DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group
Interim Evaluation Report Approval Letter

April 15, 2024

Andrew Wilson
State Medicaid Director
Division of Medicaid and Medical Assistance
1901 N. DuPont Highway, Lewis Bldg.
New Castle, Delaware 19720

Dear Director Wilson:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Interim Evaluation Reports, which are required by the Special Terms and Conditions (STCs), specifically STC #98 "Interim Evaluation Report" of the state's section 1115 demonstration, "Delaware Diamond State Health Plan" (Project No: 11-W-00036/4), effective through December 31, 2024. One of the reports focused on the demonstration's substance use disorder (SUD) component while the other report covered the non-SUD components of the demonstration. The Interim Evaluation Reports cover the period from August 2019 through December 2021. CMS determined that the Evaluation Reports, submitted on December 22, 2022 and revised on July 18, 2023 and March 17, 2024, are in alignment with the CMS-approved Evaluation Design and the requirements set forth in the STCs, and therefore, approves the state's Interim Evaluation Reports.

The Delaware Diamond State Health Plan (DSHP) section 1115 demonstration aimed to improve access to and quality of health care, rebalance long-term service supports, improve coordination of care, improve overall health status and quality of life, increase overall coverage for former foster care youth, and increase access and utilization of appropriate SUD treatment. The Interim Evaluation Reports provided evidence that the state has made progress in achieving some of its demonstration goals. The SUD component found improvements related to care coordination after hospital admission and reductions in the rate of emergency department (ED) use, inpatient visits, and readmissions for SUD beneficiaries during the evaluation period. However, the SUD component also showed that overdose deaths increased during this timeframe. Through descriptive and trend analysis, the non-SUD component of the DSHP demonstration found that continuity of enrollment and satisfaction with care improved, and the proportion of individuals who reported that they could not see a doctor due to cost decreased during the evaluation period. We look forward to further analysis of the DSHP demonstration as the state continues to refine the program.

In accordance with 42 CFR 431.424(d), the approved Interim Evaluation Reports may now be posted to the state's Medicaid website within 30 days. CMS will also post the Interim Evaluation Reports on Medicaid.gov.

We look forward to our continued partnership on Delaware's Diamond State Health Plan section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S

Digitally signed by Danielle Daly -S
Date: 2024.04.15 04:55:40 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Nicole Guess, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Medicaid & Medical Assistance

Interim Evaluation of Delaware's Section 1115 Diamond State Health Plan Demonstration for the Period August 1, 2019 to December 31, 2023

JULY 18, 2023

HMA

HEALTH MANAGEMENT ASSOCIATES

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SECTION A: Executive Summary

Delaware's Diamond State Health Plan demonstration was approved for the period August 1, 2019 through December 31, 2023. This demonstration was originally approved in 1995. Prior to this most recent approval, the demonstration has been renewed five times. Over the years, additional programs have been added to the original demonstration which focused on the implementation of a statewide managed care delivery model. There are 12 goals which reflect the variety of initiatives that the Delaware Division of Medicaid and Medical Assistance (DMMA) aims to achieve in the current demonstration period, including the following:

1. Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to home and community-based services (HCBS);
2. Rebalancing Delaware's LTC system in favor of HCBS;
3. Promoting early intervention for individuals with, or at-risk, for having, LTC needs;
4. Increasing coordination of care and supports;
5. Expanding consumer choices;
6. Improving the quality of health services, including LTC services, delivered to all Delawareans;
7. Creating a payment structure that provides incentives for resources to shift from institutions to community-based long-term care services and supports (LTSS) services where appropriate;
8. Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles;
9. Improving overall health status and quality of life of individuals enrolled in Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE);
10. Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population; and
11. Increasing enrollee access and utilization of appropriate substance use disorder (SUD) treatment services; decrease use of medically inappropriate and avoidable high-cost emergency and hospital services; increase initiation of follow-up SUD treatment after emergency department discharge; and reduce SUD readmission rates.
12. Increasing access to dental services; decrease the percent of emergency department visits for non-traumatic dental conditions in adults; increase follow up with dentists after an emergency department visit for non-traumatic dental conditions in adults; and increase the number of adults with diabetes who receive an oral exam annually.

Population Impacted by the Demonstration

At the end of Calendar Year (CY) 2021, total Medicaid enrollment in Delaware was 292,548, or 29 percent of the total state population (July 2021 Census). By the end of CY 2021, 88 percent of eligibles were enrolled in managed care. Total enrollment has grown by 17.8 percent since the start of the public health emergency (PHE) at the end of Q1-2020. The composition of Medicaid enrollees by age at the end of CY 2021 was 39 percent age 18 and younger, 54 percent age 19 to 64, and seven percent over age 65.

Evaluation Questions and Hypotheses

Burns & Associates, a Division of Health Management Associates (HMA-Burns) is serving as the Independent Evaluator for this demonstration. HMA-Burns created 13 evaluation questions and ten hypotheses to assess the impact that the demonstration has on the four principle policy objectives of the demonstration.

1. Maintain Continuity of Enrollment
2. Maintain Access to Care,
3. Maintain or Improve Health Outcomes, and
4. Rebalance LTSS in favor of HCBS.

At least one research question and one hypothesis is mapped to each of the 12 demonstration goals. As a means to answer the research questions posed, the results of 65 measures are reported on in this evaluation.

Methodology

HMA-Burns developed an Evaluation Design Plan for this demonstration which was approved by CMS on April 2, 2021. The full Evaluation Design Plan, which appears in Appendix A, reflects a range of data sources, measures and perspectives. It defines the most appropriate study population and sub-populations and describes the analytic methods included in the evaluation design which include (1) descriptive statistics; (2) statistical tests; (3) onsite reviews; (4) desk reviews; and (5) facilitated interviews.

Target Population

The target population is any Delaware Medicaid beneficiary enrolled in the demonstration in the study period. HMA-Burns created flags to identify sub-populations within the demonstration population which include the following:

1. **Individuals assigned to DSHP:** Primarily includes children and their parents as well as childless adults who became eligible for Medicaid through expansion as a result of the ACA.
2. **Individuals assigned to DSHP Plus:** Includes the population eligible for enhanced long term services and supports delivered in community settings.
3. **Individuals assigned to PROMISE**: Includes the population with a serve and persistent mental illness who are eligible for enhanced services and supports delivered in community settings in order to live and work in integrated settings.
4. **Dual eligible**: Includes the population who meet criteria for being dually-eligible for both the Medicare and Medicaid population.
5. **Former Foster Care**: Includes the population of former foster care youth under age 26 who were in foster care while living in another state and enrolled in Medicaid but now live in Delaware.
6. **Pregnant**: Includes the population who meet the criteria for having a pregnancy.
7. **Age Stratification**: Includes age 18 and younger, age 19 to 64, and age 65 and older.
8. **County stratification**: Includes the stratification of members based on their home location in one of the three counties in Delaware: New Castle, Kent, or Sussex.
9. **MCO Stratification**: Includes the stratification of members based on the MCO that they are enrolled with.

Evaluation Period

Metrics for the demonstration population and sub-populations are computed for a pre- and post-demonstration period. The pre-demonstration period is defined as January 1, 2016 through December 31, 2018. The demonstration period is defined as January 1, 2019 through December 31, 2023. To simplify the analytic plan, HMA-Burns is counting the first seven months of 2019 (for monthly measures) and CY 2019 data (for annual measures) prior to the approval of the current demonstration period as part of the demonstration period.

Data Sources

The primary data source used to compute measures in this evaluation is service utilization reported on encounters, member enrollment, and provider enrollment files from the Delaware Medicaid Enterprise System (DMES). Other data sources include primary data collected by HMA-Burns from the MCOs for focus studies; primary data collected by DMMA from MCOs; secondary data published by other sources; and qualitative feedback collected from facilitated interviews.

Results

In Section F of this report, each of the 12 demonstration goals serves as a heading. Measures are reported for each goal as they relate to the research questions posed in the Evaluation Design Plan. At the start of each subsection, there is a summary table that lists each measure reviewed that was mapped to a research question under the demonstration goal. The table shows the desired outcome for each measure, if the desired outcome is being met in the demonstration period thus far, and if the results were found to be statistically significant (when testing for significance was conducted). The test used for statistical significance is also shown, where applicable.

After the summary table, each of the individual measures examined appears on its own one-page dashboard report. Information about the research question posed, the measure and measure steward, and the data source used to analyze the measure are provided.

A summary of the results of all 65 measures, by demonstration goal, appears in Exhibit 1 at the end of this section. For Goal #11 related to increasing access to SUD services, the detailed findings appear in the separate SUD Interim Evaluation. For Goal #12 related to access to adult dental services, the benefit was just introduced in October 2020, so the results from these measures serve as the baseline. Among the 65 measures, there were 40 measures where the desired outcome was met. Statistical tests were run for 28 of the 65 measures. Among these 28 measures, there are nine measures which have a statistically significant trend in the intended direction, nine measures which have a statistically significant trend in the wrong direction, and 10 measures where the trend was found not to be statistically significant.

Conclusions

Delaware did not meet all of the desired outcomes outright but still saw many positive impacts due to the demonstration.

1. **Maintain Continuity of Enrollment**

   Noteworthy positive impacts were found in the following areas:

- Medicaid enrollment increased over time overall and for most major enrollment categories.
- The percentage of members continuously enrolled has increased for all enrollment categories examined. For the Medicaid Expansion group, the increase was substantial.
- Enrollment duration in the year also increased across-the-board.

2. **Maintain Access to Care**

   Noteworthy positive impacts between CY 2018 and CY 2021 were found in the following areas:

   - Increase in the percentage of members ages three to six and among adolescents receiving well-care visits (for adolescents, a statistically significant improvement).
   - The rate of postpartum care saw a statistically significant increase from 34.2 percent in CY 2018 to 44.2 percent in CY 2021.
   - The rate of emergency department utilization decreased significantly from 65.2 visits per 1,000 in CY 2018 to 49.2 visits per 1,000 in CY 2021.
   - Follow-up after an emergency department visit for people with multiple high-risk chronic conditions improved significantly.
   - As a percentage of applications received, the rate of enrollment in the PROMISE program increased from 30 percent in CY 2018 to 43 percent in CY 2021.
   - The PROMISE provider network also increased from 318 to 377 providers, and the percent of PROMISE members receiving PROMISE services remained relatively steady.

3. **Maintain or Improve Health Outcomes**

   Noteworthy positive impacts between CY 2018 and CY 2021 were found in the following areas:

   - The rate of adherence to antidepressant medication management improved at both the 12 week and six month mark.
   - The medication adherence rate, expressed as the proportion of days covered, saw a statistically significant increase among the DSHP Plus population.
   - Member grievances and appeals remain very low when measured on a per 1,000 member month basis.
   - Among the DSHP Plus population, improvement was seen among all six LTSS CAHPS survey composite measures during the demonstration period thus far. The rate of critical incidents per 1,000 also decreased during the demonstration period.

4. **Rebalance LTSS in favor of HCBS**.

   Noteworthy positive impacts between CY 2018 and CY 2021 were found in the following areas:

   - The utilization rate of HCBS services among DSHP Plus members.
   - The PMPM expenditures for HCBS among DSHP Plus members increased 39 percent while the PMPM expenditures for institutional care decreased 16 percent.

- The proportion of spending between HCBS and institutional care changed from a mix of 25 percent/75 percent in CY 2018 to 35 percent/65 percent in CY 2021.

The PHE likely had a confounding effect in enabling Delaware to fully meet these aims during the demonstration period. While some measures were found to remain steady between the pre-demonstration and initial years of the demonstration, other measures had results that trended in the opposite direction from what was desired. Areas in which the evaluators will focus on assessing improvement in the remainder of this demonstration period include the following:

- Well-child visits in the first 15 months of life
- Breast cancer screenings
- Adults' access to preventive and ambulatory health services
- Access to primary care and dental visits among the former foster care population
- All-cause hospital readmission rates for the DSHP Plus population
- Emergency department visits for the PROMISE population
- Follow-up visits from the emergency department related to alcohol or other drug dependence and for mental health issues for the entire population
- Initiation and engagement rates for alcohol and other drug dependence among the PROMISE population

Assessment of Opportunities for Improvement

Delaware has seen progress towards its goals related to rebalancing LTC in favor of HCBS, maintaining continuity of enrollment, and maintaining access to care thus far in this demonstration period. There are other goals where progress has yet to be seen in any meaningful way. The HMA-Burns evaluation team has identified opportunities for the DMMA to consider for continued improvement during the remainder of this demonstration period which focus on:

1. Developing performance improvement projects (PIPs) specific to improving follow-up after emergency department or hospitalization for mental illness or for alcohol and other drug dependence.
2. Enhancing managed care reporting that will allow for assessing the effectiveness of case management by tying enrollment by the member in case management with specific access or health outcomes.
3. Continuing the rate study of mental health services and considering value-based payment alternatives for providers serving the PROMISE population in particular.
4. Consider including the services specific to the PROMISE program under the responsibility of the MCOs. Or, at minimum, strengthen the oversight of the coordination of care requirements between the MCO's case manager for acute care services and the state's PROMISE care manager for PROMISE services.

Exhibit 1
Summary of Measures Examined by Demonstration Goal

	Waiver Goals	Total Measures	Measures with Results Trending in the Intended Direction	Measures with Results Trending in the Wrong Direction	Total Measures Where Tests Were Run for Statistical Significance	Of these, the Total Where Trend in Intended Direction and Statistically Significant	Of these, the Total Where Trends in Wrong Direction and Statistically Significant	Of these, the Total Where There Was No Statistically Significant Change
	MEASURES FOR GOALS #1 - #10	**60**	**40**	**20**	**28**	**9**	**9**	**10**
1	Improve access to health care for the Medicaid population	14	10	4	7	3	3	1
2	Rebalance Delaware's LTC system in favor of HCBS	4	4	0	2	2	0	0
3	Promote early intervention for individuals with, or at risk, for having LTC needs	4	2	2	4	1	2	1
4	Increase coordination of care and supports	7	4	3	7	2	2	3
5	Expand consumer choices	8	5	3	0	0	0	0
6	Improve the quality of health services, including LTC services, delivered to all Delawareans	7	7	0	0	0	0	0
7	Create a payment structure that provides incentives for resources to shift from institutions to community-based long-term services and supports	0						
8	Improve coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles	3	3	0	3	1	0	2
9	Improve overall health status and quality of life of individuals enrolled in PROMISE	10	4	6	5	0	2	3
10	Increase and strengthen overall coverage of former foster care youth to improve health outcomes	3	1	2	0	0	0	0
11	Increase enrollee access and utilization of appropriate SUD treatment services	29	Results are shown in the SUD Independent Evaluation report.					
12	Increase access to dental services; decrease adult ED visits for non-traumatic conditions	5	CY2021 is the baseline year for the results for each measure.					

SECTION B: General Background Information

Description of the Demonstration's Policy Goals

Delaware's goals in operating the demonstration are to improve the health status of low-income Delawareans by:

1. Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to home and community-based services (HCBS);
2. Rebalancing Delaware's LTC system in favor of HCBS;
3. Promoting early intervention for individuals with, or at-risk, for having, LTC needs;
4. Increasing coordination of care and supports;
5. Expanding consumer choices;
6. Improving the quality of health services, including LTC services, delivered to all Delawareans;
7. Creating a payment structure that provides incentives for resources to shift from institutions to community-based long-term care services and supports (LTSS) services where appropriate;
8. Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles;
9. Improving overall health status and quality of life of individuals enrolled in Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE);
10. Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population; and
11. Increasing enrollee access and utilization of appropriate substance use disorder (SUD) treatment services; decrease use of medically inappropriate and avoidable high-cost emergency and hospital services; increase initiation of follow-up SUD treatment after emergency department discharge; and reduce SUD readmission rates.
12. Increasing access to dental services; decrease the percent of emergency department visits for non-traumatic dental conditions in adults; increase follow up with dentists after an emergency department visit for non-traumatic dental conditions in adults; and increase the number of adults with diabetes who receive an oral exam annually.

The approved waiver has five demonstration components:

1. The Diamond State Health Plan (DSHP) DSHP Medicaid managed care program provides Medicaid state plan benefits through a comprehensive managed care delivery system to most recipients eligible under the state plan.
2. The DSHP Plus program provides LTSS to certain individuals under the State Plan and to certain demonstration populations.

3. The PROMISE program provides enhanced behavioral health services fee-for-service (FFS) to Medicaid beneficiaries with a higher level of behavioral health needs and functional limitations who need HCBS to live and work in integrated settings.

4. Coverage for former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care at age 18 (or such higher age as elected by the state), were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid.

5. Coverage for high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as institutions for mental disease (IMDs). Note that the evaluation of this component is addressed in a separate Interim Evaluation specific to SUD.

Demonstration Name, Approval Date, and Time Period of Data Analyzed in the Assessment

Name: Delaware Diamond State Health Plan

Project Number: 11-W-00036/4

Approval Date: July 31, 2019, amended effective January 19, 2021

Time Period Covered by Evaluation: Demonstration extension from August 1, 2019 through December 31, 2023.

Brief Description and History of Implementation

Delaware's Diamond State Health Plan 1115 Demonstration Waiver was initially approved in 1995 and implemented beginning on January 1, 1996. The original goal of the demonstration was to:

1. Improve the health status of low-income Delawareans by expanding access to healthcare to more individuals throughout the State;
2. Create and maintain a managed care delivery system with an emphasis on primary care; and
3. Control the growth of healthcare expenditures for the Medicaid population.

The DSHP 1115 Demonstration was designed to mandatorily enroll eligible Medicaid recipients into managed care organizations (MCOs) and to create cost efficiencies in the Medicaid program that could be used to expand coverage. Delaware invested savings from the demonstration into expanding Medicaid eligibility coverage expansion to uninsured adults up to 100 percent of the federal poverty level (FPL). Long before Medicaid expansion under the Affordable Care Act, Delaware was a pioneer in coverage expansion for individuals who would otherwise not be eligible for Medicaid. Delaware built upon this success with the eventual expansion of coverage for family planning services, leading up to participating in Medicaid expansion under the Affordable Care Act (ACA) in 2014.

Prior to the most recent demonstration renewal, this demonstration has been renewed five times. The demonstration is administered by Delaware's Division of Medicaid and Medical Assistance (DMMA).

Through an amendment approved by CMS in 2012, Delaware was authorized to the create the Diamond State Health Plan Plus (DSHP Plus), which is Delaware's managed long-term services and supports

(MLTSS) program. This amendment required additional state plan populations to receive services through MCOs. Additionally, this amendment expanded HCBS to include: (1) cost-effective and medically necessary home modifications; (2) chore services; and (3) home delivered meals.

The demonstration renewal in September 2013 extended expansion to low-income adults up to 100 percent of the FPL until December 31, 2013. After that date, the demonstration population was not necessary because it was included under the approved state plan as the new adult eligibility group authorized under the ACA (with incomes up to 133 percent of the FPL).

In 2014, the demonstration was amended to authorize coverage for enhanced behavioral health services and supports for targeted Medicaid beneficiaries through a voluntary program called PROMISE starting in 2015. PROMISE enrollees include Medicaid beneficiaries who have a severe and persistent mental illness (SPMI) and/or a SUD and require HCBS to live and work in integrated settings.

Technical changes were incorporated into the demonstration in October 2017 and an amendment was approved in December 2017 to add coverage for out-of-state former foster care youth.

In June 2018, Delaware submitted a five-year demonstration extension and an amendment to provide the state with authority to provide high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an IMD. The demonstration was amended again effective January 19, 2021 to add adult dental services to the services administered by the state's managed care system.

As much of the demonstration period occurred during the PHE, policy implementation was primarily focused on making PHE related changes to improve access to services, primarily through enhanced telehealth services and relaxation of certain prior authorization requirements. However, DMMA undertook other initiatives that had a direct impact on the demonstration.

- DMMA issued a Request for Proposals to procure MCOs in December 2021 and announced notices of award in July 2022. The effective date of the new contract is January 1, 2023. The notice was to award to the two incumbent MCOs as well as a new third MCO. In addition to the change in the number of MCOs, the new model contract has components that have been added or strengthened from the current contract, most notably related to care coordination and case management and the requirement by the MCOs to develop value-based purchasing agreements with providers.
- Under Appendix K authority, DMMA provided additional home-delivered meals to vulnerable clients served in the DSHP Plus HCBS program.
- With the continuation of the PHE, DMMA focused on addressing food insecurity through its Postpartum Food Box Partnership program to deliver meals to members who are less than eight weeks postpartum and delivered via cesarean section.
- DMMA was awarded a SUPPORT Act planning grant to assess and expand capacity to treat substance use disorder (SUD) in Medicaid.
- DMMA developed a Medicaid accountable care organization (ACO) program for the purposes of improving health outcomes while reducing costs through value based purchasing arrangements. Four health care provider groups were authorized as ACOs in September 2020. The ACOs are

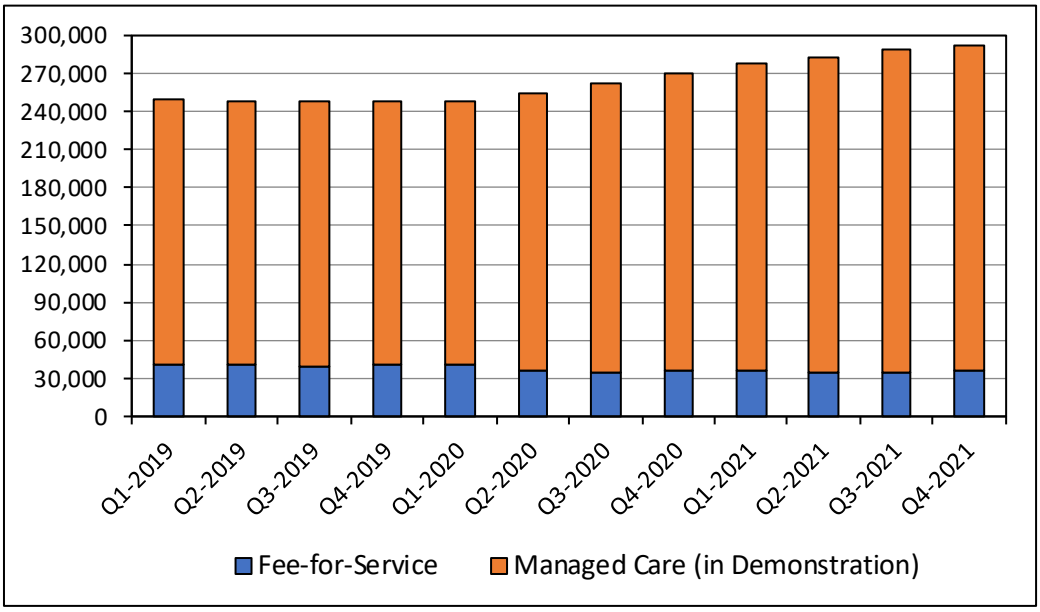
authorized to contract directly with each MCO under contract with the DMMA, provided that the ACO has participation from at least 5,000 Medicaid enrollees.

As each of these initiatives are relatively new, it was not possible to attribute any specific initiative to the observations in the Interim Evaluation. To the extent that sufficient and relevant data is available, the Summative Evaluation will provide additional details on these factors that contribute to statistically significant trends.

Population Groups Impacted by the Demonstration

At the end of Calendar Year (CY) 2021, total Medicaid enrollment in Delaware was 292,548, or 29 percent of the total state population (July 2021 Census). By the end of CY 2021, 88 percent of eligibles were enrolled in managed care. Total enrollment has grown by 17.8 percent since the start of the public health emergency (PHE) at the end of Q1-2020.

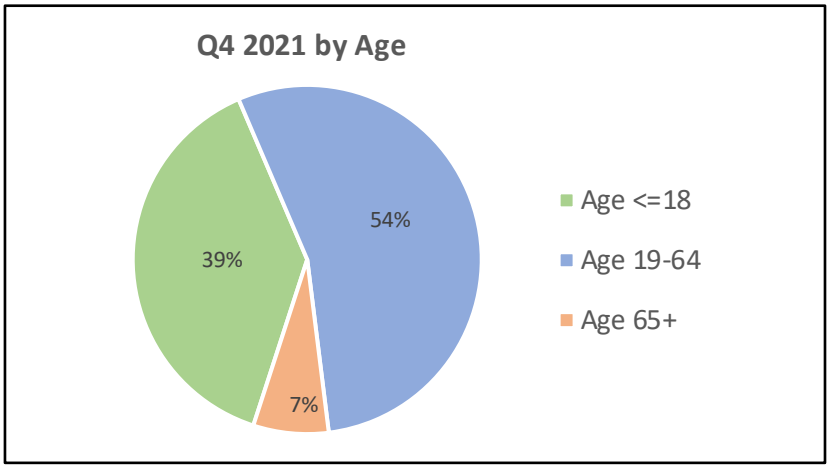
Exhibit 2
Medicaid Enrollees, by Quarter, CY 2019 - CY 2021

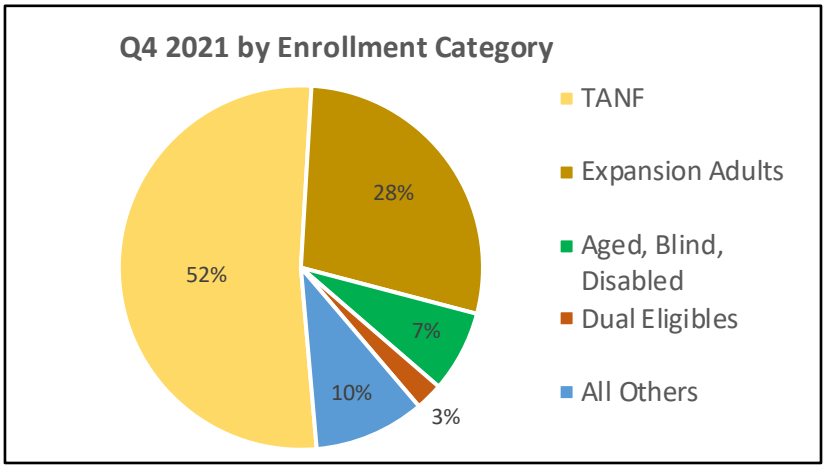


As of the fourth quarter of CY2021, 39 percent of Medicaid enrollees were children and adolescents, 54 percent were non-elderly adults, and seven percent were elderly. When viewed by enrollment category, just over half of the enrollees are TANF (Temporary Assistance for Needy Families) eligibles, or children with their parents. Another 28 percent of enrollees are childless adults that became eligible through the Affordable Care Act. Seven percent are in the aged, blind, and disabled category. Three percent of enrollees are dually eligible for both Medicare and Medicaid. The remaining ten percent of enrollees fall into various other small enrollment categories.

Exhibit 3
Profile of Medicaid Enrollees, 4th Quarter CY2021

Total Average Medicaid Enrollment in Q4 2021: 292,816





SECTION C: Evaluation Questions and Hypotheses

Defining Relationships: Aims, Primary Drivers and Secondary Drivers

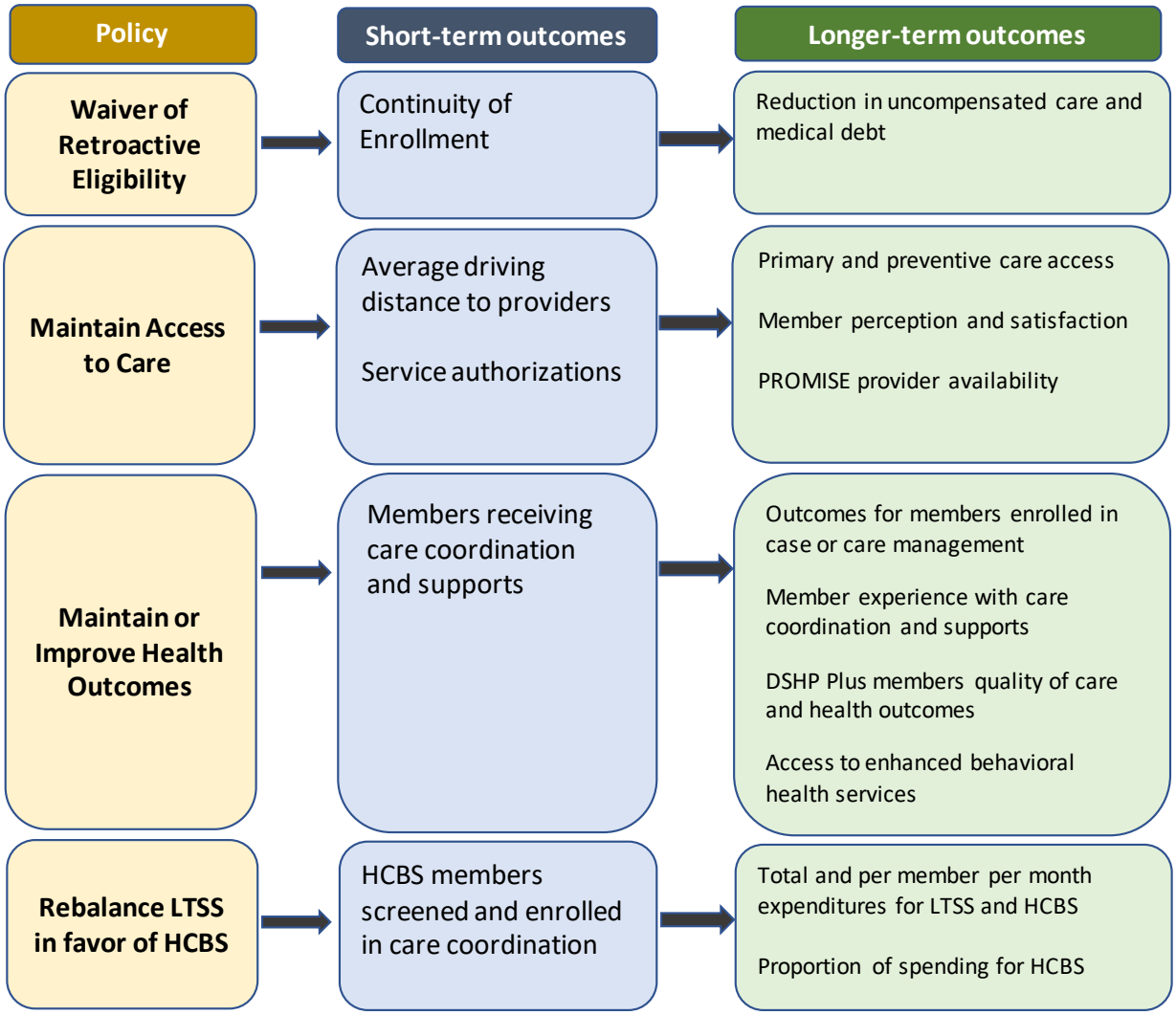
Burns & Associates, a Division of Health Management Associates (HMA-Burns) is serving as the Independent Evaluator for this demonstration. HMA-Burns constructed logic models delineating short-term and long-term outcomes associated with the four principle policy objectives of the demonstration.

1. Maintain Continuity of Enrollment
2. Maintain Access to Care,
3. Maintain or Improve Health Outcomes, and
4. Rebalance LTSS in favor of HCBS.

The determination of whether an outcome is short-term or long-term is dependent on the measure specifications and the data needed to adequately assess trends with the waiver policy. For example, because national outcome measures tend to have annual measurement periods, they are considered in this evaluation to be longer-term indicators of policy outcomes. Each logic model is tied to specific hypotheses and research questions that were outlined in the Evaluation Design Plan.

Exhibit 4 summarizes the logic models as shown in the Evaluation Design Plan.

Exhibit 4
Logic Models Developed in Demonstration Evaluation Design Plan



Hypotheses and Research Questions

HMA-Burns converted the logic models shown into a series of hypotheses and research questions. For each research question, measures were assigned as well as a targeted methodology. Exhibit 5 on the next page lists the hypotheses, the research questions, and the demonstration goals that each hypothesis is mapped to.

Exhibit 5
Mapping Hypotheses and Research Questions to Demonstration Goals

Hypothesis	Research Questions	Demonstration Goal(s)
#1: Trends in continuity of enrollment continue (or does not worsen) for Medicaid populations subject to the waiver of retroactive eligibility in the current waiver period.	Does the waiver of retroactive eligibility continue (or does not worsen) the continuity of enrollment in Medicaid in the current waiver period?	1, 10
#2: The waiver of retroactive eligibility will continue or not worsen trends in uncompensated care or medical debt in the current waiver period.	Does the waiver of retroactive eligibility continue or not worsen trends in the incidence of uncompensated care or not seeing a doctor because of cost in the current waiver period?	1
#3: Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current waiver period.	Does the level and trend of access to primary and preventive care continue (or not worsen) in the current waiver period? Do service authorizations provide an effective tool in the appropriate utilization of health care services in the current waiver period?	1, 10
#4: Trends in coordination of care and supports continues (or does not worsen) in the current waiver period.	Does the proportion of members receiving care coordination and supports continue (or not worsen) in the current waiver period?	4, 8
#5: Coordination of care and supports maintains or improves quality of care and health outcomes in the current waiver period.	Do DSHP members enrolled in case/care management achieve similar or improved quality of care and health outcomes in the waiver period? Do DSHP Plus members enrolled in case/care management achieve similar or improved quality of care and health outcomes in the waiver period? Do PROMISE members enrolled in case/care management achieve similar or improved quality of care and health outcomes in the waiver period?	3, 4, 6, 8, 9
#6: Trends in consumer satisfaction will continue (or not worsen) in the current waiver period.	Does the level of satisfaction among DSHP members continue (or not worsen) in the current waiver period?	5
#7: Creating a delivery system that provides incentives for resources to shift from institutions to community-based LTSS has maintained or increased utilization of HCBS services where appropriate in the current waiver period.	Has the rebalancing of long-term care services and supports maintained or moved more toward home- and community-based services and away from institutional services in the current waiver period?	2, 7
#8: Trends in health outcomes will continue or improve in the current waiver period for individuals enrolled in the PROMISE program.	Does the level and trend of access to enhanced behavioral health services continue (or not worsen) in the current waiver period?	9
#9: The PROMISE program network capacity will continue (or not worsen) in the current waiver period.	Does the availability of PROMISE providers continue (or not worsen) in the current waiver period?	1
#10: The availability of the adult dental benefit will improve access to dental services and will continue (or not worsen) health outcomes in the current waiver period.	Does the availability of the adult dental benefit increase access to dental services and lead to continued (or not worsen) health outcomes in the current waiver period?	12

SECTION D: Methodology Used in Assessment

Evaluation Design

The evaluation is conducted on Medicaid beneficiaries during the pre- and post-demonstration period. The approved Evaluation Design Plan is a mixed-methods approach, drawing from a range of data sources, measures, and analytics to best produce relevant and actionable study findings. The approved Evaluation Design Plan reflects a range of data sources, measures and perspectives. It defines the most appropriate study population and sub-populations and describes the analytic methods included in the evaluation design. The Evaluation Design Plan approved by CMS on April 2, 2021 appears in Appendix A.

The five analytic methods used by the evaluators include:

1. descriptive statistics
2. statistical tests
3. onsite reviews,
4. desk reviews,
5. facilitated interviews.

Target and Comparison Population

The target population is any Delaware Medicaid beneficiary enrolled in the demonstration in the study period. HMA-Burns created flags to identify sub-populations within the demonstration population which include the following:

1. **Individuals assigned to DSHP:** Primarily includes children and their parents as well as childless adults who became eligible for Medicaid through expansion as a result of the ACA.
2. **Individuals assigned to DSHP Plus:** Includes the population eligible for enhanced long term services and supports delivered in community settings.
3. **Individuals assigned to PROMISE**: Includes the population with a serve and persistent mental illness who are eligible for enhanced services and supports delivered in community settings in order to live and work in integrated settings.
4. **Dual eligible**: Includes the population who meet criteria for being dually-eligible for both the Medicare and Medicaid population.
5. **Former Foster Care**: Includes the population of former foster care youth under age 26 who were in foster care while living in another state and enrolled in Medicaid but now live in Delaware.
6. **Pregnant**: Includes the population who meet the criteria for having a pregnancy.
7. **Age Stratification**: Includes age 18 and younger, age 19 to 64, and age 65 and older.
8. **County stratification**: Includes the stratification of members based on their home location in one of the three counties in Delaware: New Castle, Kent, or Sussex.
9. **MCO Stratification**: Includes the stratification of members based on the MCO that they are enrolled with.

For the Summative Evaluation, HMA-Burns will consider computing subgroup analyses for both race/ethnicity and urbanicity for select metrics for inclusion in the report, and they will be examined further to determine appropriate breakouts based on adequate representation of selected subgroup populations.

Evaluation Period

Metrics for the demonstration population and sub-populations are computed for a pre- and post-demonstration period. The pre-demonstration period is defined as follows:

- For monthly measures, enrollment or dates of service from January 1, 2016 through December 31, 2018.
- For annual measures, enrollment or dates of services during Calendar Years 2016, 2017, and 2018.

The demonstration period is defined as follows:

- For monthly measures, enrollment or dates of service from January 1, 2019 through December 31, 2023.
- For annual measures, enrollment or dates of services during Calendar Years 2019, 2020, 2021, 2022, and 2023

To simplify the analytic plan, HMA-Burns is counting the first seven months of 2019 (for monthly measures) and CY 2019 data (for annual measures) prior to the approval of the current demonstration period as part of the demonstration period. Although CMS approved Delaware's 1115 waiver in July 2019, waiver-related activities were moving forward in anticipation of approval of the extension.

Evaluation Measures

HMA-Burns is reporting on 65 measures, each of which has been mapped to a demonstration goal. The measures that have been analyzed in this Interim Evaluation utilize a number of measure stewards, including the National Committee on Quality Assurance's (NCQA's) HEDIS®[1] measures, the Agency for Healthcare Research and Quality (e.g., CAHPS survey measures), and the Dental Quality Alliance. The HMA-Burns team has also defined measures that are specific to Delaware's demonstration goals. It should be noted that Demonstration Goal #12 relates to the expansion of adult dental services. Because this coverage did not begin until October 2020, the results of the five measures associated with this goal serve as the baseline period in this evaluation. A summary of these measures, by demonstration goal, appears in Exhibit 6 on the next page.

[1] The Healthcare Effectiveness Data and Information Set (HEDIS) is a registered trademark of the National Committee for Quality Assurance

Exhibit 6
Inventory of Measures Included in the Interim Evaluation, by Demonstration Goal

	Demonstration Goal	Measures Defined by NCQA	Measures Defined by HMA-Burns	Measures Defined by Others	Total Measures
	TOTAL	**23**	**26**	**16**	**65**
1	Improve access to health care for the Medicaid population	7	6	1	**14**
2	Rebalance Delaware's LTC system in favor of HCBS	0	4	0	**4**
3	Promote early intervention for individuals with, or at risk, of enhancing LTC needs	3	0	1	**4**
4	Increase coordination of care and supports	6	1	0	**7**
5	Expand consumer choices	0	2	6	**8**
6	Improve the quality of health services, including LTC services, delivered to all Delawareans	0	1	6	**7**
7	Create a payment structure that provides incentives for resources to shift to institutions to community for LTSS	0	0	0	**0**
8	Improve coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles	2	1	0	**3**
9	Improve overall health status and quality of life on individuals enrolled in PROMISE	5	5	0	**10**
10	Increase and strengthen overall coverage of former foster care youth to improve health outcomes	0	3	0	**3**
11	Increase enrollee access and utilization of appropriate SUD treatment services	*Reported in the SUD Demonstration Interim Evaluation*			
12	Increase access to dental services; decrease adult ED visits for non-traumatic conditions	0	3	2	**5**

In Section F of the report, each measure is shown on a separate one-page summary of findings report. The measures are organized by demonstration goal. As an introduction to each goal, a summary exhibit is provided which lists out each measure, the desired outcome, if the outcome was met or not, and if the result was statistically significant. The test applied for statistical significance is also cited.

Data Sources

HMA-Burns proposed to use a number of data sources, including primary and secondary data, to conduct the evaluation. Most of these sources are included in this Interim Evaluation, but all sources will be reported in the Summative Evaluation. The data sources include the following:

- Service utilization reported on encounters with member and provider enrollment files from the Delaware Medicaid Enterprise System (DMES);
- Primary data collected by HMA-Burns from the MCOs for focus studies;
- Primary data collected by DMMA from MCOs;
- Secondary data published by other sources; and
- Qualitative feedback collected from facilitated interviews.

For each measure that where results are reported in Section F of this report, the data source is DMES unless specifically noted. The HMA-Burns team receives utilization, member enrollment, and provider enrollment files from the DMES on a monthly basis in order to track and trend measures over the course of the demonstration period. The data is validated by the HMA-Burns team upon intake and trended against information received in prior months across multiple dimensions. The HMA-Burns team has built a comprehensive database that incorporates utilization and enrollment data going back to CY 2017 up to the present.

Although managed care encounters are the primary source for computing measures, other measures use combination of encounters, member enrollment, and provider enrollment files. An example of this is the HMA-Burns measure to track the average distance travelled by adult Medicaid members to preventive services. HMA-Burns joined data on encounters with the Medicaid member enrollment file to map the physical location where providers render services and the home address of individual Medicaid beneficiaries. Driving distance was computed for each trip using external software.

For other measures defined by HMA-Burns, the evaluators used primary data collected from MCOs for Medicaid beneficiaries enrolled in managed care. This was completed for the analysis of populations enrolled in the case management program offered at each MCO.

The DMMA requires its MCOs to provide information on a variety of topics as a means to conduct oversight of the MCOs' operations. These data are reported to the DMMA in pre-defined report templates built in Microsoft Excel. HMA-Burns used information from some of these reports to analyze trends in areas such as member grievances and appeals as well as critical incidents.

Other secondary sources were used for selected measures. Examples include information from DMMA's eligibility database, information on applications to the PROMISE program from the Division of Substance Abuse and Mental Health (DSAMH), results from Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, results from Behavioral Risk Factor Surveillance System (BRFSS) surveys.

Qualitative feedback was collected through interviews with the MCOs, but this feedback was specific to the delivery of substance use disorder services and reported on in the SUD Mid-Point Assessment and Interim Evaluation. For the Summative Evaluation, facilitated interviews will be conducted with LTSS providers, PROMISE providers, and beneficiaries of HCBS services and adult dental services.

Analytic Methods

Descriptive Statistics

For utilization-focused measures, HMA-Burns computed as a rate expressed either as a percentage of the total eligible population, on a utilization per 1,000 member basis, or on a per member per month cost basis. The numerator and denominator values are provided to show how the rate was computed. For this Interim Evaluation, for annual measures, results are shown for the four years CY 2018 through CY 2021. The baseline period is defined as CY 2018. The comparison year for the demonstration period is defined as CY 2021. The rate of change between the baseline and most recent demonstration period is shown.

Statistical Tests

Among the 65 measures examined, tests of significance were run on 28 measures. The test that was applied to assess statistical significance was either t-test or chi-square. For the Summative Evaluation, interrupted time series will be used to assess significance on all measures where t-test was applied in the Interim Evaluation and for many of the measures where chi-square was applied as well.

Onsite Reviews and Desk Reviews

For this Interim Evaluation, desk reviews were completed in lieu of onsite reviews with the MCOs due to the ongoing PHE. HMA-Burns read in data from each MCO using templates that were designed specifically for this evaluation. Data from each MCO was summarized and validated, where necessary, with each MCO individually to ensure that the data reported by the MCO was complete. For the specific focus study of service authorizations of SUD services (discussed in more depth in the SUD Interim Evaluation), the HMA-Burns team reviewed individual authorization records in the software used by each MCO via Zoom meetings in lieu of conducting an onsite review of the sample of records.

Facilitated Interviews

Two members of the HMA-Burns evaluation team conducted an interview session with representatives from both MCOs that contract with DMMA in October 2021. The MCOs were given the questions intended for the facilitated discussion in advance of the interview and were asked to include representatives from their organization that are familiar with SUD service authorization requests, care/case management, provider relations, finance, and contract compliance. Both MCOs complied with this request. The actual session was conducted via Zoom and was 90 minutes in length. There was equal participation and feedback from the representatives from both MCOs.

Separately, the HMA-Burns team members who conducted the MCO interview also conducted interviews with individual SUD providers. All of the feedback was collected through in-person interviews that were conducted remotely via Zoom that were 60 to 90 minutes in duration. Ultimately, five provider organizations agreed to participate as well as a sixth interview with staff from the Ability Network of Delaware (a provider association). An interview guide was sent to each provider in advance of the meeting to guide the topics that would be covered, but the providers were encouraged to provide feedback on any other topic important to them as well.

Once all interviews were completed, this feedback was categorized into themes. In total, 15 themes resonated with MCO and provider stakeholders. This feedback was included in the SUD Mid-Point Assessment and the SUD Interim Evaluation.

HMA-Burns will use a similar method for the Summative Evaluation to obtain feedback specifically from providers of LTSS services and services covered in the PROMISE program. Individual provider sessions will be set using a guided interview format. In addition to the one-on-one provider interviews, HMA-Burns will release a short online survey that gives providers the ability to offer feedback in more time-efficient manner. The online survey will be constructed so that it can be completed in less than 15 minutes.

HMA-Burns will also conduct focused interviews with Medicaid beneficiaries prior to submission of the Summative Evaluation. The beneficiary interviews will be conducted in person. Although the intent was to conduct the in-person beneficiary interviews for the Interim Evaluation, the PHE posed a barrier to doing this. The targeted beneficiary interviews will be with individuals enrolled with DSHP Plus and PROMISE in order to learn more about their experience receiving the community-based services specific to these programs.

SECTION E: Methodological Limitations

Limitations

The HMA-Burns assessment team identified limitations when computing measures and interpreting measures as described in the Evaluation Design Plan. Although the limitations did not impact the computations of results for the time periods reported in this Interim Evaluation, there are limitations on how best to interpret the results that are being reported.

The HMA-Burns team did identify the following items that pose limitations in this evaluation:

1. *Public health emergency*. The obvious limitation in this evaluation is the impact on service utilization and provider supply during the public health emergency period. The current demonstration began just seven months prior to the start of the PHE. Delaware, like most states, saw atypical results during the early period of the PHE both positively (e.g., lower emergency department visits) and negatively (e.g., lower rates on measures related to access to services or follow-up services). For the Summative Evaluation, in addition to adding results from CYs 2022 and 2023 to the analysis, the HMA-Burns team will assess trends not only between the pre-demonstration and current demonstration periods, but also the pace at which utilization and access measures improve as the PHE winds down. In addition, HMA-Burns will account for the COVID-19 pandemic timeframe as CY 2020 and plans to define the baseline pre-waiver period as July 1, 2017 to July 31, 2019, and the post-waiver period as December 1, 2021 to December 31, 2023. This methodology will allow for an equal time period of 25 months of data to be used in interrupted time series models, without including CY 2020 in statistical modeling.

2. *Data limitations in DMES*. There are some limitations in the data as reported in DMMA's data warehouse in the pre-demonstration period of CY 2016 and CY 2017. Information is available for both utilization and enrollment statistics for each Medicaid beneficiary for these two years, but some of the variables that are used to segment the population into sub-populations are incomplete. Specifically, the assignment to a specific program (e.g. DSHP, DSHP Plus, or PROMISE) as well as the assignment to a specific MCO is not complete for each beneficiary. For this Interim Evaluation, therefore, results are shown for the years where this information is complete (CYs 2018 through 2021)) and to allow for equal time periods for statistical analyses while taking into consideration the impact of the public health emergency on utilization. For the Summative Evaluation, information will be reported using CY 2016 and CY 2017 where possible, but these results may need to be more at the overall demonstration population level and not at the sub-population level.

3. *Small sample size*. For some measures, the entire demonstration population studied was insufficient to use statistical power to detect a difference. HMA-Burns identifies the specific measures where this is a concern in Section F. In other situations, some of the sub-populations had a limited sample to conduct meaningful evaluation. For this Interim Evaluation, results are reported for the DSHP, DSHP Plus, and PROMISE populations discretely. But other sub-populations are not reported on but will be in the Summative Evaluation when more data is available for later in the PHE period and beyond the PHE (e.g., by age or by region).

4. *Exogenous factors may impact results*. Many of the outcome measures are multi-dimensional and influenced by social determinants of health. While changes in the demonstration period related to access to care may be one dimension of various outcomes of interest and may contribute to improvements, it may be difficult to achieve statistically significant findings in the absence of data on other contributing dimensions such as social determinants of health (e.g., housing, employment and previous incarcerations).

5. *Beneficiary feedback*. The PHE prohibited the preferred method of receiving Medicaid beneficiary feedback which is through one-on-one or small group interviews face-to-face. The evaluators will conduct face-to-face interviews with beneficiaries once the PHE has concluded and report beneficiary feedback in the Summative Evaluation.

6. *Provider and MCO feedback.* While the evaluation design envisioned collecting provider and MCO feedback as part of the focus studies, the PHE resulted in suspension of authorizations and disruptions to utilization, which eliminated the ability to collect meaningful data for the Interim Evaluation. The evaluators will conduct face-to-face interviews with LTSS providers and providers of PROMISE services, and the MCOs, once the PHE has concluded and will report provider and MCO feedback in the Summative Evaluation.

7. *Low utilization*. Additional select measures may not be reported due to inadequate utilization such as DOE-A-A (Adults with diabetes – oral evaluation). HMA-Burns is unable to compute (DOE-A-A) due to insufficient utilization specifically for dental CPT code 41899 (Dental Surgery Procedure) which is performed on an Outpatient claim type. CY 2021 dental claim activity was reviewed which confirmed the lack of data volume required to report this metric. Only 907 details were returned for CPT 41899 in CY 2021.

8. *Modifications to Approved Evaluation Design, Unable to Report*. Modifications to the approved evaluation design were driven largely by the pandemic and resulting programmatic and service delivery changes. As a result, the evaluators had insufficient data and were not able to be reported on in the Interim Evaluation. The evaluators will compute the measures, once the PHE has concluded, and will include them in the Summative Evaluation.
    - Research Question 2: Does the waiver of retroactive eligibility continue or not worsen trends in the incidence of uncompensated care or not seeing a doctor because of cost in the current waiver period?
        - Metric 2.2.3 Self-identified trends in medical debt for DSHP enrollees.
    - Research Question 4: Do service authorizations provide an effective tool in the appropriate utilization of health care services in the current waiver period?
        - Metric 4.3.1 Average turnaround time for authorization decisions
        - Metric 4.3.2 Rate of approved and denied authorizations
        - Metric 4.3.3 Frequency and percentage of denial reason codes
    - Research Question 5: Does the proportion of members receiving care coordination and supports continue (or not worsen) in the current waiver period)?
        - Metric 5.4.1 Rate of DSHP members with selected special health care needs screened for care coordination

    - Metric 5.4.2 Of those members with selected special health care needs screened, the number enrolled in care coordination
    - Metric 5.4.3 Duration of enrollment w/in case/care management
- Research Question 8: Has the rebalancing of long-term care services and supports maintained or moved more toward home- and community-based services and away from institutional services in the current waiver period?
    - Metric 8.7.5 Rate of members needing HCBS services screened for care coordination
    - Metric 8.7.6 Of those members needing HCBS services screened, the number enrolled in care coordination
    - Metric 8.7.7 Member experience with care coordination and supports

9. *Modifications to Approved Evaluation Design, Added Metrics*. Modifications to the approved evaluation design were driven largely by the pandemic and resulting programmatic and service delivery changes. To compensate for those metrics that could not be included in the Interim Evaluation, the evaluators added the following metrics, with the intention of adding them to the Summative Evaluation.
    - Research Question 3: Does the level and trend of access to primary and preventive care continue (or not worsen) in the current waiver period?
        - Percent of former foster care members with a primary care visit in the year
        - Percent of former foster care members with a dental visit in the year
        - Percent of former foster care members with a hospital emergency department visit in the year
    - Research Question 11: Do PROMISE members enrolled in case/care management achieve similar or improved quality of care and health outcomes in the current waiver period?
        - ED visits per 1,000 PROMISE population
        - ED Frequent Flyer Rate
        - Plan All-Cause Readmissions (PCR)
        - Antidepressant Medication Management (AMM)
    - Research Question 12: Does the availability of PROMISE providers continue (or not worsen) in the current waiver period?
        - Metric 12.9.1 Behavioral Health Providers per 1000 Members was refocused to Number of Providers Delivering PROMISE services per 1,000 PROMISE members as it is a better indicator of the availability of PROMISE providers to PROMISE enrollees.
        - Metric 12.9.2 HCBS providers per 1000 members by geographical region was replaced with Percent of PROMISE Members receiving PROMISE Services to examine if changes in PROMISE provider availability in Metric 12.9.1 impacts use of PROMISE services.

10. *Insufficient data available to assess impact of new initiatives on the demonstration.* While DMMA did undertake several initiatives during the demonstration period, it was not possible to attribute any specific initiative to the observations in the Interim Evaluation. To the extent that

sufficient and relevant data is available, the Summative Evaluation will provide additional details on these factors that contribute to statistically significant trends.

SECTION F: Results

The findings from HMA-Burns' assessment of each of Delaware's demonstration goals is shown in Section F. Each demonstration goal serves as a heading. Measures are reported for each goal as they relate to the research questions posed in the Evaluation Design Plan. It should be noted that some measures can be mapped to more than one research question. For example, the measure for follow-up after hospitalization for mental illness maps to three research questions:

- Research Question #6 under Demonstration Goal 4 that pertains to the DSHP population (Increase coordination of care and supports)
- Research Question #9 under Demonstration Goal 8 that pertains to the DSHP Plus population (Improve coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles)
- Research Question #10 under Demonstration Goal 9 that pertains to the PROMISE population (Improve overall health status and quality of life on individuals enrolled in PROMISE)

When this occurs, HMA-Burns reports results for this measure in all three locations, but the results in each location are specific to the population that the research question and demonstration goal pertains to.

At the start of each subsection, there is a summary table that lists each measure reviewed that was mapped to a research question under the demonstration goal. The table shows the desired outcome for each measure, if the desired outcome is being met in the demonstration period thus far, and if the results were found to be statistically significant (when testing for significance was conducted). The test used for statistical significance is also shown, where applicable.

After the summary table, each of the individual measures examined appears on its own one-page dashboard report. Information about the research question posed, the measure and measure steward, and the data source used to analyze the measure are provided.

Demonstration Goal #1: Improve Access to Health Care for the Medicaid Population

Summary of Measures

Fourteen measures were examined to assess access to health care for the Medicaid population. Six measures relate to enrollment levels, enrollment duration, and the impact of waiving retroactive eligibility. Another eight measures relate specifically to access to services. Among these, seven are HEDIS measures.

In Exhibit 7 that appears on the next page, it shows that the desired outcome was met in ten out of the 14 measures. A test for statistical significance was conducted on seven of the 14 measures. For six of the seven measures, the outcome was statistically significant. More detailed information can be found on each measure in the pages that follow.

Individual Measure Results

Exhibits 8 through 19 appear in the remainder of this section to show results of each of the measures examined related to Demonstration Goal #1. The time span from application to enrollment in Medicaid was analyzed over a recent four-year period (refer to Exhibit 8). Although there was a slight drop in the most recent year of CY 2021, between 58 and 66 percent of individuals had a turnaround time of 60 days or less each year. Between 72 and 77 percent had a turnaround time within 90 days each year.

Total enrollment was tracked by calendar quarter from CY 2018 to CY 2021 for four enrollment categories and a fifth "all other" category (refer to Exhibit 9). Enrollment was higher at the end of this four-year period (Q4-CY2021) than the start of the enrollment period (Q1-2018) for each category. Enrollment has also grown since the start of the demonstration renewal period (Aug 2019) for every category except for "all other".

The same five enrollment categories were examined for the percentage of individuals continuously enrolled for at least nine months of the calendar year (Exhibit 10) and enrollment duration (Exhibit 11). The percentage of members continuously enrolled has increased for all enrollment categories examined. For the Medicaid Expansion group, the increase was substantial. Similarly, the enrollment duration in the year also increased across-the-board. For CY 2021, this was an average of 11 months, presumably because of the continuous enrollment requirements imposed by CMS during the PHE.

Results from hospital reported uninsured uncompensated care were examined from CY 2018 through CY 2021 and results were reported per 1,000 Delawareans (refer to Exhibit 12). Hospital reported uncompensated care rose 13.2% from the baseline period in CY 2018 to CY 2021.

Results from the Behavioral Risk Factor Surveillance System (BRFSS) survey were examined from CY 2017 through CY 2020 for the response to the question if individuals could not see a doctor due to cost (refer to Exhibit 13). Results reported were 12.0 percent of those surveyed responding affirmatively to this question in CY 2017, but this fell to 9.1 percent in CY 2020.

Well-child visits for children and preventive/ambulatory visits for adults were analyzed. The HMA-Burns team used the specifications from NCQA for the HEDIS measures related to Well Child Visits in the First 15 Months of Life (W15, Exhibit 13), in the Third through Sixth Years of Life (W34, Exhibit 15), for Adolescents (AWC, Exhibit 16), and Preventive Services for Adults (AAP, Exhibit 17). Results were

computed for the DSHP population meeting the criteria for each measure for CY 2018 through CY 2021 experience years. For W15, the percentage with six visits or more decreased 1.3 percent from the baseline year (CY 2018) to the latest demonstration period year (CY 2021). For W34, the change was steady but an increase of 0.7 percent from the baseline to the demonstration period was observed. For AWC, there was a statistically significant improvement of 8.0 percent between the baseline year and the demonstration period year. For adults in the AAP measure, however, there was a statistically significant decline of 9.8 percent between the baseline year and the demonstration period year.

For the adults in the AAP measure, HMA-Burns computed the average distance travelled to see a preventive care provider to determine if the reduction in utilization may be due to provider access (refer to Exhibit 18). The average distance over the four-year period studied has remained unchanged, however (between 16.1 and 16.6 miles, on average, each year). The reduction in the results in the AAP measure may more likely be due to the PHE than to provider access.

HMA-Burns computed the rate of breast cancer screenings using the HEDIS measure specification (refer to Exhibit 19). The screening rate has declined 6.5 percent from the baseline year of CY 2018 to the latest demonstration period year of CY 2021. Again, this may likely be due to suppressed utilization during the PHE.

