: High **DFH:** High

[1] Delaware First Health: Contract effective January 1, 2023.

MY 2021–2023 Performance Measure Validation					
2021 Performance Measure Validated	**Compliance Rating/Confidence Level**	**2022 Performance Measure Validated**	**Compliance Rating/Confidence Level**	**2023 Performance Measure Validated**	**Compliance Rating/Confidence Level**
Prenatal and postpartum care	**ACDE**: High **HHO**: High	Comprehensive Diabetes (Control <8.0%)	**ACDE**: High **HHO**: High	Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	**ACDE**: High **HHO**: High **DFH**: High
Immunizations for adolescents	**ACDE**: High **HHO**: High	Childhood Immunization Status CIS-CH	**ACDE**: High **HHO**: High	Well-child visits in the first 30 months of life	**ACDE**: High **HHO**: High **DFH**: High
Use of pharmacotherapy for opioid use disorder (OUD) (Percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or dispensed an US Food and Drug Administration [FDA]-approved medication for the disorder during the measurement year)	**ACDE**: No Confidence **HHO**: High	Risk of Continued Opioid Use (COU)	**ACDE**: High **HHO**: High	Controlling high blood pressure	**ACDE**: High **HHO**: High **DFH**: High

Validation of Performance Measure Assessment — Summary (MY 2021 to MY 2023)

MCOs, namely, ACDE, HHO, and DFH (new contract effective January 1, 2023), scored "High-Confidence," ratings for the most PMs (13 of 18) validated for the MY 2021 to MY 2023. The following issues were noted for which the MCOs need to take corrective action:

Issues:

MY 2023: DFH did not submit data for the State measure (QCMMR): BH acute care admissions/1000, so Mercer could not validate this measure.

MY 2022: HHO received a “No Confidence” validation rating for the State measure (QPM), 30-day Hospital Readmission Rate. HHO did not adhere to the technical specifications and included codes that were not listed or excluded codes.

MY 2021: ACDE scored “No Confidence” for the following two measures:

- Number of Medicaid members with diabetes who received an oral exam (D0150, D0120, D0180): ACDE was not compliant with the QCMMR technical specifications and did not report the data accurately. ACDE did not select the full population expected for the denominator nor did it include the pharmacy data to identify the members with diabetes.
- Use of pharmacotherapy for OUD: This measure was not accessed during the review as the data was not available. CMS Adult Core Set Specifications were not released until April 2022. Preliminary rates will not be available until August 2022, and final audited rates until November 2022.

HHO scored Low Confidence for Number of Medicaid members with diabetes who received an oral exam (D0150, D0120, D0180). HHO was not compliant with the QCMMR technical specifications and did not report the data accurately. HHO did not include all required claims (paid and unpaid). HHO was also unable to demonstrate and explain ow the full pharmacy claims are selected.

Race, Ethnicity, and Language Data Collection

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

The Medicaid and CHIP eligibility process does not require mandatory disclosure of race, ethnicity, or primary language, therefore the State relies on demographic updates to the enrollment data file, as well as MCO data collection reporting. This is a priority area of focus for DMMA for improvement to identify and address health disparities and is outlined further in the MCO MSAs.

4
Continuous Quality Improvement

DMMA expects MCOs to use resources to identify and put actions in place to improve performance and quality of care. Each MCO is expected to implement performance improvement projects that address opportunities for improvement through implementation of targeted activities actions to improve HEDIS results.

Performance Improvement Projects

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

Oral health of the LTSS population (this PIP is prescriptive in nature)

BH and physical health (PH) integration

Pediatric population

LTSS population

Non-clinical or service related

The EQRO provides an 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.

Performance Improvement Project Assessment

Of the five required PIPs, the State required the EQRO to validate three PIPs during the comprehensive 2020 compliance review cycle completed in 2021. The first PIP was the State-mandated study topic and study question for oral health of the LTSS population. The second PIP was a State-mandated topic, but MCO developed study questions for 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 ADHD and member compliance with medication and outpatient therapy. HHO's selected topic focused on improving the rate of completion of Health Risk Assessment (HRA) within 60 days.

