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Division of Medicaid & Medical Assistance

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Diamond State Health Plan

Section 1115 2022 3rd Quarterly Report

Demonstration Year 27 (1/1/2022– 12/31/2022)

Federal Fiscal Quarter 2: July 1, 2022, to September 30, 2022

November 30, 2022

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Introduction

Delaware's Diamond State Health Plan (DSHP) 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 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% 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.

Through an amendment approved by CMS in 2012, Delaware was authorized to create the Diamond State Health Plan Plus (DSHP-Plus), which is Delaware's managed long-term services and supports (MLTSS) program. Additional state plan populations to receive services through MCOs, including:

(1) individuals receiving care at nursing facilities (NF) other than intermediate care facilities for the mentally retarded (ICF/MR);
(2) children in pediatric nursing facilities;
(3) individuals who receive benefits from both Medicaid and Medicare (dual eligibles); and
(4) workers with disabilities who buy-in for coverage.

This amendment also added eligibility for the following new demonstration populations:

(1) individuals who would previously have been enrolled through the 1915(c) home and community-based services (HCBS) waiver program for the Elderly and Disabled. This includes those receiving services under the Money Follows the Person demonstration;
(2) individuals who would previously have been enrolled though the 1915(c) HCBS waiver for Individuals with Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS) Related Diseases;
(3) individuals residing in NF who no longer meet the current medical necessity criteria for NF services; and
(4) adults and children with incomes below 250 percent of the Supplemental Security Income Federal Benefit Rate who are at risk for institutionalization.

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 Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) starting in 2015. PROMISE enrollees include Medicaid beneficiaries who have a severe and persistent mental illness (SPMI) and/or a substance use disorder (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 July 2019, the demonstration was extended for an additional five years, and an amendment approved 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 Institution for Mental Diseases (IMD).

Delaware submitted an amendment to the demonstration on August 11, 2020, to revise the budget neutrality expenditures to reflect the costs associated with the adult dental benefits that were recently added to the Medicaid state plan. Delaware requested this amendment because, although the dental services are authorized under state plan authority, they will be administered through the DSHP managed care delivery system, which is authorized by this demonstration. The amendment was approved effective January 19, 2021.

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

- 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;
- Rebalancing Delaware's LTC system in favor of HCBS;
- Promoting early intervention for individuals with, or at-risk, for having, LTC needs;
- Increasing coordination of care and supports;
- Expanding consumer choices;
- Improving the quality of health services, including LTC services, delivered to all Delawareans;

- Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTSS services where appropriate;
- Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles;
- Improving overall health status and quality of life of individuals enrolled in PROMISE;
- Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population;
- Increasing 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; and
- 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 DSHP demonstration includes five distinct 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 long-term care services and supports (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; and 5) Coverage for high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as IMDs.

In accordance with the STCs of the DSHP 1115 demonstration, the Delaware Division of Medicaid and Medical Assistance submits this third quarter report (for the quarter ending September 30, 2022) Demonstration Year 27.

Enrollment Information and Enrollment Counts

Q3 2022 Enrollment

Demonstration Populations	Current Enrollees (to date)	Disenrolled in Current Quarter
Population 1: Former AFDC Children less than 21 (DSHP TANF Children)	107,765	6
Population 2: Former AFDC Adults aged 21and over (DSHP TANF Adult)	41,099	16
Population 3: Disabled Children less than 21 (DSHP SSI Children)	5,740	3
Population 4: Aged and Disabled Adults 21 and older (DSHP SSI Adults)	6,507	23
Population 5: Infants less than one year of age with income levels above 185 percent FPL through 200 percent FPL; optional targeted low income children (DSHP MCHIP)	N/A	N/A
Population 6: Uninsured Adults up to 100% FPL (DSHP Exp. Pop.)	80,533	104
Population 7: Family Planning Expansion (FP Expansion)	None; program terminated in 2013	N/A
Population 8: DSHP-Plus State Plan	10,127	122
Population 9: DSHP-Plus HCBS	6,338	117
Population 10: DSHP TEFRA-Like	302	0
Population 11: Newly Eligible Group	15,496	11
Population 12: PROMISE	1,402	45
Population 13: Former Foster Care Youth	0	0

Definition: "Current Enrollees (to date) is an unduplicated count of clients in the MCO for at least one day in the April 1, 2022, through June 30, 2022 period based on capitation claims and for the MC and PROMISE enrollment and eligibility files. Clients who were in more than one eligibility category during the quarter are reported based on their last status (most recent month). Age calculated as of the first day of the most recent month of enrollment, consistent with reporting of member months.