HMA-Burns computed the rate of adherence to antidepressant medication using the HEDIS AMM measure at both the 12-week time period and the 6-month time period (refer to Exhibit 20). For both time periods, DSHP members had statistically significant improvement in the adherence rate between the baseline year and the latest demonstration period year. For the 12-week time period, the improvement was 29.6 percent; for the 6-month time period, the improvement was 37.1 percent.

Exhibit 7
Summary of Findings for Measures Mapped to Research Questions #1, #2 and #3

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
Research Question #1: Does the waiver of retroactive eligibility continue (or does not worsen) the continuity of enrollment in Medicaid in the current demonstration period?					
1	Time span from application to enrollment in Medicaid	Steady or Decrease	Steady	N/A	no test run
2	Medicaid enrollment counts by month and aid category	Increase	Increase	N/A	no test run
3	Proportion of enrollees continuously enrolled in Medicaid by aid category and program	Increase	Increase	N/A	no test run
4	Medicaid enrollment duration by aid category	Increase	Increase	N/A	no test run
Research Question #2: Does the waiver of retroactive eligibility continue (or not worsen) trends in the incidence of not seeing a doctor because of cost in the current waiver period?					
5	Rate of hospital reported uncompensated care	Decrease	Increase	N/A	no test run
6	Could not see doctor because of cost	Decrease	Decrease	N/A	no test run
Research Question #3: Does the level and trend of access to primary and preventive care continue (or not worsen) in the current demonstration period?					
7	Well-Child Visits in the First 15 Months of Life (W15)	Increase	Decrease	Yes	Chi-square
8	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	Increase	Increase	No	Chi-square
9	Adolescent Well-Care Visits (AWC)	Increase	Increase	Yes	Chi-square
10	Adults' Access to Preventive or Ambulatory Health Services (AAP)	Increase	Decrease	Yes	Chi-square
11	Average Driving Distance to Primary Care Services	Steady or Decrease	Steady	N/A	no test run
12	Breast Cancer Screening (BCS)	Increase	Decrease	Yes	Chi-square
13	Antidepressant Medication Management (AMM), 12 weeks	Increase	Increase	Yes	Chi-square
14	Antidepressant Medication Management (AMM), 6 months	Increase	Increase	Yes	Chi-square

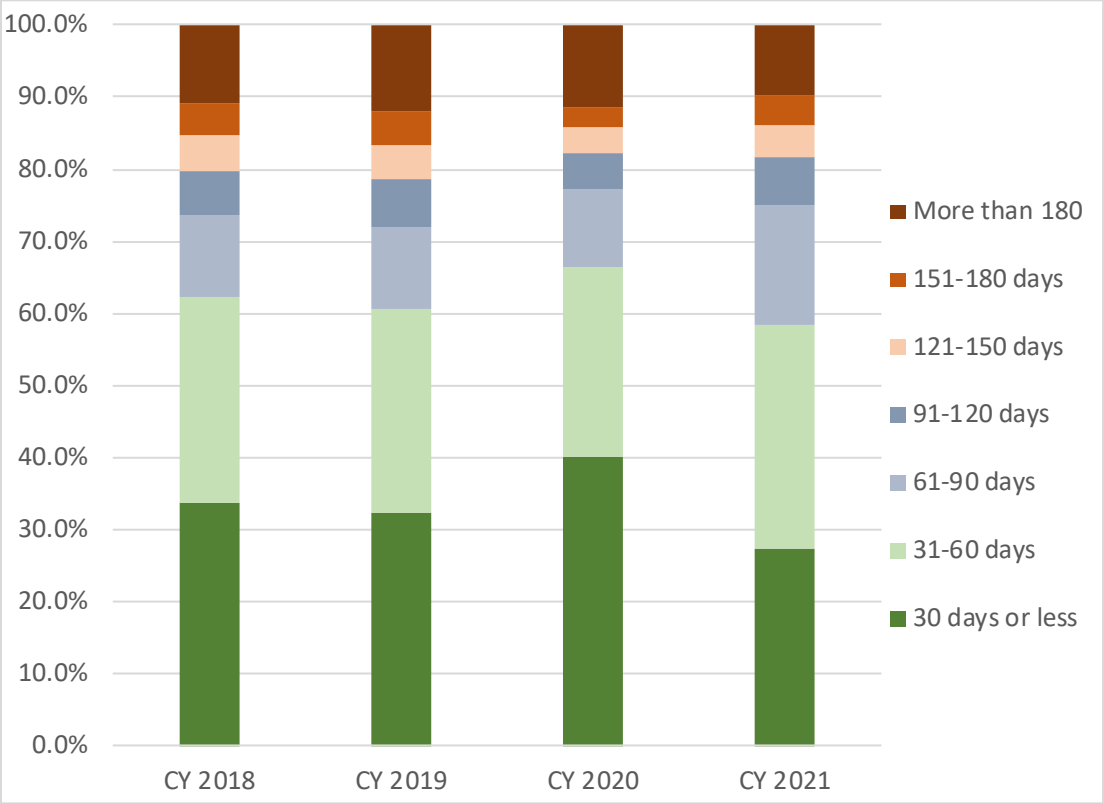
Exhibit 8
Results for Interim Evaluation Measure #1
Time Span from Application to Enrollment in Medicaid

Hypothesis:
Trends in continuity of enrollment continue (or do not worsen) for Medicaid populations subject to the waiver of retroactive eligibility in the current demonstration period.

Measure Used to Test Hypothesis:
Time Span from Application to Enrollment in Medicaid
Measure Steward: HMA-Burns
Data Source: Eligibility data from DMMA

Desired Outcome: Steady or Decrease
Actual Outcome: Steady

Results for the Entire Population in the Demonstration



Study Period	Percent of All Applications Where Turnaround Until Enrollment Was						
	30 Days or Less	31-60 Days	61-90 Days	91-120 Days	121-150 Days	151-180 Days	More than 180
CY 2018	33.7%	28.4%	11.5%	6.1%	5.0%	4.5%	10.7%
CY 2019	32.4%	28.0%	11.5%	6.6%	4.9%	4.7%	11.9%
CY 2020	40.1%	26.3%	10.8%	5.1%	3.5%	2.7%	11.5%
CY 2021	27.2%	31.0%	16.7%	6.7%	4.4%	4.3%	9.7%

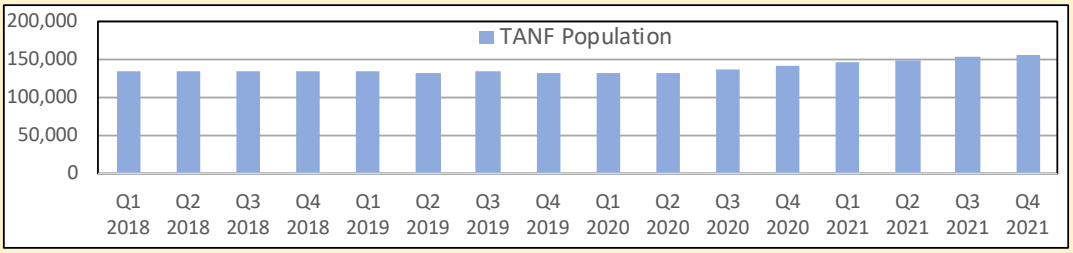
Exhibit 9
Results for Interim Evaluation Measure #2
Average Medicaid Enrollment Counts by Quarter and Major Aid Category

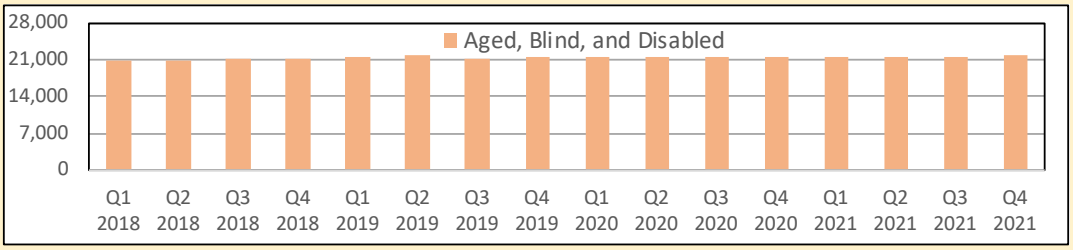
Hypothesis:
Trends in continuity of enrollment continue (or do not worsen) for Medicaid populations subject to the waiver of retroactive eligibility in the current demonstration period.

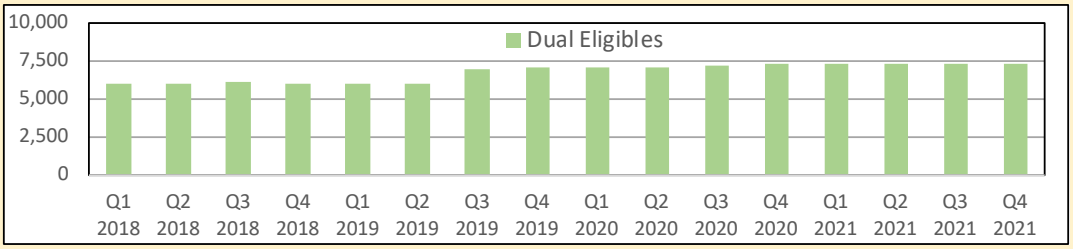
Measure(s) Used to Test Hypothesis: **Measure Steward:** HMA-Burns
Average Enrollment Counts by Quarter and Major Aid Category
Data Source: DMMA Enrollment Data

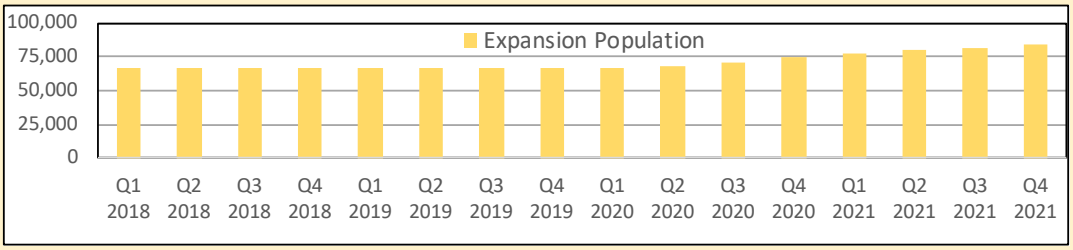
Desired Trend: Increase in enrollment in each major aid category
Actual Trend: Increase in five of the six major aid categories studied

Results









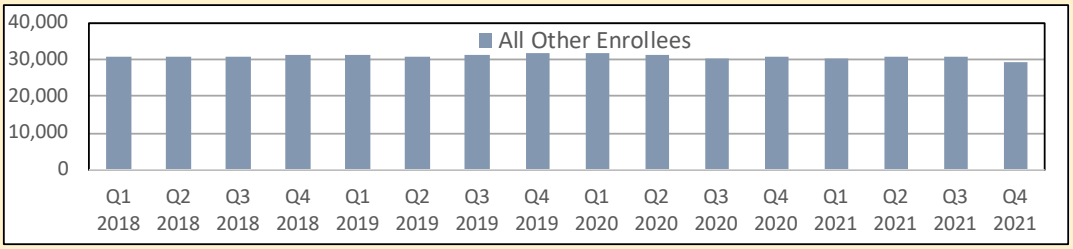


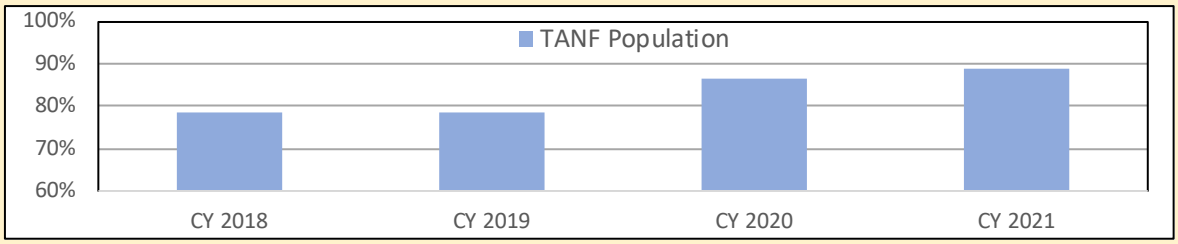
Exhibit 10
Results for Interim Evaluation Measure #3
Medicaid Continuous Enrollment by Major Aid Category

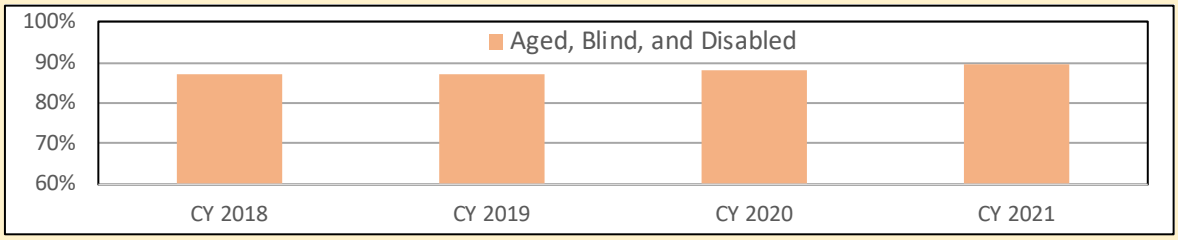
Hypothesis:
Trends in continuity of enrollment continue (or do not worsen) for Medicaid populations subject to the waiver of retroactive eligibility in the current demonstration period.

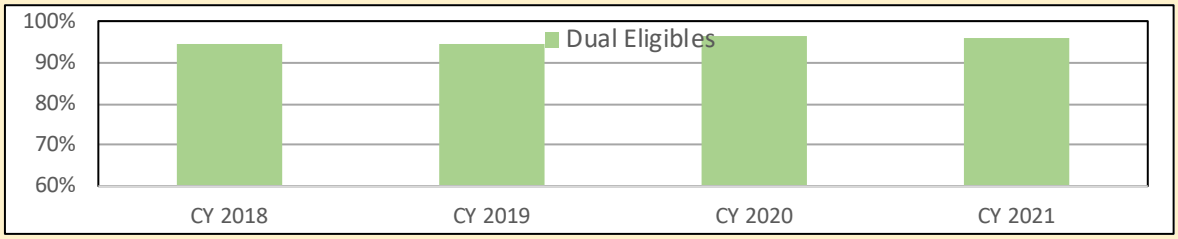
Measure(s) Used to Test Hypothesis: **Measure Steward:** HMA-Burns
Proportion of Total Enrollees Continuously Enrolled Nine Months or More by Major Aid Category
Data Source: DMMA Enrollment Data

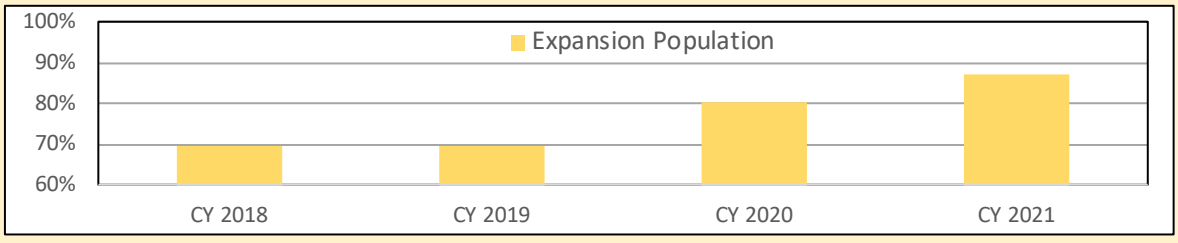
Desired Trend: Increase in continuous enrollment in each major aid category
Actual Trend: Increase in continuous enrollment in each major aid category

Results









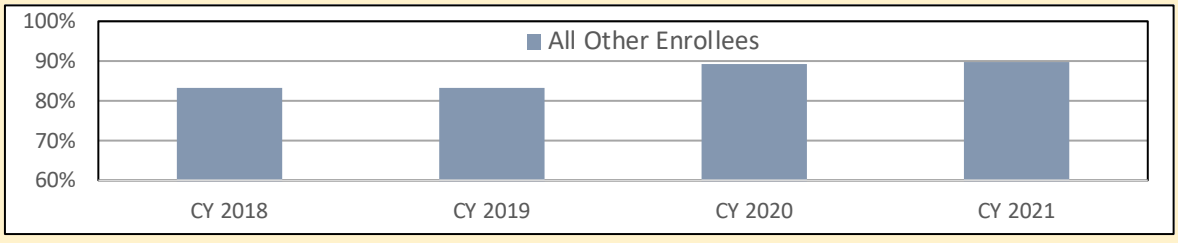


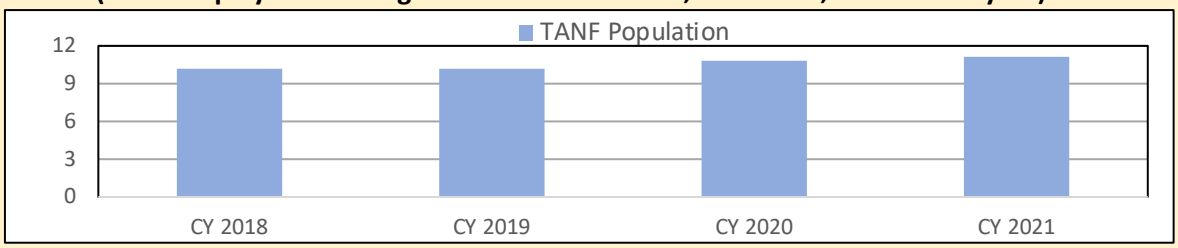
Exhibit 11
Results for Interim Evaluation Measure #4
Medicaid Average Enrollment Duration by Major Aid Category

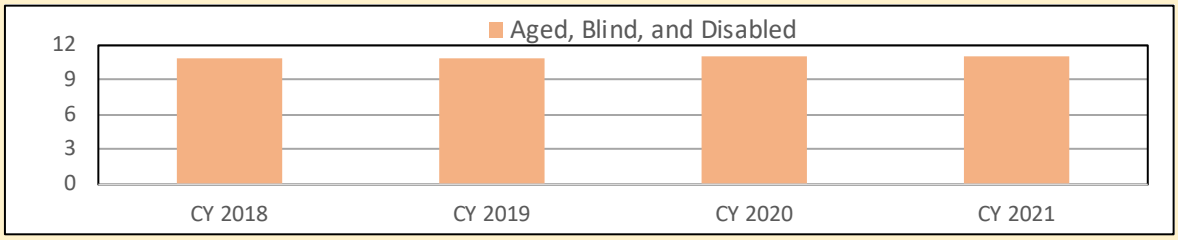
Hypothesis:
Trends in continuity of enrollment continue (or do not worsen) for Medicaid populations subject to the waiver of retroactive eligibility in the current demonstration period.

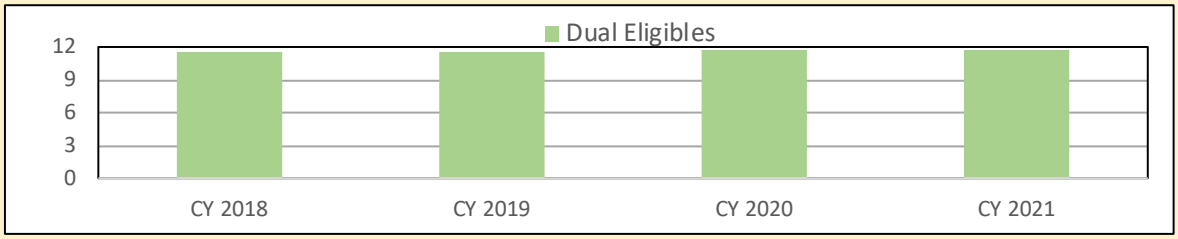
Measure(s) Used to Test Hypothesis: **Measure Steward:** HMA-Burns
Medicaid Average Enrollment Duration by Major Aid Category
Data Source: DMMA Enrollment Data

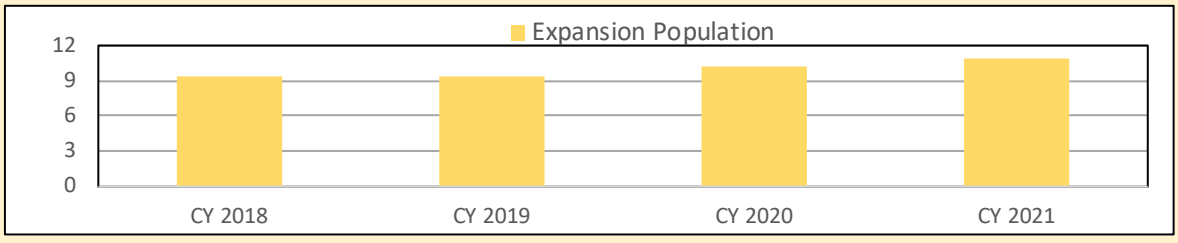
Desired Trend: Increase in average enrollment duration in each major aid category
Actual Trend: Increase in average enrollment duration in each major aid category

Results (value displayed is average enrollment duration, in months, within each year)









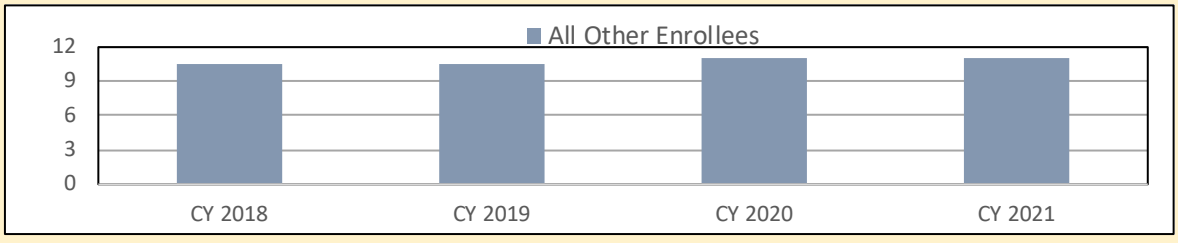


Exhibit 12
Results for Interim Evaluation Measure #5
Rate of Hospital Reported Uncompensated Care

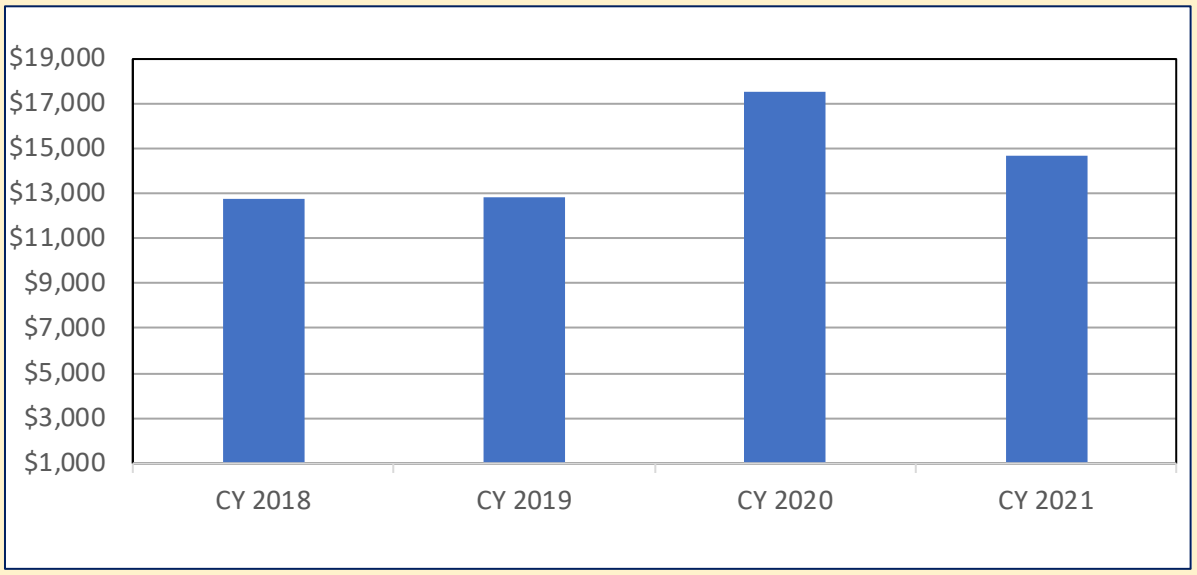
Hypothesis:
The waiver of retroactive eligibility will continue (or not worsen) trends in uncompensated care or medical debt in the current waiver period.

Measure Used to Test Hypothesis:
Response to Question: Rate of Hospital Reported Uncompensated Care per 1,000 Delawareans
Measure Steward: HMA-Burns

Data Source: Delaware Division of Medicaid and Medical Assistance

Desired Outcome: Decrease
Actual Outcome: Increase

Results



Survey Year	Numerator	Denominator	UCC Per 1000
2018	$13,313,220	1,045,130	$12,738
2019	$13,563,948	1,054,926	$12,858
2020	$18,651,673	1,064,958	$17,514
2021	$15,722,404	1,071,584	$14,672
Change Baseline (CY 2018) to Demonstration Period (CY 2021):			13.2%

Exhibit 13
Results for Interim Evaluation Measure #6
Responses to Not Seeing a Doctor Due to Cost

Hypothesis:
The waiver of retroactive eligibility will continue (or not worsen) trends in uncompensated care or medical debt in the current waiver period.

Measure Used to Test Hypothesis:
Response to Question: Could Not See a Doctor Due to Cost

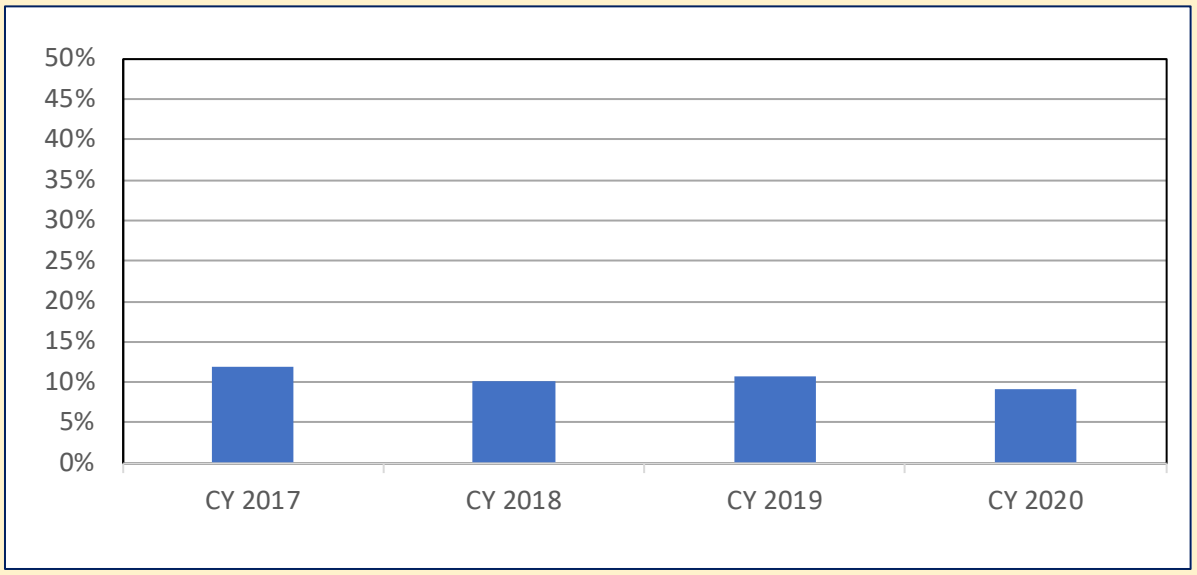
Measure Steward: U.S. Centers for Disease Control Behavioral Risk Factor Surveillance System survey

Data Source: Delaware Division of Public Health

Desired Outcome: Decrease

Actual Outcome: Decrease

Results



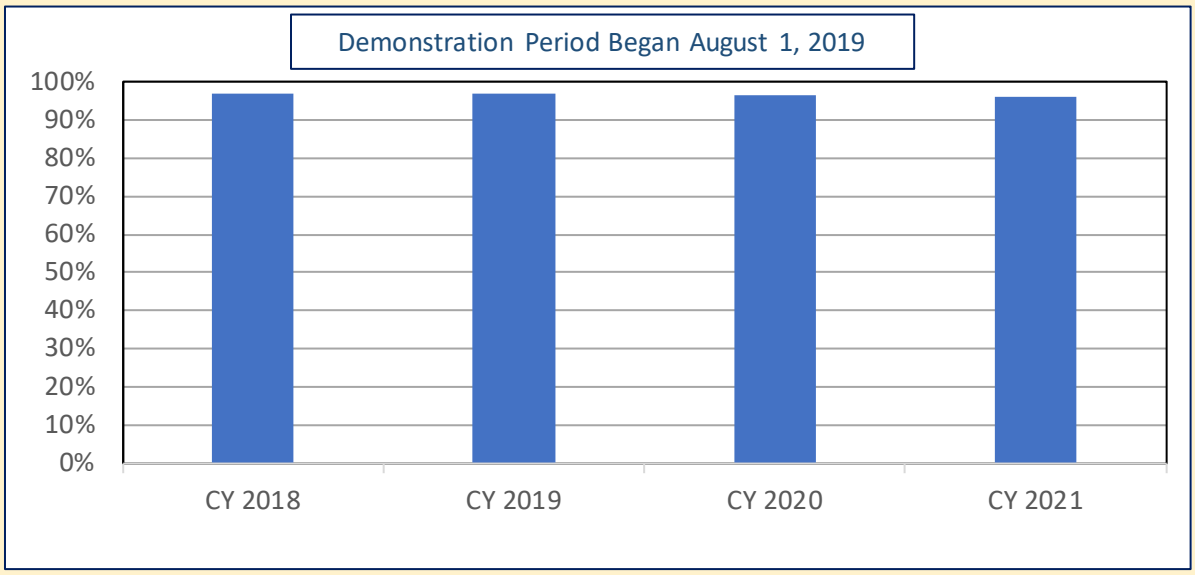
Survey Year	Numerator	Denominator	Rate
	Total indicating Yes, they could not see a doctor due to cost	Total Delawareans participating in the survey	
2017	494	4,127	12.0%
2018	530	5,221	10.2%
2019	415	3,889	10.7%
2020	367	4,017	9.1%

Exhibit 14
Results for Interim Evaluation Measure #7
Well-Child Visits in the First 15 Months of Life

Hypothesis:
Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current demonstration period.

Measure Used to Test Hypothesis:
Well-Child Visits in the First 15 Months of Life (6 or more visits)
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	3,873	3,989	97.1%	
CY 2019	4,437	4,571	97.1%	
CY 2020	4,717	4,897	96.3%	
CY 2021	5,319	5,547	95.9%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-1.3%

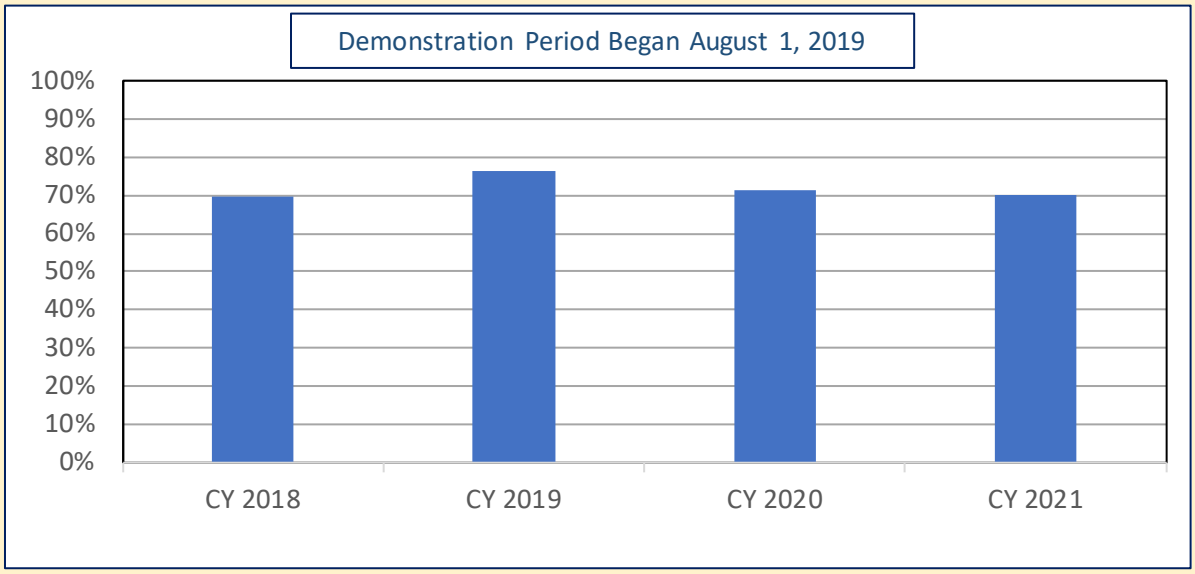
Desired Outcome:	Increase
Actual Outcome:	Decrease
Statistical Review:	Chi-Square
Probability:	0.0019
Finding:	Significant

Exhibit 15
Results for Interim Evaluation Measure #8
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Hypothesis:
Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current demonstration period.

Measure Used to Test Hypothesis:
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	12,348	17,716	69.70%	
CY 2019	13,267	17,391	76.29%	
CY 2020	13,977	19,569	71.42%	
CY 2021	14,978	21,329	70.22%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				0.7%

Desired Outcome: Increase
Actual Outcome: Increase
Statistical Review: Chi-Square
Probability: 0.2608
Finding: Not Significant

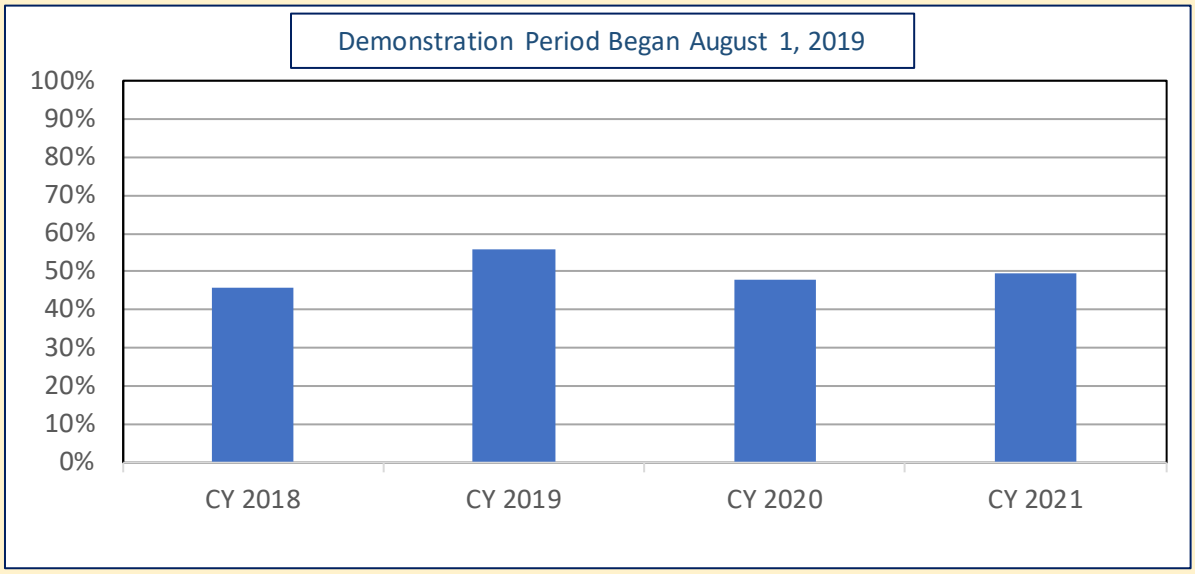
Note: Effective Measurement Year CY 2020, NCQA changed its measures for Well-Child Visits in the Third through Sixth Years of Life (W34) and Adolescent Well-Care Visits (AWC) and merged them into a single measure Child and Adolescent Well-Care Visits (WCV). For this report, HMA-Burns has retained the specifications for the W34 across all four years in order to retain continuity in reporting trends.

Exhibit 16
Results for Interim Evaluation Measure #9
Adolescent Well-Care Visits

Hypothesis:
Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current demonstration period.

Measure Used to Test Hypothesis:
Adolescent Well-Care Visits
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	15,868	34,782	45.6%	
CY 2019	19,947	35,599	56.0%	
CY 2020	19,849	41,331	48.0%	
CY 2021	22,760	45,890	49.6%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				8.0%

Desired Outcome: Increase
Actual Outcome: Increase
Statistical Review: Chi-Square
Probability: <.0001
Finding: Significant

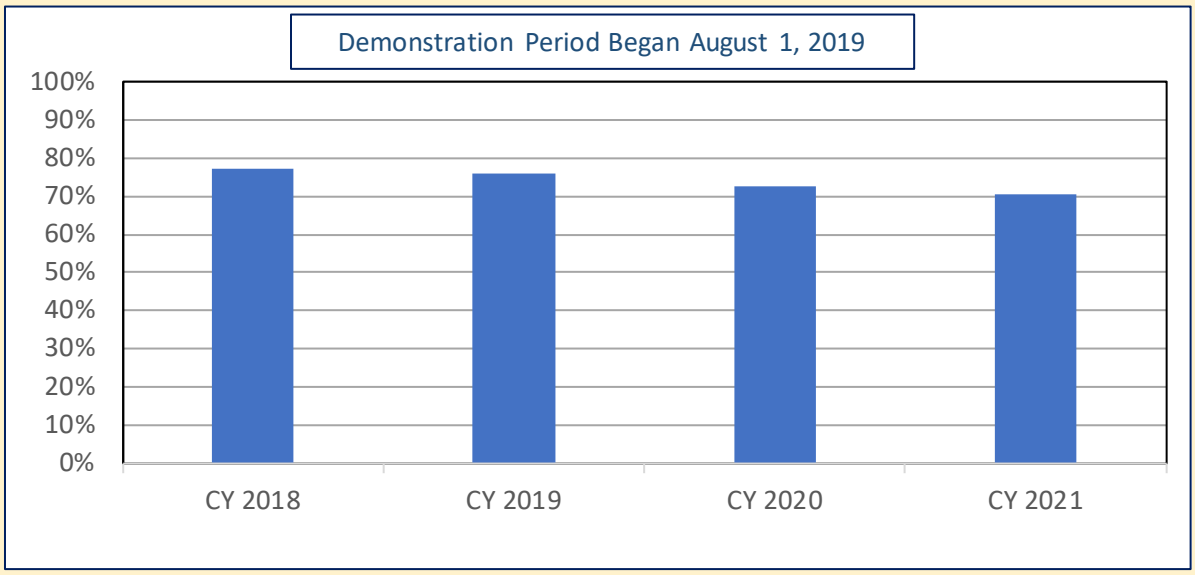
Note: Effective Measurement Year CY 2020, NCQA changed its measures for Well-Child Visits in the Third through Sixth Years of Life (W34) and Adolescent Well-Care Visits (AWC) and merged them into a single measure Child and Adolescent Well-Care Visits (WCV). For this report, HMA-Burns has retained the specifications for the W34 across all four years in order to retain continuity in reporting trends.

Exhibit 17
Results for Interim Evaluation Measure #10
Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries

Hypothesis:
Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current demonstration period.

Measure Used to Test Hypothesis:
Adults' Access to Preventive or Ambulatory Health Services
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	60,668	78,373	77.4%	
CY 2019	59,226	77,750	76.2%	
CY 2020	68,322	94,041	72.7%	
CY 2021	81,634	115,830	70.5%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-9.8%

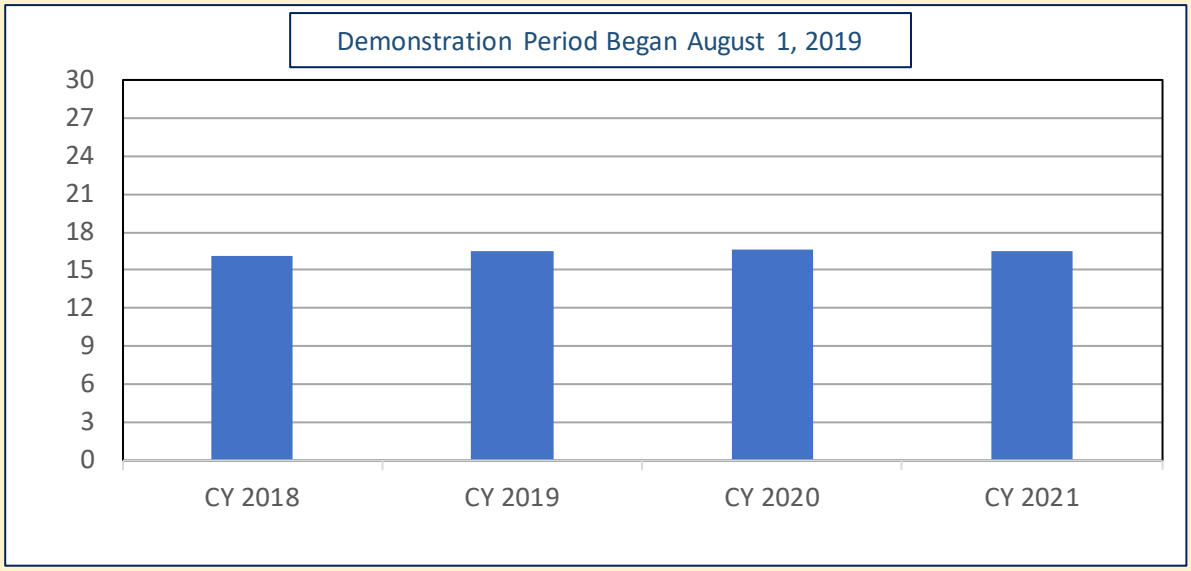
Desired Outcome:	Increase
Actual Outcome:	Decrease
Statistical Review:	Chi-Square
Probability:	<.0001
Finding:	Significant

Exhibit 18
Results for Interim Evaluation Measure #11
Average Driving Distance to Primary Care Services

Hypothesis:
Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current demonstration period.

Measure Used to Test Hypothesis:
Average Driving Distance to Primary Care Services
Measure Steward: HMA-Burns

Results for the DSHP Population in the Demonstration



Study Period	Avg Distance	Number of Trips in Study
CY 2018	16.1	252,725
CY 2019	16.5	232,261
CY 2020	16.6	253,102
CY 2021	16.5	301,000

Change Baseline (CY 2018) to Demonstration Period (CY 2021): increase 0.4 miles

Desired Outcome: Steady or Decrease
Actual Outcome: Steady
Statistical Review: None

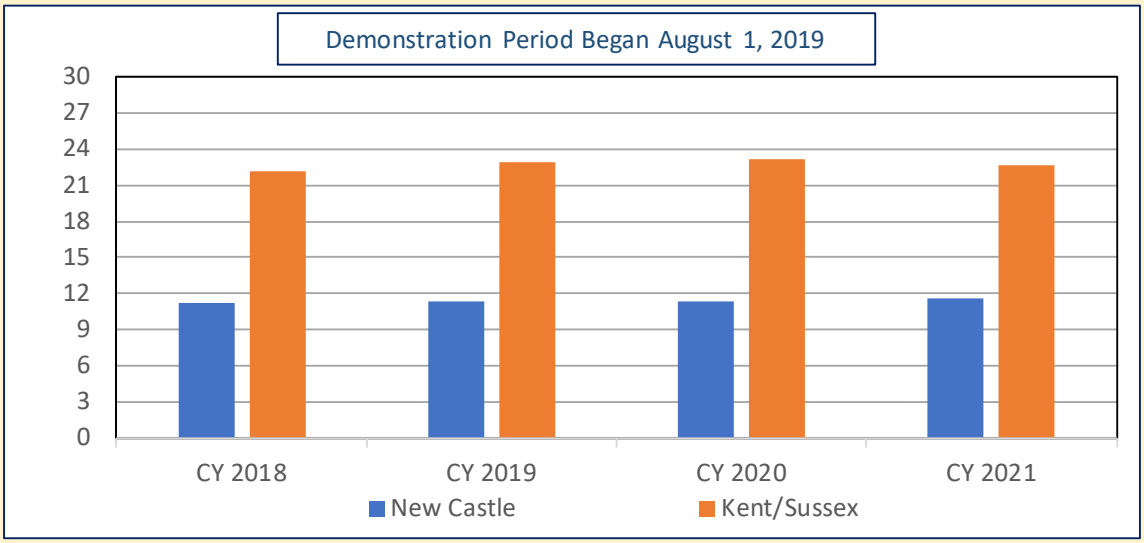
HMA-Burns used the members in the numerator of the AAP measure (Evaluation Measure #9) for consideration in this study for each calendar year. Individual preventive and ambulatory care visits as defined in the AAP measure were considered. For each Medicaid beneficiary, only a single unique beneficiary-to-provider visit was counted (i.e., repeat visits to the same provider by a beneficiary were excluded). For each visit, the turn-by-turn driving distance was determined using mapping software. The sum of all driving distance miles divided by the sum of all unique beneficiary-to-provider visits yields the average distance across all beneficiaries for each calendar year.

Exhibit 18 (Region)
Results for Interim Evaluation Measure #10
Average Driving Distance to Primary Care Services

Hypothesis:
Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current demonstration period.

Measure Used to Test Hypothesis:
Average Driving Distance to Primary Care Services
Measure Steward: HMA-Burns

Results for the DSHP Population in the Demonstration



	Study Period	Avg Distance	Number of Trips in Study	
New Castle	CY 2018	11.2	139,682	
	CY 2019	11.3	127,832	
	CY 2020	11.3	139,298	
	CY 2021	11.6	167,639	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):			increase 0.4 miles
Kent/Sussex	CY 2018	22.2	113,043	
	CY 2019	22.9	104,429	
	CY 2020	23.2	113,804	
	CY 2021	22.6	133,361	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):			increase 0.4 miles

	New Castle	Kent/Sussex
Desired Outcome:	Steady or Decrease	
Actual Outcome:	Steady	Steady
Statistical Review:	None	None

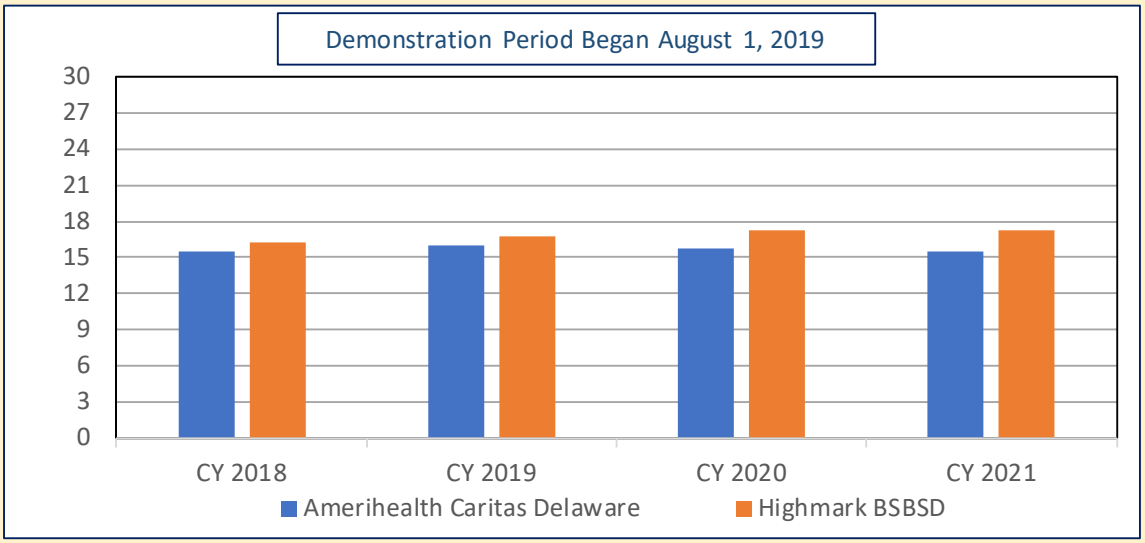
HMA-Burns used the members in the numerator of the AAP measure (Evaluation Measure #9) for consideration in this study for each calendar year. Individual preventive and ambulatory care visits as defined in the AAP measure were considered. For each Medicaid beneficiary, only a single unique beneficiary-to-provider visit was counted (i.e., repeat visits to the same provider by a beneficiary were excluded).

Exhibit 18 (MCO)
Results for Interim Evaluation Measure #10
Average Driving Distance to Primary Care Services

Hypothesis:
Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current demonstration period.

Measure Used to Test Hypothesis:
Average Driving Distance to Primary Care Services
Measure Steward: HMA-Burns

Results for the DSHP Population in the Demonstration



	Study Period	Avg Distance	Number of Trips in Study	
Amerihealth Caritas Delaware	CY 2018	15.5	45,408	
	CY 2019	16.0	60,530	
	CY 2020	15.7	84,905	
	CY 2021	15.5	106,148	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):			increase 0.0 miles
Highmark BSBSD	CY 2018	16.2	162,727	
	CY 2019	16.7	153,800	
	CY 2020	17.3	151,670	
	CY 2021	17.2	180,280	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):			increase 1.0 miles

	Amerihealth	Highmark
Desired Outcome:	Steady or Decrease	
Actual Outcome:	Steady	Increase
Statistical Review:	None	None

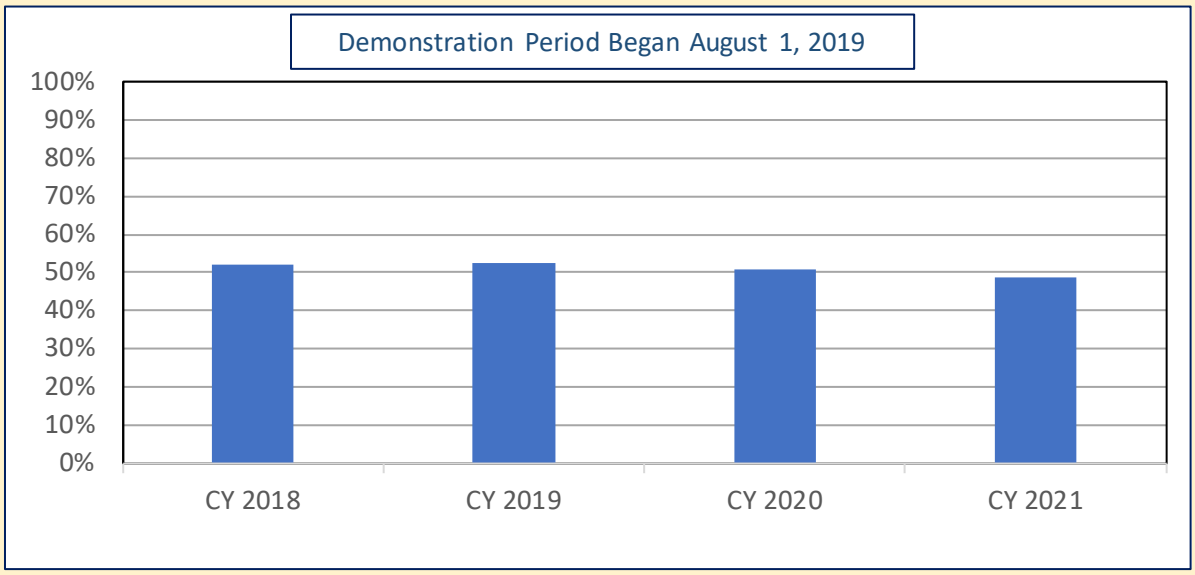
HMA-Burns used the members in the numerator of the AAP measure (Evaluation Measure #9) for consideration in this study for each calendar year. Individual preventive and ambulatory care visits as defined in the AAP measure were considered. For each Medicaid beneficiary, only a single unique beneficiary-to-provider visit was counted (i.e., repeat visits to the same provider by a beneficiary were excluded).

Exhibit 19
Results for Interim Evaluation Measure #12
Breast Cancer Screening

Hypothesis:
Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current demonstration period.

Measure Used to Test Hypothesis:
Breast Cancer Screening
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	3,891	7,499	51.9%	
CY 2019	3,971	7,547	52.6%	
CY 2020	4,384	8,645	50.7%	
CY 2021	5,442	11,174	48.7%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-6.5%

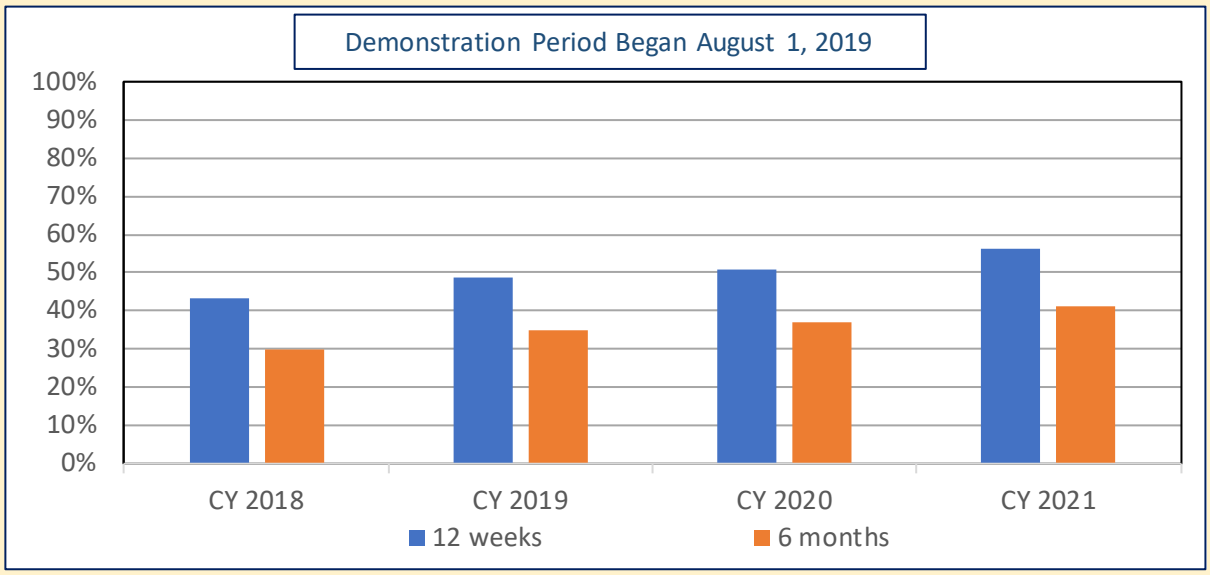
Desired Outcome:	Increase
Actual Outcome:	Decrease
Statistical Review:	Chi-Square
Probability:	<.0001
Finding:	Significant

Exhibit 20
Results for Interim Evaluation Measures #13 and #14
Antidepressant Medication Management

Hypothesis:
Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current demonstration period.

Measure Used to Test Hypothesis:
Antidepressant Medication Management
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Population in the Demonstration



	Study Period	Numerator	Denominator	Rate	
12 weeks	CY 2018	2,473	5,693	43.4%	
	CY 2019	3,159	6,504	48.6%	
	CY 2020	3,322	6,536	50.8%	
	CY 2021	3,566	6,334	56.3%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				29.6%
6 months	CY 2018	1,708	5,693	30.0%	
	CY 2019	2,274	6,504	35.0%	
	CY 2020	2,405	6,536	36.8%	
	CY 2021	2,605	6,334	41.1%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				37.1%

	12 weeks	6 months
Desired Outcome:	Increase	Increase
Actual Outcome:	Increase	Increase
Statistical Review:	Chi-Square	Chi-Square
Probability:	<.0001	<.0001
Finding:	Significant	Significant

Demonstration Goal #2: Rebalance Delaware's Long Term Care System in Favor of HCBS

Summary of Measures

Exhibit 21 below summarizes the four measures that were examined to assess utilization and spending for HCBS during the demonstration period thus far. In all four measures, the actual outcome is what is desired. For the two measures where tests were run for statistical significance, the positive results were statistically significant.

Exhibit 21
Summary of Findings for Measures Mapped to Research Question #8

Research Question #8: Has the rebalancing of long-term care services and supports maintained or moved more toward home- and community-based services and away from institutional services in the current demonstration period?

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
15	Utilization of HCBS Services Per DSHP Plus Member Per Month	Increase	Increase	N/A	no test run
16	Per Member Per Month Spending for HCBS for DSHP Plus Members	Increase	Increase	Yes	T-test
17	Per Member Per Month Spending for Institutional LTSS for DSHP Plus Members	Steady or Decrease	Decrease	Yes	T-test
18	Proportion of Spending for HCBS for DSHP Plus Members	Increase	Increase	N/A	no test run

Individual Measure Results

Individual HCBS were examined to assess utilization among DSHP Plus members for these services. The specific services examined include adult day health, day habilitation, attendant care, homemaker/chore services, personal care, respite, home-delivered meals, and self-directed services. HMA-Burns computed a per member per month (PMPM) utilization for these services among the DSHP Plus membership for the years CY 2018 through CY 2021 (refer to Exhibit 22). The rate increased 12.9 percent over the four-year period when measured on a per member per month basis among DSHP Plus members.

Total expenditures were examined for HCBS and for institutional long-term services and supports for DSHP members. HMA-Burns computed a PMPM cost for each category and trended these values from CY 2018 to CY 2021 (refer to Exhibit 23). In the four years examined, the PMPM expenditures for HCBS increased 38.8 percent while the PMPM expenditures for institutional care decreased 15.9 percent. The proportion of spending between HCBS and institutional care has improved from a mix of 25 percent/75 percent in CY 2018 to 35 percent/65 percent in CY 2021.