Results

ACDE scored moderate to high for confidence in Reporting Results, while HHO scored Low to Moderate in Reporting Results with DMMA providing ongoing technical assistance and updated reporting on improvement strategies and interventions. The full PIP EQRO findings and recommendations are available within the final Technical Summary Report, available at: https://dhss.delaware.gov/dmma/info_stats/

Children with Medical Complexity Advisory Committee

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

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

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

High-risk or vulnerable populations with functional limitations impacting their ability to perform Activities of Daily Living (ADLs).

Having high healthcare needs or utilization patterns, including requiring multiple (three or more) subspecialties, therapists, and/or surgeries.

A continuous dependence on technology to overcome functional limitations and maintain a basic quality of life.

In 2018, the work of the CMC Steering Committee was transitioned to a new group, the CMC Advisory Committee (CMCAC), which is responsible for implementing the recommendations described in the Plan. The purpose of Delaware's CMCAC is to strengthen the system of care, increase collaboration

across agencies, and encourage community involvement — with the goal of ensuring that every child with medical complexity has the opportunity to receive adequate and appropriate healthcare services.

In addition to the work conducted beginning of 2018, since 2021, the CMCAC addressed a number of the priorities and recommendations outlined in the Plan including:

Maintaining active engagement of the CMCAC through quarterly meetings and various workgroups. Representation on these workgroups included a broad array of stakeholders, including families.

Finalizing Private Duty Nursing (PDN) emergent care tools and defining extraordinary care to address workforce challenges Revising the PDN policy manual.

Finalizing PDN emergent care tools and defining extraordinary care to address workforce challenges.

Revised Medicaid policy for PDN authorizations.

Developing a Complex Care Support Needs Assessment.

Expanding community partnerships beyond Medicaid.

Curating Family Centered Care educational materials online.

Created FAQ sheets related to Durable Medical Equipment (DME)/Supplies, delivered care coordination training, and assessed patient portal availability among DME providers.

Publishing a brochure titled “What to Expect When Your Child’s Medical Equipment or Supplies Change.”

DMMA continues to encourage, support and value the work of the CMCAC and looks forward to continued progress in adopting new strategies and tools to address existing and emerging issues/challenges identified.

Electronic Visit Verification

The 21st Century Cures Act required states have an Electronic Visit Verification (EVV) system to confirm that certain services paid for by Medicaid are being provided. This federal law required states to have an EVV system in place by January 1, 2020, for Personal Care Services (PCS) and by January 1, 2023, for Home Health Services. The Delaware DMMA implemented an EVV system for both services on December 30, 2022.

EVV systems work by requiring the person providing PCS or Home Health Services to log into an electronic system using a phone, tablet, or other device to confirm the following each time they provide

care to a Medicaid member in his/her home: the caregiver, the member, type of service, date, start and end times, and location. EVV systems can also collect more information than what is required by federal law and can serve as an alert system for missed or late visits, take the place of paper timesheets, and provide access to up-to-date medical information.

Since its system go-live DMMA has been working with its provider and MCO networks to assure proper registration and submission of visit data. DMMA intends for all its payers (MCOs and fee-for-service [FFS]) to turn on hard edits for claims subject to EVV on March 31, 2026. This means claims subject to EVV must be matched with a corresponding visit to be paid. DMMA is working towards final CMS certification of its EVV system, with final approval expected soon.

Primary Care Collaborative

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

In 2019, Senate Substitute 1 for Senate Bill 116 expanded the membership of the Primary Care Reform Collaborative and created an Office of Value-Based Health Care Delivery in the Department of Insurance to reduce healthcare costs by increasing the availability of high-quality, cost-efficient health insurance products that have stable, predictable, and affordable rates. In 2021, the Delaware General Assembly passed Senate Bill 120 (SB 120) with the goal of continuing to strengthen the primary care system in the state.

The PCRC has worked to identify ways to increase access through provider recruitment through better access to waiver programs, frictionless licensure processes and holistic approaches to financial incentives. In addition, the PCRC monitors the uptake of Value-Based Care (VBC) models. PCRC provides guidance on Alternative Payment Models (APMs) and helps identify ways to reward care that reduces disparities and address health-related social needs, all while gathering stakeholder input and determining affordability standards. The PCRC continues to meet as a public stakeholder workgroup composed of State staff, providers, insurers and legislative members to address challenges and develop solutions to promote primary care in all delivery systems (e.g., commercial and government).