Outreach and Innovative Activities

2022 Q3 MCO and State Outreach Events, Special Topic Meetings and Workgroups

Expansion of Home-Delivered Meals – Under the Appendix K authority provided in the DSHP 1115 Waiver, DMMA continued providing additional home-delivered meals to vulnerable clients served in the DSHP Plus HCBS Program. Highmark Health Options and AmeriHealth Caritas DE performed extra outreach to DSHP Plus members to inform them of this extra benefit.

MCO Outreach – The MCOs were in the community during Q3. Below are examples of outreach conducted during Q3 by DMMA's MCO partners:

Highmark Health Options (HHO) Q3 Outreach Events

Highmark Health Options partnered with the Food Bank of Delaware to host five statewide food distribution events. These events were held in all three counties in Delaware. Highmark Health Options employees were on hand at each event helping to distribute food to needy families.

On August 20, 2022, Highmark Health Options participated in **Community Health and Wellness Day at Rosehill Community Center.** Highmark Health Options staff educated members about available benefits and resources. The event featured free blood pressure and A1C screenings.

AmeriHealth Caritas Delaware (ACDE) Outreach Events

On September 18, 2022, AmeriHealth Caritas DE participated in the **Wilmington Hispanic Festival.** ACDE met with members and distributed health information to members attending the festival, including information on health risk assessments (HRAs), the 24/7 Nurse Call Line, pediatric care management, immunization reminders, mammogram scheduling, parenting classes, ACDE's GED program, health education, preventive screenings, Bright Starts, and care coordination.

On September 24, 2022, ACDE participated in the **Multi-Cultural Community Wellness Fair** in New Castle. ACDE provided assistance with Screening for Life applications, clinical breast exams, mammogram scheduling, physical activity, and nutrition information. ACDE also offered blood pressure, glucose, and cholesterol testing.

DMMA Special Interest Meetings/Conferences

Delaware Family Voices – DMMA continues to support Delaware Family Voices. Caring for children with special needs is often complex, and Delaware Family Voices and the Family-to-Family Health Information Center is in the unique position to help. This organization states that "We help families of children with special needs become informed, experienced, and self-sufficient advocates for their

children and themselves." DMMA and our MCOs participate in these monthly calls assisting families to navigate the complex healthcare field. There were two monthly calls this quarter August 9, 2022, and September 13, 2022. DMMA stays in regular contact with Delaware Family Voices outside of scheduled calls to assist any Medicaid family in need.

Maternal Child Health – Maternal and child health continues to be a central priority for DMMA. DMMA's maternal & child health (MCH) workgroup continues to focus on policy changes to promote equitable coverage. In Q3, DMMA submitted SPA pages to extend postpartum Medicaid coverage from 60 days to 12 months. DMMA also proposed reimbursement for evidence-based home visiting in the July DSHP 1115 waiver amendment. Through ongoing meetings with doula stakeholders, DMMA has outlined plans for a Medicaid doula benefit.

2022 Q3 Innovative Activities

Social Determinants of Health (SDOH) – In Q3, DMMA continued our Postpartum Food Box partnership program. This program has helped to address food insecurity among our postpartum Medicaid members by delivering shelf-stable food boxes, diapers, and wipes. The program continues to be met with an overwhelming response, with an average of 350 food boxes delivered weekly in Q3.

Operational/Policy Developments/Issues

Policy and Legislative developments

In Q3, DMMA submitted an 1115 waiver amendment to CMS that included five initiatives focused on expanding HCBS services for DSHP Plus members and children as well as covering evidence-based home visiting programs for pregnant women and children. DMMA also submitted a SPA to CMS to expand post-partum eligibility from 60 days to 12 months postpartum.

DMMA Operational Issues

In December 2021, DMMA released an RFP for the re-procurement of DSHP and DSHP Plus MCOs. DMMA will have new contracts in place beginning January 1, 2023. The RFP submissions were due March 15, 2022 from interested bidders with award scheduled for July 2022.

