



DELAWARE HEALTH AND SOCIAL SERVICES

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# Diamond State Health Plan

## Section 1115 2021 2<sup>nd</sup> Quarterly Report

Demonstration Year: 26 (1/1/2021 – 12/31/2021)

Federal Fiscal Quarter: 2/2021 (4/1/2021 – 6/30/2021)

*August 31, 2021*

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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 include those receiving services under the Money Follows the Person demonstration;
- (2) individuals who would previously have been enrolled through 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.

In 2020 and 2021, Delaware submitted waiver amendment requests to provide HCBS flexibility during the COVID-19 PHE.

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 second quarter report (for the quarter ending June 30, 2021), Demonstration Year 26.

## Enrollment Information and Enrollment Counts

### Q2 2021 Enrollment

Demonstration Populations	Current Enrollees (to date)	Disenrolled in Current Quarter
Population 1: Former AFDC Children less than 21 (DSHP TANF Children)	98,871	4
Population 2: Former AFDC Adults aged 21 and over (DSHP TANF Adult)	36,374	14
Population 3: Disabled Children less than 21 (DSHP SSI Children)	5,723	2
Population 4: Aged and Disabled Adults 21 and older (DSHP SSI Adults)	6,721	26
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.)	67,588	141
Population 7: Family Planning Expansion (FP Expansion)	None; program terminated in 2013	N/A
Population 8: DSHP-Plus State Plan	10,093	82
Population 9: DSHP-Plus HCBS	5,789	77
Population 10: DSHP TEFRA-Like	301	0
Population 11: Newly Eligible Group	12,850	9
Population 12: PROMISE	1,482	99
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, 2021 to June 30, 2021 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

### Q2 MCO and State Outreach Events, Special Topic Meetings and Workgroups

Continued the Expansion of Home-Delivered Meals in Q2 – 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 – Below are examples of outreach conducted during Q2 by DMMA’s MCO partners.

- Highmark Health Options (HHO) Outreach Events

HHO held two Member Advisory Committee meetings in the second quarter. These meetings provide an opportunity for members to provide feedback that enables HHO to educate and better serve their members.

#### AmeriHealth Caritas Outreach Events

AmeriHealth Caritas DE held many virtual Zoom New Member Orientations during the second quarter of 2021. The virtual events are monthly and enable new members to learn about their medical benefits and the many community resources available to them.

In June AmeriHealth Caritas also participated in two community health fairs and health information to several of their members.

### Q2 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 three monthly calls this quarter: April 13<sup>th</sup>, May 11, and June 8, 2021. DMMA stays in regular contact with Delaware Family Voices outside of scheduled calls to assist any Medicaid family in need.

Maternal Child Health – DMMA continues to prioritize Maternal Child Health outcomes. In April, DMMA requested the External Quality Review organization to conduct a Maternal Health Focus study. The purpose of this focus study is to evaluate if pregnant members are receiving evidence-based standards of care coordination. Expected completion of this focus study is September 2021.

In June, DMMA began an internal Maternal Child Health Workgroup to examine maternal child health specific policies. The workgroup is meeting to explore the current breast pump policy, postpartum expansion coverage, and financing of evidence-based home visiting.

DMMA's Maternal Child Health Clinical lead continues to engage with other stakeholders through collaboration with continued involvement in the Delaware Perinatal Quality Collaborative (DPQC), Maternal Mortality Review (MMR), Fetal and Infant Mortality Review (FIMR), and several workgroups under the Delaware Healthy Mothers and Infants Consortium (DHMIC). DMMA continues to collaborate the DE Public Health, Maternal Child Health team through monthly meetings.

#### Post-award Public Forum

The next post-award public forum will be scheduled for August 2021 MCAC meeting.

### Q2 Innovative Activities

Social Determinants of Health (SDOH) – With the continuation of the Public Health Emergency, DMMA continued to focus on addressing food insecurity in Medicaid which was initiated in previous quarters. The first initiative focused on working with our managed care organizations, MCOs and CMS (through Appendix K authority in the 1115 Waiver) to increase the availability of home-delivered meals to DSHP Plus members receiving HCBS services.

