DELAWARE HEALTH AND SOCIAL SERVICES

Division of Medicaid & Medical Assistance

OFFICE OF THE DIRECTOR

December 30, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Administrator Brooks-LaSure:

It is my pleasure to present Delaware's Diamond State Health Plan (DSHP) Medicaid Section 1115 Demonstration Waiver extension request to the Centers for Medicare & Medicaid Services for review and approval. Renewal of the DSHP 1115 Waiver continues our long-standing partnership with the federal government to improve the lives of Delawareans, deliver high-quality and comprehensive care to the people and families we serve, and continue to address health inequities experienced by our most vulnerable citizens.

As Delaware finalized the DSHP renewal application, CMS announced several groundbreaking new opportunities for section 1115 Waivers via the approvals in Massachusetts, Oregon, Arizona and Arkansas. These approvals detail significant federal and state investments in health-related social needs that could also greatly benefit Delawareans. We look forward to working with CMS to leverage these new opportunities while securing a timely renewal of our DSHP 1115 Waiver. We look forward to our continued collaboration on the DSHP 1115 Demonstration and Delaware's Medicaid Program.

Sincerely,

DocuSigned by:
[redacted]
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Stephen M. Groff
Director

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December 30, 2022

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Becerra:

I am pleased to present Delaware's Diamond State Health Plan (DSHP) Medicaid Section 1115 Demonstration Waiver renewal request to the Centers for Medicare & Medicaid Services (CMS) for review and approval.

Our focus in the DSHP 1115 Waiver has been on improving the health of low-income Delawareans by expanding access to high-quality healthcare, emphasizing primary and delivery system innovation, and controlling the growth of health care expenditures in Medicaid since 1996. The DSHP 1115 Waiver has enabled Delaware to meet our members' most critical needs by investing in health-related social needs, support individuals who rely on long-term services and supports, and by providing mental health and substance use disorder services. Renewal of the DSHP 1115 Waiver continues our long-standing partnership with the federal government to improve the lives of Delawareans by delivering high-quality and comprehensive care to the people and families we serve and continues to address health inequities experienced by our most vulnerable citizens.

As Delaware finalized the DSHP renewal application, CMS announced several groundbreaking new opportunities for section 1115 Waivers via the approvals in Massachusetts, Oregon, Arizona and Arkansas. These approvals detail significant federal and state investments in health-related social needs that could also greatly benefit Delawareans. We look forward to working with CMS to leverage these new opportunities while securing a timely renewal of our DSHP 1115 Waiver.

We look forward to our continued collaboration on the Diamond State Health Plan to better meet the needs of Delawareans. Thank you for your consideration of this request.

Sincerely,

[redacted]

John C. Carney
Governor

Cc: Stephen Groff
DMMA Director

Delaware Health and Social Services

Delaware Diamond State Health Plan
Section 1115 Demonstration Waiver
Extension Application Request

to

The Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

State of Delaware

Stephen Groff, Director
Division of Medicaid & Medical Assistance (DMMA)

December 30, 2022

Table of Contents

Section I – Introduction

The Delaware Department of Health and Social Services/Division of Medicaid and Medical Assistance (DMMA) is requesting a five-year extension of the current Diamond State Health Plan (DSHP) Section 1115 Demonstration waiver (DSHP 1115 Waiver). The DSHP 1115 Waiver expires on December 31, 2023.

The DSHP 1115 Waiver currently includes most individuals enrolled in Medicaid and Medicaid-expansion CHIP in Delaware and authorizes DMMA to deliver most Medicaid services through managed care. The DSHP 1115 Waiver also authorizes the DSHP Plus managed long-term services and supports program, authorizes expanded behavioral health services in the PROMISE Program, authorizes substance use disorder services in institutions for mental disease settings, and expands eligibility to certain groups, including out-of-state former foster care youth.

With the pending DSHP 1115 waiver amendment and five-year waiver extension, DMMA will continue to build upon Medicaid's success with managed care and value-based payment, improve upon maternal and child health outcomes, address health inequities, expand access to substance use disorder services and invest in additional supports for individuals and families who rely on long term services and supports.

Section II – DSHP 1115 Waiver Program Background, Description, Goals and Objectives

Delaware's DSHP 1115 Demonstration Waiver (DSHP 1115 Waiver) was initially approved in 1995, and implemented on January 1, 1996. The original goal of DSHP 1115 Waiver 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.

Delaware has been successful in achieving these early objectives. The DSHP 1115 Waiver 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. 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 Medicaid expansion under the Affordable Care Act in 2014. The demonstration was previously renewed on June 29, 2000, December 12, 2003, December 21, 2006, January 31, 2011, September 30, 2013, and August 1, 2019 and has remained budget neutral to the federal government. Over the last 27 years, Delaware has demonstrated that the DSHP 1115 Waiver can provide quality physical health, behavioral health, and long-term services and supports through a private and public sector cooperation to a greater number of uninsured or underinsured individuals, and at a lesser or comparable cost than the projected fee-for-service program costs for the

Medicaid eligible population. For additional detail on Delaware's successes in meeting its goals and objectives as well as opportunities for improvement, please see the Interim Evaluation summary results in Section VIII and Attachment B for the full evaluation reports. These evaluation reports are also posted on DMMA's website at https://dhss.delaware.gov/dhss/dmma/medicaid.html.

In 2012, the DSHP 1115 Waiver was amended to add Diamond State Health Plan Plus (DSHP-Plus), Delaware's managed long-term services and supports (MLTSS) program, to help rebalance Delaware's long-term services and supports system in favor of home and community-based services (HCBS). Individuals enrolled in DSHP Plus include: (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 – including 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. As noted in the Interim Evaluation results, Delaware has been successful in our efforts to rebalance our LTSS system in greater favor of HCBS. For example, the proportion of spending between HCBS and institutional care changed from a mix of 25 percent/75 percent in CY 2018 to 35 percent/65 percent in CY 2021. The per member per month (PMPM) expenditures for HCBS among DSHP Plus members also increased 39 percent while the PMPM expenditures for institutional care decreased 16 percent.

In 2013, the DSHP 1115 Waiver 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 Affordable Care Act (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 DSHP 1115 Waiver.

The DSHP 1115 Waiver was later amended at the end of 2014 to add coverage in 2015 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). 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. As noted in the Interim Evaluation results, the creation of PROMISE has begun expanding capacity for increased access to behavioral health HCBS through expanded enrollment and provider networks, but PROMISE has not yet achieved the program's full potential.

A waiver amendment was approved in December 2017 to add coverage for out-of-state former foster care youth. The number of out-of-state former foster care youth was too small for the Interim Evaluation to observe statistically significant results.

On August 1, 2019, the DSHP 1115 waiver was extended for an additional five years and an amendment approved to provide DMMA 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 has not yet met all of the desired outcomes outright but still saw many positive impacts due to the demonstration. As noted in the Interim Evaluation, the PHE likely had a confounding effect in enabling Delaware to fully meet these aims during the demonstration period.

Since 2020, DMMA has amended the DSHP 1115 Waiver for the addition of adult dental services to the DSHP managed care delivery system and secured COVID-19 demonstration amendment authorities focused on HCBS services (e.g., provider retainer payments, expanded home-delivered meals) to address the COVID-19 Public Health Emergency (PHE). DMMA also has an amendment pending with CMS to add home-visiting coverage, a second home-delivered HCBS meal, pediatric respite, a self-directed option for parents of children receiving personal care services, and nursing facility transition services.

Delaware's goal and objectives in operating the DSHP 1115 Waiver into the future continue to be to improve the health status of low-income Delawareans by:

1. Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to home and community-based services (HCBS);
2. Rebalancing Delaware's LTC system in favor of HCBS;
3. Promoting early intervention for individuals with, or at-risk, for having, LTC needs;
4. Increasing coordination of care and supports;
5. Expanding consumer choices;
6. Improving the quality of health services, including LTC services, delivered to all Delawareans;
7. Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTSS services where appropriate;
8. Expanding coverage to additional low-income Delawareans;
9. Improving overall health status and quality of life of individuals enrolled in PROMISE;
10. Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population;
11. Increasing enrollee access to and utilization of appropriate SUD treatment services and decrease use of medically inappropriate and avoidable high-cost emergency and hospital services;
12. Increasing access to dental services, including follow-up care and care for adults with diabetes, and decrease use of emergency department visits for non-traumatic conditions;
13. Improving maternal and infant health outcomes and health disparities (new for renewal period).

Section III – Summary of the Current DSHP 1115 Demonstration

Eligibility – Most Medicaid and Medicaid-expansion CHIP state plan eligibility groups are enrolled in DSHP. The groups described in Table A below are Medicaid eligible, but excluded from enrollment in DSHP.

Table A. DSHP Eligibility Exclusions

Current DSHP Eligibility Exclusions
Individuals participating in a PACE Program
Qualified Medicare Beneficiaries (QMBs)
Specified Low Income Medicare Beneficiary (SLMB)
Qualifying Individuals (QI)
Qualified and Disabled Working Individuals
Individuals in a hospital for 30 consecutive days (acute care)
Presumptive Breast and Cervical Cancer for Uninsured Women
Breast and Cervical Cancer Program for women
Institutionalized individuals in an ICF/MR facility

DSHP also extends eligibility to non-state plan eligibility groups for their receipt of LTSS through DSHP-Plus and adds coverage for out-of-state former foster care youth. These groups are described in detail as "Demonstration Population Expenditures" in the current approved 1115 Demonstration.

Table B. Demonstration-Eligible Groups

Current DSHP Demonstration-Eligible Groups
217-Like Elderly and Disabled Home and Community Based Services (HCBS) Group: Aged and/or disabled categorically needy individuals over age 18 who meet the Nursing Facility LOC criteria in place at the time of HCBS enrollment and receive HCBS as an alternative (formerly served through an Elderly & Physically Disabled 1915c Waiver)
217-Like HIV/AIDS HCBS Group: Individuals with a diagnosis of AIDs or HIV over age 1 who meet the Hospital LOC criteria and who receive HCBS as an alternative (formerly served through an AIDS/HIV 1915c Waiver)
Aged and/or disabled individuals over age 18, who do not meet a NF LOC, but who, in the absence of HCBS, are "at-risk" of institutionalization and meet the "at-risk" for NF LOC criteria in place at the time of enrollment and who need/are receiving HCBS
TEFRA-Like Children (Katie Beckett) using the "at-risk of NF" LOC criteria in place at time of enrollment

Nursing facility residents, who do not currently meet the NF LOC criteria, but continue to meet the NF level of care criteria in place at the time of admission/enrollment.
Individuals receiving HCBS for the disabled and elderly, who do not meet the NF LOC criteria, but continue to meet the LOC criteria in place at the time of enrollment, including HCBS furnished under a terminated 1915(c) waiver.
Disabled children with incomes at or below 250 percent of the SSI, who do not meet the NF or hospital LOC criteria, but continue to meet the LOC criteria in place at the time of their enrollment.

DMMA is proposing to continue the current state plan and 1115 waiver eligibility groups for the DSHP extension.

Benefits – Individuals enrolled in the DSHP 1115 Demonstration receive most Medicaid and CHIP State Plan benefits through the DSHP 1115 Demonstration delivery system. Individuals eligible for DSHP-Plus receive comprehensive, integrated LTSS and individuals eligible for PROMISE receive enhanced behavioral health services in order to live and work in community-based integrated settings. DSHP also provides coverage for high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as IMDs.

DMMA is proposing to continue the current approved state plan and 1115 waiver benefits through the DSHP extension and add new benefit as described in Section IV.

Delivery System – DSHP and DSHP-Plus benefits are delivered through mandatory enrollment in MCOs. A limited number of benefits, such as children's dental and non-emergency transportation, are currently delivered through fee-for-service (FFS). DSHP enrollees receive these benefits through Medicaid fee-for-service, not through the DSHP 1115 Waiver. PROMISE benefits are delivered through the FFS PROMISE program administered through the Division of Substance Abuse and Mental Health (DSAMH).

Table C. FFS Benefits Excluded from the DSHP 1115 Waiver

FFS Benefits (Not currently provided through the DSHP 1115 Waiver)
Dental services for children
NEMT Transportation broker services, except for emergency ambulance transportation
Day services authorized by the Division of Developmental Disabilities Services
Medically necessary behavioral health services for children in excess of MCO plan benefit coverage, which is 30 visits for children
Prescribed pediatric extended care
Targeted case management (TCM)

DMMA is proposing to continue the managed care and FFS delivery systems described in the current DSHP waiver, with the exception of children's dental services. As described in Section IV, DMMA is proposing to include children's dental services through the DSHP MCOs.

Cost Sharing – Cost-sharing does not differ from the approved Medicaid and CHIP State Plans and DMMA is not proposing cost-sharing under the DSHP 1115 Waiver.

Section IV – Changes Under the Demonstration Extension

A. July 2022 Pending Amendment

DMMA has proposed five changes to the DSHP 1115 Waiver pending in an amendment currently under review by CMS for a proposed effective date of January 1, 2023. The changes in this amendment include:

1. Coverage of two models of evidenced-based home visiting for pregnant women and children.

   DMMA has requested authority to include access to home visiting for pregnant women and children through the Nurse Family Partnership (children up to the age of two) and Healthy Families Delaware (up through the child's third birthday) evidenced-based home visiting programs. With this new benefit, DMMA seeks to begin to address racial disparities within the maternal health crisis.

2. Permanent coverage for a second home-delivered meal for members receiving HCBS in DSHP Plus.

   In response to the COVID-19 PHE and the increased risk of food insecurity in our Medicaid DSHP Plus members receiving HCBS, DMMA sought temporary authority through an Appendix K amendment to the DSHP 1115 waiver so that DSHP Plus HCBS members could receive a second home-delivered meal per day. This additional meal has been successful in supporting members to remain in their homes, contributing to Delaware's goals of increasing supports for members needing LTSS and promoting early intervention for individuals with long-term care needs. DMMA has requested authority in the DSHP 1115 Waiver to provide up to two home-delivered meals per day as part of the permanent DSHP Plus benefit package.

3. Coverage of a pediatric respite benefit as an American Rescue Plan Act (ARP) Section 9817 HCBS Spending Plan initiative.

   Families with children with complex medical conditions (CMC), severe emotional disorders and dual diagnoses of MH/IDD face specific challenges in supporting their child within the family unit. In response to a cross section of stakeholders who provided feedback during the American Rescue Plan Act of 2021 Section 9817 HCBS Spending Plan listening sessions, DMMA has proposed to add a Medicaid-funded respite service for caregivers of children with CMC, severe emotional disorders and dual diagnoses of behavioral health/IDD.

4. Coverage of a self-directed option for parents on behalf of children receiving state plan personal care services.

   In response to extensive feedback during Delaware's HCBS Spending Plan listening sessions as well as during DMMA's work with stakeholders, including parents of children with CMC, DMMA has identified the need to address gaps in care that parents and families are experiencing as a result of the direct service provider (DSP) workforce shortage. To address this shortage and empower families to identify and provide care that meets the needs of their children, DMMA has requested authority to allow parents to self-direct the State Plan personal care (attendant care) services minor children receive today. This self-directed option will give families the flexibility to hire, for example, a neighbor, friend, or family member, including a legally responsible family member as the service provider, as long as the individual meets all employee qualifications as verified by the DSHP MCO. This option will also support the DSHP MCOs in maintaining appropriate and timely access to care.

5. Coverage of Delaware's Nursing Home Transition Program (formerly Money Follows the Person Demonstration) in the DSHP 1115 waiver.

   DMMA initially received federal funding for our Money Follows the Person program, Finding A Way Home, in 2007. In 2017, when MFP funding was exhausted, Finding A Way Home became an integral component of the nursing facility transition services under the DSHP Plus managed long-term services and supports MCO contracts. Although MFP no longer funded the transitions after 2017, these transitions have continued as DMMA and our partner MCOs sustained the MFP activities that worked well and used the lessons learned from MFP to improve upon policies for effective transitions. In CYs 2020-2021, DMMA and DSHP MCOs transitioned 230 individuals. This waiver amendment incorporates these services into the DSHP Plus waiver benefits.

Additional description of these changes can be found in the pending amendment available on the DMMA website at: https://dhss.delaware.gov/dhss/dmma/medicaid.html

DMMA is proposing to include these changes, once approved by CMS, in the waiver extension.

B. New Changes Proposed for the DSHP Extension

DMMA is proposing four new changes in the extension period, beginning January 1, 2024:

1. Expanding access by providing three-months of retroactive eligibility to all Medicaid enrollees.
2. Piloting Medicaid coverage of Delaware's Food Box Initiative for postpartum members.
3. Adding Medicaid coverage of contingency management services for certain members with a stimulant use disorder and/or opioid use disorder.

4. Adding children's dental services under the DSHP 1115 managed care delivery model.

B.1. Expanding Access by Providing Three-Months of Retroactive Eligibility to DSHP 1115 Waiver Enrollees

Proposal: DMMA will not renew the current DSHP waiver of retroactive eligibility.

Objective: DMMA will terminate this waiver authority to support our goal of expanding access to coverage, including coverage for those who need immediate care while applying for Medicaid.

Background and Details*:* Under the current DSHP 1115 waiver of Section 1902(a)(34) of the Social Security Act, retroactive eligibility is only provided to institutionalized individuals in nursing facilities, individuals in the Ticket to Work Basic Group, pregnant women and children under the age of 19 in all applicable eligibility groups for three months prior to the application month. Other eligibility groups, including the Adult Expansion Group, are not eligible for retroactive eligibility under the terms of the DSHP 1115 Waiver. This waiver authority was initially granted by CMS as part of Delaware's early expansion of Medicaid (prior to the Affordable Care Act), and is no longer necessary. Effective no later than January 1, 2024, with the expiration of the current DSHP 1115 waiver, DMMA will extend retroactive eligibility to all eligible DSHP and DSHP-Plus participants three months prior to the date that an application for medical assistance is made. DMMA's timeline for terminating this authority is based on our operational experience with adding retroactive eligibility for pregnant members and children in 2019/2020 and the anticipated efforts related to "unwinding" the COVID-19 PHE in 2023.

Waiver Impact: None. Members months associated with retroactive eligibility will be covered outside of the DSHP 1115 Waiver in Medicaid FFS.

B.2. Piloting Medicaid coverage of Delaware's Food Box Initiative for postpartum members

Proposal: DMMA proposes to pilot a Medicaid Food Box Initiative to provide home-delivered food and diapers to postpartum members enrolled in the DSHP 1115 Waiver.

Objective and Expected Outcome: The objective of the Food Box Initiative is to address food insecurity and diaper needs as health-related social needs to improve maternal and infant heath and narrow health disparities. The proposed demonstration would allow DMMA to use Medicaid funds to expand our current state-funded pilot to provide home-delivered food and diapers to postpartum members, reaching low-income postpartum members with disproportionately high rates of food insecurity and inequitable adverse maternal and birth outcomes.

Background and Details: Food insecurity is an important health-related social need, associated with poor health and recognized as a driving force of health inequities. This is particularly true for low-income mothers and their infants during the post-partum period. Compared to their food-secure peers, food insecure mothers are over twice as likely to report mental health problems during the

post-partum period, such as stress, depression and anxiety, all while caring for a newborn.[1] Food insecure mothers also experience decreased rates of breastfeeding. Breastfeeding can help protect babies against short- and long-term illnesses and disease, such as asthma, obesity, and diabetes[2]. It can help babies develop a strong immune system and protect them from illnesses, such as ear infections and stomach bugs. Breastfeeding can reduce the mother's risk of breast and ovarian cancer, diabetes, and high blood pressure. For the health of mothers and their infants, the postpartum period is a critical time to support household food security and diaper need, especially for families with limited or strained economic resources.

Food insecurity is impacted by intersecting social determinants of health, such as food access. There is significant racial inequity in the distribution of food in the United States. Access to local supermarkets is associated with increased intake of fruit and vegetables. In predominantly Black neighborhoods, the availability of supermarkets is only half that of White neighborhoods, and in predominantly Hispanic neighborhoods, it is even lower. A lack of access to healthy food choices and an abundance of access to cheap, unhealthy food disproportionately predominates the landscape of low-income and minority communities. Food access is impacted by the distance and time required to travel to buy healthy food, and, for many, the cost of transportation can be prohibitive.

In recognition of the impact of food insecurity on health outcomes and health disparities and the impact of the COVID-19 PHE on our members, DMMA began piloting a Postpartum Food Box Delivery program in February 2021, in partnership with the Food Bank of Delaware for food box supplies, with our NEMT broker for transportation, and with our DSHP MCOs for care coordination. The program was first piloted with state-only funds for the food boxes for our DSHP members who delivered via caesarean section and then expanded to all of our DSHP postpartum members in July 2021. Our DSHP postpartum members receive one shelf-stable food box, up to two boxes of diapers, and one pack of wipes per week for up to 8 weeks postpartum. As of October 2022 we have delivered almost 24,000 boxes of food, 35,000 boxes of diapers, and 17,000 boxes of wipes.

DMMA has received an overwhelmingly positive response from our members and partners. The program has also shown initial benefits in member health outcomes, including:

- Postpartum members in program (Feb 2021- March 2022): 1455 members; **85% attended a postpartum visit**
- Infants in the program (Feb 2021- March 2022): 1466 infants; **95% had at least one well child visit**

[1] https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0645
[2] https://www.cdc.gov/nccdphp/dnpao/features/breastfeeding-benefits/index.html

There are significant health disparities with our maternal/infant health outcomes, with Black infant mortality two to three times higher than White infants. This program is helping to address those health disparities. To date:

- **57% of members** who received deliveries were Black or Hispanic
- More than **40% of food box deliveries were to "high risk" zip codes in Delaware**, based on Delaware Division of Public Health data

DMMA is proposing to continue this Food Box Initiative, including food box delivery, as a Medicaid pilot in the DSHP 1115 Waiver extension period. This would allow DMMA to use Medicaid funds to continue the Food Box Initiative, including the food box supplies and transportation, and further evaluate its sustained positive impact on low-income families with disproportionately high rates of food insecurity and diaper needs and inequitable adverse maternal and birth outcomes.

Waiver Impact: Approximately 8,841 members and $8.29 million over five years.

B.3. Contingency Management

Proposal: DMMA is seeking authority to provide contingency management services for Medicaid members who are: (1) age 18 and over with a stimulant use disorder diagnosis and (2) age 18 and over, who are pregnant or up to 12 months postpartum, with an opioid use disorder diagnosis. Contingency management is an evidence-based practice that allows individuals to earn small motivational incentives for meeting treatment goals, such as negative urine drug tests or medication adherence.

Objective and Expected Outcome: The objectives of contingency management services are to expand SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder to help address the rise in fatal drug overdoses throughout Delaware. DMMA also expects this initiative to improve health outcomes and address health disparities.

Background and Details: According to the latest data from the Centers for Disease Control and Prevention, Delaware had the 3rd highest rate of drug overdoses in the country in 2020, at 47.3 deaths per 100,000 people.[3] Similar to many states, opioids and stimulants are the primary substances of recent concern. For example, in its annual report for 2021, the Delaware Division of Forensic Science (DFS) reported 515 overdose deaths in the state, an increase of 15% over the number of overdose deaths in 2020 (447).[4] Of the 515 overdose deaths reported in 2021, DFS reported that 425 deaths (82.5%) involved fentanyl, 68 deaths involved heroin (13.2%), and 221 (42.9%) involved cocaine. Deaths from methamphetamine are also on the rise, increasing from 1.9% of all postmortem cases investigated by DFS in 2017, to 8.4% in 2021.[5] Additionally, a special population of interest for

[3] https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm
[4] https://forensics.delaware.gov/resources/contentFolder/pdfs/2021 DFS Annual Report.pdf?cache=1654718076322
[5] https://forensics.delaware.gov/resources/contentFolder/pdfs/2021 DFS Annual Report.pdf?cache=1654718076322

Delaware is pregnant and postpartum people with substance use disorders (SUD). According to the latest data from the Centers for Medicare & Medicaid Services (CMS), Delaware had the 8th highest rate of SUD in the United States among Medicaid beneficiaries in the pregnant enrollment category,[6] and the 3rd highest rate of neonatal abstinence syndrome.[7]

Contingency management is the only treatment that has demonstrated robust outcomes for individuals with stimulant use disorder, including reduction or cessation of drug use and longer retention in treatment. Further, contingency management has also demonstrated a wide range of positive outcomes for individuals with an opioid use disorder,[8] including more days of abstinence from opioids, increased retention in SUD treatment, and increased adherence to medications used to treat opioid use disorder. Research also shows that contingency management is particularly well-suited for use among pregnant individuals, given the limited timeframe of pregnancy, and the potential to benefit both maternal and infant health. For example, research has shown that contingency management can both reduce illicit substance use during pregnancy[9] and reduce hospital days for newborns.[10]

DMMA plans to implement two unique contingency management programs: (1) a program for Medicaid members aged 18 and over with a stimulant use disorder diagnosis; and (2) a program for Medicaid members aged 18 and over, who are pregnant or up to 12 months postpartum, with an opioid use disorder diagnosis. See Table 1 below for a summary of the Medicaid members eligible to participate in each program, along with the core treatment goals incentivized. Under this demonstration, DMMA proposes to allow for a maximum of $599 in incentives for each eligible member participating in a contingency management program each year, with the average duration of the contingency management program expected to be between 24 to 64 weeks, depending on the population of focus (see Table 1). DMMA selected $599 as the maximum incentive amount because it is the most an individual can receive without paying taxes on these funds. Incentives would be provided in the form of low-denomination gift cards (which could not be used to purchase cannabis, tobacco, alcohol, or lottery tickets).

[6] https://www.medicaid.gov/medicaid/data-systems/downloads/2019-sud-data-book.pdf
[7] https://data.medicaid.gov/dataset/0563d88c-8fe5-42a8-9d69-f67fd21c0e91
[8] https://jamanetwork.com/journals/jamapsychiatry/article-abstract/205837 https://psycnet.apa.org/record/2013-10259-001 https://www.tandfonline.com/doi/full/10.1080/07853890.2022.2068805
[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5714659/#R32
[10] https://pubmed.ncbi.nlm.nih.gov/25835053/

Table 1: Proposed Contingency Management Programs under DSHP

Program name	Population	Eligible Providers	Core Treatment Goal (incentivized outcome)	Expected Timeframe
Contingency Management Program for Stimulant Use Disorder (CM-StUD)	Individuals ages 18 and older who are diagnosed with stimulant use disorder (e.g., methamphetamine, cocaine, similar drugs), based on a completed SUD assessment	Outpatient SUD providers	Negative drug tests[11]	24 weeks
Contingency Management Program for Pregnant and Postpartum People with Opioid Use Disorder (CM-PPP-OUD)	Individuals ages 18 and older, who are pregnant and/or up to 12 months postpartum, with a diagnosed opioid use disorder, based on a completed SUD assessment	Opioid treatment programs (OTPs), OB-GYNs, primary care providers, outpatient SUD providers	Medication adherence (i.e., adherence to medications used to treat opioid disorder, such as methadone or buprenorphine)	64 weeks

The contingency management program will be open to eligible providers across the state, with DMMA using a request for proposal or similar process to ensure participating providers are qualified and meet minimum expectations (this would be in addition to a quality assurance plan, as outlined below). MCOs will be responsible for contracting with qualified, enrolled contingency management providers.

Qualified providers will have the ability to bill a new service code for "contingency management coordination services" (e.g., providing instructions to clients regarding contingency management processes and protocols; distribution of urine drug tests; monitoring drug test results, etc.). DMMA proposes distributing funds for contingency management incentives through the DSHP MCOs, using a directed payment as allowed under 42 CFR 438.6(c). Therefore, incentive funds would flow from the

[11]Although negative drugs tests will be the core treatment goal for the CM-StUD program, DMMA views this as just one tool in a more comprehensive treatment approach. Providers will be encouraged to continue to use a harm reduction approach to treatment overall, in part by not focusing solely on abstinence as a sign of progress toward recovery.

DMMA to the MCOs, to contracted qualified providers, to eligible beneficiaries participating in contingency management programs who meet identified treatment goals.

To mitigate the risk of fraud and abuse while promoting this evidence-based practice, DMMA, in partnership with its contracted MCOs, will implement a quality assurance plan that ensures: 1) specialized training for those who implement, administer, and supervise contingency management interventions; 2) adherence to stringent documentation requirements at the program-level and in the patient's medical record; and 3) adherence to requirements that the incentives are not cash, are only disbursed upon achievement of the specific target behaviors, and are recommended by a qualified, treating clinician.

Waiver Impact: Approximately 800 members and $1.54 million over five years.

B.4. Expanding the DSHP 1115 Waiver to Include Children's Dental Services in Managed Care

Proposal: Effective January 1, 2024, DMMA is proposing to include children's dental services in the DSHP 1115 Waiver managed care delivery system.

Objective and Expected Outcome: The objective of including children's dental services in DSHP managed care is to ensure access to high-quality dental care for children and support a coordinated and integrated delivery system focused on the overall health of a child. DMMA expects dental managed care for children will result in a positive (or no negative) impact on child dental access, health outcomes and parent/caretaker satisfaction.

Background and Details: Managed care through the DSHP MCOs is the foundation of Delaware's Medicaid delivery system. Currently, children's dental services are one of only a few services excluded ("carved out") from the DSHP managed care delivery system and are instead provide on a fee-for-service basis. The DSHP MCOs are responsible for coordinating care for members between FFS and managed care, but are not responsible for ensuring that children enrolled in Medicaid have access to high-quality dental care. DMMA is proposing to carve these services in to the DSHP managed care delivery system after robust stakeholder engagement and planning. As DMMA did in 2019 with the development of the adult dental benefit, beginning in 2023, DMMA will engage stakeholders, including families and providers, throughout the process of developing the plans for implementation, continuity of care, member communication, referral and follow-up care, payment, incentives, provider education, and MCO performance standards and oversight. DMMA expects the DSHP MCOs to maintain or increase access and family satisfaction with Medicaid dental services over the demonstration.

Waiver Impact: Beginning in CY 2024, approximately 114,000 Medicaid-enrolled children will begin receiving their dental services through MCOs under the DSHP 1115 Waiver. These expenditures are currently excluded from the DSHP 1115 Waiver. Dental managed care will shift approximately $327 million in expenditures over five years from FFS to the DSHP 1115 Waiver.

Section V – Waiver and Expenditure Authorities

DMMA is requesting to continue all current approved and pending waiver and expenditure authorities, with the exception of the waiver of retroactive eligibility. DMMA is not requesting to renew the current waiver of retroactive eligibility.

