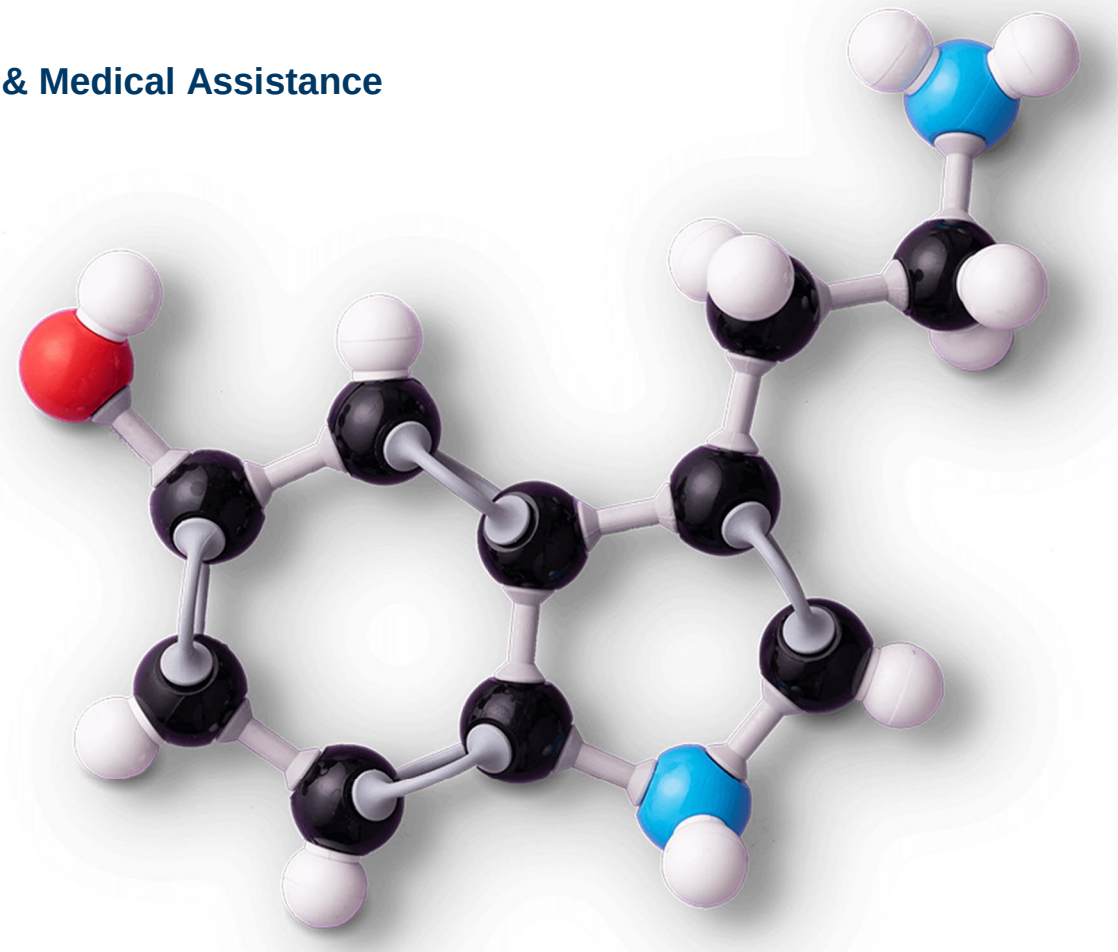
Mercer

2020 External Quality Review

Medicaid Managed Care Organization Performance Report

State of Delaware
Division of Medicaid & Medical Assistance

April 23, 2021



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1 Introduction

Purpose of Report

The State of Delaware (Delaware or State) Division of Medicaid & Medical Assistance (DMMA) contracted with Mercer Government Human Services Consulting (Mercer) to conduct an External Quality Review (EQR) of the managed care organizations (MCOs), AmeriHealth Caritas Delaware (ACDE) and Highmark Health Options (HHO), participating in the State of Delaware's Medicaid health care service programs. To complete this review, Mercer applied Federal Regulations for Medicaid Managed Care (FRMMC), the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), and State regulations, contractual requirements, each MCO's internal policies and procedures, and State-defined standards communicated to the MCO through its managed care contract and the Medicaid/Children's Health Insurance Program (CHIP)/Diamond State Health Plan (DSHP) Plus Quality Strategy (QS). This report aims to assess MCO performance in accordance with goals identified in DMMA's current QS[1]:

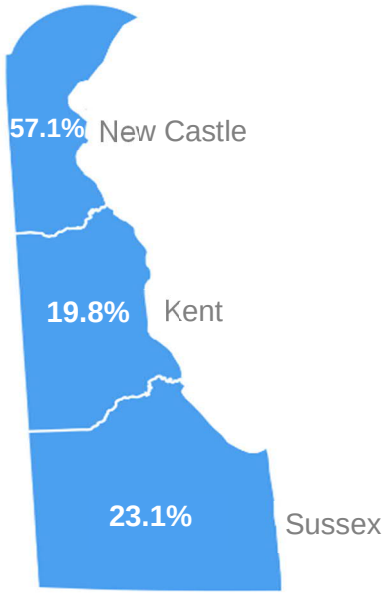
- **Goal 1:** To improve timely access to appropriate care and services for adults and children, with an emphasis on primary and preventive, behavioral healthcare, and to remain in a safe and least-restrictive environment.
- **Goal 2:** To improve quality of care and services provided to Medicaid and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

In addition to evaluating MCO performance with respect to DMMA's QS goals, this report offers a summary of the comprehensive compliance review based on the Centers for Medicare and Medicaid Services (CMS) EQR requirements under 42 CFR 438.358. Based on findings of the descriptive and comparative analyses, Mercer identified MCO strengths and opportunities for improved performance in the delivery of health care services for enrollees in Delaware's managed Medicaid programs.

[1] Division of Medicaid & Medical Services. (2018). Delaware Statewide Quality Management Strategy. New Castle: Delaware Department of Health and Social Services.

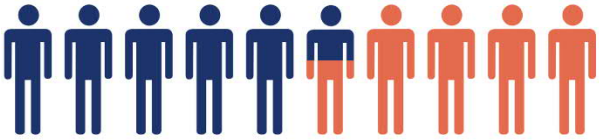
Population

Delaware's Medicaid managed care population accounts for approximately 208,000 eligible individuals. New Castle county has the highest participation at 57.1%, with Sussex county accounting for 23.1% and Kent county accounting for 19.8% of the Medicaid population.



Delaware Medicaid participation reflects a higher percentage of females at 53.8% than males at 46.2%.

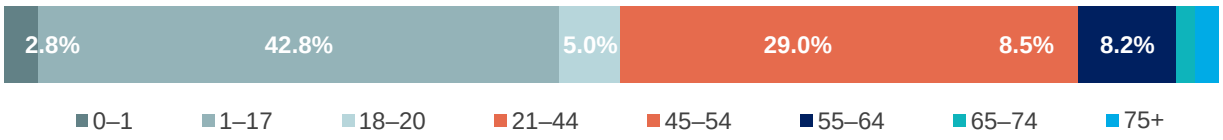
Delaware Medicaid Population by Gender*



Male: 46% **Female: 54%**

The largest eligible age groups are children and non-elderly adults making up about 96.3% of the total. Children under 18 account for the highest percentage of members at 45.6% with adults ages 21–44 making up about 29.0% of all participants.

Delaware Medicaid Population by Age Group*



Race and ethnicity breakdowns reveal that the majority of Delaware Medicaid participants are either Caucasian at 56.2% or African American at 40.7%.

