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Diamond State Health Plan

Section 1115 CY 2020 3rd Quarterly Report

Demonstration Year 25 (1/1/2020 – 12/31/2020)

Federal Fiscal Quarter 3 - 2020: 07/01/2020 – 09/30/2020

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Table of Contents

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 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'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; and
- 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.

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 ending September 30, 2020, Demonstration Years 25.

Q3 Enrollment

Demonstration Populations	Current Enrollees (to date)	Disenrolled in Current Quarter
Population 1: Former AFDC Children less than 21 (DSHP TANF Children)	91,448	5
Population 2: Former AFDC Adults aged 21and over (DSHP TANF Adult)	32,595	10
Population 3: Disabled Children less than 21 (DSHP SSI Children)	5,642	4
Population 4: Aged and Disabled Adults 21 and older (DSHP SSI Adults)	6,752	24
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: DSHP Adult Group	70,909	112
Population 7: DSHP-Plus State Plan	9,990	132
Population 8: DSHP-Plus HCBS	5,588	92
Population 9: DSHP TEFRA-Like	297	0
Population 10: PROMISE	1,435	60
Population 11: 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 July to September 30, 2020 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.

Q3 Outreach and Innovative Activities

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

MCO Outreach

Due to the COVID-19 Public Health Emergency (PHE), our MCOs suspended in-person outreach. Both MCOs increased their website information to include COVID-19 information, especially telehealth information and community resources. DMMA is in the process of establishing telephone-only telehealth coverage for certain behavioral health services. The MCO Care Coordinators and Case Managers increased their telephonic outreach to their members.

Special Interest Meetings/Conferences

Maternal Mortality (MM) Innovation Accelerator Program (IAP)—The CMS-sponsored IAP on using data to reduce maternal mortality and severe maternal morbidity concluded with a national webinar on Sept. 15th. Dr. Elizabeth Brown, DMMA CMO, presented on Delaware's experience and our progress toward sharing DMMA data to supplement the clinical information available during maternal mortality reviews.

Delaware Family Voices - DE Medicaid 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 11 and September 8, 2020. DMMA stays in regular contact with Delaware Family Voices outside of scheduled calls to assist any Medicaid family in need.

Q3 Innovative Activities

Medicaid/CHIP Accountable Care Organization Program (Medicaid ACO Program) - DMMA, under the direction of DHSS, is developing 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. The applications were due by May 15, 2020, but due to the ongoing COVID-19 response and related activities, DMMA extended the due date to Tuesday, June 30, 2020. The State received five applications from interested ACO entities. After review and evaluation, DMMA approved four Medicaid ACOs. On September 22, DHSS released a public announcement of the four authorized Medicaid ACOs. Upon announcement, the ACOs are now authorized to negotiate and enter into agreements directly with the state's two Medicaid managed care organizations (MCOs) – AmeriHealth Caritas Delaware and Highmark Health Options. The MCO/ACO contracts will begin July 1, 2021. The inaugural group of Medicaid ACOs are authorized through December 31, 2024.

Q3 Operational and Policy Issues

CMS System Funding Requests -Promoting Interoperability (PI) Program and DSAMH Health Information Exchange Initiatives - On August 31, 2020, DMMA submitted an Implementation Advanced Planning Document Update (IAPD-U) to request enhanced funding through the Health Information Technology for Clinical and Economic Health (HITECH) Act for FFY 2021 and 2022. This supports the ongoing Promoting Interoperability (PI) Program which provides incentives to Medicaid providers to implement Electronic Health Record (EHR) systems.

COVID-19 Impacts

The federal COVID PHE and the Governor's State of Emergency declaration were extended through Q3. During the PHE, DMMA has taken actions that included, but were not limited to:

- Securing additional Federal authority flexibilities available under the PHE, including 1135 requests, Appendix K requests, Disaster SPA requests, and amendments to the DSHP 1115 Waiver;
- Waiving pharmacy copayments;
- Increasing support for telehealth;
- Assessing needs associated with food insecurity;
- Working with nursing facilities to better understand the impact of COVID-19 on these facilities and their needs;
- Extending prior authorization requests;
- Developing provider retainer payment policies;
- Implementing COVID-19 testing codes; and
- Monitoring the impact on NEMT.

Expansion of HCBS Home-Delivered Meals - In order to address food insecurity exacerbated by the COVID pandemic, DMMA and the DSHP Plus MCOs have increased the number of home-

delivered meals available to vulnerable elders served in our home and community-based services program.