The Postpartum Food Box Partnership program continues to deliver meals to members <8 weeks postpartum who delivered via cesarean section. The program is delivering an average of 150 food boxes per week. DMMA is exploring expanding this program to all postpartum mothers and is currently meeting with partners to develop a plan for expansion.

Medicaid/CHIP Accountable Care Organization Program (Medicaid ACO Program) – DMMA released a second opportunity for organizations to apply to become Medicaid ACOs on March 1, 2021. Applications were due April 23, 2021. DMMA received one application which was approved for participation in the Medicaid managed care program in contract year 2022.



## Operational/Policy Developments/Issues

### Q2 Operational and Policy Issues

#### Policy and Legislative developments

COVID-19 - The Quality Director continues to represent DMMA's Quality Team at the Division of Public Health's COVID-19 Vaccination Task Force Public Meetings.

DMMA continued to focus on the rollout of the COVID-19 vaccine and the associated Medicaid policy and reimbursement decisions necessary to support vaccine administration. DMMA and CMS discussed DMMA's pending SPA for vaccine administration, DMMA developed a non-risk payment approach for MCOs, and posted Medicaid provider information and FAQs to our website.

#### MCO Operational Issues

The MCOs continue their daily outreach to assist members during the COVID-19 crisis, with a strong emphasis on social determinants of health. COVID-19 Response Teams outreached to members identified using the DHIN (the Delaware HIE) analytics, member self-reporting, claims and utilization management. Care coordinators ensure access to care, address social determinants of health concerns, verify participation with Department of Public Health and provide assistance and education on coping during the pandemic. DSHP Plus (LTSS) HCBS members have been provided additional home-delivered meals as needed and additional check-ins are performed by case managers. Members unable to attend adult day or day habilitation programs had additional attendant care services and meals authorized in lieu of on-site services. Behavioral health, including SUD, continues to be a focus for the MCO's, especially the homeless members that are residing in hotels.

#### DSHP 1115 Waiver Administration

DMMA received approval of the 1115 and SUD Evaluation Design Plans and Monitoring Plans in April 2021.

#### Other Program Issues

Support Act Grant – DMMA was awarded a \$3.58 million planning grant from CMS to assess and expand our capacity to treat substance use disorder (SUD) in Medicaid. After a supplemental award in March 2021, the total grant award is now \$3.67 million. During this period, the SUPPORT Act Planning Grant Core Team continued to meet regularly and participated in regular telephone calls with our CMS project officer and other relevant staff. Other significant achievements include the continued implementation of our Office Based Opioid Treatment (OBOT) fellowship, finalization of our inventory of current SUD rates and payment methodologies, completion our OUD/SUD prevalence study, and completion of our SUD treatment system gaps and capacity analysis.

Electronic Visit Verification – Delaware continued working toward implementation of EVV.

Program Integrity - The second quarter of 2021 has been a busy time for the Program Integrity section. Former Program Integrity Chief Bill McGonegal retired as of April 1, 2021. Former Medicaid Surveillance Administrator for the SUR unit, Ted Robinson was named Program Integrity Chief in May. This promotion set in motion several staffing changes within the SUR unit. In June, Ethel Belfon was hired to replace Ted as Medicaid Surveillance Administrator. The SUR unit is actively working to fill several positions within the unit including Social Service Administrator, Nurse Reviewer, as well as the lead Data Analyst position.

Amidst all the staffing changes, the SUR unit began post payment reviews of Chiropractic Services in the Delaware Medicaid program. The focus of the reviews is policy compliance and medical necessity. The chiropractic reviews will be the SUR unit's first time reviewing MCO encounter claims. In the past, the efforts had been concentrated on fee for service claims only. The SUR unit is excited about the new endeavor and looks forward to working the MCOs to reduce fraud, waste, and abuse in the Delaware Medicaid Program.

The SUR unit continues to collaborate with Amerihealth Caritas, Highmark Health Options, Motiv Care (NEMT contractor), and the Medicaid Fraud Control Unit meeting both monthly and quarterly to discuss trends in fraud, waste, and abuse, as well as preventive measures. The meetings have been productive and provide opportunities to strengthen communication and provide educational opportunities to all participants.