Table 1. Requested Waiver Authorities

	Waiver Authority	Use for Waiver Authority	Current/Expanded/ New/Terminated Waiver Authority Request
1.	Amount, Duration, and Scope of Services Section 1902(a)(10)(B) and 1902(a)(17)	To the extent necessary to enable Delaware to offer a different benefit package to DSHP and DSHP-Plus participants than is being offered to the traditional Medicaid population. To the extent necessary to enable Delaware to provide additional services to enrollees in the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) Program. The waiver request is being expanded to include the extension changes described in Section IV: (1) To the extent necessary to enable Delaware to provide additional services to enrollees participating in the Food Box Pilot initiative for postpartum members as described in Section IV of this application. (2) To the extent necessary to enable Delaware to provide contingency management services not otherwise available to all members in the same eligibility group but based on individual assessments of need according to criteria described in Section IV this application.	Current/Expanded

2.	Provision of Medical Assistance Section 1902(a)(8) and 1902(a)(10)	To the extent necessary to enable Delaware to limit the provision of medical assistance (and treatment as eligible) for individuals described in the eligibility group under section 1902(a)(10)(A)(ii)(XX) of the Act and the Medicaid State Plan to only former foster care youth who are under 26 years of age, were in foster care under the responsibility of another state or tribe on the date of attaining 18 years of age (or such higher age as the state has elected), were enrolled in Medicaid on that date, and now residents in Delaware applying for Medicaid.	Current
3.	Freedom of Choice Section 1902(a)(23)(A)	To the extent necessary to enable Delaware to restrict freedom-of-choice of provider through the use of mandatory enrollment into managed care plans for DSHP and DSHP- Plus participants. To the extent necessary to enable the state to use selective contracted fee-for-service (FFS) providers, including for Home and Community Based Services (HCBS) and a transportation broker for non- medical transportation. No waiver of freedom of choice is requested for family planning providers. The waiver request is being expanded to include the extension changes described in Section IV: To enable Delaware to restrict freedom of choice of provider for the Food Box Pilot Initiative, contingency management services, and children's dental services through the use of mandatory enrollment in MCOs.	Current/Expanded
3.	Retroactive Eligibility Section 1902(a)(34)	To the extent necessary to enable Delaware to not extend eligibility to DSHP and DSHP- Plus participants prior to the date that an application for assistance is made, with the exception of institutionalized individuals in nursing facilities and qualified disabled working individuals (QDWIs), as outlined in Table A of the STCs. The waiver of retroactive eligibility does not apply to pregnant women (including during the 60-day postpartum period beginning on the last day of the pregnancy), infants under age 1, or individuals under age 19.	Terminate

4.	Self-Direction of Care Section 1902(a)(32)	To the extent necessary to enable Delaware to permit parents (on behalf of children up to age 21) to self-direct state plan personal care services.	New (Pending Amendment)

Table 2. Requested Expenditure Authorities

	Use for Expenditure Authority	Currently/Expanded/ New Expenditure Authority Request
1.	**217-Like Elderly and Disabled Home and Community Based Services (HCBS) Group:** Expenditures for medical assistance for disabled individuals over age 18 who meet the Nursing Facility (NF) level of care (LOC) criteria and who would otherwise be Medicaid-eligible if the state had elected the group described in section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if enrolled and receiving services under a 1915(c) HCBS waiver program	Current
2.	**217-Like HIV/AIDS HCBS Group:** Expenditures for medical assistance for individuals over age 1, who have a diagnosis of AIDS or HIV, who meet the hospital LOC criteria, and who would otherwise be Medicaid-eligible if the state had elected the eligibility group described in section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, and they were enrolled and receiving services under a 1915(c) HCBS waiver program.	Current
3.	**"At-risk" for Nursing Facility Group:** Expenditures for medical assistance for disabled individuals over age 18 with incomes at or below 250 percent of the Supplemental Security Income (SSI) Federal Benefit Rate who do not meet the NF LOC, but are "at-risk" for institutionalization.	Current
4.	**TEFRA-Like Group:** Expenditures for medical assistance for disabled children under age 18 with incomes at or below 250 percent of the SSI who do not meet the NF LOC, but are "at-risk" of institutionalization absent the provision of DSHP services. The state will use financial institutional eligibility rules for individuals who would not be eligible in the community because of community deeming rules (in the same manner that would be used if the group were eligible under the state plan.	Current

	Use for Expenditure Authority	Currently/Expanded/ New Expenditure Authority Request
5.	**Continuing Receipt of Nursing Facility Care:** Expenditures for medical assistance for nursing facility residents, who do not currently meet the NF LOC criteria, but continue to meet the NF level of care criteria in place at the time of admission/enrollment.	Current
6.	**Continuing Receipt of Home and Community-Based Services:** Expenditures for medical assistance for individuals receiving HCBS for the disabled and elderly, who do not meet the NF LOC criteria, but continue to meet the LOC criteria in place at the time of enrollment, including HCBS furnished under a terminated 1915(c) waiver.	Current
7.	**Continuing Receipt of Medicaid State Plan Services:** Expenditures for medical assistance for disabled children with incomes at or below 250 percent of the SSI, who do not meet the NF or hospital LOC criteria, but continue to meet the LOC criteria in place at the time of their enrollment.	Current
8.	**PROMISE Services:** Expenditures for behavioral health services beyond the services described in the approved state plan for otherwise eligible individuals enrolled in the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) program.	Current
9.	**HCBS for Medicaid State Plan Eligibles**: Expenditures to provide HCBS not included in the Medicaid State Plan to individuals who are eligible for Medicaid as described in the STCs. This request includes expenditures for home-delivered meals and pediatric respite benefits that are under review by CMS in a waiver amendment.	Current/Expanded (Pending Amendment)
10.	**Residential and Inpatient Treatment for Individuals with a Substance Use Disorder (SUD):** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an Institution for Mental Diseases (IMD).	Current
11.	**Home visiting for Medicaid eligible pregnant women and children under the age of three:** Expenditures to provide evidenced-based home visiting to Medicaid eligible pregnant women and children.	New (Pending Amendment)

	Use for Expenditure Authority	Currently/Expanded/ New Expenditure Authority Request
12.	**Self-directed personal care/attendant care for children:** Expenditures to provide self-directed personal care/attendant care for children receiving state plan personal care services.	New (Pending Amendment)
13.	**Nursing facility transition services:** Expenditures to provide coverage of short-term nursing facility transition services to support a DSHP Plus member's transition from a nursing facility to an HCBS setting.	New (Pending Amendment)
14.	**Post-partum Food Box Initiative:** Expenditures to provide coverage of food boxes, including transportation to members, for members up to 12 weeks postpartum.	New
15.	**Contingency management services:** Expenditures to provide contingency management services to eligible individuals with a qualifying stimulant use and/or opioid use disorder.	New

Section VI – Summaries of Quality and Monitoring Reports

DMMA regularly monitors the DSHP 1115 Waiver and MCOs for quality assurance and improvement to ensure progress towards the demonstration's goals and objectives and compliance with CMS rules for Medicaid MCOs. This includes, but is not limited to, implementation of the DMMA Quality Strategy, External Quality Review Organization (EQRO) results and recommendations, and the quarterly and annual reports DMMA submits to CMS. Below is a summary of the most recent activities and information from Delaware's external quality review organization (EQRO) reports and ongoing quality assurance and monitoring activity.

A. Summary of External Quality Review Results 2019-2021

2019 Annual External Quality Review Reporting

During 2019, Delaware's EQRO (Mercer) completed a comprehensive compliance review of the two DSHP MCOs that encompassed the three mandatory activities, compliance review, validation of Performance Measures (PMs) and validation of Performance Improvement Projects (PIPs) for both MCOs. The EQRO identified a number of strengths and opportunities for improvement for both MCOs. The annual technical report was submitted to CMS on April 30, 2020.

The EQRO also completed a comprehensive ISCA. The Performance Measure Reporting ISCA items for both MCOs resulted in 13 of the 13 items receiving a score of "Met." There were no concerns identified

with any processes for integrating Medicaid claims, encounter, membership, provider, subcontractor and other data to calculate Medicaid PMs.

In addition to completion of mandatory activities, the EQRO conducted the following activities:

- Encounter Data Validation (EDV) of Medicaid encounter data received from the two MCOs. Overall, the EQRO found the MCOs had appropriate processes and systems for managing their encounter data submissions, and made extra effort to work with DXC to diagnose and resolve encounter related issues.

- Readiness review for managed care enrollment of Individuals with Intellectual/Developmental Disabilities (I/DD) enrolled in the 1915(c) Lifespan Waiver. After the EQRO's initial review, the MCOs submitted follow up materials which were evaluated in an iterative process and technical assistance was provided when needed. A post go-live onsite follow up review was scheduled for 2020 to focus on best practices, lessons learned and prior authorization practices subsequent to the continuity of care period.

- Technical assistance with Case Management (CM) and Care Coordination (CC) Performance Measure reporting. DMMA required the MCOs to report quarterly on Clinical Care Coordination (CCC), resource coordination and CM as one path to ensure appropriate care for DSHP and DSHP Plus members. Throughout 2018, the EQRO met with DMMA to discuss challenges with gathering accurate and reliable data on the required CCC PMs. Challenges included the MCO data submissions in different formats and programs (i.e. Word, Excel, PDF), inconsistency in the completeness of the data, as well as explanations or narrative information provided to discuss any variances, or program interventions. The EQRO reviewed and analyzed the previously submitted reports in order to assess the current state of reporting described by DMMA.

  Toward the end of 2018 and in early 2019, the EQRO began to develop updated reporting templates and guidance to ensure consistent reporting; the EQRO developed standard reporting templates for submission of the reports by both MCOs and refined the technical specifications. The new reporting templates were implemented in April 2019 when Mercer led technical assistance sessions for the use of the required standardized templates, reviewed the technical specifications and each metric within the reporting templates with the MCOs. Throughout the remainder of the year, the EQRO reviewed the quarterly PMs for accuracy and consistency in information and analysis of the data submitted as well as answered ongoing questions from the MCOs.

- Technical assistance with QCMMR. The QCMMR acts as an early alert system to address potential, emerging concerns about the quality, access and timeliness of care management operations of the State-contracted MCOs. As an early alert system, the report relies on self-reported data from the MCOs which is submitted monthly via a secure file transfer protocol site using standardized data-submission templates in Microsoft Excel. When variance in expected results occurs, the MCOs are expected to provide a brief description of the corrective action or steps taken to remediate the variance. The EQRO provides technical assistance to the MCOs to ensure the data submitted to DMMA are complete, accurate and reliable. Trends regarding the data are analyzed quarterly and comparisons are made within each MCO and across MCOs, and when changes in trends are identified, the MCOs are asked to provide a response.

2020 Annual External Quality Review Reporting

During 2020, Delaware's EQRO:

- Prepared and submitted to DMMA the 2019 Annual EQR technical report for the two DSHP MCOs. The annual technical report was submitted to CMS on April 30, 2020.
- Conducted a readiness review of the two DSHP MCOs to ensure they were ready to provide a new adult benefit to members on October 1, 2020.
- Provided technical assistance with QCMMR. The QCMMR acts as an early alert system to address potential, emerging concerns about the quality, access and timeliness of care management operations of the State-contracted MCOs.
- Provided technical assistance on DMMA's Quality Strategy.
- Conducted 2020 external quality review activities, including Information Systems Capabilities Assessments (ISCAs), and began preparation of the 2020 annual technical report.

The EQRO's annual technical report found that the MCOs were deficient in meeting expectations to improve timely access to care, to improve the quality of care, to control the growth of healthcare expenditures while ensuring members are satisfied with services as outlined in the quality strategy (QS). The EQRO noted that the MCOs had shown strong performance in compliance with federal regulations. However, as evidenced by the HEDIS results, both MCOs had room for improvement in timely access to primary and preventive services, access to maternal and pregnancy services, quality of early life and early detection services, quality of weight and nutrition management and diabetes management. While members for one MCO shared a relatively high level of satisfaction with five of the 14 CAHPS adult or child measures, they have opportunity for improvement in the remaining nine measures. The second MCO has significant opportunity to improve member satisfaction in all CAHPS adult and child measures. DMMA continued working collaboratively with the MCOs as they implemented activities towards continuous quality improvement.

2021 Annual External Quality Review Reporting

During 2021, Delaware's EQRO:

- Finalized the 2020 annual EQRO reports on April 1, 2021.
- Provided technical assistance with QCMMR.
- Provided technical assistance on DMMA's Quality Strategy and PM reporting.
- Completed a Maternal Health Focus study at the request of DMMA and produced MCO-specific reports for DMMA.
- Kicked off the National Core Indicators-Aging and Disabilities Survey

- Developed MCO-specific comprehensive EQRO reports. Mercer completed a comprehensive compliance review of the two MCOs that encompassed the three mandatory activities, compliance review, validation of performance measures, and validation of performance improvement projects for both MCOs. Mercer also completed a comprehensive ISCA.

The EQRO's annual technical report concluded that:

- AmeriHealth Caritas Delaware (ACDE) was fully compliant or "Met" all expectations in four of the eleven Subpart D and QAPI standards (provider selection, confidentiality, subcontractual relationships and delegation, and grievance and appeal system) and Highmark Health Options (HHO) was fully compliant in two areas (confidentiality and practice guidelines). However, there were a number of items within the standards needing a corrective action plan. The areas of greatest opportunity for ACDE identified in the compliance review were related to care coordination and utilization management. By contrast, the areas of greatest opportunity for HHO were related to provider network and quality.
- Based upon the ISCA review, ACDE continued to demonstrate effective partnership and collaboration between the local health plan and the enterprise ACFC teams, operations and systems and, as such, continues to perform well in supporting the systems-related requirements of Delaware's managed Medicaid program. The insights gained from ACDE's ISCA desk review and virtual discussions confirmed a strong infrastructure, claims and encounters subject matter expertise, and teamwork and commitment to Delaware.
- HHO demonstrated their continued efforts to improve their claims processing operations to effectively support Delaware's Medicaid managed care program. HHO has made substantial progress in claims remediation activities, as well as identifying and implementing process improvements that improve claims processing outcomes overall. The insights gained from HHO's ISCA desk review and virtual discussions confirmed HHO's efforts to improve the claims operations and underlying infrastructure to ensure accurate claims processing.
- Both ACDE's and HHO's ongoing collaboration with DMMA and Gainwell on identifying and remediating encounter data submission issues has been beneficial to stakeholders. Both MCOs have processes in place to generate standardized PMs (e.g., HEDIS and CAHPS) to fulfill contractual obligations. However, the validation of PM results indicated room for improvement for both MCOs in State-specific reporting.
- There is significant opportunity for improvement in HEDIS results for both MCOs. Of the 36 reported measures for ACDE, one measure, inpatient utilization — surgery average length of stay (ALOS), was at or above the 90th percentile. Seven measures, postpartum care, appropriate treatment for children with upper respiratory infection, inpatient utilization (surgery days/1,000, total inpatient days/1,000), total inpatient ALOS, and mental health (MH) utilization (inpatient services and intensive outpatient and partial hospitalization), were at or above the 75th percentile. Sixteen of ACDE's HEDIS results for these 36 measures (44%) were below the 50th percentile. Of the 36 reported measures for HHO, two measures, timeliness of prenatal care and inpatient

utilization — total inpatient ALOS, were at or above the 90th percentile. Ten measures, well-child visits in the first 30 months of life (15–30 months), inpatient utilization (maternity and surgery ALOS), medicine, surgery and total days/1,000, medicine, surgery and total discharges/1,000, and MH utilization (any services), were at or above the 75th percentile. Fifteen of HHO's HEDIS results for these 36 measures (42%) were below the 50th percentile.

- Through ongoing waiver and grant projects, as well as engagement with the provider community, DMMA supports the efforts of the MCOs to ensure that care is coordinated and managed appropriately with timely access to a stable and robust provider network that is providing high quality care. However, the compliance and HEDIS results represent opportunities for continued collaborative work with the MCOs to achieve Goal 1 (to improve timely access to appropriate care and services for adults and children), and Goal 2 (to improve quality of care and services provided to Medicaid and CHIP enrollees) detailed in the Quality Strategy.
- Both ACDE and HHO improved CAHPS results from 2020 to 2021. ACDE's members gave the highest scoring for the measure All Health Care, which was above the 90th percentile on both the adult and child CAHPS surveys. However, both the adult and child CAHPS surveys highlight a significant opportunity for improvement across Getting Needed Care and Getting Care Quickly measures with ratings falling below the 50th percentile in both categories. HHO's members gave the highest scoring to the Rating of Health Plan measure which was above the 90th percentile on both the adult and child CAHPS surveys. Additionally, adult CAHPS survey respondents gave the highest rating to the Getting Care Quickly measure; and for the child CAHPS survey, respondents gave the highest rating to Rating of Personal Doctor measure. All seven measures for the HHO adult CAHPS survey and four measures for the HHO child CAHPS survey were above the 50th percentile. The child CAHPS survey highlight a significant opportunity for improvement across Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate. These results identify an opportunity for the MCOs and DMMA to work collaboratively toward improving results for the goal of ensuring member satisfaction with services, particularly related to getting needed care and getting care quickly.

B. Ongoing Quality Assurance and Monitoring Activity

As reported in the most recent quarterly and annual reports submitted to CMS, 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.

2019 Annual Report on Quality Assurance/Monitoring Activity

- QII Task Force - The QII Task force reviewed Goals 1-3 from the Quality Strategy during the four quarterly meetings in 2019 and reviewed effective strategies as well as barriers and solutions for meeting these goals.
- Case Management Oversight - DMMA oversight staff completed approximately 754 joint visits with the MCOs which included Nursing Facilities and Community based settings. DMMA meets with each MCO quarterly to discuss joint visit findings and collaborates on ways to improve. DMMA case management oversite staff completed onsite file reviews each quarter with Highmark Health Options and AmeriHealth Caritas. DMMA reviewed the findings with each MCO and discussed opportunities for improvement for our Medicaid members.
- DMMA/MCO Meetings - DMMA holds bi-monthly meeting with the two MCOs. These meetings are a forum to discuss issues in a collaborative manner. These meetings are used to collaborate on common practices, identify issues, plan resolutions and establish connections to our sister agencies for coordination of care. Examples of issues covered include: NEMT challenges for members; the transition of Lifespan 1915(c) Waiver enrollees from fee for service to managed care for their state plan services; the new Web Based PASRR System; and post-implementation review of the newly integrated Lifespan 1915(c) waiver population into MCOs.
- Quality Strategy Review - DMMA evaluated the effectiveness of the current Quality Strategy.

2020 Annual Report on Quality Assurance/Monitoring Activity

QII Task Force – In 2020, the QII Taskforce:

- Focused on quality measurement and improvement during COVID-19. The group considered what measures are appropriate during a pandemic, what is scientifically acceptable, the feasibility of calculating the measure given the limitations of COVID-19, and how to implement quality improvement. The group also focused on revisions to the DSHP Quality Management approach. This work involved evaluating DMMA's processes, oversight and monitoring of critical incidents. It also involved a full revision to the Quality Strategy and focusing on the quality improvement process and PIPs;
- Kicked off a comprehensive review and update of our Quality Strategy;
- Actively participated in multiple opportunities for technical assistance and cross-state learning with CMS, Mathematica and AcademyHealth;
- Reviewed the critical incident reporting process;
- Planned for vaccine monitoring strategies and plans in light of COVID-19; and

- Compiled, analyzed and worked on finalizing Delaware's Core Set submission.

Case Management Oversight - DMMA oversight staff completed 2002 telephonic/virtual visits with the MCOs which included Nursing Facilities and Community based settings. Due to COVID-19, DMMA and the MCOs began telephonic/virtual visits in lieu of face to face member visits beginning mid-March 2020. DMMA meets with each MCO quarterly to discuss joint telephonic/virtual member visit findings and collaborates on ways to improve. DMMA case management oversite staff completed quarterly virtual/onsite file reviews with Highmark Health Options and AmeriHealth Caritas. DMMA reviewed the findings with each MCO and discussed opportunities for improvement for our Medicaid members.

DMMA/MCO Meetings - During 2020, DMMA's bi-monthly meetings with the MCOs included topics such as the status of the justice-involved Medicaid member initiative, EVV, the impact of COVID-19 on members, providers and plan operations, and the enrollment of Lifespan 1915(c) Waiver members into managed care.

Quality Strategy Review - DMMA began updating the Quality Strategy.

2021 Annual Report on Quality Assurance/Monitoring Activity

QII Task Force – In 2021, the QII Taskforce:

- Actively participated in multiple opportunities for technical assistance and cross-state learning with CMS, Mathematica and AcademyHealth;
- Focused on best practices for engaging community organizations
- Continued efforts to improve the critical incident reporting process;
- Focused on special topic such as the SUPPORT Act Planning Grant initiatives and the National Diabetes Prevention Program

Case Management Oversight – During 2021, DMMA case management oversite staff completed virtual/onsite file reviews with Highmark Health Options and AmeriHealth Caritas. DMMA reviewed the findings with each MCO and discussed opportunities for improvement for our Medicaid members.

Quality Strategy Review - DMMA continued updating the Quality Strategy.

C. Quality and Care Management Monitoring Report (QCMMR) Activity

The QCMMR reports on the DSHP and CHIP Medicaid Populations while the QCMMR Plus reports on the DSHP Plus population. The QCMMR and QCMMR Plus were 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.

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. Health risk assessments are submitted on a 60-day lag and for the 2021 Q4 timeline, both MCOs submitted July, August, September and October data, with ACDE reporting an average rate of 33% completion and HHO reporting an average rate of 48% completion. This is a slight increase from the 2020 Q4 average of a 23% completion rate reported by ACDE and a 34% completion rate reported by HHO. This metric has been a focus within the EQRO review and corrective action plans (CAPs) for both MCOs.
- Customer Service Call Abandon Rate: Both MCOs met the goal for call abandon rate during Q4 and 2021.
- Timely Appointments: For DSHP, MCOs report in alternating quarters on the timely appointments metric. For Q4 2021, the reporting MCO met the goal of 100% access in all of the 20 areas measured related to timely appointments.

Section VII – Budget Neutrality, Estimate of Historical and Proposed Annual Enrollment and Annual Aggregate Expenditures, and Financial Analysis of Proposed Changes

A. Budget Neutrality

The following sections include summaries of historical and projected expenditures used to calculate budget neutrality. The detailed spreadsheets, including assumptions, enrollment, expenditures and historical data are included in an Excel workbook. The workbook is part of the full application package to CMS.

Summary of historical budget neutrality, DYs 24-28

The following Table ("Summary BN Variances: DY 24-28") provides annual without waiver (WOW) spending limits by Medicaid expenditure group (MEG), annual with waiver (WW) expenditures by MEG, and total budget neutrality variance between WOW limits and WW expenditures. Actual enrollment and expenditures were used for DYs 24-26. Projected enrollment and expenditures were used for DYs 27-28. The DSHP 1115 Waiver is budget neutral for DYs 24-28.

Summary BN Variances: DY 24 - DY 28

ELIGIBILITY GROUP	Demonstration Years					
	DY 24	DY 25	DY 26	DY 27	DY 28	Total Expenditures
WOW Limit Summary						
Medicaid Pop 1: DSHP TANF Child	$ 530,292,198	$ 572,627,881	$ 662,649,012	$ 732,894,032	$ 796,094,756	$ 3,294,557,879
Medicaid Pop 2: DSHP TANF Adult	$ 309,996,349	$ 349,787,637	$ 422,774,418	$ 478,035,684	$ 500,357,896	$ 2,060,951,985
Medicaid Pop 3: DSHP SSI Child	$ 187,148,648	$ 204,379,673	$ 216,905,554	$ 230,184,057	$ 245,885,319	$ 1,084,503,250
Medicaid Pop 4: DSHP SSI Adult	$ 222,825,755	$ 246,050,663	$ 255,306,499	$ 267,857,024	$ 278,857,732	$ 1,270,897,673
Medicaid Pop 5: DSHP Plus State Plan	$ 333,872,989	$ 356,238,436	$ 365,496,531	$ 385,063,360	$ 396,835,337	$ 1,837,506,653
Total Medicaid WOW Limit	**$ 1,584,135,939**	**$ 1,729,084,290**	**$ 1,923,132,014**	**$ 2,094,034,157**	**$ 2,218,031,040**	**$ 9,548,417,440**
WW Expenditure Summary						
Medicaid Pop 1:DSHP TANF Child	$ 393,227,067	$ 377,608,327	$ 420,386,809	$ 432,998,413	$ 456,322,374	$ 2,080,542,990
Medicaid Pop 2: DSHP TANF Adult	$ 219,983,215	$ 214,245,766	$ 250,687,499	$ 258,208,124	$ 269,680,584	$ 1,212,805,187
Medicaid Pop 3: DSHP SSI Child	$ 143,545,591	$ 127,394,770	$ 130,957,098	$ 134,885,811	$ 140,281,243	$ 677,064,513
Medicaid Pop 4: DSHP SSI Adult	$ 126,163,965	$ 124,143,557	$ 139,584,308	$ 143,771,837	$ 149,544,118	$ 683,207,785
Medicaid Pop 5: DSHP Plus State Plan	$ 279,509,891	$ 230,669,027	$ 185,733,665	$ 191,305,675	$ 200,275,397	$ 1,087,493,655
Total Medicaid WW Limit	**$ 1,162,429,729**	**$ 1,074,061,446**	**$ 1,127,349,379**	**$ 1,161,169,860**	**$ 1,216,103,716**	**$ 5,741,114,130**
Total Medicaid Variance	**$ 421,706,210**	**$ 655,022,844**	**$ 795,782,635**	**$ 932,864,296**	**$ 1,001,927,324**	**$ 3,807,303,310**
STC 83 Reduction Requirement of 75%	$ 91,835,778	$ 132,363,359	$ 153,996,793	$ 184,776,653	$ 201,341,846	**$ 764,314,428**
STC 83 Reduction Requirement Phased	$ 43,490,478	$ 87,898,587	$ 107,857,720	$ 96,878,842	$ 78,623,976	**$ 414,749,603**
Total Available Savings Carry Forward	**$ 135,326,257**	**$ 220,261,945**	**$ 261,854,512**	**$ 281,655,495**	**$ 279,965,822**	**$ 1,179,064,031**
Hypothetical Variance						
Hypo 1: DSHP Adult Group						
WOW Limit	$ 633,097,627	$ 708,806,179	$ 899,795,936	$ 1,010,929,367	$ 1,059,021,620	$ 4,311,650,729
WW Expenditures	$ 528,134,765	$ 567,233,574	$ 682,745,000	$ 703,227,350	$ 731,528,086	$ 3,212,868,775
Total Hypo 1 Variance	**$ 104,962,862**	**$ 141,572,605**	**$ 217,050,936**	**$ 307,702,017**	**$ 327,493,534**	**$ 1,098,781,954**
Hypo 5: SUD-IMD						
WOW Limit						
WW Expenditures						
Total Hypo 5 Variance	$ -	$ -	$ -	$ -	$ -	$ -
Hypo 3: DSHP Plus HCBS						
WOW Limit	$ 420,417,961	$ 471,507,362	$ 511,029,795	$ 567,909,570	$ 583,611,290	$ 2,554,475,978
WW Expenditures	$ 390,911,815	$ 441,233,485	$ 433,995,520	$ 447,015,386	$ 465,369,567	$ 2,178,525,773
Total Hypo 2 Variance	**$ 29,506,146**	**$ 30,273,877**	**$ 77,034,275**	**$ 120,894,184**	**$ 118,241,723**	**$ 375,950,205**
Hypo 3: DSHP TEFRA-Like						
WOW Limit	$ 9,875,768	$ 10,682,447	$ 11,524,673	$ 12,270,348	$ 13,140,288	$ 57,493,524
WW Expenditures	$ 2,046,520	$ 1,980,140	$ 2,066,915	$ 2,004,662	$ 2,084,849	$ 10,183,086
Total Hypo 3 Variance	**$ 7,829,248**	**$ 8,702,307**	**$ 9,457,759**	**$ 10,265,686**	**$ 11,055,439**	**$ 47,310,438**
Hypo 4: DSHP Promise						
WOW Limit	$ 24,671,645	$ 26,233,258	$ 28,176,214	$ 30,060,733	$ 31,383,406	$ 140,525,256
WW Expenditures	$ 3,611,090	$ 5,291,961	$ 4,941,249	$ 7,099,253	$ 7,383,224	$ 28,326,777
Total Hypo 4 Variance	**$ 21,060,555**	**$ 20,941,296**	**$ 23,234,965**	**$ 22,961,480**	**$ 24,000,182**	**$ 112,198,479**

Projected budget neutrality, DYs 29-33

The following Table ("Summary BN Variances: DY 29-33") provides projected annual without waiver (WOW) spending limits by MEG, projected annual with waiver (WW) expenditures by MEG, and total budget neutrality variance between projected annual WOW limits and projected annual WW expenditures. The analysis utilizes the existing DSHP 1115 waiver MEGs as well as two new MEGs for new initiatives. The new initiative for children's dental is reflected by an adjustment to two existing MEGs. The new initiatives for postpartum food boxes and contingency management services are reflected in two new MEGs.

The budget neutrality model does not include budget neutrality policy changes announced by CMS in recent Section 1115 waiver approvals. DMMA will work with CMS to develop new WOW PMPM limits using the new blended approach to budget neutrality from CMS. DMMA appreciates the opportunity to work with CMS to implement this new model during negotiations.

Summary BN Variances: DY 29 - DY 33

ELIGIBILITY GROUP	Demonstration Years					Total Expenditures
	DY 29	DY 30	DY 31	DY 32	DY 33	
WOW Limit Summary						
Medicaid Pop 1: DSHP TANF Child	923,605,328	1,005,584,537	1,094,840,220	1,192,018,238	1,297,821,777	$ 5,513,870,100
Medicaid Pop 2: DSHP TANF Adult	$ 544,769,663	$ 593,123,418	$ 645,769,053	$ 703,087,514	$ 765,493,562	$ 3,252,243,210
Medicaid Pop 3: DSHP SSI Child	$ 270,251,683	$ 294,239,222	$ 320,355,895	$ 348,790,685	$ 379,749,346	$ 1,613,386,830
Medicaid Pop 4: DSHP SSI Adult	$ 303,609,145	$ 330,557,492	$ 359,897,775	$ 391,842,302	$ 426,622,225	$ 1,812,528,938
Medicaid Pop 5: DSHP Plus State Plan	$ 432,058,442	$ 470,407,949	$ 512,161,359	$ 557,620,801	$ 607,115,223	$ 2,579,363,774
Total Medicaid WOW Limit	**$ 2,474,294,260**	**$ 2,693,912,618**	**$ 2,933,024,302**	**$ 3,193,359,539**	**$ 3,476,802,132**	**$ 14,771,392,852**
WW Expenditure Summary						
Medicaid Pop 1: DSHP TANF Child	$ 919,497,479	$ 996,367,468	$ 1,079,663,788	$ 1,169,923,681	$ 1,267,729,301	$ 5,433,181,718
Medicaid Pop 2: DSHP TANF Adult	$ 542,187,816	$ 587,514,718	$ 636,630,948	$ 689,853,295	$ 747,525,031	$ 3,203,711,808
Medicaid Pop 3: DSHP SSI Child	$ 268,982,914	$ 291,469,886	$ 315,836,769	$ 342,240,722	$ 370,852,047	$ 1,589,382,338
Medicaid Pop 4: DSHP SSI Adult	$ 302,170,239	$ 327,431,671	$ 354,804,958	$ 384,466,653	$ 416,608,065	$ 1,785,481,585
Medicaid Pop 5: DSHP Plus State Plan	$ 430,010,771	$ 465,959,672	$ 504,913,901	$ 547,124,703	$ 592,864,328	$ 2,540,873,374
Total Medicaid WOW Limit	**$ 2,462,849,220**	**$ 2,668,743,414**	**$ 2,891,850,364**	**$ 3,133,609,054**	**$ 3,395,578,771**	**$ 14,552,630,824**
Total Medicaid Variance	**$ 11,445,040**	**$ 25,169,204**	**$ 41,173,938**	**$ 59,750,485**	**$ 81,223,361**	**$ 218,762,029**
Hypothetical Variance						
Hypo 1: DSHP Adult Group						
WOW Limit	$ 1,153,020,379	$ 1,255,362,468	$ 1,366,788,441	$ 1,488,104,583	$ 1,620,188,745	$ 6,883,464,615
WW Expenditures	$ 1,147,555,828	$ 1,243,491,495	$ 1,347,447,384	$ 1,460,093,985	$ 1,582,157,842	$ 6,780,746,533
Total Hypo 1 Variance	**$ 5,464,552**	**$ 11,870,973**	**$ 19,341,057**	**$ 28,010,598**	**$ 38,030,903**	**$ 13,664,211,148**
Hypo 2: SUD-IMD						
WOW Limit						
WW Expenditures	$ -	$ -	$ -	$ -	$ -	$ -
Total Hypo 2 Variance						
Hypo 3: DSHP Plus HCBS						
WOW Limit	$ 293,826,182	$ 319,906,193	$ 348,301,067	$ 379,216,270	$ 412,875,506	$ 1,754,125,218
WW Expenditures	$ 292,433,640	$ 316,881,093	$ 343,372,352	$ 372,078,281	$ 403,184,025	$ 1,727,949,391
Total Hypo 3 Variance	**$ 1,392,541**	**$ 3,025,101**	**$ 4,928,715**	**$ 7,137,989**	**$ 9,691,481**	**$ 3,482,074,609**
Hypo 3: DSHP TEFRA-Like						
WOW Limit	$ 14,306,620	$ 15,576,476	$ 16,959,044	$ 18,464,328	$ 20,103,222	$ 85,409,689
WW Expenditures	$ 14,238,816	$ 15,429,181	$ 16,719,061	$ 18,116,774	$ 19,631,336	$ 84,135,168
Total Hypo 3 Variance	**$ 67,804**	**$ 147,294**	**$ 239,983**	**$ 347,554**	**$ 471,886**	**$ 169,544,858**
Hypo 4: Promise						
WOW Limit	$ 34,168,997	$ 37,201,837	$ 40,503,872	$ 44,098,996	$ 48,013,223	$ 203,986,924
WW Expenditures	$ 34,007,058	$ 36,850,049	$ 39,930,713	$ 43,268,920	$ 46,886,202	$ 200,942,942
Total Hypo 4 Variance	**$ 161,938**	**$ 351,788**	**$ 573,159**	**$ 830,076**	**$ 1,127,021**	**$ 404,929,866**
Hypo 5 (proposed): Food Box Initiative						
WOW Limit	$ 1,500,000	$ 1,575,000	$ 1,653,750	$ 20,835,000	$ 21,881,250	$ 47,445,000
WW Expenditures	$ 1,500,000	$ 1,575,000	$ 1,653,750	$ 1,736,361	$ 1,823,554	$ 8,288,665
Total Hypo 5 Variance	**$ -**	**$ -**	**$ -**	**$ 19,098,639**	**$ 20,057,696**	**$ 39,156,335**
	$ -					
Hypo 6 (proposed): Contingency Management						
WOW Limit	$ 192,900	$ 289,350	$ 289,350	$ 385,800	$ 385,800	$ 1,543,200
WW Expenditures	$ 192,900	$ 289,350	$ 289,350	$ 385,800	$ 385,800	$ 1,543,200
Total Hypo 6 Variance	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

B. Estimate of Historical and Proposed Annual Enrollment and Annual Aggregate Expenditures and Financial Analysis of Proposed Changes

A summary of annual and aggregate historical and projected demonstration enrollment and expenditure data is provided in the tables below. Note that not all Medicaid expenditures are captured in these tables. For example, State administrative expenditures and expenditures for populations or services excluded from the current 1115 waiver are not included. Data is limited to expenditures that are considered as part of the current 1115 waiver budget neutrality and projected new expenditures where data and estimates are currently available. Demonstration projections are approximate assumptions for the purposes of the waiver renewal planning. Demonstration financing and budget neutrality assumptions will continue to evolve throughout the course of the waiver renewal process and as new budget data becomes available. The impact and timing of the ending of the PHE will impact enrollment projections. Current impact is shown in DY 28 and beyond.

Table 1. Historical Data for Current DSHP Demonstration Period

	DY24	DY25	DY26	DY27*	DY28*	Five Year Total
	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	
Total Enrollment	205,913	215,034	244,414	260,582	260,582	1,186,526
Total Expenditure (in billions)	$2.085	$2.09	$2.25	$2.32	$2.43	$11.18

*Based on projections from the current approved waiver and pending amendment request. Differences may exist due to rounding.