Policy and Legislative developments

Medicaid Adult Dental Benefit – DMMA prepared for the successful go-live on October 1, 2020 of the new adult dental benefit. On September 2, DMMA received CMS approval from CMS for our SPA to expand coverage for adults to include a dental benefit. On September 21, 2020, DMMA and our EQRO conducted readiness reviews of the two DSHP MCOs to assure they are ready to provide this new adult benefit to our members.

MCO Operational Issues

The MCOs continue their daily outreach to assist members during the COVID-19 crisis, with a strong emphasis on social determents of health. COVID-19 Response Teams outreach positive members identified using the DHIN (the Delaware HIE) analytics, member self-reporting, claims and utilization management. Care coordinators ensure access to care, address social determents 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. DMMA Managed Care Operations is facilitating weekly meetings with DSAMH and the MCOs to ensure safe transition and continued coordination of behavioral health.

Telehealth was a collaborative effort with DMMA and both MCOs to assure we were all in alignment on the telehealth codes and payments and our expectations. The MCOs closely monitored telehealth activity to assure providers continued seeing our members and provided quality care. The MCOs were also able to see which providers might need education on the possibility of telehealth.

The MCOs also noted that members were not following through with requests for appeals, due to the requirement for hardcopy/written signature after a verbal request. As a result, DMMA has sought additional relief under the DSHP 1115 waiver to address this operational issue. With the recent publication of the 2020 Medicaid managed care final rule, DMMA no longer requires 1115 authority to address this issue with signed appeals.

DSHP 1115 Waiver Administration

- Q3 2020 Budget Neutrality Report – This report is delayed due to a related issue with the CMS-64 expenditure reporting, including the Schedule C report. DMMA is requesting an

extension for the expenditure reporting and the budget neutrality reporting in order to give DMMA and CMS time to resolve these issues.

- Substance Use Disorder (SUD) Amendment – DMMA continued working on the SUD Monitoring Protocol, Draft Evaluation Design and HIT Plan.

- Electronic Visit Verification (EVV)

  DMMA was granted a good faith extension by CMS on November 25, 2019 to start both personal care services and home health services by January 1, 2021. DMMA is in the latter stage of development of this project. We are working with external stakeholders, MCO's, system vendor and FISERV (First Data) to ensure readiness by January 1, 2021. We have monthly steering committee meetings, bi-weekly provider forums and weekly MCO meetings to ensure compliance. Testing and training are slated for October and November.

Other 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. These funds will support an examination of our reimbursement system for SUD treatment providers, additional data analytic capacity to track SUD in the Medicaid population, and training for outpatient providers to increase the number of providers treating SUD.

  During the third quarter of 2020, the SUPPORT Act Planning Grant Core Team continued to meet twice a month. The team participated in monthly telephone calls with their CMS project officer and other relevant staff. The Core Team also executed two contracts with vendors for staff roles and deliverables. Other significant achievements include the completion of the structured review of surveys and reports on Delaware's SUD treatment system, the convening of six virtual stakeholder listening sessions, and the completion of 30+ stakeholder interviews. The Core Team - in partnership with vendors - also completed reports on Project ECHO and SUD care coordination models and commenced research on Medications for Addiction Treatment incentive models. Finally, the core team made significant progress on an analysis of the adequacy of our SUD-related Medicaid payments and rates.

- Social Determinants of Health - As the COVID-19 crisis remained through Q3, DMMA continued the planning process with the local Food Pantry, Logisticare and the MCOs to deliver food boxes to certain MCO members to address the risk of food insecurity in our Medicaid population. DMMA has made valuable strides towards implementation by convening working sessions with all partners to develop policies, procedures and gaining

necessary input from all partners to be able to deliver food to those in need directly to their door.

Starting in August, DSHP-Plus (HCBS) members began receiving an increased home-delivered meals benefit, allowing them to be able to receive up to two (2) meals per day throughout the course of the public health emergency. Members through one of the DSHP-Plus MCOs received an average 633 additional meals per week since implementation.

Program Integrity - The Surveillance Utilization and Review Unit (SUR) continues to work remotely with limited in-office interactions. The unit resumed its collection efforts beginning July 15, 2020.

The SUR unit continues to work with both MCOs and the MFCU to combat fraud, waste, and abuse in the Delaware Medicaid Program. The unit continues to review policy, data analytics, and nationwide trends.

The training of two new nurse reviewers is ongoing and is progressing very well, considering the challenges of working remotely. Due to an anticipated vacancy, the SUR unit is currently in the process of hiring an Internal Auditor. This position is essential to the function of the unit. Therefore, filling the position is a high priority for the unit.