**Demographic data shown above is reflective of December 2019 Delaware Medicaid Enterprise System eligibility information, as of July 2020.*

External Quality Review

CMS mandates that each state conduct an EQR for MCOs providing services to Medicaid members. Federal regulations under 42 CFR Part 438, subpart E set forth parameters the State must follow when conducting an EQR of an MCO. The EQR is a systematic analysis and evaluation by a qualified External Quality Review Organization (EQRO). The evaluation requires aggregated information about

the quality, timeliness and access to health care services that an MCO or its contractors provide under contract for Medicaid recipients.

Part of the EQR service includes validation of information furnished to complete the analysis. This includes a review of descriptive information and a review of data and procedures used to determine the extent to which they are accurate, reliable and free from bias, in accord with national standards for data collection and analysis.

Recent changes by CMS to EQR protocols address significant changes in national healthcare policy, which offer new opportunities for measuring and improving quality of health care delivery. This includes changes effected by the CHIPRA Act of 2009, the American Recovery and Reinvestment Act and the Affordable Care Act.

Methodology

Primary data sources for analysis in this report include the National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS®) and its Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, and the 2020 Delaware comprehensive EQR. The performance improvement projects (PIPs) and performance measures (PMs) DMMA selected for validation were based on DMMA's QS goals noted above.

Results for the two Delaware Medicaid MCOs have been de-identified, and respective scores for HEDIS and CAHPS performance measures are reported in comparison to national percentiles from NCQA's Quality Compass.[2] Results are grouped into a rating system of five stars (90th percentile), three stars (50th–89th percentile) or two stars (below 50th percentile). The EQRO evaluated MCO compliance with Medicaid and the CHIP managed care regulations and is presenting them in four domains: enrollee rights and protections, quality assessment and performance improvement, grievances and appeals, certification and program integrity. A similar star scoring approach was used to present results of the validation of PMs and PIPs. See Tables 1–3, below to interpret star ratings throughout the remainder of the report.

Table 1. CAHPS Performance Measure Score Scale

National Percentile Score as Reported by CAHPS	EQR Report Score
90th percentile or higher	★★★★★
50th–89th percentile	★★★
Lower than 50th percentile	★★

[2] Quality Compass provides a database of national averages among organizations submitting data to NCQA. Benchmark data comes from accredited and non-accredited organizations and consists of publicly and privately reported performance metrics. Available at: www.qualitycompass.org.

Table 2. HEDIS Performance Measure Score Scale	
National Percentile Score as Reported by HEDIS	**EQR Report Score**
90th percentile or higher	★★★★★
50th–89th percentile	★★★
Lower than 50th percentile	★★

Table 3. EQR Compliance Score Scale	
Compliance Points Earned	**EQR Report Score**
90% + of possible points	★★★★★
75%–89% of possible points	★★★
< 75% of possible points	★★

Table 4. PM and PIP Validation Score Scale	
PIP/Validation Evaluation	**EQR Report Score**
Fully compliant	★★★★★
Substantially compliant	★★★
Not compliant	★★

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Consumer Assessment of Healthcare Providers and Systems

Member Perception of Healthcare Services

One of the goals described in the Delaware Medicaid QS is to "Assure member satisfaction with services." One of the core elements of the DSHP program is to promote member-centricity. Being member-centric, means being focused on providing a positive experience for Medicaid members and designing systems that work for them. Members who exhibit confidence in services delivered to them will engage those services more effectively and frequently, increasing the likelihood of a healthier membership. CAHPS surveys (adult and pediatric) target enrollees' viewpoint and evaluation of their own experiences with health care delivery. The survey covers topics important to enrollees and focuses on aspects of quality they are best qualified to assess, such as the communication skills of providers and ease of access to health care services. The following results and subsequent ratings are based on the CAHPS composite scores developed by combining individual survey questions into broader topics.