The Program Integrity section continues to work closely with SafeGuard Services LLC (NE UPIC contractor) to identify areas within the Delaware Medicaid program which may be vulnerable to fraud, waste or abuse. Recent efforts have centered around genetic testing. Initial results showed little to no findings in the areas of duplicate billing for the same recipient. SGS will continue reviewing the top billing providers for medical necessity and policy compliance.

The SUR unit continues to dedicate a significant portion of its time overseeing the RY22 PERM audit. To date, all required data has been submitted to the PERM contractors. Initial results from the Q1 data have been positive so far. SUR will continue to work with the various PERM contractors to provide any additional data and to answer any questions that arise throughout the PERM cycle.

## Expenditure Containment Initiatives

### Q2 Expenditure Containment Initiatives

Medicaid/CHIP Accountable Care Organization Program (Medicaid ACO Program) –DMMA, under the direction of DHSS, developed a Medicaid ACO Program for the purpose of improving health outcomes while reducing costs through value based purchasing (VBP) arrangements which include downside financial risk for ACOs. The Medicaid ACO program is part of the strategies DMMA is pursuing to advance the adoption of participating Medicaid VBP models and total cost of care (TCOC) strategies.

DMMA developed an application to allow qualified provider organizations to apply to become Medicaid ACOs and subsequently contract directly with our Medicaid MCOs in a TCOC payment arrangement. DMMA believes that by working together, Medicaid ACOs and MCOs can better coordinate care for Delaware's Medicaid and CHIP members, providing better health outcomes and lower costs.

DMMA released a second opportunity for organizations to apply to become Medicaid ACOs on March 1, 2021. Applications were due April 23, 2021. DMMA received one application which was approved for participation in the Medicaid managed care program in contract year 2022.

DMMA is currently reviewing MCO/ACO provider contracts to ensure that the program implementation aligns with the ACO program as designed and described in the DMMA application.

## Financial/Budget Neutrality Development/Issues

### Q2 Financial/Budget Neutrality/Issues

DMMA continued to work on preparing documentation, by quarter by demonstration year, to discuss potential adjustments with CMS for discussions to begin in September 2021.

#### Member Month Reporting and With-Waiver PMPMs

### Q2 2021 Member Month Reporting and With-Waiver PMPMs

Eligibility Group	April 2021 Member Months	May 2021 Member Months	June 2021 Member Months	Quarter ending 6/30/2021
DSHP TANF CHILDREN	96,780	97,463	97,830	292,073
DSHP TANF ADULT	35,047	35,508	35,793	106,348
DSHP SSI CHILDREN	5,579	5,586	5,586	16,751
DSHP SSI ADULTS	6,557	6,542	6,521	19,620
DSHP MCHP (Title XIX match)*	0	0	0	0
DSHP ADULT GROUP	77,306	77,992	78,562	233,860
DSHP-Plus State Plan	9,853	9,857	9,868	29,578
DSHP-Plus HCBS	5,602	5,617	5,684	16,903
DSHP TEFRA-Like**	294	294	294	882
PROMISE	1,483	1,465	1,427	4,375

\* 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)

## Q2 2021 Member Months and WW PMPMs

Eligibility Group	Total Member Months for the Quarter	PMPM	Total Expenditures
DSHP TANF CHILDREN	292,073	\$374.13	\$109,273,824
DSHP TANF ADULT	106,348	\$619.19	\$65,849,279
DSHP SSI CHILDREN	16,751	\$1,674.36	\$28,047,223
DSHP SSI ADULTS	19,620	\$1,404.91	\$27,564,366
DSHP MCHP (Title XIX match)*	0	\$0.00	0
DSHP ADULT GROUP	233,860	\$788.40	\$184,375,175
DSHP-Plus State Plan	29,578	\$1,856.39	\$54,908,406
DSHP-Plus HCBS	16,903	\$6,179.29	\$104,448,533
DSHP TEFRA-Like**	882	\$1,673.66	\$1,476,170
PROMISE	4,375	\$242.53	\$1,061,075

\* 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)

## Consumer Issues

### Q2 Consumer Issues

There were no notable complaints or problems consumers identified about the program in the current quarter.