Exhibit 22

Results for Interim Evaluation Measure #15

Utilization of Home and Community Based Services Per DSHP Plus Member Per Month

Hypothesis:

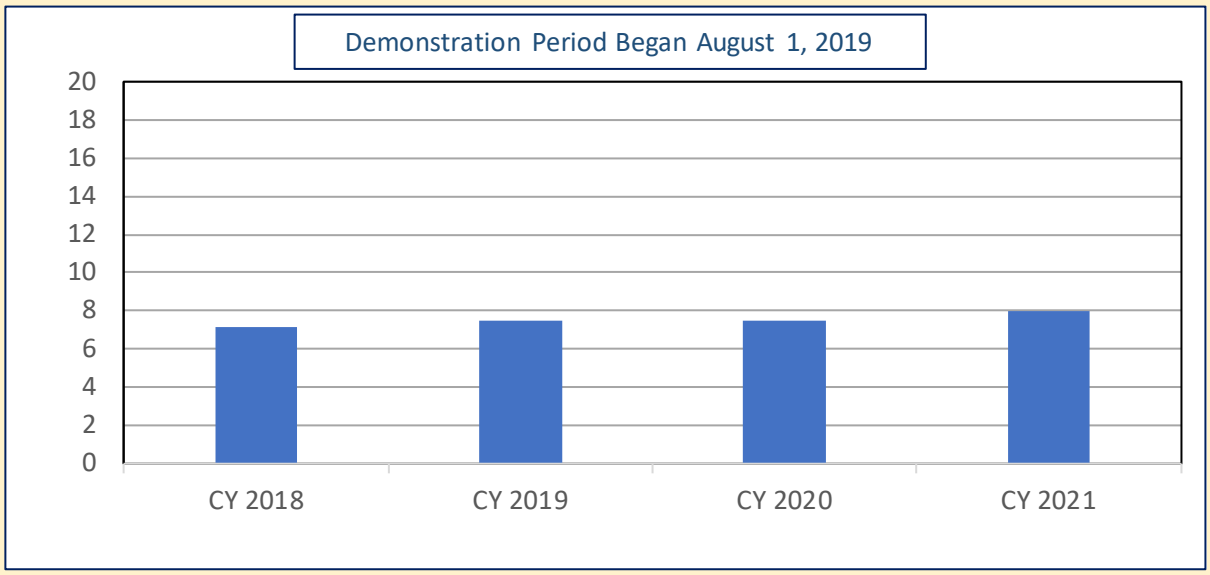
Creating a delivery system that provides incentives for resources to shift from institutions to community-based LTSS has maintained or increased utilization of HCBS where appropriate in the currrent demonstration period.

Measure Used to Test Hypothesis:

Utilization of HCBS Per DSHP Plus Member Per Month

Measure Steward: HMA-Burns

Results for the DSHP Plus Population in the Demonstration



Numerator: Number of HCB services received in the year by DSHP members

Denominator: Total member months for DSHP Plus members in the year

Study Period	Numerator	Denominator	Rate	
CY 2018	636,941	89,635	7.1	
CY 2019	717,342	95,391	7.5	
CY 2020	730,596	97,244	7.5	
CY 2021	739,321	92,181	8.0	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				12.9%

Desired Outcome: Increase

Actual Outcome: Increase

Statistical Review: None

Services included in the numerator for this measure include: adult day health, day habilitation, attendant care, homemaker/chore, personal care, respite, home delivered meals, and self-directed services. The greatest growth in utilization over the four-year period was in attendant care and home-delivered meals.

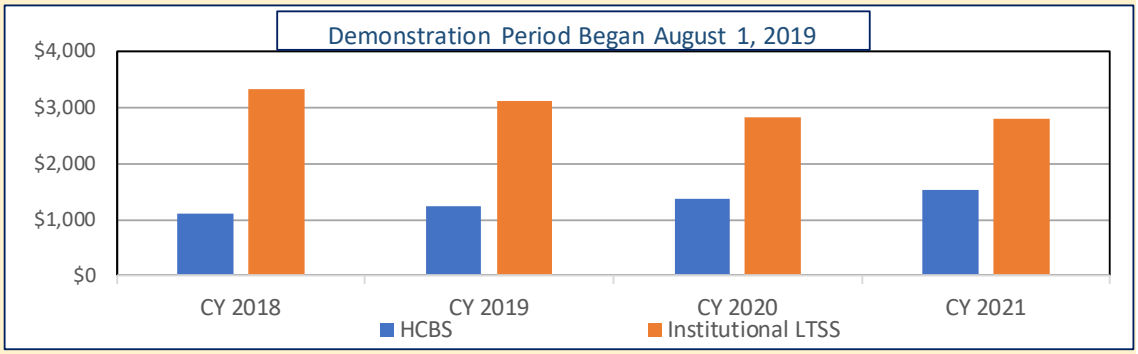
Exhibit 23
Results for Interim Evaluation Measures #16 through #18
Per Member Per Month Expenditures Among the DSHP Plus Population

Hypotheses:
Creating a delivery system that provides incentives for resources to shift from institutions to community-based LTSS has maintained or increased utilization of HCBS where appropriate in the currrent demonstration period.

Measures Used to Test Hypothesis:
1. Per Member Per Month Spending for HCBS for DSHP Plus Members
2. Per Member Per Month Spending for Institutional LTSS for DSHP Plus Members
3. Proportion of Spending for HCBS for DSHP Plus Members

Measure Steward: HMA-Burns

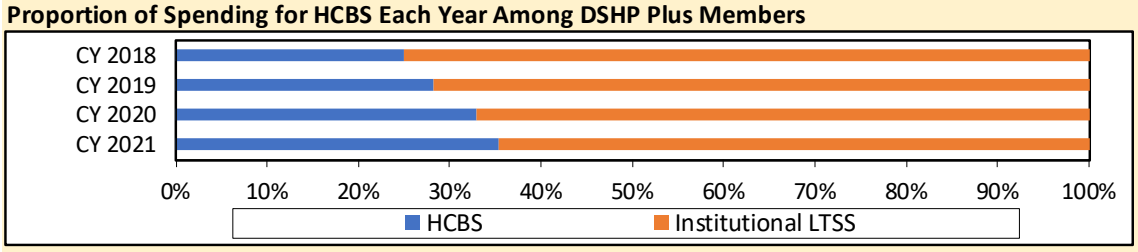
Results for the DSHP Plus Population in the Demonstration



	Study Period	Numerator	Denominator	PMPM	
HCBS	CY 2018	$99,032,839	89,635	$1,105	
	CY 2019	$117,140,282	95,391	$1,228	
	CY 2020	$134,281,048	97,244	$1,381	
	CY 2021	$141,321,907	92,181	$1,533	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				38.8%
Institutional LTSS	CY 2018	$298,509,235	89,635	$3,330	
	CY 2019	$296,965,901	95,391	$3,113	
	CY 2020	$273,689,397	97,244	$2,814	
	CY 2021	$258,254,449	92,181	$2,802	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-15.9%

	HCBS	Institutional LTSS	Proportion HCBS
Desired Outcome:	Increase	Steady or Decrease	Increase
Actual Outcome:	Increase	Decrease	Increase
Statistical Review:	T-test	T-test	no test run
Probability > [t]:	<.0001	<.0001	
Finding:	Significant	Significant	

Proportion of Spending for HCBS Each Year Among DSHP Plus Members



Results from Study of HCBS Services

Medicaid enrollees in the DSHP Plus program within the demonstration were identified who had used home- and community-based services (HCBS) during the time period of October 1, 2019 through September 30, 2020. Among this population, the members that had an inpatient hospital stay were specifically examined. Two study periods were examined:

- Group 1 is the DSHP Plus population who had an inpatient hospital stay in the six months prior to the PHE (n = 4,709).
- Group 2 is the DSHP Plus population who had an inpatient hospital stay in the first six months of the PHE (n = 4,833).

The time period that each enrollee was hospitalized was tracked. Then, HMA-Burns counted the 12 week period prior to each enrollee's hospital admission and the 12-week period after he/she was discharged from the hospital. Within each 12-week window, HMA-Burns examined the service utilization of each member among selected services. The purpose of the study was to determine if desired services (e.g., primary care, pharmacy scripts, HCBS) improved after the discharge and if undesired services (e.g., additional inpatient stays, emergency department visits) decreased.

Exhibit 24 summarizes the results of the study. In both study periods, hospital readmissions and ED visits decreased after the hospital discharge, while professional services increased. But HCBS services and pharmacy scripts also decreased. It is notable that almost 20 percent of enrollees had none of these services after discharge from their hospital stay.

Exhibit 24
Results from Study of HCBS Services Before and After a Hospital Stay

	Pre-PHE Study Population: Oct 1, 2019 – Mar 31, 2020		PHE Study Population: April 1, 2020 – Sept 30, 2020	
	in the 12 weeks before inpatient admission	in the 12 weeks after inpatient discharge	in the 12 weeks before inpatient admission	in the 12 weeks after inpatient discharge
Total Denominator Population	**4,709**		**4,833**	
Percent of Individuals with				
Another Inpatient Hospital Stay	6%	**3%**	5%	**2%**
ED Visit	9%	**5%**	8%	**3%**
Outpatient Hospital Service	17%	11%	19%	7%
Professional Service in Community	29%	**48%**	26%	**53%**
HCBS Service	10%	**8%**	9%	**3%**
Pharmacy Script Filled	48%	**45%**	51%	**44%**
None of the Services Above	32%	**18%**	30%	**19%**

Percentages highlighted in green indicate a positive trend after the hospital discharge when compared to before the hospital admission. Percentages highlighted in red indicate a negative trend. A lower percenage is preferred for inpatient stays, ED visits, and the row 'None of the Services Above'.

Demonstration Goal #3: Promote Early Intervention for Individuals With, or At Risk, For Having Long Term Care Needs

Summary of Measures

Exhibit 25 below summarizes the results of four HEDIS measures that the HMA-Burns team computed to answer the research question tied to Demonstration Goal #3. Results were mixed. For two measures, the actual outcome was the desired outcome; for the other two measures, the opposite was true. Statistical significance tests were conducted on all four measures. For three of the four measures, the results were statistically significant, including for the two measures that the actual outcome was not the desired outcome.

Exhibit 25
Summary of Findings for Measures Mapped to Research Question #9

Research Question #9: Do DSHP Plus members achieve similar or improved quality of care and health outcomes in the current demonstration period?

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
19	All-Cause Readmission, DSHP Plus Population	Decrease	Increase	Yes	Chi-square
20	Comprehensive Diabetes Care, DSHP Plus Population	Increase	Increase	No	Chi-square
21	Annual Monitoring for Patients on Persistent Medications, DSHP Plus Population	Increase	Decrease	Yes	Chi-square
22	Medication Adherence Rate, Percent of Days Covered, DSHP Plus Population	Increase	Increase	Yes	Chi-square

Individual Measure Results

For all four measures examined in this section, the population reviewed was the DSHP Plus membership. The All Readmission Rate increased from 25.8 percent in CY 2018 to 34.2 percent in CY 2021 (refer to Exhibit 26). The readmission rate was steady in the two years prior to the PHE, then increased during the PHE.

Some improvement was seen in the Comprehensive Diabetes Care measure over the four years examined, but the improvement of 3.5 percent was not statistically significant (refer to Exhibit 27). The Comprehensive Diabetes Rate was between 40.9 percent and 45.3 percent over the four years studied.

The results for Annual Monitoring for Patients on Persistent Medications were steady for the first three of four years examined, but the results dropped significantly in CY 2021, the last year examined (refer to Exhibit 28). It should be noted that the denominator population was steady in the first three years examined as well, but the population studied dropped nearly 20 percent in the final year.

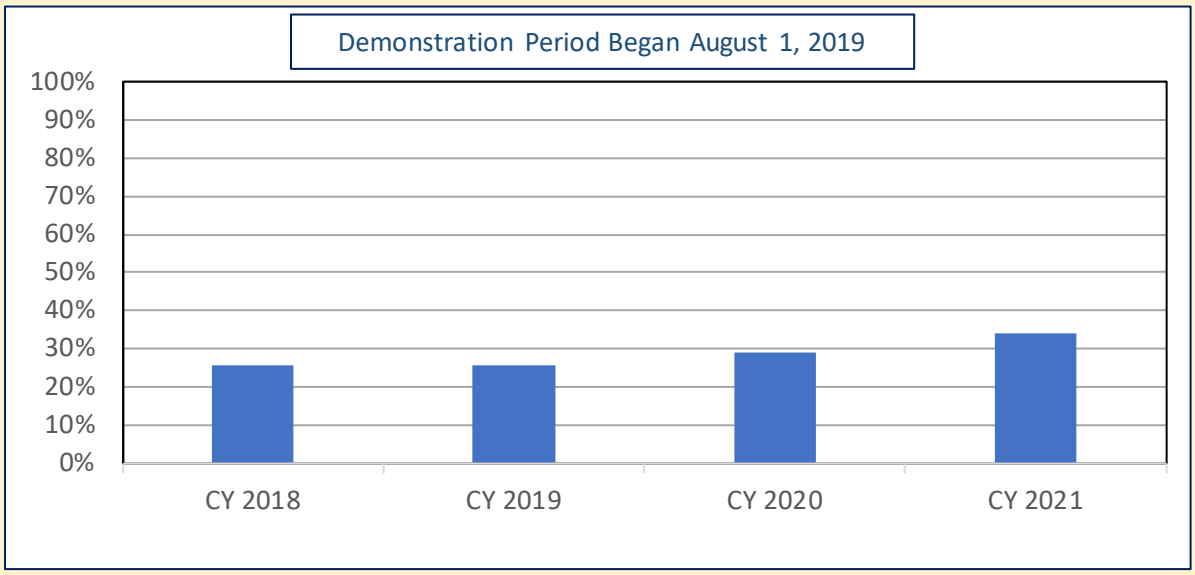
HMA-Burns computed a medication adherence rate for DSHP Plus members using a composite score for proportion of days covered derived from a measure developed by the Pharmacy Quality Alliance in total and by MCO (refer to Exhibit 29). In total, the proportion of days covered saw a statistically significant improvement over the four years examined, from 33.5 percent in CY 2018 to 41.3 percent in CY 2021. The rate was as high as 47.0 percent in the CY 2020 measurement year. Results by MCO are also statistically significant and demonstrate a similar pattern of improvement from CY 2018 to CY 2021.

Exhibit 26
Results for Interim Evaluation Measure #19
Plan All-Cause Readmissions

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP Plus members in the current demonstration period.

Measure Used to Test Hypothesis:
Plan All-Cause Readmissions
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Plus Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	504	1,951	25.8%	
CY 2019	465	1,811	25.7%	
CY 2020	480	1,660	28.9%	
CY 2021	700	2,044	34.2%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				24.6%

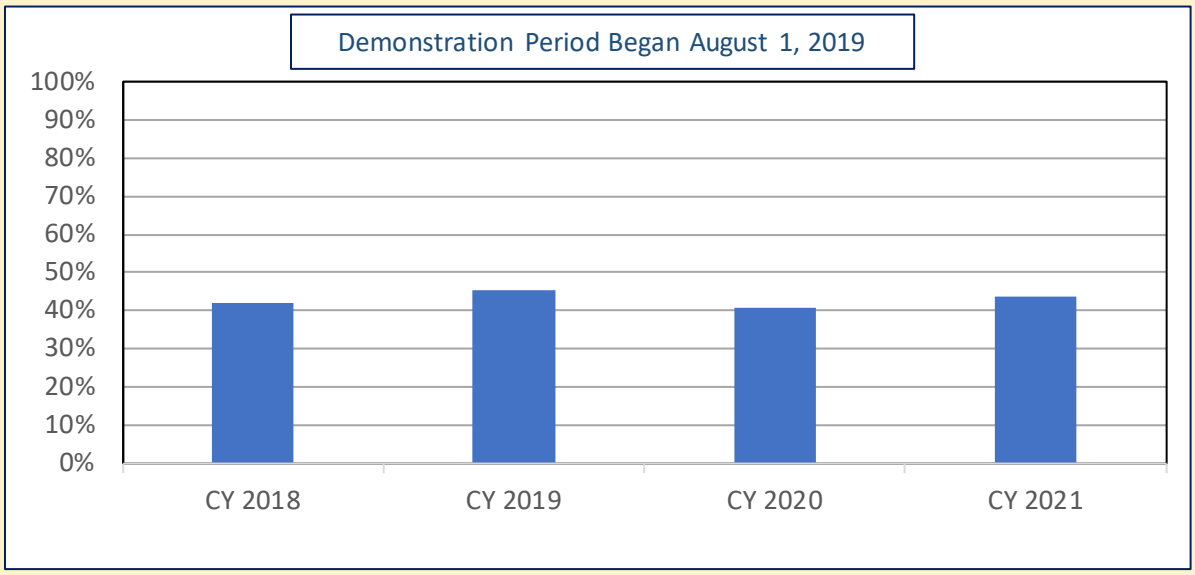
Desired Outcome:	Decrease
Actual Outcome:	Increase
Statistical Review:	Chi-Square
Probability:	<.0001
Finding:	Significant

Exhibit 27
Results for Interim Evaluation Measure #20
Comprehensive Diabetes Care

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP Plus members in the current demonstration period.

Measure Used to Test Hypothesis:
Comprehensive Diabetes Care
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Plus Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	418	994	42.1%	
CY 2019	479	1,058	45.3%	
CY 2020	422	1,032	40.9%	
CY 2021	389	893	43.6%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				3.5%

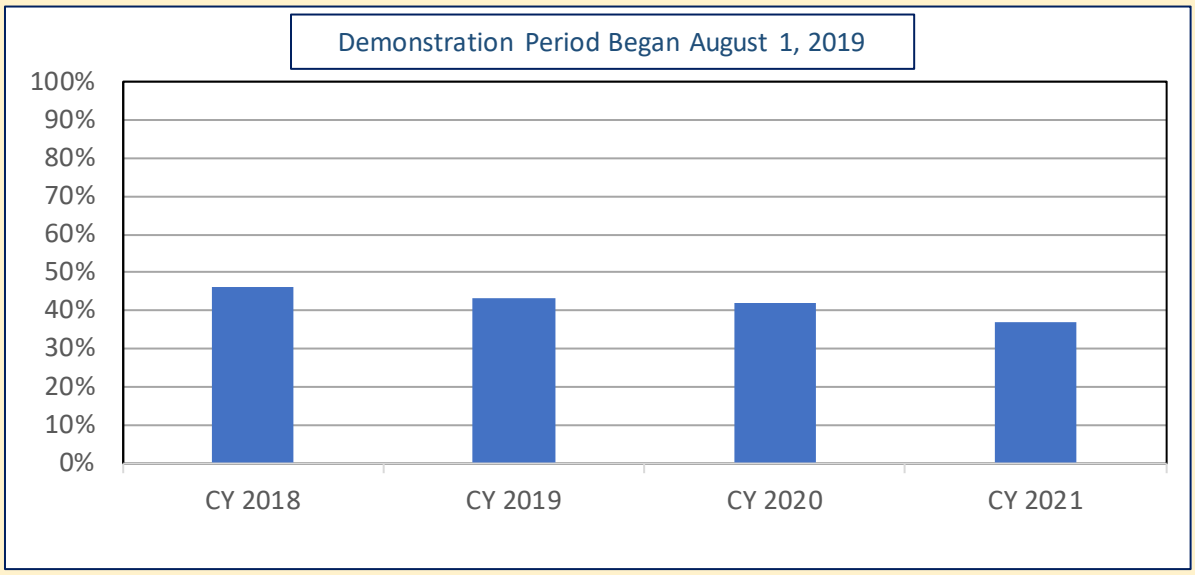
Desired Outcome:	Increase
Actual Outcome:	Increase
Statistical Review:	Chi-Square
Probability:	0.5084
Finding:	Not Significant

Exhibit 28
Results for Interim Evaluation Measure #21
Annual Monitoring for Patients on Persistent Medications

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP Plus members in the current demonstration period.

Measure Used to Test Hypothesis:
Annual Monitoring for Patients on Persistent Medications, sum of ACE Inhibitors and Diuretics
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Plus Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	295	636	46.4%	
CY 2019	270	626	43.1%	
CY 2020	261	620	42.1%	
CY 2021	188	511	36.8%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-26.1%

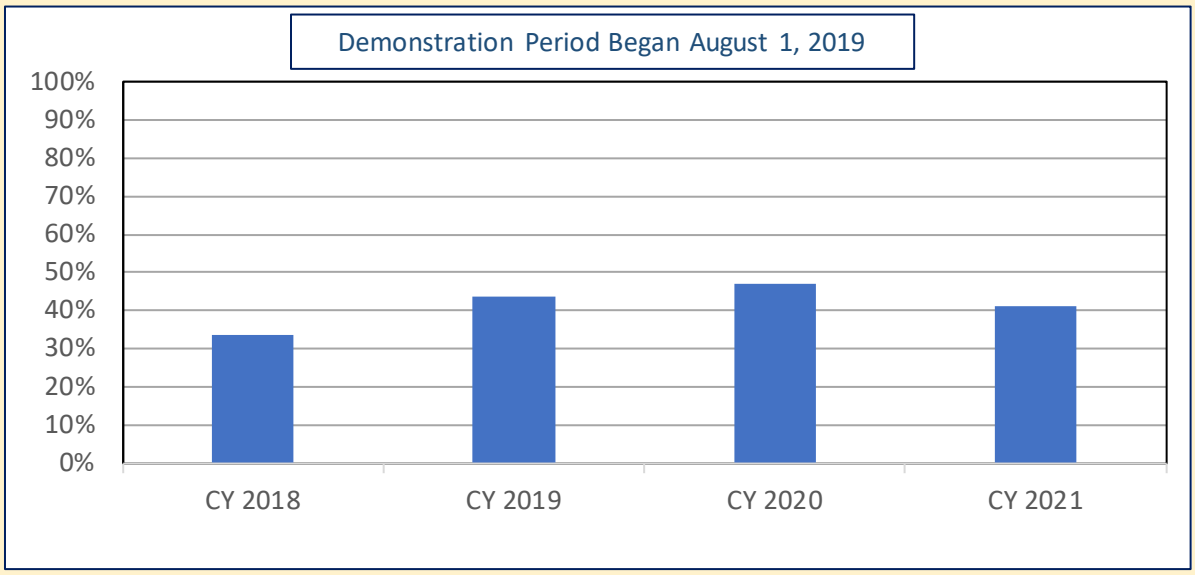
Desired Outcome:	Increase
Actual Outcome:	Decrease
Statistical Review:	Chi-Square
Probability:	0.0011
Finding:	Significant

Exhibit 29
Results for Interim Evaluation Measure #22
Medication Adherence Rate, Proportion of Days Covered

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP Plus members in the current demonstration period.

Measure Used to Test Hypothesis:
Medication Adherence Rate, Proportion of Days Covered Composite
Measure Steward: Pharmacy Quality Alliance

Results for the DSHP Plus Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	344	1,026	33.5%	
CY 2019	395	904	43.7%	
CY 2020	461	980	47.0%	
CY 2021	396	960	41.3%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				18.7%

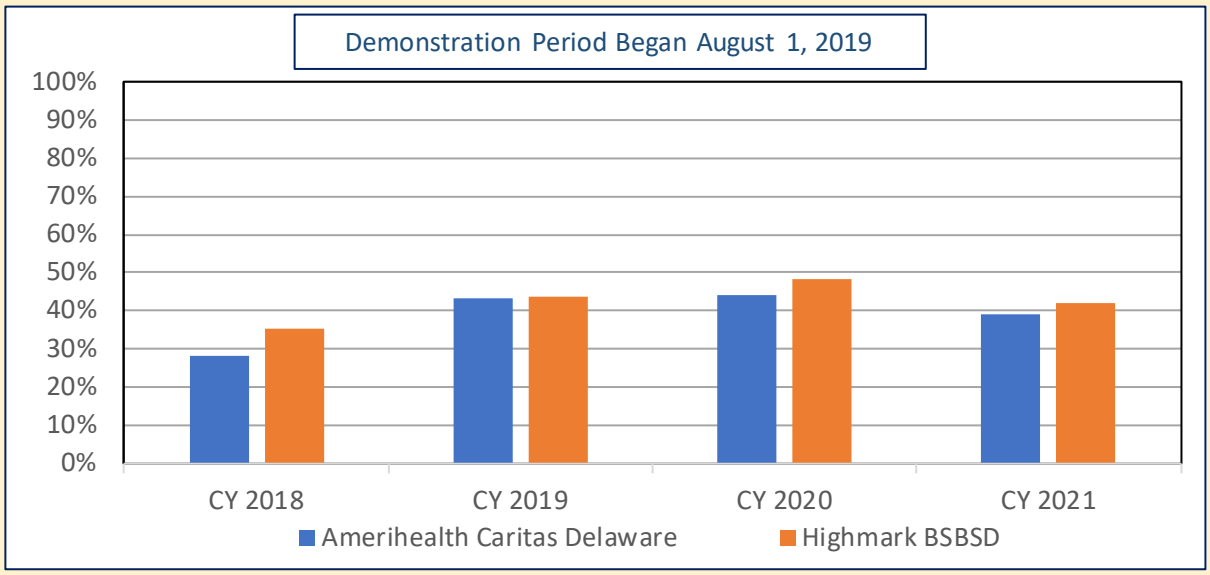
Desired Outcome:	Increase
Actual Outcome:	Increase
Statistical Review:	Chi-Square
Probability:	0.0004
Finding:	Significant

Exhibit 29 (MCO)
Results for Interim Evaluation Measure #22
Medication Adherence Rate, Proportion of Days Covered

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP Plus members in the current demonstration period.

Measure Used to Test Hypothesis:
Medication Adherence Rate, Proportion of Days Covered Composite
Measure Steward: Pharmacy Quality Alliance

Results for the DSHP Plus Population in the Demonstration



	Study Period	Numerator	Denominator	Rate	
Amerihealth Caritas Delaware	CY 2018	74	261	28.4%	
	CY 2019	101	234	43.2%	
	CY 2020	139	315	44.1%	
	CY 2021	105	269	39.0%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				27.4%
Highmark BSBSD	CY 2018	270	765	35.3%	
	CY 2019	294	670	43.9%	
	CY 2020	322	665	48.4%	
	CY 2021	291	691	42.1%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				16.2%

	Amerihealth	Highmark
Desired Outcome:	Increase	Increase
Actual Outcome:	Increase	Increase
Statistical Review:	Chi-Square	Chi-Square
Probability:	0.0093	0.0076
Finding:	Significant	Significant

Demonstration Goal #4: Increase Coordination of Care and Supports

Summary of Measures

Demonstration Goal #4 focuses on the DSHP population (TANF and Medicaid Expansion primarily). Seven measures were computed to assess coordination of care for these members. Six of the seven measures are HEDIS. Results were mixed among these measures. For four measures, the actual outcome was the desired outcome; for the other three measures, the opposite was true. Statistical significance tests were conducted on all seven measures. For four of the seven measures, the results were statistically significant, including for the two measures where the actual outcome was the desired outcome.

Exhibit 30
Summary of Findings for Measures Mapped to Research Question #6

Research Question #6: Do DSHP members enrolled in case/care management achieve similar or improved quality of care and health outcomes in the current waiver period?

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
23	Prenatal care for pregnant women-timeliness of prenatal care (PPC)	Increase	Increase	No	Chi-square
24	Postpartum care (PPC)	Increase	Increase	Yes	Chi-square
25	Follow-up After Hospitalization for Mental Illness (FUH), DSHP Population	Increase	Decrease	No	Chi-square
26	Emergency Department Visits per 1000, DSHP Population	Decrease	Decrease	Yes	T-test
27	Follow-Up After ED Visit for Alcohol or Other Drug (AOD) Dependence (FUA), DSHP Population	Increase	Increase	No	Chi-square
28	Follow-up After ED Visit for Mental Illness (FUM), DSHP Population	Increase	Decrease	Yes	Chi-square
29	Follow-up After ED Visit for People with Multiple High-Risk Chronic Conditions (FMC), DSHP Population	Increase	Decrease	Yes	Chi-square

Individual Measure Results

HMA-Burns computed the timeliness of prenatal care (Exhibit 31) and the rate of postpartum care (Exhibit 32) among pregnant women using the HEDIS specification for its PPC measure. The timeliness of prenatal care increased slightly during the four year study period but hovered near 67 percent in all four

years. The rate of postpartum care, however, increased significantly, from 34.2 percent in CY 2018 to 44.2 percent in CY 2021.

Follow-up care after hospitalization from a mental illness (HEDIS FUH measure) was low for DSHP members in all four years examined (refer to Exhibit 33) and decreased slightly from a 12.6 percent follow-up rate in CY 2018 to 12.2 percent in CY 2021.

The rate of emergency department utilization, expressed on a per 1,000 member basis, decreased significantly from 65.2 visits per 1,000 in CY 2018 to 49.2 visits per 1,000 in CY 2021 (refer to Exhibit 34). Although ED utilization fell significantly nationwide at the start of the PHE in CY 2020, the rate among DSHP members remained low in CY 2021 (ED usage increased only 4.1% between CY 2020 and CY 2021 among DSHP members).

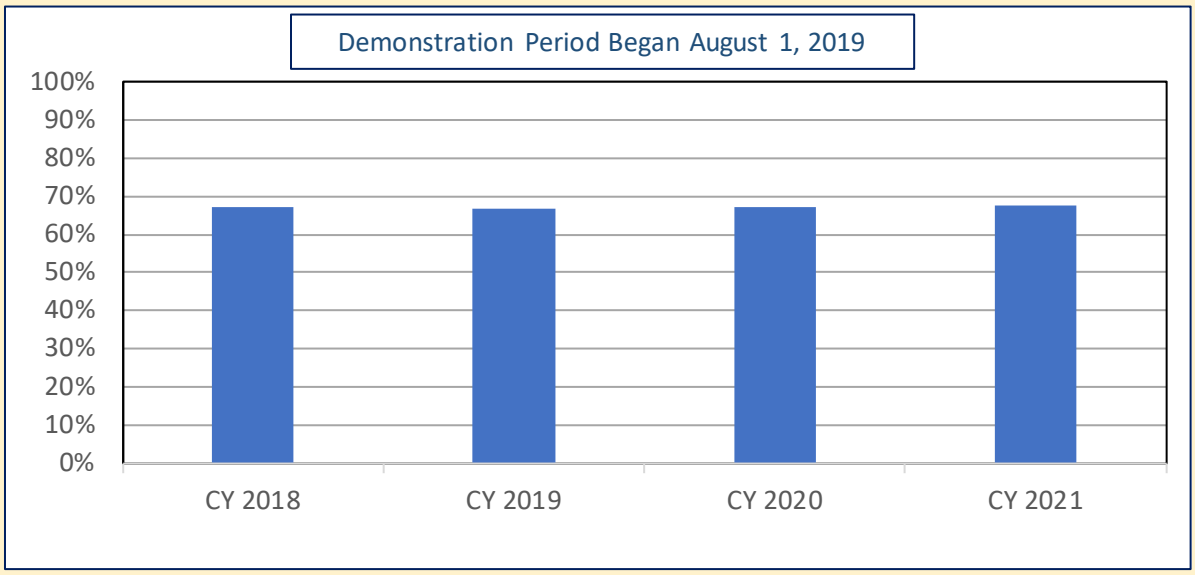
Follow-up care after an ED visit for alcohol or other drug dependence (HEDIS FUA measure) saw only modest improvement over the four years examined, from 17.6 percent in CY 2018 to 18.1 percent in CY 2021 (Exhibit 35). Follow-up care after an ED visit for mental illness (HEDIS FUM measure) fell over the four years examined, from 40.9 percent in CY 2018 to 36.1 percent in CY 2021 (Exhibit 36). Follow-up care after an ED visit for people with multiple high-risk conditions (HEDIS FMC measure) also saw a statistically significant decline, from 47.3 percent in CY 2018 to 43.4 percent in CY 2021 (Exhibit 37).

Exhibit 31
Results for Interim Evaluation Measure #23
Timeliness of Prenatal Care

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP members in the current demonstration period.

Measure Used to Test Hypothesis:
Timeliness of Prenatal Care
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	2,564	3,815	67.2%	
CY 2019	2,679	4,004	66.9%	
CY 2020	2,613	3,892	67.1%	
CY 2021	2,480	3,660	67.8%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				0.8%

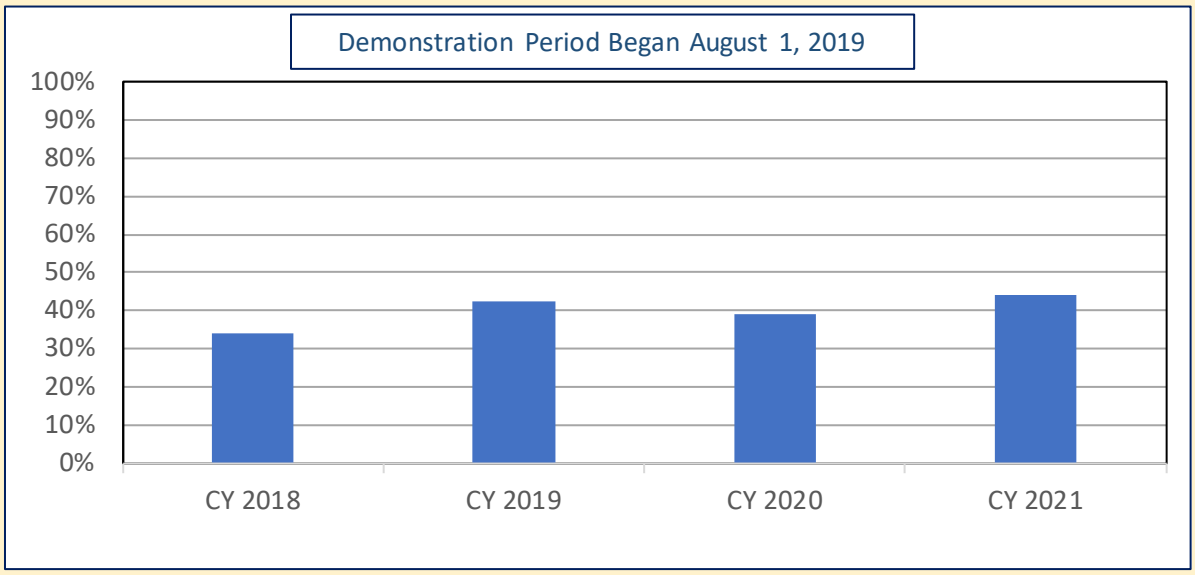
Desired Outcome:	Increase
Actual Outcome:	Increase
Statistical Review:	Chi-Square
Probability:	0.6111
Finding:	Not Significant

Exhibit 32
Results for Interim Evaluation Measure #24
Postpartum Care

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP members in the current demonstration period.

Measure Used to Test Hypothesis:
Postpartum Care
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	1,317	3,856	34.2%	
CY 2019	1,710	4,034	42.4%	
CY 2020	1,529	3,910	39.1%	
CY 2021	1,620	3,667	44.2%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				22.7%

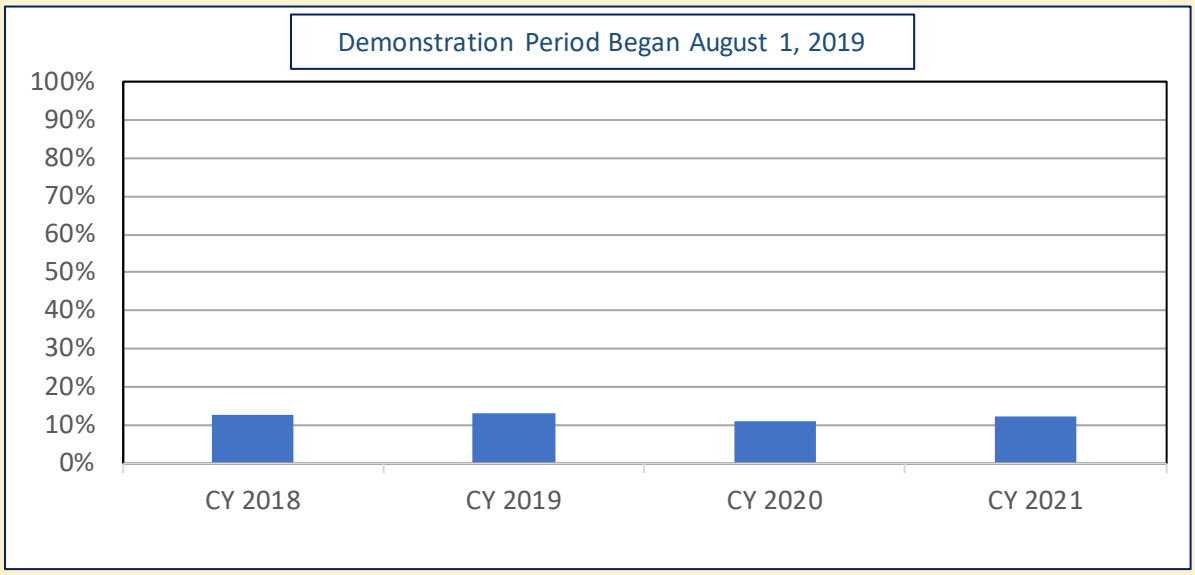
Desired Outcome:	Increase
Actual Outcome:	Increase
Statistical Review:	Chi-Square
Probability:	<.0001
Finding:	Significant

Exhibit 33
Results for Interim Evaluation Measure #25
Follow-up After Hospitalization for Mental Illness

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP members in the current demonstration period.

Measure Used to Test Hypothesis:
Follow-up After Hospitalization for Mental Illness
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	3,248	25,868	12.6%	
CY 2019	3,283	25,131	13.1%	
CY 2020	2,614	23,912	10.9%	
CY 2021	3,061	25,162	12.2%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-3.2%

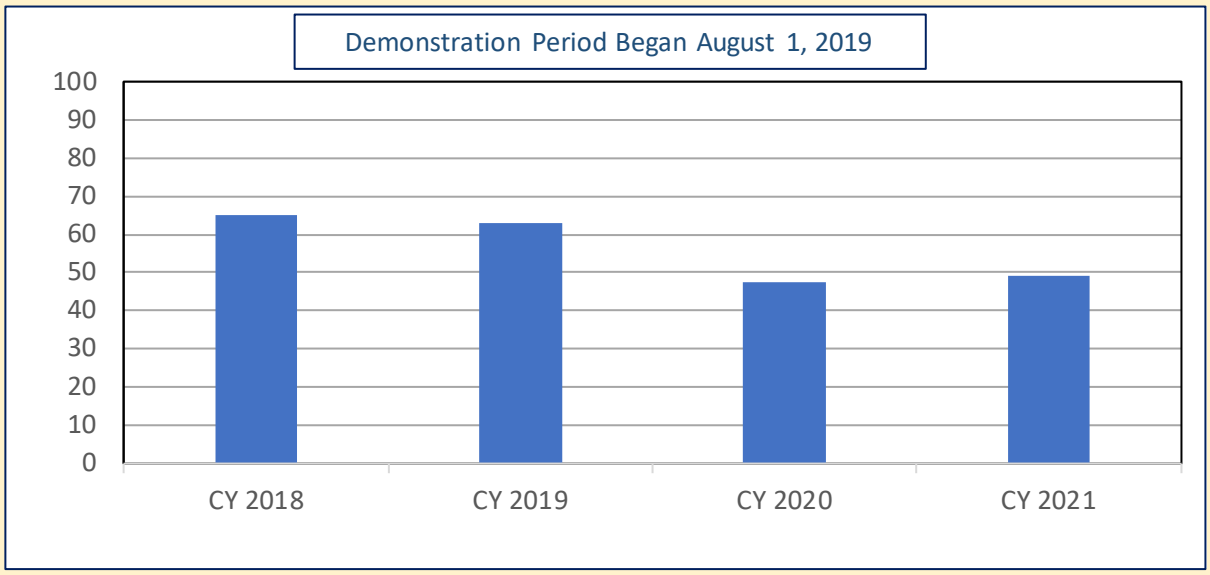
Desired Outcome: Increase
Actual Outcome: Decrease
Statistical Review: Chi-Square
Probability: 0.1799
Finding: Not Significant

Exhibit 34
Results for Interim Evaluation Measure #26
Emergency Department Visits Per 1,000 Medicaid Beneficiaries

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP members in the current demonstration period.

Measure Used to Test Hypothesis:
ED Visits Per 1,000 Medicaid Beneficiaries, DSHP
Measure Steward: HMA-Burns

Results for the DSHP Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	145,299	2,229,669	65.2	
CY 2019	139,285	2,216,204	62.8	
CY 2020	110,406	2,335,916	47.3	
CY 2021	131,194	2,664,512	49.2	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-32.4%

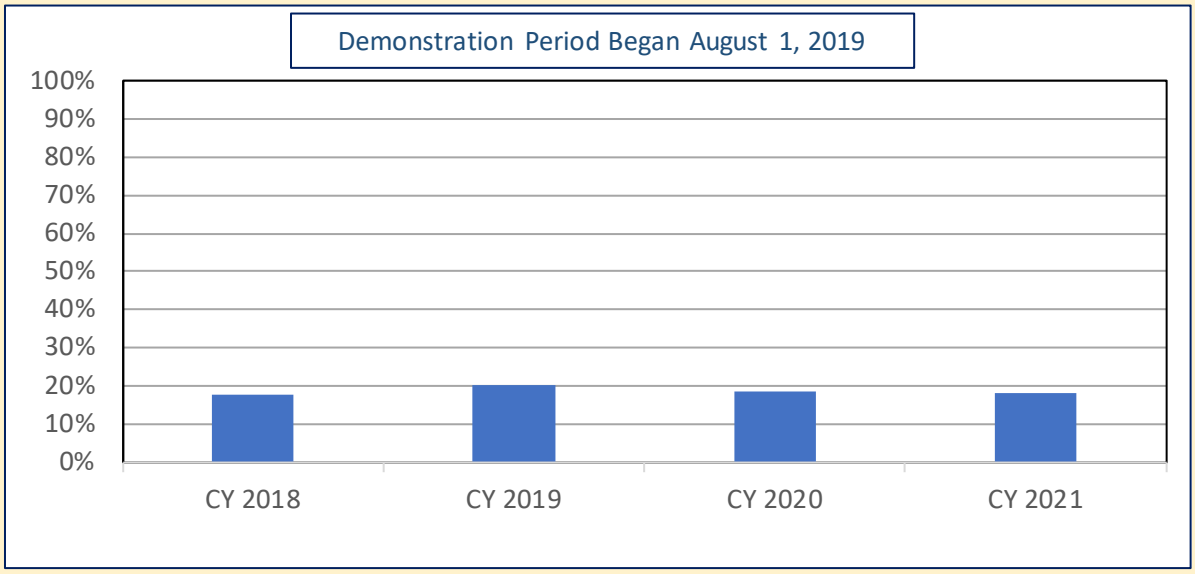
Desired Outcome:	Decrease
Actual Outcome:	Decrease
Statistical Review:	T-test
Probability > [t]:	<.0001
Finding:	Significant

Exhibit 35
Results for Interim Evaluation Measure #27
Follow-up After ED Visit for Alcohol or Other Drug (AOD) Dependence

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP members in the current demonstration period.

Measure Used to Test Hypothesis:
Follow-up After ED Visit for Alcohol or Other Drug (AOD) Dependence
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	264	1,499	17.6%	
CY 2019	328	1,619	20.3%	
CY 2020	303	1,650	18.4%	
CY 2021	317	1,749	18.1%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				2.8%

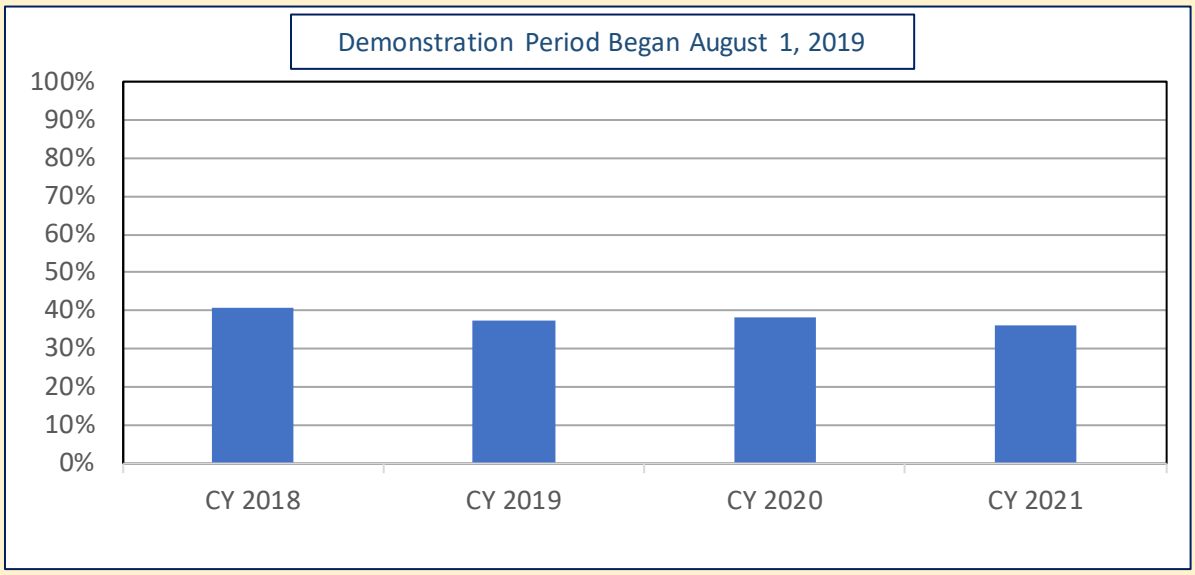
Desired Outcome:	Increase
Actual Outcome:	Increase
Statistical Review:	Chi-Square
Probability:	0.7038
Finding:	Not Significant

Exhibit 36
Results for Interim Evaluation Measure #28
Follow-up After ED Visit for Mental Illness

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP members in the current demonstration period.

Measure Used to Test Hypothesis:
Follow-up After ED Visit for Mental Illness
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	528	1,291	40.9%	
CY 2019	639	1,710	37.4%	
CY 2020	543	1,422	38.2%	
CY 2021	503	1,392	36.1%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-13.2%

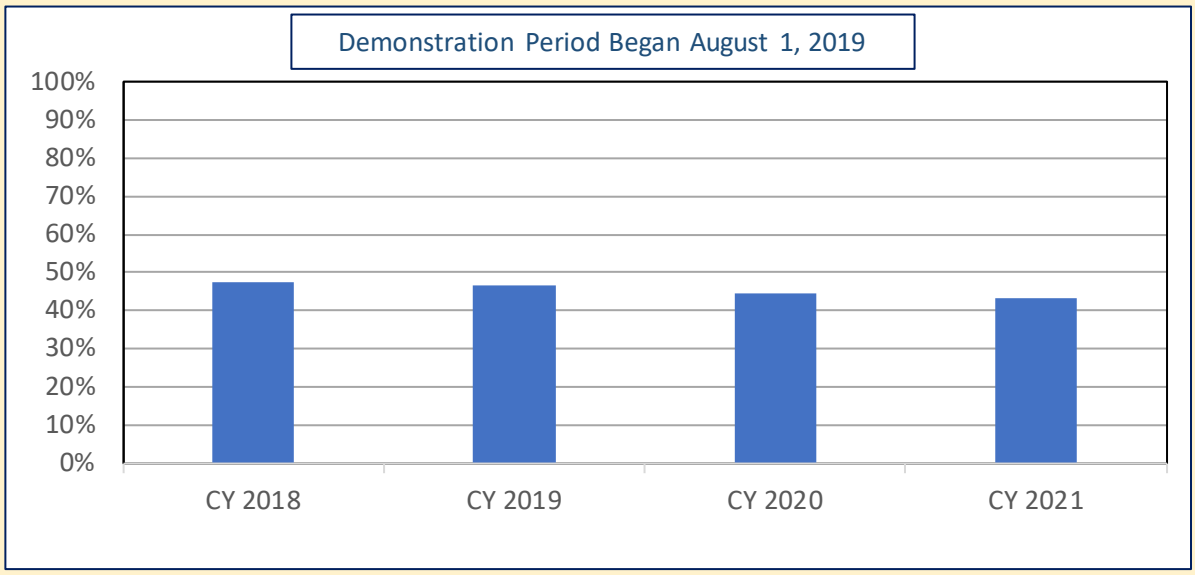
Desired Outcome:	Increase
Actual Outcome:	Decrease
Statistical Review:	Chi-Square
Probability:	0.0113
Finding:	Significant

Exhibit 37
Results for Interim Evaluation Measure #29
Follow-up After ED Visit for People with Multiple High-Risk Chronic Conditions

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP members in the current demonstration period.

Measure Used to Test Hypothesis:
Follow-up After ED Visit for People with Multiple High-Risk Chronic Conditions
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	902	1,907	47.3%	
CY 2019	907	1,950	46.5%	
CY 2020	804	1,804	44.6%	
CY 2021	822	1,893	43.4%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-8.9%

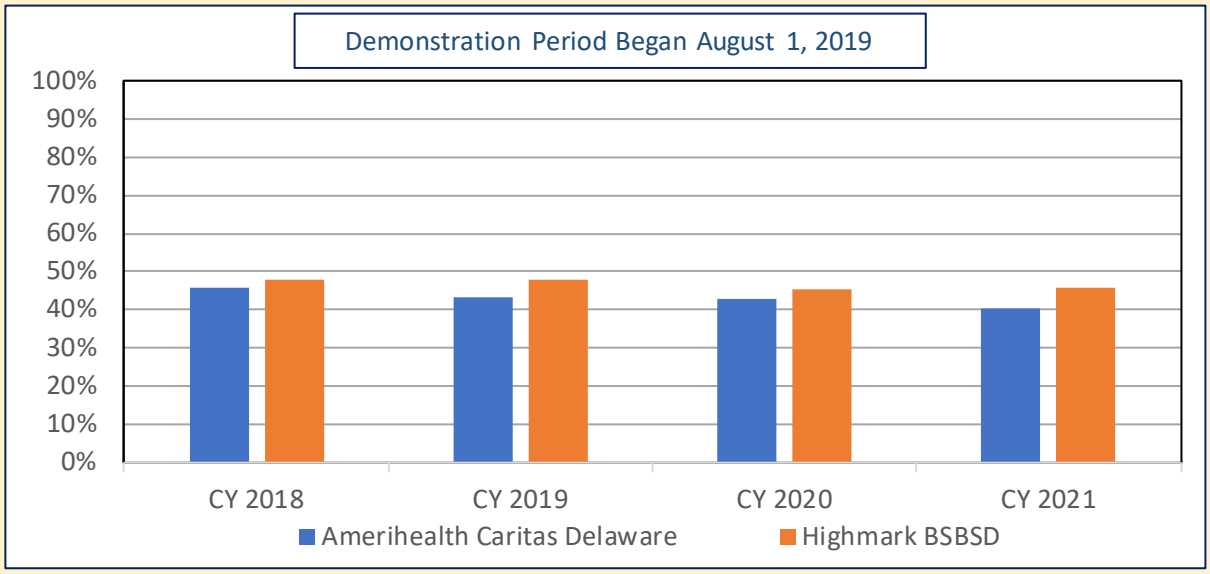
Desired Outcome:	Increase
Actual Outcome:	Decrease
Statistical Review:	Chi-Square
Probability:	0.0164
Finding:	Significant

Exhibit 37 (MCO)
Results for Interim Evaluation Measure #29
Follow-up After ED Visit for People with Multiple High-Risk Chronic Conditions

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP members in the current demonstration period.

Measure Used to Test Hypothesis:
Follow-up After ED Visit for People with Multiple High-Risk Chronic Conditions
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Population in the Demonstration



	Study Period	Numerator	Denominator	Rate	
Amerihealth Caritas Delaware	CY 2018	229	501	45.7%	
	CY 2019	265	614	43.2%	
	CY 2020	277	645	42.9%	
	CY 2021	309	769	40.2%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-13.8%
Highmark BSBSD	CY 2018	673	1,406	47.9%	
	CY 2019	642	1,336	48.1%	
	CY 2020	527	1,159	45.5%	
	CY 2021	513	1,124	45.6%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-4.9%

	Amerihealth	Highmark
Desired Outcome:	Increase	Increase
Actual Outcome:	Decrease	Decrease
Statistical Review:	Chi-Square	Chi-Square
Probability:	0.0514	0.265
Finding:	Not Significant	Not Significant

Results from Study of Prenatal Care

Medicaid women enrolled in the demonstration (managed care) who delivered a child during the period of October 1, 2019 and September 30, 2020 were analyzed to track the number of prenatal visits that they received in the last four weeks of their pregnancy prior to delivery. HMA-Burns identified the study sample using the value set for the HEDIS measure PPC: Timeliness of Prenatal Care. The delivery date of each mother was tracked specifically so that the four-week window prior to delivery could be examined to count the number of prenatal visits.

As Exhibit 38 below shows, more than 95 percent of the 3,941 women in the study were enrolled with their MCO for at least the second half of their pregnancy. Approximately 90 percent of women were enrolled with the MCO for the full second and third trimester of their pregnancy.

Exhibit 38
Number of Weeks Enrolled with the MCO Prior to Delivery

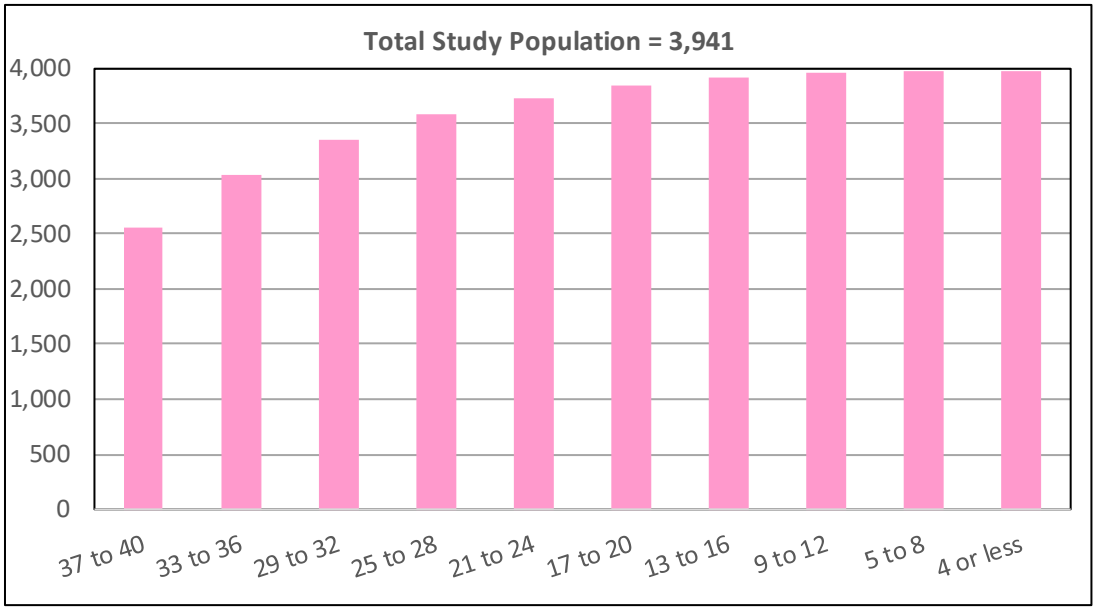
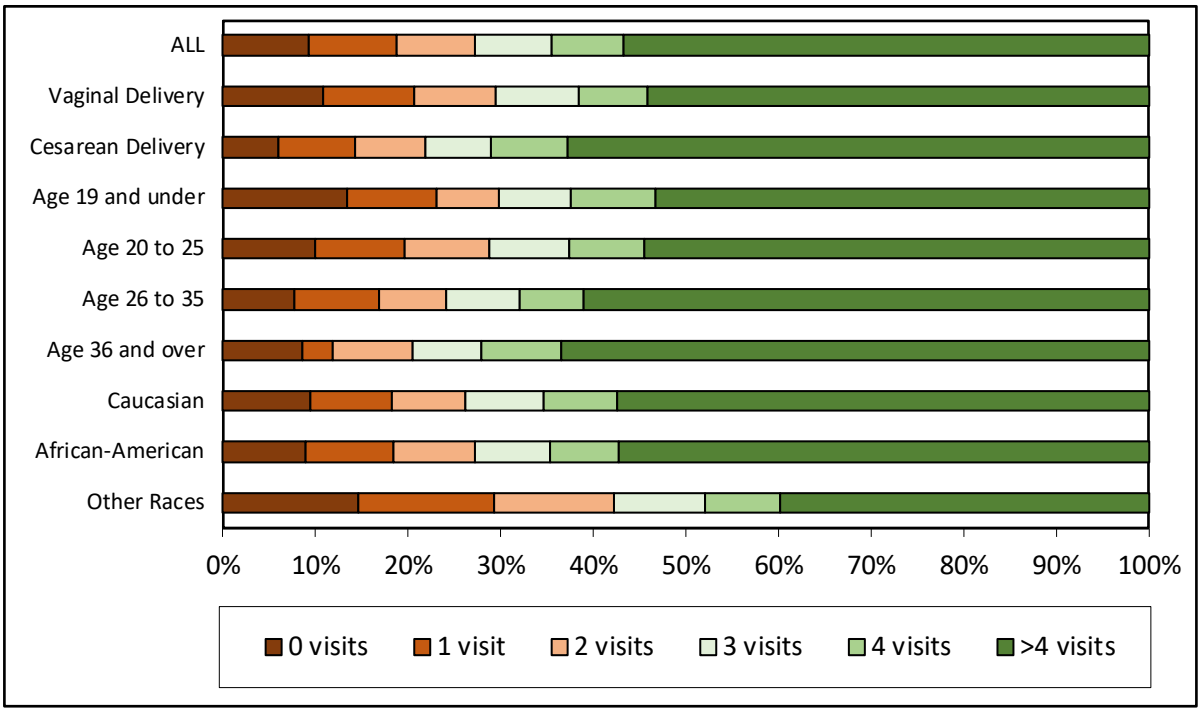


Exhibit 39 on the next page identifies the number of prenatal visits that each mother had in the four weeks prior to delivery. As seen in the exhibit above, all of the mothers were enrolled with their MCO in these last four weeks.

The American College of Obstetricians and Gynecologists recommends one prenatal visit per week in the last four weeks of pregnancy. Among the study population, 65 percent had four or more visits during this time period. Seventy-three percent of women had at least three visits. There was some variation in the percentage of women with four or more visits whether the delivery was vaginal (62% of total within this population) or Cesarean (71% of total within this population). Among the four age groups examined, between 62 and 68 percent of women in the three younger age groups had at least four visits. Seventy-two percent of women ages 36 and over had four or more visits, but the sample was small (n=93).

The percentage of Caucasian and African-American women in the DSHP program with four or more visits in the four weeks prior to delivery was the same (65%) as was the percentage with at least three visits (74%). Women of other races had a lower rate of visits, but this sample was small as well (n=123).