A star rating was assigned to each composite measure according to the following scale:

Table 5. CAHPS Performance Measure Score Scale

National Percentile Score as Reported by CAHPS	EQR Report Score
90th percentile or higher	★★★★★
50th–89th percentile	★★★
Lower than 50th percentile	★★

Consumer Assessment of Healthcare Providers and Systems Performance Evaluation

A percentile is a statistical measure that indicates performance. Typically, being in a higher percentile indicates better performance. Through its QS, DMMA established a standard of the 75th percentile for CAHPS performance. Once the 75th percentile is achieved, the MCO will work toward achieving the

90th percentile. CAHPS performance varied across domain and by population within each MCO. A side-by-side comparison of both MCOs shows differences in performance as well.

Table 6. CAHPS Performance Measure Ratings — Adult		
Measure Description	**2020 MCO A Ratings**	**2020 MCO B Ratings**
Rating of personal doctor	★★	★★
Rating of specialist	★★★	★★★
Rating of all health care	★★★	★★★
Rating of health plan	★★★	★★★★★
Getting needed care	★★	★★★★★
Getting care quickly	★★★	★★★★★
How well doctors communicate	★★	★★★

Table 7. CAHPS Performance Measure Ratings — Child		
Measure Description	**2020 MCO A Ratings**	**2020 MCO B Ratings**
Rating of personal doctor	★★	★★★★★
Rating of specialist	★★	★★★
Rating of all health care	★★	★★★
Rating of health plan	★★	★★★★★
Getting needed care	★★	★★
Getting care quickly	★★★	★★
How well doctors communicate	★★	★★

Overall Member Experience with Care

MCO B had three measures, rating of health plan, getting needed care and getting care quickly that were at or above the 90th percentile. Both MCOs had moderately good ratings for two adult areas: rating of specialist and rating of all health care. Both MCOs have opportunities for improvement in rating of personal doctor; other measure results varied between the MCOs..

Both MCOs have opportunities for improvement in the majority of the child areas. MCO B had strong results on the child measures of rating personal doctor and rating of health plan while MCO A's results were low. MCO A had moderate results on the child measure getting care quickly while MCO B results

were low. Both MCOs had low results in the child area of how well doctors communicate; other measure results varied between the MCOs.

MCO A performed moderately well on the adult and low on the child CAHPS survey. MCO A performed at or above the benchmark for the 50th percentile for CAHPS metrics nationwide for adult measures with the exceptions of the rating of personal doctor, getting needed care, and how well doctors communicate that all scored lower than the 50th national percentile. Plan members who completed the CAHPS survey scored three adult metrics as moderate (rating of specialist, rating of all health care, rating of health plan and getting care quickly). While there were positive results within the adult CAHPS survey, the child survey results for MCO A highlight opportunities for improvement. Plan members who completed the CAHPS survey scored one child metric as moderate (getting care quickly) and the rest of the child metrics as low (rating of personal doctor, rating of specialist, rating of all health care, rating of health plan, getting needed care and how well doctors communicate).

Members rated MCO B's performance at or above the 90th percentile benchmark for three of the adult measures (rating of health plan, getting needed care, and getting care quickly) as well as two of the child measures (rating of personal doctor and rating of health plan). Areas in need of improvement for MCO B are the adult measure rating of personal doctor as well as the child measures for getting needed care, getting care quickly, and how well doctors communicate (lower than the 50th percentile). All other metrics reveal moderate performance between the 50th and 90th percentiles for MCO B.

Comparing MCO A to MCO B suggests opportunities for improvement at both MCOs. Primary concerns for MCO A revealed by this year's reporting include the adult and child metrics for rating of personal doctors, getting needed care and how well doctors communicate. Primary concerns for MCO B include the adult metric for rating of personal doctors and child metrics for getting needed care, getting care quickly and how well doctors communicate.

3

Healthcare Effectiveness Data and Information Set Results

This section provides an overview of two HEDIS domains of care: Access to Care and Quality of Care. Analysis using HEDIS for performance evaluation is industry standard for external reporting in the managed care industry. HEDIS is developed and maintained by NCQA. Data used for calculating HEDIS results include information from medical charts and provider claims (i.e., encounter data from electronic health records, claims data from billing systems, etc.) within Delaware's Medicaid managed care network. NCQA originally designed HEDIS to allow consumers to compare health plan performance against the quality of other health plans, as well as national and regional benchmarks. A star rating was assigned as follows for each composite measure.