HBM (Enrollment Broker) Update –Automated Health System, AHS, our Health Benefits Manager, continues to assist our members with health information questions regarding the two managed care organizations, Highmark Health Options and AmeriHealth Caritas DE.

Second quarter activities were a continuation of operations. A total of 10,260 calls were received, with an average of 3,422 per month. Enrollments totaled 1,071 and transfers totaled 58. Mailings continued

for the program, totaling 16,969. Customer Surveys began in January to ensure quality and satisfaction. The program is preparing materials for open enrollment, with the high-level schedule completed in June.

Children with Medical Complexity Advisory Council – The Children with Medical Complexity Advisory Council (Advisory Council) continues to hold meetings remotely due to the COVID-19 Public Health Emergency. The 2<sup>nd</sup> Quarter Advisory Council meeting convened on April 12, 2021. The Advisory Council agreed through consensus to form a new workgroup to help implement the 2021 priorities of the Children with Medical Complexity (CMC) Advisory Committee related to durable medical equipment (DME) and supplies (e.g., pharmacy supplies, enteral feeding solutions, wound care supplies, etc.). The DME & Supplies Workgroup kickoff meeting convened on May 25, 2021. The workgroup has been meeting remotely every two weeks to identify ways to streamline, simplify, and make transparent the prior authorization process for children with medical complexity as it relates to DME and supplies and ensure adequate availability of resources. The Data Workgroup continues to remain on hiatus until further notice from the Advisory Council. The Skilled Home Health Nursing Workgroup, in lieu of the Data Workgroup’s hiatus, monitors the progression of the Family Satisfaction Survey. The Family Satisfaction Survey was completed this quarter; and the research team is in the process of compiling the data. The Skilled Home Health Nursing Workgroup also oversees the progression of the Private Duty Nursing Workforce Capacity Study and anticipates completion of the Study at the end of July 2021. The Skilled Home Health Workgroup continues to work with both MCOs on finalizing the “What to Expect” and Welcome Letters.

## Quality Assurance/Monitoring Activity

### Q2 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.

QII Activity – During Q2:

- Over the course of the quarter, an internal workgroup has been meeting weekly to maintain momentum.
- DMMA actively participated in multiple opportunities for technical assistance and cross-state learning with CMS, Mathematica and AcademyHealth, including:
  - CMS QTAG: April 21, 2021 – State experiences stratifying Quality Measures by Race and Ethnicity
  - MAC QX: April 22, 2021 – Obtaining Medicare Data for Quality Measurement and Care Coordination for Dually Eligible Beneficiaries
  - CMS QTAG: May 19, 2021 – Medicaid and CHIP Quality Improvement Initiatives
  - MAC QX: May 27, 2021 - Preparing for Mandatory Reporting: State Experiences with the Developmental Screening (DEV-CH) Measure in the Child Core Set
  - CMS QTAG: June 16, 2021 - Co-Designing a Medicaid and CHIP Quality Improvement Learning System
  - MAC QX: June 24, 2021 - State Perspectives on Quality Measurement Using Electronic Clinical Data Systems (ECDS)

The Quality Improvement Initiative (QII) Task Force held the quarterly meeting on April 22<sup>nd</sup>, 2021. DMMA invited Kim Petrella of the Delaware Perinatal Quality Collaborative (DPQC) to present on the DPQC and its experience with collaboration and best practices. The guest presentation included:

- What is the DPQC and its membership?
- How the DPQC measures its objectives and reporting them.
  - How the DPQC collects its data.
  - Who the data is reported to.
- Lessons learned from experiences
- Benefits of Collaboration
- An interactive Question and Answer session with the MCOs and the presenter.

Case Management Oversight - Due to the COVID-19 PHE, MCO case management was primarily provided telephonically since March 2020. In Q2 2021, due to State of Delaware lifting restrictions, The MCO resumed face to face visits. The MCOs submit weekly telephonic case management files for the DMMA clinical staff to review. DMMA clinical staff reviewed approximately 477 telephonic/virtual reviews in Q2 2021 which is a combination of care coordination and LTSS case management. DMMA communicates with the MCOs areas of concern or need for improvement that our oversight team finds.