The SUR unit continues to work closely with contractor IBM Watson to develop the most effective ways to utilize ranking reports to identify provider types to audit. The education provided by IBM Watson continues to be pivotal in assisting the team with creating reports that are efficient and easy for all members of the unit to utilize. The SUR team is currently redesigning its audit process and working with contractor IBM Watson to secure statistician services to assist with sample validation and extrapolation functions.

The partnership with the Unified Program Integrity Contractor (UPIC), Safeguard Services (SGS), continues to be a valuable resource to the SUR team. The UPIC contractor is supporting the SUR unit by performing post-payment claims reviews for Medicaid Credit Balance Reports as well as genetic testing.

The SUR unit continues to use all available resources to meet its goal of eliminating fraud, waste and abuse in Delaware Medicaid.

Q3 Expenditure Containment Initiatives

See description of Medicaid ACOs above.

Q3 Financial/Budget Neutrality/Issues

The Q3 report on budget neutrality is delayed due to a related issue with the CMS-64 expenditure reporting, including the Schedule C report. DMMA is requesting an extension for the expenditure reporting and the budget neutrality reporting in order to give DMMA and CMS time to resolve these issues.

Q3 Member Month Reporting and With-Waiver PMPMs

Q3 2020 Member Months

Eligibility Group	Month 7 July 2020 Member Months	Month 8 Aug 2020 Member Months	Month 9 Sept 2020 Member Months	Total Quarter ending Sept 30, 2020
DSHP TANF CHILDREN	89,171	90,199	90,745	270,115
DSHP TANF ADULT	31,352	31,914	32,167	95,433
DSHP SSI CHILDREN	5,526	5,542	5,558	16,626
DSHP SSI ADULTS	6,598	6,589	6,615	19,802
DSHP MCHP (Title XIX match)*	0	0	0	0
DSHP ADULT GROUP	67,693	68,716	69,389	205,798
DSHP-Plus State Plan	9,813	9,808	9,827	29,448
DSHP-Plus HCBS	5,441	5,475	5,472	16,388
DSHP TEFRA-Like**	291	292	293	876
PROMISE	1,419	1,407	1,384	4,210

* 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 2020 Member Months and WW PMPMs

Eligibility Group	Total Member Months for the Quarter	PMPM	Total Expenditures
DSHP TANF CHILDREN	270,115		
DSHP TANF ADULT	95,433		
DSHP SSI CHILDREN	16,626		
DSHP SSI ADULTS	19,802		
DSHP MCHP (Title XIX match)*	0		
DSHP ADULT GROUP	205,798		
DSHP-Plus State Plan	29,448		
DSHP-Plus HCBS	16,388		
DSHP TEFRA-Like**	876		
PROMISE	4,210		

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

Q3 Consumer Issues

Children with Medical Complexity Advisory Council:-The Children with Medical Complexity Advisory Committee (CMCAC) continues to meet remotely and held its 3rd Quarterly meeting via Zoom on July 15, 2020. The CMCAC is overseeing the work of two research studies, and both research teams, the University of Delaware and Vital Research, joined the July Advisory Committee meeting to give an overview of their projects. Vital Research's study, the Family Satisfaction Survey, began in the 2nd quarter of 2020, and is overarching study of children with medical complexity (CMC) and their families' perspective on health care services in Delaware. The University of Delaware, Center of Disability Studies, gave an overview into their Private Duty Nursing Workforce Capacity Study, which was just beginning at the time of their presentation. This study will delve into the issues CMC and their families face with obtaining private duty nursing services in Delaware. The Data Workgroup met its quarterly goals and is on hiatus until further notice from the CMCAC. The Skilled Home Health Nursing Workgroup continues to meet remotely on a biweekly basis via Zoom.

Medical Care Advisory Committee (MCAC): The MCAC met on July 22, 2020. Issues discussed included: COVID-19 PHE flexibilities and trends, PASRR, the new adult dental benefit, status of EVV implementation, and DMMA's efforts to address food insecurity.

HBM (Enrollment Broker) Highlights: Open Enrollment (OE) activities began in July with the preparation of materials for member mailings. The HBM conducted a 60 day open enrollment telephone notification campaign. They called 109,000 member households informing them OE was starting October 1, 2020. Informational Packets were mailed to all head of households enrolled in a managed care, there were comparison guides and brochures for each plan. A second telephone call campaign was done in September, reminding members about OE.

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.