Table 8. HEDIS Performance Measure Score Scale

National Percentile Score as Reported by HEDIS	EQR Report Score
90th percentile or higher	★★★★★
50th–89th percentile	★★★
Lower than 50th percentile	★★

Evaluation of Effectiveness and Access to Health Care

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

Timely Access to Primary and Preventive Services

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

MCO B was at or above the 50th percentile in six of the seven timely access to primary and preventive services measures, with the exception of adults ages 20 years–44 years, which was below the 50th percentile. MCO A was at or above the 50th percentile on only one of the seven timely access to primary and preventive services measures; the MCO was below the 50th percentile in all of the child and adult access to preventive services with the exception of adults ages 65+ years, which was above the 50th percentile.

Table 9. Timely Access to Primary and Preventive Services

HEDIS Performance Measure Description	2020 MCO A Ratings	2020 MCO B Ratings
Children's access to primary care physician (PCP) (Ages 12 months–24 months)	★★	★★★
Children's access to PCP (Ages 25 months–6 years)	★★	★★★
Children's access to PCP (Ages 7 years–11 years)	★★	★★★
Adolescent's access to PCP (Ages 12 years–19 years)	★★	★★★
Adult's access to preventive/ambulatory health services (Ages 20 years–44 years)	★★	★★
Adult's access to preventive/ambulatory health services (Ages 45 years–64 years)	★★	★★★
Adult's access to preventive/ambulatory health services (Ages 65+ years)	★★★	★★★

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

Access to Maternal and Pregnancy Services

Early and consistent access to quality prenatal care services can improve chances of delivering healthy babies and decreasing maternal and infant deaths. Providing access to comprehensive maternal and prenatal services impacts MCO service delivery significantly, and constitutes effective means of preventing lifelong disability via healthy deliveries. MCO A and MCO B both performed below the 50th percentile for access to maternal and pregnancy services during 2020.

Table 10. Access to Maternal and Pregnancy Services		
HEDIS Performance Measure Description	**2020 MCO A Ratings**	**2020 MCO B Ratings**
Prenatal and postpartum care — timeliness of prenatal care	★★	★★
Prenatal and postpartum care — postpartum care	★★	★★

Overall Access Performance

HEDIS results provide a litmus test for evaluating patient access to care. The comparisons of reportable-HEDIS data between MCOs and against the national benchmarks, above, indicate both MCOs need to focus quality improvement strategies for accessing preventive and maternity care.

Evaluation of Quality of Care

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

Evaluation of Neonatal Services

Effective preventive care begins early in life. Healthier children will be more likely to remain healthier as adults. High-quality health care in early stages of life promotes a healthier membership pool. As shown in the following table, MCO A performed below the 50th percentile in all measures for quality of early life services, while MCO B performed above the 50th percentile.

Table 11. Quality of Early Life Services		
HEDIS Performance Measure Description	**2020 MCO A Ratings**	**2020 MCO B Ratings**
Childhood immunization status (Combination 2)	★★	★★★
Sufficient (6+) well-child visits in first 15 months of life	★★	★★★
Well-child visits in years 3–6	★★	★★★

Evaluation of Early Detection Services

Routine screenings and early detection services allow providers to identify and address health concerns at an early stage, often preventing costly and invasive interventions associated with later

detection. As shown below, MCO A performed below the 50th percentile for cervical cancer screening, while MCO B performed below the 50th percentile for both breast cancer and cervical cancer screening.

Table 12. Early Detection Service Quality		
HEDIS Performance Measure Description	**2020 MCO A Ratings**	**2020 MCO B Ratings**
Breast cancer screenings	NR	★★
Cervical cancer screenings	★★	★★

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

Quality of Diabetes Management Services

Diabetes mellitus has a strong association with morbidity and mortality in the United States. Often associated with inadequate diabetes management, comorbidities such as hypercholesterolemia (high cholesterol), hypertension (high blood pressure), and other chronic conditions merit attention. Comprehensive care for this disease includes a variety of monitoring services. As shown below, both MCOs' HEDIS scores indicate the need for improvement in diabetes care.