In Q2 2021, DMMA's oversight team completed Q1 case file reviews with each MCO virtually. DMMA staff reviewed approximately 100 random files to review for contractual compliance by MCO's in areas of Care Coordination, Case Management and Nursing Facility Transitions. DMMA reviews the findings with each MCO's and discusses areas needing improvement in Care Coordination and LTSS Case Management for our Medicaid population.



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. We are resuming Bi-monthly MCO meetings in third quarter of 2021.

Incident Management System - DMMA continued the review and development of the work plan to operationalize improvement recommendations for the incident management system process for DSHP and DSHP-Plus. Internal meetings were initiated in the previous quarter to begin this work plan review and to best address these recommendations, DMMA has implemented some necessary changes to address the current process. The Quality unit continues to intake, track and facilitate the reporting of critical incidents into the department using the current technology solutions.

DMMA continues to look for a software/database solution which will allow the department to address recommendations and improvements identified after reviewing the current process and system being utilized. One of the primary goals of updating the technology being used is to improve reporting capabilities and to better align DMMA systems with our sister agencies. One of the central focuses is to improve reporting capabilities and align DMMA systems with our sister agencies in DHSS. Work with a vendor continues and the development of processes that align with any new solution will occur concurrently with any changes in the software solution being utilized.

## Managed Care Reporting Requirements

### Q2 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.

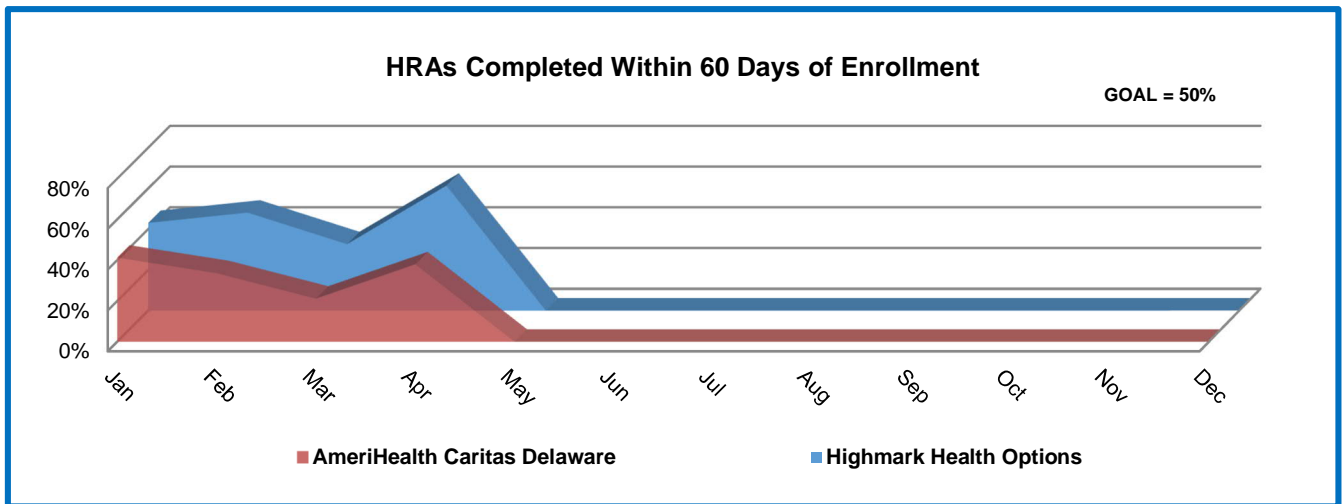
DMMA Managed Care Operations unit developed the full circle approach to the QCMMR and QCMMR Plus reporting. The reports are reviewed by the Managed Care Operations team and an agenda is developed for our monthly meeting with each MCO to discuss the findings from the reports. Managed Care Operation's 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.