In Q3, DMMA announced new contracts with three MCOs, effective January 1, 2023. DMMA will contract with the two current incumbents, AmeriHealth Caritas DE, and Highmark Health Options, and will add a third MCO, Delaware First Health (Centene). DMMA Managed Care Operations has been busy on-boarding the new MCO and preparing for three Readiness Reviews in November 2022.

In Q3, DMMA also continued efforts to prepare for "unwinding" Medicaid activities related to the COVID-19 PHE, including planning for eligibility redeterminations after the maintenance of eligibility period ends.

DSHP 1115 Waiver Administration

In July 2022, DMMA submitted a DSHP 1115 waiver amendment to CMS for an effective date of January 1, 2023. This amendment included proposals for:

- Coverage of new evidence-based home visiting models
- Coverage of a permanent HCBS home-delivered meal benefit, in order to transition from the DSHP 1115 temporary Appendix K authority.
- Coverage of self-directed State Plan personal care/attendant care for children
- Coverage of a pediatric respite benefit
- Coverage of the DSHP Plus Nursing Facility Transition Program

DMMA also continued to work on the initiatives to be included in the proposed five-year extension (renewal) of the DSHP 1115 waiver and preparing the draft application for public comment.

Other Program Issues

SUPPORT Act Planning Grant and Demonstration Project – DMMA is now operating two SUPPORT Act initiatives -- the SUPPORT Act Planning Grant and SUPPORT Act Demonstration Project. During Q3, DMMA disseminated a technical assistance document on Medications for Opioid Use Disorder (MOUD) for pregnant and postpartum people and served as faculty in an MOUD-focused ECHO program. DMMA also released SUD rate changes for public comment, finalized rate models, began a series of requisite systems changes, and developed and submitted relevant budget materials/requests to implement rate changes on 1/1/23. DMMA also conducted research to develop programmatic specifications for a contingency management program and developed a framework for managed care organization MOUD provider network assessment and anti-stigma initiatives.

Electronic Visit Verification (EVV) – EVV for personal care and home health services is on track to be implemented on December 30, 2022. DMMA launched a pilot with a few select providers, passed CMS operational readiness review for system certification, and will be completing provider training in December.

Program Integrity – The Surveillance and Utilization Review Unit (SUR) worked diligently to identify, correct, and prevent fraud waste and abuse in the Delaware Medicaid Program in Q3. These efforts included continuing to identify ways to utilize and analyze Managed Care Organization (MCO) encounter data to ensure proper payment of claims. The SUR unit is completing two post payment chiropractic services reviews. IBM continues to provide services and analytical guidance to the SUR team. The SUR unit is training new staff members and interviewing for a new Internal Auditor and a Registered Nurse reviewer.

The SUR team used various data mining strategies to guide the post payment auditing and review efforts of the unit. Recent data mining projects have focused on to screen and enroll Applied Behavior

Analysis (ABA) providers who wish to provide autism spectrum disorder (ASD) services.

The SUR management analysts collaborate regularly with both MCOs and the Medicaid Fraud Control Unit (MFCU) to ensure that efforts are not duplicative but remain effective for fighting fraud. The unit continues to strengthen its relationship with NEMT provider Modivcare by facilitating monthly collaborative meetings designed to discuss areas of the program that may be vulnerable to fraud, waste, or abuse.

The Program Integrity section is working closely with SafeGuard Services LLC (SGS) (NE UPIC contractor) to identify areas within the Delaware Medicaid program which may be vulnerable to fraud, waste, or abuse. Recent efforts have centered Personal Care Attendants. SGS will continue reviewing the top billing providers for medical necessity and policy compliance.

To date, all required data has been submitted to the PERM contractors. We are waiting for the final error rate results before the end of 2022.

Expenditure Containment Initiatives

Medicaid/CHIP Accountable Care Organization Program (Medicaid ACO Program)

No new activities in Q3. DHSS developed a Medicaid ACO Program for the purpose of improving health outcomes while reducing costs through value-based purchasing (VBP) arrangements that include downside financial risk for ACOs. The Medicaid ACO program continues to be one of the strategies DMMA is pursuing to advance the adoption of participating Medicaid VBP models and total cost of care (TCOC) strategies. In 2019, DMMA developed an application allowing qualified provider organizations to apply to become Medicaid ACOs and subsequently contract directly with our Medicaid managed care organizations (MCOs) in a TCOC payment arrangement. The initial application cycle ended in 2020 and four Medicaid ACOs were approved. The MCO/ACO contracts Began July 1, 2021. The inaugural group of Medicaid ACOs are authorized through December 31, 2024. In 2021, DMMA completed its work to add an additional Medicaid ACO for CY 2022 participation.