Substance Use Disorder Initiatives

Delaware Medicaid has implemented a set of targeted initiatives to improve access to evidence-based SUD treatment, strengthen care delivery across settings, and improve outcomes for Medicaid members with SUD. These initiatives build on foundational coverage policies and are designed to address persistent gaps in engagement, retention, and continuity of care.

Foundational Coverage and Policy Initiatives

DMMA has established broad access to core SUD services through statewide coverage policies, including elimination of copays and prior authorization requirements for medications for opioid use disorder (MOUD), inclusion of naloxone on a universal preferred drug list, and approval of an 1115 SUD demonstration allowing coverage of SUD services delivered in institutions for mental disease (IMD) settings. These policies provide the infrastructure necessary to support expanded treatment access and delivery system reforms.

Management of Addiction in Routine Care (MARC) Pilot

DMMA launched the Management of Addiction in Routine Care (MARC) pilot to expand access to MOUD in primary care settings. The pilot uses enhanced payment to support primary care providers prescribing MOUD, recognizing the additional clinical, coordination, and administrative demands associated with SUD treatment. MARC is intended to increase the number of MOUD-prescribing providers, expand geographic access to treatment, and reduce reliance on specialty-only SUD treatment settings.

Contingency Management Initiatives

DMMA has implemented contingency management initiatives as an evidence-based strategy to improve engagement and retention in SUD treatment. Delaware is one of only five states awarded an 1115 waiver to pay for these services through Medicaid. One pathway of this initiative is for people ages 18 and older with stimulant use disorder. The other is for pregnant and postpartum adults aged 18 with opioid use disorder. These initiatives are designed to support participation in treatment, reduce dropout rates, and improve continuity of care, particularly for individuals at high risk of disengagement. Data from these initiatives are used to assess impact on engagement, utilization, and outcomes and to inform future policy and payment decisions.

SUD Treatment for Pregnant and Postpartum Individuals

Through a State Opioid Response (SOR) grant and American Rescue Plan Act of 2021 (ARPA) funding, DMMA developed and disseminated best practice guidance for treatment of SUD in pregnant and postpartum individuals, along with corresponding reimbursement guidance to support provider implementation. These efforts focus on improving access to timely, evidence-based care during pregnancy and supporting continuity of treatment in the postpartum period, a time of elevated risk for relapse and adverse outcomes.

Care Coordination and Managed Care Expectations

DMMA expects managed care organizations to support coordination of SUD services across medical, behavioral health, and social support systems, particularly during high-risk transitions, such as pregnancy, postpartum, and transitions between levels of care. These expectations are reinforced

through managed care oversight, reporting requirements, and performance improvement activities related to SUD care.

Monitoring and Continuous Improvement

DMMA monitors the impact of SUD initiatives using managed care reporting, quality measures, and pilot-specific data. Areas of focus include treatment initiation and engagement, MOUD access and continuity, provider participation, utilization patterns, and outcomes for high-risk populations. Findings from these monitoring activities are used to guide continuous quality improvement and inform decisions about refinement or expansion of SUD initiatives.

5
Waiver Assurances

DSHP Plus HCBS Waiver Assurances

Performance measures in the QS specific to DSHP Plus program, were initially established based on certain Section 1915(c) assurances and sub-assurances, including administrative authority, level of care (LOC), qualified providers, service plan, and participant safeguards. DMMA established 11 core domains and performance measures to monitor under the 1115 waiver authority to ensure prompt remediation of individual findings and promote system improvements in the managed LTSS delivery system. Although these performance measures were included in the MC QS, comprehensive results will be reported separately to CMS per their guidance annually beginning in June 2026. Therefore, we are only providing high-level observations of these specific sub-assurance performance measures in this evaluation of the MC QS.