Exhibit 39
Number of Prenatal Visits in Last 4 Weeks Before Delivery



	Number of Women (n=3,941)					
	0 visits	**1 visit**	**2 visits**	**3 visits**	**4 visits**	**>4 visits**
ALL	**9%**	**9%**	**8%**	**8%**	**8%**	**57%**
Vaginal Delivery	11%	10%	9%	9%	7%	54%
Cesarean Delivery	6%	8%	8%	7%	8%	63%
Age 19 and under	13%	10%	7%	8%	9%	53%
Age 20 to 25	10%	10%	9%	9%	8%	55%
Age 26 to 35	8%	9%	7%	8%	7%	61%
Age 36 and over	9%	3%	9%	8%	9%	63%
Caucasian	9%	9%	8%	8%	8%	57%
African-American	9%	10%	9%	8%	7%	57%
Other Races	15%	15%	13%	10%	8%	40%

Demonstration Goal #5: Expand Consumer Choices

Summary of Measures

Eight measures were examined to assess feedback from Medicaid members—six related to the annual CAHPS survey administered by each of the Medicaid MCOs, two other measures related to member grievances and appeals. Among the six CAHPS composite measures examined, improvement was seen in four of the six during the demonstration period thus far. Member grievances have increased since the start of the demonstration period, but member appeals have decreased.

Exhibit 40
Summary of Findings for Measures Mapped to Research Question #7

Research Question #7: Does the level and satisfaction among DSHP members continue (or not worsen) in the current waiver period?

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
30	CAHPS, Rating of Health Plan	Increase	Increase	No statistical tests were run on these measures	
31	CAHPS, Rating of Personal Doctor	Increase	Increase		
32	CAHPS, Getting Needed Care	Increase	Decrease		
33	CAHPS, Getting Care Quickly	Increase	Decrease		
34	CAHPS, How Well Doctors Communicate	Increase	Increase		
35	CAHPS, Customer Service	Increase	Increase		
36	Member Grievances per 1,000	Decrease	Increase		
37	Member Appeals per 1,000	Decrease	Decrease		

Individual Measure Results

Exhibit 41 summarizes the results of all six CAHPS composite measures. For each measure, results are shown for both MCOs (AmeriHealth Caritas Delaware, or ACDE and Highmark Health Options, or HHO) as well as separate results for the CAHPS Adult and CAHPS Child Surveys. Results were compared for the CY 2019, CY 2020 and CY 2021 survey years.

The Rating of Health Plan increased across both MCOs and surveys with the most recent year ratings showing 87 to 94 percent of members giving the MCOs a rating of 8, 9, or 10 on a 10-point scale. Similarly, Customer Service increased over the three years examined in three of the four survey instruments. The results for Getting Needed Care and Getting Care Quickly decreased between CY 2019 and CY 2021. But even in CY 2021, approximately 85 percent of respondents answered "usually" or "always" to these two questions in all surveys conducted. The Rating of Personal Doctor and How Well Doctors Communicate remain high.

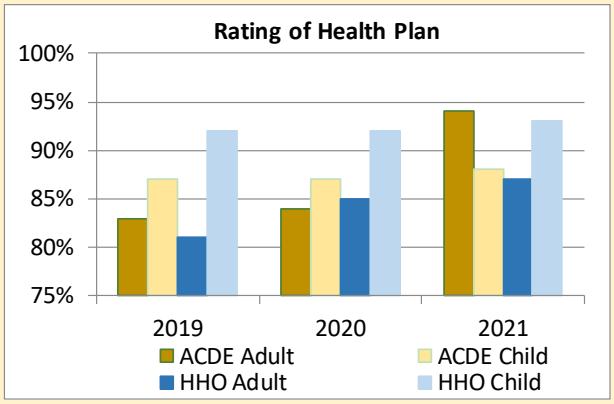
Exhibit 42 shows the results for member grievances and appeals. Both grievances and appeals remain very low when measured on a per 1,000 member month basis. Grievances increased in CY 2020 and CY 2021 among the DSHP Plus population, but appeals remain low. Results by MCO follow similar trends.

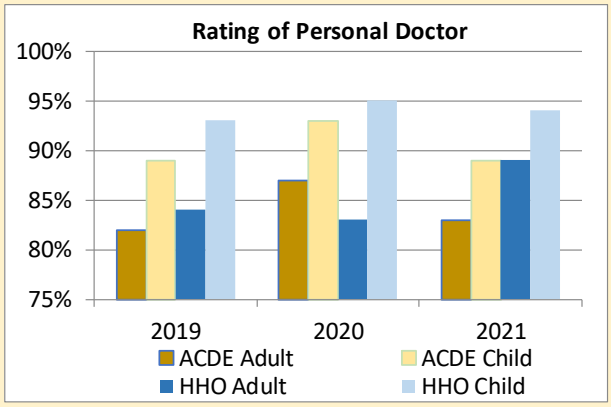
Exhibit 41
Results for Interim Evaluation Measures #30 through #35
Consumer Assessment of Healthcare Providers and Systems

Hypothesis:
Trends in consumer satisfaction will continue (or not worsen) in the current demonstration period.

Measures Used to Test Hypothesis:	The six composite measures shown below for the DSHP population
Measure Steward:	Agency for Healthcare Research and Quality
Data source:	Results included in reports prepared by certified CAHPS surveyors and submitted to DMMA by the MCOs

Results on Composite Measures where members giving a rating of 8, 9 or 10 on 10-point scale
Legend: ACDE = AmeriHealth Caritas Delaware; HHO = Highmark Health Options



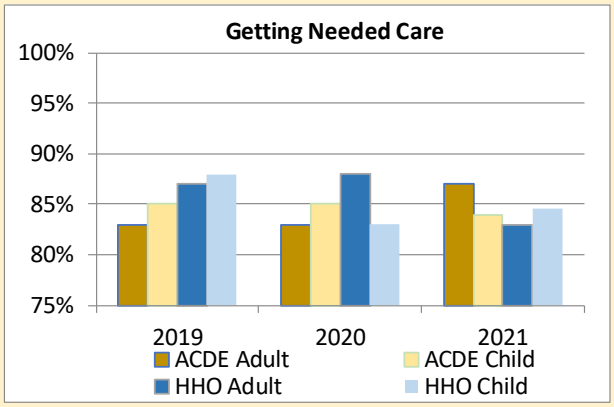


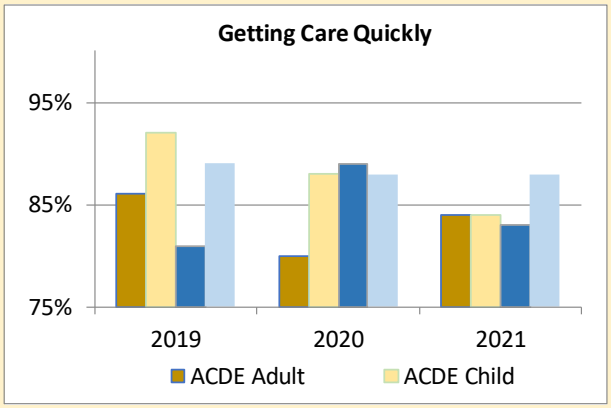
	2019	2020	2021	Change*
MCO Average	85.8%	87.0%	90.5%	4.8%
ACDE Adult	83.0%	84.0%	94.0%	11.0%
ACDE Child	87.0%	87.0%	88.0%	1.0%
HHO Adult	81.0%	85.0%	87.0%	6.0%
HHO Child	92.0%	92.0%	93.0%	1.0%

	2019	2020	2021	Change*
MCO Average	87.0%	89.5%	88.8%	1.8%
ACDE Adult	82.0%	87.0%	83.0%	1.0%
ACDE Child	89.0%	93.0%	89.0%	0.0%
HHO Adult	84.0%	83.0%	89.0%	5.0%
HHO Child	93.0%	95.0%	94.0%	1.0%

*Change Baseline (CY 2019) to Demonstration Period (CY 2021)

Results on Composite Measures where percentage of respondents answered "Usually" or "Always"





	2019	2020	2021	Change*
MCO Average	85.8%	84.8%	84.7%	-1.1%
ACDE Adult	83.0%	83.0%	87.0%	4.0%
ACDE Child	85.0%	85.0%	84.0%	-1.0%
HHO Adult	87.0%	88.0%	83.0%	-4.0%
HHO Child	88.0%	83.0%	84.6%	-3.4%

	2019	2020	2021	Change*
MCO Average	87.0%	86.3%	84.8%	-2.3%
ACDE Adult	86.0%	80.0%	84.0%	-2.0%
ACDE Child	92.0%	88.0%	84.0%	-8.0%
HHO Adult	81.0%	89.0%	83.0%	2.0%
HHO Child	89.0%	88.0%	88.0%	-1.0%

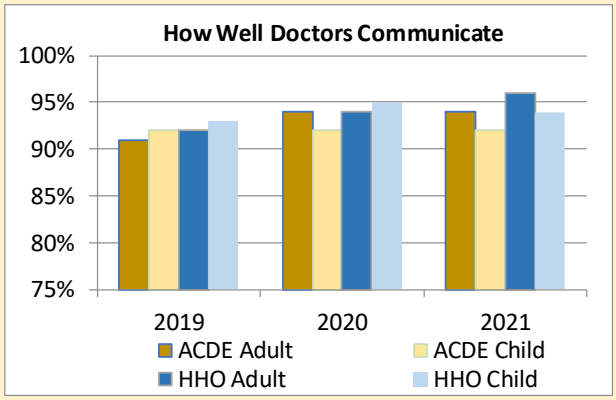
*Change Baseline (CY 2019) to Demonstration Period (CY 2021)

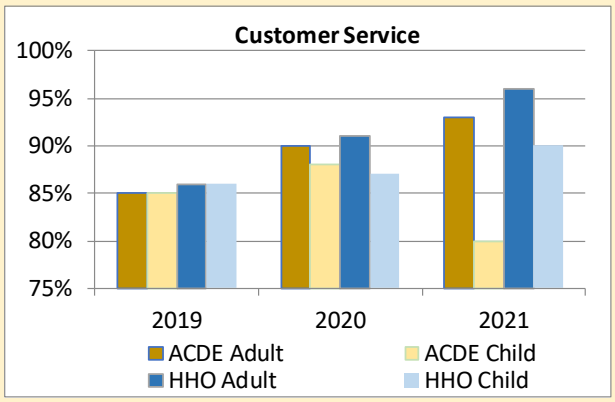
Exhibit 41 (continued)
Results for Interim Evaluation Measures #30 through #35
Consumer Assessment of Healthcare Providers and Systems

Hypothesis:
Trends in consumer satisfaction will continue (or not worsen) in the current demonstration period.

Measures Used to Test Hypothesis:	The six composite measures shown below for the DSHP population
Measure Steward:	Agency for Healthcare Research and Quality
Data source:	Results included in reports prepared by certified CAHPS surveyors and submitted to DMMA by the MCOs

Results on Composite Measures where members giving a rating of 8, 9 or 10 on 10-point scale
Legend: ACDE = AmeriHealth Caritas Delaware; HHO = Highmark Health Options





	2019	2020	2021	Change*
MCO Average	92.0%	93.8%	94.0%	2.0%
ACDE Adult	91.0%	94.0%	94.0%	3.0%
ACDE Child	92.0%	92.0%	92.0%	0.0%
HHO Adult	92.0%	94.0%	96.0%	4.0%
HHO Child	93.0%	95.0%	94.0%	1.0%

	2019	2020	2021	Change*
MCO Average	85.5%	89.0%	89.8%	4.3%
ACDE Adult	85.0%	90.0%	93.0%	8.0%
ACDE Child	85.0%	88.0%	80.0%	-5.0%
HHO Adult	86.0%	91.0%	96.0%	10.0%
HHO Child	86.0%	87.0%	90.0%	4.0%

*Change Baseline (CY 2019) to Demonstration Period (CY 2021)

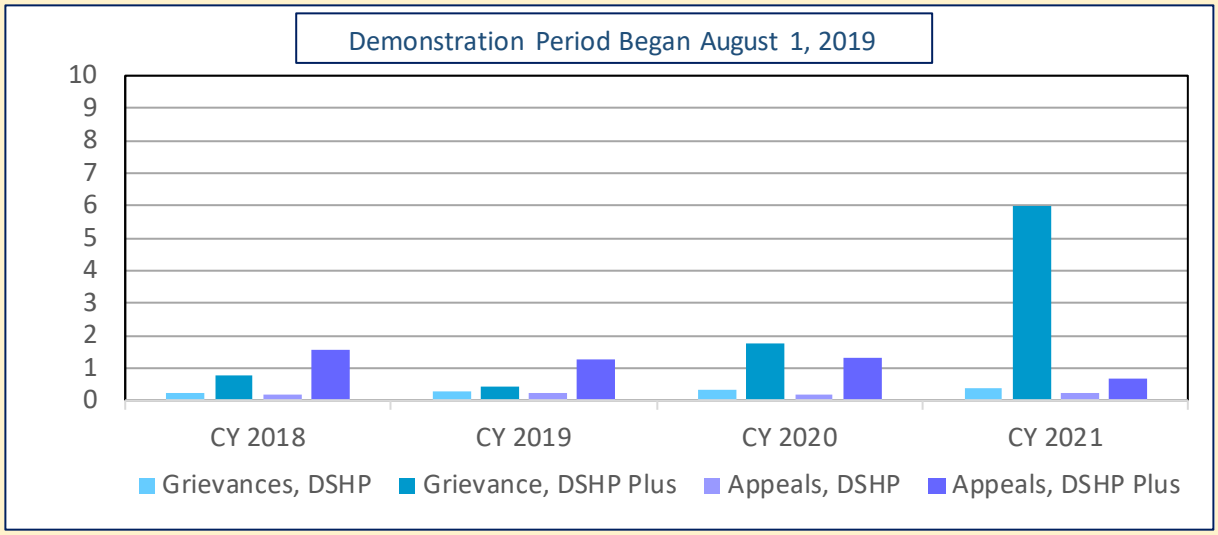
Exhibit 42 (All)
Results for Interim Evaluation Measures #36 and #37
Member Grievances and Appeals

Hypothesis:
Trends in consumer satisfaction will continue (or not worsen) in the current demonstration period.

Measures Used to Test Hypothesis:
1. Grievances per 1,000 Member Months, DSHP and DSHP Plus Populations separately
2. Appeals per 1,000 Member Months, DSHP and DSHP Plus Populations separately

Measure Steward: HMA-Burns
Data Source: Quarterly reports submitted by the MCOs to DMMA

Results for the DSHP and DSHP Plus Populations in the Demonstration



	Study Period	Numerator	Denominator	Rate
Grievances, DSHP	CY 2018	565	2,229,669	0.3
	CY 2019	626	2,216,204	0.3
	CY 2020	754	2,335,916	0.3
	CY 2021	956	2,664,512	0.4
Grievances, DSHP Plus	CY 2018	69	89,635	0.8
	CY 2019	43	95,391	0.5
	CY 2020	170	97,244	1.7
	CY 2021	553	92,149	6.0
Appeals, DSHP	CY 2018	448	2,229,669	0.2
	CY 2019	555	2,216,204	0.3
	CY 2020	465	2,335,916	0.2
	CY 2021	587	2,664,512	0.2
Appeals, DSHP Plus	CY 2018	138	89,635	1.5
	CY 2019	120	95,391	1.3
	CY 2020	127	97,244	1.3
	CY 2021	60	92,149	0.7

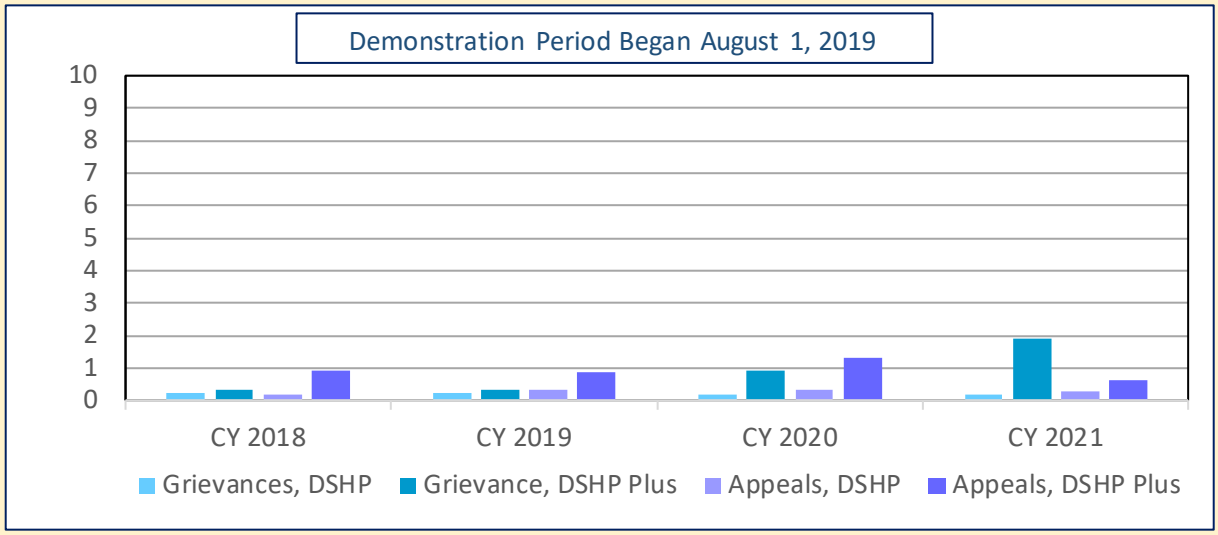
Exhibit 42 (AmeriHealth Caritas)
Results for Interim Evaluation Measures #36 and #37
Member Grievances and Appeals

Hypothesis:
Trends in consumer satisfaction will continue (or not worsen) in the current demonstration period.

Measures Used to Test Hypothesis:
1. Grievances per 1,000 Member Months, DSHP and DSHP Plus Populations separately
2. Appeals per 1,000 Member Months, DSHP and DSHP Plus Populations separately

Measure Steward: HMA-Burns
Data Source: Quarterly reports submitted by the MCOs to DMMA

Results for the DSHP and DSHP Plus Populations in the Demonstration - AmeriHealth Caritas



	Study Period	Numerator	Denominator	Rate
Grievances, DSHP	CY 2018	119	525,883	0.2
	CY 2019	153	687,890	0.2
	CY 2020	144	846,993	0.2
	CY 2021	179	1,029,806	0.2
Grievances, DSHP Plus	CY 2018	9	26,635	0.3
	CY 2019	11	31,521	0.3
	CY 2020	33	36,427	0.9
	CY 2021	69	36,315	1.9
Appeals, DSHP	CY 2018	108	525,883	0.2
	CY 2019	227	687,890	0.3
	CY 2020	264	846,993	0.3
	CY 2021	312	1,029,806	0.3
Appeals, DSHP Plus	CY 2018	24	26,635	0.9
	CY 2019	28	31,521	0.9
	CY 2020	47	36,427	1.3
	CY 2021	23	36,315	0.6

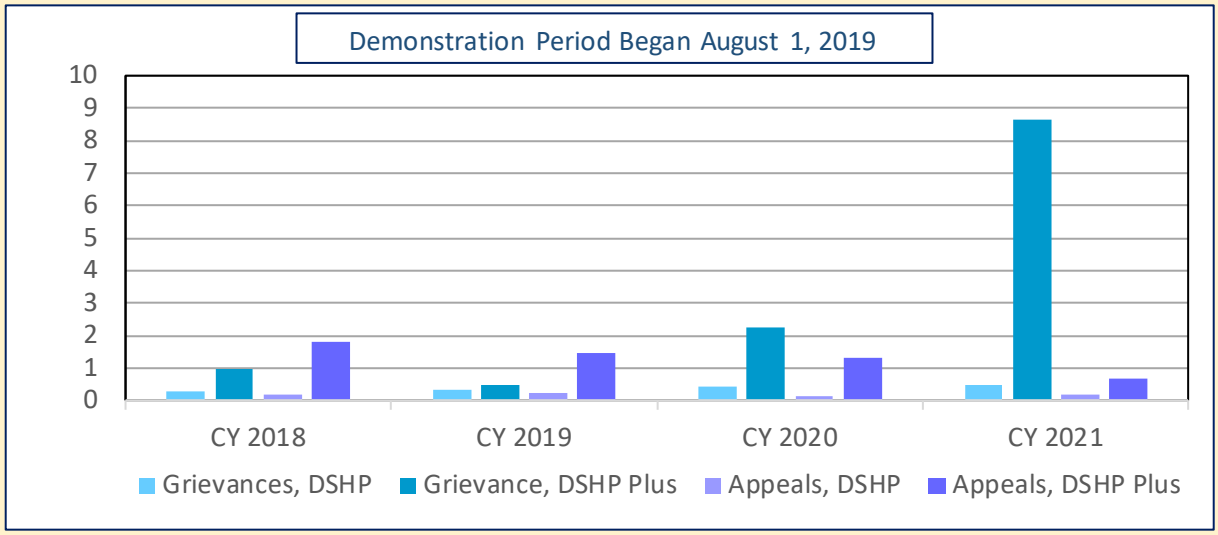
Exhibit 42 (Highmark Health Options)
Results for Interim Evaluation Measures #36 and #37
Member Grievances and Appeals

Hypothesis:
Trends in consumer satisfaction will continue (or not worsen) in the current demonstration period.

Measures Used to Test Hypothesis:
1. Grievances per 1,000 Member Months, DSHP and DSHP Plus Populations separately
2. Appeals per 1,000 Member Months, DSHP and DSHP Plus Populations separately

Measure Steward: HMA-Burns
Data Source: Quarterly reports submitted by the MCOs to DMMA

Results for the DSHP and DSHP Plus Populations in the Demonstration - Highmark Health Options



	Study Period	Numerator	Denominator	Rate
Grievances, DSHP	CY 2018	446	1,703,786	0.3
	CY 2019	473	1,528,314	0.3
	CY 2020	610	1,488,923	0.4
	CY 2021	777	1,634,706	0.5
Grievances, DSHP Plus	CY 2018	60	63,000	1.0
	CY 2019	32	63,870	0.5
	CY 2020	137	60,817	2.3
	CY 2021	484	55,834	8.7
Appeals, DSHP	CY 2018	340	1,703,786	0.2
	CY 2019	328	1,528,314	0.2
	CY 2020	201	1,488,923	0.1
	CY 2021	275	1,634,706	0.2
Appeals, DSHP Plus	CY 2018	114	63,000	1.8
	CY 2019	92	63,870	1.4
	CY 2020	80	60,817	1.3
	CY 2021	37	55,834	0.7

Demonstration Goal #6: Improve the Quality of Health Services, Including Long Term Care Services, Delivered to All Delawareans

Summary of Measures

As a way to assess the quality of long term care services, six CAHPS measures were once again examined, but this time the results are specific to a separate CAHPS survey that is administered to the population receiving long term services and supports (LTSS). Among the six LTSS CAHPS composite measures examined, improvement was seen in all six measures during the demonstration period thus far. Critical incidents were also examined among the DSHP Plus population (the population that most often uses LTSS). The rate of critical incidents per 1,000 has decreased during the demonstration period.

Exhibit 43
Summary of Findings for Measures Mapped to Research Question #9

Research Question #9: Do DSHP Plus members achieve similar or improved quality of care and health outcomes in the current demonstration period?

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
38	LTSS CAHPS, Rating of Health Plan	Increase	Increase	No statistical tests were run on these measures	
39	LTSS CAHPS, Rating of Personal Doctor	Increase	Increase		
40	LTSS CAHPS, Getting Needed Care	Increase	Increase		
41	LTSS CAHPS, Getting Care Quickly	Increase	Increase		
42	LTSS CAHPS, How Well Doctors Communicate	Increase	Increase		
43	LTSS CAHPS, Customer Service	Increase	Increase		
44	Critical Incidents per 1,000	Decrease	Decrease		

Individual Measure Results

Exhibit 44 summarizes the results of all six LTSS CAHPS composite measures. For each measure, results are shown for both MCOs (ACDE and HHO) and each MCO separately for the CY 2019, CY 2020 and CY 2021 survey years.

Customer Service and How Well Doctors Communicate received the highest rating of any of the composite scores examined. Both MCOs had at least 92 percent of respondents answer "usually" or "always" to these two questions. The rating for Getting Needed Care improved over the three years of surveys examined, while Getting Care Quickly remained steady. For both composite measures, between 87 and 89 percent of respondents from both MCOs answered "usually" or "always" to these two questions. Only one composite measure, Rating of Health Plan, saw a lower score in CY 2021 than CY 2019, but this is for HHO only. For ACDE, the rating increased. The average of the two scores increased over the three-year period.

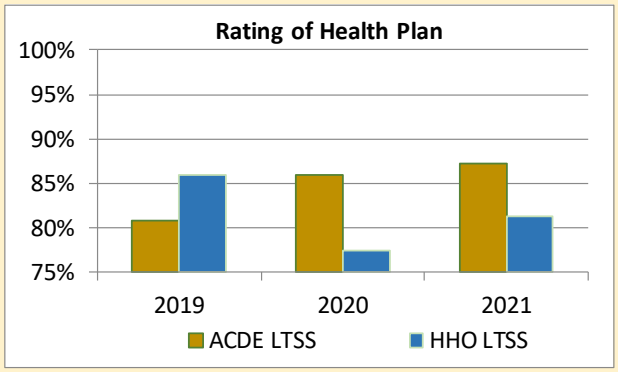
Exhibit 45 shows the results for critical incidents reported among DSHP Plus members for both MCOs and each MCO separately. When measured on a per 1,000 member month basis, the rate decreased from 6.1 per 1,000 in CY 2018 to 2.1 per 1,000 in both CY 2020 and CY 2021.

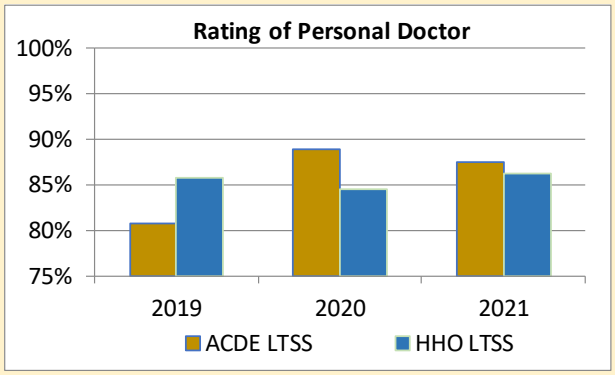
Exhibit 44
Results for Interim Evaluation Measures #38 through #43
Consumer Assessment of Healthcare Providers and Systems, LTSS

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP Plus members in the current demonstration period.

Measures Used to Test Hypothesis: The six composite measures shown below for the DSHP Plus population
Measure Steward: Agency for Healthcare Research and Quality
Data source: Results included in reports prepared by certified CAHPS surveyors and submitted to DMMA by the MCOs

Results on Composite Measures where members giving a rating of 8, 9 or 10 on 10-point scale
Legend: ACDE = AmeriHealth Caritas Delaware; HHO = Highmark Health Options



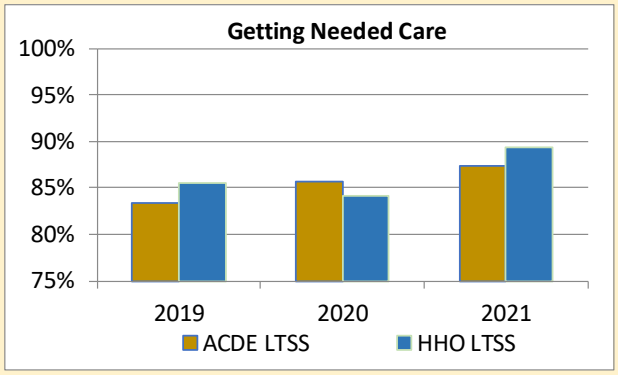


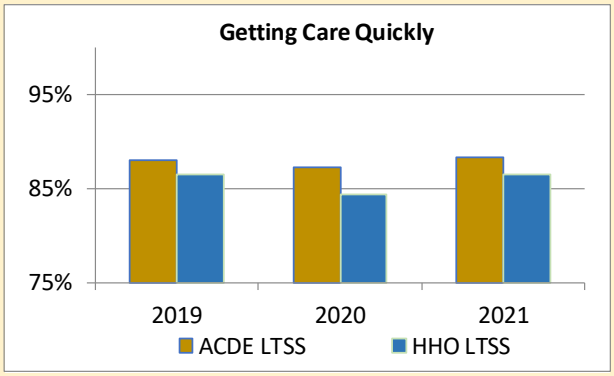
	2019	2020	2021	Change*
MCO Average	83.5%	81.7%	84.3%	0.8%
ACDE LTSS	80.9%	86.0%	87.2%	6.3%
HHO LTSS	86.0%	77.4%	81.4%	-4.6%

	2019	2020	2021	Change*
MCO Average	83.3%	86.7%	86.9%	3.7%
ACDE LTSS	80.8%	88.9%	87.5%	6.7%
HHO LTSS	85.7%	84.5%	86.3%	0.6%

*Change Baseline (CY 2019) to Demonstration Period (CY 2021)

Results on Composite Measures where percentage of respondents answered "Usually" or "Always"





	2019	2020	2021	Change*
MCO Average	84.4%	84.9%	88.4%	4.0%
ACDE LTSS	83.3%	85.7%	87.4%	4.1%
HHO LTSS	85.5%	84.1%	89.4%	3.9%

	2019	2020	2021	Change*
MCO Average	87.2%	85.8%	87.4%	0.2%
ACDE LTSS	88.0%	87.2%	88.3%	0.3%
HHO LTSS	86.4%	84.3%	86.5%	0.1%

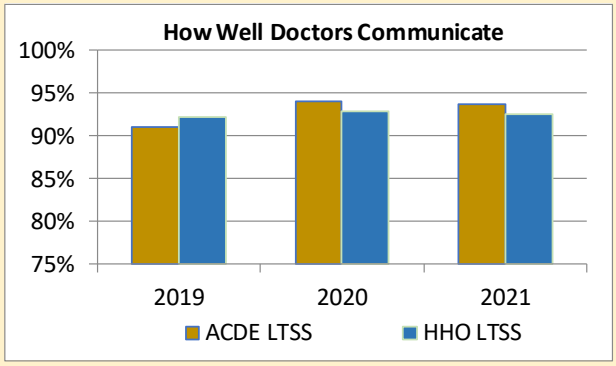
*Change Baseline (CY 2019) to Demonstration Period (CY 2021)

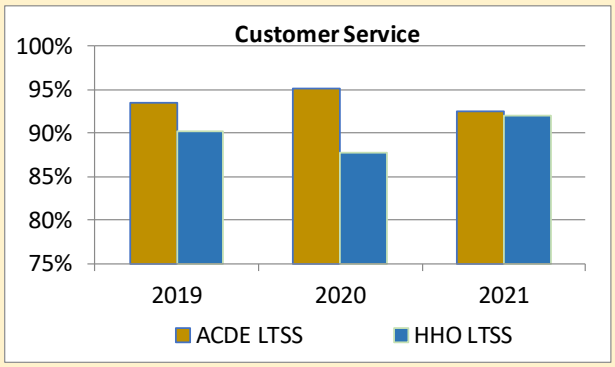
Exhibit 44 (continued)
Results for Interim Evaluation Measures #38 through #43
Consumer Assessment of Healthcare Providers and Systems, LTSS

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP Plus members in the current demonstration period.

Measures Used to Test Hypothesis: The six composite measures shown below for the DSHP Plus population
Measure Steward: Agency for Healthcare Research and Quality
Data source: Results included in reports prepared by certified CAHPS surveyors and submitted to DMMA by the MCOs

Results on Composite Measures where members giving a rating of 8, 9 or 10 on 10-point scale
Legend: ACDE = AmeriHealth Caritas Delaware; HHO = Highmark Health Options





	2019	2020	2021	Change*
MCO Average	91.7%	93.5%	93.2%	1.5%
ACDE LTSS	91.1%	94.1%	93.8%	2.7%
HHO LTSS	92.3%	92.9%	92.5%	0.2%

	2019	2020	2021	Change*
MCO Average	91.9%	91.5%	92.4%	0.4%
ACDE LTSS	93.5%	95.2%	92.6%	-0.9%
HHO LTSS	90.3%	87.8%	92.1%	1.8%

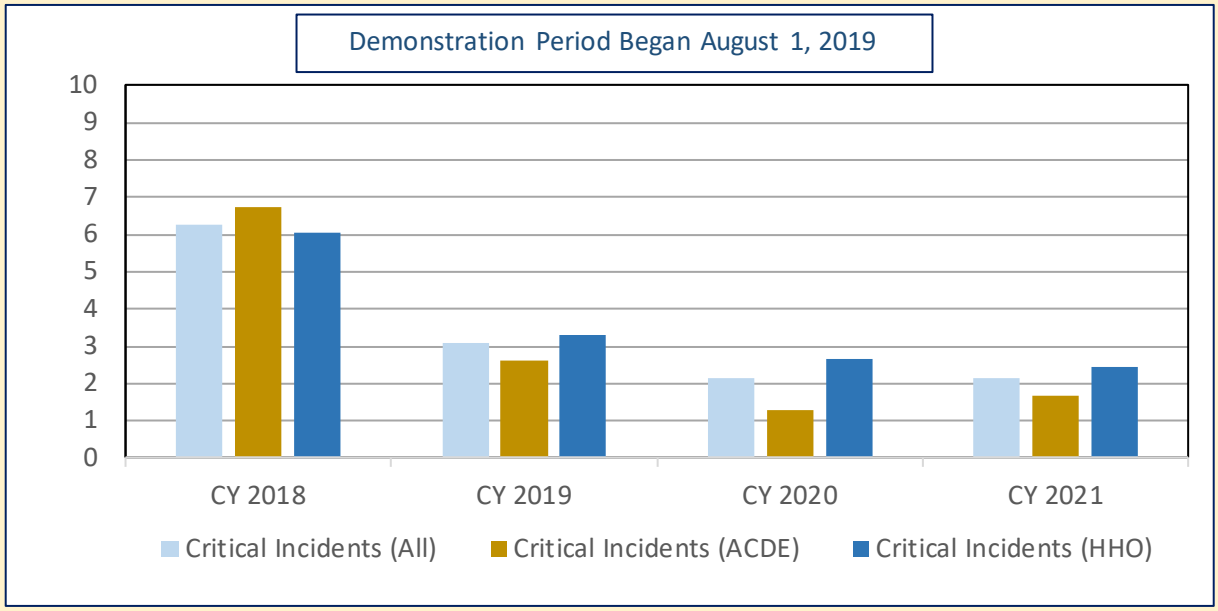
*Change Baseline (CY 2019) to Demonstration Period (CY 2021)

Exhibit 45
Results for Interim Evaluation Measure #44
Critical Incidents

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP Plus members in the current demonstration period.

Measure Used to Test Hypothesis:
Critical Incidents per 1,000 Member Months, DSHP Plus Population
Measure Steward: HMA-Burns
Data Source: Quarterly reports submitted by the MCOs to DMMA

Results for the DSHP Plus Population in the Demonstration



	Study Period	Numerator	Denominator	Rate
All MCOs	CY 2018	560	89,635	6.2
	CY 2019	293	95,391	3.1
	CY 2020	208	97,244	2.1
	CY 2021	197	92,149	2.1
Amerihealth Caritas Delaware	CY 2018	179	26,635	6.7
	CY 2019	82	31,521	2.6
	CY 2020	47	36,427	1.3
	CY 2021	61	36,315	1.7
Highmark Health Options	CY 2018	381	63,000	6.0
	CY 2019	211	63,870	3.3
	CY 2020	161	60,817	2.6
	CY 2021	136	55,834	2.4

Demonstration Goal #7: Create a Payment Structure that Provides Incentives for Resources to Shift from Institutions to Community-Based Long Term Care Services and Supports Where Appropriate

Actions Taken

HMA-Burns is not reporting any specific measures related to this demonstration goal, but the DMMA has taken action to create payment structures to incentivize the delivery of community-based services, particularly related to substance use disorder and mental health services.

DMMA recently completed a rate study of its community-based substance use disorder services. This was the first comprehensive review of rates since CY 2016. DMMA met with providers and a cost survey instrument was administered to providers to collect current costs to deliver each service. Providers were educated on the rate models that were developed for each service using costs and other market-based data, with components factored in including staff salary and fringe benefits, down-time during the week not meeting with clients face-to-face, program expenses, and administrative costs. A review of the substance use disorder provider manual was conducted to ensure that staffing and client ratio requirements in the provider manual are aligned with the new rate model assumptions.

After reviewing materials with providers on an informal basis, DMMA issued a public notice that showed the rate models in a transparent method on how the rates were built "from the ground up". The new rates go into effect on January 1, 2023. In all but two instances, rates for individual services are increasing between 14 percent and 45 percent. Rate updates are being made for the following services:

- ASAM Level 1 services: Assessments, Counseling, Peer Supports
- ASAM Level 2 services: Ambulatory Withdrawal Management, Intensive Outpatient, Partial Hospitalization
- ASAM Level 3 services: Per diem rates for each ASAM residential service level 3.1, 3.3, 3.5, 3.7, and 3.7-WM

Using a similar process, the DMMA is partnering with its sister agency the Division of Substance Abuse and Mental Health (DSAMH) to conduct a rate study of mental health services, including services offered to Medicaid members enrolled in PROMISE. It is anticipated that there will be a high level of engagement with the providers of these services which will include the release of a cost survey to providers. Rate models will be built in a transparent manner for each service in the study. Both an informal and a formal public notice process will be conducted. The initial results for stakeholder feedback on rate changes is anticipated for the Spring of 2023.

Demonstration Goal #8: Improve Coordination and Integration of Medicare and Medicaid Benefits for Full-Benefit Dual Eligibles

Summary of Measures

Demonstration Goal #8 focuses on the DSHP Plus population. Four measures were computed to assess coordination and integration of care for dual eligibles. One of the four measures (HEDIS FUM) was tested, but it is not reported due to low sample size. For the three measures that are reported, the actual outcome was the desired outcome in all cases. For one measure, the improvement was statistically significant.

Exhibit 46
Summary of Findings for Measures Mapped to Research Question #9

Research Question #9: Do DSHP Plus members achieve similar or improved quality of care and health outcomes in the current demonstration period?

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
45	Follow-up After Hospitalization for Mental Illness (FUH), DSHP Plus Population	Increase	Increase	No	Chi-square
46	Emergency Department Visits per 1000, DSHP Plus Population	Decrease	Decrease	No	Chi-square
47	Follow-up After ED Visit for People with Multiple High-Risk Chronic Conditions (FMC), DSHP Plus Population	Increase	Increase	Yes	Chi-square

	Follow-up After ED Visit for Mental Illness (FUM), DSHP Plus Population	Increase	Examined but not reported due to low sample (less than 100 observations in denominator each year)

Individual Measure Results

The rate of emergency department utilization, expressed on a per 1,000 member basis, decreased from 27.5 visits per 1,000 in CY 2018 to 26.3 visits per 1,000 in CY 2021 (refer to Exhibit 48). ED utilization actually fell for the DSHP Plus population between CY 2020 and CY 2021.

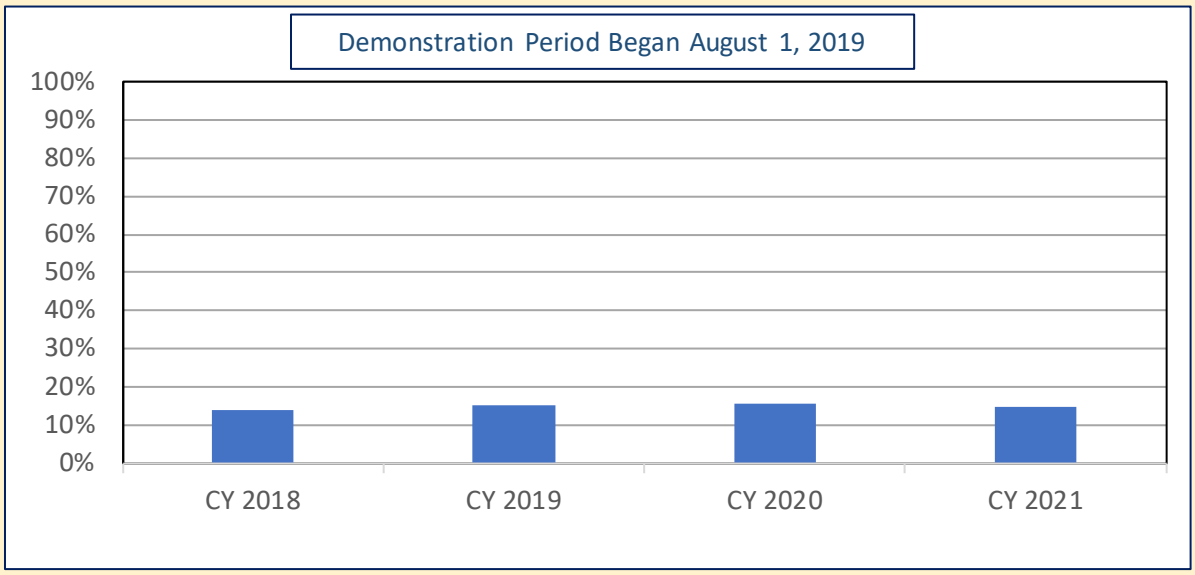
Follow-up care after hospitalization from a mental illness (HEDIS FUH measure) was low for DSHP Plus members in all four years examined (refer to Exhibit 47), but results were slightly higher than seen for the DSHP population. The follow-up rate increased slightly, from 14.1 percent in CY 2018 to 14.6 percent in CY 2021. Follow-up care after an ED visit for people with multiple high-risk conditions (HEDIS FMC measure) also saw a statistically significant increase, from 35.9 percent in CY 2018 to 48.5 percent in CY 2021 (Exhibit 49).

Exhibit 47
Results for Interim Evaluation Measure #45
Follow-up After Hospitalization for Mental Illness

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP Plus members in the current demonstration period.

Measure Used to Test Hypothesis:
Follow-up After Hospitalization for Mental Illness
Measure Steward: National Committee for Quality Assurance

Results for the DSHP Plus Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	260	1,843	14.1%	
CY 2019	260	1,719	15.1%	
CY 2020	247	1,567	15.8%	
CY 2021	278	1,908	14.6%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				3.2%

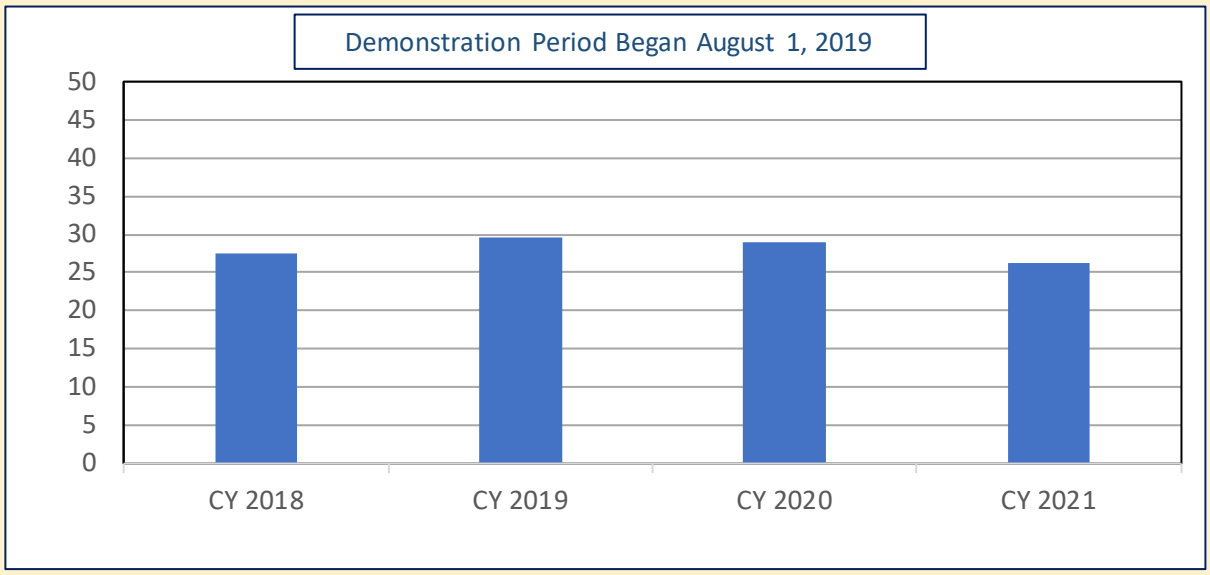
Desired Outcome:	Increase
Actual Outcome:	Increase
Statistical Review:	Chi-Square
Probability:	0.686
Finding:	Not Significant

Exhibit 48
Results for Interim Evaluation Measure #46
Emergency Department Visits Per 1,000 Medicaid Beneficiaries

Hypothesis:
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP Plus members in the current demonstration period.

Measure Used to Test Hypothesis:
ED Visits Per 1,000 Medicaid Beneficiaries, DSHP Plus
Measure Steward: HMA-Burns

Results for the DSHP Plus Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	2,465	89,635	27.5	
CY 2019	2,820	95,391	29.6	
CY 2020	2,810	97,244	28.9	
CY 2021	2,427	92,149	26.3	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-4.4%

Desired Outcome: Decrease
Actual Outcome: Decrease
Statistical Review: T-test
Probability > [t]: 0.4187
Finding: Not Significant

Exhibit 49

Results for Interim Evaluation Measure #47

Follow-up After ED Visit for People with Multiple High-Risk Chronic Conditions

Hypothesis:

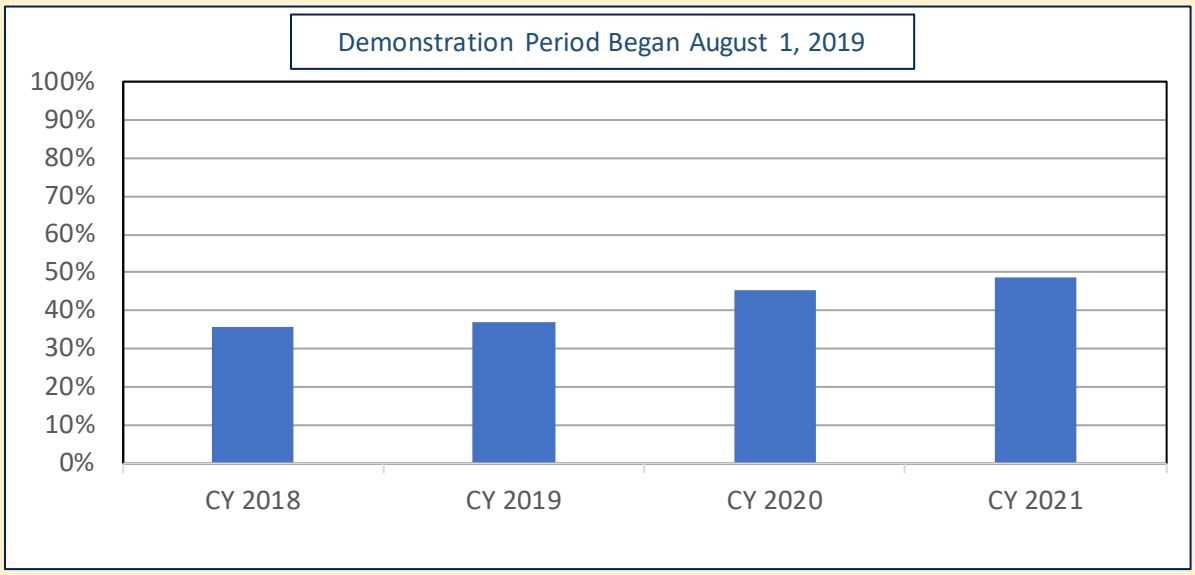
Coordination of care and supports maintains or improves quality of care and health outcomes for DSHP Plus members in the current demonstration period.

Measure Used to Test Hypothesis:

Follow-up After ED Visit for People with Multiple High-Risk Chronic Conditions

Measure Steward: National Committee for Quality Assurance

Results for the DSHP Plus Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	127	354	35.9%	
CY 2019	112	303	37.0%	
CY 2020	149	329	45.3%	
CY 2021	147	303	48.5%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				26.1%

Desired Outcome:	Increase
Actual Outcome:	Increase
Statistical Review:	Chi-Square
Probability:	0.0011
Finding:	Significant

Demonstration Goal #9: Improve Overall Health Status and Quality of Life of Individuals Enrolled in Promoting Optimal Mental Health for Individuals Through Supports and Empowerment (PROMISE)

Summary of Measures

Demonstration Goal #9 focuses on the PROMISE population. Twelve measures were computed to assess overall health status for PROMISE members. Two of the 12 measures are not being reported due to low sample size. Exhibit 50 on the next page summarizes the results of each measure. For the ten measures that are reported, for four measures the actual outcome was the desired outcome. For the other six measures, the opposite was true. Tests for statistical significance were conducted on five of the ten measures. In two of the five cases, the results were found to be statistically significant.

Individual Measure Results

HMA-Burns analyzed data from DSAMH, the division that processes PROMISE applications, to determine the percentage of applicants who are approved to enroll in PROMISE for the years CY 2018 to CY 2021 (refer to Exhibit 51). The enrollment rate increased from 30 percent in CY 2018 to 43 percent in CY 2021.

Many of the HEDIS measures that were computed for the DSHP and DSHP Plus populations were also computed specifically for the PROMISE population. Follow-up care measures were analyzed for PROMISE enrollees. The rate of follow-up after hospitalization for mental illness (HEDIS FUH) decreased from 13.3 percent in CY 2018 to 12.7 percent in CY 2021 (Exhibit 52). The rate of follow-up after an ED visit for mental illness (HEDIS FUM) saw a statistically significant decrease, from 76.5 percent in CY 2018 to 65.1 percent in CY 2021 (Exhibit 53).

Rates for the initiation and engagement of alcohol or other drug abuse dependence treatment (HEDIS IET) also decreased. The rate of initiation decreased from 54.9 percent in CY 2018 to 46.0 percent in CY 2021. The rate of engagement decreased from 25.0 percent in CY 2018 to 23.0 percent in CY 2021 (Exhibit 54).

The all-cause readmission rate (HEDIS PCR) remained steady at 48 percent for three of the four years, the exception being CY 2019 at 39 percent (Exhibit 55).

Whereas the rate of ED utilization decreased for DSHP and DSHP Plus members, the rate increased slightly in the first years of the demonstration for the PROMISE population, from a rate of 193.6 per 1,000 in CY 2018 to 200.2 per 1,000 in CY 2021 (refer to Exhibit 56). HMA-Burns also examined PROMISE members who are frequent users of the ED. The rate among members who presented at the ED more than five times in one year increased from 8.0 percent in CY 2018 to 9.7 percent in CY 2021.

The reduction in utilization for some services does not appear to correlate with the PROMISE provider network, since the network of providers has actually increased in the last four years from 318 to 377 providers (refer to Exhibit 57). Although PROMISE enrollment has also grown, the providers per 1,000 PROMISE members has increased 13.9 percent between CY 2018 and CY 2021, while the percent of PROMISE members receiving PROMISE services remained relatively steady during the same time period (refer to Exhibit 58).

Exhibit 50
Summary of Findings for Measures Mapped to Research Questions #10, #11 and #12

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
Research Question #10: Does the level and trend of access to enhanced behavioral health services continue (or not worsen) in the curent waiver period?					
48	Rate of Identified Members Who Enroll in PROMISE	Increase	Increase	N/A	no test run
49	Follow-up After Hospitalization for Mental Illness (FUH), PROMISE Population	Increase	Decrease	No	Chi-square
50	Follow-up After ED Visit for Mental Illness (FUM), PROMISE Population	Increase	Decrease	Yes	Chi-square
51	Initiation of AOD Dependence Treatment (IET), PROMISE Population	Increase	Decrease	No	Chi-square
52	Engagement of AOD Dependence Treatment (IET), PROMISE Population	Increase	Decrease	Yes	Chi-square

Note that the following measures were computed for the PROMISE population but are not reported due to low sample size:

Follow-Up After Discharge from the Emergency Department for Alcohol or Other Drug (AOD) Dependence (FUA)	Denominator <100 in each year examined

Research Question #11: Do PROMISE members enrolled in case/care management achieve similar or improved quality of care and health outcomes in the current waiver period?					
53	All-Cause Readmission, PROMISE Population	Decrease	Decrease	No	Chi-square
54	Emergency Department Visits per 1000, PROMISE Population	Decrease	Increase	N/A	no test run
55	Emergency Department Visit Frequent Users Rate, PROMISE Population	Decrease	Increase	N/A	no test run

Note that the following measures were computed for the PROMISE population but are not reported due to low sample size:

Antidepressant Medication Management (AMM), 12 weeks and 6 months	Denominator <50 in each year examined

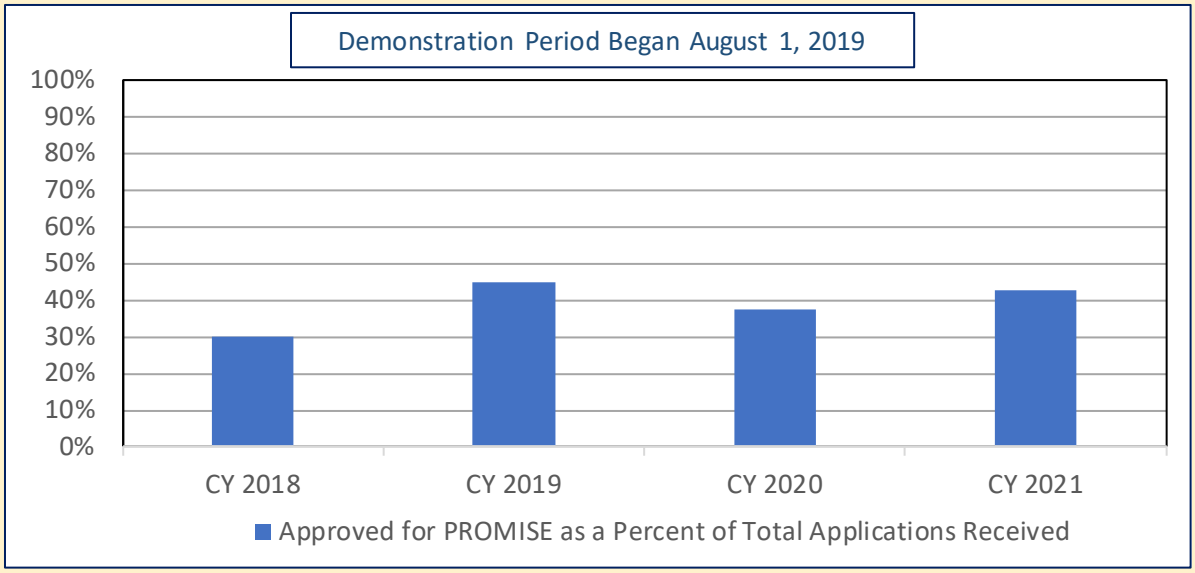
Research Question #12: Does the availability of PROMISE providers continue (or not worsen) the current waiver period?					
56	Number of Providers Delivering PROMISE Services per 1,000 PROMISE Members	Increase	Increase	N/A	no test run
57	Percent of PROMISE Members receiving PROMISE Services	Steady or Increase	Steady	N/A	no test run

Exhibit 51
Results for Interim Evaluation Measure #48
Rate of Identified Members Who Enroll in PROMISE

Hypothesis:
Trends in health outcomes will continue or improve in the current demonstration period for individuals enrolled in the PROMISE program.

Measure Used to Test Hypothesis:
Rate of Identified Members Who Enroll in PROMISE
Measure Steward: HMA-Burns
Data source: Applications from Division of Substance Abuse and Mental Health

Results



Study Period	Numerator: Applications Approved	Denominator: Applications Received	Rate	
CY 2018	426	1,424	29.9%	
CY 2019	377	836	45.1%	
CY 2020	404	1,080	37.4%	
CY 2021	335	782	42.8%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				30.2%

Average Enrollment in PROMISE Program	
CY 2018	1,796
CY 2019	1,761
CY 2020	1,799
CY 2021	1,833

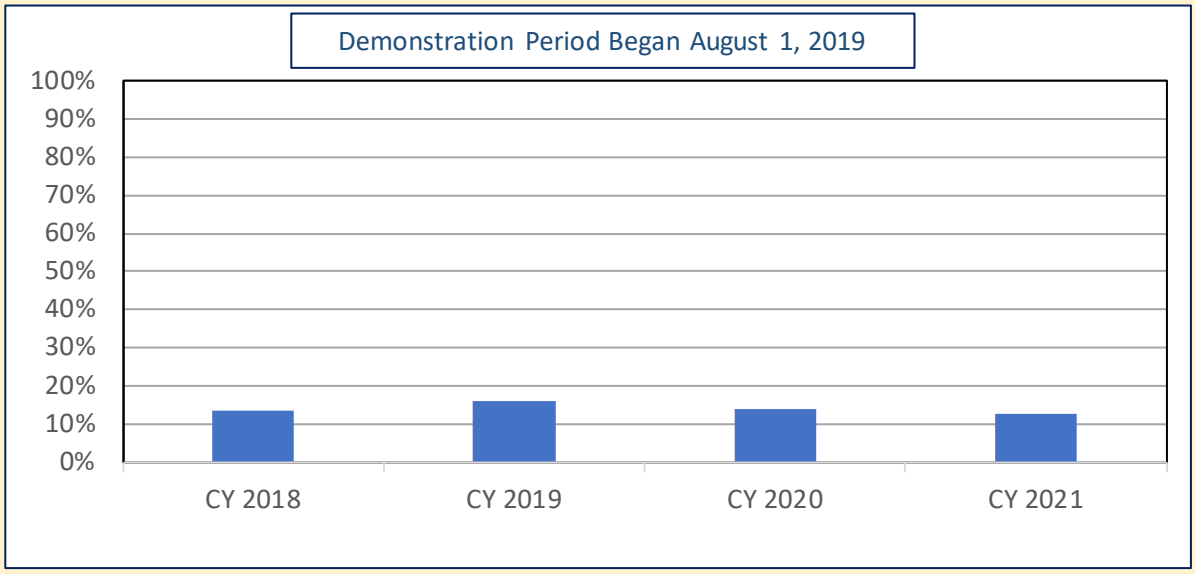
Desired Outcome: Increase
Actual Outcome: Increase

Exhibit 52
Results for Interim Evaluation Measure #49
Follow-up After Hospitalization for Mental Illness

Hypothesis:
Trends in health outcomes will continue or improve in the current demonstration period for individuals enrolled in the PROMISE program.