Table 13. Quality of Diabetes Management		
HEDIS Performance Measure Description	**2020 MCO A Ratings**	**2020 MCO B Ratings**
Comprehensive diabetes care — HbA1c testing	★★	★★
Comprehensive diabetes care — dilated retinal eye exam	★★	★★

Weight and Nutrition Management Quality

Also associated with morbidity and mortality in the United States is obesity and its related health conditions. Expenditures attributed to these conditions are also on the rise. When initiated early in life, proper nutrition, physical activity, weight assessment and control effectively prevent obesity and the associated disease burden. Nutrition counseling is an important means of educating individuals in order to help them lead healthier, more productive lives. MCO A is at or above the 50th percentile for counseling for nutrition and physical activity among children and below the 50th percentile for adult body mass index assessment. MCO B is below the 50th percentile for all of the clinical quality of weight and nutrition management measures.

Table 14. Clinical Quality of Weight and Nutrition Management		
HEDIS Performance Measure Description	**2020 MCO A Ratings**	**2020 MCO B Ratings**
Adult body mass index assessment	★★	★★

Table 14. Clinical Quality of Weight and Nutrition Management		
Counseling for nutrition	★★★	★★
Counseling for physical activity	★★★	★★

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

Overall Quality Performance

Strengths and Opportunities

MCO A scored low to moderate for overall performance on measures pertaining to timely access to primary and preventive services as well as the quality of early life services. MCO A's performance was lower than the 50th percentile on measures pertaining to access to maternal and pregnancy services. MCO A is at or above the 50th percentile for counseling for nutrition and physical activity among children and below the 50th percentile for adult body mass index assessment. These preventive services as well as services to the young and vulnerable population are keys to improving the health outcomes of the Delaware Medicaid population.

MCO B reached or was above the 50th percentile for all but one of the timely access to primary and preventive services as well as the quality of early life services. MCO B's performance was lower than the 50th percentile on measures pertaining to access to maternal and pregnancy services. Both MCOs have opportunities for significant improvement with early detection and service intervention as well as with diabetes management. This topic has been an ongoing theme targeted by DMMA's Quality Improvement Initiative task force and MCO quality committees. Significantly improved performance in these areas could improve the quality of life, decrease illness of Delaware Medicaid enrollees.

4

External Quality Review: Compliance

Compliance Scoring

As required by CMS under federal regulation, Mercer, acting as the EQRO, completed a comprehensive compliance review of the MCOs using the CMS protocol "Assessment of Compliance with Medicaid Managed Care Regulations." The review has been grouped into the compliance areas below:

- Enrollee rights and protections
- Quality assessment and performance improvement
- Grievances and appeals
- Certifications and program integrity

The EQRO compliance evaluation assigns the MCO a score for each metric that makes up these four review areas. The assessment of "Met", "Substantially Met", "Partially Met", "Minimally Met" and "Not Met" is given a score, and an equal weighting was assigned to each of the four standards. Regulation mandates MCOs develop a required corrective action plan (CAP) for all metrics resulting in a "Substantially Met", "Partially Met", "Minimally Met" or "Not Met" rating. All CAPs are reviewed and approved for implementation by DMMA prior to integration. A star rating was assigned to the MCOs based on their overall compliance score according to the rating scale below.

Table 15. EQR Compliance Score Scale

Compliance Points Earned	EQR Report Score
90% + of possible points	★★★★★
75%–89% of possible points	★★★
<75% of possible points	★★

Compliance Evaluation

MCO A scored above 90% on all four content areas of the compliance review. MCO B scored above 90% in the areas of enrollee rights and protections, grievances and appeals and certifications and program integrity. The area in need of the most improvement for MCO B is quality assessment and performance improvement. (Table 16).