Performance measures pertaining to the DSHP Plus program will be established based on results from the baseline assessment and are established with the stretch goal of 90% compliance. Results that fell below the 75% compliance threshold required a CAP. Of the 11 overall goals, four goals were above the 75% threshold:

100% compliance with offering choice between institutional settings and HCBS

98% compliance with offering choice of HCBS providers

86% compliance with individuals receiving education on identifying abuse

86% compliance with individuals receiving HCBS have a back-up plan in place

The goals with data demonstrating less than 75% compliance, therefore requiring a CAP, were:

MCOs providing documentation that a provider meets minimum qualifications prior to enrollment into DSHP Plus

Individuals having an annual plan of care review

The plan of care reflects the individual’s goals

Services match the plan of care

In addition, three goals were identified that require additional refinement to the performance measure itself and the methodology for collecting the data to properly measure the desired calculated goal. For example, the percentage of individuals with an approved pre-admission evaluation (PAE) prior to enrollment in the DSHP Plus LTSS program. The data is not available to be calculated due to the current approach of tracking the outcome of each Pre-Admission Screening (PAS) requesting a LOC) determination. In lieu of that data, DMMA has reviewed the number of referrals to PAS for a determination of LOC, which were 4,862 in calendar year (CY) 2023 and 4,857 in CY 2024 for reference. In addition, effective November 2024, work with a new data vendor has enabled data to demonstrate compliance with two of the current goals to be more effectively captured. These goals are the number and percentage of DSHP Plus LTSS files with a critical incident that demonstrate a prevention plan is in place and unauthorized restrictive interventions per number of DSHP Plus individuals.

To continue to bolster effective goal setting and monitoring, DMMA continues to work with CMS on the upcoming HCBS measure changes and plans to incorporate these changes into the HCBS assurance reporting.

PROMISE Performance Measurement

The PROMISE performance measures were initially established on certain Section 1915(i) assurances and sub-assurances. Performance measures were established based on results from the baseline target and are established with the stretch goal of 90% compliance. Results that fall below the 75% compliance threshold require a CAP. Although these performance measures were included in the MC QS, similar to the above, these results will be reported separately to CMS annually beginning in June 2026. Therefore, we are only providing high-level observations of these specific sub-assurance performance measures in this evaluation of the MC QS.

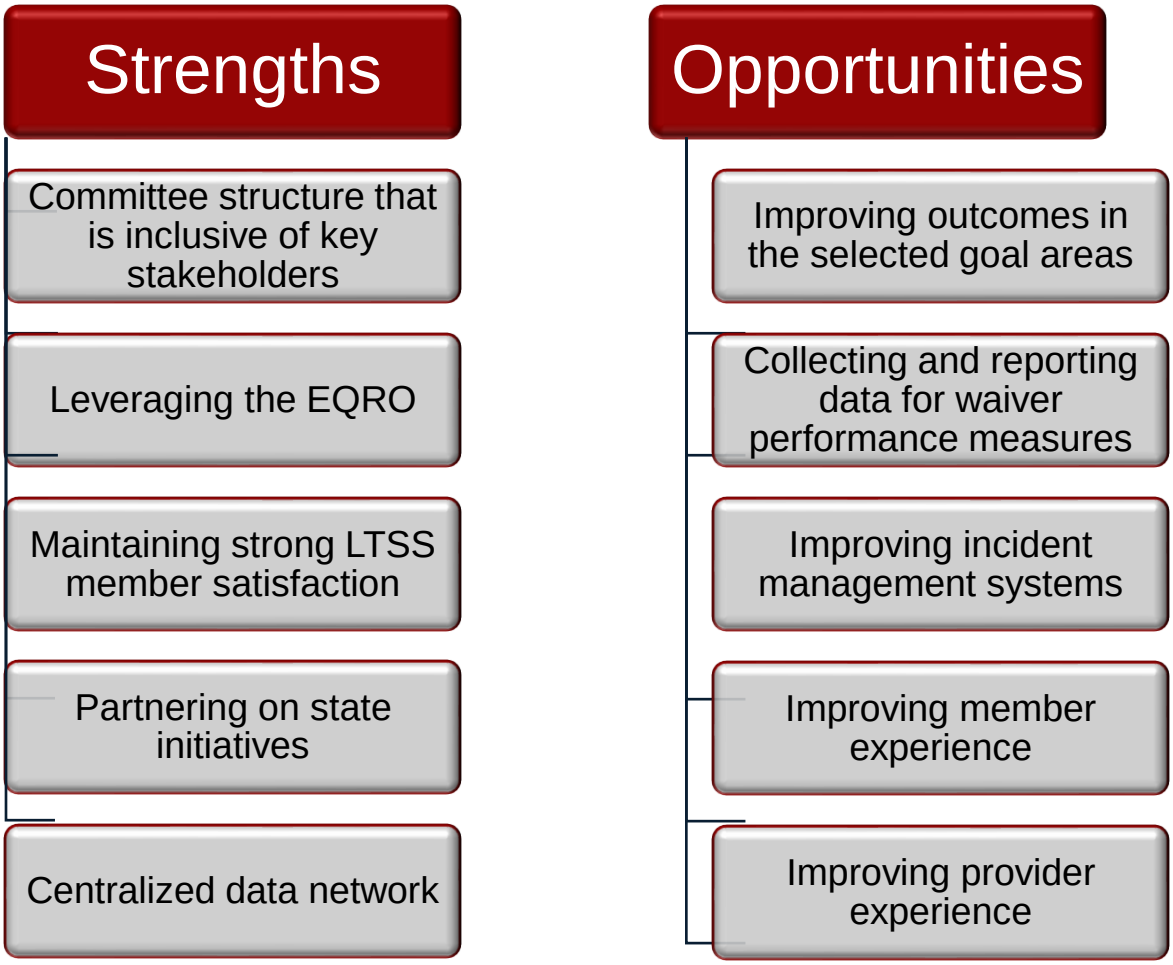
Broadly, there are 11 goals with associated performance measures specific to the PROMISE program. An identified opportunity for improvement within the stated goals is a re-evaluation of the data available to properly measure the goals established. Some of the stated measures have data limitations which will require a revision of the stated performance measures in the next cycle. In addition, the PROMISE program is administered through a fee-for-service delivery system, which adds a level of complexity to effectively capture data and attribute it to MCOs associated with the individual.