Financial/Budget Neutrality Development/Issues

Q3 2022 Member Month Reporting and With-Waiver PMPMs

Eligibility Group	July 2022 Member Months	August 2022 Member Months	September 2022 Member Months	Quarter ending 09/30/2022
DSHP TANF CHILDREN	105,258	105,495	105,687	**316,440**
DSHP TANF ADULT	39,462	39,721	40,044	**119,227**
DSHP SSI CHILDREN	5,590	5,601	5,620	**16,811**
DSHP SSI ADULTS	6,352	6,351	6,330	**19,033**
DSHP MCHP (Title XIX match) *	0	0	0	**0**
DSHP ADULT GROUP	92,074	92,928	93,604	**278,606**
DSHP-Plus State Plan	9,966	9,912	9,881	**29,759**
DSHP-Plus HCBS	6,101	6,138	6,233	**18,472**
DSHP TEFRA-Like**	294	295	296	**885**
PROMISE	1,378	1,372	1,338	**4,088**

* This EG does not include children funded through title XXI. Please note within the report, if the state must use title XIX funds for other uninsured children meeting the definition specified in section 2110(b)(1) of the Social Security Act if the state exhausts title XXI funds

**These TEFRA counts are PROXY Counts compiled by taking 5% of total SSI Children (and reducing the SSI Children by that Amount)

Q3 2022 Member Months and WW PMPMs

Eligibility Group	Total Member Months for the Quarter	PMPM	Total Expenditures
DSHP TANF CHILDREN	316,440	$380.10	$120,278,164
DSHP TANF ADULT	119,227	$681.85	$81,294,372
DSHP SSI CHILDREN	16,811	$2,315.13	$38,919,732
DSHP SSI ADULTS	19,033	$2,072.56	$39,446,950
DSHP MCHP (Title XIX match)*	0	$0.00	
DSHP ADULT GROUP	278,606	$725.54	$202,139,152
DSHP-Plus State Plan	29,759	$1,534.55	$45,666,771
DSHP-Plus HCBS	18,472	$6,512.63	$120,301,283
DSHP TEFRA-Like**	885	$2,314.58	$2,048,406
PROMISE	4,088	$155.58	$636,027

* This EG does not include children funded through title XXI. Please note within the report, if the state must use title XIX funds for other uninsured children meeting the definition specified in section 2110(b)(1) of the Social Security Act if the state exhausts title XXI funds

**These TEFRA counts are PROXY Counts compiled by taking 5% of total SSI Children (and reducing the SSI Children by that Amount)

Financial/Budget Neutrality/Issues

No change in Q3. DMMA completed its reconciliation analysis and presented our findings to CMS in November 2021. DMMA met with CMS to provide an overview of the major issues identified, the process used to identify the issues, and the impact on budget neutrality for the demonstration period covering CY 2014 through 2018. DMMA scheduled several follow up meetings with CMS to walk through each DY and each adjustment to document the reconciliation process and to seek guidance from CMS on any adjustments within the financial reporting system (MBES/CBES) to address the reporting issues. DMMA has determined that the DSHP 1115 Waiver had a budget neutrality margin of $834 million dollars.

CMS staff informed DMMA that they were recommending no reporting changes through MBES but suggested an extension of STC 73(b) beyond the 12/31/21 reconciliation due date to allow CMS to determine how best to effectuate any reporting corrections necessary for the completion of the reconciliation process. CMS has reached out to DMMA seeking additional documentation of claiming for the Adult Group in 2014 prior to the creation of the Adult Group MEG. DMMA is working to identify all documentation around claims made before and after the Adult Group MEG was created in MBES. DMMA is also working to address CMS questions on Schedule C reporting through the PMDA system.

Quality Assurance/Monitoring Activity

2022 Q3 Quality Assurance/Monitoring Activity

The Delaware Quality Strategy (QS) incorporates quality assurance (QA) monitoring and ongoing quality improvement (QI) processes to coordinate, assess and continually improve the delivery of quality care. The Quality Improvement Initiative (QII) Task Force, whose membership includes a multi-disciplinary statewide group of external contractors and state agencies, participates in oversight and monitoring of quality plans and improvement activities of Medicaid and Title XXI DSHP-funded programs based upon the goals identified in the QS. The QII Task Force assists in monitoring the goals of the DSHP 1115 demonstration.