Measure Used to Test Hypothesis:
Follow-up After Hospitalization for Mental Illness
Measure Steward: National Committee for Quality Assurance

Results for the PROMISE Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	164	1,231	13.3%	
CY 2019	204	1,259	16.2%	
CY 2020	180	1,298	13.9%	
CY 2021	175	1,378	12.7%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-4.9%

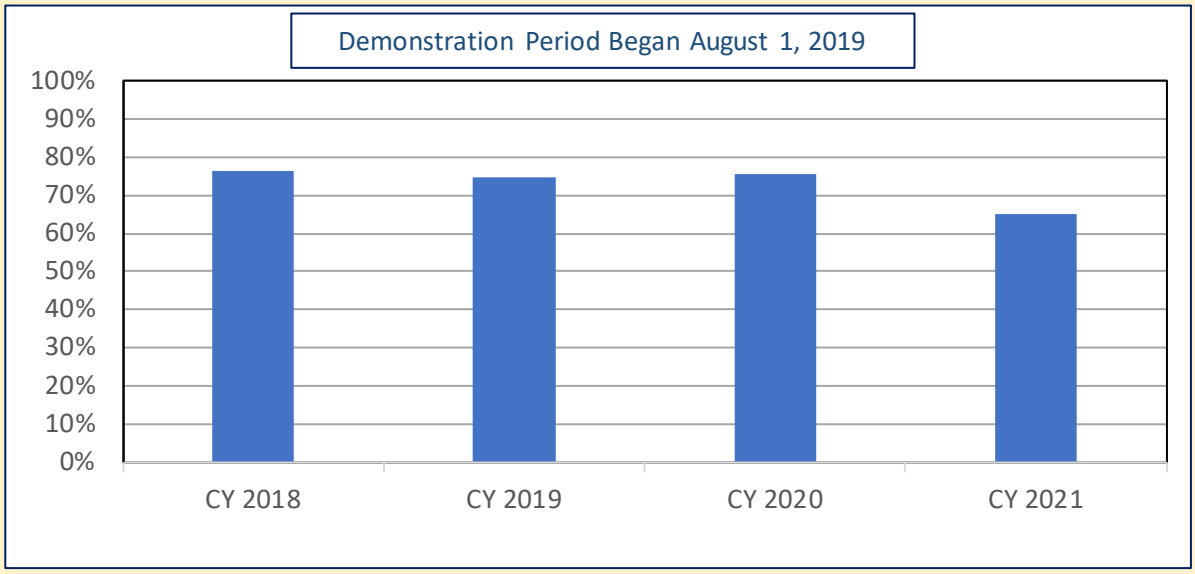
Desired Outcome: Increase
Actual Outcome: Decrease
Statistical Review: Chi-Square
Probability: 0.6366
Finding: Not Significant

Exhibit 53
Results for Interim Evaluation Measure #50
Follow-up After ED Visit for Mental Illness

Hypothesis:
Trends in health outcomes will continue or improve in the current demonstration period for individuals enrolled in the PROMISE program.

Measure Used to Test Hypothesis:
Follow-up After ED Visit for Mental Illness
Measure Steward: National Committee for Quality Assurance

Results for the PROMISE Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	218	285	76.5%	
CY 2019	215	287	74.9%	
CY 2020	192	254	75.6%	
CY 2021	162	249	65.1%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-17.6%

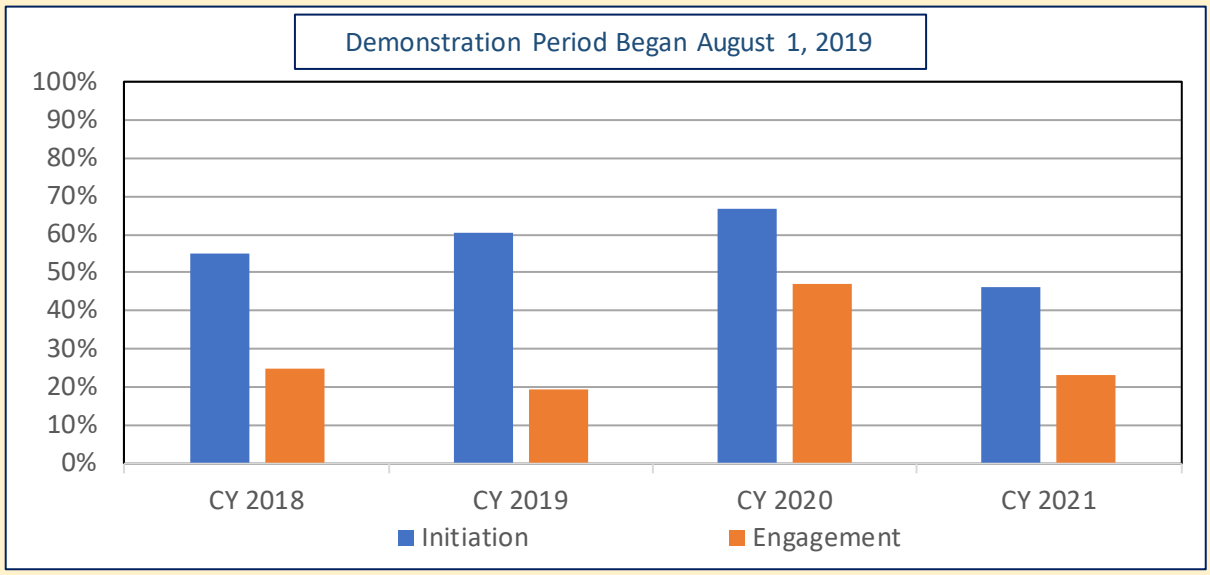
Desired Outcome:	Increase
Actual Outcome:	Decrease
Statistical Review:	Chi-Square
Probability:	0.0036
Finding:	Significant

Exhibit 54
Results for Interim Evaluation Measures #51 and #52
Initiation and Engagement of Alcohol or Other Drug Abuse Dependence Treatment

Hypothesis:
Trends in health outcomes will continue or improve in the current demonstration period for individuals enrolled in the PROMISE program.

Measure Used to Test Hypothesis:
Initiation and Engagement of Alcohol or Other Drug Abuse Dependence Treatment
Measure Steward: National Committee for Quality Assurance

Results for the PROMISE Population in the Demonstration



	Study Period	Numerator	Denominator	Rate	
Initiation, Total AOD	CY 2018	128	233	54.9%	
	CY 2019	128	212	60.4%	
	CY 2020	177	266	66.5%	
	CY 2021	87	189	46.0%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-16.2%
Engagement, Total AOD	CY 2018	32	128	25.0%	
	CY 2019	25	128	19.5%	
	CY 2020	83	177	46.9%	
	CY 2021	20	87	23.0%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-8.0%

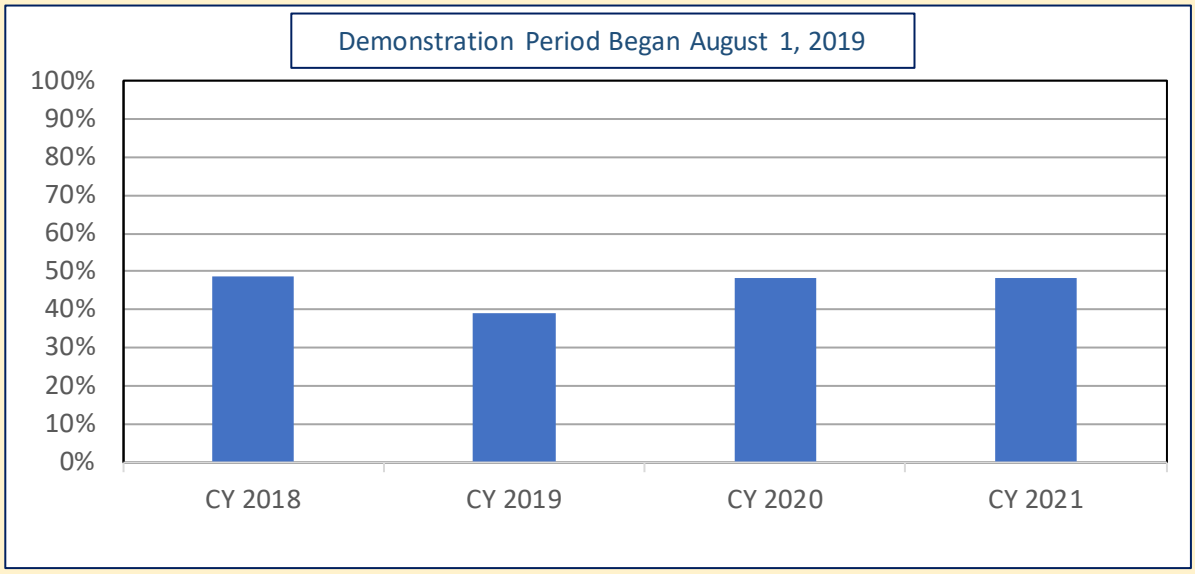
	Initiation	Engagement
Desired Outcome:	Increase	Increase
Actual Outcome:	Decrease	Decrease
Statistical Review:	Chi-Square	Chi-Square
Probability:	0.0688	0.7353
Finding:	Not Significant	Significant

Exhibit 55
Results for Interim Evaluation Measure #53
Plan All-Cause Readmissions

Hypothesis:
Trends in health outcomes will continue or improve in the current demonstration period for individuals enrolled in the PROMISE program.

Measure Used to Test Hypothesis:
Plan All-Cause Readmissionss
Measure Steward: National Committee for Quality Assurance

Results for the PROMISE Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	767	1,572	48.8%	
CY 2019	523	1,338	39.1%	
CY 2020	715	1,477	48.4%	
CY 2021	740	1,537	48.1%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-1.3%

Desired Outcome: Decrease
Actual Outcome: Decrease
Statistical Review: Chi-Square
Probability: 0.7188
Finding: Not Significant

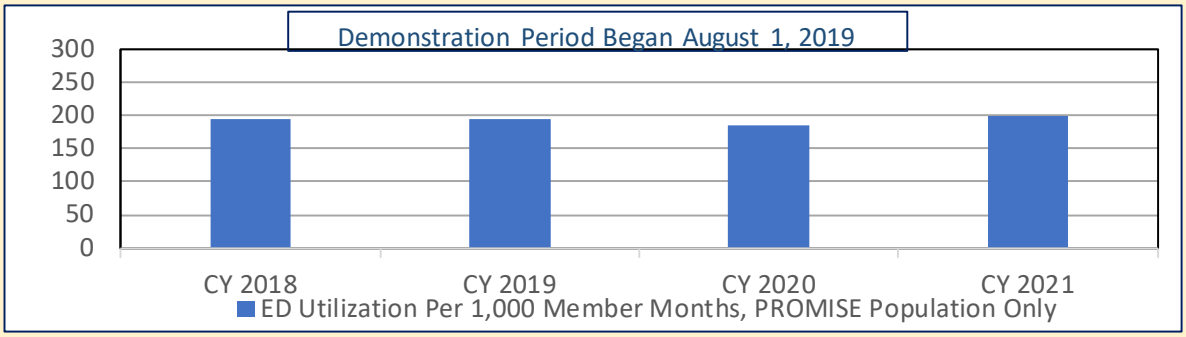
Exhibit 56
Results for Interim Evaluation Measures #54 and #55
Emergency Department Visits

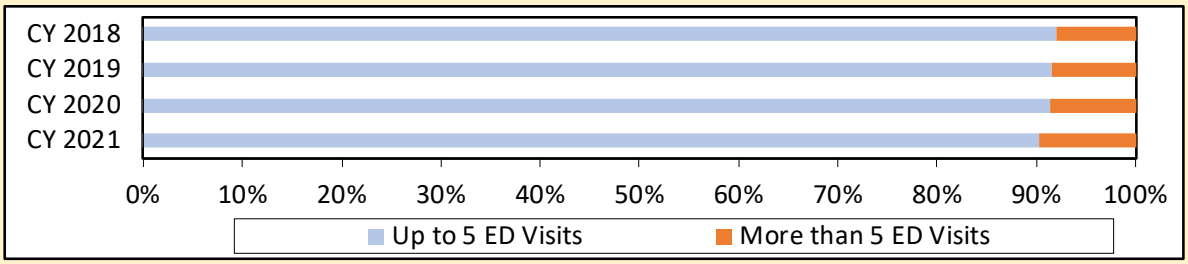
Hypothesis:
Trends in health outcomes will continue or improve in the current demonstration period for individuals enrolled in the PROMISE program.

Measures Used to Test Hypothesis:
1. ED Visits Per 1,000 Medicaid Beneficiaries, PROMISE
2. ED Visit Frequent Users Rate, PROMISE

Measure Steward: HMA-Burns

Results for the PROMISE Population in the Demonstration





	Study Period	Numerator	Denominator	Rate	
ED Visits Per 1,000	CY 2018	3,225	16,654	193.6	
	CY 2019	3,212	16,520	194.4	
	CY 2020	3,155	17,021	185.4	
	CY 2021	3,674	18,353	200.2	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				3.3%
PROMISE ED Users, >5 ED Visits	CY 2018	143	1,796	8.0%	
	CY 2019	150	1,761	8.5%	
	CY 2020	154	1,799	8.6%	
	CY 2021	177	1,833	9.7%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				17.5%

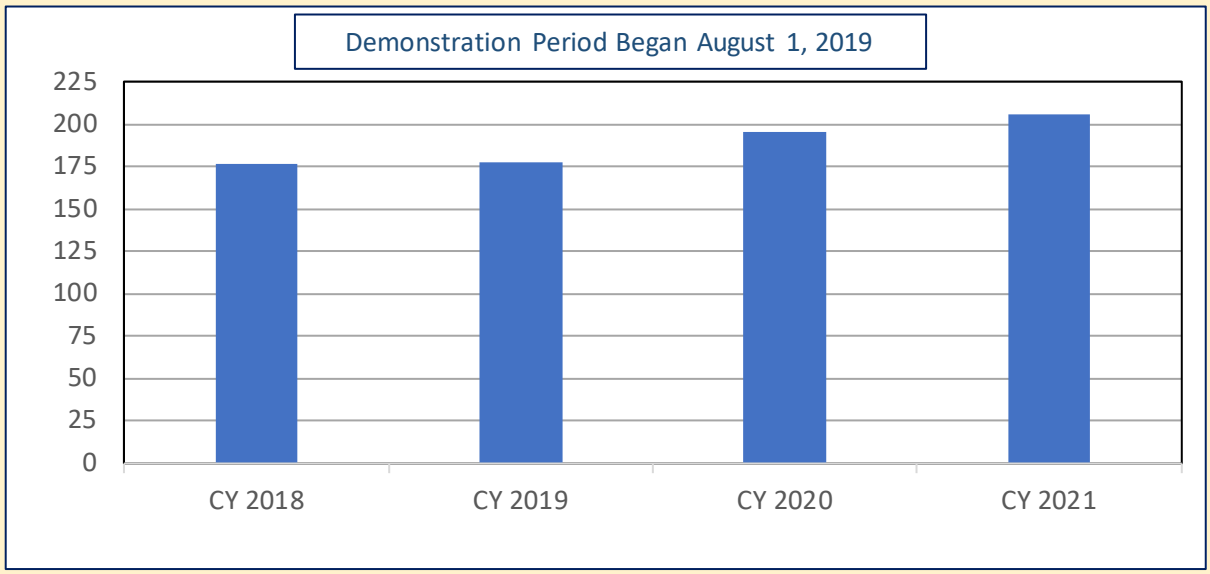
	ED Visits Per 1,000 PROMISE	Frequent ED Users PROMISE
Desired Outcome:	Decrease	Decrease
Actual Outcome:	Increase	Increase
Statistical Review:	T-test	Note that statistical testing was only conducted on the first measure, ED Visits Per 1,000
Probability > [t]:	0.5093	
Finding:	Not Significant	

Exhibit 57
Results for Interim Evaluation Measure #56
PROMISE Service Providers

Hypothesis:
The PROMISE program network capacity will continue (or not worsen) in the current demonstration period.

Measure Used to Test Hypothesis:
Number of Providers Delivering PROMISE Services per 1,000 PROMISE Members
Measure Steward: HMA-Burns

Results for the PROMISE Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	318	1,796	177.1	
CY 2019	313	1,761	177.7	
CY 2020	352	1,799	195.7	
CY 2021	377	1,833	205.7	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				13.9%

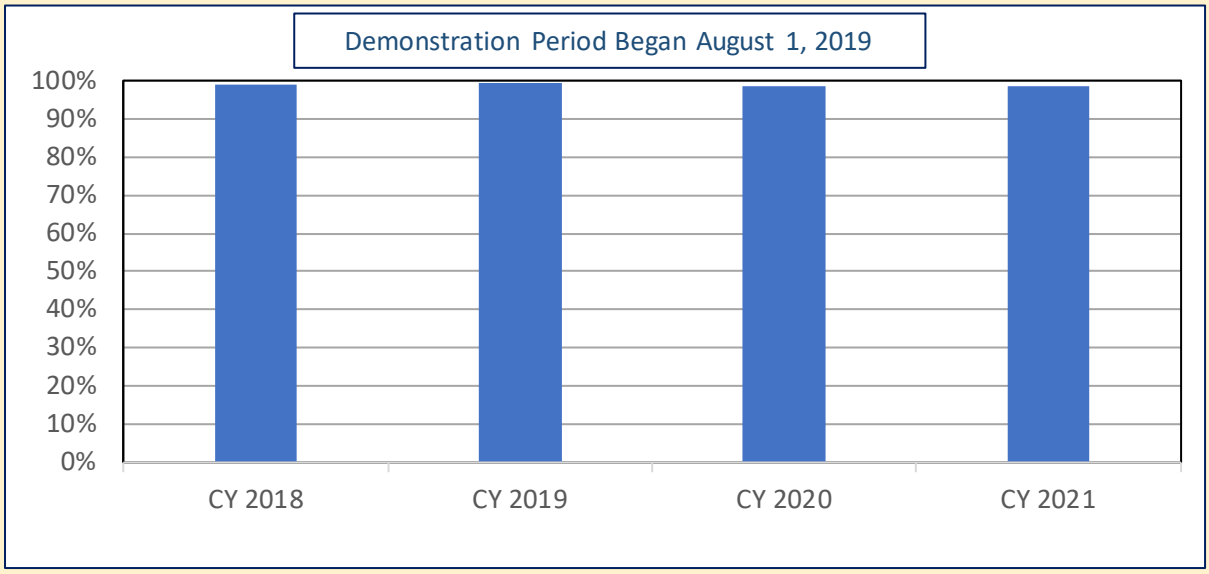
Desired Outcome: Increase
Actual Outcome: Increase

Exhibit 58
Results for Interim Evaluation Measure #57
PROMISE Service Providers

Hypothesis:
The PROMISE program network capacity will continue (or not worsen) in the current demonstration period.

Measure Used to Test Hypothesis:
Percent of PROMISE Members receiving PROMISE Services
Measure Steward: HMA-Burns

Results for the PROMISE Population in the Demonstration



Study Period	Numerator	Denominator	Rate	
CY 2018	1,780	1,796	99.1%	
CY 2019	1,748	1,761	99.3%	
CY 2020	1,772	1,799	98.5%	
CY 2021	1,805	1,833	98.5%	
Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-0.6%

Desired Outcome: Steady
Actual Outcome: Steady

Demonstration Goal #10: Increase and Strengthen Overall Coverage of Former Foster Care Youth to Improve Health Outcomes for the Population

Summary of Measures

Three measures were examined to assess service utilization of the population of former foster care youth. The population in this cohort continues to grow, from 1,017 identified former foster care youth in CY 2018 to 2,781 in CY 2021. For this Interim Evaluation, HMA-Burns examined service usage of three common services as an initial way to start to assess health outcomes. Among the three measures examined, the desired outcomes was met in only one measure.

Exhibit 59
Summary of Findings for Measures Mapped to Research Question #3

Research Question #3: Does the level and trend of access to primary and preventive care continue (or not worsen) in the current demonstration period for former foster care children?

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
58	Percent of former foster care members with a primary care visit in the year	Increase	Decrease	N/A	no test run
59	Percent of former foster care members with a dental visit in the year	Increase	Decrease	N/A	no test run
60	Percent of former foster care members with a hospital emergency department visit in the year	Decrease	Decrease	N/A	no test run

Individual Measure Results

The results of each of these measures appears in Exhibit 60 on the next page. For all three measures, the same cohort population was examined for their use of primary care visits, dental visits, and ED visits. The percent of users was computed over four state fiscal year (SFY) periods from 2018 to 2021.

The percent of users of primary care among former foster care youth declined from 50.9 percent of the total population in CY 2018 to 31.9 percent in CY 2021. For dental services, the percent of users declined from 15.5 percent of the total population in CY 2018 to 6.6 percent in CY 2021. For ED use, the percent declined (a positive finding) from 18.5 percent of the total population in CY 2018 to 14.0 percent in CY 2021.

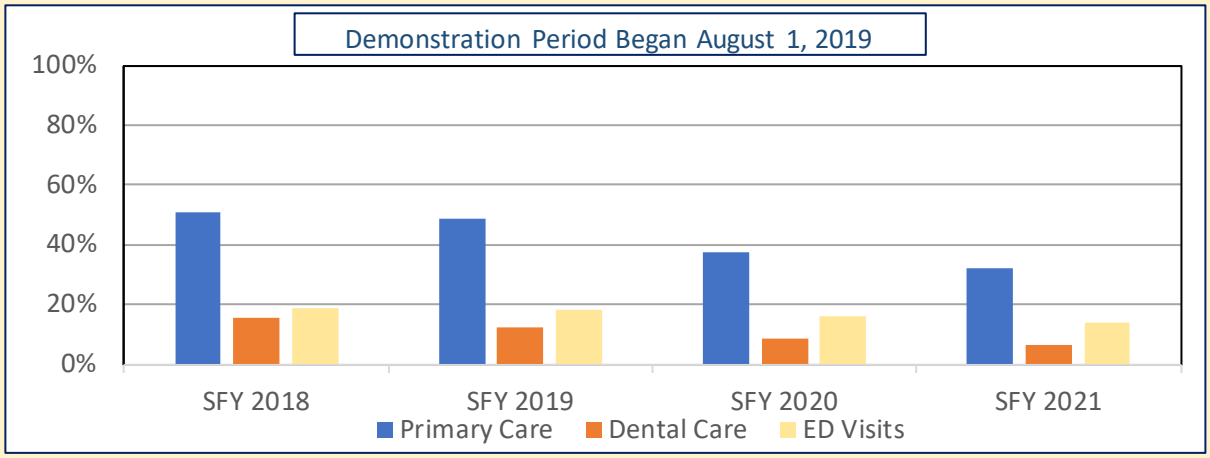
Exhibit 60
Results for Interim Evaluation Measures #58, #59 and #60
Utilization of Services for Former Foster Care Members

Hypothesis:
Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current demonstration period.

Measures Used to Test Hypothesis:
1. Percent of Former Foster Care Members with a Primary Care Visit Each Year
2. Percent of Former Foster Care Members with a Dental Visit Each Year
3. Percent of Former Foster Care Members with an Emergency Dept Visit Each Year

Measure Steward: HMA-Burns

Results for the Former Foster Care Population in the Demonstration



	Study Period	Numerator	Denominator	Rate	
Primary Care	SFY 2018	518	1,017	50.9%	
	SFY 2019	1,017	2,084	48.8%	
	SFY 2020	881	2,362	37.3%	
	SFY 2021	888	2,781	31.9%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-37.3%
Dental Care	SFY 2018	158	1,017	15.5%	
	SFY 2019	259	2,084	12.4%	
	SFY 2020	201	2,362	8.5%	
	SFY 2021	184	2,781	6.6%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-57.4%
ED Visit	SFY 2018	188	1,017	18.5%	
	SFY 2019	378	2,084	18.1%	
	SFY 2020	383	2,362	16.2%	
	SFY 2021	389	2,781	14.0%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-24.3%

	Primary Care	Dental Care	ED Visit
Desired Outcome:	Increase	Increase	Decrease
Actual Outcome:	Decrease	Decrease	Decrease

Demonstration Goal #11: Increase Enrollee Access and Utilization of Appropriate SUD Treatment Services

Summary of Measures

Because the terms and conditions of Delaware's demonstration requires a separate Interim Evaluation for SUD services, the results of the measures related to Demonstration Goal #11 appear in a separate Interim Evaluation which is being submitted to CMS simultaneously with this Interim Evaluation.

The format of the presentation of findings for SUD measures mirrors what is presented in this evaluation. In total, HMA-Burns is reporting on 29 measures in the SUD Interim Evaluation. Among these measures,

- 15 measures are trending in the intended direction. Among these 15, the results of eight measures were found to be statistically significant.
- 14 measures are trending in the wrong direction. Among these 14, the results of 11 measures were found to be statistically significant.

The eight measures where statistically significant improvement were found include:

- Percentage of Beneficiaries with a SUD Diagnosis who used SUD Services Per Month
- Use of Opioids at High Dosage in Persons Without Cancer
- Concurrent Use of Opioids and Benzodiazepines
- Rate of ED Visits for SUD Per 1,000 Medicaid Beneficiaries, Age 18-64
- Inpatient Stays for SUD Per 1,000 Medicaid Beneficiaries, Age 18-64
- Readmissions Among Beneficiaries with SUD
- Per Member Per Month Expenditures for SUD Services Among the SUD Population (increase)
- Per Member Per Month Expenditures for non-SUD Services Among the SUD Population (decrease)

The 11 measures where statistically significant declines were found include:

- Initiation of Alcohol and Other Drug Dependence Treatment (3 subpopulations and the total AOD population)
- Engagement of Alcohol and Other Drug Dependence Treatment (3 subpopulations and the total AOD population)
- Continuity of Pharmacotherapy for Opioid Use Disorder
- Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD
- Rate of Overdose Deaths Per 1,000 Medicaid Beneficiaries

Demonstration Goal #12: Increase Access to Adult Dental Services and Decrease Adult ED Visits for Non-Traumatic Conditions

Summary of Measures

Five measures were examined to assess the access to adult dental services. Because this benefit was just introduced in October 2020, the results shown here are considered the baseline. In the Summative Evaluation, these same measures will be computed for CY 2022 and CY 2023 and comparisons will be made across the three years.

Exhibit 61
Summary of Findings for Measures Mapped to Research Question #13

Research Question #13: Does the availability of the adult dental benefit increase access to dental services and lead to continued (or not worsen) health outcomes in the current waiver period?

	Measure Examined	Desired Outcome	Actual Outcome
61	Utilization of Dental Services Per 1,000 Adults	Increase	Baseline is CY2021 results: 31 per 1,000
62	Dental Providers Per 1,000 Members	Increase	Baseline is CY2021 results: 3.5 per 1,000
63	Average Driving Distance to Dental Care Providers	Decrease	Baseline is CY2021 results: 13.8 miles
64	Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-A-A)	Decrease	Baseline is CY2021 results: 109 per 100,000
65	Follow-up After Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDF-A-A)	Increase	Baseline is CY2021 results: 8.5% for visit within 7 days and 14.0% within 30 days of ED visit

No statistical tests were run on these measures since the adult dental benefit was introduced in October 2020. There is no pre-demonstration period to compare to.

Individual Measure Results

Detailed information, including the numerators and denominators for each measure, are shown in Exhibit 62 on the next page. HMA-Burns serves as the measure steward for three of the five measures. For the other two measures, the HMA-Burns team followed the specifications to compute results where the measure steward is the Dental Quality Alliance (EDV-A-A and EDF-A-A).

Exhibit 62
Results for Interim Evaluation Measures #61 through #65
Adult Dental Metrics

Hypothesis:
The availability of the adult dental benefit will improve access to dental services and will continue (or not worsen) health outcomes in the current demonstration period.

Measure Used to Test Hypothesis:
1. Utilization of Dental Services per 1,000 Adult Members
2. Dental Providers per 1,000 Adult Members
3. Average Driving Distance to Dental Services for Adult Members
4. Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-A-A)

5. Follow-up After Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDF-A-A)

Measure Steward: For Measures 1, 2, and 3: HMA-Burns
For Measures 4 and 5: Dental Quality Alliance

Results for the Adult Population in the Demonstration

	Study Period	Numerator	Denominator	Rate	Desired Outcome
Utilization of Dental Services per 1,000	CY 2021	48,949 Total adult dental visits in the year	1,581,576 Total adult member months in the year	31	Increase
Dental Providers per 1,000	CY 2021	464 Total adult dental billing providers in the year	131,798 Average monthly adult members in the year	3.5	Increase
Average Driving Distance to Dental Services	CY 2021	26,106 Number of unique member-to-provider pairings among the total 48,949 adult dental claims		13.8 miles	Decrease
EDV-A-A	CY 2021	1,726 Total adult ED visits with a diagnosis in measure specification	1,581,576 Total adult member months in the year	109 Expressed on a per 100,000 member month basis	Decrease
EDF-A-A	CY 2021, 7 day CY 2021, 30 day	127 209 Number of members in EDV-A-A that had a follow-up dental visit in 7 or 30 days after ED visit	1,495 1,495 Number of members in EDV-A-A	8.5% 14.0%	Increase

CY 2021 data is the baseline year. Results will be trended in the Summative Evaluation between CY2021, CY2022 and CY 2023 utilization.

SECTION G: Conclusions

Assessment of the Effectiveness of the Demonstration

When considering the logic models shown in the Evaluation Design Plan, Delaware did not meet all of desired outcomes outright but still saw many positive impacts due to the demonstration.

1. **Maintain Continuity of Enrollment**

   Noteworthy positive impacts were found in the following areas:

   - Medicaid enrollment increased over time overall and for most major enrollment categories.
   - The percentage of members continuously enrolled has increased for all enrollment categories examined. For the Medicaid Expansion group, the increase was substantial.
   - Enrollment duration in the year also increased across-the-board.
   - Results from the BRFSS survey to the question if individuals could not see a doctor due to cost dropped from 12.0 percent in CY 2017 to 9.1 percent in CY 2020.

2. **Maintain Access to Care**

   Noteworthy positive impacts between CY 2018 and CY 2021 were found in the following areas:

   - Increase in the percentage of members ages three to six and among adolescents receiving well-care visits (for adolescents, a statistically significant improvement).
   - The rate of postpartum care saw a statistically significant increase from 34.2 percent in CY 2018 to 44.2 percent in CY 2021.
   - The rate of emergency department utilization decreased significantly from 65.2 visits per 1,000 in CY 2018 to 49.2 visits per 1,000 in CY 2021.
   - Follow-up after an emergency department visit for people with multiple high-risk chronic conditions improved significantly.
   - As a percentage of applications received, the rate of enrollment in the PROMISE program increased from 30 percent in CY 2018 to 43 percent in CY 2021.
   - The PROMISE provider network also increased from 318 to 377 providers, and the percent of PROMISE members receiving PROMISE services remained relatively steady.

3. **Maintain or Improve Health Outcomes**

   Noteworthy positive impacts between CY 2018 and CY 2021 were found in the following areas:

   - The rate of adherence to antidepressant medication management improved at both the 12 week and six month mark.
   - The medication adherence rate, expressed as the proportion of days covered, saw a statistically significant increase among the DSHP Plus population.

- Member grievances and appeals remain very low when measured on a per 1,000 member month basis.
- Among the DSHP Plus population, improvement was seen among all six LTSS CAHPS composite measures during the demonstration period thus far. The rate of critical incidents per 1,000 also decreased during the demonstration period.

4. **Rebalance LTSS in favor of HCBS**.

   Noteworthy positive impacts between CY 2018 and CY 2021 were found in the following areas:

   a. The utilization rate of HCBS services among DSHP Plus members.
   b. The PMPM expenditures for HCBS among DSHP Plus members increased 38.8 percent while the PMPM expenditures for institutional care decreased 15.9 percent.
   c. The proportion of spending between HCBS and institutional care changed from a mix of 25 percent/75 percent in CY 2018 to 35 percent/65 percent in CY 2021.

The PHE likely had a confounding effect in enabling Delaware to fully meet these aims during the demonstration period. While some measures were found to remain steady between the pre-demonstration and initial years of the demonstration, other measures had results that trended in the opposite direction from what was desired. Areas in which the evaluators will focus on assessing improvement in the remainder of this demonstration period include the following:

- Well-child visits in the first 15 months of life
- Breast cancer screenings
- Adults' access to preventive and ambulatory health services
- Access to primary care and dental visits among the former foster care population
- All-cause hospital readmission rates for the DSHP Plus population
- Emergency department visits for the PROMISE population
- Follow-up visits from the emergency department related to alcohol or other drug dependence and for mental health issues for the entire population
- Initiation and engagement rates for alcohol and other drug dependence among the PROMISE population

When considering each of the demonstration goals, Delaware did see some success in each goal, albeit perhaps not as much as desired. Exhibit 63, which appears on the next page, summarizes all of the measures that were reviewed. Among the 65 measures, there were 40 measures where the desired outcome was met. Statistical tests were run for 28 of the 65 measures. Among these 28 measures, there are nine measures which have a statistically significant trend in the intended direction, nine measures which have a statistically significant trend in wrong direction, and 10 measures where the trend was found not to be statistically significant.

Exhibit 63
Summary of Measures Examined by Demonstration Goal

	Waiver Goals	Total Measures	Measures with Results Trending in the Intended Direction	Measures with Results Trending in the Wrong Direction	Total Measures Where Tests Were Run for Statistical Significance	Of these, the Total Where Trend in Intended Direction and Statistically Significant	Of these, the Total Where Trends in Wrong Direction and Statistically Significant	Of these, the Total Where There Was No Statistically Significant Change
	MEASURES FOR GOALS #1 - #10	**60**	**40**	**20**	**28**	**9**	**9**	**10**
1	Improve access to health care for the Medicaid population	14	10	4	7	3	3	1
2	Rebalance Delaware's LTC system in favor of HCBS	4	4	0	2	2	0	0
3	Promote early intervention for individuals with, or at risk, for having LTC needs	4	2	2	4	1	2	1
4	Increase coordination of care and supports	7	4	3	7	2	2	3
5	Expand consumer choices	8	5	3	0	0	0	0
6	Improve the quality of health services, including LTC services, delivered to all Delawareans	7	7	0	0	0	0	0
7	Create a payment structure that provides incentives for resources to shift from institutions to community-based long-term services and supports	0						
8	Improve coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles	3	3	0	3	1	0	2
9	Improve overall health status and quality of life of individuals enrolled in PROMISE	10	4	6	5	0	2	3
10	Increase and strengthen overall coverage of former foster care youth to improve health outcomes	3	1	2	0	0	0	0
11	Increase enrollee access and utilization of appropriate SUD treatment services	29	Results are shown in the SUD Independent Evaluation report.					
12	Increase access to dental services; decrease adult ED visits for non-traumatic conditions	5	CY2021 is the baseline year for the results for each measure.					

Assessment of Opportunities for Improvement

Delaware has seen progress towards its goals related to rebalancing LTC in favor of HCBS, maintaining continuity of enrollment, and maintaining access to care thus far in this demonstration period. There are other goals where progress has yet to be seen in any meaningful way. The HMA-Burns evaluation team has identified opportunities for the DMMA to consider for continued improvement during the remainder of this demonstration period which include the following:

1. In collaboration with the managed care organizations, develop performance improvement projects (PIPs) specific to improving follow-up after emergency department or hospitalization for mental illness or for alcohol and other drug dependence for the DSHP, the DSHP Plus and the PROMISE populations. The DMMA may consider one or more of these measures as a quality performance measure as outlined in its new contract with the MCOs effective January 1, 2023.
2. Although there are some reporting requirements already related to the reporting of members enrolled in case management by sub-population (e.g., pregnant women, DSHP Plus LTSS, justice-involved), consider modifying managed care reporting that will allow for assessing the effectiveness of case management by tying enrollment by the member in case management with specific access or health outcomes.
3. DMMA has taken action to create payment structures to incentivize the delivery of community-based services, particularly related to substance use disorder and is embarking on payment update changes for mental health services. The DMMA is encouraged to continue the rate study of mental health services and to consider value-based payment alternatives for providers serving the PROMISE population in particular.
4. Currently, state staff at DSAMH review and approve eligibility in the PROMISE program. The PROMISE program enrollees are assigned to an MCO for acute care and many community-based services, while PROMISE services specifically are outside of the managed care program. Case management of PROMISE members is also the responsibility of state staff, not the MCO. In an effort to strengthen the continuity of care for these members and to ensure sufficient access to PROMISE services, the DMMA may consider including the services specific to the PROMISE program under the responsibility of the MCOs. Or, at minimum, strengthen the oversight of the coordination of care requirements between the MCO's case manager for acute care services and the state's PROMISE care manager for PROMISE services.

SECTION H: Interpretations, Policy Implications, and Interactions with Other State Initiatives

Policy Implications

Understandably, the public health emergency required states to amend existing policies and procedures in order to ensure that services were continually rendered when needed to Medicaid beneficiaries. As the PHE unwinds, many of these policies will be rescinded. It will be important for the DMMA to monitor the effects of PHE-related policy decisions on access to care for its managed care enrollees.

The DMMA issued a Request for Proposals in December 2021 and announced notices of award in July 2022. The effective date of the new contract is January 1, 2023. The notice was to award to the two incumbent MCOs as well as a new third MCO. In addition to the change in the number of MCOs, the new model contract has components that have been added or strengthened from the current contract, most notably related to care coordination and case management and the requirement by the MCOs to develop value-based purchasing agreements with providers. It will be important for the DMMA to assess how these new contract requirements—among others—has an impact on improved access to care and health outcomes for managed care enrollees.

Interactions with Other State Initiatives

During the initial years of the demonstration period, the DMMA undertook other initiatives that had a direct impact on the demonstration. As the demonstration period continues, the DMMA will be mindful of these initiatives as they relate to improving access, improving health outcomes, and rebalancing expenditures more toward HCBS.

1. Under the Appendix K authority, DMMA provided additional home-delivered meals to vulnerable clients served in the DSHP Plus HCBS program.
2. With the continuation of the PHE, DMMA focused on addressing food insecurity through its Postpartum Food Box Partnership program to deliver meals to members who are less than eight weeks postpartum and delivered via cesarean section.
3. DMMA was awarded a SUPPORT Act planning grant to assess and expand capacity to treat substance use disorder (SUD) in Medicaid.
4. DMMA developed a Medicaid accountable care organization (ACO) program for the purposes of improving health outcomes while reducing costs through value based purchasing arrangements. Four health care provider groups were authorized as ACOs in September 2020. The ACOs are authorized to contract directly with each MCO under contract with the DMMA, provided that the ACO has participation from at least 5,000 Medicaid enrollees.

State of Delaware Interpretations from the Evaluation Findings

The DMMA agrees with the findings on measures reported in this Interim Evaluation as the results for many measures track with our own calculations of Child and Adult Core Measures that we submit to CMS. We agree that the public health emergency posed extraordinary challenges for the continued provision of services, particularly as it relates to primary care services for children and other wellness-

based measures such as breast cancer screenings. The DMMA agrees that specific focus will need to be made to ensure that the results for these measures improve as we moved out of the public health emergency.

The DMMA agrees that more work needs to be done to improve the rates of initiation and engagement for individuals with alcohol and drug abuse as well as for community-based follow-up for individuals with mental health disorders, substance use disorders, or both. We are hopeful that language in our new managed care contract that will become effective January 1, 2023 will assist us in seeing improvement in these measures.

Provider access more generally is a continual pressure on our program, particularly as it pertains to community-based programs for vulnerable populations such as individuals enrolled in DSHP Plus and PROMISE. We have made strides to improve access to SUD services through significant fee-for-service rate increases for community-based SUD providers effective January 1, 2023. We aim to replicate this by engaging with community mental health providers to enhance the fee-for-service rates for the services that they provide. These steps we consider just the first step, however, as DMMA aims to evolve to value-based reimbursement models for primary care services and specialized community-based services. Our goal is to enhance our provider networks and to ensure more stable access to services across urban and rural regions of the state. Our hope is that these changes, in conjunction with enhanced care coordination under the new managed care contract, will enhance access to services and improved outcomes for all Medicaid beneficiaries in the demonstration.

SECTION I: Lessons Learned and Recommendations

Lessons Learned

As it worked to implement many new initiatives in the initial years of its demonstration while navigating the public health emergency, Delaware's DMMA learned some lessons to be mindful of moving forward.

1. Data systems can often inhibit the effective implementation of new program initiatives. Gaining a thorough understanding of systems changes is important when standing up new programs as well as an appreciation for the time commitment involved. Although the adult dental benefit was ultimately successfully launched in October 2020, implementation was delayed from the initial target of April 2020 due to systems changes and the onsite of the PHE.
2. Enhancing the linkages between state agencies for citizens who are eligible for multiple programs is important for both continuity of care and for health outcomes. The DMMA has added language to its managed care contracts to ensure proper linkages for individuals that are Medicaid eligible and justice-involved as well as individuals eligible for Medicaid as well as DSAMH's PROMISE program.

Recommendations

Delaware's DMMA offers the following recommendations to other states from what was learned from the evaluation of our own demonstration.

1. Delaware recommends to other states to convene its providers and managed care entities on a regular basis to communicate what is happening on the ground, particularly at the introduction of a new service, expansion of an existing service, or fundamental change in billing or reimbursement of existing services. In addition to providing a forum for multiple viewpoints to successfully implement demonstration activities, these meetings foster collaboration between stakeholders and offer the state the ability to share its vision with all parties.
2. Delaware recommends to other states that feedback be given to MCOs on a regular basis with a quick turnaround on any reports submitted by the MCOs to the state. DMMA offers feedback to its MCOs after the submission of quarterly reports to DMMA both to assess the integrity of the data submitted on reports as well as to discuss the interpretation of the findings reported.
3. The coordination and communication among entities that deliver supports to vulnerable populations is essential to ensure that each beneficiary receives the supports that they need. This coordination includes written protocols on the scope of each entity's area of responsibility, the procedures that will be followed by each entity, and the protocols for the seamless transfer of information about beneficiaries, when applicable.

APPENDIX: Approved Evaluation Design Plan

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

April 2, 2021

Stephen M. Groff
Medicaid Director
Division of Medicaid and Medical Assistance
Department of Health and Social Services
1901 N. Dupont Highway
New Castle, DE 19720

Dear Mr. Groff:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Substance Use Disorder (SUD) / the Diamond State Health Plan (DSHP) Evaluation Design, which is required by the Special Terms and Conditions (STC) #88 of Delaware's section 1115 demonstration entitled, "Delaware Diamond State Health Plan 1115 Demonstration" (Project Number 11-W-00036/4), and effective through December 31, 2023. CMS has determined that the evaluation design, which was submitted on May 29, 2020 and revised on February 25, 2021, meets the requirements set forth in the STCs and our evaluation design guidance, and therefore, approves the state's SUD / DSHP evaluation design.

CMS added the approved evaluation design to the demonstration's Special Terms and Conditions (STC) as Attachment H. A copy of the STCs, which includes the new attachment are enclosed with this letter. The approved evaluation design may now be posted to the state's Medicaid website within thirty days, per 42 CFR 431.424(c). CMS will also post the approved evaluation design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an interim evaluation report, consistent with the approved evaluation design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a summative evaluation report, consistent with this approved design, is due to CMS within 18 months of the end of the demonstration period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

We appreciate our continued partnership with Delaware on the Diamond State Health Plan section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S
Digitally signed by Danielle Daly -S
Date: 2021.04.02 14:59:28 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

Andrea J. Casart -S
Digitally signed by Andrea J. Casart -S
Date: 2021.04.05 06:09:51 -04'00'

Andrea J. Casart
Director
Division of Eligibility and Coverage Demonstrations

cc: Talbatha Myatt, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

EVALUATION DESIGN PLAN FOR DELAWARE'S 1115 MEDICAID DEMONSTRATION WAIVER

FINAL DRAFT
FEBRUARY 25, 2021

BURNS & ASSOCIATES, INC.
A DIVISION OF HEALTH MANAGEMENT ASSOCIATES

Evaluation Team Members:

Mark Podrazik, Principal Investigator

Akhilesh Pasupulati
Ryan Sandhaus
Debbie Saxe
Barry Smith
Shawn Stack

TABLE OF CONTENTS

Listing of Exhibits

Abbreviations List

Abbreviation	Meaning
ACA	Affordable Care Act
AIDS	Acquired Immunodeficiency Syndrome
B&A	Burns & Associates, Inc.
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CY	Calendar Year
DHSS	Delaware Department of Health and Social Services
DMES	Delaware Medicaid Enterprise System
DMMA	Division of Medicaid and Medical Assistance
DR	Desk Review
DS	Descriptive Statistics
DSAMH	Division of Substance Abuse and Mental Health
DSHP	Diamond State Health Plan
DSHP-Plus	Diamond State Health Plan Plus
DXC	DXC Technologies
EDW	Enterprise Data Warehouse
E&M	Evaluation & Management
ED	Emergency Department
ESRD	End Stage Renal Disease
FFS	Fee-For-Service
FG	Focus Groups
FI	Facilitated Interviews
FPL	Federal Poverty Level
HCBS	Home and Community-Based Services
HCPCS	Healthcare Common Procedure Coding System
HIV	Human Immunodeficiency Virus
I/DD	Intellectual and Developmental Disabilities
ICF/IDD	Intermediate Care Facilities for the Intellectually/ Developmentally Disabled

Abbreviation	Meaning
IMDs	Institutions for Mental Disease
ITS	Single Segment Interrupted Time Series
LOC	Level of Care
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MLTSS	Managed Long-Term Services and Supports
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
OPPS	Outpatient Prospective Payment System
OR	Onsite Reviews
PACE	Program for All Inclusive Care for the Elderly
PCP	Primary Care Provider
PROMISE	Promoting Optimal Mental Health for Individuals through Supports and Empowerment
PS	Provider Surveys
QCMMR	Quality and Care Management Measurement and Reporting
QCMMR Plus	Quality and Care Management Measurement and Reporting Plus
QI	Qualifying Individuals
QMB	Qualified Medicare Beneficiaries
RCT	Randomized Control Trials
SFY	State Fiscal Year
SLMB	Specified Low Income Medicare Beneficiary
SPMI	Severe and Persistent Mental Illness
SSI	Supplemental Security Income
STC	Special Terms and Conditions
SUD	Substance Use Disorder
TCM	Targeted Case Management
TEFRA	Tax Equity and Fiscal Responsibility Act

SECTION I: GENERAL BACKGROUND INFORMATION

I.A INTRODUCTION[1]

Delaware has had a long-standing Section 1115(a) demonstration which was originally approved in 1995 and then implemented effective January 1, 1996. The demonstration waiver was selected as a mechanism to allow Delaware to improve the health status of low-income Delawareans through use of a managed care delivery system. The waiver was also created to expand access to healthcare to more individuals throughout the State using the savings achieved through mandatory enrollment of eligible populations into managed care.

Over the years, Delaware has amended the waiver to add populations and services to the demonstration. The most current extension was approved on July 31, 2019. The latest waiver renewal contains an amendment intended to expand substance use disorder (SUD) services in the demonstration by including expenditure authority for services in institutions for mental diseases (IMD) as well as maintaining existing non-SUD services for beneficiaries.

Delaware continues to use the Diamond State Health Plan (DSHP) 1115 Demonstration to improve the health status of low-income Delawareans by using the goals as described in Section I.C to guide the administration and implementation of the demonstration.

I.B NAME, APPROVAL DATE AND TIME PERIOD COVERED

Name: Delaware Diamond State Health Plan
Project Number: 11-W-00036/4
Approval Date: July 31, 2019, amended effective January 19, 2021
Time Period Covered by Evaluation: Demonstration extension from August 1, 2019 through December 31, 2023.

Note that this 1115 Evaluation Design Plan covers the non-SUD portion of Delaware's 1115 Diamond State Health Plan waiver. The 1115 SUD Evaluation Design Plan will be submitted as a separate independent evaluation plan.

I.C DEMONSTRATION GOALS[2]

Delaware's goals in operating the demonstration are to improve the health status of low-income Delawareans by:

1. Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to home and community-based services (HCBS);
2. Rebalancing Delaware's LTC system in favor of HCBS;

[1] Delaware Diamond State Health Plan 1115(a) Demonstration Special Terms and Conditions, accessed at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/de/de-dshp-ca.pdf
[2] Ibid, pages 9-10 of 166

3. Promoting early intervention for individuals with, or at-risk, for having, LTC needs;
4. Increasing coordination of care and supports;
5. Expanding consumer choices;
6. Improving the quality of health services, including LTC services, delivered to all Delawareans;
7. Creating a payment structure that provides incentives for resources to shift from institutions to community-based long-term care services and supports (LTSS) services where appropriate;
8. Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles;
9. Improving overall health status and quality of life of individuals enrolled in Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE);
10. Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population; and
11. Increase enrollee access and utilization of appropriate SUD treatment services; decrease use of medically inappropriate and avoidable high-cost emergency and hospital services; increase initiation of follow-up SUD treatment after emergency department discharge; and reduce SUD readmission rates.
12. Increasing access to dental services; decrease the percent of emergency department visits for non-traumatic dental conditions in adults; increase follow up with dentists after an emergency department visit for non-traumatic dental conditions in adults; and increase the number of adults with diabetes who receive an oral exam annually.

The approved waiver has five demonstration components:

1. The DSHP Medicaid managed care program provides Medicaid state plan benefits through a comprehensive managed care delivery system to most recipients eligible under the state plan.
2. The DSHP Plus program provides LTSS to certain individuals under the State Plan, and to certain demonstration populations.
3. The PROMISE program provides enhanced behavioral health services fee-for-service (FFS) to Medicaid beneficiaries with a higher level of behavioral health needs and functional limitations who need HCBS to live and work in integrated settings.
4. Coverage for former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care at age 18 (or such higher age as elected by the state), were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid.

5. Coverage for high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as IMDs.

I.D BRIEF DESCRIPTION AND HISTORY OF IMPLEMENTATION[3]

Delaware's Diamond State Health Plan 1115 Demonstration Waiver was initially approved in 1995 and implemented beginning on January 1, 1996. The original goal of the demonstration was to improve the health status of low-income Delawareans by expanding access to healthcare to more individuals throughout the State; creating and maintaining a managed care delivery system with an emphasis on primary care; and controlling the growth of healthcare expenditures for the Medicaid population. The DSHP 1115 Demonstration was designed to mandatorily enroll eligible Medicaid recipients into managed care organizations (MCOs) and to create cost efficiencies in the Medicaid program that could be used to expand coverage.

Delaware achieved its objective of implementation of mandatory managed care focused on primary care in 1996 and invested the resulting waiver savings in Delaware's Medicaid eligibility coverage expansion to uninsured adults up to 100 percent of the federal poverty level (FPL). Long before Medicaid expansion under the Affordable Care Act, Delaware was a pioneer in coverage expansion for individuals who would otherwise not be eligible for Medicaid. Delaware built upon this success with the eventual expansion of coverage for family planning services, leading up to participating in Medicaid expansion under the Affordable Care Act (ACA) in 2014.

The demonstration has previously been renewed on June 29, 2000, December 12, 2003, December 21, 2006, January 31, 2011, and September 30, 2013.

Through an amendment approved by CMS in 2012, Delaware was authorized to the create the Diamond State Health Plan Plus (DSHP-Plus), which is Delaware's managed long-term services and supports (MLTSS) program. This amendment requires additional state plan populations to receive services through MCOs. Additionally, this amendment expanded HCBS to include: (1) cost-effective and medically necessary home modifications; (2) chore services; and (3) home delivered meals.

In 2013, the demonstration was renewed and amended to provide authority to extend the low-income adult demonstration population to individuals with incomes up to 100 percent of the FPL until December 31, 2013. After that date, the demonstration population was not necessary because it was included under the approved state plan as the new adult eligibility group authorized under the ACA. The new adult group, for individuals with incomes up to 133 percent of the FPL, receive medical assistance through enrollment in MCOs pursuant to this demonstration. In addition, Delaware's authority for the family planning expansion program under this demonstration expired December 31, 2013 when individuals became eligible for Medicaid expansion or Marketplace coverage options.

The demonstration was amended in 2014 to authorize coverage for enhanced behavioral health services and supports for targeted Medicaid beneficiaries through a voluntary program called PROMISE starting

[3] Delaware Diamond State Health Plan 1115(a) Demonstration Special Terms and Conditions, accessed at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/de/de-dshp-ca.pdf, Section II, pages 6-9 of 166

in 2015. PROMISE enrollees include Medicaid beneficiaries who have a severe and persistent mental illness (SPMI) and/or a SUD and require HCBS to live and work in integrated settings.

Technical changes were incorporated into the demonstration in October 2017 and an amendment was approved in December 2017 to add coverage for out-of-state former foster care youth.

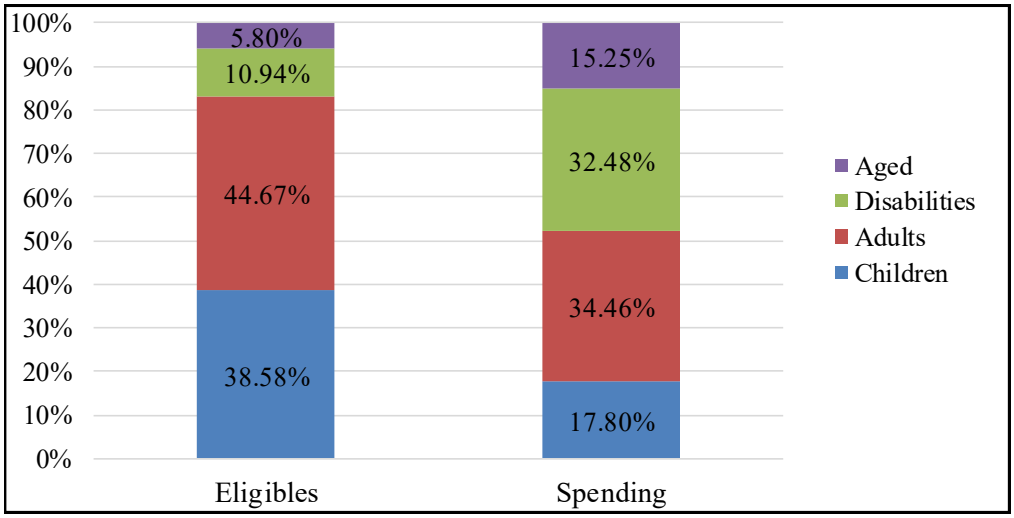
In June 2018, Delaware submitted a five-year demonstration extension and an amendment to provide the state with authority to provide high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an IMD. The demonstration was amended effective January 19, 2021 to add adult dental services to the services administered by the state's managed care system.

I.E POPULATION GROUPS IMPACTED

Overview of Delaware's Medicaid Program

The Division of Medicaid and Medical Assistance (DMMA) of the Delaware Department of Health and Social Services (DHSS) has responsibility for the administration and oversight of Delaware's Medicaid program under the waiver and state plan authorities. During State Fiscal Year (SFY) 2019, there were 293,091 unduplicated individuals eligible for Delaware's Medicaid program. Children comprise approximately 39 percent of enrollees whereas adults comprise approximately 45 percent. The aged and disabled comprise approximately 16 percent of the enrollees but almost 48 percent of the total Medicaid expenditures.

Exhibit I.1
Medicaid Enrollment and Spending: SFY 2019[4]



Delaware's Medicaid program provides access to healthcare through either a traditional FFS model or managed care. The majority of individuals eligible for Delaware Medicaid are enrolled in the Demonstration and receive services through one of the State's two risk-based managed care plans with either the DSHP or DSHP-Plus benefit plan.

The **Delaware Diamond State Health Plan (DSHP)** began in 1996 with mandatory enrollment in an MCO for eligible populations which includes State Plan Mandatory and Optional Medicaid Eligibility Groups, as well as Demonstration Eligible Groups. Specific populations enrolled in DSHP can be found in Exhibit I.2 on page I-6.

DSHP enrollees are entitled to receive all mandatory and optional state plans services approved under the Medicaid state plan and alternative benefit plan for the Medicaid expansion population. Services are primarily provided through a combination of contracts with MCOs. Some services, however, are delivered through FFS[5]:

[4] Joint Finance Committee Hearing testimony of Director Stephen M. Groff accessed at https://dhss.delaware.gov/dhss/files/dmma2021presentation_02262020.pdf

[5] Delaware Diamond State Health Plan 1115(a) Demonstration Special Terms and Conditions, accessed at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/de/de-dshp-ca.pdf, Section V, page 29 of 166

- Child dental
- Non-emergency medical transportation (NEMT), which is provided one transportation broker
- Day habilitation services authorized by the Division of Developmental Disabilities Services
- Medically necessary behavioral health services for children in excess of the MCO plan benefit coverage (which is 30 visits for children)
- Medically necessary behavioral health services for adults under the PROMISE program
- Prescribed pediatric extended care, and
- Targeted case management (TCM)

Exhibit I.2
Diamond State Health Plan Eligibility and Benefit Plan Groups[6]

Eligibility Group Description	DSHP Benefit Package	DSHP Plus Benefit Package*	Alternative Benefits Plan Package
State Plan Mandatory Medicaid Eligibility Groups			
Qualified Pregnant Women, Mandatory Poverty Level Related Pregnant Women	X		
Qualified Children, Mandatory Poverty Level Infants, Children Aged 1-5 and Children Aged 6-18	X		
SSI Adults without Medicare	X		
SSI Children without Medicare	X		
Section 4913 Children – lost SSI because of the PRWORA disability definition	X		
Parents and Caretaker Relatives	X		
Extended Medicaid due to Child or Spousal support Collections	X		
Transitional Medical Assistance	X		
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	X		
Continuous eligibility for pregnancy and postpartum period	X		
Deemed newborns	X		
Working disabled under 1619(b)	X		
Disabled Adult Children	X		
Institutionalized Individuals Continuously Eligible Since 1973		X	
Individuals Receiving Mandatory State supplements	X		
Individuals who become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 (Pickle amendment)	X		
Disabled widows/widowers ineligible for SSI due to an increase in OASDI	X		
Disabled early widows/widowers ineligible for SSI due to early receipt of Social Security	X		
SSI Adults with Medicare		X	
SSI Children with Medicare	X	X	
Former Foster Care Children	X		
Individuals who lost eligibility for SSI/SSP due to an increase in OASDI benefits in 1972	X		
State Plan Mandatory Medicaid Eligibility Groups			
Optional Infants less than one year old: Optional targeted low-income children Title XXI funding	X		
Adult Group ages 19-64			X
TEFRA Children (Katie Beckett) Qualified Disabled Children under 19	X		
Individuals who would be eligible for SSI/OSS if not for residing in an institutional setting		X	
Children with Non-IV-E Adoption Assistance	X		
Optional State Supplement Recipients – 1634 States, and SSI Criteria States with 1616 Agreements individuals living in an adult residential care facility or assisted living facility	X	X	
Optional State supplement – individuals who lose eligibility for Medicaid due to receipt of SSDI and are not yet eligible for Medicare	X		
Institutionalized individuals in Nursing Facilities who meet the Nursing Facility LOC criteria in place at the time of enrollment into the facility (with and without Medicare) even if they later do not meet the current LOC criteria		X	
Ticket to Work Basic Group	X	X	
Out-of-State Former Foster Care Children	X		
Demonstration Eligible Groups			
TEFRA-Like Children (Katie Beckett) using the "at-risk of NF" LOC criteria in place at time of enrollment	X		
Aged and/or disabled categorically needy individuals over age 18 who meet the Nursing Facility LOC criteria in place at the time of HCBS enrollment and receive HCBS as an alternative (formerly served through an Elderly & Physically Disabled 1915c Waiver)		X	
Individuals with a diagnosis of AIDs or HIV over age 1 who meet the Hospital LOC criteria and who receive HCBS as an alternative (formerly served through an AIDS/HIV 1915c Waiver)		X	
Aged and/or disabled individuals over age 18, who do not meet a NF LOC, but who, in the absence of HCBS, are "at-risk" of institutionalization and meet the "at-risk" for NF LOC criteria in place at the time of enrollment and who need/are receiving HCBS		X	

* Any individual needing Nursing Facility services and is eligible for such services will receive Nursing Facility services through DSHP Plus.