Table 2. Projected Data for DSHP Demonstration Extension Period

	DY29	DY30	DY31	DY32	DY33	Five Year Total
	CY 2024	CY 2025	CY 2026	CY 2027	CY 2028	
Total Enrollment	266,379	274,434	282,734	291,285	300,096	1,414,928
Total Expenditure (in billions)	$2.62	$2.75	$2.89	$3.04	$3.19	$14.50

Note: Includes amounts from Table 3. Differences may exist due to rounding.

Table 3. Projected Expenditures and Enrollment for New Demonstration Proposals in Renewal Period

	DY29 CY 2024	DY30 CY 2025	DY31 CY 2026	DY32 CY 2027	DY33 CY 2028	Five Year Total
Retroactive Eligibility	NA	NA	NA	NA	NA	NA
Children's Dental Managed Care Expenditures	$59,190,092	$62,149,597	$65,257,077	$68,519,930	$71,945,927	$327,062,623
Members Impacted	114,012	117,433	120,956	124,584	128,322	605,307
Food Box Initiative Expenditures	$1,500,000	$1,575,000	$1,653,750	$1,736,438	$1,823,259	$8,288,447
Members Impacted	1,600	1,680	1,764	1,852	1,945	8,841
Contingency Management Expenditures	$192,900	$289,350	$289,350	$385,800	$385,800	$1,543,200
Members Impacted	100	150	150	200	200	800

Note: All amounts in this table are included in the total expenditures in Table 2. Differences may exist due to rounding.

Section VIII – Interim Evaluation Results and Renewal Evaluation Design

A. Interim Evaluation Results

Per STC #93, an independent external evaluator is tasked with evaluating the demonstration, including data analysis and validation relative to the demonstration hypotheses, the development of quarterly monitoring reports, an interim evaluation report, and a final evaluation report. DMMA commissioned Burns & Associates, a Division of Health Management Associates (HMA-Burns), as the independent external evaluator for the overall evaluation of the DSHP 1115 Waiver and a separate interim evaluation of the SUD component of the DSHP 1115 Waiver. The following is a summary of the two Interim Evaluation reports. A copy of the full Interim Evaluation Reports can be found in Attachment B and on DMMA's website: https://dhss.delaware.gov/dhss/dmma/medicaid.html

1. SUD Interim Evaluation Results

HMA-Burns noted that DMMA saw progress towards our aim to expand SUD-specific services to our Medicaid population through the initial phase of the SUD demonstration period. This occurred through the expansion of coverage for short-term stays in residential and hospital inpatient treatment settings that qualify as institutions for mental disease (IMDs), new services added across the ASAM continuum,

and a concentrated effort to increase access to existing SUD services. The Interim Evaluation concluded that DMMA did not meet all of the desired outcomes outright but still saw many positive impacts due to the DSHP 1115 Waiver. HMA-Burns also noted the PHE likely had a confounding effect in enabling DMMA to fully meet these aims during the demonstration period. When considering the CMS Milestones, DMMA saw success in each milestone with the exception of Milestone 6, "Improved Access to Care for Physical Health Conditions Among Beneficiaries."

Among 29 measures reviewed, HMA-Burns found there were 15 where the desired outcome was met. Of these, eight measures had an outcome that was statistically significant in the desired direction. For the 14 measures where the desired outcome was not met, 11 measures had a statistically significant change in the wrong direction. DMMA was also successful in large part in the activities we set out to do in our SUD Implementation Plan. Among the eight activities identified, five were completed in full and the remainder are in progress.

HMA-Burns also identified eight opportunities for improvement for DMMA to consider as we continue to enhance service delivery and access. HMA-Burns' recommendations focus on reimbursement strategies to encourage greater provider participation, education to providers on ASAM criteria and authorization requests, and strategies to incentivize the MCOs to improve initiation and engagement in treatment for SUD beneficiaries.

2. Comprehensive Interim Evaluation Results

HMA-Burns noted that DMMA has seen progress towards our goals related to rebalancing long term care in favor of HCBS, maintaining continuity of enrollment, and maintaining access to care thus far in this demonstration period. The Interim Evaluation concluded that DMMA did not meet all of the desired outcomes outright but still saw many positive impacts due to the DSHP 1115 Waiver. HMA-Burns also noted the PHE likely had a confounding effect in enabling DMMA to fully meet these aims during the demonstration period.

Among the 63 measures, there were 39 measures where the desired outcome was met. Statistical tests were run for 28 of the 63 measures. Among these 28 measures, there are nine measures which have a statistically significant trend in the intended direction, nine measures which have a statistically significant trend in the wrong direction, and 10 measures where the trend was found not to be statistically significant.

HMA-Burns noted the following positive impacts due to the DSHP 1115 Waiver:

Maintaining Continuity of Enrollment
Noteworthy positive impacts were found in the following areas:

- Medicaid enrollment increased over time overall and for most major enrollment categories.

- The percentage of members continuously enrolled has increased for all enrollment

categories examined. For the Medicaid Expansion group, the increase was substantial.

- Enrollment duration in the year also increased across-the-board.

Maintaining Access to Care
Noteworthy positive impacts between CY 2018 and CY 2021 were found in the following areas:

- Increase in the percentage of members ages three to six and among adolescents receiving well-care visits (for adolescents, a statistically significant improvement).

- The rate of postpartum care saw a statistically significant increase from 34.2 percent in CY 2018 to 44.2 percent in CY 2021.

- The rate of emergency department utilization decreased significantly from 65.2 visits per 1,000 in CY 2018 to 49.2 visits per 1,000 in CY 2021.

- Follow-up after an emergency department visit for people with multiple high-risk chronic conditions improved significantly.

- As a percentage of applications received, the rate of enrollment in the PROMISE program increased from 30 percent in CY 2018 to 43 percent in CY 2021.

- The PROMISE provider network also increased from 318 to 377 providers.

Maintaining or Improving Health Outcomes
Noteworthy positive impacts between CY 2018 and CY 2021 were found in the following areas:

- The rate of adherence to antidepressant medication management improved at both the 12 week and six month mark.

- The medication adherence rate, expressed as the proportion of days covered, saw a statistically significant increase among the DSHP Plus population.

- Member grievances and appeals remain very low when measured on a per 1,000 member month basis.

- Among the DSHP Plus population, improvement was seen among all six LTSS CAHPS survey composite measures during the demonstration period thus far. The rate of critical incidents per 1,000 also decreased during the demonstration period.

Rebalancing LTSS in favor of HCBS.
Noteworthy positive impacts between CY 2018 and CY 2021 were found in the following areas:

- The utilization rate of HCBS services among DSHP Plus members.

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

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

Areas in which HMA-Burns will focus on assessing improvement in the remainder of this demonstration period include the following:

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

HMA-Burns also identified opportunities for improvement for DMMA to consider during the remainder of the demonstration period which focus on:

1. 1. Developing performance improvement projects (PIPs) specific to improving follow-up after emergency department or hospitalization for mental illness or for alcohol and other drug dependence.

   2. Enhancing managed care reporting that will allow for assessing the effectiveness of case management by tying enrollment by the member in case management with specific access or health outcomes.

   3. Continuing the rate study of mental health services and considering value-based payment alternatives for providers serving the PROMISE population in particular.

2. 4. Consider including the services specific to the PROMISE program under the responsibility of the MCOs. Or, at minimum, strengthen the oversight of the coordination of care requirements between the MCO's case manager for acute care services and the state's PROMISE care manager for PROMISE services.

B. Proposed Renewal Evaluation Design

Table 1. Proposed Hypotheses and Evaluation Design

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
1.	DSHP members who participate in the Food Box Initiative for postpartum members will have reduced food insecurity, reduced health disparities and improved health outcomes compared to eligible members who do not participate.	The percentage of participating members who attend postpartum visits and infant well-child visits will increase as compared to members who do not participate in the Food Box initiative. Participating members will report increased food security during the postpartum period impacted by the Food Box Initiative.	CMS Adult, Child and Maternity Core Sets Claims and encounter data New survey (e.g., The Six-Item Short Form of the Food Security Survey Model, USDA)	New
2.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	The percentage of eligible Medicaid beneficiaries who participate in contingency management will increase during the five-year period.	Claims and encounter data	New

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
3.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	The rate of participation in contingency management programs should be relatively similar across racial and ethnic groups, factoring in any underlying differences in substance use across these populations (i.e., contingency management should be promoted to, and ideally utilized by, eligible Medicaid members regardless of race or ethnic background).	Claims and encounter data Medicaid enrollment data	New
4.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	SUD treatment retention rates will increase among eligible individuals who participate in contingency management programs.	Claims and encounter data	New
5.	Expanding SUD/OUD treatment for	The rate of negative drug tests will be higher among individuals with	Claims and encounter data, including relevant diagnosis	New

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	stimulant use disorder who participate in contingency management than among individuals who do not participate in contingency management.	codes: R82.998 for a positive urine test, and Z71.51 for a negative urine test)	
7.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	Increasing access to contingency management will reduce emergency department utilization and preventable hospital admissions.	Claims and encounter data	New
8.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use	Increasing access to contingency management will reduce fatal and non-fatal drug overdoses.	Claims and encounter data DFS death data/toxicology reports	New

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.			
9.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	Pregnant people who participate in contingency management will have newborns with lower rates of neonatal abstinence syndrome, when compared to their counterparts who did not participate in contingency management.	Claims and encounter data	New
10.	Dental managed care for children will result in a positive (or no negative) impact on child dental access, health outcomes and	MCOs will maintain access to dentists at or above FFS levels. Parents/caretakers will report satisfaction with key access measures of dental managed care.	Modified CAHPS Dental Plan Survey Claims, provider enrollment data, reports submitted by MCOs	New

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	parent/caretaker satisfaction.			
11.	Trends observed in access to health care through the DSHP 1115 Waiver for the Medicaid population continue (or does not worsen) in the current waiver period.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
12.	Trends in coordination of care and supports continues (or does not worsen) in the current waiver period	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
13.	Coordination of care and supports maintains or improves quality of care and health outcomes in the current waiver period	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
14.	Trends in consumer satisfaction will continue (or not worsen) in the current waiver period.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
15.	Creating a delivery system that provides incentives for resources to shift from institutions	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	to community-based LTSS has maintained or increased utilization of HCBS services where appropriate in the current waiver period.			
16.	Trends in health outcomes will continue or improve in the current waiver period for individuals enrolled in the PROMISE program	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
17.	The PROMISE program network capacity will continue (or not worsen) in the current waiver period.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
18.	The availability of the adult dental benefit will improve access to dental services and will continue (or not worsen) health outcomes in the current waiver period.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
19.	The demonstration will increase or maintain the	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDs.			
20.	The demonstration will increase or maintain adherence to and retention in treatment for OUD	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
21.	Approved service authorizations improve appropriate utilization of health care services in the post-waiver period	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
22.	The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
23.	The demonstration will increase or maintain the percentage of beneficiaries with	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	SUD who experience care for comorbid conditions			
24.	Among beneficiaries receiving care for SUD, the demonstration will reduce or maintain readmissions to SUD treatment.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
25.	The demonstration will decrease the rate of overdose deaths due to opioids.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
26.	The demonstration will increase or maintain the use of Delaware's PDMP.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
27.	The demonstration will decrease or maintain per beneficiary per month costs.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
28.	The demonstration will increase or maintain per beneficiary per month costs for SUD services versus non-SUD services.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
29.	The demonstration will decrease or maintain per beneficiary costs for SUD-related ED visits and inpatient stays	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
30.	The addition of two evidence-based home visiting models will improve the health and wellbeing of the Medicaid participants.	No change from the amendment currently under CMS review. DMMA is in the process of defining the evaluation measures, which may include measures such as: Mother Child Depression Screening, post-partum visit, treatment for a behavioral health condition, and dental visit.		New (Pending CMS review of amendment)
31.	The provision of home-delivered meals and nursing facility transition services, as part of an HCBS benefit package, will succeeds in supporting Delaware's goals of improving access to health care by expanding access to HCBS and rebalancing Delaware's long-term care system in favor of HCBS.	No change from the amendment currently under CMS review. DMMA intends to incorporate the addition of a second home delivered meal into the current Evaluation design that assesses whether the provision of meals, as part of a package of HCBS services, succeeds in supporting Delaware's waiver goals. DMMA will also add a measure related to the percentage of reinstitutionalizations lasting more than 30 days, using claims and encounter data, and work with CMS to align DSHP 1115 waiver measures with Money Follows the Person (MFP).		New (Pending CMS review of amendment)
32.	The provision of a respite benefit for caregivers reduces informal caregiver burnout and increases	No change from the amendment currently under CMS review. These items will be measured through the administration of a family/caregiver survey that will be included as part of the current Evaluation design.		New (Pending CMS review of amendment)

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	family/caregiver satisfaction with the program.			
33.	The provision of a self-directed option for children receiving Medicaid State Plan personal care (attendant care) will increase family satisfaction with this Medicaid benefit and expand the DSP workforce.	No change from the amendment currently under CMS review. Family satisfaction will be measured through the administration of a family/caregiver survey that will be included as part of the current Evaluation design. Additionally, DMMA will add a measure related to the percentage increase in DSP network participation, using MCO provider enrollment data, because of this option.		New (Pending CMS review of amendment)

Section IX – Documentation of Compliance with 1115 Transparency Requirements and Post-Award Forum

1. Delaware provided a state public comment period from November 14, 2022 through December 13, 2022 on the DSHP draft extension application.

2. Delaware published a notice of public comment in the Delaware News Journal and the Delaware State News on November 13, 2022. A copy of these notices can be found in Attachment A.

3. Full public notice of the Section 1115 Demonstration Waiver extension application (consistent with 42 CFR 431.408) was posted on the Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) website on November 11, 2022. A copy of this notice is available at: http://dhss.delaware.gov/dhss/dmma/medicaid.html.

4. A draft of this Section 1115 Demonstration Waiver extension application was posted on the Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) website on November 11, 2022 at: http://dhss.delaware.gov/dhss/dmma/medicaid.html.

5. Delaware presented to the Medical Care Advisory Committee on November 30, 2022.

6. Delaware conducted two public hearings on the DSHP 1115 Demonstration extension. The information for these hearings is as follows:

1. **Meeting #1**

In-Person and Virtual Meeting
November 18, 2022
12:00pm – 1:30pm

DHSS Herman M. Holloway Sr. Campus
1901 N DuPont Hwy
New Castle DE 19720
DHSS Chapel (located on DHSS campus)

Via Zoom:
https://us06web.zoom.us/j/82520214976
Webinar ID: 825 2021 4976
Or Telephone: US: +1 646 931 3860

2. Meeting #2

Virtual meeting
November 30, 2022
DMMA Medical Care Advisory Committee (MCAC)
9:00am – 11:00am

Via Zoom:
https://zoom.us/j/99696774582?pwd=SDJCcGpVamx3Sy9jMkRiNXpJaStNdz09

Meeting ID: 996 9677 4582
Passcode: 080737
Or Telephone: US: +1 301 715 8592
Meeting ID: 996 9677 4582
Passcode 080737#

7. Delaware certifies it used an electronic mailing list to notify the public.

8. Hardcopies of the public notice and draft waiver application were available by contacting Melissa Dohring as described below. Comments and input were to be submitted in the following ways:

By email: dhss_dmma_publiccomment@delaware.gov

By fax: 302-255-4481 to the attention of Melissa Dohring

By mail:

1115 Demonstration Waiver Extension Attn: Melissa Dohring
Division of Medicaid and Medical Assistance
Planning and Policy Unit
1901 North DuPont Highway P.O. Box 906
New Castle, Delaware 19720-0906

9. The following is a summary of the comments received and DMMA's responses:

Delaware received two comments on the draft application:

- One commenter asked why DMMA planned to include dental services for children in managed care and whether DMMA expected increased access to dentists. DMMA responded that our primary motivation is addressing oral health as part of overall health and coordinating that approach for children with the rest of the benefits that are included under the responsibility of

the DSHP MCOs. DMMA is not expecting any reductions in dental access. DMMA expects the efforts of the MCOs around health promotion and meeting EPSDT requirements will result in better education and greater utilization of dental services.

- A second commenter supported DMMA's decision to not renew the waiver of retroactive eligibility and requested that DMMA terminate this waiver of retroactive eligibility before January 1, 2024. DMMA appreciates the commenter's support for this change. We understand the commenter's request for more immediate termination of this provision but note our requested timeline is based on the feasibility of implementing necessary policy, operational, and system changes as well as our concerns with regard to simultaneously implementing this change during the unwinding of the federal Public Health Emergency.

10. DMMA conducted the post-award forums required by 42 CFR 431.420(c) through the Delaware Medical Care Advisory Committee meetings. The initial post-award forum was held on January 14, 2020 and no comments on the waiver progress were received. DMMA posted the date, time and location of the forum on its website 30 days prior to the post-award forum. DSHP is a standing agenda item for each quarterly MCAC meeting and these meetings also serve as the annual post-award forums. Frequent areas for updates and comments on progress include: MCO contracting; managed care enrollment; the DSHP 1115 Waiver July 2022 amendment, and special initiatives (e.g., adult dental implementation, COVID-19 PHE, APRA Section 9817 HCBS Spending Plan and PROMISE).

See Attachment A for documentation of compliance with the requirements for transparency and public notice.

Section X – Demonstration Administration

Name and Title: Kimberly Xavier, Chief of Planning and Policy, DMMA
Telephone Number: (302) 255-9628
Email Address: Kimberly.Xavier@state.de.us

Attachment A – Documentation for 1115 Waiver Transparency Requirements

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

State of Delaware
Public Notice
Delaware Health and Social Services
Division of Medicaid & Medical Assistance

Delaware Diamond State Health Plan (DSHP)
DRAFT 1115 Demonstration Waiver Extension Request

I. Summary Description and Purpose

Pursuant to the Special Terms and Conditions of Delaware's approved Medicaid demonstration waiver, the Delaware Department of Health and Social Services (DHSS), Division of Medicaid and Medical Assistance (DMMA) is required to submit a public notice consistent with 42 C.F.R 431.408 of its intent to submit a Section 1115 Waiver extension request to the Centers for Medicare & Medicaid Services (CMS). The current Diamond State Health Plan (DSHP) 1115 Waiver expires December 31, 2023 and DMMA is required by CMS to request an extension by December 31, 2022. DMMA is requesting a five-year extension (renewal) of the DSHP 1115 Demonstration Waiver and changes to the program features to be effective January 1, 2024 through December 31, 2028.

DMMA's draft Medicaid DSHP 1115 waiver extension application and current DSHP 1115 Waiver can be found here: http://dhss.delaware.gov/dhss/dmma/medicaid.html

II. Summary of Proposed 1115 DSHP Waiver Extension, Goals and Objectives

Delaware's DSHP 1115 Demonstration Waiver (DSHP 1115 Waiver) was initially approved in 1995, and implemented on January 1, 1996. The original goal of DSHP 1115 Waiver 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.

In order to achieve this goal, the DSHP 1115 Waiver was designed to mandatorily enroll eligible Medicaid recipients into managed care organizations (MCOs) and create

efficiencies in the Medicaid program. Initial savings achieved under managed care enabled the expansion of coverage to certain individuals who would otherwise not be eligible for Medicaid, leading up to Medicaid expansion under the Affordable Care Act in 2014. Since 2012, the DSHP 1115 Waiver has provided long-term services and supports (LTSS) to eligible individuals through DSHP Plus, as well as enhanced behavioral health services and supports for targeted Medicaid beneficiaries through a voluntary program begun in 2015 called PROMISE. Most individuals enrolled in Medicaid and Medicaid-expansion CHIP are enrolled in the DSHP 1115 Waiver and in MCOs. A limited number of benefits, such as non-emergency transportation and PROMISE services, are delivered through fee-for-service. In 2019, the DSHP 1115 waiver was extended for an additional five years and amended to include 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. Since 2020, DMMA has amended the DSHP 1115 Waiver for the addition of adult dental services to the DSHP managed care delivery system and secured COVID-19 demonstration amendment authorities focused on LTSS services (e.g., provider retainer payments, expanded home-delivered meals) to address the COVID-19 Public Health Emergency (PHE). DMMA also has an amendment pending with CMS to add home-visiting coverage, a second home-delivered HCBS meal, pediatric respite, a self-directed option for parents of children receiving personal care services, and nursing facility transition services.

DMMA is proposing four new changes in the extension period:

1. Expanding access by providing three-months of retroactive eligibility to all Medicaid enrollees;
2. Piloting Medicaid coverage of Delaware's Food Box Initiative for postpartum members;
3. Adding Medicaid coverage of contingency management services for certain members with a stimulant use disorder and/or opioid use disorder; and
4. Adding children's dental services under the DSHP 1115 managed care delivery model.

Delaware's goal and objectives in operating the DSHP 1115 Waiver into the future continue to be to improve the health status of low-income Delawareans by:

1. Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to home and community-based services (HCBS);
2. Rebalancing Delaware's LTC system in favor of HCBS;
3. Promoting early intervention for individuals with, or at-risk, for having, LTC needs;
4. Increasing coordination of care and supports;
5. Expanding consumer choices;
6. Improving the quality of health services, including LTC services, delivered to all Delawareans;

7. Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTSS services where appropriate;
8. Expanding coverage to additional low-income Delawareans;
9. Improving overall health status and quality of life of individuals enrolled in PROMISE;
10. Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population;
11. Increasing enrollee access and utilization of appropriate SUD treatment services and decrease use of medically inappropriate and avoidable high-cost emergency and hospital services;
12. Increasing access to dental services, including follow-up care and care for adults with diabetes, and decrease use of emergency department visits for non-traumatic conditions; and
13. Improving maternal and infant health outcomes and health disparities *(new for the extension)*.

Delaware will continue working towards these goals and objectives during the DSHP 1115 extension. DMMA is requesting continuation of the current DSHP 1115 waiver, as approved today, with the additional changes described below. A complete description of the current DSHP 1115 Waiver is available at:

http://dhss.delaware.gov/dhss/dmma/medicaid.html

III. Summary of the Current DSHP 1115 Waiver

DSHP 1115 Waiver Eligibility

Most Medicaid and Medicaid-expansion CHIP state plan eligibility groups are enrolled in DSHP. The groups described below are Medicaid eligible, but excluded from enrollment in DSHP.

Current DSHP Eligibility Exclusions
Individuals participating in a PACE Program
Qualified Medicare Beneficiaries (QMBs)
Specified Low Income Medicare Beneficiary (SLMB)
Qualifying Individuals (QI)
Qualified and Disabled Working Individuals
Individuals in a hospital for 30 consecutive days (acute care)
Presumptive Breast and Cervical Cancer for Uninsured Women
Breast and Cervical Cancer Program for women
Institutionalized individuals in an ICF/MR facility

DSHP also extends eligibility to non-state plan eligibility groups for their receipt of LTSS through DSHP-Plus and adds coverage for out-of-state former foster care youth. These groups are described in detail as “Demonstration Population Expenditures” in the current approved 1115 Demonstration.

Current DSHP Demonstration-Eligible Groups
217-Like Elderly and Disabled Home and Community Based Services (HCBS) Group: Aged and/or disabled categorically needy individuals over age 18 who meet the Nursing Facility LOC criteria in place at the time of HCBS enrollment and receive HCBS as an alternative (formerly served through an Elderly & Physically Disabled 1915c Waiver)
217-Like HIV/AIDS HCBS Group: Individuals with a diagnosis of AIDs or HIV over age 1 who meet the Hospital LOC criteria and who receive HCBS as an alternative (formerly served through an AIDS/HIV 1915c Waiver)
Aged and/or disabled individuals over age 18, who do not meet a NF LOC, but who, in the absence of HCBS, are “at-risk” of institutionalization and meet the “at-risk” for NF LOC criteria in place at the time of enrollment and who need/are receiving HCBS
TEFRA-Like Children (Katie Beckett) using the “at-risk of NF” LOC criteria in place at time of enrollment
Nursing facility residents, who do not currently meet the NF LOC criteria, but continue to meet the NF level of care criteria in place at the time of admission/enrollment.
Individuals receiving HCBS for the disabled and elderly, who do not meet the NF LOC criteria, but continue to meet the LOC criteria in place at the time of enrollment, including HCBS furnished under a terminated 1915(c) waiver.
Disabled children with incomes at or below 250 percent of the SSI, who do not meet the NF or hospital LOC criteria, but continue to meet the LOC criteria in place at the time of their enrollment.

DMMA is proposing to continue the current state plan and 1115 waiver eligibility groups for the DSHP extension.

DSHP 1115 Waiver Benefits

Individuals enrolled in the DSHP 1115 Demonstration receive most Medicaid and CHIP State Plan benefits through the DSHP 1115 Demonstration delivery system. Individuals eligible for DSHP-Plus receive comprehensive, integrated LTSS and individuals eligible for PROMISE receive enhanced behavioral health services in order to live and work in community-based integrated settings. DSHP also provides coverage for high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as IMDs.

DMMA is proposing to continue the current approved state plan and 1115 waiver benefits through the DSHP extension and add new benefit as described in “Changes Under the Demonstration.”

DSHP 1115 Waiver Delivery System
DSHP and DSHP-Plus benefits are delivered through mandatory enrollment in MCOs. A limited number of benefits, such as children's dental and non-emergency transportation, are currently delivered through fee-for-service (FFS). DSHP enrollees receive these benefits through Medicaid fee-for-service, not through the DSHP 1115 Waiver. PROMISE benefits are delivered through the FFS PROMISE program administered through the Division of Substance Abuse and Mental Health (DSAMH).

FFS Benefits (Not currently provided through the DSHP 1115 Waiver)
Dental services for children
NEMT Transportation broker services, except for emergency ambulance transportation
Day services authorized by the Division of Developmental Disabilities Services
Medically necessary behavioral health services for children in excess of MCO plan benefit coverage, which is 30 visits for children
Prescribed pediatric extended care
Targeted case management (TCM)

DMMA is proposing to continue the managed care and FFS delivery systems described in the current DSHP waiver, with the exception of children's dental services. DMMA is proposing to include children's dental services through the DSHP MCOs.

DSHP 1115 Waiver Cost-Sharing
Cost-sharing does not differ from the approved Medicaid and CHIP State Plans and DMMA is not proposing cost-sharing under the DSHP 1115 Waiver.

IV. Proposed Changes Under the Demonstration Extension:

A. July 2022 Pending Amendment
DMMA has proposed five changes to the DSHP 1115 Waiver that are pending in an amendment currently under review by CMS for an effective date of January 1, 2023. The changes in this amendment include:

1. Coverage of two models of evidenced-based home visiting for pregnant women and children.

2. Permanent coverage for a second home-delivered meal for members receiving HCBS in DSHP Plus.

3. Coverage of a pediatric respite benefit as an American Rescue Plan Act (ARP) Section 9817 HCBS Spending Plan initiative.

4. Coverage of a self-directed option for parents on behalf of children receiving state plan personal care services.

5. Coverage of Delaware's Nursing Home Transition Program (formerly Money Follows the Person Demonstration) in the DSHP 1115 waiver.

Additional description of these changes can be found in the pending amendment available on DMMA's website at: https://dhss.delaware.gov/dhss/dmma/medicaid.html

Delaware is proposing to include these changes, once approved by CMS, in the waiver extension.

B. New Changes Proposed for the DSHP Extension

DMMA is proposing four new changes in the extension period:

1. **Expanding access by providing three-months of retroactive eligibility to all DSHP 1115 Waiver enrollees.** DMMA is requesting to terminate the DSHP waiver of retroactive eligibility. Effective no later than January 1, 2024, with the expiration of the current DSHP 1115 waiver, DMMA will extend retroactive eligibility to all eligible DSHP and DSHP-Plus participants three months prior to the date that an application for medical assistance is made. Delaware will terminate this waiver authority to support our goal of expanding access to coverage, including coverage for those who need immediate care while applying for Medicaid.

   Waiver Impact: None. Members months associated with retroactive eligibility will be covered outside of the DSHP 1115 Waiver in Medicaid FFS.

2. **Piloting Medicaid coverage of Delaware's Food Box Initiative for postpartum members.** DMMA proposes to add Medicaid coverage of our Medicaid Food Box Initiative for postpartum members under the DSHP 1115 Waiver. The objective of the Food Box Initiative is to address food insecurity and diaper needs as health-related social needs to improve maternal and infant heath and reduce health disparities. The proposed demonstration would allow DMMA to use Medicaid funds to expand our current state-funded pilot to provide home-delivered food and diapers to postpartum members, reaching low-income postpartum members with disproportionately high rates of food insecurity and inequitable adverse maternal and birth outcomes.

   Waiver Impact: Approximately 8,841 members and $8.29 million over five years.

3. **Adding Medicaid coverage of contingency management services for certain members with a stimulant use disorder and/or opioid use disorder.** DMMA is proposing to add coverage of contingency management services for Medicaid members who are: (1) age 18 and over with a stimulant use disorder diagnosis and (2) age 18 and over, who are pregnant or up to 12 months postpartum, with an opioid use disorder diagnosis. Contingency management is an evidence-based practice that allows individuals to earn small motivational incentives for meeting treatment goals, such as negative urine drug tests or medication

adherence. The objectives of contingency management services are to expand SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder to help address the rise in fatal drug overdoses throughout Delaware. DMMA also expects this initiative to improve health outcomes and address health disparities.

Proposed Contingency Management Programs under DSHP

Program name	Population	Eligible Providers	Core Treatment Goal (incentivized outcome)	Expected Timeframe
Contingency Management Program for Stimulant Use Disorder (CM-StUD)	Individuals ages 18 and older who are diagnosed with stimulant use disorder (e.g., methamphetamine, cocaine, similar drugs), based on a completed SUD assessment	Outpatient SUD providers	Negative drug tests[1]	24 weeks
Contingency Management Program for Pregnant and Postpartum People with Opioid Use Disorder (CM-PPP-OUD)	Individuals ages 18 and older, who are pregnant and/or up to 12 months postpartum, with a diagnosed opioid use disorder, based on a completed SUD assessment	Opioid treatment programs (OTPs), OB-GYNs, primary care providers, outpatient SUD providers	Medication adherence (i.e., adherence to medications used to treat opioid disorder, such as methadone or buprenorphine)	64 weeks

Waiver Impact: Approximately 800 members and $1.54 million over five years.

4. **Adding children's state plan dental services under the DSHP 1115 managed care delivery model.** Effective January 1, 2024, DMMA is proposing to include children's dental services in the DSHP 1115 Waiver managed care delivery system. The objective of including children's dental services in DSHP managed care is to

[1]Although negative drugs tests will be the core treatment goal for the CM-StUD program, DMMA views this as just one tool in a more comprehensive treatment approach. Providers will be encouraged to continue to use a harm reduction approach to treatment overall, in part by not focusing solely on abstinence as a sign of progress toward recovery.

ensure access to high-quality dental care for children and support a coordinated and integrated delivery system. DMMA expects dental managed care for children will result in a positive (or no negative) impact on child dental access, health outcomes and parent/caretaker satisfaction.

Waiver Impact: Beginning in CY 2024, approximately 114,000 Medicaid-enrolled children will begin receiving their dental services through MCOs under the DSHP 1115 Waiver. These expenditures are currently excluded from the DSHP 1115 Waiver. Dental managed care will shift approximately $327 million in expenditures over five years from FFS to the DSHP 1115 Waiver.

V. DSHP 1115 Waiver and Expenditure Authorities

DMMA is requesting to continue all current approved and pending waiver and expenditure authorities, with the exception of the waiver of retroactive eligibility. DMMA is not requesting to renew the current waiver of retroactive eligibility.