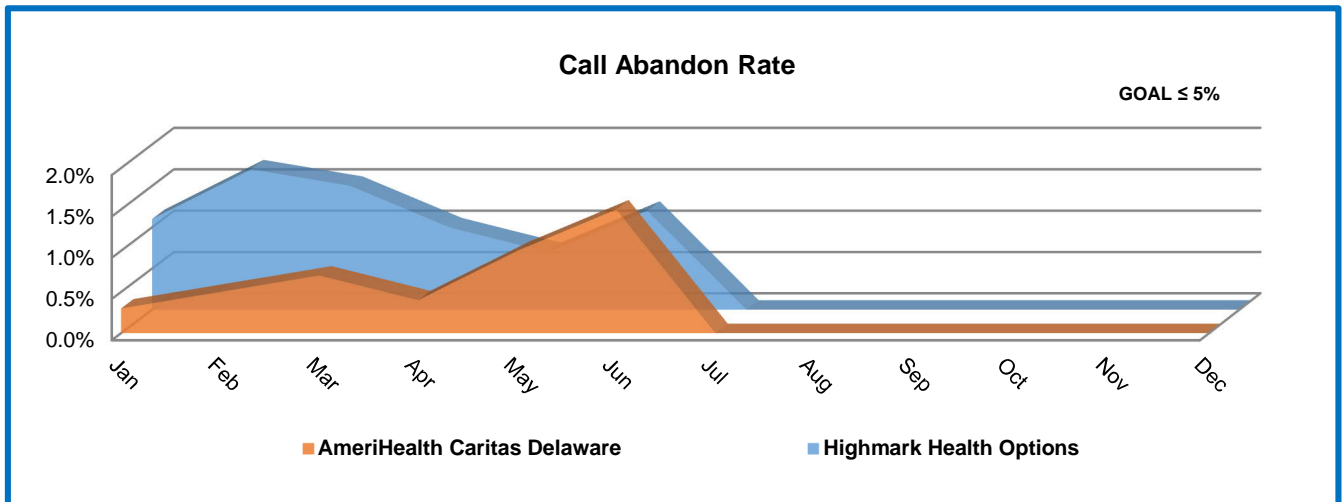
QCMMR Reporting Examples:

*Health Risk Assessment (HRA) Completion Rate*



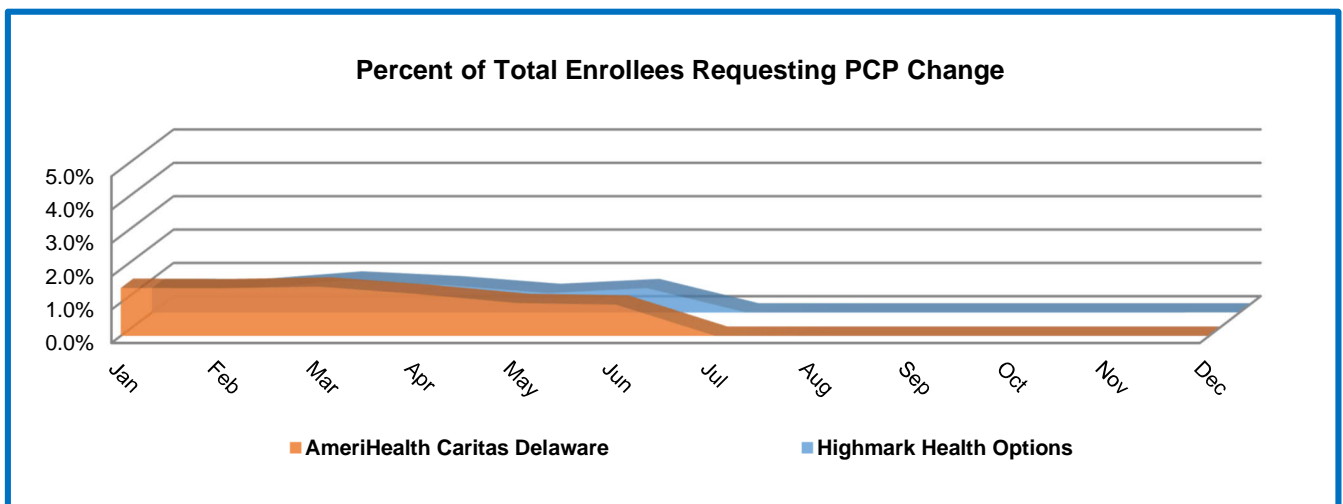
HRAs serve as a key to identifying and engaging members in need of services early in their experience with an MCO. The MCOs are contractually required to complete HRAs with at least 50% of their newly enrolled members within 60 days of enrollment. Neither of the MCOs has met the goal of completing health risk assessments for at least 50% of new Medicaid enrollees within 60 days of enrollment. Both MCOs submitted January, February and March data, with ACDE reporting an average rate of 32% completion and HHO reporting an average rate of 41% completion. This is an increase from the 2020 Q4 average of a 23% completion rate reported by ACDE and a 34% completion rate reported by HHO. DMMA has placed each MCO on a corrective action plan (CAP), which requires incremental increases as a way of working toward contractual goals.