QII Activity – During Q3:

- DMMA kicked off the comprehensive review and update of our quality strategy with a workgroup meeting on Friday, July 10th. Over the course of the quarter, an internal workgroup has been meeting weekly to maintain momentum. We are on schedule to have a draft ready for public review by March 2021.

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

    - Medicaid Medical Director's Network (MMDN): July 16, 2020, Introduction to Pediatric Quality Measurement Program Learning Collaborative
    - Mathematica: July 17, 2020 NCHS National Data for Core Set Reporting, Delaware 1:1 TA
    - CMS QTAG: July 22, 2020 MAC TA IHI Open School
    - MAC QX: Aug. 27, 2020 Co-Designing a Quality Improvement (QI) Initiative to Improve the Quality of Care and Health Outcomes for Children in Foster Care
    - CMS QTAG Sept 16, 2020: 2021 Child and Adult Core Set Annual Review Stakeholder Workgroup recommendations
    - MAC QX: Sept. 24, 2020 Finding and Lessons Learned from the Medicaid and CHIP State Testing Collaborative. (NOTE: Delaware was one of the 5 pilot states that participated).

The Quality Improvement Initiative (QII) Task Force held the quarterly meeting October 22nd, 2020. During this meeting, DMMA reported on an internal review of the critical incident reporting process; updates to the DMMA quality strategy; and QTAG discussion on recommended core set measure changes. Each MCO presented on their vaccine monitoring strategies and plans for the upcoming influenza season in the context of COVID.

In recognition of the large proportion of maternal and child health care covered by DSHP, DMMA created a Maternal Child Health Clinical Lead nursing position. We began interviewing candidates in July 2020, and had the position filled on September 14, 2020. The MCH Clinical Lead provides DMMA with increased capacity to engage with other stakeholders, including the Delaware Healthy Mothers and Infants Consortium (DHMIC), Delaware Perinatal Quality Collaborative (DPQC), Maternal Mortality Review (MMR), and Fetal and Infant Mortality Review (FIMR). The position will also work directly with the MCO quality teams on MCH initiatives. DMMA participated in the following MCH related meetings this quarter:

- FIMR: July 7, 2020
- DPQC: July 16, 2020; August 20, 2020; September 17, 2020
- MMR: August 3, 2020 (including CDC sponsored training session and MMR Case Review)
- DHMIC: September 9, 2020

Case Management Oversight - Due to the Covid-19 PHE, case management switched to telephonic and began in Mid-March for the Medicaid Managed Care population. The MCO's submit weekly telephonic case management files for the DMMA clinical staff to review and communicate with the MCO's areas of concern or need for improvement. The staff have completed approximately 1160 joint visit reviews which is a combination of care coordination and LTSS. Q1 Quarterly case file reviews took place via zoom meetings with DMMA staff and the MCO's in Aug 2020.

DMMA/MCO Managed Care Meeting - The Bi-Monthly Managed Care meetings are a forum to discuss issues in a collaborative manner. The meeting is used to collaborate on common practices, identify issues, plan resolutions and establish connections to our sister agencies for coordination of care.

DMMA held our July 21, 2020 MCO Bi-Monthly meeting. The topic was Electronic Visit Verification, EVV. DMMA is implementing a new EVV system on January 1, 2021. This was an opportunity for the vendor, Fiserve, to introduce themselves to our MCO team. There was an overview of the EVV system and explained EVV is a federal requirement in the 21st Century Cures Act.

Q3 Managed Care Reporting Requirements

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.

The 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.