Table 1. Requested Waiver Authorities

	Waiver Authority	Use for Waiver/Expenditure Authority	Current/Expanded/ New/Terminated Waiver Authority Request
1.	Amount, Duration, and Scope of Services Section 1902(a)(10)(B) and 1902(a)(17)	To the extent necessary to enable Delaware to offer a different benefit package to DSHP and DSHP-Plus participants than is being offered to the traditional Medicaid population. To the extent necessary to enable Delaware to provide additional services to enrollees in the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) Program. The waiver request is being expanded to include the extension changes described in Section IV: (1) To the extent necessary to enable Delaware to provide additional services to enrollees participating in the Food Box Pilot initiative for postpartum members as described in Section IV of this application	Current/Expanded

		(2) To the extent necessary to enable Delaware to provide contingency management services not otherwise available to all members in the same eligibility group but based on individual assessments of need according to criteria described in Section IV this application.	
2.	Provision of Medical Assistance Section 1902(a)(8) and 1902(a)(10)	To the extent necessary to enable Delaware to limit the provision of medical assistance (and treatment as eligible) for individuals described in the eligibility group under section 1902(a)(10)(A)(ii)(XX) of the Act and the Medicaid State Plan to only former foster care youth who are under 26 years of age, were in foster care under the responsibility of another state or tribe on the date of attaining 18 years of age (or such higher age as the state has elected), were enrolled in Medicaid on that date, and now residents in Delaware applying for Medicaid.	Current
3.	Freedom of Choice Section 1902(a)(23)(A)	To the extent necessary to enable Delaware to restrict freedom-of-choice of provider through the use of mandatory enrollment into managed care plans for DSHP and DSHP- Plus participants. To the extent necessary to enable the state to use selective contracted fee-for-service (FFS) providers, including for Home and Community Based Services (HCBS) and a transportation broker for non- medical transportation. No waiver of freedom of choice is requested for family planning providers. The waiver request is being expanded to include the extension changes described in Section IV: To enable Delaware to restrict freedom of choice of provider for the Food Box Pilot	Current/Expanded

		Initiative, contingency management services, and children's dental services through the use of mandatory enrollment in MCOs.	
3.	Retroactive Eligibility Section 1902(a)(34)	To the extent necessary to enable Delaware to not extend eligibility to DSHP and DSHP- Plus participants prior to the date that an application for assistance is made, with the exception of institutionalized individuals in nursing facilities and qualified disabled working individuals (QDWIs), as outlined in Table A of the STCs. The waiver of retroactive eligibility does not apply to pregnant women (including during the 60-day postpartum period beginning on the last day of the pregnancy), infants under age 1, or individuals under age 19.	Terminate
4.	Self-Direction of Care Section 1902(a)(32)	To the extent necessary to enable Delaware to permit parents (on behalf of children up to age 21) to self-direct state plan personal care services.	New (Pending Amendment)

Table 2. Requested Expenditure Authorities

	Use for Expenditure Authority	Currently/Expanded/ New Expenditure Authority Request
1.	**217-Like Elderly and Disabled Home and Community Based Services (HCBS) Group:** Expenditures for medical assistance for disabled individuals over age 18 who meet the Nursing Facility (NF) level of care (LOC) criteria and who would otherwise be Medicaid-eligible if the state had elected the group described in section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if enrolled and receiving services under a 1915(c) HCBS waiver program	Current

	Use for Expenditure Authority	Currently/Expanded/ New Expenditure Authority Request
2.	**217-Like HIV/AIDS HCBS Group:** Expenditures for medical assistance for individuals over age 1, who have a diagnosis of AIDS or HIV, who meet the hospital LOC criteria, and who would otherwise be Medicaid-eligible if the state had elected the eligibility group described in section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, and they were enrolled and receiving services under a 1915(c) HCBS waiver program.	Current
3.	**"At-risk" for Nursing Facility Group:** Expenditures for medical assistance for disabled individuals over age 18 with incomes at or below 250 percent of the Supplemental Security Income (SSI) Federal Benefit Rate who do not meet the NF LOC, but are "at-risk" for institutionalization.	Current
4.	**TEFRA-Like Group:** Expenditures for medical assistance for disabled children under age 18 with incomes at or below 250 percent of the SSI who do not meet the NF LOC, but are "at-risk" of institutionalization absent the provision of DSHP services. The state will use financial institutional eligibility rules for individuals who would not be eligible in the community because of community deeming rules (in the same manner that would be used if the group were eligible under the state plan.	Current
5.	**Continuing Receipt of Nursing Facility Care:** Expenditures for medical assistance for nursing facility residents, who do not currently meet the NF LOC criteria, but continue to meet the NF level of care criteria in place at the time of admission/enrollment.	Current
6.	**Continuing Receipt of Home and Community-Based Services:** Expenditures for medical assistance for individuals receiving HCBS for the disabled and elderly, who do not meet the NF LOC criteria, but continue to meet the LOC criteria in place at the time of enrollment, including HCBS furnished under a terminated 1915(c) waiver.	Current

	Use for Expenditure Authority	Currently/Expanded/ New Expenditure Authority Request
7.	**Continuing Receipt of Medicaid State Plan Services:** Expenditures for medical assistance for disabled children with incomes at or below 250 percent of the SSI, who do not meet the NF or hospital LOC criteria, but continue to meet the LOC criteria in place at the time of their enrollment.	Current
8.	**PROMISE Services:** Expenditures for behavioral health services beyond the services described in the approved state plan for otherwise eligible individuals enrolled in the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) program.	Current
9.	**HCBS for Medicaid State Plan Eligibles**: Expenditures to provide HCBS not included in the Medicaid State Plan to individuals who are eligible for Medicaid as described in the STCs. This request includes expenditures for home-delivered meals and pediatric respite benefits that are under review by CMS in a waiver amendment.	Current/Expanded (Pending Amendment)
10.	**Residential and Inpatient Treatment for Individuals with a Substance Use Disorder (SUD):** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an Institution for Mental Diseases (IMD).	Current
11.	**Home visiting for Medicaid eligible pregnant women and children under the age of three:** Expenditures to provide evidenced-based home visiting to Medicaid eligible pregnant women and children.	New (Pending Amendment)
12.	**Self-directed personal care/attendant care for children:** Expenditures to provide self-directed personal care/attendant care for children receiving state plan personal care services.	New (Pending Amendment)
14.	**Post-partum Food Box Initiative:** Expenditures to provide coverage of food boxes, including transportation to members, for members up to 12 weeks postpartum.	New

	Use for Expenditure Authority	Currently/Expanded/ New Expenditure Authority Request
15.	**Contingency management services:** Expenditures to provide contingency management services to eligible individuals with a qualifying stimulant use and/or opioid use disorder.	New

VI. DSHP 1115 Waiver Estimates of Historical and Proposed Annual Enrollment and Annual Aggregate Expenditures and Financial Analysis of Proposed Changes

A summary of annual and aggregate historical and projected demonstration enrollment and expenditure data is provided in the tables below. Note that not all Medicaid expenditures are captured in these tables. For example, State administrative expenditures and expenditures for populations or services excluded from the current 1115 waiver are not included. Data is limited to expenditures that are considered as part of the current 1115 waiver budget neutrality and projected new expenditures where data and estimates are currently available. Demonstration projections are approximate assumptions for the purposes of the waiver renewal planning. Demonstration financing and budget neutrality assumptions will continue to evolve throughout the course of the waiver renewal process and as new budget data becomes available. The impact and timing of the ending of the PHE will impact enrollment projections. Current impact is shown in DY 28 and beyond.

Table 1. Historical Data for Current DSHP Demonstration Period

	DY24	DY25	DY26	DY27*	DY28*	Five Year Total
	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	
Total Enrollment	205,913	215,034	244,414	260,582	260,582	1,186,526
Total Expenditure (in billions)	$2.085	$2.09	$2.25	$2.32	$2.43	$11.18

*Based on projections from the current approved waiver and pending amendment request.
Differences may exist due to rounding.

Table 2. Projected Data for DSHP Demonstration Extension Period

	DY29	DY30	DY31	DY32	DY33	Five Year Total
	CY 2024	CY 2025	CY 2026	CY 2027	CY 2028	
Total Enrollment	266,379	274,434	282,734	291,285	300,096	1,414,928
Total Expenditure (in billions)	$2.62	$2.75	$2.89	$3.04	$3.19	$14.50

Note: Includes amounts from Table 3. Differences may exist due to rounding.

Table 3. Projected Expenditures and Enrollment for New Demonstration Proposals in Renewal Period

	DY29	DY30	DY31	DY32	DY33	Five Year Total
	CY 2024	CY 2025	CY 2026	CY 2027	CY 2028	
Retroactive Eligibility	NA	NA	NA	NA	NA	NA
Children's Dental Managed Care Expenditures	$59,190,092	$62,149,597	$65,257,077	$68,519,930	$71,945,927	$327,062,623
Members Impacted	114,012	117,433	120,956	124,584	128,322	605,307
Food Box Initiative Expenditures	$1,500,000	$1,575,000	$1,653,750	$1,736,438	$1,823,259	$8,288,447
Members Impacted	1,600	1,680	1,764	1,852	1,945	8,841
Contingency Management Expenditures	$192,900	$289,350	$289,350	$385,800	$385,800	$1,543,200
Members Impacted	100	150	150	200	200	800

Note: All amounts in this table are included in the total expenditures in Table 2. Differences may exist due to rounding.

VII. DSHP 1115 Waiver Interim Evaluation Results and Renewal Evaluation

A. Interim Evaluation Results

Per STC #93, an independent external evaluator is tasked with evaluating the demonstration, including data analysis and validation relative to the demonstration hypotheses, the development of quarterly monitoring reports, an interim evaluation report, and a final evaluation report. DMMA commissioned Burns & Associates, a Division of Health Management Associates (HMA-Burns), as the independent external evaluator for the overall evaluation of the DSHP 1115 Waiver and a separate interim evaluation of the SUD component of the DSHP 1115 Waiver. The following is a summary of the two Interim Evaluation reports. A copy of the full Interim Evaluation Reports can be found in Appendix B (reserved for final application to CMS) and on DMMA's website as part of the draft application:

https://dhss.delaware.gov/dhss/dmma/medicaid.html

1. SUD Interim Evaluation Results

HMA-Burns noted that DMMA saw progress towards our aim to expand SUD-specific services to our Medicaid population through the initial phase of the SUD demonstration period. This occurred through the expansion of coverage for short-term stays in residential and hospital inpatient treatment settings that qualify as institutions for mental disease (IMDs), new services added across the ASAM continuum, and a concentrated effort to increase access to existing SUD services. The Interim Evaluation concluded that DMMA did not meet all of the desired outcomes outright but still saw many positive impacts due to the DSHP 1115 Waiver. HMA-Burns also noted the PHE likely had a confounding effect in enabling DMMA to fully meet these aims during the demonstration period. When considering the CMS Milestones, DMMA saw success in each milestone with the exception of Milestone 6, Improved Access to Care for Physical Health Conditions Among Beneficiaries.

Among 29 measures reviewed, HMA-Burns found there were 15 where the desired outcome was met. Of these, eight measures had an outcome that was statistically significant in the desired direction. For the 14 measures where the desired outcome was not met, 11 measures had a statistically significant change in the wrong direction. DMMA was also successful in large part in the activities we set out to do in our SUD Implementation Plan. Among the eight activities identified, five were completed in full and the remainder are in progress.

HMA-Burns also identified eight opportunities for improvement for DMMA to consider as we continue to enhance service delivery and access. HMA-Burns' recommendations focus on reimbursement strategies to encourage greater provider participation, education to providers on ASAM criteria and authorization requests, and strategies to incentivize the MCOs to improve initiation and engagement in treatment for SUD beneficiaries.

2. Comprehensive Interim Evaluation Results

HMA-Burns noted that DMMA has seen progress towards our goals related to rebalancing LTC in favor of HCBS, maintaining continuity of enrollment, and maintaining access to care thus far in this demonstration period. The Interim Evaluation concluded that DMMA did not meet all of the desired outcomes outright but still saw many positive impacts due to the DSHP 1115 Waiver. HMA-Burns also noted the PHE likely had a confounding effect in enabling DMMA to fully meet these aims during the demonstration period.

Among the 63 measures, there were 39 measures where the desired outcome was met. Statistical tests were run for 28 of the 63 measures. Among these 28 measures, there are nine measures which have a statistically significant trend in the intended direction, nine measures which have a statistically significant trend in the wrong direction, and 10 measures where the trend was found not to be statistically significant.

HMA-Burns noted the following positive impacts due to the DSHP 1115 Waiver:

<u>Maintaining Continuity of Enrollment</u>
Noteworthy positive impacts were found in the following areas:

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

<u>Maintaining Access to Care</u>
Noteworthy positive impacts between CY 2018 and CY 2021 were found in the following areas:

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

- The PROMISE provider network also increased from 318 to 377 providers.

Maintaining or Improving Health Outcomes
Noteworthy positive impacts between CY 2018 and CY 2021 were found in the following areas:

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

Rebalancing LTSS in favor of HCBS.
Noteworthy positive impacts between CY 2018 and CY 2021 were found in the following areas:

- The utilization rate of HCBS services among DSHP Plus members.
- The PMPM expenditures for HCBS among DSHP Plus members increased 39 percent
  while the PMPM expenditures for institutional care decreased 16 percent.
- The proportion of spending between HCBS and institutional care changed from a mix of
  25 percent/75 percent in CY 2018 to 35 percent/65 percent in CY 2021.

Areas in which HMA-Burns will focus on assessing improvement in the remainder of this demonstration period include the following:

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

HMA-Burns also identified eight opportunities for improvement for DMMA to consider during the remainder of the demonstration period which focus on:

1. Developing performance improvement projects (PIPs) specific to improving follow-up after emergency department or hospitalization for mental illness or for alcohol and other drug dependence.

2. Enhancing managed care reporting that will allow for assessing the effectiveness of case management by tying enrollment by the member in case management with specific access or health outcomes.

3. Continuing the rate study of mental health services and considering value-based payment alternatives for providers serving the PROMISE population in particular.

4. Consider including the services specific to the PROMISE program under the responsibility of the MCOs. Or, at minimum, strengthen the oversight of the coordination of care requirements between the MCO's case manager for acute care services and the state's PROMISE care manager for PROMISE services.

B. Proposed Renewal Evaluation Design

Proposed Hypotheses and Evaluation

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
1.	DSHP members who participate in the Food Box Initiative for postpartum members will have reduced food insecurity, reduced health disparities and improved health outcomes compared to eligible members who do not participate.	The percentage of participating members who attend postpartum visits and infant well-child visits will increase as compared to members who do not participate in the Food Box initiative. Participating members will report increased food security during the postpartum period impacted by the Food Box Initiative.	CMS Adult, Child and Maternity Core Sets Claims and encounter data New survey (e.g., The Six-Item Short Form of the Food Security Survey Model, USDA)	New

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
2.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	The percentage of eligible Medicaid beneficiaries who participate in contingency management will increase during the five-year period.	Claims and encounter data	New
3.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	The rate of participation in contingency management programs should be relatively similar across racial and ethnic groups, factoring in any underlying differences in substance use across these populations (i.e., contingency management should be promoted to, and ideally utilized by, eligible Medicaid members regardless of race or ethnic background).	Claims and encounter data Medicaid enrollment data	New

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
4.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	SUD treatment retention rates will increase among eligible individuals who participate in contingency management programs.	Claims and encounter data	New
5.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	The rate of negative drug tests will be higher among individuals with stimulant use disorder who participate in contingency management than among individuals who do not participate in contingency management.	Claims and encounter data, including relevant diagnosis codes: R82.998 for a positive urine test, and Z71.51 for a negative urine test)	New
7.	Expanding SUD/OUD treatment for	Increasing access to contingency management will	Claims and encounter data	New

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	reduce emergency department utilization and preventable hospital admissions.		
8.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	Increasing access to contingency management will reduce fatal and non-fatal drug overdoses.	Claims and encounter data DFS death data/toxicology reports	New
9.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use	Pregnant people who participate in contingency management will have newborns with lower rates of neonatal	Claims and encounter data	New

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	abstinence syndrome, when compared to their counterparts who did not participate in contingency management.		
10.	Dental managed care for children will result in a positive (or no negative) impact on child dental access, health outcomes and parent/caretaker satisfaction.	MCOs will maintain access to dentists at or above FFS levels. Parents/caretakers will report satisfaction with key access measures of dental managed care.	Modified CAHPS Dental Plan Survey Claims, provider enrollment data, reports submitted by MCOs	New
11.	Trends observed in access to health care through the DSHP 1115 Waiver for the Medicaid population continue (or does not worsen) in the current waiver period.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
12.	Trends in coordination of care and supports continues (or	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	does not worsen) in the current waiver period			
13.	Coordination of care and supports maintains or improves quality of care and health outcomes in the current waiver period	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
14.	Trends in consumer satisfaction will continue (or not worsen) in the current waiver period.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
15.	Creating a delivery system that provides incentives for resources to shift from institutions to community-based LTSS has maintained or increased utilization of HCBS services where appropriate in the current waiver period.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
16.	Trends in health outcomes will continue or improve in the current waiver period for	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	individuals enrolled in the PROMISE program			
17.	The PROMISE program network capacity will continue (or not worsen) in the current waiver period.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
18.	The availability of the adult dental benefit will improve access to dental services and will continue (or not worsen) health outcomes in the current waiver period.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
19.	The demonstration will increase or maintain the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDs.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
20.	The demonstration will increase or maintain adherence to and retention in treatment for OUD	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
21.	Approved service authorizations improve appropriate utilization of health care services in the post-waiver period	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
22.	The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
23.	The demonstration will increase or maintain the percentage of beneficiaries with SUD who experience care for comorbid conditions	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
24.	Among beneficiaries receiving care for SUD, the demonstration will reduce or maintain readmissions to SUD treatment.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
25.	The demonstration will decrease	No change from current approved DSHP 1115 waiver evaluation design, described in		Continuing

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	the rate of overdose deaths due to opioids.	Attachment H of the approved DSHP 1115 Waiver.		
26.	The demonstration will increase or maintain the use of Delaware's PDMP.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
27.	The demonstration will decrease or maintain per beneficiary per month costs.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
28.	The demonstration will increase or maintain per beneficiary per month costs for SUD services versus non-SUD services.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
29.	The demonstration will decrease or maintain per beneficiary costs for SUD-related ED visits and inpatient stays	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
30.	The addition of two evidence-based home visiting models will improve the health and wellbeing of the Medicaid participants.	No change from the amendment currently under CMS review. DMMA is in the process of defining the evaluation measures, which may include measures such as: Mother Child Depression Screening, post-partum visit, treatment for a behavioral health condition, and dental visit.		New (Pending CMS review of amendment)

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
31.	The provision of home-delivered meals and nursing facility transition services, as part of an HCBS benefit package, will succeeds in supporting Delaware's goals of improving access to health care by expanding access to HCBS and rebalancing Delaware's long-term care system in favor of HCBS.	No change from the amendment currently under CMS review. DMMA intends to incorporate the addition of a second home delivered meal into the current Evaluation design that assesses whether the provision of meals, as part of a package of HCBS services, succeeds in supporting Delaware's waiver goals. DMMA will also add a measure related to the percentage of reinstitutionalizations lasting more than 30 days, using claims and encounter data, and work with CMS to align DSHP 1115 waiver measures with Money Follows the Person (MFP).		New (Pending CMS review of amendment)
32.	The provision of a respite benefit for caregivers reduces informal caregiver burnout and increases family/caregiver satisfaction with the program.	No change from the amendment currently under CMS review. These items will be measured through the administration of a family/caregiver survey that will be included as part of the current Evaluation design.		New (Pending CMS review of amendment)
33.	The provision of a self-directed option for children receiving Medicaid State Plan personal care (attendant care) will increase family satisfaction with	No change from the amendment currently under CMS review. Family satisfaction will be measured through the administration of a family/caregiver survey that will be included as part of the current Evaluation design. Additionally, DMMA will add a measure related to the percentage increase in DSP network participation, using MCO provider enrollment data, because of this option.		New (Pending CMS review of amendment)

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	this Medicaid benefit and expand the DSP workforce.			

VIII. Public Comment Submission Process

As required by 42 CFR 431.408, DMMA must provide opportunity for a 30-day public comment period on the proposed DSHP 1115 Waiver extension. The public is invited to review and comment on the proposed DSHP 1115 Waiver extension beginning November 14, 2022 through December 13, 2022. **Comments must be received by 4:30pm on December 13, 2022.**

This public notice, a copy of the draft waiver extension request, a copy of the current approved waiver, a copy of the pending amendment and copies if the DSHP 1115 Waiver Interim Evaluation reports are posted on the DMMA website at: http://dhss.delaware.gov/dhss/dmma/medicaid.html

Comments on the extension may be submitted the following ways:

By email: dhss_dmma_publiccomment@delaware.gov

By fax: 302-255-4481 to the attention of Melissa Dohring

By mail:

1115 Demonstration Waiver Extension Attn: Melissa Dohring
Division of Medicaid and Medical Assistance
Planning and Policy Unit
1901 North DuPont Highway P.O. Box 906
New Castle, Delaware 19720-0906

The hardcopy waiver extension application will be available by request via email at: DMMA_PublicHearing@delaware.gov (Please identify in the subject line: 1115 Demonstration Waiver Extension)

Public Comment Meetings:

DMMA will hold two public meetings with opportunity for public comment, as listed below:

1. **Meeting #1**

In-Person and Virtual Meeting
November 18, 2022
12:00pm – 1:30pm

DHSS Herman M. Holloway Sr. Campus
1901 N DuPont Hwy
New Castle DE 19720
DHSS Chapel (located on DHSS campus)

Via Zoom:
https://us06web.zoom.us/j/82520214976
Webinar ID: 825 2021 4976
Or Telephone: US: +1 646 931 3860

2. **Meeting #2**

Virtual meeting
November 30, 2022
DMMA Medical Care Advisory Committee (MCAC)
9:00am – 11:00am

Via Zoom:
https://zoom.us/j/99696774582?pwd=SDJCcGpVamx3Sy9jMkRiNXpJaStNdz09

Meeting ID: 996 9677 4582
Passcode: 080737
Or Telephone: US: +1 301 715 8592
Meeting ID: 996 9677 4582
Passcode 080737#

Any public feedback received will be summarized including any changes that will be made as a result of the public comments on the DSHP 1115 Waiver extension.

If you require special assistance and/or services to participate in the public meeting (e.g., sign language interpretation or other translation services, etc.), please call or email the following contact at least ten (10) days in advance (when possible) prior to the meeting for arrangements:

Melissa Dohring (302) 255-9674; melissa.dohring@delaware.gov

The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations in advance.

The deadline to provide public comment is Monday, December 13, 2022 at 4:30pm ET.

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State of Delaware:

County of Kent:

Before me, a Notary Public, for the County and State aforesaid. Darel LaPrade, known to me to be such, who being sworn according to law deposed and says that he is the Publisher of **Delaware State News,** a daily newspaper published at Dover, County of Kent, and State of Delaware,and that the notice, a copy of which is hereto attached, as published in the **Delaware State News** in its issue of 11/13/22.

[redacted]

Publisher
Independent Newsmedia Inc. USA

Sworn to and subscribed before me this 13th Day of November, A.D., 2022

ROXANNE BROOKS
NOTARY PUBLIC
STATE OF DELAWARE
MY COMMISSION EXPIRES March 9, 2023

Roxanne Brooks
Notary Public

State of Delaware
Public Notice
Delaware Health and Social Services

Delaware Diamond State Health Plan (DSHP)
1115 Demonstration Waiver Extension Request

Summary Description and Purpose

Pursuant to the Special Terms and Conditions of Delaware's approved Medicaid demonstration waiver, the Delaware Department of Health and Social Services (DHSS), Division of Medicaid and Medical Assistance (DMMA) is required to submit a public notice consistent with 42 C.F.R 431.408 of its intent to submit a Section 1115 Waiver extension request to the Centers for Medicare & Medicaid Services (CMS). The current Diamond State Health Plan (DSHP) 1115 Waiver expires December 31, 2023 and DMMA is required by CMS to request an extension by December 31, 2022. DMMA is requesting a five-year extension (renewal) of the DSHP 1115 Demonstration Waiver and changes to the program features to be effective January 1, 2024 through December 31, 2028.

Summary of Proposed 1115 DSHP Waiver Extension

Delaware's DSHP 1115 Demonstration Waiver (DSHP 1115 Waiver) was initially approved in 1995, and implemented on January 1, 1996. The original goal of DSHP 1115 Waiver 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.

In order to achieve this goal, the DSHP 1115 Waiver was designed to mandatorily enroll eligible Medicaid recipients into managed care organizations (MCOs) and create efficiencies in the Medicaid program. Initial savings achieved under managed care enabled the expansion of coverage to certain individuals who would otherwise not be eligible for Medicaid, leading up to Medicaid expansion under the Affordable Care Act in 2014. Since 2012, the DSHP 1115 Waiver has provided long-term services and supports (LTSS) to eligible individuals through DSHP Plus, as well as enhanced behavioral health services and supports for targeted Medicaid beneficiaries through a voluntary program begun in 2015 called PROMISE. Most individuals enrolled in Medicaid and Medicaid-expansion CHIP are enrolled in the DSHP 1115 Waiver and in MCOs. A limited number of benefits, such as non-emergency transportation and PROMISE services, are delivered through fee-for-service. In 2019, the DSHP 1115 waiver was extended for an additional five years and amended to include 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. Since 2020, DMMA has amended the DSHP 1115 Waiver for the addition of adult dental services to the DSHP managed care delivery system and secured COVID-19 demonstration amendment authorities focused on LTSS services (e.g., provider retainer payments, expanded home-delivered meals) to address the COVID-19 Public Health Emergency (PHE). DMMA also has an amendment pending with CMS to add home-visiting coverage, a second home-delivered HCBS meal, pediatric respite, a self-directed option for parents of children receiving personal care services, and nursing facility transition services.

Delaware's goal and objectives in operating the DSHP 1115 Waiver into the future continue to be to improve the health status of low-income Delawareans by:

1. Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to home and community-based services (HCBS);
2. Rebalancing Delaware's LTC system in favor of HCBS;
3. Promoting early intervention for individuals with, or at-risk, for having, LTC needs;
4. Increasing coordination of care and supports;
5. Expanding consumer choices;
6. Improving the quality of health services, including LTC services, delivered to all Delawareans;
7. Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTSS services where appropriate;
8. Expanding coverage to additional low-income Delawareans;
9. Improving overall health status and quality of life of individuals enrolled in PROMISE;
10. Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population;
11. Increasing enrollee access and utilization of appropriate SUD treatment services and decrease use of medically inappropriate and avoidable high-cost emergency and hospital services;
12. Increasing access to dental services, including follow-up care and care for adults with diabetes, and decrease use of emergency department visits for non-traumatic conditions; and
13. Improving maternal and infant health outcomes and health disparities (new).

Delaware will continue working towards these goals and objectives during the DSHP 1115 extension. DMMA is requesting continuation of the current DSHP 1115 waiver, as approved today, with the additional changes described below. A complete description of the current DSHP 1115 Waiver is available at:

http://dhss.delaware.gov/dhss/dmma/medicaid.html

Changes Under the Demonstration Extension

July 2022 Pending Amendment
DMMA has proposed five changes to the DSHP 1115 Waiver that are pending in an amendment currently under review by CMS for an effective date of January 1, 2023. The changes in this amendment include:

1. Coverage of two models of evidenced-based home visiting for pregnant women and children.

2. Permanent coverage for a second home-delivered meal for members receiving HCBS in DSHP Plus.

3. Coverage of a pediatric respite benefit as an American Rescue Plan Act (ARP) Section 9817 HCBS Spending Plan initiative.

4. Coverage of a self-directed option for parents on behalf of children receiving state plan personal care services.

5. Coverage of Delaware's Nursing Home Transition Program (formerly Money Follows the Person Demonstration) in the DSHP 1115 waiver.

Additional description of these changes can be found in the pending amendment available on the DMMA website at: http://dhss.delaware.gov/dhss/dmma/medicaid.html

Delaware is proposing to include these changes, once approved by CMS, in the waiver extension.

New Changes Proposed for the DSHP Extension
Delaware is proposing four new changes in the extension period:

1. **Expand access by providing three-months of retroactive eligibility to all DSHP 1115 Waiver enrollees.** DMMA is requesting to terminate the DSHP waiver of retroactive eligibility. Effective no later than January 1, 2024, with the expiration of the current DSHP 1115 waiver, DMMA will extend retroactive eligibility to all eligible DSHP and DSHP-Plus participants three months prior to the date that an application for medical assistance is made. Delaware will terminate this waiver authority to support our goal of expanding access to coverage, including coverage for those who need immediate care while applying for Medicaid.

2. **Pilot Medicaid coverage of Delaware's Food Box Initiative for postpartum members.** DMMA proposes to add Medicaid coverage of our Medicaid Food Box Initiative for postpartum members under the DSHP 1115 Waiver. The objective of the Food Box Initiative is to address food insecurity and diaper needs as health-related social needs to improve maternal and infant heath and reduce health disparities. The proposed demonstration would allow DMMA to use Medicaid funds to expand our current state-funded pilot to provide home-delivered food and diapers to postpartum members, reaching low-income postpartum members with disproportionately high rates of food insecurity and inequitable adverse maternal and birth outcomes.

3. **Add Medicaid coverage of contingency management services for certain members with a stimulant use disorder and/or opioid use disorder.** DMMA is proposing to add coverage of contingency management services for Medicaid members who are: (1) age 18 and over with a stimulant use disorder diagnosis and (2) age 18 and over, who are pregnant or up to 12 months postpartum, with an opioid use disorder diagnosis. Contingency management is an evidence-based practice that allows individuals to earn small motivational incentives for meeting treatment goals, such as negative urine drug tests or medication adherence. The objectives of contingency management services are to expand SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder to help address the rise in fatal drug overdoses throughout Delaware.

4. **Add children's state plan dental services under the DSHP 1115 managed care delivery model.** Effective January 1, 2024, DMMA is proposing to include children's dental services in the DSHP 1115 Waiver managed care delivery system. The objective of including children's dental services in DSHP managed care is to ensure access to high-quality dental care for children and support a coordinated and integrated delivery system.

Public Comment Submission Process
As required by 42 CFR 431.408, DMMA must provide opportunity for a 30-day public comment period on the proposed DSHP 1115 Waiver extension. The public is invited to review and comment on the proposed DSHP 1115 Waiver extension beginning November 14, 2022 through December 13, 2022. **Comments must be received by 4:30pm on December 13, 2022.**

569825 DSN 11/13/2022

Continued On Next Page

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Before me, a Notary Public, for the County and State aforesaid. Darel LaPrade, known to me to be such, who being sworn according to law deposed and says that he is the Publisher of **Delaware State News,** a daily newspaper published at Dover, County of Kent, and State of Delaware,and that the notice, a copy of which is hereto attached, as published in the **Delaware State News** in its issue of 11/13/22.

[redacted]

Publisher
Independent Newsmedia Inc. USA

Sworn to and subscribed before me this 13th Day of November, A.D., 2022

ROXANNE BROOKS
NOTARY PUBLIC
STATE OF DELAWARE
MY COMMISSION EXPIRES
March 9, 2023

Roxanne Brooks
Notary Public

Continued From Previous Page

This public notice, a copy of the draft waiver extension request, a copy of the current approved waiver, a copy of the pending amendment and a copy of the interim evaluation reports are posted on the DMMA website at: http://dhss.delaware.gov/dhss/dmma/medicaid.html

Comments on the extension may be submitted the following ways:

By email: dhss_dmma_publiccomment@delaware.gov

By fax: 302-255-4481 to the attention of Melissa Dohring

By mail:

1115 Demonstration Waiver Extension
Division of Medicaid and Medical Assistance
Planning and Policy Unit
1901 North DuPont Highway P.O. Box 906
New Castle, Delaware 19720-0906

The hardcopy waiver extension application will be available by request via email at: DMMA_PublicHearing@delaware.gov (Please identify in the subject line: 1115 Demonstration Waiver Extension)

Public Comment Meetings:

DMMA will hold two public meetings with opportunity for public comment, as listed below:

1. **Meeting #1**

In-Person and Virtual Meeting
November 18, 2022
12:00pm – 1:30pm

DHSS Herman M. Holloway Sr. Campus
1901 N DuPont Hwy
New Castle DE 19720
DHSS Chapel (located on DHSS campus)

Via Zoom:
https://us06web.zoom.us/j/82520214976
Webinar ID: 825 2021 4976
Or Telephone: US: +1 646 931 3860

2. **Meeting #2**

Virtual meeting
November 30, 2022

DMMA Medical Care Advisory Committee (MCAC)
9:00am – 11:00am

Via Zoom:
https://zoom.us/j/99696774582?pwd=SDJCcGpVamx3Sy9jMkRiNXpJaStNdz09

Meeting ID: 996 9677 4582
Passcode: 080737
Or Telephone: US: +1 301 715 8592
Meeting ID: 996 9677 4582
Passcode 080737#

Any public feedback received will be summarized including any changes that will be made as a result of the public comments on the DSHP 1115 Waiver extension.

If you require special assistance and/or services to participate in the public meeting (e.g., sign language interpretation or other translation services, etc.), please call or email the following contact at least ten (10) days in advance (when possible) prior to the meeting for arrangements:

Melissa Dohring (302) 255-9674; melissa.dohring@delaware.gov

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Stephen M. Groff
Director
Division of Medicaid and Medical Assistance
569832 DSN 11/13/2022

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DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

State of Delaware
Public Notice
Delaware Health and Social Services

Delaware Diamond State Health Plan (DSHP)
1115 Demonstration Waiver Extension Request

Summary Description and Purpose
Pursuant to the Special Terms and Conditions of Delaware's approved Medicaid demonstration waiver, the Delaware Department of Health and Social Services (DHSS), Division of Medicaid and Medical Assistance (DMMA) is required to submit a public notice consistent with 42 C.F.R 431.408 of its intent to submit a Section 1115 Waiver extension request to the Centers for Medicare & Medicaid Services (CMS). The current Diamond State Health Plan (DSHP) 1115 Waiver expires December 31, 2023 and DMMA is required by CMS to request an extension by December 31, 2022. DMMA is requesting a five-year extension (renewal) of the DSHP 1115 Demonstration Waiver and changes to the program features to be effective January 1, 2024 through December 31, 2028.

Summary of Proposed 1115 DSHP Waiver Extension
Delaware's DSHP 1115 Demonstration Waiver (DSHP 1115 Waiver) was initially approved in 1995, and implemented on January 1, 1996. The original goal of DSHP 1115 Waiver 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.