[6] Delaware Diamond State Health Plan 1115(a) Demonstration Special Terms and Conditions, accessed at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/de/de-dshp-ca.pdf, Section IV Table A, pages 16-25 of 166

The **Delaware Diamond State Health Plan Plus (DSHP-Plus)** was created through an amendment approved by CMS in 2012 as Delaware's MLTSS program. In DSHP-Plus, additional state plan populations are required to receive services through MCOs, such as those listed in Exhibit I.2 on the previous page. Members enrolled in DSHP-Plus have more complex medical needs than those enrolled in DSHP. In addition to DSHP services, the DSHP-Plus benefit package includes the services in Exhibit I-3 below. Participants have the option to self-direct some of these HCBS services.

Exhibit I.3
DSHP-Plus HCBS Benefit Plan[7]

Service	Provider Directed	Participant Directed
Adult Day Services	X	
Case Management	X	
Cognitive Services	X	
Community Based Residential Alternatives	X	
Day Habilitation	X	
Home Delivered Meals	X	
Independent Activities of Daily living (Chore)	X	X
Minor Home Modifications	X	
Nutritional Supports	X	
Personal Care/Attendant Care	X	X
Personal Emergency Response System	X	
Respite	X	X
Specialized Medical Equipment & Supplies	X	
Support for Participant Direction	X	

Traditional Medicaid (FFS) is comprised of the remaining Medicaid enrollees who are not enrolled in DSHP or DSHP-Plus. Specifically, the following populations and services are covered under Traditional Medicaid and do not receive benefits through the demonstration[8]:

- Program for All Inclusive Care for the Elderly (PACE)
- Qualified Medicare Beneficiaries (QMB)
- Specified Low Income Medicare Beneficiary (SLMB)
- Qualifying Individuals (QI)
- Qualified and Disabled Working Individuals
- Individuals in a hospital for 30 or more consecutive days
- Presumptive Breast and Cervical Cancer for Uninsured Women
- Breast and Cervical Cancer Program for Women
- Individuals residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities

[7] Delaware Diamond State Health Plan 1115(a) Demonstration Special Terms and Conditions, accessed at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/de/de-dshp-ca.pdf, Section VI, page 30-31 of 166
[8] Ibid, Section IV Table B, page 26-27 of 166

Enrollment at a Glance

Enrollment in Delaware's Medicaid program has experienced a slight decline but overall remains relatively stable near 300,000 unique beneficiaries from SFY 2017 through SFY 2019 (refer to Exhibit I.4).

During this same time period, the majority of Delaware's Medicaid beneficiaries participated in the Demonstration (87-90%). The Demonstration population increased from SFY 2017 to SFY 2019 (refer to Exhibit I.5).

Exhibit I.4 Number of Unique Beneficiaries

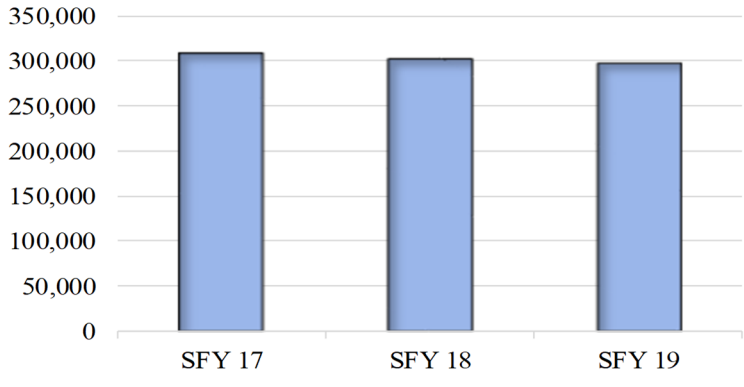
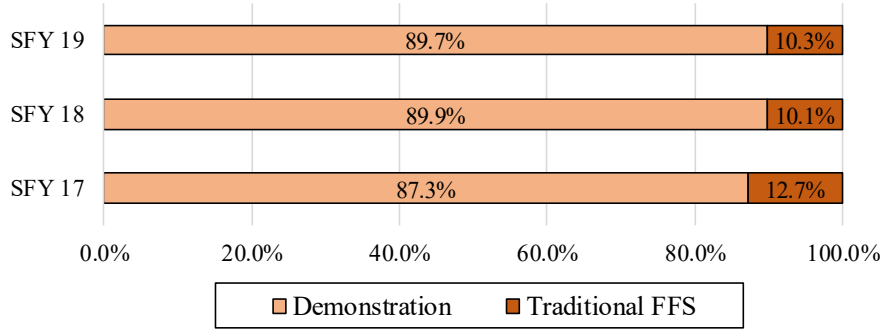


Exhibit I.5 Unique Beneficiaries by Delivery System



Of those members enrolled in the demonstration in SFY 2019, 56.4% were Caucasian, 40.5% were African-American, and 3.1% were other race/ethnicities (refer to Exhibit I.6).

Exhibit I.6 Demonstration Population by Race

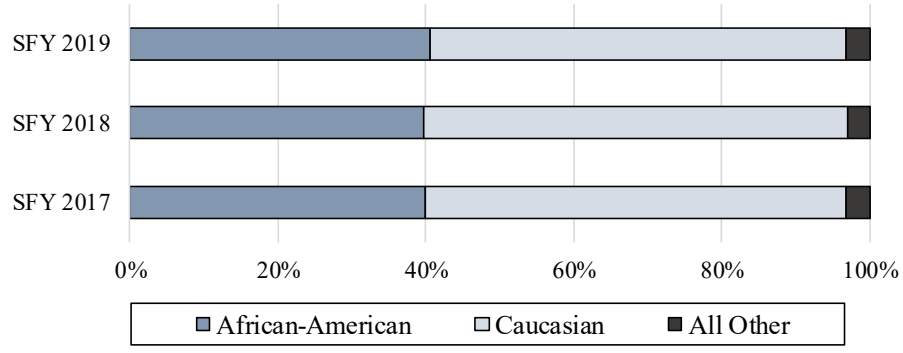
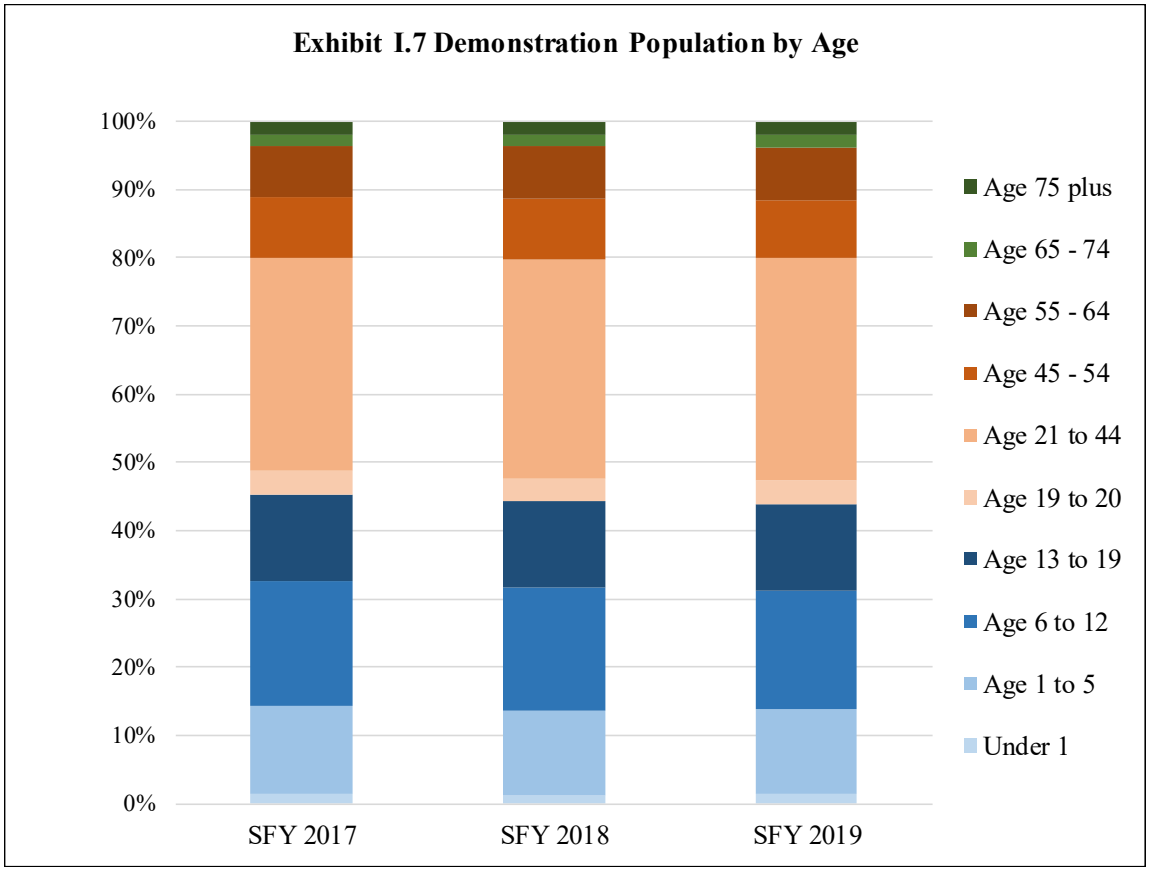


Exhibit I.7 distributes enrollment in the demonstration by the age of the members. In this exhibit, the blue colors represent different age groups among children while the peach/orange colors represent different age groups among adults age 64 and under. The green colors represent adults age 65 and older.



SECTION II: EVALUATION QUESTIONS AND HYPOTHESES

II.A Translating Demonstration Goals into Quantifiable Targets for Improvement

Burns & Associates, a Division of HMA (B&A), the State's Independent Evaluator, examined the relationships between the CMS domains of focus and the Delaware Medicaid demonstration components and goals included in the approved 1115 waiver and special terms and conditions (STCs). To begin development of an evaluation design that is responsive to CMS guidance, each demonstration component was linked to waiver goals and the suggested domains of focus as found in the matrix in Exhibit II.1. Note that demonstration component five and waiver goal eleven will be addressed separately in the 1115 SUD Evaluation Design Plan; therefore, neither is included in this 1115 Demonstration Evaluation Design Plan.

Exhibit II.1
Linking Demonstration Components to Waiver Goals and Domains of Focus

		Demonstration Components				
		C.1	C.2	C.3	C.4	C.5
		Managed Care Delivery System	Managed LTSS	PROMISE	Former Foster Care	SUD IMD
Waiver Goals						
G.1	Access improves and provides increasing options for MLTSS	X	X			
G.2	Rebalancing LTC in favor of HCBS		X			
G.3	Promote early intervention for at risk for LTC		X			
G.4	Increase care coordination and supports	X	X		X	
G.5	Expand consumer choice	X	X		X	
G.6	Improve quality of health services, including LTC	X	X		X	
G.7	Payment structure incentivizes shift from institution to community LTSS		X			
G.8	Duals integration		X			
G.9	PROMISE improves enrollee overall health status and quality of life			X		
G.10	Increase and strengthen coverage for former foster care	X			X	
G.11	Increase access to and appropriate use of SUD services					X
G.12	Increase access to and appropriate use of dental	X				
Domain of Focus						
F.1	Rebalancing LTSS		X			
F.2	Early Intervention cost benefit for LTC		X			
F.3	MLTSS care coordination		X			
F.4	PROMISE care coordination and enhanced BH			X		
F.5	PROMISE enrollee health status and quality improvements			X		
F.6	Former foster care youth gain coverage and improved health outcomes	X			X	X
F.7	Impact of waiving retroactive eligibility and enrollment	X				X
F.8	Impact of adult dental on access and health outcomes	X				

II.B Defining Relationships: Waiver Policy, Short-term and Longer-term Outcomes

As part of the examination of the relationships between demonstration components, waiver goals, and the domains of focus, and due to the maturity of evaluating a long term demonstration, B&A constructed logic models delineating short-term and longer-term outcomes associated with the four principle policy objectives of the demonstration.

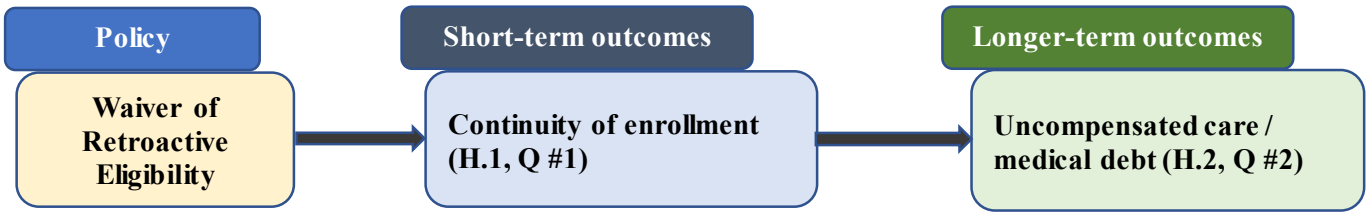
1. Maintain Continuity of Enrollment
2. Maintain Access to Care,
3. Maintain or Improve Health Outcomes, and
4. Rebalance Long-term Care Services and Supports (LTSS) in favor of Home and Community-based Services (HCBS).

The determination of whether an outcome is short-term or longer-term is dependent on the measure specifications including measurement period, and data needed to adequately assess trends with the waiver policy. For example, because national outcome measures tend to have annual measurement periods, they are considered in this evaluation to be longer-term indicators of policy outcomes. Each of the four principle policy objectives are described in detail and include logic models to illustrate both short-term and longer-term outcomes. Each logic model also provides a reference to specific hypotheses and research questions that will be described in Section II.C.

Maintain Continuity of Enrollment

B&A chose Maintain Continuity of Enrollment as the first policy objective as it is responsive to Waiver Goals #1 and #10 and Domain of Focus #7 which focus on access and an assessment of the impact of the waiver of retroactive eligibility. Exhibit II.2 illustrates the baseline assumption is that continuing the policy of waiving retroactive eligibility for specified Medicaid eligibility groups will not have an adverse impact on trends in continuity of Medicaid enrollment in the short term. On a longer-term basis, the assumption is that trends in uncompensated care and medical debt will not worsen over the course of the demonstration. Both process and outcome measures are proposed to assess impact.

Exhibit II.2
Logic Model 1: Maintain Continuity of Enrollment

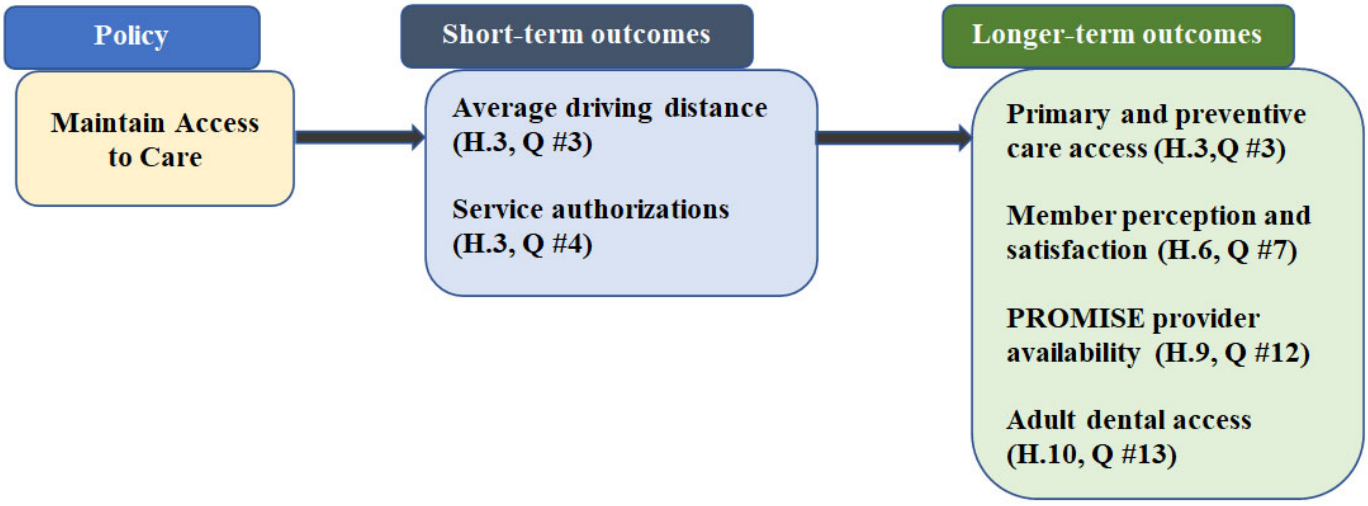


Maintain Access to Care

Maintain Access to Care is the second policy objective and it is based on Waiver Goal #1. Exhibit II.3 on the following page illustrates the assumption that trends in access to care continue or do not worsen. In the short term, a mix of outcome and process measures will be used to assess trends in access to care by focusing on average driving distance and service authorizations. To evaluate access to care on a longer-

term basis, B&A is proposing to use established outcome measures of access, measures of member perceptions, utilization and provider availability.

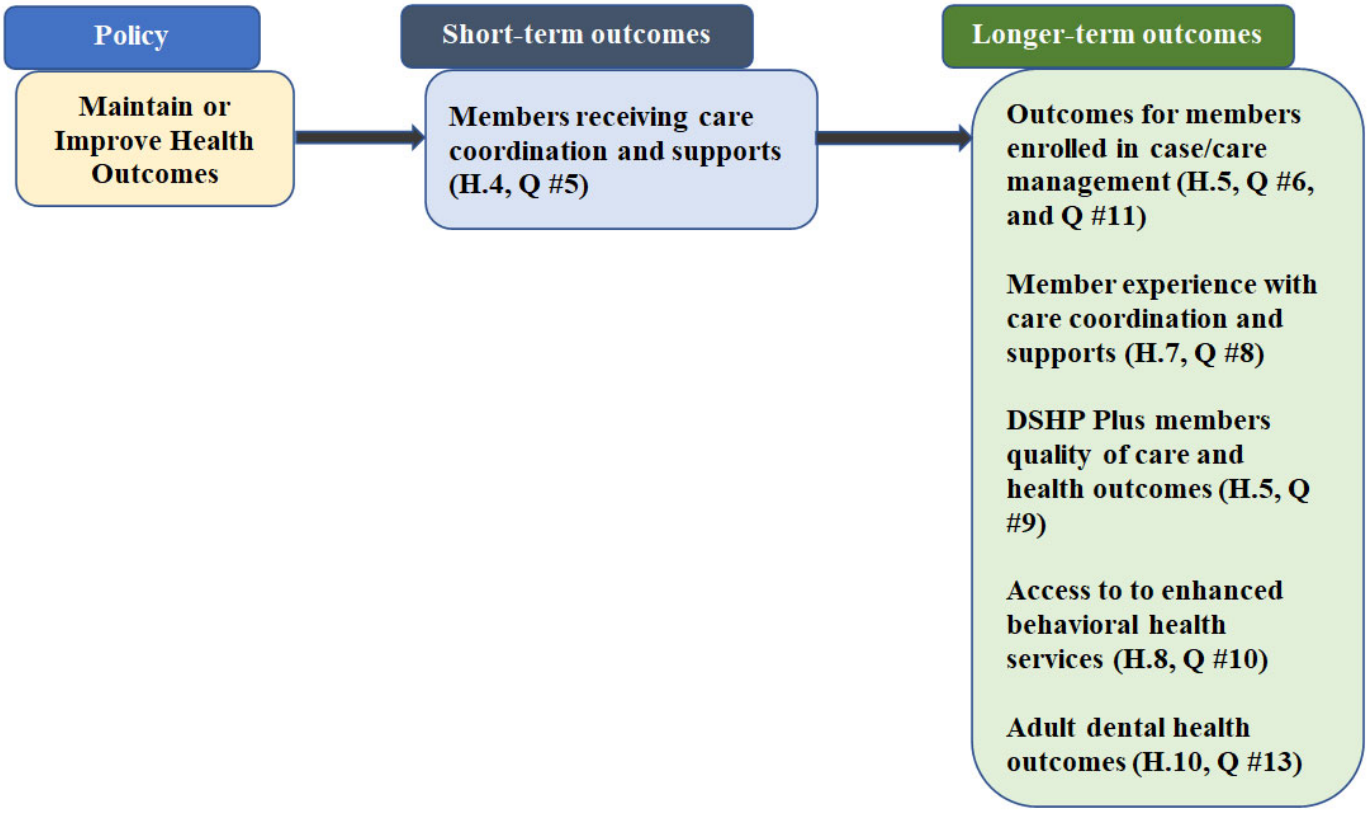
Exhibit II.3
Logic Model 2: Maintain or Improve Access



Maintain or Improve Health Outcomes

The third policy objective is Maintain or Improve Health Outcomes and it encompasses Waiver Goals #3, 4, 6, 9 and 12. Domains of Focus #3, 4, 5 and 8 which all focus on some of the most vulnerable Delaware Medicaid beneficiaries. Exhibit II.4 on the following page illustrates the assumption that Medicaid beneficiaries enrolled in the demonstration will maintain or improve health outcomes. In the short term, process measures will measure access to care coordination and supports. On a longer-term basis, national health outcome metrics and B&A customized process measures focusing on care coordination will complete the assessment of the third principle policy objective.

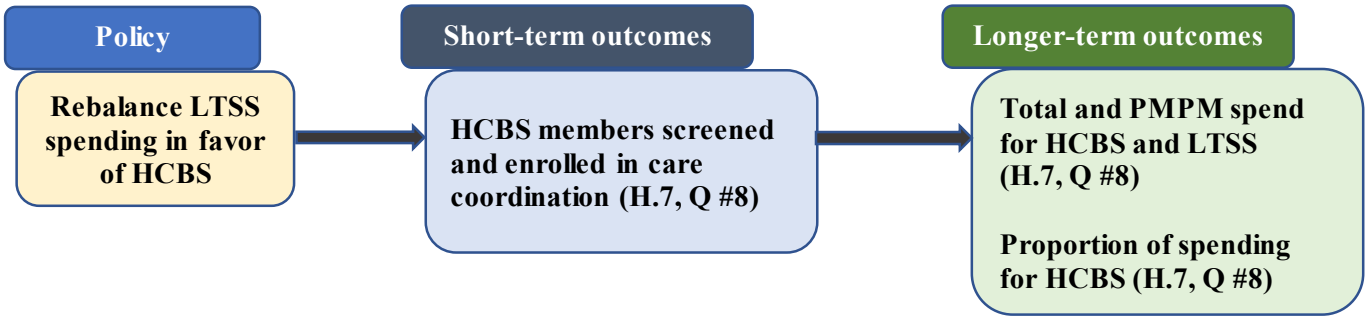
Exhibit II.4
Logic Model 3: Maintain or Improve Health Outcomes



Rebalance LTSS in favor of HCBS

Rebalance LTSS in favor of HCBS is the fourth policy objective and is based on Waiver Goals #2 and 7, and Domains of Focus #1 and #2. As depicted in Exhibit 5, the assumption is that over the course of the demonstration, rebalancing efforts will continue to maintain or increase utilization of HCBS services where appropriate. Member rates of screening and enrollment will be used to assess short-term impact. Longer-term impact will be assessed using a combination of utilization and expenditure metrics, and member satisfaction with their care coordination experiences.

Exhibit II.5
Logic Model 4: Rebalance LTSS spending in favor of HCBS



B&A found that there are existing, nationally-recognized outcome measures associated with principle policy objectives two and three, and the specifications and data sources for many of these measures were already described as part of Delaware Medicaid's Quality Strategy and are required to be reported by the managed care organizations. In addition to using nationally recognized outcome measures, B&A will fill gaps with custom measures developed by us where needed.

A more detailed description of the data, measures, and analyses to be used are described in Section III of the Evaluation Design document.

II.C Hypotheses and Research Questions

The four principle policy areas depicted in the logic models in Section II.B were converted into ten hypotheses (H) and thirteen research questions (Q); and the latter each assigned measures and targeted analytic methodology, described in detail in Section III. Methodology. As described in Section II.B, the evaluation has been constructed to measure trends in each of the demonstration's four long standing policy objectives and assess outcomes both on a short- or longer-term basis. Exhibit II.6 on the following page provides a high-level overview of each hypothesis and the associated research question. In most cases, the research question assesses impact either on a short- or longer-term basis, except for Q #3 and Q #8 which have measures that assess both short- and long-term impact.

Exhibit II.6
Hypotheses and Research Questions

Hypothesis	Research Question	Outcomes: Short-term	Outcomes: Longer-term
H.1: Trends in continuity of enrollment continue (or does not worsen) for Medicaid populations subject to the waiver of retroactive eligibility in the current waiver period.			
	Q #1: ***Does the waiver of retroactive eligibility continue (or does not worsen) the continuity of enrollment in Medicaid in the current waiver period?***	**X**	
H.2: The waiver of retroactive eligibility will continue or not worsen trends in uncompensated care or medical debt in the current waiver period.			
	Q #2: ***Does the waiver of retroactive eligibility continue or not worsen trends in the incidence of uncompensated care or not seeing a doctor because of cost in the current waiver period?***		**X**
H.3: Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current waiver period.			
	Q #3: ***Does the level and trend of access to primary and preventive care continue (or not worsen) in the current waiver period?***	**X**	**X**
	Q #4: ***Do service authorizations provide an effective tool in the appropriate utilization of health care services in the current waiver period?***	**X**	
H.4: Trends in coordination of care and supports continues (or does not worsen) in the current waiver period.			
	Q #5: ***Does the proportion of members receiving care coordination and supports continue (or not worsen) in the current waiver period?***	**X**	
H.5: Coordination of care and supports maintains or improves quality of care and health outcomes in the current waiver period.			
	Q #6: ***Do DSHP members enrolled in case/care management achieve similar or improved quality of care and health outcomes in the current waiver period?***		**X**
	Q #9: ***Do DSHP Plus members achieve similar or improved quality of care and health outcomes in the current waiver period?***		**X**
	Q #11: ***Do PROMISE members enrolled in case/care management achieve similar or improved quality of care and health outcomes in the current waiver period?***		**X**
H.6: Trends in consumer satisfaction will continue (or not worsen) in the current waiver period.			
	Q #7: ***Does the level of satisfaction among DSHP members continue (or not worsen) in the current waiver period?***		**X**
H.7: Creating a delivery system that provides incentives for resources to shift from institutions to community-based LTSS has maintained or increased utilization of HCBS services where appropriate in the current waiver period.			
	Q #8: ***Has the rebalancing of long-term care services and supports maintained or moved more toward home- and community-based services and away from institutional services in the current waiver period?***	**X**	**X**
H.8: Trends in health outcomes will continue or improve in the current waiver period for individuals enrolled in the PROMISE program.			
	Q #10: ***Does the level and trend of access to enhanced behavioral health services continue (or not worsen) in the current waiver period?***		**X**
H.9: The PROMISE program network capacity will continue (or not worsen) in the current waiver period.			
	Q #12: ***Does the availability of PROMISE providers continue (or not worsen) in the current waiver period?***		**X**
H.10: The availability of the adult dental benefit will improve access to dental services and will continue (or not worsen) health outcomes in the current waiver period.			
	Q #13: ***Does the availability of the adult dental benefit increase access to dental services and lead to continued (or not worsen) health outcomes in the current waiver period?***		**X**

II.D Alignment with Demonstration Goals

As described in Section II.B, the demonstration components have been linked to the waiver goals and domains of focus. Building upon the matrix shown in Section II.B, each hypothesis was cross-referenced to demonstration goals and domains of focus. This was to ensure that the evaluation hypotheses and research questions are responsive to the CMS guidance in the approved waiver STCs. As demonstrated in Exhibit II.7, each hypothesis addresses at least one demonstration goal and, in many cases, cross multiple goals. Further, the evaluation design ensures that the domains of focus suggested by CMS in the approved waiver STCs are also addressed in this Evaluation Design Plan.

Exhibit II.7
Alignment of Hypotheses with Demonstration Goals and Domains of Focus

		Hypotheses									
		H.1	H.2	H.3	H.4	H.5	H.6	H.7	H.8	H.9	H.10
		Continuity of Enrollment	Uncomp. Care Medical Debt	Acces to Health Care	Coordination of Care & Supports	Coordination of Care & Supports Maintains Outcomes	Consumer Satisfaction	Resources Shift From LTSS to HCBS	Health Outcomes for PROMISE	PROMISE Network Capacity	Adult Dental Access and Outcomes
Waiver Goals											
G.1	Access improves and provides increasing options for MLTSS	X	X	X				X		X	
G.2	Rebalancing LTC in favor of HCBS							X			
G.3	Promote early intervention for at risk for LTC					X					
G.4	Increase care coordination and supports				X	X					
G.5	Expand consumer choice						X				
G.6	Improve quality of health services, including LTC					X					
G.7	Payment structure incentivizes shift from institution to community LTSS							X			
G.8	Duals integration				X						
G.9	PROMISE improves enrollee overall health status and quality of					X			X		
G.10	Increase and strengthen coverage for former foster care	X	X								X
G.11	Increase access to and appropriate use of SUD services	Addressed in SUD Evaluation Design Plan									
G.12	Increase access to and appropriate use of dental services										X
Domain of Focus											
F.1	Rebalancing LTSS							X			
F.2	Early Intervention cost benefit for LTC							X			
F.3	MLTSS care coordination				X						
F.4	PROMISE care coordination and enhanced BH services				X						
F.5	PROMISE enrollee health status and quality improves								X	X	
F.6	Former foster care youth gain coverage and improved health			X							X
F.7	Impact of waiving retroactive eligibility and enrollment	X	X								
F.8	Impact of adult dental on access and health outcomes										X

II.E How Hypotheses and Research Questions Promote Objectives of Titles XIX and XXI

The Evaluation Design Plan hypotheses were also cross referenced with the objectives of the Medicaid program[9] to ensure that the plan promotes the objectives of Titles XIX and XXI of the Social Security Act as required in Attachment F of the approved waiver STCs. As demonstrated in Exhibit II.8, each hypothesis addresses at least one objective and, in some cases, multiple objectives of the Medicaid and Children's Health Insurance Program (CHIP).

Exhibit II.8
Alignment of Hypotheses with Medicaid and CHIP Program Objectives

		Hypotheses									
		H.1	H.2	H.3	H.4	H.5	H.6	H.7	H.8	H.9	H.10
		Continuity of Enrollment	Uncomp. Care Medical Debt	Acces to Health Care	Coordination of Care & Supports	Coordination of Care & Supports Maintains Outcomes	Consumer Satisfaction	Resources Shift From LTSS to HCBS	Health Outcomes for PROMISE	PROMISE Network Capacity	Adult Dental Access and Outcomes
Objectives of Medicaid and Children's Health Insurance Program											
O.1	Improve access to services that produce positive health outcomes	X	X	X		X	X				X
O.2	Promote efficiencies							X			
O.3	Support coordinated strategies to address certain health determinants				X	X			X		X
O.4	Strengthen beneficiary engagement	X	X		X	X	X	X			
O.5	Enhance alignment between Medicaid policies and commercial health insurance	X						X			X
O.6	Advance innovative delivery system and payment models							X		X	

[9]Accessed at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html

SECTION III: METHODOLOGY

III.A Evaluation Design

The evaluation design is a mixed-methods approach, drawing from a range of data sources, measures and analytics to best produce relevant and actionable study findings. B&A tailored the approach for each of the thirteen research questions described in Section II, Evaluation Questions and Hypotheses. The evaluation plan reflects a range of data sources, measures and perspectives. It also defines the most appropriate study population and sub-populations, as well as describes the five analytic methods included in the evaluation design.

The five analytic methods proposed for use across the ten hypotheses and thirteen research questions include:

1. Descriptive statistics (DS),
2. Statistical tests (ST),
3. Onsite reviews (OR)
4. Desk reviews (DR) and,
5. Facilitated interviews (FI).

Exhibit III.1 on the next page presents a chart displaying which method(s) are used for each hypothesis. It also includes a brief description of the indicated methods as well as the sources of data on which they rely. The five methods are ordered and abbreviated as described above.

As described in Section II.B, the majority of the hypotheses and associated research questions focus on whether the 1115 Demonstration made an impact on key DMMA waiver goals (i.e., short-term and longer-term outcomes). In order to facilitate evaluation on whether a statistically significant difference between the pre-waiver and current waiver period can be detected, the data, measures and methods for these research questions will be tested using healthcare claims, member enrollment data, MCO report submissions and provider enrollment data. The proposed metrics blend nationally-recognized measure specifications with custom metrics developed by B&A (where national metrics are unavailable). Analytic methods include ITS and descriptive statistics using chi-square tests or t-tests as applicable.

The focus shifts to assessing member perception to measure consumer satisfaction, choice, and quality. Given that these require information beyond what is available in claims or other public data sets, this section draws upon a set of mixed methods to evaluate progress. Where possible, measures will be incorporated into a reporting dashboard that tracks results from the pre-waiver period and the waiver-to-date period. Wherever possible, data will be tracked and reported on a quarterly basis.

Exhibit III.1
Summary of Five Analytic Methods by Hypotheses

	Hypothesis Description	Method					Analytic Method Examples
		DS	ST	OR	DR	FI	
1	Trends in continuity of enrollment continue (or does not worsen) for Medicaid populations subject to the waiver of retroactive eligibility in the current waiver period.	X		X	X	X	**DS**: trends in frequencies and percentages of time span from application to enrollment stratified by aid category, assignment plan, delivery system). **OR**: Eligibility Process Review (2 rounds). Data sources: enrollment data.
2	The waiver of retroactive eligibility will continue or not worsen trends in uncompensated care or medical debt in the current waiver period.	X		X	X	X	**DS**: trends in DE-reported percentages over the demonstration period; comparison to baseline period and available national and regional values. Data sources: reports submitted by hospitals, BRFSS Health Care Access Module, interviews with members.
3	Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current waiver period.	X	X	X	X	X	**DS**: trends in frequencies and percentages. **ST**: chi square or t-tests of significance; ITS. **OR**: Eligibility Process Review and Service Authorizations focus studies (2 rounds for each). Data sources: claims and enrollment data, reports submitted by MCOs (validated by B&A).
4	Trends in coordination of care and supports continues (or does not worsen) in the current waiver period.	X		X	X	X	**DS**: trends tracked separately for (1) PROMISE enrollees, (2) DSHP Plus eligibles, (3) selected special health care need categories. **OR**: Care Coordination and Transitions to Care focus studies (2 rounds for each). Data sources: claims, reports submitted by MCOs
5	Coordination of care and supports maintains or improves quality of care and health outcomes in the current waiver period.	X	X	X	X	X	**DS**: trends in frequencies and percentages. **ST**: chi square or t-tests comparing target population to baseline, with stratification to sub-population based on metric; ITS. Data sources: claims, reports submitted by MCOs
6	Trends in consumer satisfaction will continue (or not worsen) in the current waiver period.	X	X		X	X	**ST**: chi square or t-tests of significance comparing target population to baseline, stratified by MCO, adults and children; ITS. **OR**: Critical Incidents, Appeals and Grievances focus study (2 rounds). Data sources: CAHPS survey results, reports submitted by MCOs quarterly to DMMA, ad hoc reports for sub-population reporting, as needed.
7	Creating a delivery system that provides incentives for resources to shift from institutions to community-based LTSS has maintained or increased utilization of HCBS services where appropriate in the current waiver period.	X	X	X	X	X	**ST**: chi square or t-tests of significance comparing target population to baseline; ITS. **OR**: Care Coordination and Transitions to Care focus studies (2 rounds of each). Data sources: claims, reports submitted by the MCOs (validated by B&A), a targeted member survey.
8	Trends in health outcomes will continue or improve in the current waiver period for individuals enrolled in the PROMISE program.	X	X		X		**ST**: chi square or t-tests of significance comparing target population (PROMISE enrollees) to baseline; ITS. Data sources: claims, reports submitted by MCOs quarterly to DMMA.
9	The PROMISE program network capacity will continue (or not worsen) in the current waiver period.	X	X		X		**DS**: trends rates stratified by MCO and region. **ST**: chi square or t-tests of significance comparing target population (PROMISE enrollees) to baseline. Data sources: claims, provider enrollment data.
10	The availability of the adult dental benefit will improve access to dental services and will continue (or not worsen) health outcomes in the current waiver period.	X	X	X	X	X	**DS**: trends rates stratified by MCO and region. **ST**: chi square or t-tests of significance comparing target population to baseline; ITS. **OR**: Baseline Access to Dental Care focus studies (two rounds), with Dental Transitions to Care (in round two). Data sources: claims, provider enrollment data, reports submitted by MCOs.

DS = Descriptive Statistics; ST = Statistical Tests; OR = Onsite Reviews; DR = Desk Reviews; FI = Facilitated Interviews

III.B Target and Comparison Populations

Target Population

The target population is any Delaware Medicaid beneficiary enrolled in the demonstration in the study period. B&A will use Section IV, Table A in the approved waiver STCs as the basis for identification of beneficiaries enrolled in the demonstration. B&A will create flags to identify Medicaid members and providers that will be part of the analytics. Flags will be assigned to attribute individuals to each sub-population group which includes, but is not limited to:

- MCO enrolled with
- DSHP and DSHP Plus enrollment
- Member enrolled in PROMISE
- Native American status
- Member former foster care status
- Member age (for specified age groups)
- Member home location (e.g., city/county/region)
- Member dual eligible status
- New member enrollment due to COVID

There will also be flags assigned to providers. The provider type and specialty will be tracked. B&A will use these indicators and create other flags that may require the joining of existing variables to assign providers by:

- Regional location
- Level of care
- Newly-enrolled and long-standing enrolled providers

The matrices included in Section III.G identify the target population and stratification proposed for each hypothesis and research question.

Comparison Groups

Two ideal comparison groups described in the CMS technical advisory guidance on selection of comparison groups include another state Medicaid population and/or prospectively collected information prior to the start of the intervention.[10] Specifically, a Medicaid population with similar demographics but in another state without those waiver flexibilities described in Delaware, would be an ideal comparator. However, identifying whether such a state exists or the ability to obtain data from another state given the sensitivity of Medicaid privacy concerns as it relates to data sharing is not feasible; therefore, it is outside the scope of this evaluation. The other example of a control group described in the design guide is to collect prospective data. To our knowledge, there is no known prospective data collection on which to build baselines. Given the lack of an available and appropriate comparison group, B&A will use an analytic method which creates a pre-waiver and current waiver (intervention) group upon which to compare outcomes. See Section III.F for more details on the analytic methods.

Available results from CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults will be used as a benchmark comparator for those nationally-recognized metrics included in the evaluation design. Results of these measures are reported at a statewide level by Medicaid program. In this case, comparator states will be identified and included within the Summative Evaluation. Comparator states will be chosen in consultation with the State, CMS and other stakeholders.

[10] Comparison Group Evaluation Design. https://www.medicaid.gov/medicaid/section-1115-demo/downloads/ evaluation-reports/comparison-grp-eval-dsgn.pdf.

III.C Evaluation Period

A pre-waiver and current wavier period will be defined as three calendar years before and five calendar years after waiver implementation. The pre-waiver period is defined as enrollment or dates of service from January 1, 2016 through December 31, 2018. The current waiver period is defined as enrollment or dates of service from August 1, 2019 through December 31, 2023. In support of the analytic methods described in Section III.F, the calendar year data will be further defined into both monthly and quarterly segments such that both the pre-periods will include 12 quarters or 36 months from the pre-waiver period, and 20 quarters or 60 months from the current waiver period.

To simplify the analytic plan, B&A is making an assumption about the first seven months of 2019 prior to the waiver being approved. For annual measures in which a national steward has defined measure specifications, B&A will consider the entire 12 months of CY 2019 in the period prior to the current approved demonstration that became effective August 1, 2019. Although CMS approved Delaware's 1115 waiver in July 2019, waiver-related activities were moving forward in anticipation of approval of the extension. For ease of conducting and describing the analysis, the evaluation period will include the seven months in the calendar year prior to July 2019 approval as the current waiver period for monthly and quarterly metrics. For annual metrics, January 1, 2020 through December 31, 2023 will be considered the demonstration period.

It should be noted that, while this is the expected current evaluation period, modifications may be warranted to better reflect differences in the time period upon which one would expect to see a change in outcome resulting from waiver activities. At this time, there was little data or similar studies available on which to base specific alternatives to the proposed current evaluation period. B&A, therefore, will examine time series data in order to identify whether the current evaluation period should be delayed. For example, if review of the data shows a distinctive change in the fourth quarter of 2019, the current period would be adjusted such that the first, second and third quarter data would not be considered in the interrupted time series analysis described in Section III.F.

III.D Evaluation Measures

The measures included in the Evaluation Design Plan directly relate to the four principle policy objectives and short-term and longer-term outcomes described in Section II. The measures fall into three primary domains: quality, access and financial. Exhibit III.2 on the following page summarizes the list of measures included in the evaluation plan. A comprehensive summary of measures, which includes measure stewards as well as a description of numerators and denominators, can be found in the detailed matrices in Section III.G.

Exhibit III.2 Evaluation Measures by Domain

Quality

- Rate of DSHP members with special health care needs screened for care coordination
- Of those members with special health care needs screened, the number enrolled in care coordination
- Duration of enrollment within case/care management
- Prenatal care for pregnant women (PPC), control groups those in/not in case/care management
- Follow-Up After Hospitalization for Mental Illness (FUH)
- Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)
- Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)
- Getting Needed Care Composite
- Getting Care Quickly Composite
- How Well Doctors Communicate Composite
- Rating of Personal Doctor
- Rating of Health Plan
- Grievances per 1000 members
- Total number of grievances by category
- Appeals per 1000 members
- Total number of appeals by category
- Critical incidents per 1000 members
- Rate of members needing HCBS services screened for care coordination
- Of those members needing HCBS services screened, the number enrolled in care coordination
- Member experience with care coordination and supports
- Annual Monitoring for Patients on Persistent Medications
- Medication Adherence Rates - Percent of Days Covered (PDC)
- Comprehensive Diabetes Care (CDC)
- Plan All-Cause Readmissions (PCR)*
- Rate of identified members who enroll in PROMISE
- Follow-Up After Hospitalization for Mental Illness (FUH)
- Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)
- Follow-Up After Discharge from the Emergency Department for Alcohol or Other Drug (AOD) Dependence*
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
- Antidepressant Medication Management (AMM)
- Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-A-A)
- Follow-up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDF-A-A)
- Adults with Diabetes – Oral Evaluation (DOE-A-A)

Access

- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC)
- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Breast Cancer Screening (BCS)
- Proportion of enrollees continuously enrolled in Medicaid by aid category, delivery system, MCO
- Enrollment duration by aid category
- Medicaid enrollment counts by month and aid category
- Time span from application to enrollment in Medicaid
- Average turnaround time for authorization decisions
- Could Not See Doctor Because of Cost
- Self-identified trends in medical debt
- Rate of approved and denied authorizations
- Frequency and percentage of denial reason codes
- Utilization of HCBS services per 1000 members
- Emergency Department (ED) visits per 1000
- Emergency Department (ED) Frequent Flyer rate
- Average driving distance to primary care services
- Behavioral health providers per 1000 members by geographical region
- HCBS providers per 1000 members by region
- Utilization of dental services per 1000 members
- Dental providers per 1000 members by region
- Average driving distance to dental care services

Financial

- Spending in total and on a per member month basis for HCBS services
- Spending in total and on a per member month basis for institutional LTSS services
- Proportion of spending for HCBS services
- Rate of hospital reported uncompensated care

* Denotes metric that is also part of the SUD Evaluation.

III.E Data Sources

As described in Section III.A, Evaluation Design, B&A will use existing secondary data sources as well as collect primary data. The evaluation design relies most heavily on the use of Delaware Medicaid administrative data, i.e., enrollment, claims and encounter data. Supplemental administrative data, such as prior approval denials and authorizations, will also be incorporated. Primary data will be limited and will include data created by desk review and facilitated interview instruments. A brief description of these data and their strengths and weaknesses follow.

Delaware Medicaid Administrative Data

Claims and encounters with dates of service (DOS) from January 1, 2016 and ongoing will be collected from the Delaware Medicaid Enterprise System (DMES) Data Warehouse (EDW), facilitated by DMMA's EDW vendor, Gainwell (formerly DXC) Technologies. Managed care encounter data has the same record layout as fee-for-service and includes variables such as charges and payments at the header and line level. Payment data for MCO encounters represents actual payments made to providers. In total, three MCOs will have encounter data in the dataset, but not every MCO will have data for all years in the evaluation. Delaware has contracted with Highmark and AmeriHealth Caritas DE from 2018 to present. Prior to 2018, Highmark and United Healthcare Community Plan were the contracted MCOs. This means that United Healthcare Community Plan will only have encounter data in the pre-waiver period, while Highmark and AmeriHealth Caritas DE will have data in the pre-waiver and current demonstration time period.

A data request specific to the 1115 Evaluation Design Plan will be given to DMMA and the data will be delivered to B&A in an agreed-upon format. The initial EDW data set will include historical data up to the point of the delivery. Subsequent data will be sent to B&A on a monthly basis. The last query of the EDW will occur on January 1, 2025 for claims with DOS in the study period. All data delivered to B&A from the DMMA will come directly from the DMES EDW. B&A will leverage all data validation techniques used by Gainwell before the data is submitted to the EDW. B&A will also conduct its own validations upon receipt of each monthly file from the DMES to ensure accuracy and completeness when creating our multi-year historical database.

When additional data is deemed necessary for the evaluation, B&A will outreach directly to the MCOs when they are determined to be the primary source. B&A will build data validation techniques specific to the ad hoc requests from the MCOs.

Additional data from the MCOs and the State will be collected on prior authorizations, denials, denial reason codes as well as data on care coordination activities. There could be some data validity or quality issues with these sources as they are not as rigorously collected as claims and encounters data. That being said, we will use a standard quality review and data cleaning protocol in order to validate these data, as well as provide detailed specifications and reporting tools to the MCOs and the state to minimize potential for differences in reporting of the requested ad-hoc data.

Survey and Facilitated Interview Data

CAHPS® Health Plan Survey 5.0 (Medicaid)[11]

The Consumer Assessment of Healthcare Providers & Systems (CAHPS)® Health Plan Survey is a survey of Medicaid beneficiaries enrolled in managed care used to identify their experiences with health plans and services. It is used to assess performance of health plans which provide access to health care for Delaware's demonstration enrollees. Data is reported for adults, children, and at the MCO level and will be used to review for descriptive trends over time using chi square tests of significance.

Facilitated Interview Guides

B&A will construct facilitated interview guide instruments as a means to collect primary data for the focus studies. The types of respondents that the evaluators propose to interview are identified at the metric level in Section III. G. Respondents will include the MCOs, non-SUD providers, non-SUD beneficiaries, PROMISE providers and PROMISE beneficiaries. Where focused interviews are used to collect data, B&A will use semi-structured interview protocols that are intended to be standardized within the population being interviewed. The interview protocols will vary, however, for each population interviewed due to the type of information that is intended to be collected. Although semi-structured in nature, each stakeholder will have the opportunity to convey additional information that he/she would like to convey to the evaluators in an open-ended format at the conclusion of each interview.

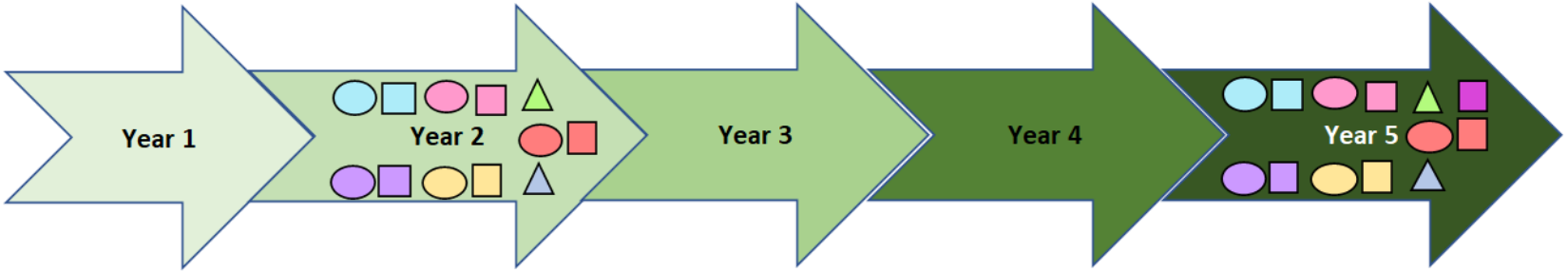
Whereas the Delaware Medicaid administrative data will be collected and used on a monthly basis throughout the waiver period and after the waiver concludes to produce the Summative Evaluation, B&A anticipates that data from our sources will be collected in CY 2021 and CY 2024 for use in evaluation activities. Exhibit III.3 that appears on page III-8 contains the proposed primary data collection activities by source, year, and hypotheses. Exhibit III.4 that appears on page III-9 demonstrates the proposed primary data collection timeline by type, year, and hypotheses.

[11] Accessed at https://www.ahrq.gov/cahps/surveys-guidance/hp/index.html

Exhibit III.3
Proposed Primary Data Collection Activities, by Source, Year and Hypotheses

		Desk / Onsite Review			Facilitated Interviews / Focus Groups			
	Source	**MCOs**	**Other State Partners**	**State Agencies**	**Members**	**Other State Partners**	**State Agencies**	**MCOs**
Hypotheses	**Contract Year 1, CY 2020**							
	All Hypotheses			X				
	Contract Year 2, CY 2021							
	1 Continuity of Enrollment		X	X				
	2 Uncompensated Care/Medical Debt			X	X			
	3 Trends in Access to Care	X	X	X		X	X	X
	4 Trends in Coordination of Care and Supports	X	X	X		X	X	X
	5 Coordination of Care and Supports Maintains Outcomes	X	X	X		X	X	X
	6 Trends in Consumer Satisfaction	X	X	X		X	X	X
	7 Resources Shift From LTCF to HCBS				X			
	8 Trends in Health Outcomes for PROMISE							
	9 PROMISE Network Capacity							
	10 Adult Dental Access and Outcomes							
	Contract Year 3, CY 2022							
	All Hypotheses			X				
	Contract Year 4, CY 2023							
	All Hypotheses			X				
	Contract Year 5, CY 2024							
	1 Continuity of Enrollment		X	X				
	2 Uncompensated Care/Medical Debt			X	X			
	3 Trends in Access to Care	X	X	X		X	X	X
	4 Trends in Coordination of Care and Supports	X	X	X		X	X	X
	5 Coordination of Care and Supports Maintains Outcomes	X	X	X		X	X	X
	6 Trends in Consumer Satisfaction	X	X	X		X	X	X
	7 Resources Shift From LTCF to HCBS				X			
	8 Trends in Health Outcomes for PROMISE							
	9 PROMISE Network Capacity							
	10 Adult Dental Access and Outcomes	X						X

Exhibit III.4
Proposed Primary Data Collection Timeline, by Type, Year and Hypotheses



Hypotheses

1 Continuity of Enrollment
2 Uncompensated Care/Medical Debt
3 Trends in Access to Care
4 Trends in Coordination of Care and Supports
5 Coordination of Care and Supports Maintains Outcomes
6 Trends in Consumer Satisfaction
7 Resources Shift From LTCF to HCBS
8 Trends in Health Outcomes for PROMISE
9 PROMISE Network Capacity
10 Adult Dental Access and Outcomes

Desk Review/Onsite Review
Member Survey
Facilitated Interview/Focus Group

* Years correspond to Independent Evaluator contract years, with Year 1 beginning in 2020. Note: Presently, the State only has the authority to contract with B&A through February 28, 2022. There are deliverables due to CMS after February 28, 2022.

III.F Analytic Methods

Exhibit III.1 depicted the five analytic methods to be used in the analysis. A detailed discussion of each method is described below. This includes, where applicable, B&A's approach to address the impact of the COVID-19 pandemic within each method.

Method #1: Descriptive Statistics

In order to facilitate ongoing monitoring, all measures will be summarized on an ongoing basis over the course of the waiver. The descriptive statistics will be stratified by MCE and FFS delivery systems, and/or by region where possible. For reporting purposes, the descriptive studies will be subject to determination of a minimum number of beneficiaries in an individual reported cell (i.e., minimum cell size) and subject to blinding if the number falls below this threshold. While a conventional threshold is 10 or fewer observations, given the sensitivity of small population size and the public dissemination of report findings, a higher threshold may be established by the evaluators upon review of the final data.

Results will primarily be reported in terms of longitudinal descriptive statistics of defined groups of non-SUD beneficiaries and using regional maps where possible.

COVID-19 Considerations

For metrics where descriptive trends is the appropriate methodology, the evaluators propose to include a marker of pre- and post- COVID overlaid onto any graphs so one can visually inspect if there is an obvious change in the particular outcome starting mid-2020 and adding a comparator group.

In both cases, newly eligible members who became Medicaid eligible as a result of COVID will be identified by aid category and benefit plan and treated as a subpopulation in the analysis. This will allow the evaluators to continue to include those newly eligible members for which enrollment is unrelated to the pandemic (e.g., aged, blind and disabled, pregnant women, children, etc.).

Method 2: Statistical Tests

T-test or Chi-square test

Tests will be used to determine whether the observed differences in the mean value or rate differs for the most recent evaluation two-year period compared to the two-year period prior to waiver implementation. To assess if results for each metric compared to the pre-waiver timeframe are not due to chance alone, the evaluators will use chi-square tests for categorical data and t-tests for continuous data. Testing of the assumptions of normality and adjustments will be made before performing the final statistics and discussed below.

COVID-19 Considerations

For those metrics where simple statistics (chi square or t-test) is the appropriate quantitative methodology, the evaluators propose testing two separate post years to baseline to estimate the treatment effects before, during and after the pandemic. In both cases, members who became newly-eligible for Medicaid as a result of COVID will be identified by aid category and benefit plan and treated as a subpopulation in the

analysis. By doing this, B&A will be able to continue to include other newly-eligible members for which enrollment in Medicaid is unrelated to the pandemic (e.g., aged, blind and disabled, pregnant women, newborns).

T-test

The t test is a type of inferential statistics. It is used to determine whether there is a significant difference between the means of two groups. Conceptually, it represents how many standardized units of the means of the pre- and post-populations differ. There are generally five factors to contribute whether a statistically significant difference between the pre- and post-periods will be considered significant:[12]

William Sealy Gosset .pdf(1905) first published a t-test. He worked at the Guiness Brewery in Dublin and published under the name Student. The test was called Studen*t* Test (later shortened to *t* test).

1. How large is the difference? The larger the difference, the greater the likelihood that a statistically significant mean difference exists and confidence increased.
2. How much overlap is there between the groups? The smaller the variances between the two groups, the greater probability a difference exists, hence increasing confidence in results.
3. How many subjects are in the two samples? The larger the sample size, the more stable and hence, confidence in results.
4. What alpha level is being used to test the mean difference? It is much harder to find differences between groups when you are only willing to have your results occur by chance 1 out of a 100 times ($p < .01$) as compared to 5 out of 100 times ($p < .05$) but confidence in results is less.
5. Is a directional (one-tailed) or non-directional (two-tailed) hypothesis being tested? Other factors being equal, smaller mean differences result in statistical significance with a directional hypothesis so less confidence can be assigned to the results.

The assumptions underlying the t-test include:

- The samples have been randomly drawn from their respective population.
- The scores in the population are normally distributed.
- The scores in the populations have the same variance (s1=s2). A different calculation for the standard error may be used if they are not.

There are two types of errors associated with the t-test:

- Type I error —whereby the evaluator would detect a difference between the groups when there really was not a difference. The probability of making a Type I error is the chosen alpha level; therefore, an alpha level at $p < .05$, results in a 5% chance that you will make a Type I error.
- Type II error —whereby the evaluator detects no difference between the groups when there really was one.

[12] T-test. https://researchbasics.education.uconn.edu/t-test/#. Accessed May 14, 2020.

The evaluators will consider results significant at a level of probability of $p < .05$. A test statistic will be generated in the SAS© statistical program. Assumptions will be tested and addressed if detected, including tests of normality and variance in the pre- and post- data. Metrics which are continuous will be tested using a t-test. The lowest level of reliable granularity available and reliable will be used for conducting tests (i.e., monthly or quarterly observations instead of annual).

Chi-square test

A chi-square test may be used in lieu of the t-test for some categorical variables. Chi-square may be preferable to t-test for comparing rates. All χ^2 tests are two sided.