The QS goals serve as a basis for guiding QII Task Force activities for all Task Force membership. The QII Task Force guiding values and principles are to: seek to achieve excellence through ongoing QII activities; employ a multi-disciplinary approach to identify, measure and access timeliness and quality of care of services to members; hold providers of care accountable; identify collaborative activities; achieve cultural sensitivity; link the community and other advocacy and professional groups; create a forum for communication and open exchange of ideas.

Quality Improvement Activity – During Q3:

- DMMA's internal workgroup has been meeting weekly to maintain momentum. We have delayed our public comment on the QS due to internal discussions.

- DMMA actively participated in multiple opportunities for technical assistance and cross-state learning with CMS, Mathematica and AcademyHealth, including:

    - CMS QTAG: July 20, 2022 – New Medicaid and CHIP Analytic Products
    - MAC QX: July 2022 – No MAC QX meeting in July 2022
    - CMS QTAG: August 2022 - No QTAG meeting in August 2022
    - MAC QX: August 2022 - No MAC QX meeting in August 2022
    - CMS QTAG: September 21, 2022 - Discussion of 2023 Child and Adult Core Set Annual Review Stakeholder Workgroup Recommendations
    - MAC QX: September 22, 2022 - Medicaid Program and CHIP; Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting (CMS-2440-P)

- DMMA has emphasized a focus on improving access to treatment for the Maternal and Children population. In Q3, DMMA continued to work with its MCOs to conduct a performance improvement project (PIP) to increase the number of pregnant & postpartum Medicaid members who receive medications for opioid use disorder (MOUD).

Case Management Oversight – The MCOs submit weekly telephonic case management files for the DMMA clinical staff to review. DMMA clinical staff reviewed approximately 623 telephonic/virtual reviews in Q3 2022, which is a combination of Care Coordination, LTSS case management and Nursing Facility. Each MCO receives a quarterly report and DMMA meets with each MCO to go over and review findings, also discuss areas identified as needing improvement to meet contractual standards.

In Q3 2022, DMMA's oversite team completed Q2 case file reviews with each MCO virtually. DMMA staff reviewed approximately 100 random files for contractual compliance of the MCO's in areas of Care Coordination, Case Management and Nursing Facility Transitions. DMMA reviews the findings, then meets with each MCO to discuss areas needing improvement in Care Coordination and LTSS Case Management for our Medicaid members.

DMMA/MCO Managed Care Meetings – The Bi-Monthly Managed Care meetings are a forum to discuss issues in a collaborative manner. The meetings are used to collaborate on common practices, identify issues, plan resolutions, and establish connections to our sister agencies for coordination of care. DMMA did not have a Managed Care meeting in Q3 due to the efforts necessary to evaluate MCO responses to the RFP as part of the MCO reprocurement. DMMA met with the MCOs individually to address concerns or best practices. We will restart these meeting in Quarter 1 of 2023.

Q3 Incident Management System – DMMA has been moving forward with the review and improvement recommendations of the current critical incident process for intake, review, and reporting of critical incidents for DSHP and DSHP Plus. The DMMA Quality Unit continues to be responsible for critical incident processing using our current technological solutions.

The joint workgroup, which includes all the relevant Divisions of the Department of Health and Social

Services, has been defined and meetings have started on a bi-weekly cadence in order to allow focus and urgency in finding a joint technological solution. This consistency will allow DMMA and our sister Divisions the ability to coordinate tracking and reporting to ensure increased protection of the populations that we serve. The workgroup has been meeting to define the critical incident needs of each Division and will be reviewing technological solutions that are readily available to DHSS to perform a proper assessment. If these in-house solutions do not fit the needs of DHSS, the workgroup will determine if a procurement of an outside additional vendor is needed.

2022 Q3 Consumer Issues

HBM (Enrollment Broker) Update – **Q3** – The HBM continues to support our members, providing information on the two managed care organizations delivering our Medicaid Medical benefit to our members.