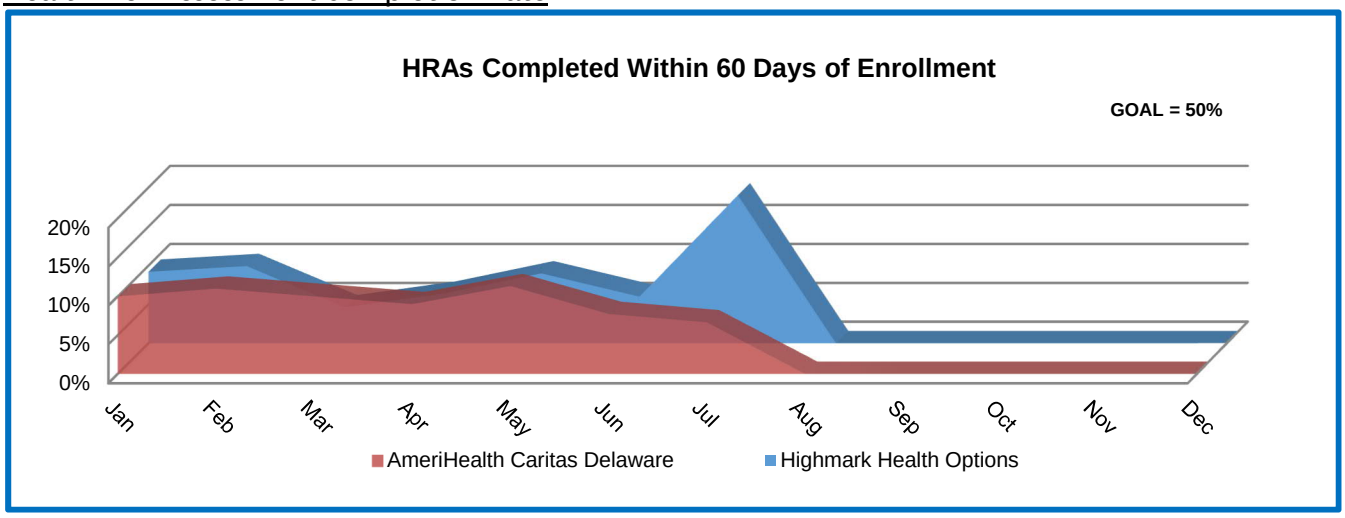
DMMA continues to evaluate the QCMMR reports for both DSHP and DSHP Plus populations. DMMA has been working in conjunction with the MCOs to redefine and modify the reporting template to assure both MCOs are pulling and reporting the same data. Data historically reported to CMS in quarterly reports is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

QCMMR Reporting Examples

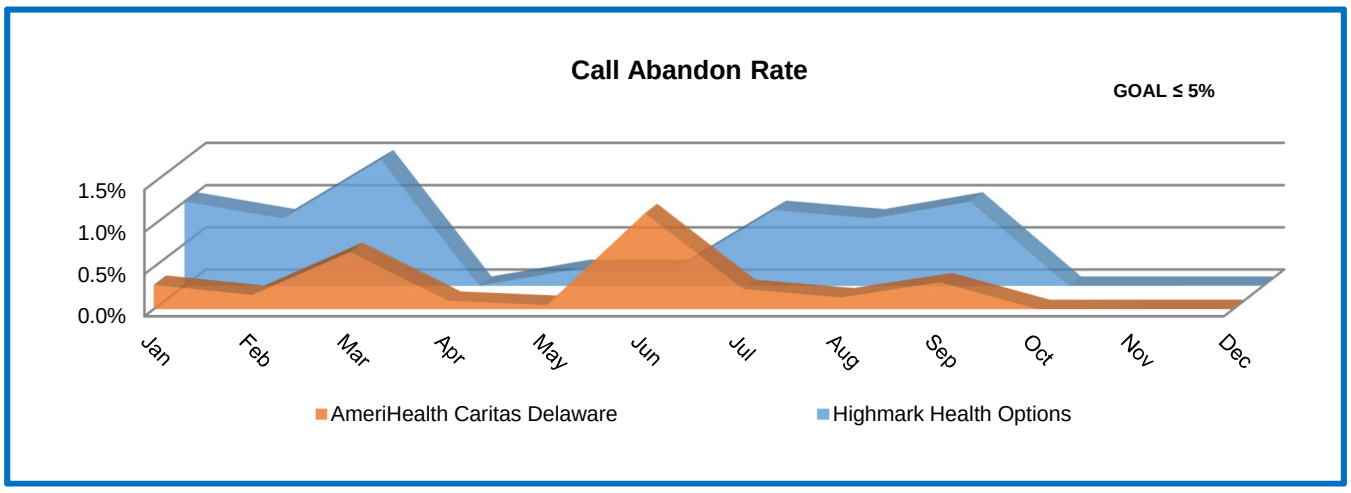
Q3 Health Risk Assessment (HRA) Completion Rate

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. May and June data will be included in the Q3 report. This metric has been a focus of the EQRO review.