As a part of this MC QS evaluation, we are highlighting the PROMISE sub-assurance reporting as an area to develop more fully and optimize the upcoming HCBS measure reporting changes as a part of the development.

6
Strengths and Opportunities

This report reflects DMMA's continued emphasis to improve quality and outcomes for the DSHP/CHIP and DSHP Plus populations enrolled in the State's Medicaid Managed Care program as outlined in the MC QS. The infrastructure and outcomes were evaluated to examine capability for monitoring and improving quality of services and outcomes. The evaluation results help set priorities and measurable objectives, assess the causes of suboptimal performance, and identify interventions to address challenges. This process has created a tool to focus improvement efforts and support the development of the 2026 MC QS.

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



Strengths

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

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

DMMA to gain meaningful insights into the DSHP Plus program, comparing experiences between individuals served in home and community-based settings and those who reside in long-term care institutional settings.

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

The DHIN is a centralized statewide resource used to strengthen care coordination, enhance transparency, and promote continuous quality improvement across the Medicaid managed care program.

Opportunities

The three MCOs have opportunities for further outcome improvement in the goal areas of chronic condition management, behavioral health condition identification and management and reducing communicable diseases. These topics has been an ongoing theme targeted by DMMA's QII task force and MCO quality committees. DMMA has also implemented annual quality performance measure penalties related to a sub-set of the chronic disease and communicable disease measures to enhance MCO focus.

Recommendations to re-evaluate the waiver performance measure data collection and methodology to optimize data collection and analysis to ensure desired outcomes are met.

DMMA has made strides in the improvement of incident management related to critical incident reporting through their recent launch of a new incident management system. This will support data collection and aggregate reporting which will strengthen investigative processes, increasing frequency of oversight and reporting, revising policy/auditing, broadening data sources, and linking incident management to fraud, waste, and abuse.

Annual member experience surveys provide insights into experiences with healthcare services. For both child and adult members, enhanced quality of services can lead to improved member satisfaction and health outcomes.

Provider experience surveys provide insights into administrative challenges and workforce issues. Focus from the MCOs on areas of opportunity identified through the annual surveys can improve partnership with the Delaware provider network for improved member care.

State of Delaware
Division of Medicaid & Medical Assistance