*Customer Service: Call Abandon Rate*



Both MCOs met the goal for call abandon rate during Q2.

*Percent of Enrollees Requesting a Change in Primary-Care Provider*



Both MCOs had similar percentages of PCP change requests during the second quarter.

Access in Q2 –Q2 findings are consistent with Q1 provider numbers.

Q2 Grievances – For DSHP, there were 247 grievances, up from 210 grievances in Q1. The breakdown across areas is described below:

- Access and availability: 27
- Benefits: 4
- Billing and/or claims: 41
- Cultural competency: 2
- MCO staff issue: 7
- Quality of care: 47
- Quality of service: 85
- Transportation to medical appointment: 19
- Other: 15

For DSHP Plus, there were 108 grievances for Q2, up from 71 in Q1. The breakdown across areas is described below:

- Access and availability: 9
- Benefits: 0
- Billing and/or claims: 11
- Cultural competency: 0
- MCO staff issue: 8
- Quality of care: 27
- Quality of service: 30
- Transportation to medical appointment: 8
- Other: 8
- Case management HCBS and institutional experience: 46

Q2 Appeals - Appeals are documented in the month in which they are filed, and any appeals resolved are marked within the month they are resolved. Both MCOs reported a higher number of appeals in Q2 (152) compared to Q1. The number of appeals upheld were higher than those withdrawn and overturned for one MCO while the number of appeals withdrawn and overturned were higher than those upheld for the other MCO.

For DSHP Plus, the overall number of appeals is low. One MCO reported two appeals during Q2, one of which was withdrawn (50%) and one was overturned prior to appeals committee (50%); The second MCO reported six appeals, four of which were overturned prior to appeals committee (67%), one of which were overturned at appeals committee (17%) and one was withdrawn (17%).

Dental appeals are documented in the month in which they are filed, and any appeals resolved are marked within the month are resolved. There were 14 grievances and 4 dental appeals (3, after one was withdrawn). The number of dental appeals upheld were higher than those withdrawn or overturned.

There was one dental appeal for ere no dental appeals for DSHP Plus that has been carried over into

Q3.

Pharmacy appeals in DSHP are documented in the month in which they are filed, and any appeals resolved are marked within the month they are resolved. There were 82 pharmacy grievances and 126 pharmacy appeals. The number of pharmacy appeals overturned and withdrawn for both MCOs are higher than those upheld.

Pharmacy appeals in DSHP Plus are documented in the month in which they are filed, and any appeals resolved are marked within the month they are resolved. The overall number of appeals is low. One MCO reported one pharmacy appeal during Q2, one of which was upheld (100%). The other MCO reported eight pharmacy appeals, three of which were overturned at appeals committee (38%), three were denied (38%), one was withdrawn (13%) and one was upheld (13%).

Q2 Critical Incident Reporting – For Q2, there were 26 total critical incidents (CIs), up from 22 in Q1. The distribution of CIs heavily concentrates on HCBS versus institutional services. Listed below are the categories for CIs for Q2:

- Unexpected deaths: 2
- Physical, mental, sexual abuse or neglect: 14
- Theft or exploitation: 9
- Severe injury: 1
- Medication error: 0
- Unprofessional provider: 0

## Q2 External Quality Review (EQR) Reporting

- The 2020 annual EQRO report was finalized on April 1, 2021.

## Demonstration Evaluation

### Q2 Demonstration Evaluation Activities

#### Q2 Demonstration Evaluation Activities

CMS approved the 1115 Evaluation Design and SUD Monitoring Protocols on April 2, 2021.

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