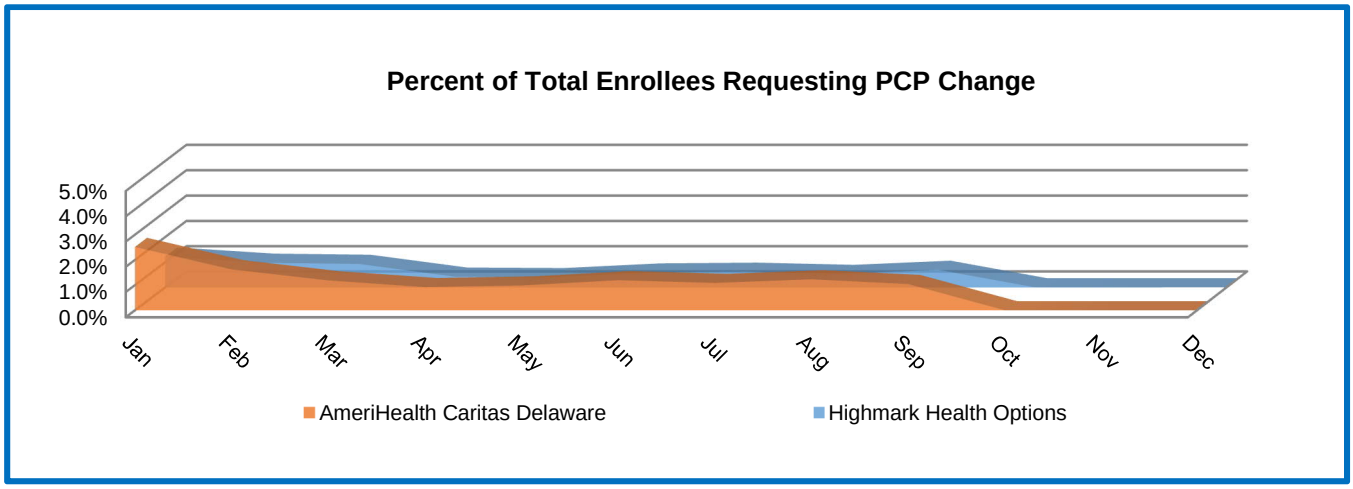
Health Risk Assessment Completion Rate



Q3 Customer Service



Percent of Total Enrollees Requesting PCP Change



Grievances and Appeals in Q3

DSHP Grievances and Appeals

For DSHP, there were 264 grievances (including pharmacy) for Q3 and the distribution across MCOs was an expected result given the differences in membership between the MCOs. The breakdown across areas is described below:

- Access and availability: 24
- Benefits: 8
- Billing and/or claims: 34
- Cultural competency: 0
- MCO staff issue: 5
- Quality of care: 64
- Quality of service: 87
- Transportation to medical appointment: 11
- Pharmacy: 16
- Other: 15

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. The two MCOs reported a total of 138 appeals (non-pharmacy) and 128 appeals (pharmacy). The number of appeals withdrawn and overturned are higher than those upheld.

DSHP Plus Grievances and Appeals

For DSHP Plus, the MCOs reported a total of 73 grievances for Q3, returning to Q1 levels after a significant decline in Q2. Listed below are the categories for grievances:

- Access and availability: 5
- Benefits: 0
- Billing and/or claims: 7
- Cultural competency: 0
- MCO staff issue: 3
- Quality of care: 18
- Quality of service: 12
- Transportation to medical appointment: 9
- Other: 7
- Case management (HCBS and institutional experience): 12

Appeals should be 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 18 appeals during Q3 2020, 12 of which were overturned (67%); and the second MCO reporting 18 appeals, 7of which were overturned (39%).

Critical Incident Reporting in Q3

There were 29 critical incidents reported in Q3, down from 30 in Q2. Listed below are the categories for Q3 critical incidents:

- Unexpected deaths: 1
- Physical, mental, sexual abuse or neglect: 15
- Theft or exploitation: 6
- Severe injury: 4
- Medication error: 1
- Unprofessional provider: 2

Q3 External Quality Review Reporting

Information Systems Capabilities Assessments (ISCA) - Managed Care Operations staff and our External Quality Review organization, Mercer conducted two Information Systems Capabilities Assessment (ISCA) reviews in the last couple of weeks. AmeriHealth Caritas DE was reviewed week of September 15 and Highmark Health Options was reviewed week of September 22. ISCA

reviews are mandated by CMS to assure our managed care organization meet regulatory requirements to process and pay claims correctly, maintain eligibility files of our members, provider data entry, encounter accuracy and transmission of data to the state.

Q3 Demonstration Evaluation Activities

Since the renewal and extension of the DSHP 1115 Waiver in August 2019, Delaware has secured an independent 1115 evaluator and is in the process of finalizing Evaluation Design. Delaware submitted a draft evaluation design on June 1st.

Enclosures/Attachments

None. The SUD Implementation Plan (including the SUD HIT Plan) and Monitoring Protocol have not yet been approved by CMS.

State Contacts

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