In order to achieve this goal, the DSHP 1115 Waiver was designed to mandatorily enroll eligible Medicaid recipients into managed care organizations (MCOs) and create efficiencies in the Medicaid program. Initial savings achieved under managed care enabled the expansion of coverage to certain individuals who would otherwise not be eligible for Medicaid, leading up to Medicaid expansion under the Affordable Care Act in 2014. Since 2012, the DSHP 1115 Waiver has provided long-term services and supports (LTSS) to eligible individuals through DSHP Plus, as well as enhanced behavioral health services and supports for targeted Medicaid beneficiaries through a voluntary program begun in 2015 called PROMISE. Most individuals enrolled in Medicaid and Medicaid-expansion CHIP are enrolled in the DSHP 1115 Waiver and in MCOs. A limited number of benefits, such as non-emergency transportation and PROMISE services, are delivered through fee-for-service. In 2019, the DSHP 1115 waiver was extended for an additional five years and amended to include 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. Since 2020, DMMA has amended the DSHP 1115 Waiver for the addition of adult dental services to the DSHP managed care delivery system and secured COVID-19 demonstration amendment authorities focused on LTSS services (e.g., provider retainer payments, expanded home-delivered meals) to address the COVID-19 Public Health Emergency (PHE). DMMA also has an amendment pending with CMS to add home-visiting coverage, a second home-delivered HCBS meal, pediatric respite, a self-directed option for parents of children receiving personal care services, and nursing facility tran-

sition services.

Delaware's goal and objectives in operating the DSHP 1115 Waiver into the future continue to be to improve the health status of low-income Delawareans by:

1. Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to home and community-based services (HCBS);
2. Rebalancing Delaware's LTC system in favor of HCBS;
3. Promoting early intervention for individuals with, or at-risk, for having, LTC needs;
4. Increasing coordination of care and supports;
5. Expanding consumer choices;
6. Improving the quality of health services, including LTC services, delivered to all Delawareans;
7. Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTSS services where appropriate;
8. Expanding coverage to additional low-income Delawareans;
9. Improving overall health status and quality of life of individuals enrolled in PROMISE;
10. Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population;
11. Increasing enrollee access and utilization of appropriate SUD treatment services and decrease use of medically inappropriate and avoidable high-cost emergency and hospital services;
12. Increasing access to dental services, including follow-up care and care for adults with diabetes, and decrease use of emergency department visits for non-traumatic conditions; and
13. Improving maternal and infant health outcomes and health disparities (new).

Delaware will continue working towards these goals and objectives during the DSHP 1115 extension. DMMA is requesting continuation of the current DSHP 1115 waiver, as approved today, with the additional changes described below. A complete description of the current DSHP 1115 Waiver is available at:

http://dhss.delaware.gov/dhss/dmma/medicaid.html

Changes Under the Demonstration Extension

July 2022 Pending Amendment
DMMA has proposed five changes to the DSHP 1115 Waiver that are pending in an amendment currently under review by CMS for an effective date of January 1, 2023. The changes in this amendment include:

1. Coverage of two models of evidenced-based home visiting for pregnant women and children.
2. Permanent coverage for a second home-delivered meal for members receiving HCBS in DSHP Plus.
3. Coverage of a pediatric respite benefit as an American Rescue Plan Act (ARP) Section 9817 HCBS Spending Plan initiative.
4. Coverage of a self-directed option for parents on behalf of children receiving state plan personal care services.
5. Coverage of Delaware's Nursing Home Transition Program (formerly Money Follows the Person Demonstration) in the DSHP 1115 waiver.

Additional description of these changes can be found in the pending amendment available on the DMMA website at: http://dhss.delaware.gov/dhss/dmma/medicaid.html

Delaware is proposing to include these changes, once approved by CMS, in the waiver extension.

New Changes Proposed for the DSHP Extension
Delaware is proposing four new changes in the extension period:

1. **Expand access by providing three-months of retroactive eligibility to all DSHP 1115 Waiver enrollees**. DMMA is requesting to terminate the DSHP waiver of retroactive eligibility. Effective no later than January 1, 2024, with the expiration of the current DSHP 1115 waiver, DMMA will extend retroactive eligibility to all eligible DSHP and DSHP-Plus participants three months prior to the date that an application for medical assistance is made. Delaware will terminate this waiver authority to support our goal of expanding access to coverage, including coverage for those who need immediate care while applying for Medicaid.
2. **Pilot Medicaid coverage of Delaware's Food Box Initiative for postpartum members. DMMA proposes to add Medicaid coverage of our Medicaid Food Box Initi**ative for postpartum members under the DSHP 1115 Waiver. The objective of the Food Box Initiative is to address food insecurity and diaper needs as health-related social needs to improve maternal and infant heath and reduce health disparities. The proposed demonstration would allow DMMA to use Medicaid funds to expand our current state-funded pilot to provide home-delivered food and diapers to postpartum members, reaching low-income postpartum members with disproportionately high rates of food insecurity and inequitable adverse maternal and birth outcomes.
3. **Add Medicaid coverage of contingency management services for certain members with a stimulant use disorder and/or opioid use dis**

order.
DMMA is proposing to add coverage of contingency management services for Medicaid members who are: (1) age 18 and over with a stimulant use disorder diagnosis and (2) age 18 and over, who are pregnant or up to 12 months postpartum, with an opioid use disorder diagnosis. Contingency management is an evidence-based practice that allows individuals to earn small motivational incentives for meeting treatment goals, such as negative urine drug tests or medication adherence. The objectives of contingency management services are to expand SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder to help address the rise in fatal drug overdoses throughout Delaware.

4. **Add children's state plan dental services under the DSHP 1115 managed care delivery model.** Effective January 1, 2024, DMMA is proposing to include children's dental services in the DSHP 1115 Waiver managed care delivery system. The objective of including children's dental services in DSHP managed care is to ensure access to high-quality dental care for children and support a coordinated and integrated delivery system.

Public Comment Submission Process
As required by 42 CFR 431.408, DMMA must provide opportunity for a 30-day public comment period on the proposed DSHP 1115 Waiver extension. The public is invited to review and comment on the proposed DSHP 1115 Waiver extension beginning November 14, 2022 through December 13, 2022. **Comments must be received by 4:30pm on December 13, 2022.**

This public notice, a copy of the draft waiver extension request, a copy of the current approved waiver, a copy of the pending amendment and a copy of the interim evaluation reports are posted on the DMMA website at: http://dhss.delaware.gov/dhss/dmma/medicaid.html

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   Webinar ID: 825 2021 4976
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Stephen M. Groff, Director
Division of Medicaid and Medical Assistance
11/13-NJ

0005484648-01

Attachment B – Interim Evaluation Reports

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Medicaid & Medical Assistance

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

OCTOBER 31, 2022

HMA

HEALTH MANAGEMENT ASSOCIATES

Table of Contents

LISTING OF EXHIBITS

Number	Appears in	Exhibit Title
20	Section F	Summary of Findings for Measures Mapped to Research Question #8
21	Section F	Utilization of Home and Community Based Services Per DSHP Plus Member Per Month
22	Section F	Per Member Per Month Expenditures Among the DSHP Plus Population
23	Section F	Results from Study of HCBS Services Before and After a Hospital Stay
24	Section F	Summary of Findings for Measures Mapped to Research Question #9
25	Section F	Plan All-Cause Readmissions, DSHP Plus
26	Section F	Comprehensive Diabetes Care, DSHP Plus
27	Section F	Annual Monitoring for Patients on Persistent Medications, DSHP Plus
28	Section F	Medication Adherence Rate, Proportion of Days Covered, DSHP Plus
29	Section F	Summary of Findings for Measures Mapped to Research Question #6
30	Section F	Timeliness of Prenatal Care, DSHP
31	Section F	Postpartum Care, DSHP
32	Section F	Follow-up After Hospitalization for Mental Illness, DSHP
33	Section F	Emergency Department Visits Per 1,000 Medicaid Beneficiaries, DSHP
34	Section F	Follow-up After ED Visit for Alcohol or Other Drug (AOD) Dependence, DSHP
35	Section F	Follow-up After ED Visit for Mental Illness, DSHP
36	Section F	Follow-up After ED Visit for People with Multiple High-Risk Chronic Conditions, DSHP
37	Section F	Number of Weeks Enrolled with the MCO Prior to Delivery
38	Section F	Number of Prenatal Visits in Last 4 Weeks Before Delivery
39	Section F	Summary of Findings for Measures Mapped to Research Question #7
40	Section F	Consumer Assessment of Healthcare Providers and Systems

Number	Appears in	Exhibit Title
41	Section F	Member Grievances and Appeals
42	Section F	Summary of Findings for Measures Mapped to Research Question #9
43	Section F	Consumer Assessment of Healthcare Providers and Systems, LTSS
44	Section F	Critical Incidents
45	Section F	Summary of Findings for Measures Mapped to Research Question #9
46	Section F	Follow-up After Hospitalization for Mental Illness, DSHP Plus
47	Section F	Emergency Department Visits Per 1,000 Medicaid Beneficiaries, DSHP Plus
48	Section F	Follow-up After ED Visit for People with Multiple High-Risk Chronic Conditions, DSHP Plus
49	Section F	Summary of Findings for Measures Mapped to Research Questions #10 and #12
50	Section F	Rate of Identified Members Who Enroll in PROMISE
51	Section F	Plan All-Cause Readmissions, PROMISE
52	Section F	Follow-up After Hospitalization for Mental Illness, PROMISE
53	Section F	Emergency Department Visits, PROMISE
54	Section F	Follow-up After ED Visit for Mental Illness, PROMISE
55	Section F	Initiation and Engagement of Alcohol or Other Drug Abuse Dependence Treatment, PROMISE
56	Section F	PROMISE Service Providers
57	Section F	Summary of Findings for Measures Mapped to Research Question #3
58	Section F	Utilization of Services for Former Foster Care Members
59	Section F	Summary of Findings for Measures Mapped to Research Question #13
60	Section F	Adult Dental Metrics
61	Section G	Summary of Measures Examined by Demonstration Goal

SECTION A: Executive Summary

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

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

Population Impacted by the Demonstration

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

Evaluation Questions and Hypotheses

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

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

At least one research question and one hypothesis is mapped to each of the 12 demonstration goals. As a means to answer the research questions posed, the results of 63 measures are reported on in this evaluation.

Methodology

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

Target Population

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

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

Evaluation Period

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

Data Sources

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

Results

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

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

A summary of the results of all 63 measures, by demonstration goal, appears in Exhibit 1 at the end of this section. For Goal #11 related to increasing access to SUD services, the detailed findings appear in the separate SUD Interim Evaluation. For Goal #12 related to access to adult dental services, the benefit was just introduced in October 2020, so the results from these measures serve as the baseline. Among the 63 measures, there were 39 measures where the desired outcome was met. Statistical tests were run for 28 of the 63 measures. Among these 28 measures, there are nine measures which have a statistically significant trend in the intended direction, nine measures which have a statistically significant trend in the wrong direction, and 10 measures where the trend was found not to be statistically significant.

Conclusions

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

1. **Maintain Continuity of Enrollment**

   Noteworthy positive impacts were found in the following areas:

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

2. **Maintain Access to Care**

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

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

3. **Maintain or Improve Health Outcomes**

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

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

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

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

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

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

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

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

Assessment of Opportunities for Improvement

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

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

Exhibit 1
Summary of Measures Examined by Demonstration Goal

	Waiver Goals	Total Measures	Measures with Results Trending in the Intended Direction	Measures with Results Trending in the Wrong Direction	Total Measures Where Tests Were Run for Statistical Significance	Of these, the Total Where Trend in Intended Direction and Statistically Significant	Of these, the Total Where Trends in Wrong Direction and Statistically Significant	Of these, the Total Where There Was No Statistically Significant Change
	MEASURES FOR GOALS #1 - #10	**58**	**39**	**19**	**28**	**9**	**9**	**10**
1	Improve access to health care for the Medicaid population	13	10	3	7	3	3	1
2	Rebalance Delaware's LTC system in favor of HCBS	4	4	0	2	2	0	0
3	Promote early intervention for individuals with, or at risk, for having LTC needs	4	2	2	4	1	2	1
4	Increase coordination of care and supports	7	4	3	7	2	2	3
5	Expand consumer choices	8	5	3	0	0	0	0
6	Improve the quality of health services, including LTC services, delivered to all Delawareans	7	7	0	0	0	0	0
7	Create a payment structure that provides incentives for resources to shift from institutions to community-based long-term services and supports	0						
8	Improve coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles	3	3	0	3	1	0	2
9	Improve overall health status and quality of life of individuals enrolled in PROMISE	9	3	6	5	0	2	3
10	Increase and strengthen overall coverage of former foster care youth to improve health outcomes	3	1	2	0	0	0	0
11	Increase enrollee access and utilization of appropriate SUD treatment services	29	Results are shown in the SUD Independent Evaluation report.					
12	Increase access to dental services; decrease adult ED visits for non-traumatic conditions	5	CY2021 is the baseline year for the results for each measure.					

SECTION B: General Background Information

Description of the Demonstration's Policy Goals

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

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

The approved waiver has five demonstration components:

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

3. The PROMISE program provides enhanced behavioral health services fee-for-service (FFS) to Medicaid beneficiaries with a higher level of behavioral health needs and functional limitations who need HCBS to live and work in integrated settings.
4. Coverage for former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care at age 18 (or such higher age as elected by the state), were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid.
5. Coverage for high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as institutions for mental disease (IMDs). Note that the evaluation of this component is addressed in a separate Interim Evaluation specific to SUD.

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

Name: Delaware Diamond State Health Plan

Project Number: 11-W-00036/4

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

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

Brief Description and History of Implementation

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

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

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

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

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

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

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

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

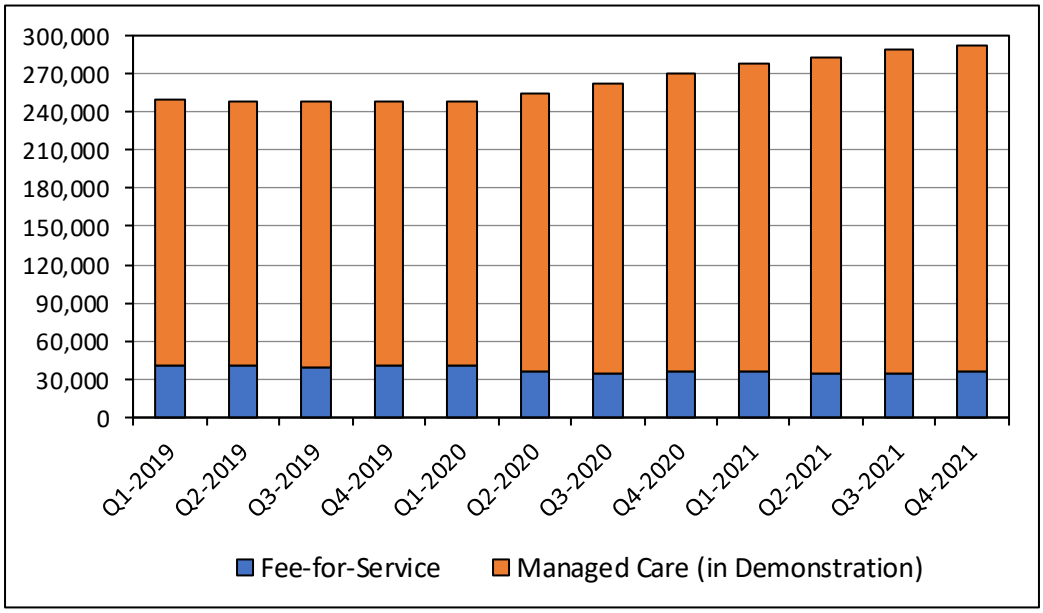
Technical changes were incorporated into the demonstration in October 2017 and an amendment was approved in December 2017 to add coverage for out-of-state former foster care youth.

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

Population Groups Impacted by the Demonstration

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

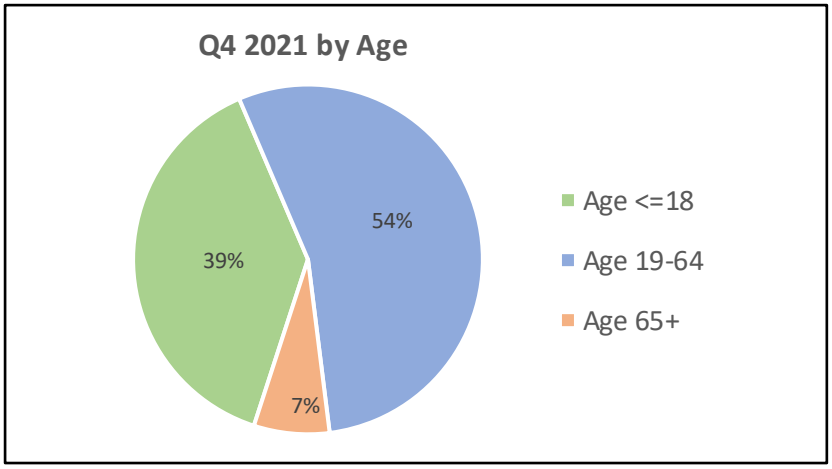
Exhibit 2
Medicaid Enrollees, by Quarter, CY 2019 - CY 2021

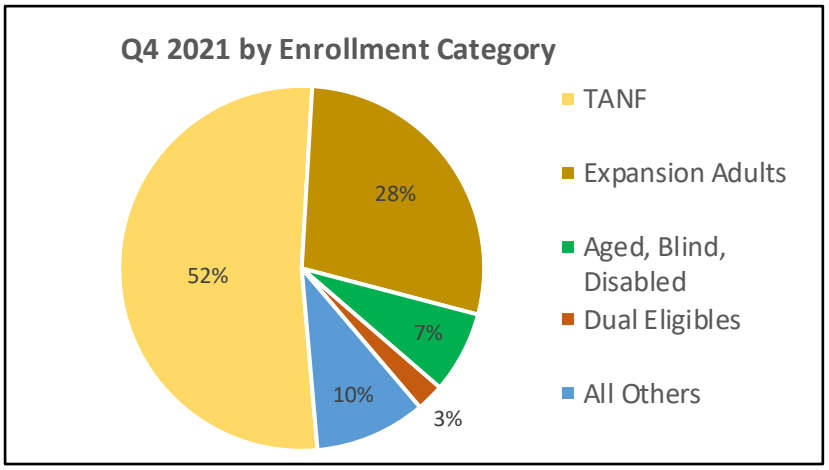


As of the fourth quarter of CY2021, 39 percent of Medicaid enrollees were children and adolescents, 54 percent were non-elderly adults, and seven percent were elderly. When viewed by enrollment category, just over half of the enrollees are TANF (Temporary Assistance for Needy Families) eligibles, or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

Exhibit 3
Profile of Medicaid Enrollees, 4th Quarter CY2021

Total Average Medicaid Enrollment in Q4 2021: 292,816





SECTION C: Evaluation Questions and Hypotheses

Defining Relationships: Aims, Primary Drivers and Secondary Drivers

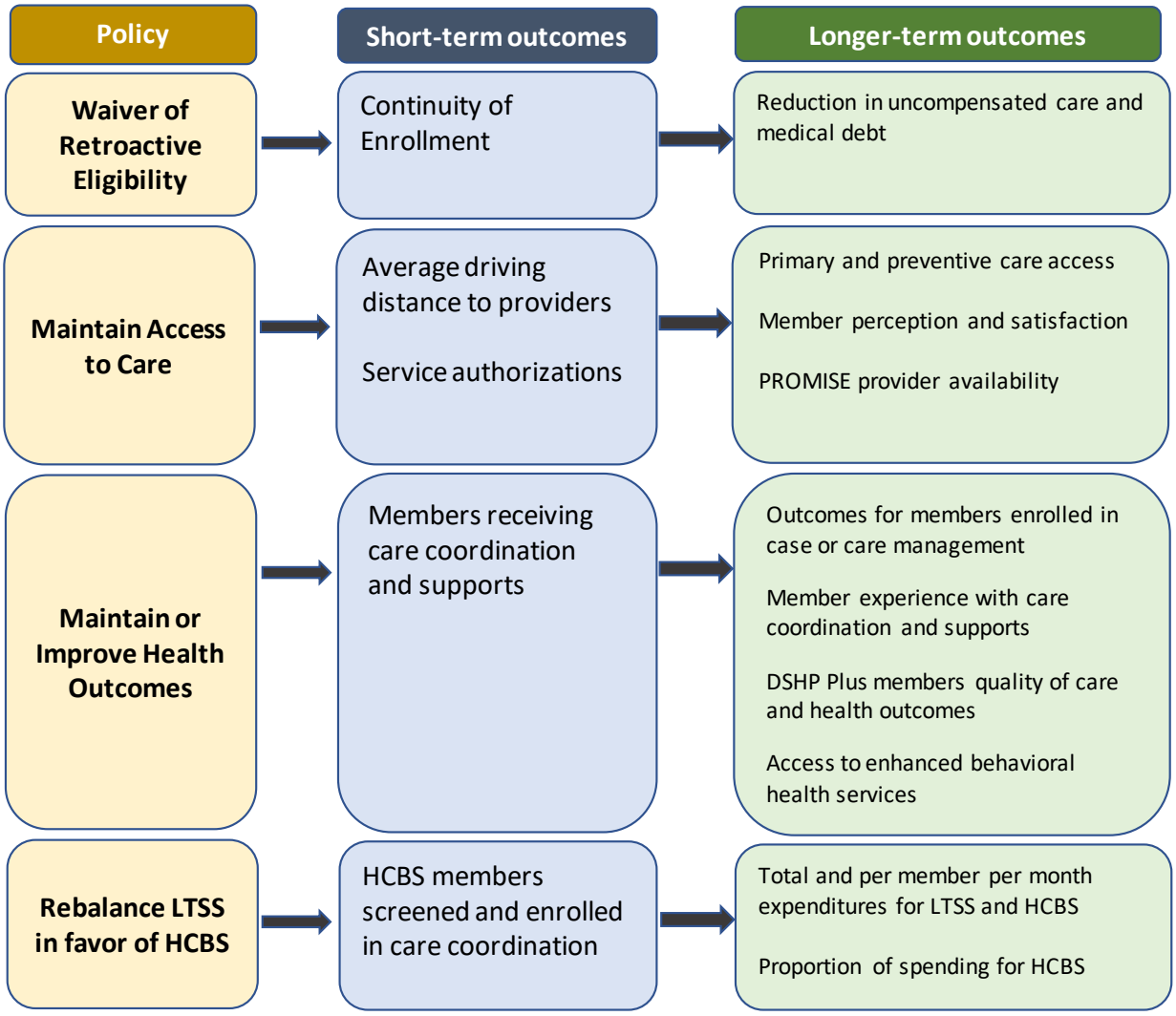
Burns & Associates, a Division of Health Management Associates (HMA-Burns) is serving as the Independent Evaluator for this demonstration. HMA-Burns constructed logic models delineating short-term and long-term outcomes associated with the four principle policy objectives of the demonstration.

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

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

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

Exhibit 4
Logic Models Developed in Demonstration Evaluation Design Plan



Hypotheses and Research Questions

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

Exhibit 5
Mapping Hypotheses and Research Questions to Demonstration Goals

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

SECTION D: Methodology Used in Assessment

Evaluation Design

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

The five analytic methods used by the evaluators include:

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

Target and Comparison Population

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

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

Evaluation Period

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

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

The demonstration period is defined as follows:

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

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

Evaluation Measures

HMA-Burns is reporting on 63 measures, each of which has been mapped to a demonstration goal. The measures that have been analyzed in this Interim Evaluation utilize a number of measure stewards, including the National Committee on Quality Assurance's (NCQA's) HEDIS®[1] measures, the Agency for Healthcare Research and Quality (e.g., CAHPS survey measures), and the Dental Quality Alliance. The HMA-Burns team has also defined measures that are specific to Delaware's demonstration goals. It should be noted that Demonstration Goal #12 relates to the expansion of adult dental services. Because this coverage did not begin until October 2020, the results of the five measures associated with this goal serve as the baseline period in this evaluation. A summary of these measures, by demonstration goal, appears in Exhibit 6 on the next page.

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

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

	Demonstration Goal	Measures Defined by NCQA	Measures Defined by HMA-Burns	Measures Defined by Others	Total Measures
	TOTAL	**23**	**24**	**16**	**63**
1	Improve access to health care for the Medicaid population	7	5	1	**13**
2	Rebalance Delaware's LTC system in favor of HCBS	0	4	0	**4**
3	Promote early intervention for individuals with, or at risk, of enhancing LTC needs	3	0	1	**4**
4	Increase coordination of care and supports	6	1	0	**7**
5	Expand consumer choices	0	2	6	**8**
6	Improve the quality of health services, including LTC services, delivered to all Delawareans	0	1	6	**7**
7	Create a payment structure that provides incentives for resources to shift to institutions to community for LTSS	0	0	0	**0**
8	Improve coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles	2	1	0	**3**
9	Improve overall health status and quality of life on individuals enrolled in PROMISE	5	4	0	**9**
10	Increase and strengthen overall coverage of former foster care youth to improve health outcomes	0	3	0	**3**
11	Increase enrollee access and utilization of appropriate SUD treatment services	*Reported in the SUD Demonstration Interim Evaluation*			
12	Increase access to dental services; decrease adult ED visits for non-traumatic conditions	0	3	2	**5**

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

Data Sources

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

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

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

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

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

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

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

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

Analytic Methods

Descriptive Statistics

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

Statistical Tests

Among the 63 measures examined, tests of significance were run on 28 measures. The test that was applied to assess statistical significance was either t-test or chi-square. For the Summative Evaluation, interrupted time series will be used to assess significance on all measures where t-test was applied in the Interim Evaluation and for many of the measures where chi-square was applied as well.

Onsite Reviews and Desk Reviews

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

Facilitated Interviews

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

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

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

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

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

SECTION E: Methodological Limitations

Limitations

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

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

1. *Public health emergency*. The obvious limitation in this evaluation is the impact on service utilization and provider supply during the public health emergency period. The current demonstration began just seven months prior to the start of the PHE. Delaware, like most states, saw atypical results during the early period of the PHE both positively (e.g., lower emergency department visits) and negatively (e.g., lower rates on measures related to access to services or follow-up services). For the Summative Evaluation, in addition to adding results from CYs 2022 and 2023 to the analysis, the HMA-Burns team will assess trends not only between the pre-demonstration and current demonstration periods, but also the pace at which utilization and access measures improve as the PHE winds down.

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

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

4. *Exogenous factors may impact results*. Many of the outcome measures are multi-dimensional and influenced by social determinants of health. While changes in the demonstration period related to access to care may be one dimension of various outcomes of interest and may contribute to improvements, it may be difficult to achieve statistically significant findings in the

absence of data on other contributing dimensions such as social determinants of health (e.g., housing, employment and previous incarcerations).

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

SECTION F: Results

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

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

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

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

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

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

Summary of Measures

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

In Exhibit 7 that appears on the next page, it shows that the desired outcome was met in ten out of the 13 measures. A test for statistical significance was conducted on seven of the 13 measures. For six of the seven measures, the outcome was statistically significant. More detailed information can be found on each measure in the pages that follow.

Individual Measure Results

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

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

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

Results from the Behavioral Risk Factor Surveillance System (BRFSS) survey were examined from CY 2017 through CY 2020 for the response to the question if individuals could not see a doctor due to cost (refer to Exhibit 12). Results reported were 12.0 percent of those surveyed responding affirmatively to this question in CY 2017, but this fell to 9.1 percent in CY 2020.

Well-child visits for children and preventive/ambulatory visits for adults were analyzed. The HMA-Burns team used the specifications from NCQA for the HEDIS measures related to Well Child Visits in the First 15 Months of Life (W15, Exhibit 13), in the Third through Sixth Years of Life (W34, Exhibit 14), for Adolescents (AWC, Exhibit 15), and Preventive Services for Adults (AAP, Exhibit 16). Results were computed for the DSHP population meeting the criteria for each measure for CY 2018 through CY 2021 experience years. For W15, the percentage with six visits or more decreased 1.3 percent from the baseline year (CY 2018) to the latest demonstration period year (CY 2021). For W34, the change was

steady but an increase of 0.7 percent from the baseline to the demonstration period was observed. For AWC, there was a statistically significant improvement of 8.0 percent between the baseline year and the demonstration period year. For adults in the AAP measure, however, there was a statistically significant decline of 9.8 percent between the baseline year and the demonstration period year.

For the adults in the AAP measure, HMA-Burns computed the average distance travelled to see a preventive care provider to determine if the reduction in utilization may be due to provider access (refer to Exhibit 17). The average distance over the four-year period studied has remained unchanged, however (between 16.1 and 16.6 miles, on average, each year). The reduction in the results in the AAP measure may more likely be due to the PHE than to provider access.

HMA-Burns computed the rate of breast cancer screenings using the HEDIS measure specification (refer to Exhibit 18). The screening rate has declined 6.5 percent from the baseline year of CY 2018 to the latest demonstration period year of CY 2021. Again, this may likely be due to suppressed utilization during the PHE.

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

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

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

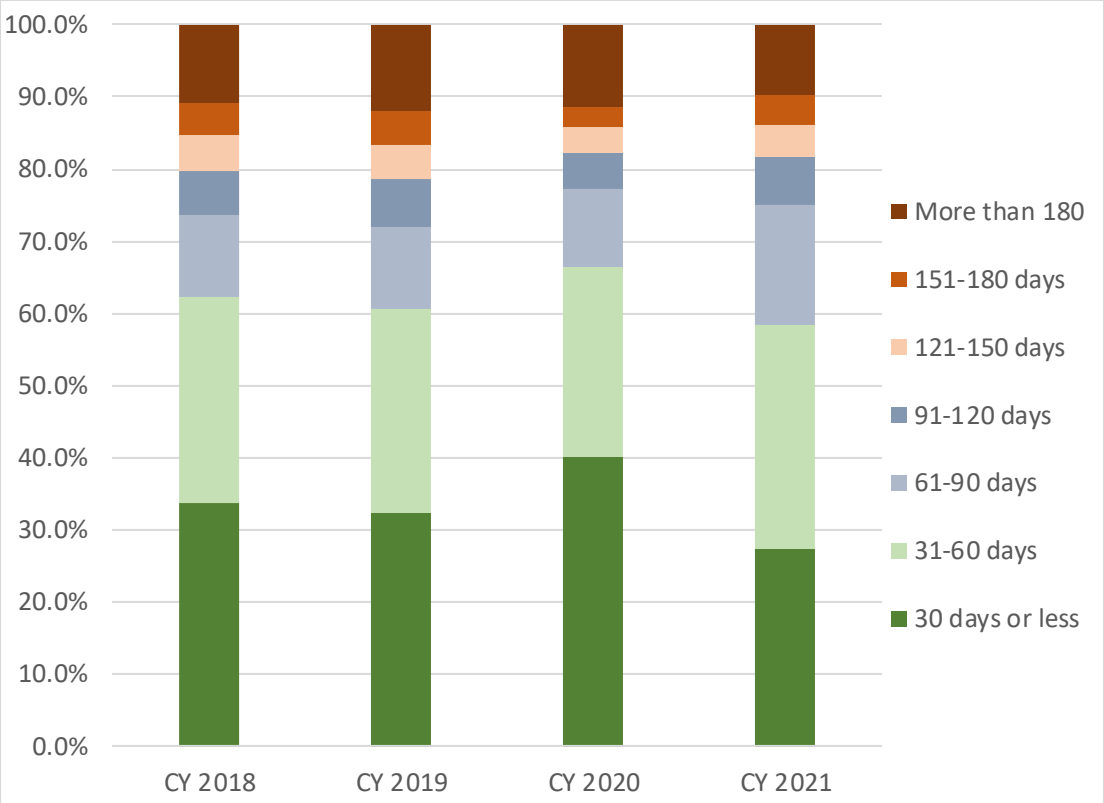
Exhibit 8
Results for Interim Evaluation Measure #1
Time Span from Application to Enrollment in Medicaid

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

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

Desired Outcome: Steady or Decrease
Actual Outcome: Steady

Results for the Entire Population in the Demonstration



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

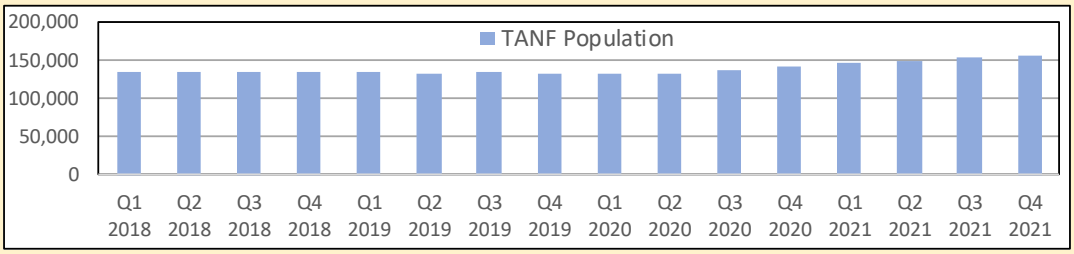
Exhibit 9
Results for Interim Evaluation Measure #2
Average Medicaid Enrollment Counts by Quarter and Major Aid Category

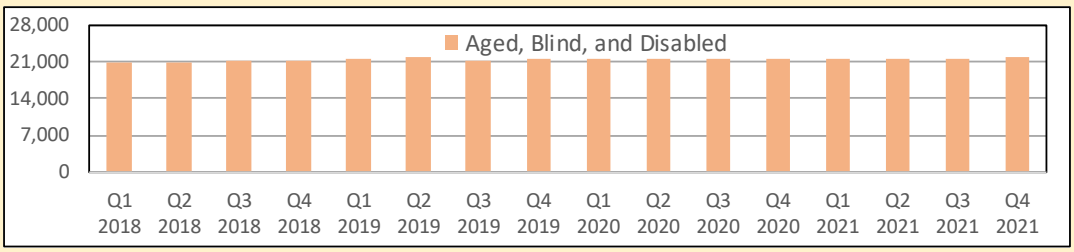
Hypothesis:
Trends in continuity of enrollment continue (or do not worsen) for Medicaid populations subject to the waiver of retroactive eligibility in the current demonstration period.