In July the HBM started preparations for our upcoming Open Enrollment. This Open Enrollment will include the addition of the third MCO, Delaware First Health. Open Enrollment is October 1, 2022 through October 31, 2022.

Children with Medical Complexity (CMC) Advisory Council – **Q3** – The CMC Advisory Council continues to meet quarterly and is making progress on the work plan for this year. The CMC Advisory Council met in July and will meet again in October.

Medical Care Advisory Council (MCAC) – **Q3** – The MCAC met on August 17, 2022. Discussion included the results of DMMA's MCO reprocurement, maternal and child health initiatives, and DMMA's HCBS Spending Plan activities.

Managed Care Reporting Requirements

2022 Q3 QCMMR and QCMMR Plus Reporting

The Medical Management Managed Care Team has developed and refined our **Quality and Care Management Measurement Reporting Templates (QCMMR) and QCMMR Plus**. The QCMMR reports on the DSHP and CHIP Medicaid Populations while the QCMMR Plus reports on the DSHP Plus population. The Managed Care Operations Team worked in conjunction with Mercer, our EQRO contractor, and the MCOs in developing the guidelines and reporting templates. The QCMMR and QCMMR Plus was developed as a method to specify the metrics to be reported monthly, compare metrics for the two MCO, monitor the results at the State level, and roll up the results quarterly and annually for executive level reporting on the managed care program. The metrics or measures flow from contractual requirements or federal or state regulations contained in the Managed Care program contract.

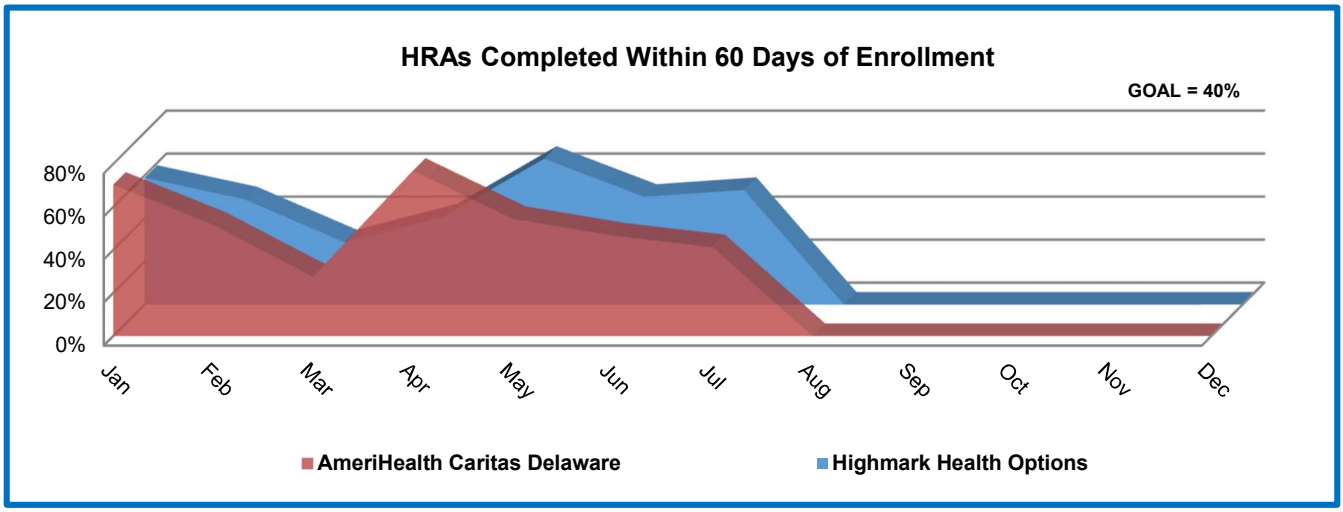
DMMA Managed Care Operations unit developed the full circle approach to the QCMMR and

QCMMR Plus reporting. The reports are reviewed by the Managed Care Operations team and an agenda is developed for our monthly meeting with each MCO to discuss the findings from the reports. Manage Care Operation's goal is to establish a partnership with the MCOs to improve quality of care for our Medicaid population.

DMMA continues to evaluate the QCMMR reports for both DSHP and DSHP Plus populations. DMMA has been working in conjunction with the MCOs to redefine and modify the reporting template to assure both MCOs are pulling and reporting the same data. Data historically reported to CMS in quarterly reports is provided below with additional detail provided on grievances and appeals. DMMA is in the process of developing a new format for additional QCMMR data to be reported to CMS as part of the quarterly and annual reports.