The chi-square test for goodness of fit determines how well the frequency distribution from that sample fits the model distribution. For each categorical outcome tested, the frequency of patients in the pre- and post-period would be tested. The chi-square test for goodness of fit would determine if the observed frequencies were different than expected; in other words, whether the difference in the pre- and post-outcomes were significantly different statistically than what would have been expected given the pre-period. The null hypothesis, therefore, is that the expected frequency distribution of all wards is the same. Rejecting the null would indicate the differences were statistically significant (i.e., exceeded difference than would be expected at a given confidence level).

The chi-square formula is: $\chi 2=\sum i=1k(O^i-E^i)2/E^i$

The assumptions of the chi-square are:

- Simple random sample
- Sample size. Small samples subject to Type II error.
- Expected cell count. Recommended 5-10 expected counts.
- Independence. Evaluation of the appropriateness of a McNemar's test may be warranted.

The evaluators will consider results significant at a level of probability of $p < .05$. A test statistic will be generated in the SAS© statistical program. Annually-reported categorical metrics for chi-square testing will either be derived from pooled population data (i.e., create on rate in pooled years of pre- and post-data) or two calendar year time periods (i.e., compare last year pre-waiver to last year post-waiver). Final approach will be determined upon examination of the data.

Interrupted Time Series (ITS)

Interrupted time series (ITS) is a quasi-experimental method used to evaluate health interventions and policy changes when randomized control trials (RTC) are not feasible or appropriate.[13,14,15] As it would not be ethical or consistent with Medicaid policy to withhold services resulting from waiver changes from

[13] Bonell CP, Hargreaves J, Cousens S et al.. Alternatives to randomisation in the evaluation of public health interventions: Design challenges and solutions. J Epidemiol Community Health 2009;65:582-87.
[14] Victora CG , Habicht J-P, Bryce J. Evidence-based public health: moving beyond randomized trials. Am J Public Health 2004;94:400–05.
[15] Campbell M , Fitzpatrick R, Haines A, Kinmonth AL, Sandercock P, Spiegelhalter D, et al. . Framework for design and evaluation of complex interventions to improve health. BMJ 2000;321:694.

a sub-set of beneficiaries for purposes of evaluation, an RTC is therefore, not possible. Per CMS technical guidance, the ITS is the preferred alternative approach to RTC in the absence of an available, adequate comparison group for conducting cost-related evaluation analyses. The ITS method is particularly suited for interventions introduced at the population level which have a clearly defined time period and targeted health outcomes.[16,17,18]

An ITS analysis relies on a continuous sequence of observations on a population taken at equal intervals over time in which an underlying trend is "interrupted" by an intervention. In this evaluation, the waiver is the intervention and it occurs at a known point in time. The trend in the post-waiver is compared against the expected trend in the absence of the intervention.

While there are no fixed limits regarding the number of data points because statistical power depends on a number of factors like variability of the data and seasonality, it is likely that a small number of observations paired with small expected effects may be underpowered.[19] The expected change in many outcomes included in the evaluation are likely to be small; therefore, the evaluators will use 72 monthly observations where possible and 24 quarterly observations where monthly data are not deemed reliable.

In order to determine whether monthly or quarterly observations will be created, a reliability threshold of having a denominator of a minimum number of 100 observations at the monthly or quarterly level will be used. If quarterly reporting is not deemed reliable under this threshold, the measure and/or stratification will not be tested using ITS. Instead, these measures will be computed using calendar year data in the pre- and post- period and reported descriptively.

ITS Descriptive Statistics

All demographic, population flags, and measures will be computed and basic descriptive statistics will be created: mean, median, minimum, maximum, standard deviation. These data will be inspected for identification of anomalies and trends.

To identify underlying trends, seasonal patterns and outliers, scatter plots of each measure will be created and examined. Moreover, each outcome will undergo bivariate comparisons; a Pearson correlation coefficient will be produced for each measure compared to the others as well as each measure in the pre- and post- periods.

[16] Soumerai SB. How do you know which health care effectiveness research you can trust? A guide to study design for the perplexed. Prev Chronic Dis 2015;12:E101.
[17] Wagner AK , Soumerai SB, Zhang F, Ross-Degnan D. Segmented regression analysis of interrupted time series studies in medication use research. J Clin Pharm Ther 2002;27:299-309.
[18] James Lopez Bernal, Steven Cummins, Antonio Gasparrini; Interrupted time series regression for the evaluation of public health interventions: a tutorial, International Journal of Epidemiology, Volume 46, Issue 1, 1 February 2017, Pages 348–355, https://doi.org/10.1093/ije/dyw098
[19] James Lopez Bernal, Steven Cummins, Antonio Gasparrini; Interrupted time series regression for the evaluation of public health interventions: a tutorial, International Journal of Epidemiology, Volume 46, Issue 1, 1 February 2017, Pages 348–355, https://doi.org/10.1093/ije/dyw09 8

Regression Analysis

Wagner et al. described the single segmented regression equation as[20]:

$$\hat{Y}_t = \beta_0 + \beta_1 * time_t + \beta_2 * intervention_t + \beta_3 * time\_after\_intervention_t + e_t$$

Where: Y_t is the outcome

time indicates the number of months or quarters from the start of the series

intervention is a dummy variable taking the values 0 in the pre-intervention segment and 1 in the post-intervention segment

time_after_intervention is 0 in the pre-intervention segment and counts the quarters in the post-intervention segment at time t

β_0 estimates the base level of the outcome at the beginning of the series

β_1 estimates the base trend, i.e. the change in outcome in the pre-intervention segment

β_2 estimates the change in level from the pre- to post-intervention segment

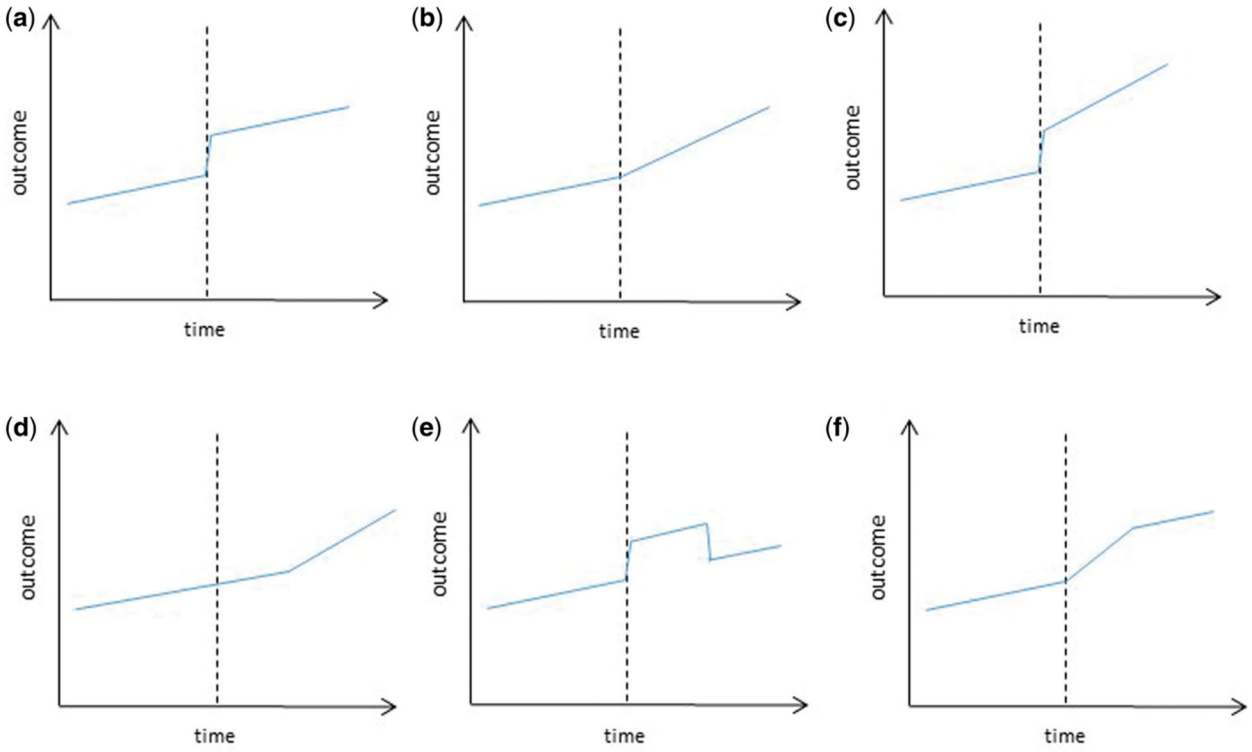
β_3 estimates the change in trend in the post-intervention segment

e_t estimates the error

Visualization and interpretation will be done as depicted in the Exhibit III.5. Each outcome will be assessed for one of the following types of relationships in the pre- and post-waiver period: (a) Level change; (b) Slope change; (c) Level and slope change; (d) Slope change following a lag; (e) Temporary level change; (f) Temporary slope change leading to a level change.

[20] Wagner AK , Soumerai SB, Zhang F, Ross-Degnan D. Segmented regression analysis of interrupted time series studies in medication use research. J Clin Pharm Ther 2002;27:299-309.

Exhibit III.5 Illustration of Potential ITS Relationships[21]



Seasonality and Autocorrelation

One strength of the ITS approach is that it is less sensitive to typical confounding variables which remain fairly constant, such as population age or socio-economic status, as these changes relatively slowly over time. However, ITS may be sensitive to seasonality. To account for seasonality in the data, the same time period, measured in months or quarters, will be used in the pre- and post-waiver period. Should it be necessary, a dummy variable can be added to the model to account for the month or quarter of each observation to control for the seasonal impact.

An assumption of linear regression is that errors are independent. When errors are not independent, as is often the case for time series data, alternative methods may be warranted. To test for the independence, the evaluators will review a residual time series plot and/or autocorrelation plots of the residuals. In addition, a Durbin-Watson test will be constructed to detect the presence of autocorrelation. If the Durbin-Watson test statistic value is well below 1.0 or well above 3.0, there is an indication of serial correlation.

[21] From: Interrupted time series regression for the evaluation of public health interventions: a tutorial Int J Epidemiol. 2016;46(1):348-355. doi:10.1093/ije/dyw098. Int J Epidemiol.

If autocorrelation is detected, an autoregressive regression model, like the Cochrane-Orcutt model, will be used in lieu of simple linear regression.

Other assumptions of linear regression are that data are linear and that there is constant variance in the errors versus time. Heteroscedasticity will be diagnosed by examining a plot of residuals verses predicted values. If the points are not symmetrically distributed around a horizontal line, with roughly constant variance, then the data may be nonlinear and transformation of the dependent variable may be warranted. Heteroscedasticity often arises in time series models due to the effects of inflation and/or real compound growth. Some combination of logging and/or deflating may be necessary to stabilize the variance in this case.

For these reasons and in accordance with CMS technical guidance specific to models with cost-based outcomes, the evaluators will use log costs rather than untransformed costs, as costs are often not normally distributed. For example, many person-months may have zero healthcare spending and other months very large values. To address these issues, B&A will use a two-part model that includes zero costs (logit model) and non-zero costs (generalized linear model).

Controls and Stratification

As described in Section III.B, the regression analysis will be run both on the entire non-SUD target population and stratified by relevant sub-populations. The sub-population level analysis may reveal waiver effects that would otherwise be masked if only run on the entire non-SUD population. Similarly, common demographic covariates such as age, gender, and race will be included in these models to the extent they improve the explanatory power of the ITS models.

COVID-19 Considerations

For those metrics where multivariate analysis is the appropriate quantitative methodology, the evaluators propose to construct a 0/1 dummy variable that indicates if the observations are post-March 2020 until a defined "post" COVID period for use as a control in the regression model. Members who became newly-eligible for Medicaid as a result of COVID will be identified by aid category and benefit plan and treated as a subpopulation in the analysis. This will allow the evaluators to continue to include those newly-eligible members for which enrollment is unrelated to the pandemic (e.g., aged, blind and disabled, pregnant women, newborns).

<u>Method #3: Onsite Reviews</u>

In order to fill gaps and address questions for which claims-based data and other sources are insufficient, a number of onsite reviews are proposed. These onsite reviews will seek to gain insight on nuanced differences in approach, use and effectiveness of different MCO and DMMA approaches to the following topics:

- Care Coordination and Transitions to Care
- Critical Incidents, Appeals and Grievances
- Eligibility Process Review
- Service Authorization

- Quality/Outcome Focused Study – topic to be finalized with DMMA

The onsite reviews rely on creating a standardized set of questions that will capture information on process, documentation and beneficiary-level records if applicable. The questions may include onsite documentation gathering and data validation related to those topics described above. In some cases, the onsite reviews will employ a sampling approach whereby a limited number of beneficiaries are selected based on a set of criteria. Internal records specific to those beneficiaries stored at each MCO will be reviewed. The sample criteria would be developed to reflect the representativeness with the demonstration population or sub-population served by each MCO. This will help aid in the comparability of the results of the onsite review across MCOs. Finally, the same reviewer (or group of reviewers) will be used for all MCO reviews to strengthen inter-reliability.

Method #4: Desk Reviews

A limited number of desk reviews will supplement the other study methods included in the evaluation. These reviews will focus on hypotheses which are directed at assessment of process outcomes like avoidance of implementation delays, system changes according to schedules, transparency of policy and rates, and utility of stakeholder tools and analytics. Each desk review will use a questionnaire that asks for the information sought, the documentation reviewed, and the finding. Any gaps in information will also be noted as findings. The evaluator will review publicly available information and/or documentation specifically requested from the DMMA and/or the MCOs.

Method #5 Facilitated and/or Focus Group Interviews

As needed, B&A will construct facilitated interview guide instruments as a means to collect primary data for the focus studies. Intended respondents will include the MCOs, non-SUD providers, non-SUD beneficiaries, PROMISE providers and PROMISE beneficiaries. Where focused interviews are used to collect data, B&A will use semi-structured interview protocols that are intended to be standardized within the population being interviewed. The interview protocols will vary, however, for each population interviewed due to the type of information that is intended to be collected. Although semi-structured in nature, each stakeholder will have the opportunity to convey additional information that he/she would like to convey to the evaluators in an open-ended format at the conclusion of each interview.

B&A will ensure that, for each population that interviews are conducted, there is sufficient representation within the population among those being surveyed. Sampling may be completed by using geographic location, provider size (large and small), and beneficiary age, to name a few.

III.G Other Additions

Starting on the next page, a matrix summarizing the methods for each research question and hypothesis is presented. Attachment D contains the detailed evaluation matrix which presents the demonstration components and domains of focus for each research question and hypothesis.

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #1: ***Does the waiver of retroactive eligibility continue (or does not worsen) the continuity of enrollment in Medicaid in the current waiver period?***						
Demonstration Goal: G.1 Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS; and G.10 Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population.						
Evaluation Hypothesis #1: Trends in continuity of enrollment continue (or does not worsen) for Medicaid populations subject to the waiver of retroactive eligibility in the current waiver period.						
Short Term (Continuity of Enrollment)	Time span from application to enrollment in Medicaid	Burns & Associates, Inc.	Frequency distribution of enrollees by number of days from application to enrollment during the measurement period.		Enrollment data	Descriptive statistics (trends in frequencies and percentages of time span from application to enrollment stratified by aid category)
	Medicaid enrollment counts by month and aid category	Burns & Associates, Inc.	Count of enrollees by month and aid category during the measurement period.		Enrollment data	Descriptive statistics (trends in enrollment counts over time stratified by aid category)
	Medicaid Enrollment duration by aid category and assignment plan	Burns & Associates, Inc.	Frequency distribution of enrollees by the number of months of eligibility in the measurement period, stratified by aid category and assignment		Enrollment data	Descriptive statistics (trends in enrollment duration by aid category and assignment plan)
	Proportion of enrollees continuously enrolled in Medicaid by aid category, assignment plan and delivery system	Burns & Associates, Inc.	Frequency distribution of enrollees continuously enrolled 9 or more months in the measurement period, stratified by aid category, assignment plan and delivery system.	Total number of enrollees during the measurement period.	Enrollment data	Descriptive statistics (trends in the proportion of enrollees continuously enrolled by aid category, assignment plan and delivery system)

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #2: ***Does the waiver of retroactive eligibility continue or not worsen trends in the incidence of uncompensated care or not seeing a doctor because of cost in the current waiver period?***						
Demonstration Goal: G.1 Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS; and G.10 Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population.						
Evaluation Hypothesis #2: The waiver of retroactive eligibility will continue or not worsen trends in uncompensated care or medical debt in the current waiver period.						
Long Term (Uncompensated Care)	Rate of hospital reported uncompensated care	Burns & Associates, Inc.	Hospital reported uninsured uncompensated care	Number of Delawareans expressed as per 1,000	DMMA Form DSH-1, Line 21	Descriptive statistics (trends in frequencies and percentages over the demonstration period) with comparison to baseline period
	Could Not See Doctor Because of Cost	CDC, BRFSS	Weighted percentage of respondents who reported there was a time over the past 12 months when they needed to see a doctor but could not because of cost (MEDCOST)		Health Care Access Module	Descriptive statistics (trends in Delaware reported percentages over the demonstration period); comparison to baseline period and available national and regional values
	Self-identified trends in medical debt for DSHP enrollees	Burns & Associates, Inc.	Number of respondents reporting if medical debt has improved, stayed the same or not worsened over the past twelve months	Total number of respondents.	Focus Group	Descriptive statistics (trends in frequencies and percentages over the demonstration period) with comparison to baseline period

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #3: ***Does the level and trend of access to primary and preventive care continue (or not worsen) in the current waiver period?***						
Demonstration Goal: G.1 Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS; and G.10 Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population.						
Evaluation Hypothesis #3: Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current waiver period.						
Long Term (Access to Care)	Well-Child Visits in the First 15 Months of Life (W15)	NCQA	Number of children who turned 15 months old during the measurement year who had 6 or more well-child visits with a PCP	Number of children who turned 15 months old during the measurement year.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	NCQA	Number of children who are 3 to 6 years old as of December 31 and had one or more visits with a PCP during the measurement year.	Number of children who are 3 to 6 years old as of December 31 of the measurement year.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Adolescent Well-Care Visits (AWC)	NCQA	Number of enrolled members age 12 to 21 years, as of December 31,who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.	Number of enrolled members age 12 to 21 years as of December 31 of the measurement year.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Breast Cancer Screening (BCS)	NCQA	Number of women age 50-54 years who had a screening mammogram as of December 31 in the measurement year.	Number of women age 50-54 years as of December 31 in the measurement year.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Adults' Access to Preventive/Ambulatory Health Services (AAP)	NCQA	Number of members who had an ambulatory or preventive care visit as of December 31 in the measurement year, reported using three age stratifications: 22-44 years; 45-64 years; 65+	Number of members as of December 31 in the measurement year, with counts for each of the three age stratifications: 22-44 years; 45-64 years; 65+ years.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
Short Term (Access to Care)	Average driving distance to primary care services	Burns & Associates, Inc.	Sum of the driving distances traveled from member home to their primary care provider	Sum of the unique trips to the member's primary care provider in the year	Claims data	Descriptive statistics (trends in average driving distance stratified by MCO and region)

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #4: ***Do service authorizations provide an effective tool in the appropriate utilization of health care services in the current waiver period?***						
Demonstration Goal: G.1 Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS.						
Evaluation Hypothesis #3: Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current waiver period.						
Short Term (Access to Care)	Average turnaround time for authorization decisions	Burns & Associates, Inc.	Total number of days turnaround time for monthly authorization requests	Total number of monthly authorizations requests (approved and denied)	MCO-submitted report	Descriptive statistics (will be stratified by MCO and by subpopulations PROMISE and All Other)
	Rate of approved and denied authorizations	Burns & Associates, Inc.	Number of monthly (1) approvals and (2) denials for authorization requests	Total number of monthly authorization requests	MCO-submitted report	Descriptive statistics (will be stratified by MCO and by subpopulations PROMISE and All Other)
	Frequency and percentage of denial reason codes	Burns & Associates, Inc.	Count of monthly denied authorization requests, by denial reason code	Total number of monthly denied authorizations requests	MCO-submitted report	Descriptive statistics (will be stratified by MCO and by subpopulations PROMISE and All Other)

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #5: ***Does the proportion of members receiving care coordination and supports continue (or not worsen) in the current waiver period?***						
Demonstration Goal: G.4 Increasing coordination of care and supports; and G.8 Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles.						
Evaluation Hypothesis #4: Trends in coordination of care and supports continues (or does not worsen) in the current waiver period.						
Short Term (Improved Outcomes)	Rate of DSHP members with selected special health care needs screened for care coordination	Burns & Associates, Inc.	Number of DSHP members with selected special health care needs screened for care coordination.	Number of DSHP members with selected special health care needs	MCO-submitted report	Descriptive statistics (trends tracked separately for three populations: (1) enrolled in PROMISE, (2) DSHP Plus eligible, (3) other selected special health care need categories in State Quality Strategy Plan)
	Of those members with selected special health care needs screened, the number enrolled in care coordination	Burns & Associates, Inc.	Number of DSHP members with selected special health care needs screened for and enrolled in care coordination	Number of DSHP members with selected special health care needs screened for care coordination	MCO-submitted report	Descriptive statistics (trends tracked separately for three populations: (1) enrolled in PROMISE, (2) DSHP Plus eligible, (3) other selected special health care need categories in State Quality Strategy Plan)
	Duration of enrollment w/in case/care management	Burns & Associates, Inc.	Frequency distribution by days of enrollment in case/care management		MCO-submitted report	Descriptive statistics (trends tracked separately for three populations: (1) enrolled in PROMISE, (2) DSHP Plus eligible, (3) other selected special health care need categories in State Quality Strategy Plan)

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #6: ***Do DSHP members enrolled in case/care management achieve similar or improved quality of care and health outcomes in the current waiver period?***						
Demonstration Goal: G.4 Increasing coordination of care and supports; and G.10 Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population.						
Evaluation Hypothesis #5: Coordination of care and supports maintains or improves quality of care and health outcomes in the current waiver period.						
Long Term (Improved Outcomes)	Prenatal care for pregnant women (PPC), control groups those in/not in case/care management.	NCQA	1. Timeliness of Prenatal Care. Number of women having a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or w/in 42 days of enrollment in the organization.	1. Timeliness of Prenatal Care. Number of deliveries of live births.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
		NCQA	2. Postpartum Care. Number of women having a postpartum visit on or between 21 and 56 days after delivery.	2. Postpartum Care. Number of deliveries of live births.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA	Discharges for members age 6 and older who were hospitalized for treatment of mental illness or intentional self-harm and who had a follow-up visit with a MH practitioner w/in 30 days after discharge.	1. Discharges for members age 6 and older who were hospitalized for treatment of mental illness.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)	NCQA	ED visits for members age 6 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit w/ MH practitioner w/in 30 days of ED visit.	1. ED visits for members age 6 and older who had a principal diagnosis of mental illness or intentional self-harm.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	NCQA	Number of ED visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service w/in 7 days of the ED visit.	Number of members 18 years and older who have multiple high-risk chronic conditions.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline. Report for age stratifications (18-64, 65 and older), and total for Interim Evaluation; ITS for Summative Evaluation

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #7: ***Does the level of satisfaction among DSHP members continue (or not worsen) in the current waiver period?***						
Demonstration Goal: G.5 Expanding consumer choices.						
Evaluation Hypothesis #6: Trends in consumer satisfaction will continue (or not worsen) in the current waiver period.						
Long Term (Access to Care)	Getting Needed Care Composite	CAHPS	Number of respondents reporting always or usually.	Total number of respondents.	CAHPS® 5.0 Health Plan	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline. Stratify by adults and children and MCO for Interim Evaluation; ITS for Summative Evaluation
	Getting Care Quickly Composite	CAHPS	Number of respondents reporting always or usually.	Total number of respondents.	CAHPS® 5.0 Health Plan	
	How Well Doctors Communicate Composite	CAHPS	Number of respondents reporting always or usually.	Total number of respondents.	CAHPS® 5.0 Health Plan	
	Rating of Personal Doctor	CAHPS	Number of respondents reporting a rating of 8 to 10 out of a maximum score of 10.	Total number of respondents.	CAHPS® 5.0 Health Plan	
	Rating of Health Plan	CAHPS	Number of respondents reporting a rating of 8 to 10 out of a maximum score of 10.	Total number of respondents.	CAHPS® 5.0 Health Plan	
	Grievances per 1000 members	DMMA	Count of grievances during the reporting period.	Total number of DSHP member months in 12-month study period (result of this formula expressed as per 1,000 member months)	QCMMR	Descriptive statistics (frequencies and percentages).
	Total number of grievances by category	DMMA	Count of grievances during the reporting period by category.		QCMMR	Descriptive statistics (frequencies and percentages). Stratify by category and MCO.
	Appeals per 1000 members	Burns & Associates, Inc.	Count of appeals during the reporting period.	Total number of DSHP member months in 12-month study period (result of this formula expressed as per 1,000 member months)	QCMMR	Descriptive statistics (frequencies and percentages).
	Total number of appeals by category	Burns & Associates, Inc.	Count of grievances during the reporting period by category.		QCMMR	Descriptive statistics (frequencies and percentages). Stratify by category and MCO.
	Critical incidents per 1000 members	Burns & Associates, Inc.	Count of critical incidents during the reporting period.	Total number of DSHP member months in 12-month study period (result of this formula expressed as per 1,000 member months)	QCMMR DSHP Plus	Descriptive statistics (frequencies and percentages).

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #8: ***Has the rebalancing of long-term care services and supports maintained or moved more toward home- and community-based services and away from institutional services in the current waiver period?***						
Demonstration Goal: G.1 Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS; G.2 Rebalancing Delaware's LTC system in favor of HCBS; and G.7 Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTSS services where appropriate.						
Evaluation Hypothesis #7: Creating a delivery system that provides incentives for resources to shift from institutions to community-based LTSS has maintained or increased utilization of HCBS services where appropriate in the current waiver period.						
Long Term (LTSS Rebalancing)	Utilization of HCBS services per 1000 members	Burns & Associates, Inc.	Count of HCBS services by category. Categories are: (1) personal care/attendant care/chore services, (2) home-delivered meals, (3) specialized medical equipment/supplies, home modifications, personal emergency response system	Total number of DSHP member months in a 12-month study period (result of this formula expressed as per 1,000 member months)	Claims data	Descriptive statistics (frequencies and percentages) reported at HCBS service category
	Spending in total and on a per member month basis for HCBS services	Burns & Associates, Inc.	Total spend for HCBS services	Total DSHP Plus member months in a 12-month study period	Claims data	Descriptive statistics (frequencies and percentages) for Interim Evaluation; ITS for Summative Evaluation
	Spending in total and on a per member month basis for institutional LTSS services	Burns & Associates, Inc.	Total spend for institutional MLTSS	Total DSHP Plus member months in a 12-month study period	Claims data	Descriptive statistics (frequencies and percentages) for Interim Evaluation; ITS for Summative Evaluation
	Proportion of spending for HCBS services	Burns & Associates, Inc.	Total spend for HCBS services	Total spend for all MLTSS services	Claims data	Descriptive statistics (frequencies and percentages) for Interim Evaluation; ITS for Summative Evaluation
Short Term (Improved Outcomes)	Rate of members needing HCBS services screened for care coordination	Burns & Associates, Inc.	Number of members utilizing HCBS screened for care coordination	Number of members utilizing HCBS	MCO-submitted report	Descriptive statistics (trends rates stratified by MCO and region)
	Of those members needing HCBS services screened, the number enrolled in care coordination	Burns & Associates, Inc.	Number of members utilizing HCBS screened for and enrolled in care coordination	Number of members utilizing HCBS screened for care coordination	MCO-submitted report	Descriptive statistics (trends rates stratified by MCO and region)
	Member experience with care coordination and supports	Burns & Associates, Inc.	Member experience with care coordination and supports, and the extent to which it has facilitated transition to the next appropriate level of care		Member survey	Descriptive statistics (frequencies and percentages)

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #9: ***Do DSHP Plus members achieve similar or improved quality of care and health outcomes in the current waiver period?***						
Demonstration Goal: G.3 Promoting early intervention for individuals with, or at-risk, for having, LTC needs; G.4 Increasing coordination of care and supports; and G.8 Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles.						
Evaluation Hypothesis #5: Coordination of care and supports maintains or improves quality of care and health outcomes in the current waiver period.						
Long Term (Improved Outcomes)	Plan All-Cause Readmissions (PCR)[a]	NCQA	At least one acute unplanned readmission for any diagnosis w/in 30 days of the date of discharge from the index hospital stay, that is on or between the second day of the measurement year and the end of the measurement year	DSHP Plus Medicaid beneficiaries age 18 and older with a discharge from an acute IP stay (index hospital stay) on or between January 1 and December 1 of the measurement year	Claims data	Descriptive statistics; chi square tests of significance comparing target population to baseline and to the comparison group for Interim Evaluation; ITS for Summative Evaluation
	Comprehensive Diabetes Care (CDC)	NCQA	Members 18–75 years of age with diabetes (type 1 and type 2) who had a Hemoglobin A1c (HbA1c) testing	Total members 18-75 years of age with diabetes (type 1 and type 2).	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Annual Monitoring for Patients on Persistent Medications (MPM)	NCQA	Members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Metric #1: ACE inhibitor or angiotensin receptive blocker (ARB). Metric #2: Members on diuretics. Metric #3: Sum of the two.	Members on persistent medications (i.e., members who received at least 180 treatment days of ambulatory medication in the measurement year).	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Medication Adherence Rates - Percent of Days Covered (PDC)	PQA	Number of Days in Period covered by the same or another drug in its therapeutic class for Asthma, COPD and Diabetes	Number of Days in Period	Claims data	Descriptive statistics (trend over time for conditions of interest with stratification by cohort population and by MCO

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #10: ***Does the level and trend of access to enhanced behavioral health services continue (or not worsen) in the current waiver period?***						
Demonstration Goal: G.9 Improving overall health status and quality of life of individuals enrolled in PROMISE.						
Evaluation Hypothesis #8: Trends in health outcomes will continue or improve in the current waiver period for individuals enrolled in the PROMISE program.						
Long Term (Improved Outcomes)	Rate of identified members who enroll in PROMISE	Burns & Associates, Inc.	Members identified for and referred to that enroll in PROMISE	Members identified or referred to PROMISE	QCMMR	Descriptive statistics (trends in percentage); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA	Discharges for members age 6+ who were hospitalized for treatment of MI or intentional self-harm and who had a f/u visit with a MH practitioner w/in 30 days after discharge.	1. Discharges for members age 6 and older who were hospitalized for treatment of mental illness.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population (PROMISE enrollees) to baseline for Interim Evaluation; ITS for Summative
	Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)	NCQA	ED visits for members age 6+ with a principal diagnosis of MI or intentional self-harm and who had a follow-up visit w/ MH practitioner w/in 30 days of ED visit.	1. ED visits for members age 6 and older who had a principal diagnosis of mental illness or intentional self-harm.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population (PROMISE enrollees) to baseline for Interim Evaluation; ITS for Summative
	Follow-Up After Discharge from the Emergency Department for Alcohol or Other Drug (AOD) Dependence[a]	NCQA	Members who had a follow-up visit to and ED visit w/ SUD indicator w/in 30 days of discharge w/in the previous rolling 12 months.	Individuals with an ED visit (with SUD indicator) w/in the previous rolling 12 months	Claims data	Descriptive statistics; chi square or t-tests of significance comparing target population (PROMISE enrollees) to baseline and comparison group for Interim
	Initiation and engagement of alcohol and other drug dependence treatment[a]	NQF #0004	Initiation: Number of patients who began initiation of treatment through IP admission, OP visits, IOP encounter or partial hosp. w/in 14 days of index episode start date	Patients who were diagnosed with a new episode of alcohol or drug dependency during the first 10 and ½ months of the measurement year	Claims data	Descriptive statistics; chi square or t-tests of significance comparing target population (PROMISE enrollees) to baseline for Interim Evaluation; ITS for Summative Evaluation
	Initiation and engagement of alcohol and other drug dependence treatment[a]	NQF #0004	Engagement: Initiation of treatment and two or more IP admissions, OP visits, IOP encounters or partial hosp. with any alcohol/drug diagnosis w/in 30 days after date of initiation encounter	Patients who were diagnosed with a new episode of alcohol or drug dependency during the first 10 and ½ months of the measurement year	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population (PROMISE enrollees) to baseline for Interim Evaluation; ITS for Summative Evaluation

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #11: ***Do PROMISE members enrolled in case/care management achieve similar or improved quality of care and health outcomes in the current waiver period?***						
Demonstration Goal: G.4 Increase care coordination and supports; and G.9 Improving overall health status and quality of life of individuals enrolled in PROMISE						
Evaluation Hypothesis #5: Coordination of care and supports maintains or improves quality of care and health outcomes in the current waiver period.						
Long Term (Improved Outcomes)	Plan All-Cause Readmissions (PCR)[a]	NCQA	At least one acute unplanned readmission for any diagnosis w/in 30 days of the date of discharge from the index hospital stay, that is on or between the second day of the measurement year and the end of the measurement year	DSHP Plus Medicaid beneficiaries age 18 and older with a discharge from an acute IP stay (index hospital stay) on or between January 1 and December 1 of the measurement year	Claims data	Descriptive statistics; chi square tests of significance comparing target population (PROMISE enrollees) to baseline and to the comparison group for Interim Evaluation; ITS for Summative Evaluation
	Emergency Department (ED) visits per 1000	Burns & Associates, Inc.	Count of ED visits for DSHP Plus members enrolled in PROMISE in the measurement period	Total DSHP Plus PROMISE enrollee member months	Claims data	Descriptive statistics (frequencies and percentages); chi square tests of significance comparing target population (PROMISE enrollees) to baseline for Interim Evaluation; ITS for Summative Evaluation
	Emergency Department (ED) Frequent Flyer rate	Burns & Associates, Inc.	Frequency distribution of DSHP Plus members enrolled in PROMISE by count of ED visits in the measurement period		Claims data	
	Antidepressant Medication Management (AMM)	NCQA	1. Members 18 years and older treated with antidepressant medication, had a diagnosis of major depression, and who remained on antidepressant medication treatment for at least 84 days (12 weeks).	1. Members 18 years of age and older who had a diagnosis of major depression.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
		NCQA	2. Members 18 years and older treated with antidepressant medication, had a diagnosis of major depression, and who remained on antidepressant medication treatment for at least 180 days (6 months).	2. Members 18 years of age and older who had a diagnosis of major depression.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #12: ***Does the availability of PROMISE providers continue (or not worsen) in the current waiver period?***						
Demonstration Goal: G.1 Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS						
Evaluation Hypothesis #9: The PROMISE program network capacity will continue (or not worsen) in the current waiver period.						
Long Term (Access to Care)	Behavioral health providers per 1000 members by geographical region	Burns & Associates, Inc.	Unique count of behavioral health providers	Total PROMISE enrollee member months for a 12-month study period (result of this formula expressed as per 1,000 member months)	Claims and Provider Enrollment data	Descriptive statistics (trends rates stratified by MCO and region)
	HCBS providers per 1000 members by geographical region	Burns & Associates, Inc.	Unique count of HCBS providers	Total PROMISE enrollee member months for a 12-month study period (result of this formula expressed as per 1,000 member months)	Claims and Provider Enrollment data	Descriptive statistics (trends rates stratified by MCO and region)

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #13: ***Does the availability of the adult dental benefit increase access to dental services and lead to continued (or not worsen) health outcomes in the current waiver period?***						
Demonstration Goal: G.10 Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population; and G.12 Increasing access to dental services; decrease the percent of emergency department visits for non-traumatic dental conditions in adults; increase follow up with dentists after an emergency department visit for non-traumatic dental conditions in adults; and increase the number of adults with diabetes who receive an oral exam annually.						
Evaluation Hypothesis #10: The availability of the adult dental benefit will improve access to dental services and will continue (or not worsen) health outcomes in the current waiver period.						
Long Term (Access to Care)	Utilization of dental services per 1000	Burns & Associates, Inc.	Count of dental services in the measurement period for DSHP and DSHP Plus enrollees	Total DSHP and DSHP Plus enrollee member months for a 12-month study period (result of this formula expressed as per 1,000 member months)	Claims data	Descriptive statistics (frequencies and percentages) stratified by age, MCO and region; chi square tests of significance comparing target population (adult enrollees) to baseline for Interim Evaluation; ITS for Summative Evaluation
	Dental providers per 1000 members by geographical region	Burns & Associates, Inc.	Unique count of dental providers	Total DSHP and DSHP Plus enrollee member months for a 12-month study period (result of this formula expressed as per 1,000 member months)	Claims and Provider Enrollment data	Descriptive statistics (trends rates stratified by MCO and region)
	Average driving distance to dental care services	Burns & Associates, Inc.	Sum of the driving distances traveled from member home to their dental care provider	Sum of the unique trips to the member's dental care provider in the year	Claims data	Descriptive statistics (trends in average driving distance stratified by age, MCO and region)
Long Term (Improved Outcomes)	Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-A-A)	Dental Quality Alliance	Number of ED visits with an ambulatory care sensitive non-traumatic dental condition diagnosis code among individuals 18 years and older	All member months for individuals 18 years and older during the reporting year (result of this formula expressed per 100,000 member months for adults)	Claims data	Descriptive statistics (trends in percentage); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Follow-up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDF-A-A)	Dental Quality Alliance	Number of ambulatory care sensitive non-traumatic dental condition ED visits in the reporting period for which the member visited a dentist within (a) 7 days (NUM1) and (b) 30 days (NUM2) of the ED visit	Number of ambulatory care sensitive non-traumatic dental condition ED visits in the reporting period	Claims data	Descriptive statistics (trends in percentage); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Adults with Diabetes – Oral Evaluation (DOE-A-A)	Dental Quality Alliance	Unduplicated number of adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation	Unduplicated number of adults with diabetes	Claims data	Descriptive statistics (trends in percentage); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation

[a] Denotes metric that is also part of SUD Evaluation Design Plan

SECTION IV: METHODOLOGICAL LIMITATIONS

There are inherent limitations to both the study design and its specific application to the 1115 waiver evaluation. That being said, the proposed design is feasible and is a rational explanatory framework for evaluating the impact of the 1115 waiver on the demonstration population. Moreover, to fill gaps left by the limitations of this study design, a limited number of onsite reviews, desk reviews, and facilitated interviews/focus groups are proposed to provide a more holistic and comprehensive evaluation. Some known limitations are addressed below.

Since Delaware's population will be small compared to other states, some metrics and/or sub-populations may not be meaningful for reporting and insufficient statistical power to detect a difference is a concern. For any observational studies, especially if the population size, exposures and the outcomes being assessed are rare, it is difficult to find statistically significant results. This would be true in the case of former foster care youth. It is not unexpected, therefore, that many of the outcome measure sample sizes will be too small to observe statistically significant results. We recommend a threshold for minimum numbers of observations. For any measures below this threshold, the expectation of statistical testing would be waived.

While CMS prefers a true comparator group from another state, this would require significantly more resources and cooperation with another state on sharing data. Therefore, B&A is recommending the use of ITS and descriptive statistics including the use of chi square or t-tests as the starting point in development of the evaluation design. One exception to this would be to use available results from CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults as a benchmark comparator for nationally recognized metrics included in the evaluation design. In this scenario, B&A would compare these trends to two other states if desired and if the data is available. The determination of the states to compare to would be done in consultation with the State, CMS and other stakeholders

The fact that most of the 1115 waiver components have been in place during what would be considered the pre-waiver period for evaluation purposes will make identifying any changes in outcomes directly attributable to waiver implementation difficult. Therefore, it is expected that not all outcomes or process measures included in the study will show a demonstrable change descriptively.

Equally, observed changes in outcome metrics in the current waiver period will be difficult, if not impossible, to attribute to one specific demonstration component given the interrelationship of the components themselves and the longstanding nature of the demonstration. Therefore, it will be important to use statistical tests of significance so that findings are properly put into context.

Related to the issues mentioned above, many of the outcome measures are multi-dimensional and influenced by social determinants of health. While changes under the waiver related to access to care may be one dimension of various outcomes of interest, and may contribute to improvements, it may be difficult to achieve statistically significant findings in the absence of data on other contributing dimensions, such as housing, employment, and previous incarcerations.

Lastly, the evaluators recognize that the utilization patterns that will occur relatively early in this demonstration period will be severely disrupted due to the COVID-19 pandemic. The predictability of future utilization patterns remains uncertain as of the date of this document. The evaluators are prepared to work with CMS in the event that guidance is provided to states for all waiver evaluations as to options

that CMS will offer with respect to how to account for the acute period of the pandemic. The initial plan for handling COVID-19 effects are addressed in Section III. Methodology.

ATTACHMENT A: INDEPENDENT EVALUATOR

Process

Burns & Associates, a division of HMA, (B&A) submitted a proposal through a competitive bid process to be retained for professional services with the Delaware Department of Health and Social Services (DHSS). The current contract was entered into effective March 1, 2019 with an end date of February 28, 2022.

The DHSS has the authority under this professional services agreement to seek proposals from vendors for targeted scope of work activities. The Division of Medicaid and Medical Assistance (DMMA), one of the Divisions under the DHSS, requested that B&A submit a proposal to conduct evaluation activities related to Delaware's 1115 Diamond State Health Plan Waiver Demonstration Project. B&A submitted a proposal based upon the criteria set forth in the waiver's Special Terms and Conditions as approved by the Centers for Medicare and Medicaid Services (CMS). The DMMA accepted the proposal from B&A and proceeded with contracting with B&A to perform the evaluation of Delaware's 1115 Diamond State Health Plan Waiver Demonstration Project. B&A provided a proposed budget to complete all activities required for the waiver evaluation as well as a modified budget to encompass activities through February 28, 2022.

Vendor Qualifications

B&A was founded in 2006 and works almost exclusively with state Medicaid agencies or related social services agencies in state government. Since that time, B&A has worked with 33 state agencies in 26 states. The B&A team proposed to complete the evaluation of Delaware's 1115 Diamond State Health Plan Waiver Demonstration Project serves as the independent evaluator of Indiana's 1115 Substance Use Disorder waiver, including development of the approved Evaluation Design Plan, Interim Evaluation and MidPoint Assessment. B&A has also conduced independent assessments of Indiana's 1915(b) waiver for Hoosier Care Connect, and has served as the External Quality Review Organization (EQRO) for Indiana since 2007. B&A has written an External Quality Review (EQR) report each year since that time which has been submitted to CMS. B&A has also conducted two Independent Assessments of Indiana's 1915(c) waiver and has conducted independent evaluations for state agencies in Minnesota, New York and Oklahoma. B&A was acquired by Health Management Associates as of September 1, 2020.

Assuring Independence

In accordance with standard term and condition (STC) 86 Independent Evaluator, Attachment F – Developing the Evaluation Design, B&A attests to having no conflicts to perform the tasks needed to serve as an independent evaluator on this engagement. B&A's Principal Investigator is prepared to deliver a signed attestation to this effect upon request.

ATTACHMENT B: EVALUATION BUDGET

As part of the procurement process, Burns & Associates, a Division of HMA (B&A) was required to submit a cost proposal that presents the level of effort to complete all deliverables associated with the independent evaluation of Delaware's Diamond State Health Plan. Presently, the State only has the authority to contract with B&A through February 28, 2022, and there are deliverables due to CMS after February 28, 2022 which are reflected in the evaluation budget.

In an effort to show the complete level of effort that would be proposed to complete all deliverables, Exhibit B.1 Proposed Hours for 1115 Waiver Evaluation found on page B-2 enumerates the proposed staffing and level of effort by labor category for each component of the evaluation. Likewise, Exhibit B.2 Proposed Costs for 1115 Waiver Evaluation as found on page B-3 summarizes the total amount to complete all deliverables associated with the independent evaluation for each deliverable due to CMS. The total estimated cost for the independent evaluation of Delaware's 1115 Demonstration Waiver Diamond State Health Plan is $1,335,660 to complete all deliverables through June 30, 2025.

	PROPOSED HOURS FOR 1115 WAIVER EVALUATION						
	Mark Podrazik	Debbie Saxe	Ryan Sandhaus	Shawn Stack	Akhilesh Pasupulati	Barry Smith	TOTAL
	Project Director	Project Manager	Statistician	Senior Consultant	SAS Programmer	Consultant	
	817	1,388	362	540	2,154	708	5,961
SECTION A: PROJECT MANAGEMENT	**104**	**165**	**0**	**46**	**223**	**8**	**546**
1 Kickoff Meeting	8	10	0	4	4	0	26
2 Project Management	70	114	0	42	18	0	244
3 Obtain and Read in Data for Project	26	41	0	0	201	8	276
SECTION B: MONITORING ACTIVITIES	**88**	**326**	**32**	**0**	**1200**	**170**	**1816**
4 Build and Maintain Data Warehouse, Compute Metrics	24	70	0	0	176	42	312
5 Ongoing activities each quarter - compute and validate metrics	64	256	32	0	1024	128	1504
SECTION C: EVALUATION DESIGN	**36**	**128**	**0**	**20**	**30**	**8**	**222**
6 Develop Evaluation Design	36	128	0	20	30	8	222
SECTION D: INTERIM EVALUATION ACTIVITIES	**341**	**407**	**148**	**288**	**351**	**276**	**1803**
7 Focus Study: Care Coordination/Transitions to Care	85	0	0	62	64	44	255
8 Focus Study: Critical Incidents (CI), Grievances and Appeals (G&A)	8	60	0	40	4	20	124
9 Focus Study: Review Retroactive Eligibility Process	0	60	0	34	28	14	136
10 Focus Study: Review Authorization Process	76	0	0	44	20	44	184
11 Focus Study: Baseline Access to Dental Care	84	0	0	50	88	50	272
12 Prepare Interim Evaluation	88	287	148	58	147	104	832
SECTION E: SUMMATIVE EVALUATION ACTIVITIES	**248**	**362**	**182**	**186**	**350**	**246**	**1574**
7 Focus Study: Care Coordination/Transitions to Care	56	0	0	36	60	36	188
8 Focus Study: Critical Incidents (CI), Grievances and Appeals (G&A)	6	38	0	20	4	16	84
9 Focus Study: Review Retroactive Eligibility Process	0	32	0	16	28	14	90
10 Focus Study: Review Authorization Process	46	0	0	26	20	44	136
11 Focus Study: Baseline Access to Dental Care + Transitions to Care	40	0	0	16	64	36	156
13 Prepare Summative Evaluation	100	292	182	72	174	100	920

	PROPOSED COSTS FOR 1115 WAIVER EVALUATION						
	Mark Podrazik	Debbie Saxe	Ryan Sandhaus	Shawn Stack	Akhilesh Pasupulati	Barry Smith	TOTAL
	Project Director	Project Manager	Statistician	Senior Consultant	SAS Programmer	Consultant	
	$250.00	$230.00	$230.00	$230.00	$215.00	$200.00	
	$204,250	$319,240	$83,260	$124,200	$463,110	$141,600	$1,335,660
SECTION A: PROJECT MANAGEMENT	**$26,000**	**$37,950**	**$0**	**$10,580**	**$47,945**	**$1,600**	**$124,075**
1 Kickoff Meeting	$2,000	$2,300	$0	$920	$860	$0	$6,080
2 Project Management	$17,500	$26,220	$0	$9,660	$3,870	$0	$57,250
3 Obtain and Read in Data for Project	$6,500	$9,430	$0	$0	$43,215	$1,600	$60,745
SECTION B: MONITORING ACTIVITIES	**$22,000**	**$74,980**	**$7,360**	**$0**	**$258,000**	**$34,000**	**$396,340**
4 Build and Maintain Data Warehouse, Compute Metrics	$6,000	$16,100	$0	$0	$37,840	$8,400	$68,340
5 Ongoing activities each quarter - compute and validate metrics	$16,000	$58,880	$7,360	$0	$220,160	$25,600	$328,000
SECTION C: EVALUATION DESIGN	**$9,000**	**$29,440**	**$0**	**$4,600**	**$6,450**	**$1,600**	**$51,090**
6 Develop Evaluation Design	$9,000	$29,440	$0	$4,600	$6,450	$1,600	$51,090
SECTION D: INTERIM EVALUATION ACTIVITIES	**$85,250**	**$93,610**	**$34,040**	**$66,240**	**$75,465**	**$55,200**	**$409,805**
7 Focus Study: Care Coordination/Transitions to Care	$21,250	$0	$0	$14,260	$13,760	$8,800	$58,070
8 Focus Study: Critical Incidents (CI), Grievances and Appeals (G&A)	$2,000	$13,800	$0	$9,200	$860	$4,000	$29,860
9 Focus Study: Review Retroactive Eligibility Process	$0	$13,800	$0	$7,820	$6,020	$2,800	$30,440
10 Focus Study: Review Authorization Process	$19,000	$0	$0	$10,120	$4,300	$8,800	$42,220
11 Focus Study: Baseline Access to Dental Care	$21,000	$0	$0	$11,500	$18,920	$10,000	$61,420
12 Prepare Interim Evaluation	$22,000	$66,010	$34,040	$13,340	$31,605	$20,800	$187,795
SECTION E: SUMMATIVE EVALUATION ACTIVITIES	**$62,000**	**$83,260**	**$41,860**	**$42,780**	**$75,250**	**$49,200**	**$354,350**
7 Focus Study: Care Coordination/Transitions to Care	$14,000	$0	$0	$8,280	$12,900	$7,200	$42,380
8 Focus Study: Critical Incidents (CI), Grievances and Appeals (G&A)	$1,500	$8,740	$0	$4,600	$860	$3,200	$18,900
9 Focus Study: Review Retroactive Eligibility Process	$0	$7,360	$0	$3,680	$6,020	$2,800	$19,860
10 Focus Study: Review Authorization Process	$11,500	$0	$0	$5,980	$4,300	$8,800	$30,580
11 Focus Study: Baseline Access to Dental Care + Transitions to Care	$10,000	$0	$0	$3,680	$13,760	$7,200	$34,640
13 Prepare Summative Evaluation	$25,000	$67,160	$41,860	$16,560	$37,410	$20,000	$207,990

ATTACHMENT C: TIMELINE AND MILESTONES

As part of the procurement process, Burns & Associates, a Division of HMA (B&A) was required to submit a work plan, including major tasks and milestones to complete the scope of work. Presently, the State only has the authority to contract with B&A through February 28, 2022. There are deliverables due to CMS after February 28, 2022.

B&A has built a work plan for the independent evaluation of Delaware's 1115 Demonstration Waiver Diamond State Health Plan that is constructed around the development of each deliverable identified as part of CMS required deliverables and the State's obligations related to monitoring and evaluation (M&E) activities. A summary of tasks in this work plan scheduled out by month appears at the end of this section.