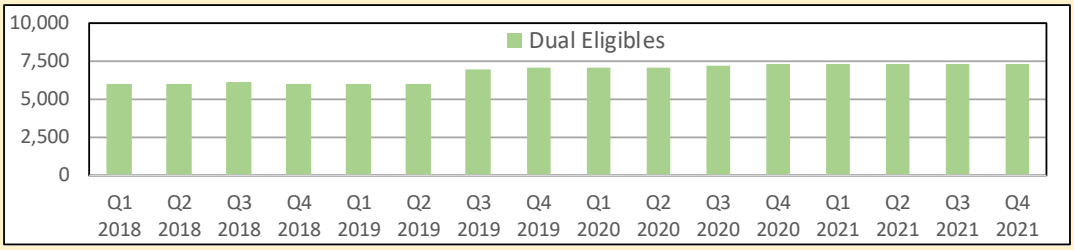
Measure(s) Used to Test Hypothesis: **Measure Steward:** HMA-Burns
Average Enrollment Counts by Quarter and Major Aid Category
Data Source: DMMA Enrollment Data

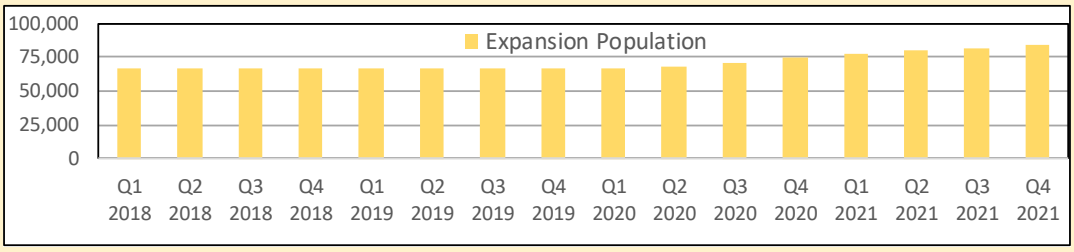
Desired Trend: Increase in enrollment in each major aid category
Actual Trend: Increase in five of the six major aid categories studied

Results









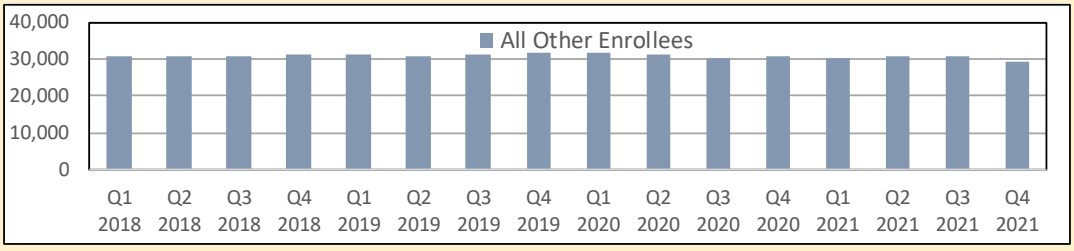


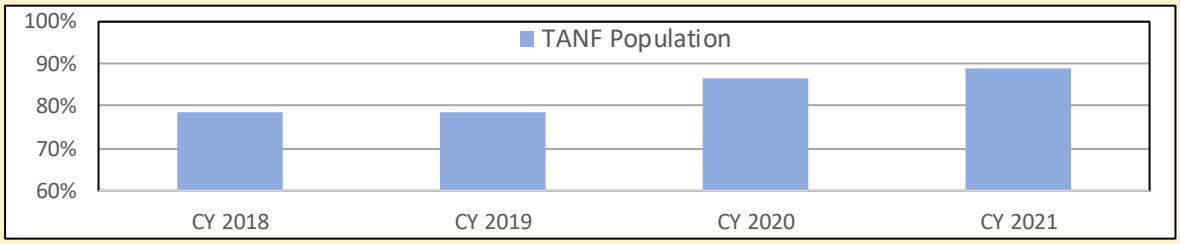
Exhibit 10
Results for Interim Evaluation Measure #3
Medicaid Continuous Enrollment by Major Aid Category

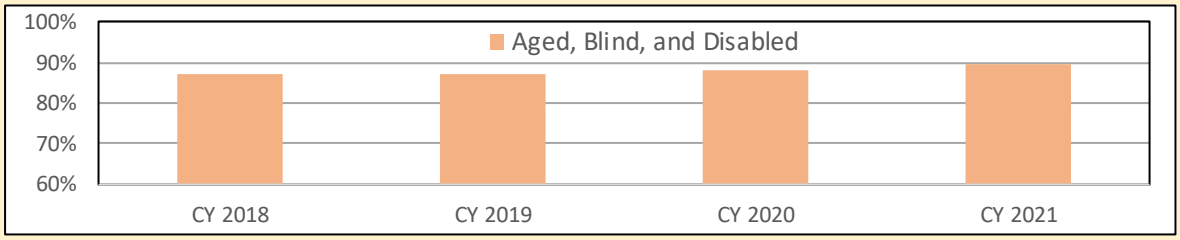
Hypothesis:
Trends in continuity of enrollment continue (or do not worsen) for Medicaid populations subject to the waiver of retroactive eligibility in the current demonstration period.

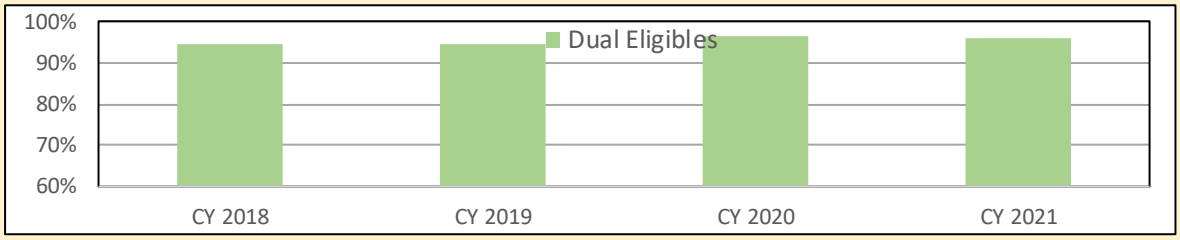
Measure(s) Used to Test Hypothesis: **Measure Steward:** HMA-Burns
Proportion of Total Enrollees Continuously Enrolled Nine Months or More by Major Aid Category
Data Source: DMMA Enrollment Data

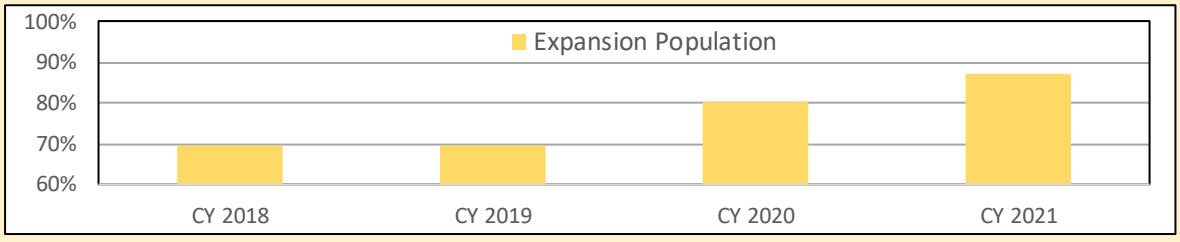
Desired Trend: Increase in continuous enrollment in each major aid category
Actual Trend: Increase in continuous enrollment in each major aid category

Results









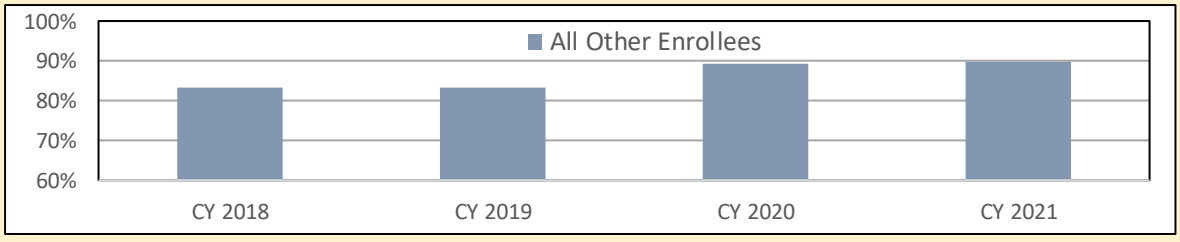


Exhibit 11
Results for Interim Evaluation Measure #4
Medicaid Average Enrollment Duration by Major Aid Category

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

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

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

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

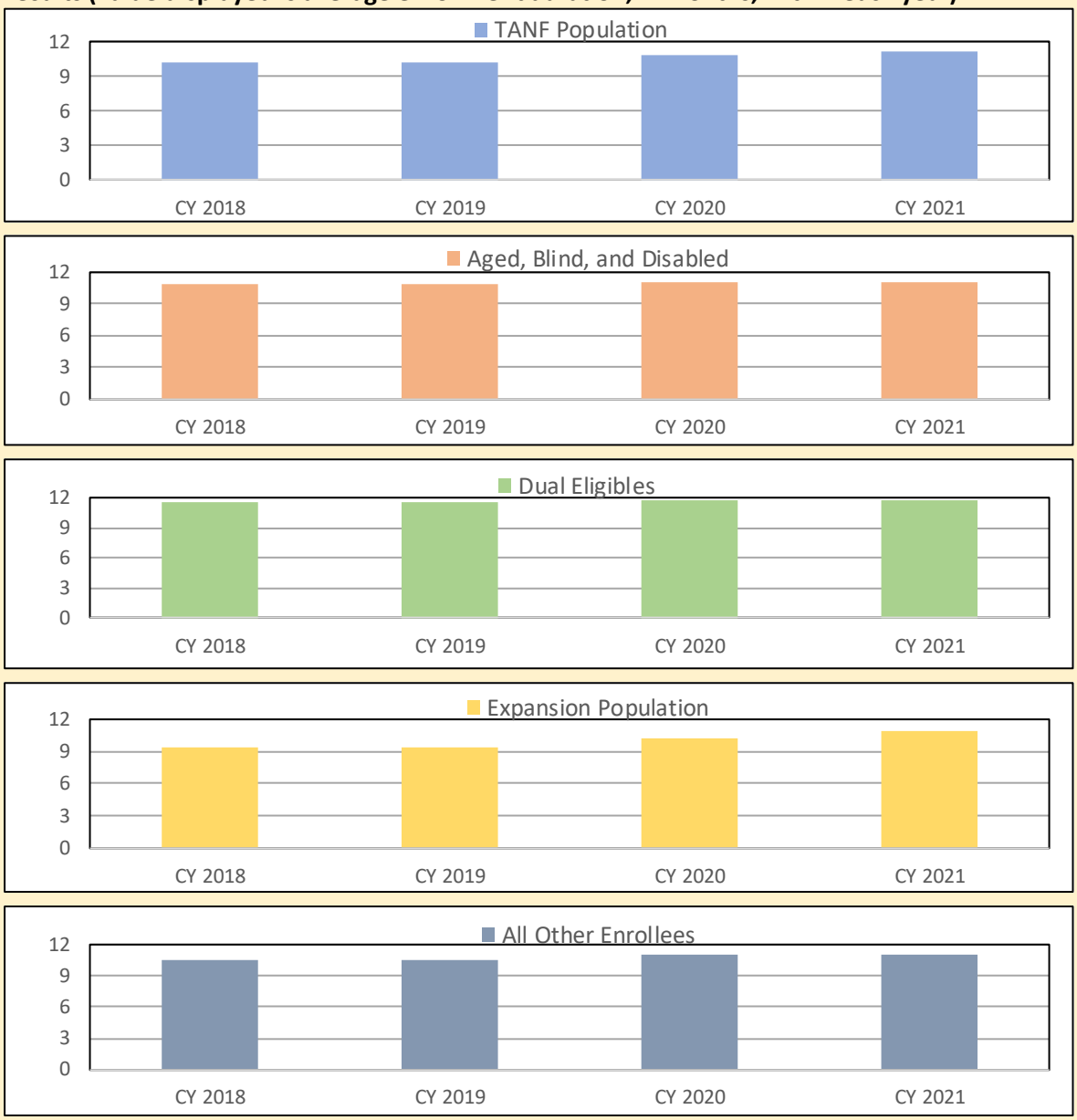


Exhibit 12
Results for Interim Evaluation Measure #5
Responses to Not Seeing a Doctor Due to Cost

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

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

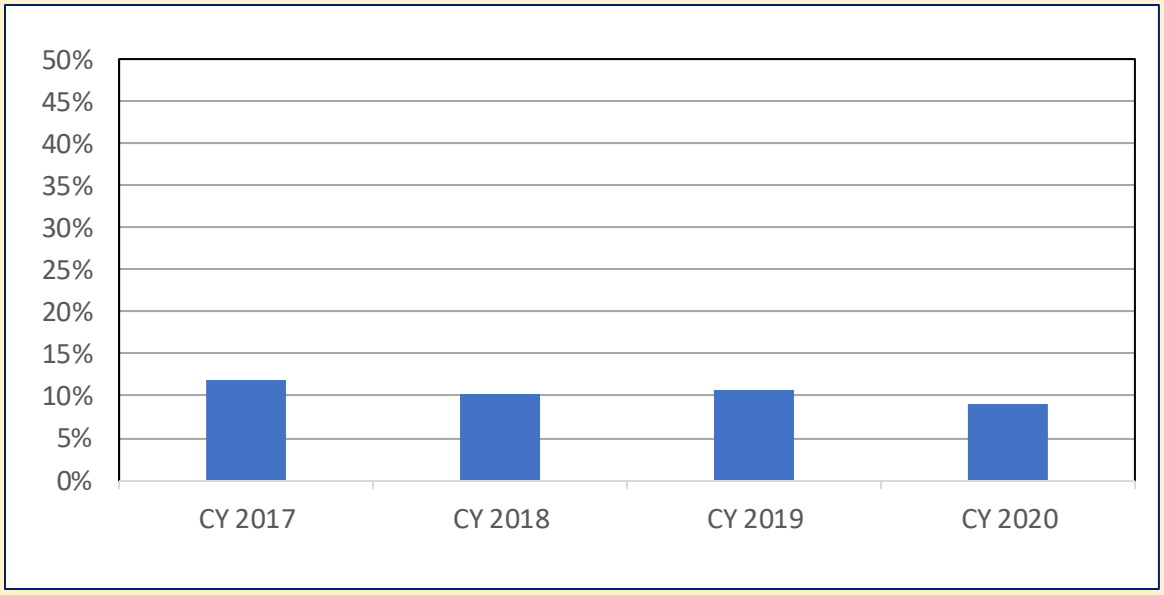
Measure Steward: U.S. Centers for Disease Control Behavioral Risk Factor Surveillance System survey

Data Source: Delaware Division of Public Health

Desired Outcome: Decrease

Actual Outcome: Decrease

Results



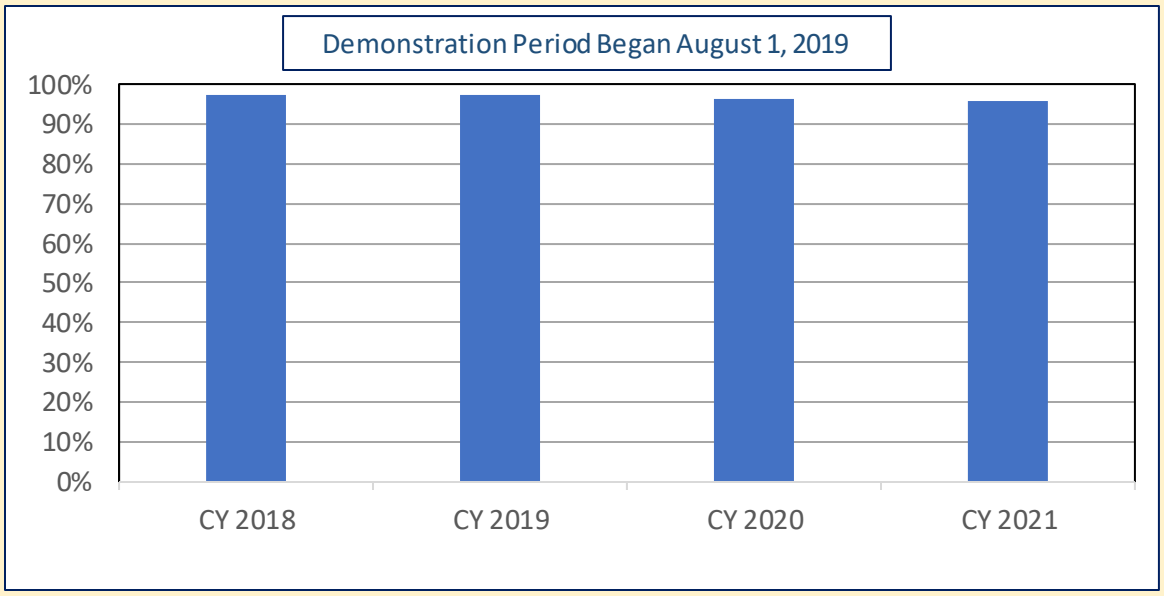
Survey Year	Numerator Total indicating Yes, they could not see a doctor due to cost	Denominator Total Delawareans participating in the survey	Rate
2017	494	4,127	12.0%
2018	530	5,221	10.2%
2019	415	3,889	10.7%
2020	367	4,017	9.1%

Exhibit 13
Results for Interim Evaluation Measure #6
Well-Child Visits in the First 15 Months of Life

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

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

Results for the DSHP Population in the Demonstration



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

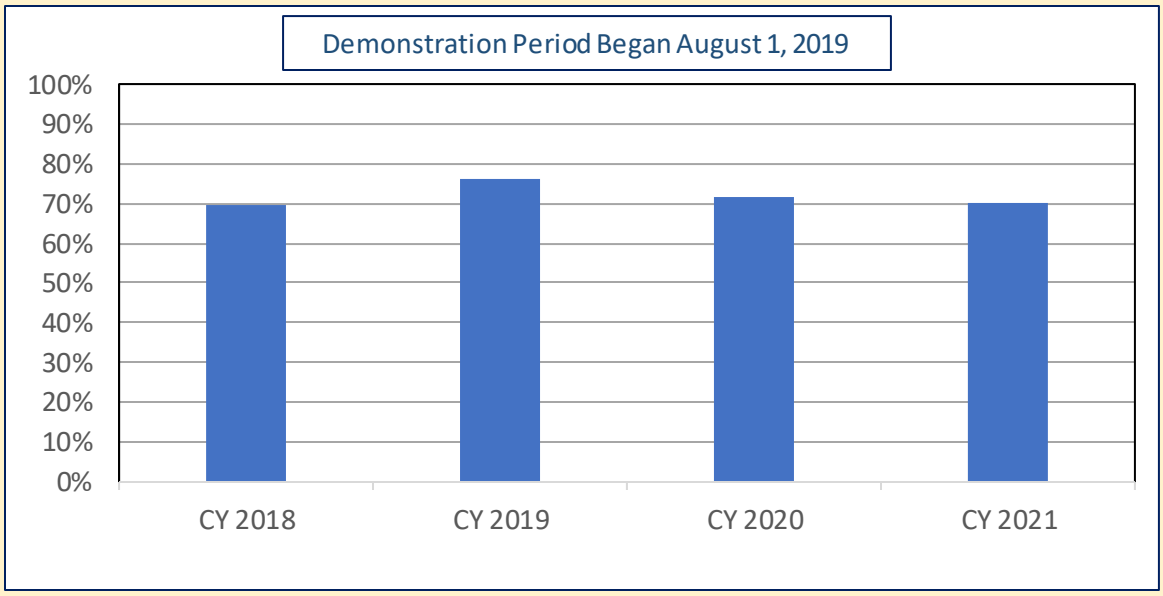
Desired Outcome:	Increase
Actual Outcome:	Decrease
Statistical Review:	Chi-Square
Probability:	0.0019
Finding:	Significant

Exhibit 14
Results for Interim Evaluation Measure #7
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

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

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

Results for the DSHP Population in the Demonstration



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

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

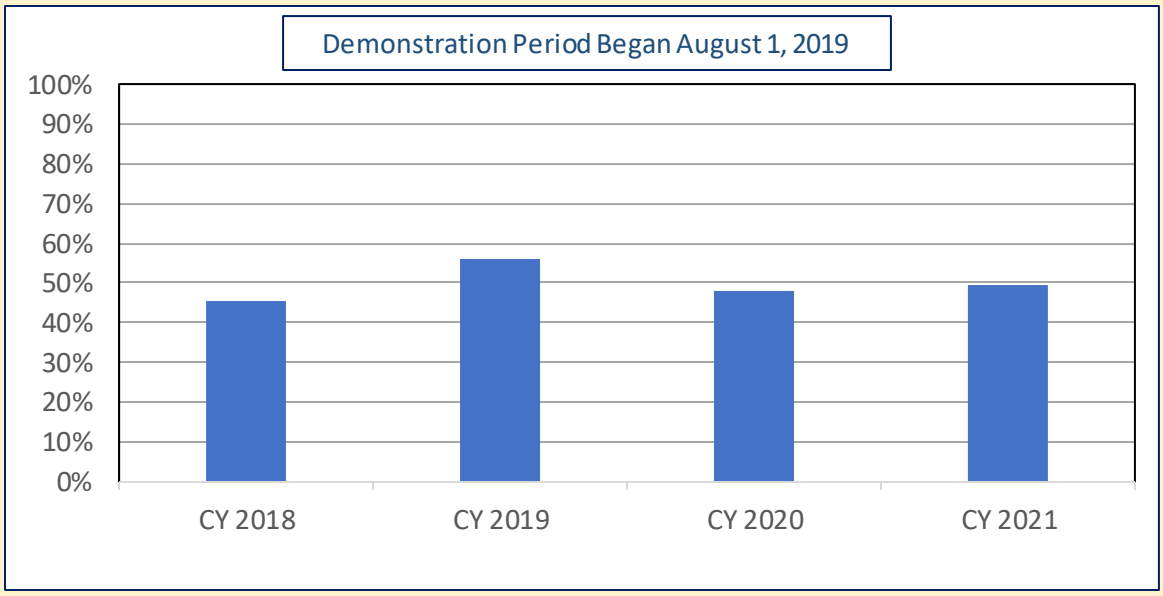
Note: Effective Measurement Year CY 2020, NCQA changed its measures for Well-Child Visits in the Third through Sixth Years of Life (W34) and Adolescent Well-Care Visits (AWC) and merged them into a single measure Child and Adolescent Well-Care Visits (WCV). For this report, HMA-Burns has retained the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

Exhibit 15
Results for Interim Evaluation Measure #8
Adolescent Well-Care Visits

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

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

Results for the DSHP Population in the Demonstration



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

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

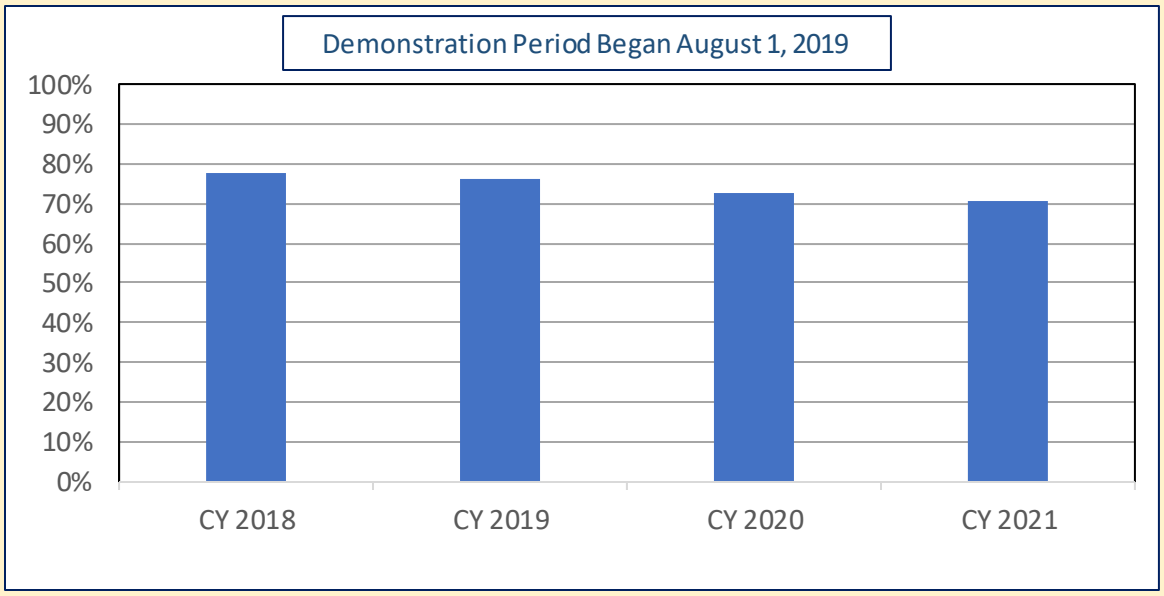
Note: Effective Measurement Year CY 2020, NCQA changed its measures for Well-Child Visits in the Third through Sixth Years of Life (W34) and Adolescent Well-Care Visits (AWC) and merged them into a single measure Child and Adolescent Well-Care Visits (WCV). For this report, HMA-Burns has retained the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

Exhibit 16
Results for Interim Evaluation Measure #9
Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries

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

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

Results for the DSHP Population in the Demonstration



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

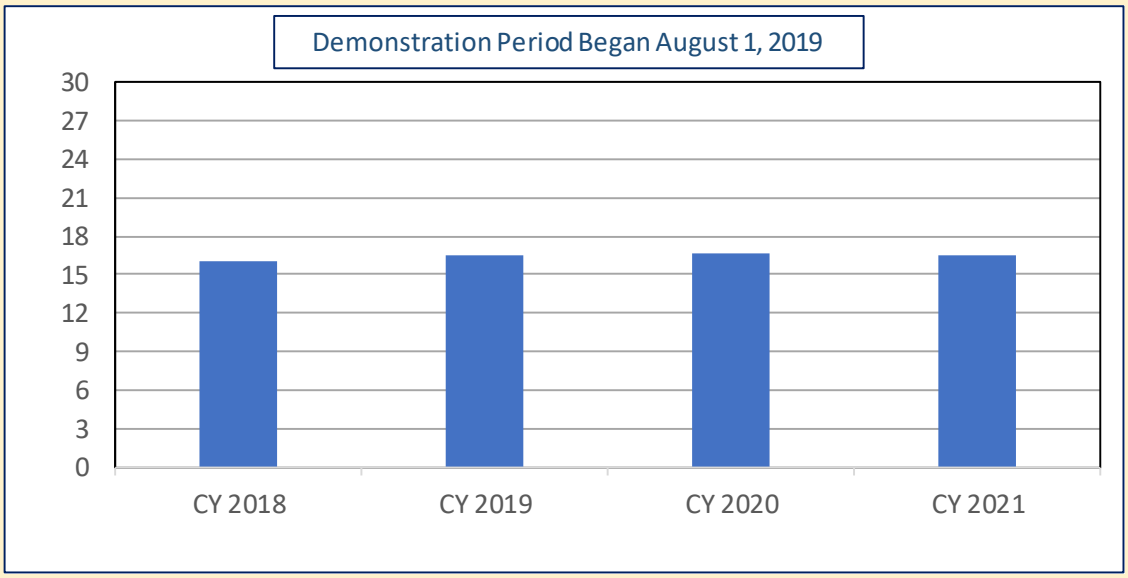
Desired Outcome: Increase
Actual Outcome: Decrease
Statistical Review: Chi-Square
Probability: <.0001
Finding: Significant

Exhibit 17
Results for Interim Evaluation Measure #10
Average Driving Distance to Primary Care Services

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

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

Results for the DSHP Population in the Demonstration



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

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

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

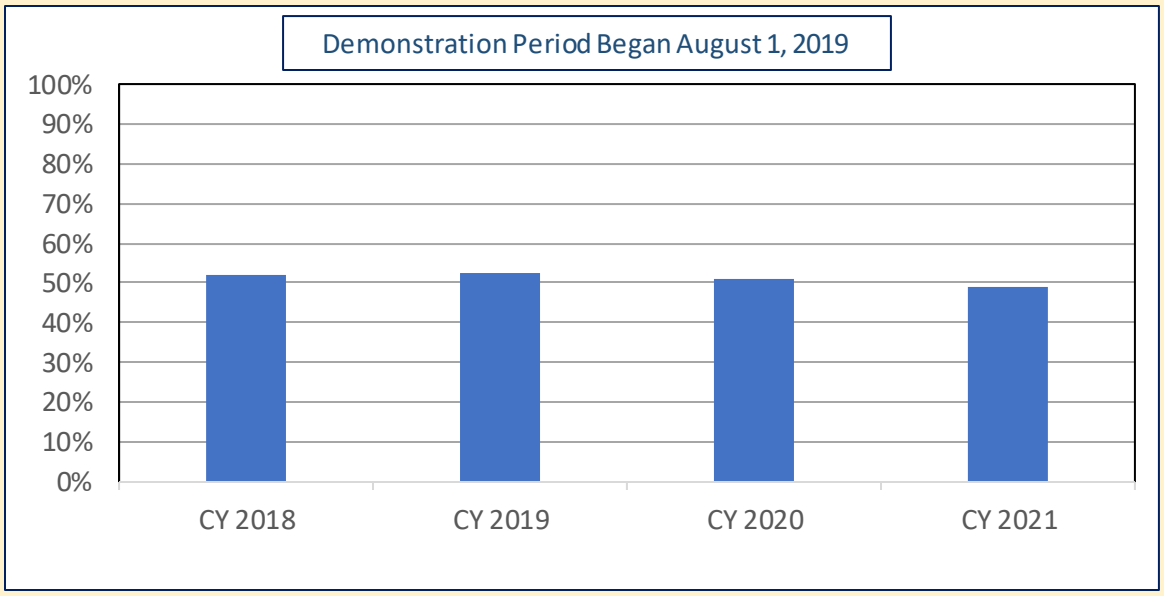
HMA-Burns used the members in the numerator of the AAP measure (Evaluation Measure #9) for consideration in this study for each calendar year. Individual preventive and ambulatory care visits as defined in the AAP measure were considered. For each Medicaid beneficiary, only a single unique beneficiary-to-provider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

Exhibit 18
Results for Interim Evaluation Measure #11
Breast Cancer Screening

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

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

Results for the DSHP Population in the Demonstration



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

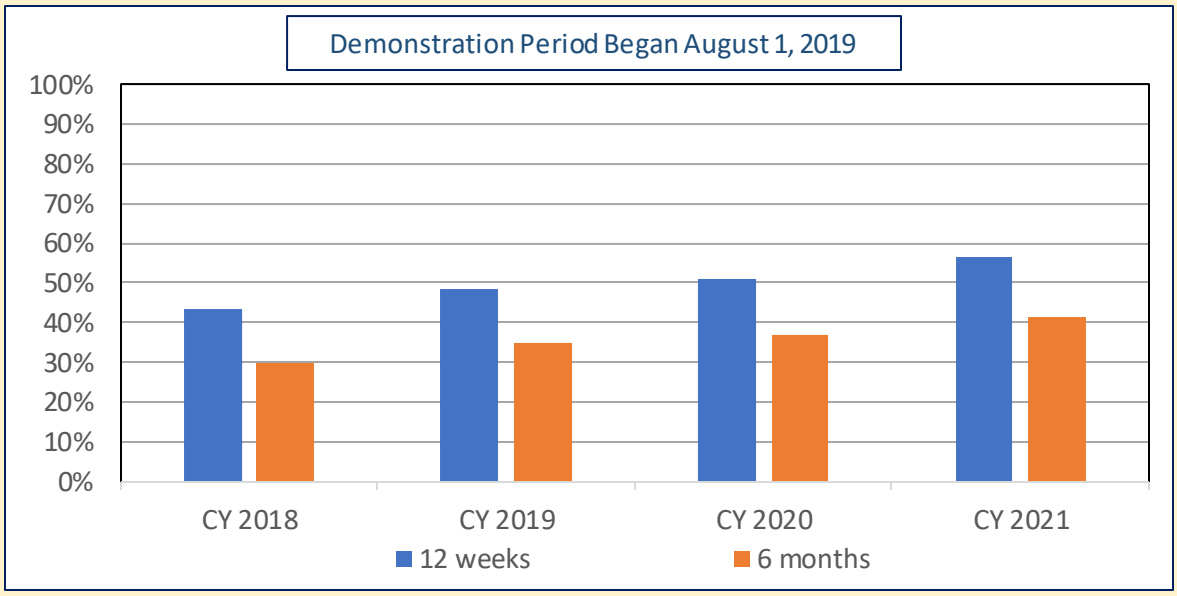
Desired Outcome:	Increase
Actual Outcome:	Decrease
Statistical Review:	Chi-Square
Probability:	<.0001
Finding:	Significant

Exhibit 19
Results for Interim Evaluation Measures #12 and #13
Antidepressant Medication Management

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

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

Results for the DSHP Population in the Demonstration



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

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

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

Summary of Measures

Exhibit 20 below summarizes the four measures that were examined to assess utilization and spending for HCBS during the demonstration period thus far. In all four measures, the actual outcome is what is desired. For the two measures where tests were run for statistical significance, the positive results were statistically significant.