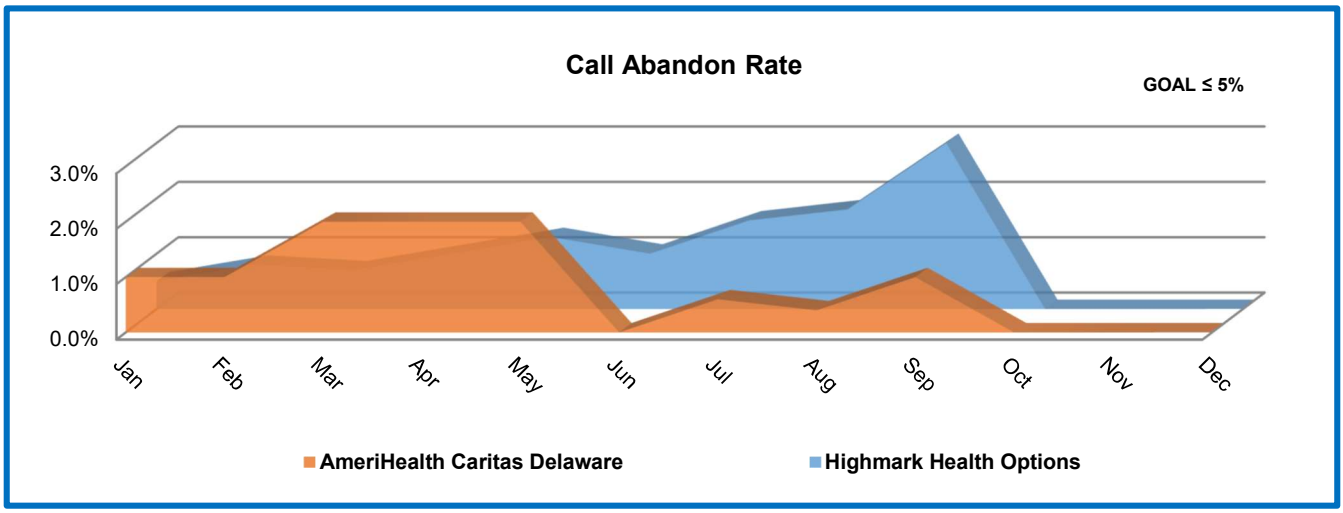
QCMMR Reporting Examples:

Health Risk Assessment (HRA) Completion Rate



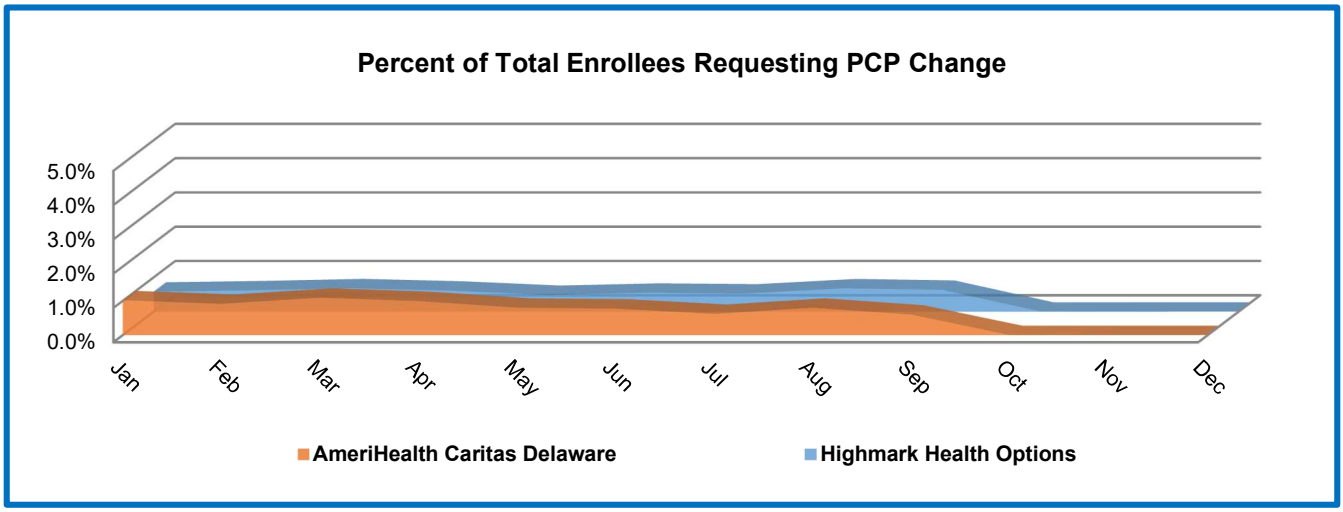
Health risk assessment data are submitted on a 60-day lag.