The main sections of the work plan are as follows:

- Section A, ***Project Management***, includes Tasks 1, 2 and 3. The tasks in the section will be conducted across the entire engagement.
    - Deliverables in this section:
        - Monthly status and other project management reports
        - Reports on data validation of information received from the DMES

- Section B, ***Monitoring Activities***, includes Tasks 4 and 5. It is anticipated that the work in this section will start immediately upon contract execution and continue until March 31, 2024.
    - Deliverables in this section:
        - Creation and maintenance of the analytic data warehouse specific to the Evaluation Design Plan and associated focus studies
        - Compute and validate metrics specific to the Evaluation Design Plan on a quarterly basis (6 quarters Q4 2020 – Q1 2022, and then 10 additional quarters after this time period)

- Section C, ***Evaluation Activities***, includes Tasks 6 through 11. It is expected that the work in this section will start immediately upon contract execution and continue until August 31, 2022.
    - Deliverables in this section:
        - Draft Evaluation Design to CMS (May 31, 2020)
        - Final Evaluation Design approved by CMS (August 31, 2020)

- Section D, ***Interim Evaluation Activities,*** includes Tasks 7 through 12. It is expected that the work in this section will start in Q1 of CY 2021 and continue until March 31, 2023. Tasks 7 through 11 represent five different focus studies. Each will include an internal report to DMMA. Results from each study will also be included in the Interim Evaluation to CMS. Task 12 represents work to produce the Interim Evaluation report itself.
    - Deliverables in this section:
        - Conduct Four Focus Studies (June 30, 2021 – February 28, 2022) – Interim reports for each focus study delivered intermittently during this 13-month period
        - Conduct a Fifth Focus Study if a contract extension is authorized (July 31, 2022)
        - Detailed outline of the Interim Evaluation (May 31, 2022)
        - Draft Version of Interim Evaluation (November 30, 2022)
        - Final Version of Interim Evaluation (December 31, 2022)

- Section E, Summative Evaluation Deliverables, includes Tasks 7 and 11 again and Task 13. Tasks 7 through 11 are repeated because a follow-up on each focus study reported on in the Interim Evaluation is proposed so that updates can be reported in the Summative Evaluation. It is expected that the work in this section will start in Q1 of CY 2024 and continue until June 30, 2025.
    - Deliverables in this section:
        - Conduct Five Focus Studies (May 31, 2024 – December 31, 2024) – Interim reports for each focus study delivered intermittently during this 8-month time period
        - Detailed outline of the Summative Evaluation (November 30, 2024)
        - Draft Version of Summative Evaluation (May 15, 2025)
        - Final Version of Summative Evaluation (June 30, 2025)

CONTRACT YEAR 1

Indicates ongoing work toward task

Indicates submission to CMS

Task Number	Task Name	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
		2020								
SECTION A: PROJECT MANAGEMENT										
1	Kickoff Meeting									
2	Project Management									
3	Obtain and Read in Data for Project									
SECTION B: MONITORING ACTIVITIES										
4	Build and Maintain Data Warehouse, Develop and Compute Metrics									
5	Ongoing Activities Each Quarter - Compute and Validate Metrics									
SECTION C: EVALUATION DESIGN										
6	Develop Evaluation Design									
SECTION D: INTERIM EVALUATION ACTIVITIES										
7	Focus Study: Care Coordination/Transitions to Care									
8	Focus Study: Critical Incidents (CI), Grievances and Appeals									
9	Focus Study: Review Retroactive Eligibility Process									
10	Focus Study: Review Authorization Process									
11	Focus Study: Baseline Access to Dental Care									
12	Prepare Interim Evaluation									
SECTION E: SUMMATIVE EVALUATION ACTIVITIES										
7	Focus Study: Care Coordination/Transitions to Care									
8	Focus Study: Critical Incidents (CI), Grievances and Appeals									
9	Focus Study: Review Retroactive Eligibility Process									
10	Focus Study: Review Authorization Process									
11	Focus Study: Baseline Access to Dental Care + Transitions to Care									
13	Prepare Summative Evaluation									

CONTRACT YEAR 2

Indicates ongoing work toward task

Indicates submission to CMS

Task Number	Task Name	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
		2021											
SECTION A: PROJECT MANAGEMENT													
1	Kickoff Meeting												
2	Project Management												
3	Obtain and Read in Data for Project												
SECTION B: MONITORING ACTIVITIES													
4	Build and Maintain Data Warehouse, Develop and Compute Metrics												
5	Ongoing Activities Each Quarter - Compute and Validate Metrics												
SECTION C: EVALUATION DESIGN													
6	Develop Evaluation Design												
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7	Focus Study: Care Coordination/Transitions to Care												
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9	Focus Study: Review Retroactive Eligibility Process												
10	Focus Study: Review Authorization Process												
11	Focus Study: Baseline Access to Dental Care												
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SECTION E: SUMMATIVE EVALUATION ACTIVITIES													
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9	Focus Study: Review Retroactive Eligibility Process												
10	Focus Study: Review Authorization Process												
11	Focus Study: Baseline Access to Dental Care + Transitions to Care												
13	Prepare Summative Evaluation												

CONTRACT YEAR 3

Indicates ongoing work toward task

Indicates submission to CMS

Task Number	Task Name	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
		2022											
SECTION A: PROJECT MANAGEMENT													
1	Kickoff Meeting												
2	Project Management												
3	Obtain and Read in Data for Project												
SECTION B: MONITORING ACTIVITIES													
4	Build and Maintain Data Warehouse, Develop and Compute Metrics												
5	Ongoing Activities Each Quarter - Compute and Validate Metrics												
SECTION C: EVALUATION DESIGN													
6	Develop Evaluation Design												
SECTION D: INTERIM EVALUATION ACTIVITIES													
7	Focus Study: Care Coordination/Transitions to Care												
8	Focus Study: Critical Incidents (CI), Grievances and Appeals												
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10	Focus Study: Review Authorization Process												
11	Focus Study: Baseline Access to Dental Care												
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8	Focus Study: Critical Incidents (CI), Grievances and Appeals												
9	Focus Study: Review Retroactive Eligibility Process												
10	Focus Study: Review Authorization Process												
11	Focus Study: Baseline Access to Dental Care + Transitions to Care												
13	Prepare Summative Evaluation												

CONTRACT YEAR 4

Indicates ongoing work toward task

Indicates submission to CMS

Task Number	Task Name	Jan 2023	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
SECTION A: PROJECT MANAGEMENT													
1	Kickoff Meeting												
2	Project Management												
3	Obtain and Read in Data for Project												
SECTION B: MONITORING ACTIVITIES													
4	Build and Maintain Data Warehouse, Develop and Compute Metrics												
5	Ongoing Activities Each Quarter - Compute and Validate Metrics												
SECTION C: EVALUATION DESIGN													
6	Develop Evaluation Design												
SECTION D: INTERIM EVALUATION ACTIVITIES													
7	Focus Study: Care Coordination/Transitions to Care												
8	Focus Study: Critical Incidents (CI), Grievances and Appeals												
9	Focus Study: Review Retroactive Eligibility Process												
10	Focus Study: Review Authorization Process												
11	Focus Study: Baseline Access to Dental Care												
12	Prepare Interim Evaluation												
SECTION E: SUMMATIVE EVALUATION ACTIVITIES													
7	Focus Study: Care Coordination/Transitions to Care												
8	Focus Study: Critical Incidents (CI), Grievances and Appeals												
9	Focus Study: Review Retroactive Eligibility Process												
10	Focus Study: Review Authorization Process												
11	Focus Study: Baseline Access to Dental Care + Transitions to Care												
13	Prepare Summative Evaluation												

CONTRACT YEAR 5

Indicates ongoing work toward task

Indicates submission to CMS

Task Number	Task Name	Jan 2024	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
SECTION A: PROJECT MANAGEMENT													
1	Kickoff Meeting												
2	Project Management												
3	Obtain and Read in Data for Project												
SECTION B: MONITORING ACTIVITIES													
4	Build and Maintain Data Warehouse, Develop and Compute Metrics												
5	Ongoing Activities Each Quarter - Compute and Validate Metrics												
SECTION C: EVALUATION DESIGN													
6	Develop Evaluation Design												
SECTION D: INTERIM EVALUATION ACTIVITIES													
7	Focus Study: Care Coordination/Transitions to Care												
8	Focus Study: Critical Incidents (CI), Grievances and Appeals												
9	Focus Study: Review Retroactive Eligibility Process												
10	Focus Study: Review Authorization Process												
11	Focus Study: Baseline Access to Dental Care												
12	Prepare Interim Evaluation												
SECTION E: SUMMATIVE EVALUATION ACTIVITIES													
7	Focus Study: Care Coordination/Transitions to Care												
8	Focus Study: Critical Incidents (CI), Grievances and Appeals												
9	Focus Study: Review Retroactive Eligibility Process												
10	Focus Study: Review Authorization Process												
11	Focus Study: Baseline Access to Dental Care + Transitions to Care												
13	Prepare Summative Evaluation												

CONTRACT YEAR 6

Indicates ongoing work toward task

Indicates submission to CMS

Task Number	Task Name	Jan 2025	Feb	Mar	Apr	May	June
SECTION A: PROJECT MANAGEMENT							
1	Kickoff Meeting						
2	Project Management						
3	Obtain and Read in Data for Project						
SECTION B: MONITORING ACTIVITIES							
4	Build and Maintain Data Warehouse, Develop and Compute Metrics						
5	Ongoing Activities Each Quarter - Compute and Validate Metrics						
SECTION C: EVALUATION DESIGN							
6	Develop Evaluation Design						
SECTION D: INTERIM EVALUATION ACTIVITIES							
7	Focus Study: Care Coordination/Transitions to Care						
8	Focus Study: Critical Incidents (CI), Grievances and Appeals						
9	Focus Study: Review Retroactive Eligibility Process						
10	Focus Study: Review Authorization Process						
11	Focus Study: Baseline Access to Dental Care						
12	Prepare Interim Evaluation						
SECTION E: SUMMATIVE EVALUATION ACTIVITIES							
7	Focus Study: Care Coordination/Transitions to Care						
8	Focus Study: Critical Incidents (CI), Grievances and Appeals						
9	Focus Study: Review Retroactive Eligibility Process						
10	Focus Study: Review Authorization Process						
11	Focus Study: Baseline Access to Dental Care + Transitions to Care						
13	Prepare Summative Evaluation						

ATTACHMENT D: DETAILED EVALUATION DESIGN PLAN TABLE

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #1: ***Does the waiver of retroactive eligibility continue (or does not worsen) the continuity of enrollment in Medicaid in the current waiver period?***						
Demonstration Component #1: The DSHP Medicaid managed care program provides Medicaid state plan benefits through a comprehensive managed care delivery system to most recipients eligible under the state plan.						
Demonstration Component #4: Coverage for former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care at age 18 (or such higher age as elected by the state), were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid.						
Demonstration Goal: G.1 Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS; and G.10 Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population.						
Domain of Focus: F.7 Hypotheses for the waiver of retroactive eligibility will include (but not be limited to): the effects of the waiver on enrollment and eligibility continuity (including for different subgroups of individuals, such as individuals who are healthy, individuals with complex medical needs, prospective applicants, and existing beneficiaries in different care settings.						
Evaluation Hypothesis #1: Trends in continuity of enrollment continue (or does not worsen) for Medicaid populations subject to the waiver of retroactive eligibility in the current waiver period.						
Short Term (Continuity of Enrollment)	Time span from application to enrollment in Medicaid	Burns & Associates, Inc.	Frequency distribution of enrollees by number of days from application to enrollment during the measurement period.		Enrollment data	Descriptive statistics (trends in frequencies and percentages of time span from application to enrollment stratified by aid category)
	Medicaid enrollment counts by month and aid category	Burns & Associates, Inc.	Count of enrollees by month and aid category during the measurement period.		Enrollment data	Descriptive statistics (trends in enrollment counts over time stratified by aid category)
	Medicaid Enrollment duration by aid category and assignment plan	Burns & Associates, Inc.	Frequency distribution of enrollees by the number of months of eligibility in the measurement period, stratified by aid category and assignment plan.		Enrollment data	Descriptive statistics (trends in enrollment duration by aid category and assignment plan)
	Proportion of enrollees continuously enrolled in Medicaid by aid category, assignment plan and delivery system	Burns & Associates, Inc.	Frequency distribution of enrollees continuously enrolled 9 or more months in the measurement period, stratified by aid category, assignment plan and delivery system.	Total number of enrollees during the measurement period.	Enrollment data	Descriptive statistics (trends in the proportion of enrollees continuously enrolled by aid category, assignment plan and delivery system)

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #2: ***Does the waiver of retroactive eligibility continue or not worsen trends in the incidence of uncompensated care or not seeing a doctor because of cost in the current waiver period?***						
Demonstration Component #1: The DSHP Medicaid managed care program provides Medicaid state plan benefits through a comprehensive managed care delivery system to most recipients eligible under the state plan.						
Demonstration Component #4: Coverage for former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care at age 18 (or such higher age as elected by the state), were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid.						
Demonstration Goal: G.1 Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS; and G.10 Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population.						
Domain of Focus: F.7 Hypotheses for the waiver of retroactive eligibility will include (but not be limited to): the effects of the waiver on enrollment and eligibility continuity (including for						
Evaluation Hypothesis #2: The waiver of retroactive eligibility will continue or not worsen trends in uncompensated care or medical debt in the current waiver period.						
Long Term (Uncompensated Care)	Rate of hospital reported uncompensated care	Burns & Associates, Inc.	Hospital reported uninsured uncompensated care	Number of Delawareans expressed as per 1,000	DMMA Form DSH-1, Line 21	Descriptive statistics (trends in frequencies and percentages over the demonstration period) with comparison to baseline period
	Could Not See Doctor Because of Cost	CDC, BRFSS	Weighted percentage of respondents who reported there was a time over the past 12 months when they needed to see a doctor but could not because of cost (MEDCOST)		Health Care Access Module	Descriptive statistics (trends in Delaware reported percentages over the demonstration period); comparison to baseline period and available national and regional values
	Self-identified trends in medical debt for DSHP enrollees	Burns & Associates, Inc.	Number of respondents reporting if medical debt has improved, stayed the same or not worsened over the past twelve months	Total number of respondents.	Focus Group	Descriptive statistics (trends in frequencies and percentages over the demonstration period) with comparison to baseline period

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #3: ***Does the level and trend of access to primary and preventive care continue (or not worsen) in the current waiver period?***						
Demonstration Component #1: The DSHP Medicaid managed care program provides Medicaid state plan benefits through a comprehensive managed care delivery system to most recipients eligible under the state plan.						
Demonstration Component #4: Coverage for former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care at age 18 (or such higher age as elected by the state), were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid.						
Demonstration Goal: G.1 Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS; and G.10 Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population.						
Domain of Focus: F.6 The extent to which including former foster care youth who "aged out" of foster care in a different state increases and strengthens overall coverage for former foster care youth and improves health outcomes for these youth.						
Evaluation Hypothesis #3: Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current waiver period.						
Long Term (Access to Care)	Well-Child Visits in the First 15 Months of Life (W15)	NCQA	Number of children who turned 15 months old during the measurement year who had 6 or more well-child visits with a PCP	Number of children who turned 15 months old during the measurement year.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	NCQA	Number of children who are 3 to 6 years old as of December 31 and had one or more visits with a PCP during the measurement year.	Number of children who are 3 to 6 years old as of December 31 of the measurement year.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Adolescent Well-Care Visits (AWC)	NCQA	Number of enrolled members age 12 to 21 years, as of December 31,who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.	Number of enrolled members age 12 to 21 years as of December 31 of the measurement year.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Breast Cancer Screening (BCS)	NCQA	Number of women age 50-54 years who had a screening mammogram as of December 31 in the measurement year.	Number of women age 50-54 years as of December 31 in the measurement year.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Adults' Access to Preventive/Ambulatory Health Services (AAP)	NCQA	Number of members who had an ambulatory or preventive care visit as of December 31 in the measurement year, reported using three age stratifications: 22-44 years; 45-64 years; 65+ years.	Number of members as of December 31 in the measurement year, with counts for each of the three age stratifications: 22-44 years; 45-64 years; 65+ years.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
Short Term (Access to Care)	Average driving distance to primary care services	Burns & Associates, Inc.	Sum of the driving distances traveled from member home to their primary care provider	Sum of the unique trips to the member's primary care provider in the year	Claims data	Descriptive statistics (trends in average driving distance stratified by MCO and region)

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #4: ***Do service authorizations provide an effective tool in the appropriate utilization of health care services in the current waiver period?***						
Demonstration Component #1: The DSHP Medicaid managed care program provides Medicaid state plan benefits through a comprehensive managed care delivery system to most recipients eligible under the state plan.						
Demonstration Component #2: The DSHP Plus program provides long-term care services and supports (LTSS) to certain individuals under the State Plan, and to certain demonstration						
Demonstration Component #3: The PROMISE program provides enhanced behavioral health services fee-for-service (FFS) to Medicaid beneficiaries with a higher level of behavioral health needs and functional limitations who need HCBS to live and work in integrated settings.						
Demonstration Component #4: Coverage for former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care at age 18 (or such higher age as elected by the state), were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid.						
Demonstration Goal: G.1 Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS.						
Domain of Focus: F.3 The cost-effectiveness and efficiency of DSHP Plus in ensuring that appropriate health care services are provided in an effective and coordinated fashion.						
Evaluation Hypothesis #3: Trends observed in access to health care through the DSHP for the Medicaid population continues (or does not worsen) in the current waiver period.						
Short Term (Access to Care)	Average turnaround time for authorization decisions	Burns & Associates, Inc.	Total number of days turnaround time for monthly authorization requests	Total number of monthly authorizations requests (approved and denied)	MCO-submitted report	Descriptive statistics (will be stratified by MCO and by subpopulations PROMISE and All Other)
	Rate of approved and denied authorizations	Burns & Associates, Inc.	Number of monthly (1) approvals and (2) denials for authorization requests	Total number of monthly authorization requests	MCO-submitted report	Descriptive statistics (will be stratified by MCO and by subpopulations PROMISE and All Other)
	Frequency and percentage of denial reason codes	Burns & Associates, Inc.	Count of monthly denied authorization requests, by denial reason code	Total number of monthly denied authorizations requests	MCO-submitted report	Descriptive statistics (will be stratified by MCO and by subpopulations PROMISE and All Other)

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #5: ***Does the proportion of members receiving care coordination and supports continue (or not worsen) in the current waiver period?***						
Demonstration Component #1: The DSHP Medicaid managed care program provides Medicaid state plan benefits through a comprehensive managed care delivery system to most recipients eligible under the state plan.						
Demonstration Component #2: The DSHP Plus program provides long-term care services and supports (LTSS) to certain individuals under the State Plan, and to certain demonstration						
Demonstration Component #3: The PROMISE program provides enhanced behavioral health services fee-for-service (FFS) to Medicaid beneficiaries with a higher level of behavioral health needs and functional limitations who need HCBS to live and work in integrated settings.						
Demonstration Component #4: Coverage for former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care at age 18 (or such higher age as elected by the state), were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid.						
Demonstration Goal: G.4 Increasing coordination of care and supports; and G.8 Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles.						
Domains of Focus: F2 The costs and benefits of providing early intervention for individuals with, or at-risk, for having LTC needs; F.3 The cost-effectiveness and efficiency of DSHP Plus in ensuring that appropriate health care services are provided in an effective and coordinated fashion; and F.4 Effectiveness of the coordination of the MCO and DSAMH case managers, as well as the services provided by the MCO with the enhanced behavioral health services provided by PROMISE.						
Evaluation Hypothesis #4: Trends in coordination of care and supports continues (or does not worsen) in the current waiver period.						
Short Term (Improved Outcomes)	Rate of DSHP members with selected special health care needs screened for care coordination	Burns & Associates, Inc.	Number of DSHP members with selected special health care needs screened for care coordination.	Number of DSHP members with selected special health care needs	MCO-submitted report	Descriptive statistics (trends tracked separately for three populations: (1) enrolled in PROMISE, (2) DSHP Plus eligible, (3) other selected special health care need categories in State Quality Strategy Plan)
	Of those members with selected special health care needs screened, the number enrolled in care coordination	Burns & Associates, Inc.	Number of DSHP members with selected special health care needs screened for and enrolled in care coordination	Number of DSHP members with selected special health care needs screened for care coordination	MCO-submitted report	Descriptive statistics (trends tracked separately for three populations: (1) enrolled in PROMISE, (2) DSHP Plus eligible, (3) other selected special health care need categories in State Quality Strategy Plan)
	Duration of enrollment w/in case/care management	Burns & Associates, Inc.	Frequency distribution by days of enrollment in case/care management		MCO-submitted report	Descriptive statistics (trends tracked separately for three populations: (1) enrolled in PROMISE, (2) DSHP Plus eligible, (3) other selected special health care need categories in State Quality Strategy Plan)

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #6: ***Do DSHP members enrolled in case/care management achieve similar or improved quality of care and health outcomes in the current waiver period?***						
Demonstration Component #1: The DSHP Medicaid managed care program provides Medicaid state plan benefits through a comprehensive managed care delivery system to most recipients eligible under the state plan.						
Demonstration Component #4: Coverage for former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care at age 18 (or such higher age as elected by the state), were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid.						
Demonstration Goal: G.4 Increasing coordination of care and supports; and G.10 Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population.						
Domain of Focus: F.3 The cost-effectiveness and efficiency of DSHP Plus in ensuring that appropriate health care services are provided in an effective and coordinated fashion; and F.4 Effectiveness of the coordination of the MCO and DSAMH case managers, as well as the services provided by the MCO with the enhanced behavioral health services provided by PROMISE.						
Evaluation Hypothesis #5: Coordination of care and supports maintains or improves quality of care and health outcomes in the current waiver period.						
Long Term (Improved Outcomes)	Prenatal care for pregnant women (PPC), control groups those in/not in case/care management.	NCQA	1. Timeliness of Prenatal Care. Number of women having a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or w/in 42 days of enrollment in the organization.	1. Timeliness of Prenatal Care. Number of deliveries of live births.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
		NCQA	2. Postpartum Care. Number of women having a postpartum visit on or between 21 and 56 days after delivery.	2. Postpartum Care. Number of deliveries of live births.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA	Discharges for members age 6 and older who were hospitalized for treatment of mental illness or intentional self-harm and who had a follow-up visit with a MH practitioner w/in 30 days after discharge.	1. Discharges for members age 6 and older who were hospitalized for treatment of mental illness.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)	NCQA	ED visits for members age 6 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit w/ MH practitioner w/in 30 days of ED visit.	1. ED visits for members age 6 and older who had a principal diagnosis of mental illness or intentional self-harm.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	NCQA	Number of ED visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service w/in 7 days of the ED visit.	Number of members 18 years and older who have multiple high-risk chronic conditions.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline. Report for age stratifications (18-64, 65 and older), and total for Interim Evaluation; ITS for Summative Evaluation

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #7: ***Does the level of satisfaction among DSHP members continue (or not worsen) in the current waiver period?***						
Demonstration Component #1: The DSHP Medicaid managed care program provides Medicaid state plan benefits through a comprehensive managed care delivery system to most recipients eligible under the state plan.						
Demonstration Component #4: Coverage for former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care at age 18 (or such higher age as elected by the state), were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid.						
Demonstration Goal: G.5 Expanding consumer choices.						
Domain of Focus: F.4 Effectiveness of the coordination of the MCO and DSAMH case managers, as well as the services provided by the MCO with the enhanced behavioral health services provided by PROMISE; and F.5 The extent to which the PROMISE services improve the overall health status and quality of life of the individuals enrolled in PROMISE.						
Evaluation Hypothesis #6: Trends in consumer satisfaction will continue (or not worsen) in the current waiver period.						
Long Term (Access to Care)	Getting Needed Care Composite	CAHPS	Number of respondents reporting always or usually.	Total number of respondents.	CAHPS® 5.0 Health Plan	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline. Stratify by adults and children and MCO for Interim Evaluation; ITS for Summative Evaluation
	Getting Care Quickly Composite	CAHPS	Number of respondents reporting always or usually.	Total number of respondents.	CAHPS® 5.0 Health Plan	
	How Well Doctors Communicate Composite	CAHPS	Number of respondents reporting always or usually.	Total number of respondents.	CAHPS® 5.0 Health Plan	
	Rating of Personal Doctor	CAHPS	Number of respondents reporting a rating of 8 to 10 out of a maximum score of 10.	Total number of respondents.	CAHPS® 5.0 Health Plan	
	Rating of Health Plan	CAHPS	Number of respondents reporting a rating of 8 to 10 out of a maximum score of 10.	Total number of respondents.	CAHPS® 5.0 Health Plan	
	Grievances per 1000 members	DMMA	Count of grievances during the reporting period.	Total number of DSHP member months in 12-month study period (result of this formula expressed as per 1,000 member months)	QCMMR	Descriptive statistics (frequencies and percentages).
	Total number of grievances by category	DMMA	Count of grievances during the reporting period by category.		QCMMR	Descriptive statistics (frequencies and percentages). Stratify by category and MCO.
	Appeals per 1000 members	Burns & Associates, Inc.	Count of appeals during the reporting period.	Total number of DSHP member months in 12-month study period (result of this formula expressed as per 1,000 member months)	QCMMR	Descriptive statistics (frequencies and percentages).
	Total number of appeals by category	Burns & Associates, Inc.	Count of grievances during the reporting period by category.		QCMMR	Descriptive statistics (frequencies and percentages). Stratify by category and MCO.
	Critical incidents per 1000 members	Burns & Associates, Inc.	Count of critical incidents during the reporting period.	Total number of DSHP member months in 12-month study period (result of this formula expressed as per 1,000 member months)	QCMMR DSHP Plus	Descriptive statistics (frequencies and percentages).

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #8: ***Has the rebalancing of long-term care services and supports maintained or moved more toward home- and community-based services and away from institutional services in the current waiver period?***						
Demonstration Component #2: The DSHP Plus program provides long-term care services and supports (LTSS) to certain individuals under the State Plan, and to certain demonstration						
Demonstration Goal: G.1 Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS; G.2 Rebalancing Delaware's LTC system in favor of HCBS; and G.7 Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTSS services where appropriate.						
Domain of Focus: F.1 The impact of rebalancing the LTC system in favor of HCBS; F.2 The costs and benefits of providing early intervention for individuals with, or at-risk, for having LTC needs; and F.3 The cost-effectiveness and efficiency of DSHP Plus in ensuring that appropriate health care services are provided in an effective and coordinated fashion.						
Evaluation Hypothesis #7: Creating a delivery system that provides incentives for resources to shift from institutions to community-based LTSS has maintained or increased utilization of HCBS services where appropriate in the current waiver period.						
Long Term (LTSS Rebalancing)	Utilization of HCBS services per 1000 members	Burns & Associates, Inc.	Count of HCBS services by category. Categories are: (1) personal care/attendant care/chore services, (2) home-delivered meals, (3) specialized medical equipment/supplies, home modifications, personal emergency response system	Total number of DSHP member months in a 12-month study period (result of this formula expressed as per 1,000 member months)	Claims data	Descriptive statistics (frequencies and percentages) reported at HCBS service category
	Spending in total and on a per member month basis for HCBS services	Burns & Associates, Inc.	Total spend for HCBS services	Total DSHP Plus member months in a 12-month study period	Claims data	Descriptive statistics (frequencies and percentages) for Interim Evaluation; ITS for Summative Evaluation
	Spending in total and on a per member month basis for institutional LTSS services	Burns & Associates, Inc.	Total spend for institutional MLTSS	Total DSHP Plus member months in a 12-month study period	Claims data	Descriptive statistics (frequencies and percentages) for Interim Evaluation; ITS for Summative Evaluation
	Proportion of spending for HCBS services	Burns & Associates, Inc.	Total spend for HCBS services	Total spend for all MLTSS services	Claims data	Descriptive statistics (frequencies and percentages) for Interim Evaluation; ITS for Summative Evaluation
Short Term (Improved Outcomes)	Rate of members needing HCBS services screened for care coordination	Burns & Associates, Inc.	Number of members utilizing HCBS screened for care coordination	Number of members utilizing HCBS	MCO-submitted report	Descriptive statistics (trends rates stratified by MCO and region)
	Of those members needing HCBS services screened, the number enrolled in care coordination	Burns & Associates, Inc.	Number of members utilizing HCBS screened for and enrolled in care coordination	Number of members utilizing HCBS screened for care coordination	MCO-submitted report	Descriptive statistics (trends rates stratified by MCO and region)
	Member experience with care coordination and supports	Burns & Associates, Inc.	Member experience with care coordination and supports, and the extent to which it has facilitated transition to the next appropriate level of care		Member survey	Descriptive statistics (frequencies and percentages)

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #9: ***Do DSHP Plus members achieve similar or improved quality of care and health outcomes in the current waiver period?***						
Demonstration Component #2: The DSHP Plus program provides long-term care services and supports (LTSS) to certain individuals under the State Plan, and to certain demonstration						
Demonstration Goal: G.3 Promoting early intervention for individuals with, or at-risk, for having, LTC needs; G.4 Increasing coordination of care and supports; and G.8 Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles.						
Domain of Focus: F.2 The costs and benefits of providing early intervention for individuals with, or at-risk, for having LTC needs; and F.3 The cost-effectiveness and efficiency of DSHP Plus in ensuring that appropriate health care services are provided in an effective and coordinated fashion.						
Evaluation Hypothesis #5: Coordination of care and supports maintains or improves quality of care and health outcomes in the current waiver period.						
Long Term (Improved Outcomes)	Plan All-Cause Readmissions (PCR)[a]	NCQA	At least one acute unplanned readmission for any diagnosis w/in 30 days of the date of discharge from the index hospital stay, that is on or between the second day of the measurement year and the end of the measurement year	DSHP Plus Medicaid beneficiaries age 18 and older with a discharge from an acute IP stay (index hospital stay) on or between January 1 and December 1 of the measurement year	Claims data	Descriptive statistics; chi square tests of significance comparing target population to baseline and to the comparison group for Interim Evaluation; ITS for Summative Evaluation
	Comprehensive Diabetes Care (CDC)	NCQA	Members 18–75 years of age with diabetes (type 1 and type 2) who had a Hemoglobin A1c (HbA1c) testing	Total members 18-75 years of age with diabetes (type 1 and type 2).	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Annual Monitoring for Patients on Persistent Medications (MPM)	NCQA	Members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Metric #1: ACE inhibitor or angiotensin receptive blocker (ARB). Metric #2: Members on diuretics. Metric #3: Sum of the two.	Members on persistent medications (i.e., members who received at least 180 treatment days of ambulatory medication in the measurement year).	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Medication Adherence Rates - Percent of Days Covered (PDC)	PQA	Number of Days in Period covered by the same or another drug in its therapeutic class for Asthma, COPD and Diabetes	Number of Days in Period	Claims data	Descriptive statistics (trend over time for conditions of interest with stratification by cohort population and by MCO

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #10: ***Does the level and trend of access to enhanced behavioral health services continue (or not worsen) in the current waiver period?***						
Demonstration Component #3: The PROMISE program provides enhanced behavioral health services fee-for-service (FFS) to Medicaid beneficiaries with a higher level of behavioral health needs and functional limitations who need HCBS to live and work in integrated settings.						
Demonstration Goal: G.9 Improving overall health status and quality of life of individuals enrolled in PROMISE.						
Domain of Focus: F.4 Effectiveness of the coordination of the MCO and DSAMH case managers, as well as the services provided by the MCO with the enhanced behavioral health services provided by PROMISE.; and F.5 The extent to which the PROMISE services improve the overall health status and quality of life of the individuals enrolled in PROMISE.						
Evaluation Hypothesis #8: Trends in health outcomes will continue or improve in the current waiver period for individuals enrolled in the PROMISE program.						
Long Term (Improved Outcomes)	Rate of identified members who enroll in PROMISE	Burns & Associates, Inc.	Members identified for and referred to that enroll in PROMISE	Members identified or referred to PROMISE	QCMMR	Descriptive statistics (trends in percentage); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative
	Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA	Discharges for members age 6+ who were hospitalized for treatment of MI or intentional self-harm and who had a f/u visit with a MH practitioner w/in 30 days after discharge.	1. Discharges for members age 6 and older who were hospitalized for treatment of mental illness.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population (PROMISE enrollees) to baseline for Interim Evaluation; ITS for Summative
	Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)	NCQA	ED visits for members age 6+ with a principal diagnosis of MI or intentional self-harm and who had a follow-up visit w/ MH practitioner w/in 30 days of ED visit.	1. ED visits for members age 6 and older who had a principal diagnosis of mental illness or intentional self-harm.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population (PROMISE enrollees) to baseline for Interim Evaluation; ITS for Summative
	Follow-Up After Discharge from the Emergency Department for Alcohol or Other Drug (AOD) Dependence[a]	NCQA	Members who had a follow-up visit to and ED visit w/ SUD indicator w/in 30 days of discharge w/in the previous rolling 12 months.	Individuals with an ED visit (with SUD indicator) w/in the previous rolling 12 months	Claims data	Descriptive statistics; chi square or t-tests of significance comparing target population (PROMISE enrollees) to baseline and comparison group for Interim Evaluation; ITS for Summative
	Initiation and engagement of alcohol and other drug dependence treatment[a]	NQF #0004	Initiation: Number of patients who began initiation of treatment through IP admission, OP visits, IOP encounter or partial hosp. w/in 14 days of index episode start date	Patients who were diagnosed with a new episode of alcohol or drug dependency during the first 10 and ½ months of the measurement year	Claims data	Descriptive statistics; chi square or t-tests of significance comparing target population (PROMISE enrollees) to baseline for Interim Evaluation; ITS for Summative Evaluation
	Initiation and engagement of alcohol and other drug dependence treatment[a]	NQF #0004	Engagement: Initiation of treatment and two or more IP admissions, OP visits, IOP encounters or partial hosp. with any alcohol/drug diagnosis w/in 30 days after date of initiation encounter	Patients who were diagnosed with a new episode of alcohol or drug dependency during the first 10 and ½ months of the measurement year	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population (PROMISE enrollees) to baseline for Interim Evaluation; ITS for Summative Evaluation

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #11: ***Do PROMISE members enrolled in case/care management achieve similar or improved quality of care and health outcomes in the current waiver period?***						
Demonstration Component #3: The PROMISE program provides enhanced behavioral health services fee-for-service (FFS) to Medicaid beneficiaries with a higher level of behavioral health needs and functional limitations who need HCBS to live and work in integrated settings.						
Demonstration Goal: G.4 Increase care coordination and supports; and G.9 Improving overall health status and quality of life of individuals enrolled in PROMISE						
Domain of Focus: F.4 Effectiveness of the coordination of the MCO and DSAMH case managers, as well as the services provided by the MCO with the enhanced behavioral health services provided by PROMISE; and F.5 The extent to which the PROMISE services improve the overall health status and quality of life of the individuals enrolled in PROMISE.						
Evaluation Hypothesis #5: Coordination of care and supports maintains or improves quality of care and health outcomes in the current waiver period.						
Long Term (Improved Outcomes)	Plan All-Cause Readmissions (PCR)[a]	NCQA	At least one acute unplanned readmission for any diagnosis w/in 30 days of the date of discharge from the index hospital stay, that is on or between the second day of the measurement year and the end of the measurement year	DSHP Plus Medicaid beneficiaries age 18 and older with a discharge from an acute IP stay (index hospital stay) on or between January 1 and December 1 of the measurement year	Claims data	Descriptive statistics; chi square tests of significance comparing target population (PROMISE enrollees) to baseline and to the comparison group for Interim Evaluation; ITS for Summative Evaluation
	Emergency Department (ED) visits per 1000	Burns & Associates, Inc.	Count of ED visits for DSHP Plus members enrolled in PROMISE in the measurement period	Total DSHP Plus PROMISE enrollee member months	Claims data	Descriptive statistics (frequencies and percentages); chi square tests of significance comparing target population (PROMISE enrollees) to baseline for Interim Evaluation; ITS for Summative Evaluation
	Emergency Department (ED) Frequent Flyer rate	Burns & Associates, Inc.	Frequency distribution of DSHP Plus members enrolled in PROMISE by count of ED visits in the measurement period		Claims data	
	Antidepressant Medication Management (AMM)	NCQA	1. Members 18 years and older treated with antidepressant medication, had a diagnosis of major depression, and who remained on antidepressant medication treatment for at least 84 days (12 weeks).	1. Members 18 years of age and older who had a diagnosis of major depression.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
		NCQA	2. Members 18 years and older treated with antidepressant medication, had a diagnosis of major depression, and who remained on antidepressant medication treatment for at least 180 days (6 months).	2. Members 18 years of age and older who had a diagnosis of major depression.	Claims data	Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #12: ***Does the availability of PROMISE providers continue (or not worsen) in the current waiver period?***						
Demonstration Component #3: The PROMISE program provides enhanced behavioral health services fee-for-service (FFS) to Medicaid beneficiaries with a higher level of behavioral health needs and functional limitations who need HCBS to live and work in integrated settings.						
Demonstration Goal: G.1 Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS						
Domain of Focus: F.4 Effectiveness of the coordination of the MCO and DSAMH case managers, as well as the services provided by the MCO with the enhanced behavioral health services provided by PROMISE; and F.5 The extent to which the PROMISE services improve the overall health status and quality of life of the individuals enrolled in PROMISE.						
Evaluation Hypothesis #9: The PROMISE program network capacity will continue (or not worsen) in the current waiver period.						
Long Term (Access to Care)	Behavioral health providers per 1000 members by geographical region	Burns & Associates, Inc.	Unique count of behavioral health providers	Total PROMISE enrollee member months for a 12-month study period (result of this formula expressed as per 1,000 member months)	Claims and Provider Enrollment data	Descriptive statistics (trends rates stratified by MCO and region)
	HCBS providers per 1000 members by geographical region	Burns & Associates, Inc.	Unique count of HCBS providers	Total PROMISE enrollee member months for a 12-month study period (result of this formula expressed as per 1,000 member months)	Claims and Provider Enrollment data	Descriptive statistics (trends rates stratified by MCO and region)

Outcome	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #13: ***Does the availability of the adult dental benefit increase access to dental services and lead to continued (or not worsen) health outcomes in the current waiver period?***						
Demonstration Component #1: The DSHP Medicaid managed care program provides Medicaid state plan benefits through a comprehensive managed care delivery system to most recipients eligible under the state plan.						
Demonstration Goal: G.10 Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population; and G.12 Increasing access to dental services; decrease the percent of emergency department visits for non-traumatic dental conditions in adults; increase follow up with dentists after an emergency department visit for non-traumatic dental conditions in adults; and increase the number of adults with diabetes who receive an oral exam annually.						
Domain of Focus: F.6 The extent to which including former foster care youth who "aged out" of foster care in a different state increases and strengthens overall coverage for former foster care youth and improves health outcomes for these youth; and F.8 If the addition of adult dental benefits increases access to dental services and ultimately improved health outcomes for adults in Delaware.						
Evaluation Hypothesis #10: The availability of the adult dental benefit will improve access to dental services and will continue (or not worsen) health outcomes in the current waiver period.						
Long Term (Access to Care)	Utilization of dental services per 1000	Burns & Associates, Inc.	Count of dental services in the measurement period for DSHP and DSHP Plus enrollees	Total DSHP and DSHP Plus enrollee member months for a 12-month study period (result of this formula expressed as per 1,000 member months)	Claims data	Descriptive statistics (frequencies and percentages) stratified by age, MCO and region; chi square tests of significance comparing target population (adult enrollees) to baseline for Interim Evaluation; ITS for Summative Evaluation
	Dental providers per 1000 members by geographical region	Burns & Associates, Inc.	Unique count of dental providers	Total DSHP and DSHP Plus enrollee member months for a 12-month study period (result of this formula expressed as per 1,000 member months)	Claims and Provider Enrollment data	Descriptive statistics (trends rates stratified by MCO and region)
	Average driving distance to dental care services	Burns & Associates, Inc.	Sum of the driving distances traveled from member home to their dental care provider	Sum of the unique trips to the member's dental care provider in the year	Claims data	Descriptive statistics (trends in average driving distance stratified by age, MCO and region)
Long Term (Improved Outcomes)	Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-A-A)	Dental Quality Alliance	Number of ED visits with an ambulatory care sensitive non-traumatic dental condition diagnosis code among individuals 18 years and older	All member months for individuals 18 years and older during the reporting year (result of this formula expressed per 100,000 member months for adults)	Claims data	Descriptive statistics (trends in percentage); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Follow-up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDF-A-A)	Dental Quality Alliance	Number of ambulatory care sensitive non-traumatic dental condition ED visits in the reporting period for which the member visited a dentist within (a) 7 days (NUM1) and (b) 30 days (NUM2) of the ED visit	Number of ambulatory care sensitive non-traumatic dental condition ED visits in the reporting period	Claims data	Descriptive statistics (trends in percentage); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative Evaluation
	Adults with Diabetes – Oral Evaluation (DOE-A-A)	Dental Quality Alliance	Unduplicated number of adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation	Unduplicated number of adults with diabetes	Claims data	Descriptive statistics (trends in percentage); chi square or t-tests of significance comparing target population to baseline for Interim Evaluation; ITS for Summative

[a] Denotes metric that is also part of SUD Evaluation Design Plan

DE 1115 and SUD Waiver CMS Questions Regarding the Interim Evaluation Reports, Approach and Report Modifications

#	1115	SUD	CMS Feedback	Interim Evaluation Language	State Response
1.	**X**	**X**	**Provide explanation for deviations from the approved pre-demonstration periods.** CMS expects the pre-demonstration period to include CY2016 and CY2017. The approved DSHP Evaluation Design notes that the pre-demonstration period is defined as enrollment or dates of service from January 1, 2016 through December 31, 2018. For the approved SUD Evaluation Design, the pre-demonstration period is defined as enrollment or dates of service from August 1, 2016 through July 31, 2019. Additionally, the state described plans to define the pre-demonstration period from July 1, 2017 to July 31, 2019 in the upcoming Summative Evaluation Report for the interrupted time series (ITS) analyses. The change in pre-demonstration periods for both evaluation reports is a significant deviation from the approved Evaluation Design. In addition to the data limitations provided, CMS requests the state discuss the implications of these limitations and how this impacts its evaluation findings and overall understanding of the demonstration. In particular, ITS analyses require longer baseline periods (e.g. three to four years) to model baseline trends, control for any long-term seasonality and increase the power of statistical tests used to detect changes in outcomes after the demonstration was implemented. The state should also provide details for obtaining approved pre-demonstration data for the Summative Evaluation Report and any potential implications for not reporting CY 2016 and CY 2017 data, if the data is unavailable. Please include a response below.	As included in the July 18, 2023 Change Summary, language was added to Section E: Methodological Limitations in both reports as follows, with the language appearing on page 22 in the SUD evaluation and page 25 in the 1115 evaluation: **Public Health Emergency –** "In addition, HMA-Burns will account for the COVID-19 pandemic timeframe as CY 2020 and plans to define the baseline pre-waiver period as July 1, 2017 to July 31, 2019, and the post-waiver period as December 1, 2021 to December 31, 2023. This methodology will allow for an equal time period of 25 months of data to be used in interrupted time series models, without including CY 2020 in statistical modeling. " **Data limitations in DMES –** "There are some limitations in the data as reported in DMMA's data warehouse in the pre-demonstration period of CY 2016 and CY 2017. Information is available for both utilization and enrollment statistics for each Medicaid beneficiary for these two years, but some variables such as MCO assignment are incomplete. For this Interim Evaluation, therefore, results are shown for the years where this information is complete (CYs 2018 through 2021) and to allow for equal time periods for statistical analyses while taking into consideration the impact of the public health emergency on utilization. For the Summative Evaluation, information will be reported using CY 2016 and CY 2017 where possible, but these results may need to be more at the overall demonstration population level and not at the sub-population level."	Both evaluation reports include a statement regarding the limitations of the CY 2016 and CY 2017 data and provide assurances that for the Summative Evaluation, information will be reported using CY 2016 and CY 2017 where possible, but these results may need to be more at the overall demonstration population level and not at the sub-population level. Insufficient data will be noted as a methodological limitation. While the data for CY 2016 and CY 2017 will be included where possible, HMA-Burns plans to define the baseline pre-waiver period as July 1, 2017 to July 31, 2019, and the post-waiver period as December 1, 2021 to December 31, 2023 to allow for an equal pre and post time period of 25 months of data to be used in interrupted time series models, without including CY 2020, the COVID-19 pandemic timeframe, in statistical modeling.

#	1115	SUD	CMS Feedback	Interim Evaluation Language	State Response
2	X	X	**Missing qualitative data.** In the approved DSHP Evaluation Design, Exhibit III.1 (Page III-2), the state listed facilitated interviews as a data source for eight hypotheses. The approved DSHP Evaluation Design also notes that data collection would begin in 2021 and would include MCOs, non-SUD providers, non-SUD beneficiaries, PROMISE providers and PROMISE beneficiaries as respondents. However, the DSHP Interim Evaluation Report does not include findings from facilitated interviews. The evaluator noted facilitated interviews conducted during the demonstration only focused on the SUD component of the demonstration. Additionally, the state did not report the measure titled "Self-identified trends in medical debt for DSHP enrollees" which would be collected via focus groups. The evaluator noted that while the Evaluation Design proposed collecting provider and MCO feedback as part of the focus studies, the Public Health Emergency (PHE) resulted in suspension of authorizations and disruptions to utilization, which eliminated the ability to collect meaningful data for the Interim Evaluation. Furthermore, the approved SUD Evaluation Design in Exhibit III.1 (Page III-2) indicates the evaluator would conduct facilitated interview with Medicaid MCOs. However, in the SUD Interim Evaluation Report, the state copied over qualitative findings from the SUD Mid-Point Assessment (August 1, 2019 through June 30, 2021). CMS requests the state describe plans to conduct and include findings from facilitated interviews in the Summative Evaluation Report to ensure adherence to the approved Evaluation Design. Please include a response below.	Both reports include language in Section E: Methodological Limitations, Beneficiary feedback, that "… The evaluators would conduct face-to-face interviews with beneficiaries once the PHE has concluded and report beneficiary feedback in the Summative Evaluation." This appears on page 23 of the SUD evaluation and page 26 of the 1115 evaluation. As described in the July 18, 2023 Change Summary, language was added to the 1115 evaluation in Section E: Methodological Limitations regarding inclusion of qualitative data from MCOs and providers and modifications to the approved evaluation design plan . Specific language follows: **Provider and MCO feedback –** "…The evaluators will conduct face-to-face interviews with LTSS providers and providers of PROMISE services, and the MCOs, once the PHE has concluded and will report provider and MCO feedback in the Summative Evaluation." This appears on page 26 of the report. **Modifications to Approved Evaluation Design, Unable to Report –** "… Modifications to the approved evaluation design were driven largely by the pandemic and resulting programmatic and service delivery changes. As a result, the evaluators had insufficient data and were not able to be reported on in the Interim Evaluation. The evaluators will compute the measures, once the PHE has concluded, and will include them in the Summative Evaluation." Metric 2.2.3 Self-identified trends in medical debt for DSHP enrollees was included in the list of metrics that HMA-Burns was unable to report on and that is will be included in the Summative Evaluation. This is included on page 26 of the report.	As stated in the interim evaluation reports, the independent evaluator will collect qualitative data, in accordance with the approved evaluation design plans, from beneficiaries, MCOs and providers. The data will be reported in the Summative Evaluation as long as there is sufficient data. Likewise, metrics that could not be computed due to the pandemic and resulting programmatic and service delivery changes, will be computed and included in the Summative Evaluation as long as there is sufficient data. Insufficient data will be noted as a methodological limitation.

#	1115	SUD	CMS Feedback	Interim Evaluation Language	State Response
3	**X**	**X**	**COVID sub-analyses.** The approved Evaluation Design notes that the evaluators would test two separate post years to baseline to estimate the treatment effects before, during and after the pandemic. In both cases, members who became newly-eligible for Medicaid as a result of COVID will be identified by aid category and benefit plan and treated as a subpopulation in the analysis. B&A will then be able to continue to include other newly-eligible members for which enrollment in Medicaid is unrelated to the pandemic (e.g., aged, blind and disabled, pregnant women, newborns). CMS requests the state provide an update on the proposed analyses, and if these were not conducted in the Interim Evaluation Report, the state should provide detailed steps on incorporating this into the Summative Evaluation Report and implications of the data limitations in the methodology section. Please include a response below.		As the PHE has concluded, the independent evaluator intends to conduct the COVID sub-analyses as described in the approved evaluation design plans for SUD and the 1115 demonstration Summative Evaluations. Results will be reported where there is sufficient data. Insufficient data will be noted as a methodological limitation.

DE 1115 and SUD Waiver CMS Questions Regarding the Interim Evaluation Reports, Approach and Report Modifications

#	1115	SUD	CMS Feedback	Interim Evaluation Language	State Response
4			**Missing measures stratifications and analyses.** CMS identified that the report resubmission is still missing a total of 16 metrics as well as several stratifications analyses (e.g., analyses by assignment plan, delivery system, MCO assignment, region). While CMS understands state challenges due to the COVID-19 pandemic, CMS requests the state explore ways to more fully align with the approved Evaluation Design to include missing measures, stratifications, and analyses. CMS requests the state provide details for incorporating the missing measures and stratifications in the attached table under the Column entitled "State Response". The state can submit this information by copying Table 1 into a separate document with the last column of this table ("State Responses") completed and e-mailing the document to the state's Demonstration Team.	See Table 1	See Table 1

Table 1. Missing measures, stratifications and analyses			
Research Question	**Measures**	**CMS Feedback/Recommendations**	**State Response**
Evaluation Question #1: Does the waiver of retroactive eligibility continue (or does not worsen) the continuity of enrollment in Medicaid in the current waiver period?	1. Time span from application to enrollment in Medicaid 2. Medicaid enrollment counts by month and aid category 3. Medicaid Enrollment duration by aid category and assignment plan 4. Proportion of enrollees continuously enrolled in Medicaid by aid category, assignment plan and delivery system	• Stratification analyses missing by assignment plan for measures "Medicaid enrollment duration by aid category and assignment plan" and "Proportion of enrollees continuously enrolled in Medicaid by aid category, assignment plan and delivery system". • Stratification analyses missing by delivery system for "Proportion of enrollees continuously enrolled in Medicaid by aid category, assignment plan and delivery system".	As stated in Section E: Methodological Limitations, Data Limitations in DMES, the assignment to a specific program (e.g., DSHP, DSHP Plus, or PROMISE) as well as the assignment to a specific MCO is not complete for each beneficiary. For this Interim Evaluation, therefore, results are shown for the years where this information is complete (CYs 2018 through 2021) and to allow for equal pre and post time periods for statistical analyses while taking into consideration the impact of the public health emergency on utilization. For the Summative Evaluation, information will be reported using CY 2016 and CY 2017 where possible, but these results may need to be more at the overall demonstration population level and not at the sub-population level. Insufficient data will be noted as a methodological limitation.

Table 1. Missing measures, stratifications and analyses			
Research Question	**Measures**	**CMS Feedback/Recommendations**	**State Response**
Evaluation Question #2: Does the waiver of retroactive eligibility continue or not worsen trends in the incidence of uncompensated care or not seeing a doctor because of cost in the current waiver period?	5. Rate of hospital reported uncompensated care (DDMA data) 6. Could Not See Doctor Because of Cost (Health Care access module) 7. Self-identified trends in medical debt for DSHP enrollees (focus group)	• Measure "Self-identified trends in medical debt for DSHP enrollees" is missing.	The revised 1115 Interim Evaluation report dated July 18, 2023 addresses Section E: Methodological Limitations – Modifications to the approved evaluation design plan as follows: "… Modifications to the approved evaluation design were driven largely by the pandemic and resulting programmatic and service delivery changes. As a result, the evaluators had insufficient data and were not able to be reported on in the Interim Evaluation. The evaluators will compute the measures, once the PHE has concluded, and will include them in the Summative Evaluation." Please see page 26 of the revised report. Metric 2.2.3 (#7) Self-identified trends in medical debt for DSHP enrollees was included in the list of metrics that HMA-Burns was unable to report on and that it will be included in the Summative Evaluation, providing there is sufficient data to report on. Please see page 26 of the revised report. Insufficient data will be noted as a methodological limitation.
Evaluation Question #3: Does the level and trend of access to primary and preventive care continue (or not worsen) in the current waiver period?	8. Well-Child Visits in the First 15 Months of Life (W15) 9. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) 10. Adolescent Well-Care Visits (AWC) 11. Breast Cancer Screening (BCS) 12. Adults' Access to Preventive/Ambulatory Health Services (AAP) 13. Average driving distance to primary care services	• Stratification analyses missing by MCO and region for Measure "Average driving distance to primary care services".	The revised 1115 Interim Evaluation report dated July 18, 2023 includes subgroup stratification for average distance to primary care services by region [please see Exhibit 18 (Region) on page 44] and MCO [please see Exhibit 18 (MCO) on page 45].

Table 1. Missing measures, stratifications and analyses			
Research Question	**Measures**	**CMS Feedback/Recommendations**	**State Response**
Evaluation Question #4: Do service authorizations provide an effective tool in the appropriate utilization of health care services in the current waiver period?	14. Average turnaround time for authorization decisions 15. Rate of approved and denied authorizations 16. Frequency and percentage of denial reason codes	• All measures for this Research Question are missing. The report includes three measures related to foster care members, which were not included in the approved Evaluation Design.	Language was added to the July 18, 2023 revised 1115 Interim Evaluation in Section E: Methodological Limitations – Modifications to the approved evaluation design plan as follows: "… Modifications to the approved evaluation design were driven largely by the pandemic and resulting programmatic and service delivery changes. As a result, the evaluators had insufficient data and were not able to be reported on in the Interim Evaluation. The evaluators will compute the measures, once the PHE has concluded, and will include them in the Summative Evaluation." Please see page 26 of the revised report. Insufficient data will be noted as a methodological limitation. Research question 4 and its related measures [4.3.1 (#14), 4.3.2 (#15), and 4.3.3 (#16)] are included in the list of metrics that HMA-Burns was unable to report on and that they will be included in the Summative Evaluation. Please see page 26 of the revised report.

Table 1. Missing measures, stratifications and analyses			
Research Question	**Measures**	**CMS Feedback/Recommendations**	**State Response**
Evaluation Question #5: Does the proportion of members receiving care coordination and supports continue (or not worsen) in the current waiver period)?	17. Rate of DSHP members with selected special health care needs screened for care coordination 18. Of those members with selected special health care needs screened, the number enrolled in care coordination 19. Duration of enrollment w/in case/care management	• The Research Question was not addressed in the report and all measures are missing.	Language was added to the July 18, 2023 revised 1115 Interim Evaluation in Section E: Methodological Limitations – Modifications to the approved evaluation design plan as follows: "… Modifications to the approved evaluation design were driven largely by the pandemic and resulting programmatic and service delivery changes. As a result, the evaluators had insufficient data and were not able to be reported on in the Interim Evaluation. The evaluators will compute the measures, once the PHE has concluded, and will include them in the Summative Evaluation." Please see page 26 of the revised report. Insufficient data will be noted as a methodological limitation. Research question 5 and its related measures [5.4.1 (#17), 5.4.2 (#18) and 5.4.3 (#19)] are included in the list of metrics that HMA-Burns was unable to report on and that they will be included in the Summative Evaluation. Please see pages 26-27 of the revised report.

Table 1. Missing measures, stratifications and analyses			
Research Question	**Measures**	**CMS Feedback/Recommendations**	**State Response**
Evaluation Question #6: Do DSHP members enrolled in case/care management achieve similar or improved quality of care and health outcomes in the current waiver period?	20. Prenatal care for pregnant women (PPC), control groups those in/not in case/care management 21. Follow-Up After hospitalization for Mental Illness (FUH) 22. Follow-Up After emergency Department (ED) Visit for Mental Illness (FUM) 23. Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	• Stratification analyses missing by case management for measure "Prenatal care for pregnant women (PPC), control groups those in/not in case/care management".	Language was added to the July 18, 2023 revised 1115 Interim Evaluation in Section E: Methodological Limitations – Modifications to the approved evaluation design plan as follows: "… Modifications to the approved evaluation design were driven largely by the pandemic and resulting programmatic and service delivery changes. As a result, the evaluators had insufficient data and were not able to be reported on in the Interim Evaluation. The evaluators will compute the measures, once the PHE has concluded, and will include them in the Summative Evaluation." Please see page 26 of the revised report. Insufficient data will be noted as a methodological limitation. As case/care management status data from Research Question 5 would have been needed to stratify PPC, stratification was not possible in the Interim Evaluation. The evaluators will stratify the PPC measure in accordance with the evaluation design and will include results in the Summative Evaluation, providing there is sufficient data to report.

Table 1. Missing measures, stratifications and analyses			
Research Question	**Measures**	**CMS Feedback/Recommendations**	**State Response**
Evaluation Question #7: Does the level of satisfaction among DSHP members continue (or not worsen) in the current waiver period?	24. Getting need care composite 25. Getting care quickly composite 26. How well Doctors Communicate Composite 27. Rating of Personal Doctor 28. Rating of Health Plan 29. Grievances per 1000 members 30. Total number of grievances by category 31. Appeals per 100 members 32. Total number of appeals by category 33. Critical incidents per 1000 members	• Chi-square or t-tests statistical tests are missing for measures 24-27. • Stratification analyses missing by category and MCO for measures "Total number of grievances by category" and "Total number of appeals by category." • Descriptive statistics (frequency and percentage) missing for measure "Critical incidents per 1000 members".	The revised Interim Evaluation report dated July 18, 2023 includes descriptive statistics for metrics 24 through 27. As described in Section E: Methodological Limitations – Public Health Emergency, the HMA-Burns team will assess trends not only between the pre-demonstration and current demonstration periods, but also the pace at which access measures such as metrics 24 through 27 and metric 33 improve as the PHE winds down in the Summative Evaluation as described on page 25 of the revised report. Statistical modeling will be performed taking into account the COVID-19 pandemic timeframe and conducted as described on page 25 of the revised report. Insufficient data will be noted as a methodological limitation. The revised 1115 Interim Evaluation report dated July 18, 2023 includes stratification and analyses by MCO for Metric 30 Total number of Grievances by category and Metric 32. It appears as the numerator in: Exhibit 42 (All) – see page 74; Exhibit 42 (AmeriHealth Caritas) – see page 75; and Exhibit 42 (Highmark Health Options) – see page 76.

Table 1. Missing measures, stratifications and analyses			
Research Question	**Measures**	**CMS Feedback/Recommendations**	**State Response**
Evaluation Question #8: Has the rebalancing of long-term care services and supports maintained or moved more toward home- and community-based services and away from institutional services in the current waiver period?	34. Utilization of HCBS services per 1000 members 35. Spending in total and on a per member month basis for HCBS services 36. Spending in total and on a per member month basis for institutional LTSS services 37. Proportion of spending for HCBS services 38. Rate of members needing HCBS services screened for care coordination 39. Of those members needing HCBS services screened, the number enrolled in care coordination 40. Member experience with care coordination and supports	• Measures "Rate of members needing HCBS services screened for care coordination", "Of those members needing HCBS services screened, the number enrolled in care coordination" and "Member experience with care coordination and supports" are missing.	Language was added to the July 18, 2023 revised 1115 Interim Evaluation in Section E: Methodological Limitations – Modifications to the approved evaluation design plan as follows: "… Modifications to the approved evaluation design were driven largely by the pandemic and resulting programmatic and service delivery changes. As a result, the evaluators had insufficient data and were not able to be reported on in the Interim Evaluation. The evaluators will compute the measures, once the PHE has concluded, and will include them in the Summative Evaluation." Please see page 26 of the revised report. Insufficient data will be noted as a methodological limitation. Research question 8 and metrics 8.7.5 (#38), 8.7.6 (#39) and 8.7.7 (#40) are included in the list of metrics that HMA-Burns was unable to report on and that they will be included in the Summative Evaluation. Please see page 27 of the revised report.
Evaluation Question #9: Do DSHP Plus members achieve similar or improved quality of care and health outcomes in the current waiver period?	41. Plan All-Cause Readmissions (PCR) 42. Comprehensive diabetes Care (CDC) 43. Annual Monitoring for Patients on Persistent Medications (MPM) 44. Medication Adherence Rates - Percent of Days Covered (PDC)	• Stratification analyses missing by cohort population for the "Medication Adherence Rates - Percent of Days Covered (PDC)" measures."	The revised 1115 Interim Evaluation report dated July 18, 2023 includes subgroup stratification Medication Adherence Rate, Proportion of Days Covered in: the results on page 53; for DSHP Plus overall in Exhibit 29 on page 57; and by MCO in Exhibit 29 (MCO) on page 58.

Table 1. Missing measures, stratifications and analyses			
Research Question	**Measures**	**CMS Feedback/Recommendations**	**State Response**
Evaluation Question #10: Does the level and trend of access to enhanced behavioral health services continue (or not worsen) in the current waiver period?	45. Rate of identified members who enroll in PROMISE 46. Follow-Up After hospitalization for Mental Illness (FUH) 47. Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM) 48. Follow-Up After Discharge from the Emergency Department for Alcohol or Other Drug (AOD) Dependence (FUA) 49. Initiation and engagement of alcohol and other drug dependence treatment 50. Initiation and engagement of alcohol and other drug dependence treatment	Chi-square or t-tests statistical tests are missing for "Rate of identified me members who enroll in PROMISE."	The revised Interim Evaluation report dated July 18, 2023 includes descriptive statistics for the Rate of identified Members who enroll in PROMISE. As described in Section E: Methodological Limitations – Public Health Emergency, the HMA-Burns team will assess trends not only between the pre-demonstration and current demonstration periods, but also the pace at which access measures improve as the PHE winds down in the Summative Evaluation as described on page 25 of the revised report. Statistical modeling will be performed taking into account the COVID-19 pandemic timeframe and conducted as described on page 25 of the revised report. Insufficient data will be noted as a methodological limitation.

Table 1. Missing measures, stratifications and analyses			
Research Question	**Measures**	**CMS Feedback/Recommendations**	**State Response**
Evaluation Question #11: Do PROMISE members enrolled in case/care management achieve similar or improved quality of care and health outcomes in the current waiver period?	51. Plan All-Cause Readmissions (PCR) 52. Emergency Department (ED) visits per 1000 53. Emergency Department (ED) Frequent Flyer rate 54. Antidepressant Medication Management (AMM) (12 weeks, 6 months)	• Chi-square or t-tests statistical tests are missing for measure "ED visits per 1000", and "ED visits frequent flyer" missing statistical test".	The revised 1115 Interim Evaluation report dated July 18, 2023 includes T-test for ED Visits per 1000 as found in Exhibit 56 on page 94. The revised Interim Evaluation report dated July 18, 2023 includes descriptive statistics for ED visits frequent flyer. As described in Section E: Methodological Limitations – Public Health Emergency, the HMA-Burns team will assess trends not only between the pre-demonstration and current demonstration periods, but also the pace at which utilization and access measures improve as the PHE winds down in the Summative Evaluation as described on page 25 of the revised report. Statistical modeling will be performed taking into account the COVID-19 pandemic timeframe and conducted as described on page 25 of the revised report. Insufficient data will be noted as a methodological limitation.

Evaluation Question #12: Does the availability of PROMISE providers continue (or not worsen) in the current waiver period?	55. Behavioral health providers per 1000 members by geographical region 56. HCBS providers per 1000 members by geographical region	• Measures "Behavioral health providers per 1000 members by geographical region" and "HCBS providers per 1000 members by geographical region" are missing.	In the revised 1115 Interim Evaluation report dated July 18, 2023, modifications to the approved evaluation design were driven largely by the pandemic and resulting programmatic and service delivery changes. To compensate for those metrics that could not be included in the Interim Evaluation, the evaluators added the following metrics, with the intention of adding them to the Summative Evaluation. Metric 12.9.1 Behavioral Health Providers per 1000 Members was refocused to Number of Providers Delivering PROMISE services per 1,000 PROMISE members as it is a better indicator of the availability of PROMISE providers to PROMISE enrollees. In addition, Metric 12.9.2 HCBS providers per 1000 members by geographical region was replaced with Percent of PROMISE Members receiving PROMISE Services to examine if changes in PROMISE provider availability in Metric 12.9.1 impacts use of PROMISE services. The refocused metrics are found in Section E: Methodological Limitations – Modifications to Approved Evaluation Design, Added Metrics on page 27 of the revised report. HMA-Burns intends to compute the measures "Behavioral health providers per 1000 members by geographical region" and "HCBS providers per 1000 members by geographical region" as part of the Summative Evaluation and will include them in the report provided there is sufficient data. Insufficient data will be noted as a methodological limitation.

Table 1. Missing measures, stratifications and analyses			
Research Question	**Measures**	**CMS Feedback/Recommendations**	**State Response**
Evaluation Question #13: Does the availability of the adult dental benefit increase access to dental services and lead to continued (or not worsen) health outcomes in the current waiver period?	57. Utilization of dental services per 1000 58. Dental providers per 1000 members by geographical region 59. Average driving distance to dental care services 60. Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-A-A) 61. Follow-up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDF-A-A) 62. Adults with Diabetes – Oral Evaluation (DOE-A-A)	• Statistical test for "Utilization of dental services, EDV-A-A, EDF-A-A" are missing. • Stratification analyses missing • by age, MCO and region for measures "Utilization of dental services per 1000" and "Average driving distance to dental care services". • Stratification analyses missing by MCO and region for measures "Dental providers per 1000 members by geographical region".	For Goal #12, Evaluation Question #13, as related to access to adult dental services, the benefit was just introduced in October 2020, so the CY 2021 results from these measures serve as the baseline. Given that only one year of data was available, it was not possible to conduct statistical testing. In the Summative Evaluation, all measures will be computed, and statistical modeling and stratification analyses will be performed in accordance with the approved evaluation design plan. Results will be included in the report providing there is sufficient data. Insufficient data will be noted as a methodological limitation.