Exhibit 20
Summary of Findings for Measures Mapped to Research Question #8

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

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

Individual Measure Results

Individual HCBS were examined to assess utilization among DSHP Plus members for these services. The specific services examined include adult day health, day habilitation, attendant care, homemaker/chore services, personal care, respite, home-delivered meals, and self-directed services. HMA-Burns computed a per member per month (PMPM) utilization for these services among the DSHP Plus membership for the years CY 2018 through CY 2021 (refer to Exhibit 21). The rate increased 12.9 percent over the four-year period when measured on a per member per month basis among DSHP Plus members.

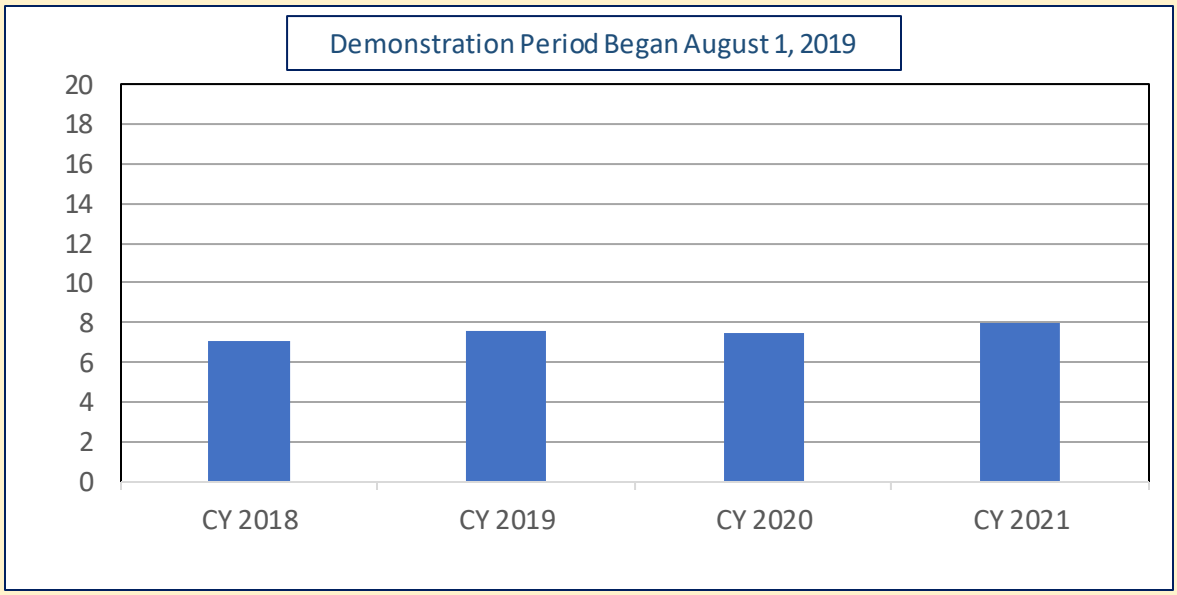
Total expenditures were examined for HCBS and for institutional long-term services and supports for DSHP members. HMA-Burns computed a PMPM cost for each category and trended these values from CY 2018 to CY 2021 (refer to Exhibit 22). In the four years examined, the PMPM expenditures for HCBS increased 38.8 percent while the PMPM expenditures for institutional care decreased 15.9 percent. The proportion of spending between HCBS and institutional care has improved from a mix of 25 percent/75 percent in CY 2018 to 35 percent/65 percent in CY 2021.

Exhibit 21
Results for Interim Evaluation Measure #14
Utilization of Home and Community Based Services Per DSHP Plus Member Per Month

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

Measure Used to Test Hypothesis:
Utilization of HCBS Per DSHP Plus Member Per Month
Measure Steward: HMA-Burns

Results for the DSHP Plus Population in the Demonstration



Numerator: Number of HCB services received in the year by DSHP members
Denominator: Total member months for DSHP Plus members in the year

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

Desired Outcome: Increase
Actual Outcome: Increase
Statistical Review: None

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

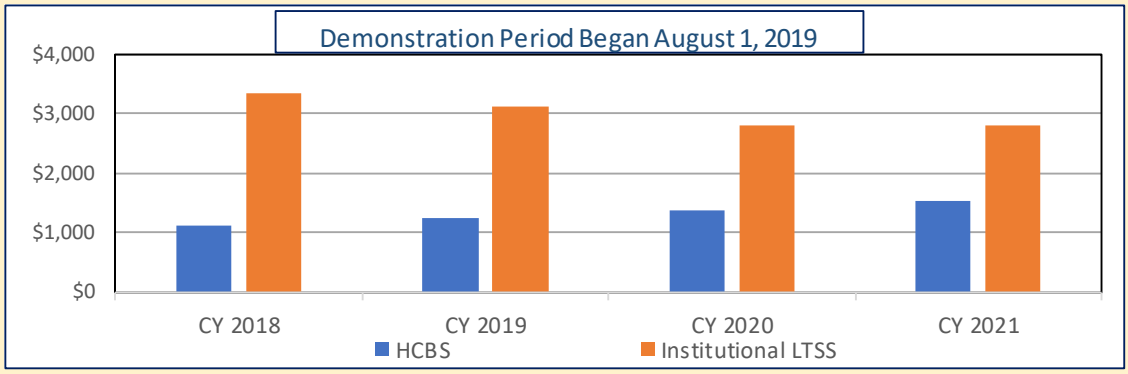
Exhibit 22
Results for Interim Evaluation Measures #15 through #17
Per Member Per Month Expenditures Among the DSHP Plus Population

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

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

Measure Steward: HMA-Burns

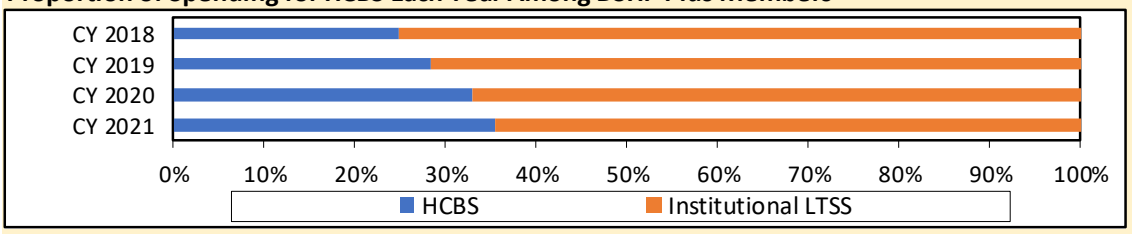
Results for the DSHP Plus Population in the Demonstration



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

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

Proportion of Spending for HCBS Each Year Among DSHP Plus Members



Results from Study of HCBS Services

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

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

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

Exhibit 23 summarizes the results of the study. In both study periods, hospital readmissions and ED visits decreased after the hospital discharge, while professional services increased. But HCBS services and pharmacy scripts also decreased. It is notable that almost 20 percent of enrollees had none of these services after discharge from their hospital stay.

Exhibit 23
Results from Study of HCBS Services Before and After a Hospital Stay

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

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

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

Summary of Measures

Exhibit 24 below summarizes the results of four HEDIS measures that the HMA-Burns team computed to answer the research question tied to Demonstration Goal #3. Results were mixed. For two measures, the actual outcome was the desired outcome; for the other two measures, the opposite was true. Statistical significance tests were conducted on all four measures. For three of the four measures, the results were statistically significant, including for the two measures that the actual outcome was not the desired outcome.

Exhibit 24
Summary of Findings for Measures Mapped to Research Question #9

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

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

Individual Measure Results

For all four measures examined in this section, the population reviewed was the DSHP Plus membership. The All Readmission Rate increased from 25.8 percent in CY 2018 to 34.2 percent in CY 2021 (refer to Exhibit 25). The readmission rate was steady in the two years prior to the PHE, then increased during the PHE.

Some improvement was seen in the Comprehensive Diabetes Care measure over the four years examined, but the improvement of 3.5 percent was not statistically significant (refer to Exhibit 26). The Comprehensive Diabetes Rate was between 40.9 percent and 45.3 percent over the four years studied.

The results for Annual Monitoring for Patients on Persistent Medications were steady for the first three of four years examined, but the results dropped significantly in CY 2021, the last year examined (refer to Exhibit 27). It should be noted that the denominator population was steady in the first three years examined as well, but the population studied dropped nearly 20 percent in the final year.

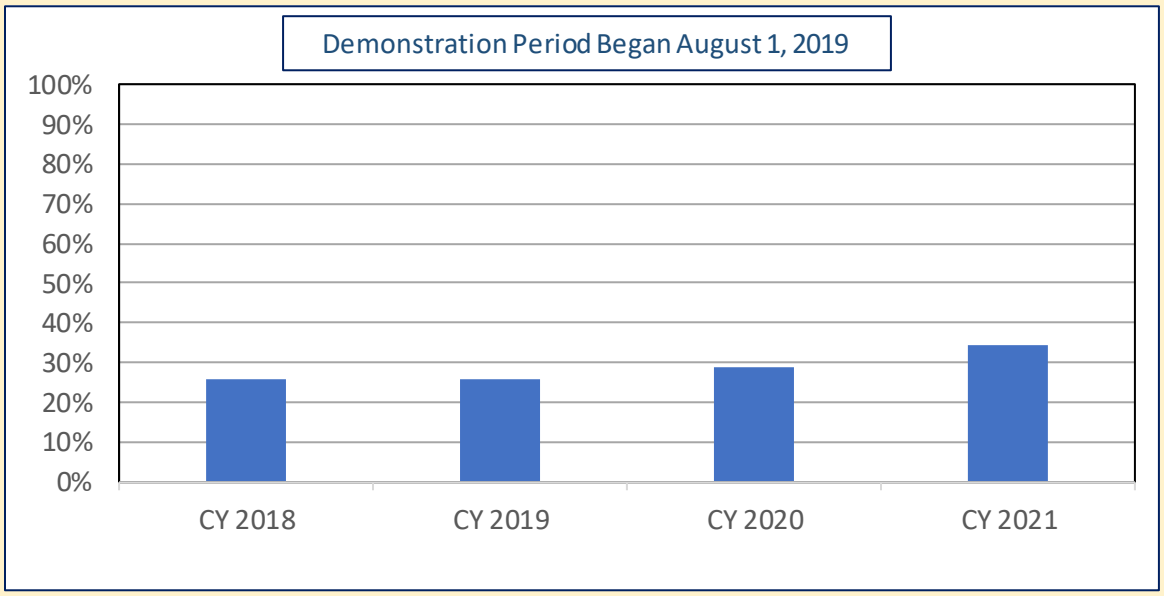
HMA-Burns computed a medication adherence rate for DSHP Plus members using a composite score for proportion of days covered derived from a measure developed by the Pharmacy Quality Alliance (refer to Exhibit 28). The proportion of days covered saw a statistically significant improvement over the four years examined, from 33.5 percent in CY 2018 to 41.3 percent in CY 2021. The rate was as high as 47.0 percent in the CY 2020 measurement year.

Exhibit 25
Results for Interim Evaluation Measure #18
Plan All-Cause Readmissions

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

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

Results for the DSHP Plus Population in the Demonstration



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

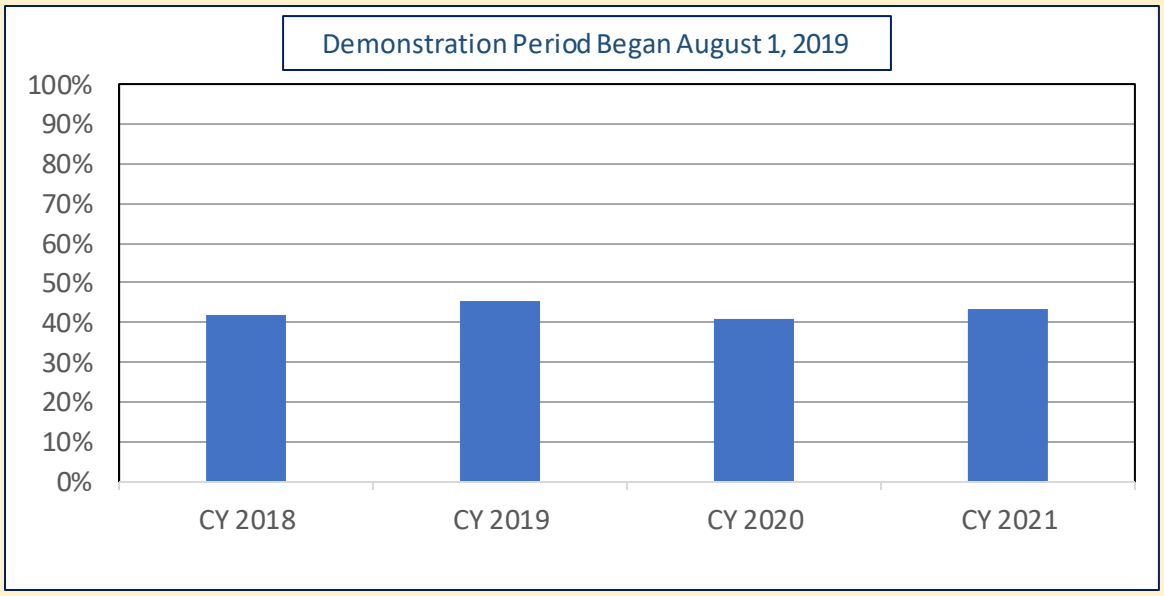
Desired Outcome:	Decrease
Actual Outcome:	Increase
Statistical Review:	Chi-Square
Probability:	<.0001
Finding:	Significant

Exhibit 26
Results for Interim Evaluation Measure #19
Comprehensive Diabetes Care

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

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

Results for the DSHP Plus Population in the Demonstration



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

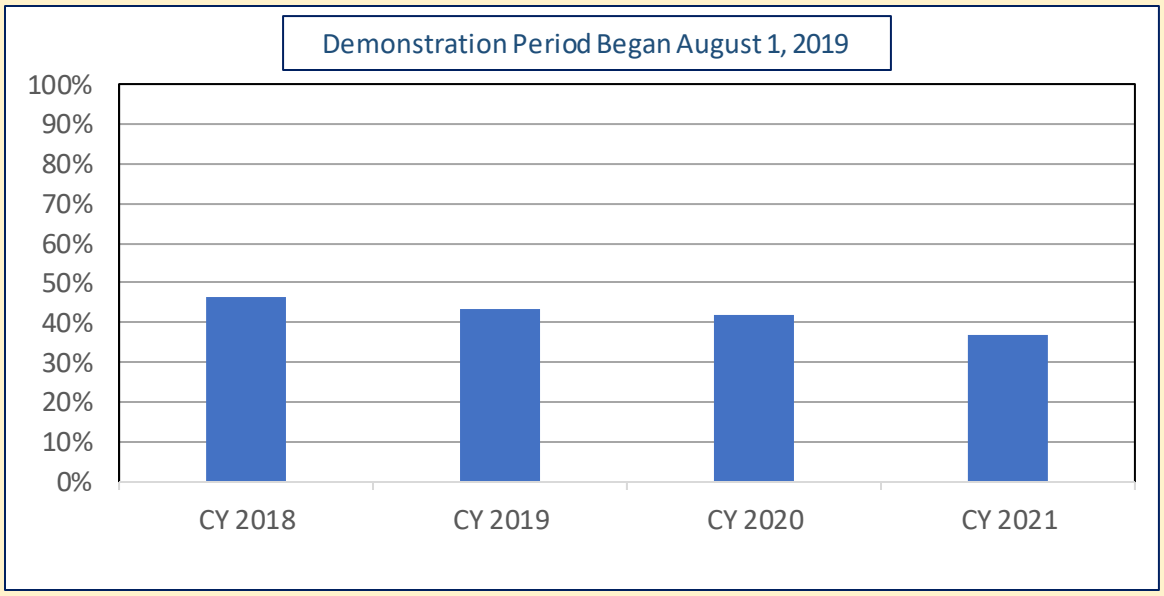
Desired Outcome: Increase
Actual Outcome: Increase
Statistical Review: Chi-Square
Probability: 0.5084
Finding: Not Significant

Exhibit 27
Results for Interim Evaluation Measure #20
Annual Monitoring for Patients on Persistent Medications

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

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

Results for the DSHP Plus Population in the Demonstration



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

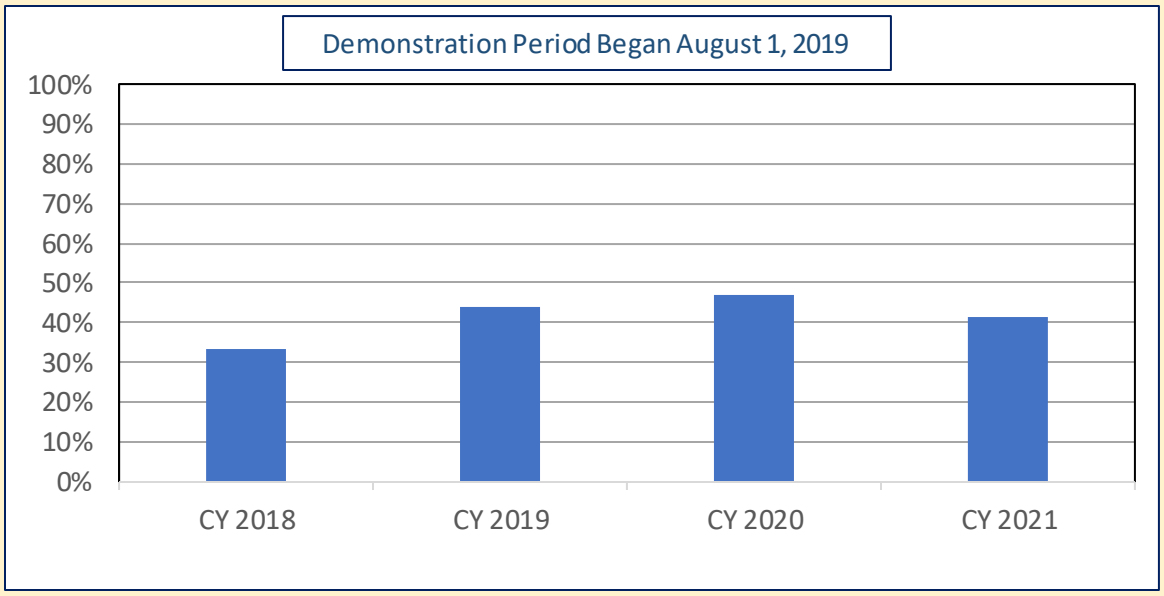
Desired Outcome:	Increase
Actual Outcome:	Decrease
Statistical Review:	Chi-Square
Probability:	0.0011
Finding:	Significant

Exhibit 28
Results for Interim Evaluation Measure #21
Medication Adherence Rate, Proportion of Days Covered

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

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

Results for the DSHP Plus Population in the Demonstration



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

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

Demonstration Goal #4: Increase Coordination of Care and Supports

Summary of Measures

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

Exhibit 29
Summary of Findings for Measures Mapped to Research Question #6

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

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

Individual Measure Results

HMA-Burns computed the timeliness of prenatal care (Exhibit 30) and the rate of postpartum care (Exhibit 31) among pregnant women using the HEDIS specification for its PPC measure. The timeliness of prenatal care increased slightly during the four year study period but hovered near 67 percent in all four

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

Follow-up care after hospitalization from a mental illness (HEDIS FUH measure) was low for DSHP members in all four years examined (refer to Exhibit 32) and decreased slightly from a 12.6 percent follow-up rate in CY 2018 to 12.2 percent in CY 2021.

The rate of emergency department utilization, expressed on a per 1,000 member basis, decreased significantly from 65.2 visits per 1,000 in CY 2018 to 49.2 visits per 1,000 in CY 2021 (refer to Exhibit 33). Although ED utilization fell significantly nationwide at the start of the PHE in CY 2020, the rate among DSHP members remained low in CY 2021 (ED usage increased only 4.1% between CY 2020 and CY 2021 among DSHP members).

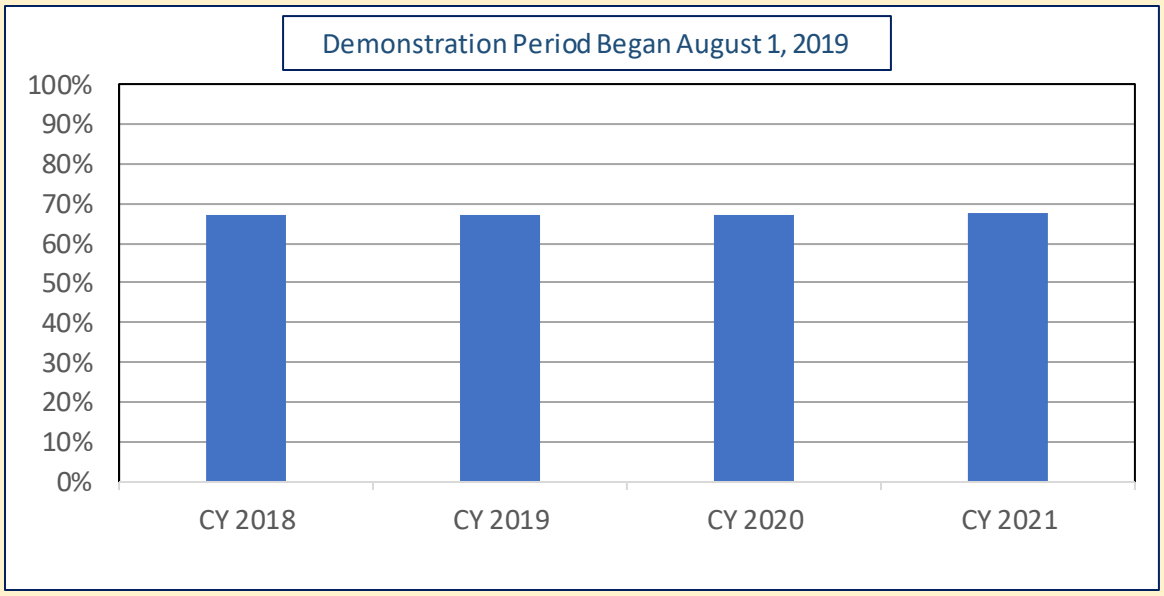
Follow-up care after an ED visit for alcohol or other drug dependence (HEDIS FUA measure) saw only modest improvement over the four years examined, from 17.6 percent in CY 2018 to 18.1 percent in CY 2021 (Exhibit 34). Follow-up care after an ED visit for mental illness (HEDIS FUM measure) fell over the four years examined, from 40.9 percent in CY 2018 to 36.1 percent in CY 2021 (Exhibit 35). Follow-up care after an ED visit for people with multiple high-risk conditions (HEDIS FMC measure) also saw a statistically significant decline, from 47.3 percent in CY 2018 to 43.4 percent in CY 2021 (Exhibit 36).

Exhibit 30
Results for Interim Evaluation Measure #22
Timeliness of Prenatal Care

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

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

Results for the DSHP Population in the Demonstration



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

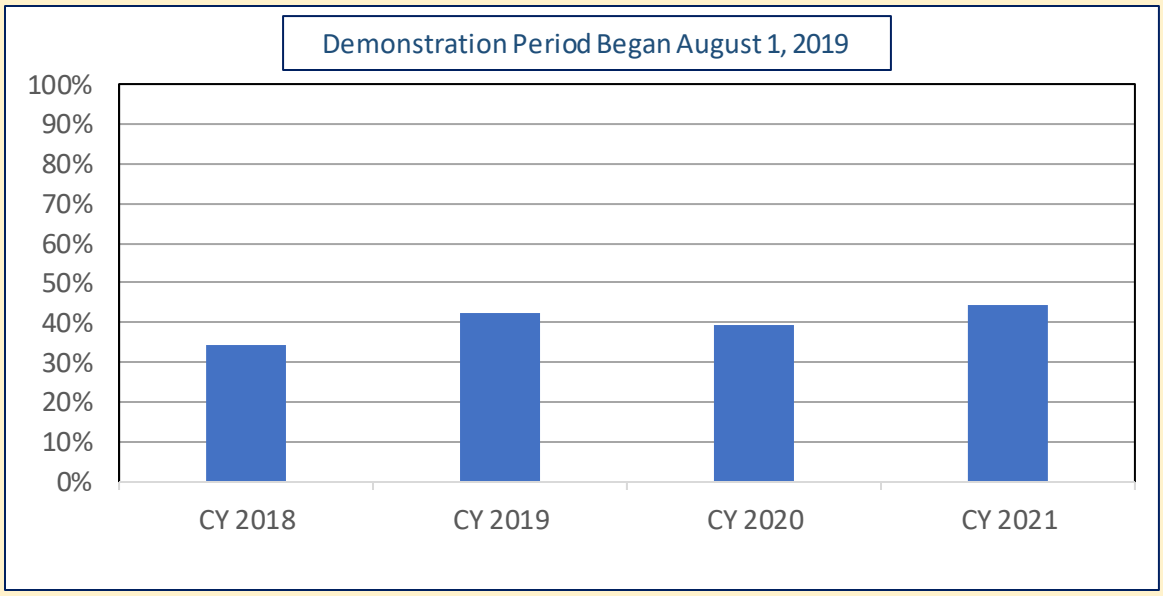
Desired Outcome: Increase
Actual Outcome: Increase
Statistical Review: Chi-Square
Probability: 0.6111
Finding: Not Significant

Exhibit 31
Results for Interim Evaluation Measure #23
Postpartum Care

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

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

Results for the DSHP Population in the Demonstration



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

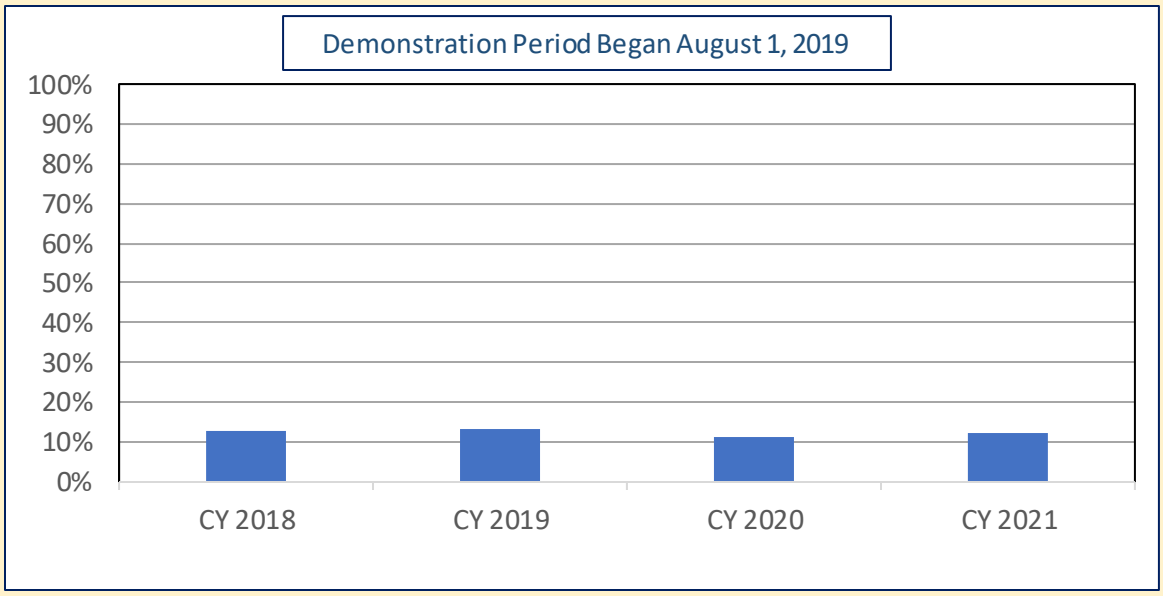
Desired Outcome:	Increase
Actual Outcome:	Increase
Statistical Review:	Chi-Square
Probability:	<.0001
Finding:	Significant

Exhibit 32
Results for Interim Evaluation Measure #24
Follow-up After Hospitalization for Mental Illness

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

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

Results for the DSHP Population in the Demonstration



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

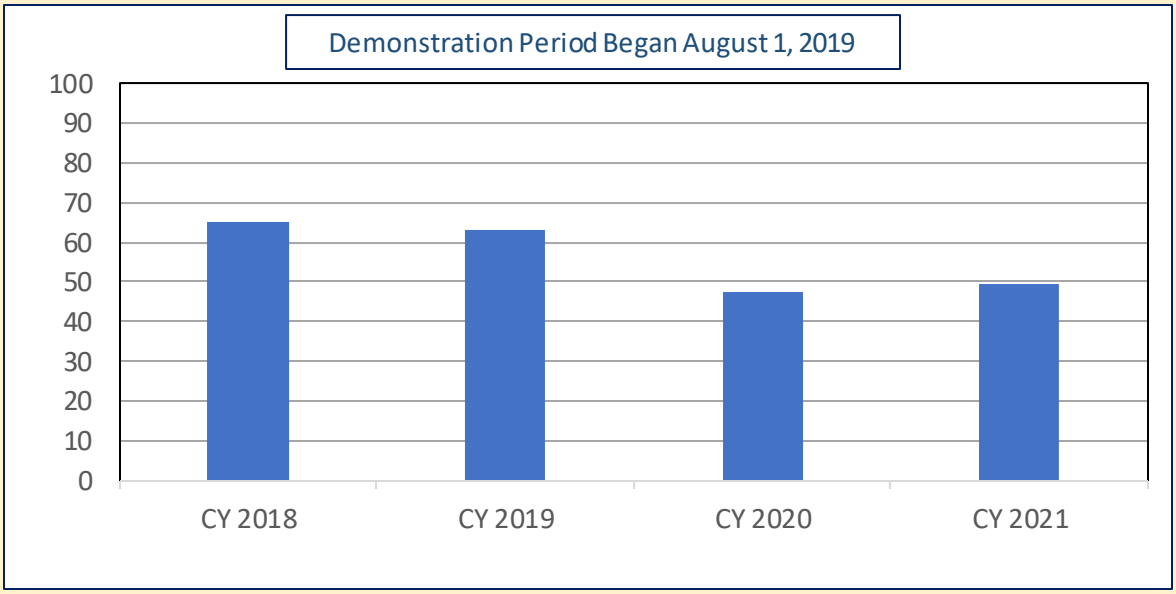
Desired Outcome: Increase
Actual Outcome: Decrease
Statistical Review: Chi-Square
Probability: 0.1799
Finding: Not Significant

Exhibit 33
Results for Interim Evaluation Measure #25
Emergency Department Visits Per 1,000 Medicaid Beneficiaries

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

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

Results for the DSHP Population in the Demonstration



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

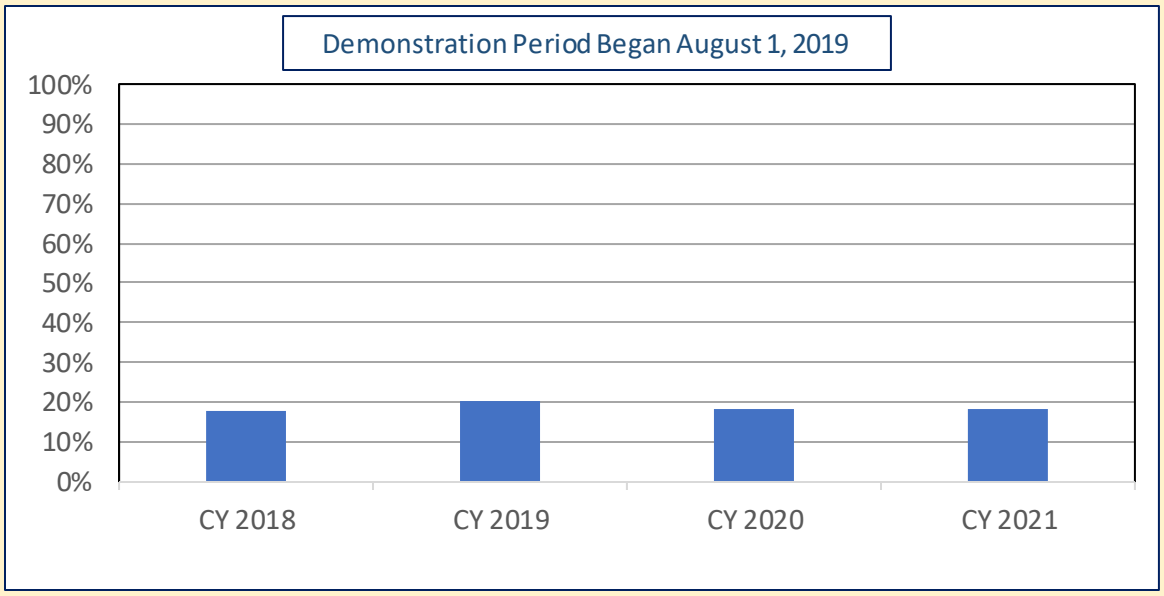
Desired Outcome:	Decrease
Actual Outcome:	Decrease
Statistical Review:	T-test
Probability > [t]:	<.0001
Finding:	Significant

Exhibit 34
Results for Interim Evaluation Measure #26
Follow-up After ED Visit for Alcohol or Other Drug (AOD) Dependence

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

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

Results for the DSHP Population in the Demonstration



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

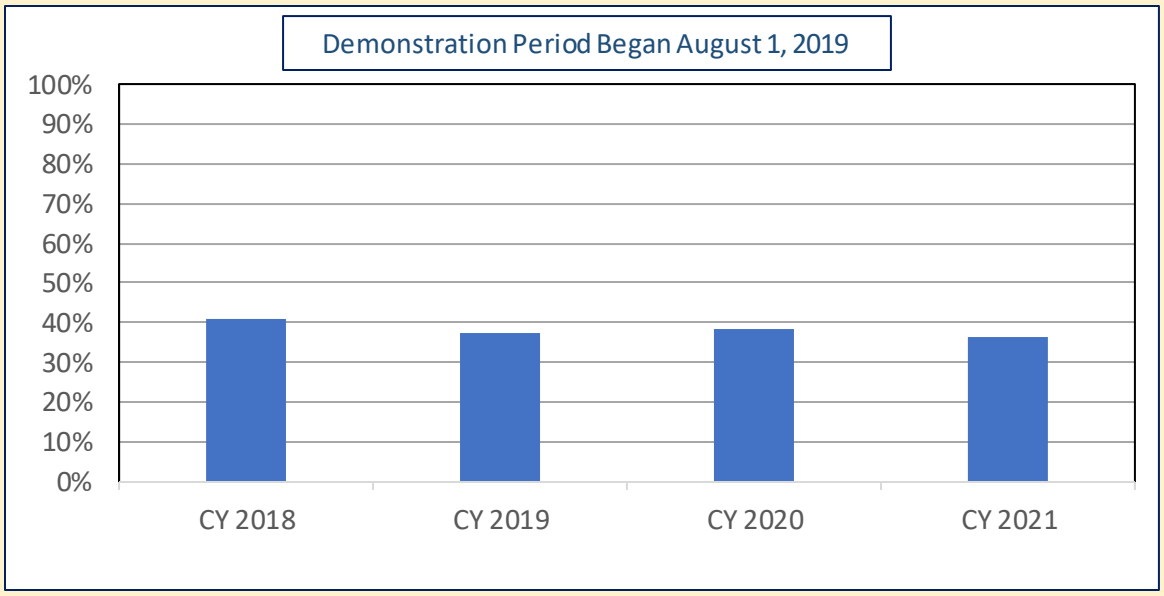
Desired Outcome: Increase
Actual Outcome: Increase
Statistical Review: Chi-Square
Probability: 0.7038
Finding: Not Significant

Exhibit 35
Results for Interim Evaluation Measure #27
Follow-up After ED Visit for Mental Illness

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

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

Results for the DSHP Population in the Demonstration



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

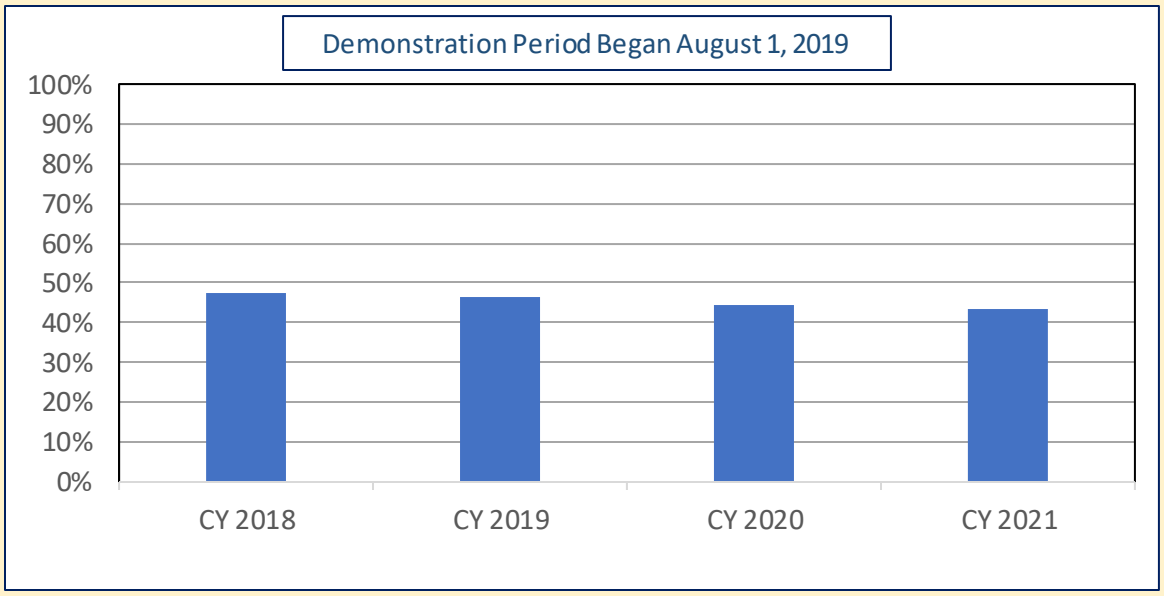
Desired Outcome:	Increase
Actual Outcome:	Decrease
Statistical Review:	Chi-Square
Probability:	0.0113
Finding:	Significant

Exhibit 36
Results for Interim Evaluation Measure #28
Follow-up After ED Visit for People with Multiple High-Risk Chronic Conditions

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

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

Results for the DSHP Population in the Demonstration



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

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

Results from Study of Prenatal Care

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

As Exhibit 37 below shows, more than 95 percent of the 3,941 women in the study were enrolled with their MCO for at least the second half of their pregnancy. Approximately 90 percent of women were enrolled with the MCO for the full second and third trimester of their pregnancy.