Customer Service: Call Abandon Rate



Both MCOs met the goal for call abandon rate during Q3.

Percent of Enrollees Requesting a Change in Primary-Care Provider



Access in Q2 and Q3 – The MCOs report in alternating quarters on this metric. For Q2, the reporting MCO met scored 100% on 20 of the 20 access areas measured. In Q3, the reporting MCO's scores ranged between 75% and 100% on the 20 access areas measured. The lowest percentages were in the area of routine pediatric specialty care provider access and non-emergency behavioral health access.

For DSHP Plus, the monthly average number of providers for Home and Community-Based Services (HCBS) are similar in Q3.

Q3 Grievances – For DSHP, there were 401 grievances, up from 309 in Q2. The breakdown across areas is described below:

- Access and availability: 45
- Benefits: 6
- Billing and/or claims: 124
- Cultural competency: 3
- MCO staff issue: 20
- Quality of care: 60
- Quality of service: 110
- Transportation to medical appointment: 18
- Other: 15

For DSHP Plus, there were 125 grievances for Q3, down from 143 in Q2. The breakdown across areas is described below:

- Access and availability: 13
- Benefits: 2
- Billing and/or claims: 9
- Cultural competency: 0
- MCO staff issue: 6
- Quality of care: 31
- Quality of service: 36
- Transportation to medical appointment: 18
- Other: 10

The combined case management (HCBS and institutional experience) grievances totaled 68.

Q3 Appeals – For DSHP, medical and behavioral health appeals are documented in the month in which they are filed, and any appeals resolved are marked within the month they are resolved. One MCO reported 85 appeals and the second MCO reported 47 appeals. The number of appeals withdrawn and overturned are higher than those upheld for both MCOs.

Dental appeals are documented in the month in which they are filed, and any appeals resolved are marked within the month in which they have been resolved. One MCO reported 9 dental grievances and 1 dental appeal, while the second MCO reported 8 dental grievances and 1 dental appeal.

Pharmacy appeals are documented in the month in which they are filed, and any appeals resolved are marked within the month in which they have been resolved. One MCO reported 16 pharmacy grievances and 34 pharmacy appeals, while the second MCO reported 71 pharmacy grievances and 78 pharmacy appeals.

For DSHP Plus, medical, and behavioral health appeals are documented in the month in which they are filed, and any appeals resolved should be reported within the month in which they have been resolved. The overall number of appeals is low, with one MCO reporting 11 appeals during Q3 and the second MCO reporting 18 appeals.

Dental appeals are documented in the month in which they are filed, and any appeals resolved are marked within the month in which they have been resolved. One MCO reported zero dental grievances or dental appeals, while the second MCO reported 2 dental grievances and zero dental appeals.

Pharmacy appeals are documented in the month in which they are filed, and any appeals resolved are marked within the month in which they have been resolved. One MCO reported zero pharmacy grievances and one pharmacy appeal, while the second MCO reported 13 pharmacy grievances and 11 pharmacy appeals.

Q3 Critical Incident Reporting – For Q3 there were 34 total critical incidents (CIs), down from 42 in Q2. The distribution of CIs heavily concentrates on HCBS versus institutional services. Listed below are the categories for CIs for Q3:

- Unexpected deaths: 8
- Physical, mental, sexual abuse or neglect: 12
- Theft or exploitation: 7
- Severe injury: 4
- Medication error: 0
- Unprofessional provider: 3

2022 Q3 External Quality Review (EQR) Reporting

The EQRO summarized the work of the June MCO onsite reviews and began preparing for the Q4 MCO readiness reviews.

Demonstration Evaluation

During Q3, the independent evaluator continued work to finalize the draft Interim Evaluation report for DMMA's review in October 2022.

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