Table 16. 2020 MCO Overall Compliance Ratings

	MCO A			MCO B		
Content Area	**Possible Points**	**Points Scored**	**Percent**	**Possible Points**	**Points Scored**	**Percent**
Enrollee Rights and Protections	25	25.00	100.0%	25	25.00	100.0%
Quality Assessment and Performance Improvement	25	24.74	98.9%	25	22.19	88.8%
Grievances and Appeals	25	25.00	100.0%	25	24.73	98.9%
Certifications and Program Integrity	25	25.00	100.0%	25	25.00	100.0%
Total	100	99.74	99.7%	100	96.92	96.9%
Total Compliance Rating	★★★★★			★★★★★		

Overall Compliance Performance

Strengths and Opportunities

Both of Delaware's Medicaid MCOs performed well overall in 2020, scoring in the highest compliance-rating tier. While MCO A attained greater than 90% of possible points in all four areas, MCO B earned greater than 90% of the points possible in three areas: Enrollee Rights and Protections, Grievances and Appeals and Certifications and Program Integrity. These results indicate that both MCOs are compliant with the majority of federal regulations and State contract expectations.

Findings of the compliance review indicate room for improvement at MCO B for Quality Assessment and Performance Improvement (QAPI) measures. Identifying which parts of a healthcare system need attention requires a strong QAPI framework — a key to quality improvement throughout complex healthcare delivery systems.

While both MCOs performed well, even those areas that achieved more than 90% compliance may still have items that require a CAP. The State reviews, approves all CAPs, and monitors those action plans to ensure that all identified issues are corrected.

5
Performance Measurement

Validation of Performance Measures

Performance measurement uses robust tools and methodologies to collect information about large complex health care delivery systems. The objective of the PM validation in the compliance process is to validate accuracy of Medicaid, CHIP and DSHP/DSHP Plus PMs reported by the MCOs to DMMA. The review process includes application of the CMS protocol entitled "Validating Performance Measures," which is aimed at assessing compliance with specifications for each PM.

The measures reviewed for 2020 were mandated by the State and used technical specifications developed as part of the State's Quality Care Management Monitoring Report and CMS Adult and Pediatric Core Measure reporting. To validate the PMs, Mercer referenced the annual compliance review and Information Systems Capabilities Assessment Request for Information responses with supporting documentation. During onsite meetings, Mercer led discussions about data management processes, report generation, data validation, and data submission. After all audit elements were assessed, a validation finding for each measure was determined based on the magnitude of errors detected in the review. The following table summarizes the scale used to evaluate performance measure compliance.

Table 17. Performance Measure Validation Scoring Scale

Validation Evaluation	EQR Report Score
Fully compliant	★★★★★
Substantially compliant	★★★
Not compliant	★★

The following table shows a breakdown of PMs that were validated for 2020:

Table 18. Performance Measures Validated

Measure Description	Reporting Frequency	Reporting Format
Chlamydia Screening in Women	Annual	CMS Core Measure
Prenatal and postpartum care (timeliness of prenatal care)	Annual	CMS Core Measure
HIV Viral Load Suppression	Annual	CMS Core Measure

Table 18. Performance Measures Validated		
Measure Description	**Reporting Frequency**	**Reporting Format**
Developmental Screening in the First 3 Years of Life	Annual	CMS Core Measure
Access — timely appointments Maternity 3rd trimester	Quarterly	Quality and Care Management Measurement Reporting Templates (QCMMR)
Case Management Reassessments	Monthly	QCMMR

Validation of Performance Measure Assessment

The validation process reveals that both MCO A's and MCO B's reported performance measurement was fully compliant. The following table shows a side-by-side comparison of the results for both MCOs:

Table 19. Performance Measure Validation Ratings		
Measure Description	**MCO A**	**MCO B**
Chlamydia Screening in Women	★★★★★	★★★★★
Prenatal and postpartum care (timeliness of prenatal care)	★★★★★	★★★★★
HIV Viral Load Suppression	★★★★★	★★★★★
Developmental Screening in the First 3 Years of Life	★★★★★	★★★★★
Access — timely appointments Maternity 3rd trimester	★★★	★★★★★
Case Management Reassessments	★★	★★★★★

6

Performance Improvement Projects

Validation of Performance Improvement Projects

The CMS regulations require each state MCO to establish PIPs as part of their quality assurance program. These PIPs, which are validated using the CMS Protocol, are intended to evaluate and improve upon the processes and outcomes associated with specified health care targets. DMMA has mandated that each MCO conduct three PIPs. The State selected all three PIPs for independent validation by the EQRO during the 2020 compliance review cycle. The first PIP was a State-mandated study topic and study question. The second PIP was a State-mandated topic, but MCO-developed study questions. The third required PIP allows for a topic selected by the individual MCO that is relevant to its population and approved by DMMA as relevant to the needs of Delaware's Medicaid and CHIP populations. Table 20 below includes the study topics validated and confidence in the reported results.

Table 20. PIP Validation Score

Measure Description	MCO A Confidence in Reported Results	MCO B Confidence in Reported Results
Oral health for DSHP Plus long term services and supports membership	Moderate	Low
ADHD clinical practice guidelines, medication and therapy	High	
Benzodiazepines and Opioids concomitant use	High	
Physical Health and Behavioral Health Care Coordination		Moderate
Pediatric Lead Screening		Moderate

Assessment for MCO A

Throughout 2018, there was a significant investment by DMMA in technical assistance to MCO A to ensure there was a solid foundation for assessment of the baseline year of the PIPs at the time of the 2019 EQR. This foundation is critical to ensure rapid cycle analysis can be performed during the initial year of interventions and barrier analysis to drive improvement from the baseline. In 2019, the PIPs

were clearly written, detailed and aligned with identified population health concerns. Given the technical assistance sessions and the desk review assessment of compliance with expectations, the majority of the onsite discussion was focused on the initial interventions developed, the barrier analysis completed to date and baseline results. The EQR evaluation demonstrated a high degree of confidence in the foundational steps.

DMMA has mandated that each MCO conduct a minimum of five PIPs covering specific topics; MCO A has not met the minimum requirements for PIPs based on the Delaware Quality Strategy as of the 2020 EQR. As an essential component of a MCO's quality program to identify, assess, and monitor improvement in processes or outcomes of care, MCO A should assess opportunities across the spectrum of the organization and business units to identify and implement PIPs.

Assessment for MCO B

Throughout 2015, there was a significant investment by DMMA in technical assistance to MCO B to ensure there was a solid foundation for assessment of the baseline year of the PIPs at the time of the 2016 EQR. In 2016, the EQR reported that the PIPs were clearly written, detailed and aligned with identified population health concerns. At that time the EQR evaluation demonstrated a high degree of confidence in the foundational steps. In 2017, the EQR evaluation indicated only moderate confidence in the PIPs. These results were based on challenges with data collection, system changes that impeded accurate reporting of data, as well as limited barrier analysis, delayed implementation of interventions and lack of consistent rapid cycle analysis. In 2018 the EQRO reported there was not the significant improvement the EQRO anticipated in process and results for the PIPs.

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

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

Any issues identified with the PIP documentation or the MCOs ability to demonstrate continual improvement efforts require a CAP. The State reviews and approves all CAPs and monitors those actions plans to ensure that all identified issues are corrected. As a result, MCO's must submit quarterly progress updates to the State outlining their movement towards achieving desired outcomes.

7

Conclusion

The summary results of the EQR as presented above indicate that the MCOs in Delaware are deficient in meeting expectations to improve timely access to care, to improve the quality of care, to control the growth of healthcare expenditures while ensuring members are satisfied with services as outlined in the QS.

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

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

DMMA will continue working collaboratively with the MCOs as they implement activities towards continuous quality improvement.

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