Exhibit 37
Number of Weeks Enrolled with the MCO Prior to Delivery

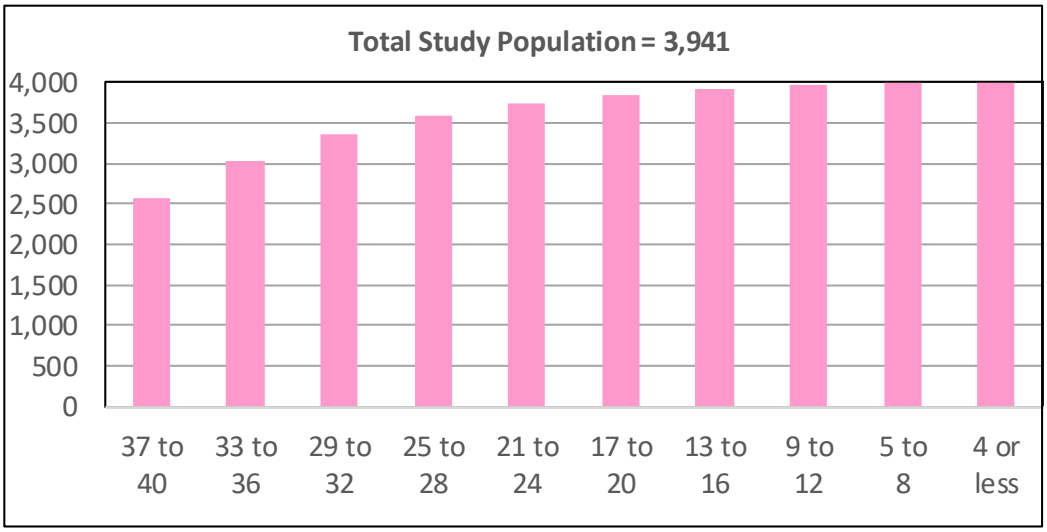
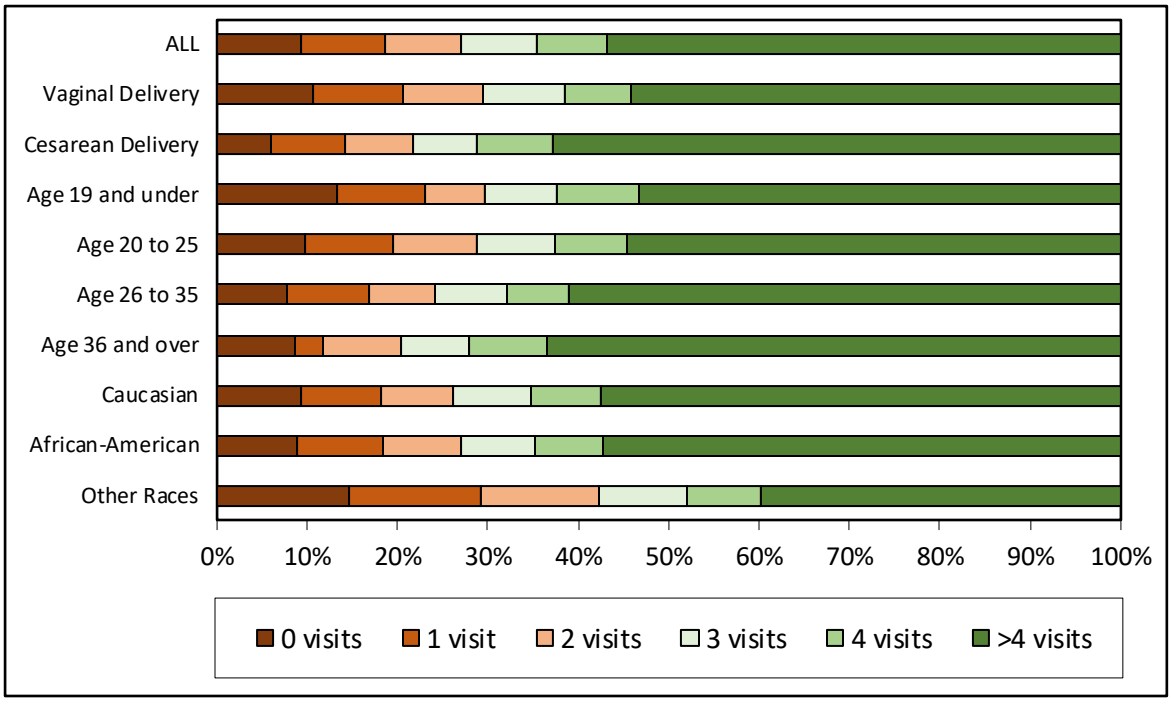


Exhibit 38 on the next page identifies the number of prenatal visits that each mother had in the four weeks prior to delivery. As seen in the exhibit above, all of the mothers were enrolled with their MCO in these last four weeks.

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

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

Exhibit 38
Number of Prenatal Visits in Last 4 Weeks Before Delivery



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

Demonstration Goal #5: Expand Consumer Choices

Summary of Measures

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

Exhibit 39
Summary of Findings for Measures Mapped to Research Question #7

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

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

Individual Measure Results

Exhibit 40 summarizes the results of all six CAHPS composite measures. For each measure, results are shown for both MCOs (AmeriHealth Caritas Delaware, or ACDE and Highmark Health Options, or HHO) as well as separate results for the CAHPS Adult and CAHPS Child Surveys. Results were compared for the CY 2019, CY 2020 and CY 2021 survey years.

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

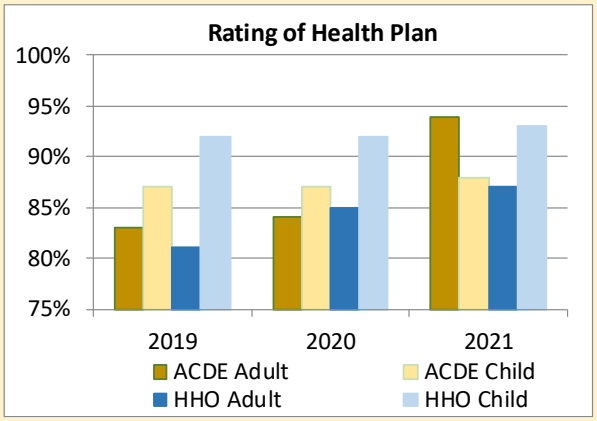
Exhibit 41 shows the results for member grievances and appeals. Both grievances and appeals remain very low when measured on a per 1,000 member month basis. Grievances increased in CY 2020 and CY 2021 among the DSHP Plus population, but appeals remain low.

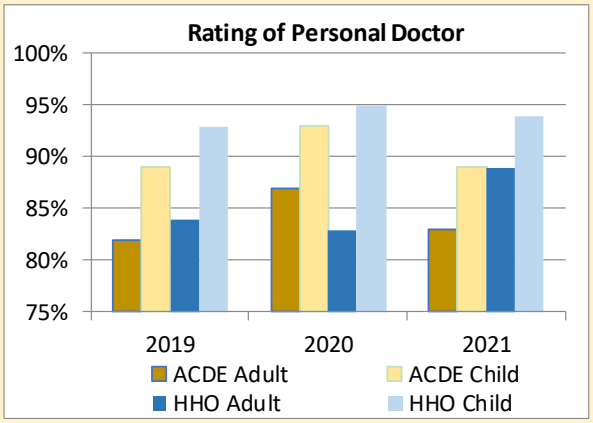
Exhibit 40
Results for Interim Evaluation Measures #29 through #34
Consumer Assessment of Healthcare Providers and Systems

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

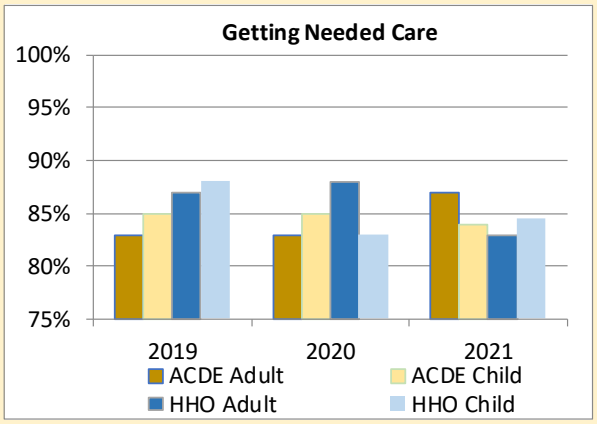
Measures Used to Test Hypothesis:	The six composite measures shown below for the DSHP population
Measure Steward:	Agency for Healthcare Research and Quality
Data source:	Results included in reports prepared by certified CAHPS surveyors and submitted to DMMA by the MCOs

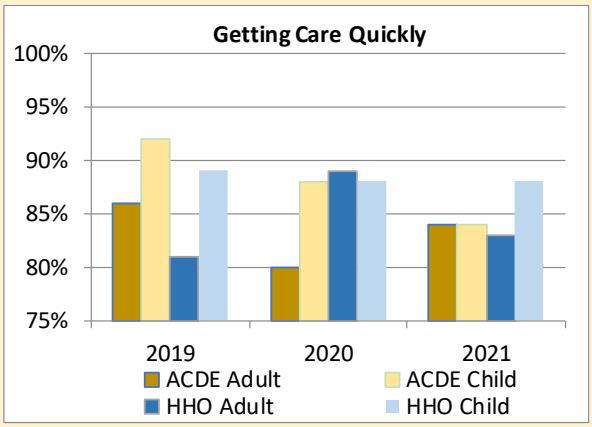
Results on Composite Measures where members giving a rating of 8, 9 or 10 on 10-point scale
Legend: ACDE = AmeriHealth Caritas Delaware; HHO = Highmark Health Options

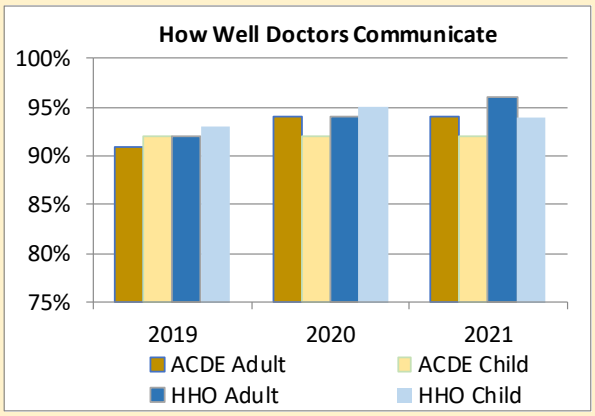




Results on Composite Measures where percentage of respondents answered "Usually" or "Always"







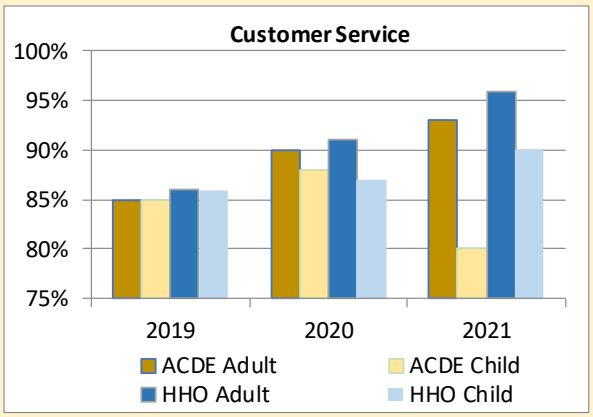


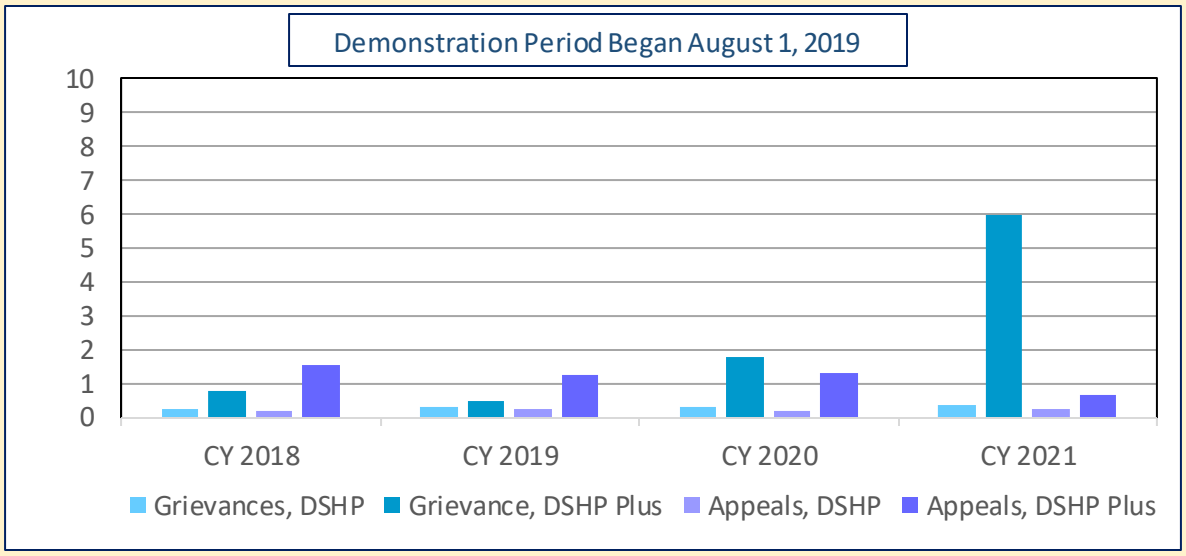
Exhibit 41
Results for Interim Evaluation Measures #35 and #36
Member Grievances and Appeals

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

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

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

Results for the DSHP and DSHP Plus Populations in the Demonstration



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

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

Summary of Measures

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

Exhibit 42
Summary of Findings for Measures Mapped to Research Question #9

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

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

Individual Measure Results

Exhibit 43 summarizes the results of all six LTSS CAHPS composite measures. For each measure, results are shown for both MCOs (ACDE and HHO) for the CY 2019, CY 2020 and CY 2021 survey years.

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

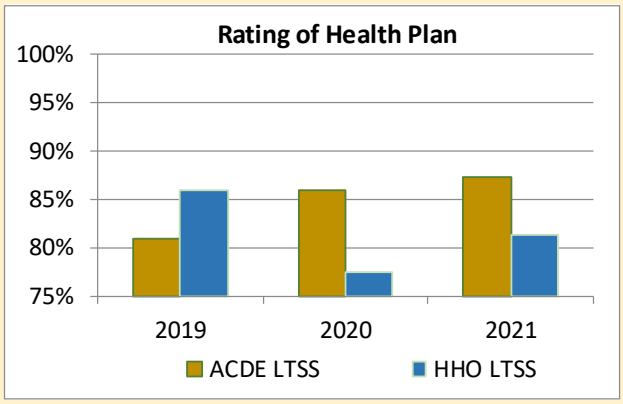
Exhibit 44 shows the results for critical incidents reported among DSHP Plus members. When measured on a per 1,000 member month basis, the rate decreased from 6.1 per 1,000 in CY 2018 to 2.1 per 1,000 in both CY 2020 and CY 2021.

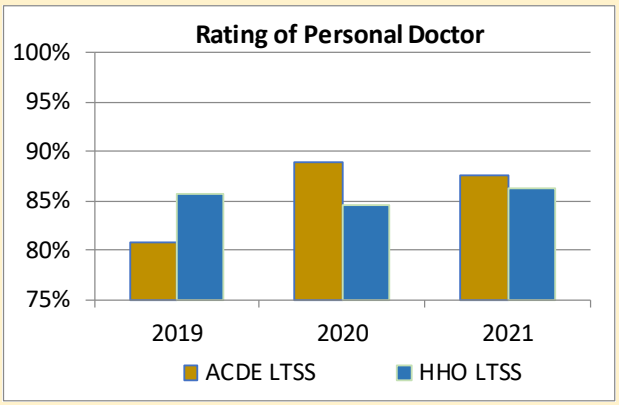
Exhibit 43
Results for Interim Evaluation Measures #37 through #42
Consumer Assessment of Healthcare Providers and Systems, LTSS

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

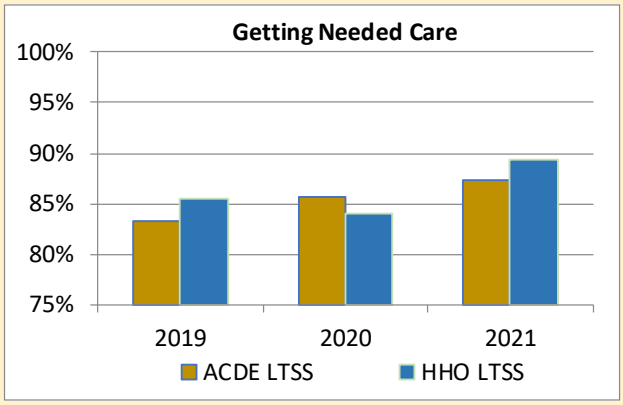
Measures Used to Test Hypothesis: The six composite measures shown below for the DSHP Plus population
Measure Steward: Agency for Healthcare Research and Quality
Data source: Results included in reports prepared by certified CAHPS surveyors and submitted to DMMA by the MCOs

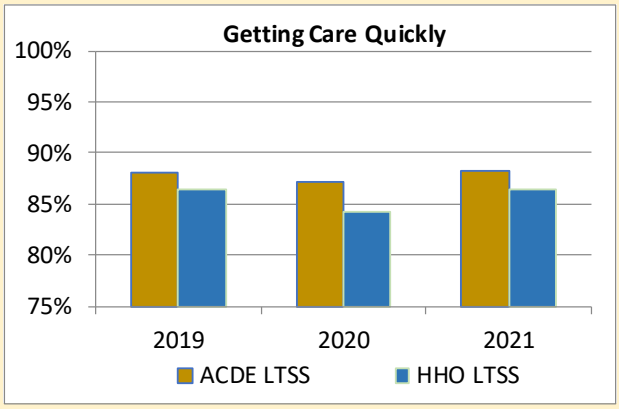
Results on Composite Measures where members giving a rating of 8, 9 or 10 on 10-point scale
Legend: ACDE = AmeriHealth Caritas Delaware; HHO = Highmark Health Options

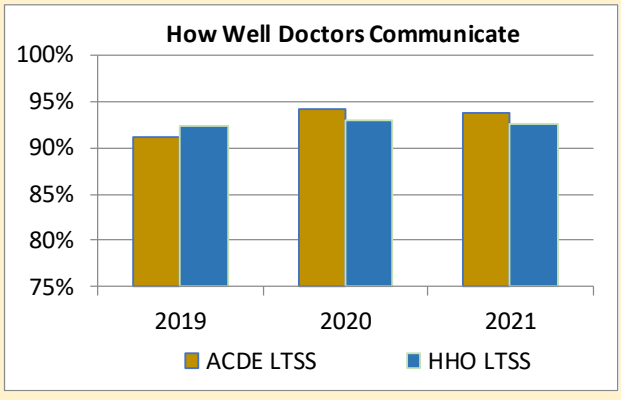




Results on Composite Measures where percentage of respondents answered "Usually" or "Always"







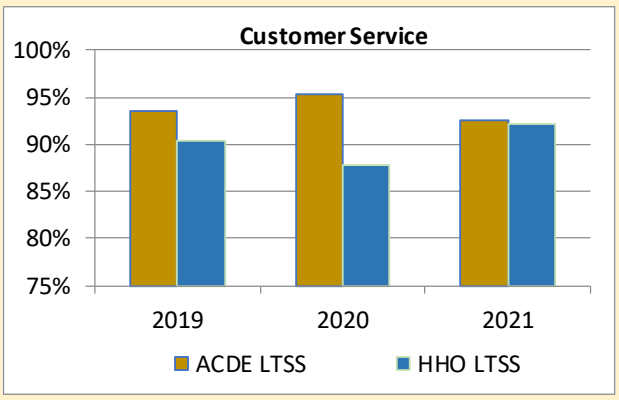
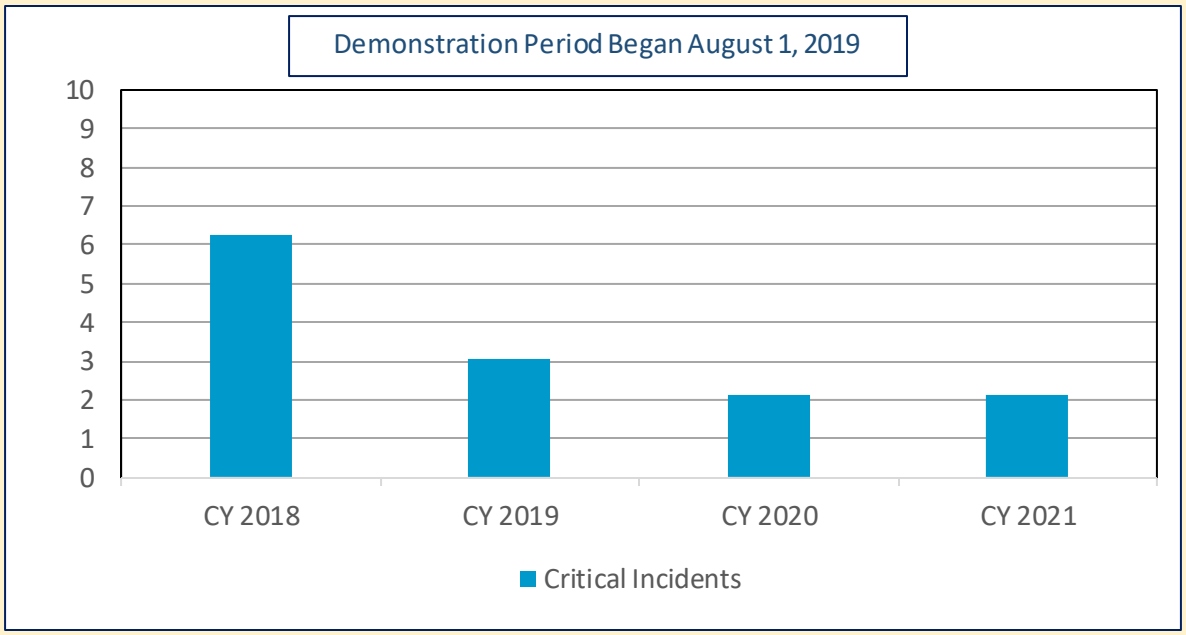


Exhibit 44
Results for Interim Evaluation Measure #43
Critical Incidents

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

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

Results for the DSHP Plus Population in the Demonstration



Study Period	Numerator	Denominator	Rate
CY 2018	560	89,635	6.2
CY 2019	293	95,391	3.1
CY 2020	208	97,244	2.1
CY 2021	197	92,149	2.1

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

Actions Taken

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

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

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

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

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

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

Summary of Measures

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

Exhibit 45
Summary of Findings for Measures Mapped to Research Question #9

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

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

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

Individual Measure Results

The rate of emergency department utilization, expressed on a per 1,000 member basis, decreased from 27.5 visits per 1,000 in CY 2018 to 26.3 visits per 1,000 in CY 2021 (refer to Exhibit 47). ED utilization actually fell for the DSHP Plus population between CY 2020 and CY 2021.

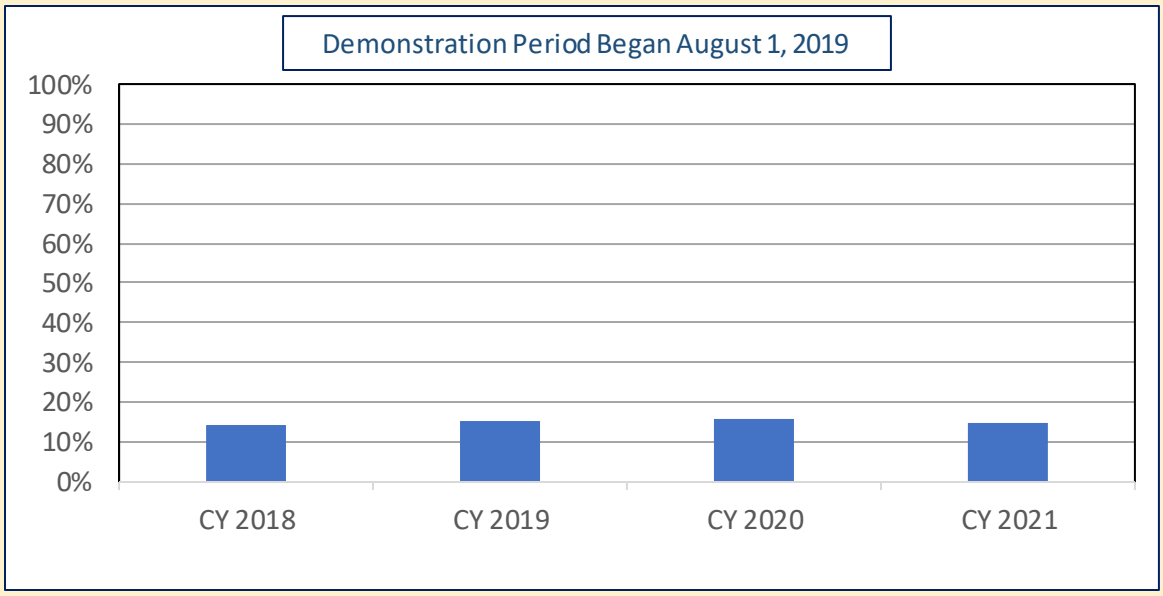
Follow-up care after hospitalization from a mental illness (HEDIS FUH measure) was low for DSHP Plus members in all four years examined (refer to Exhibit 46), but results were slightly higher than seen for the DSHP population. The follow-up rate increased slightly, from 14.1 percent in CY 2018 to 14.6 percent in CY 2021. Follow-up care after an ED visit for people with multiple high-risk conditions (HEDIS FMC measure) also saw a statistically significant increase, from 35.9 percent in CY 2018 to 48.5 percent in CY 2021 (Exhibit 48).

Exhibit 46
Results for Interim Evaluation Measure #44
Follow-up After Hospitalization for Mental Illness

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

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

Results for the DSHP Plus Population in the Demonstration



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

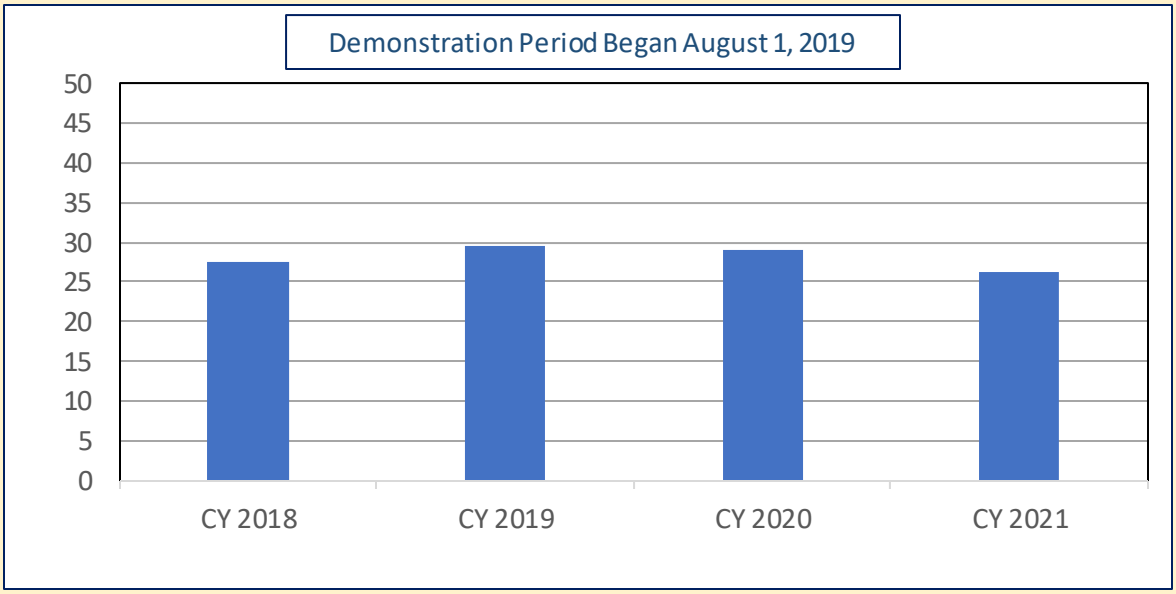
Desired Outcome: Increase
Actual Outcome: Increase
Statistical Review: Chi-Square
Probability: 0.686
Finding: Not Significant

Exhibit 47
Results for Interim Evaluation Measure #45
Emergency Department Visits Per 1,000 Medicaid Beneficiaries

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

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

Results for the DSHP Plus Population in the Demonstration



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

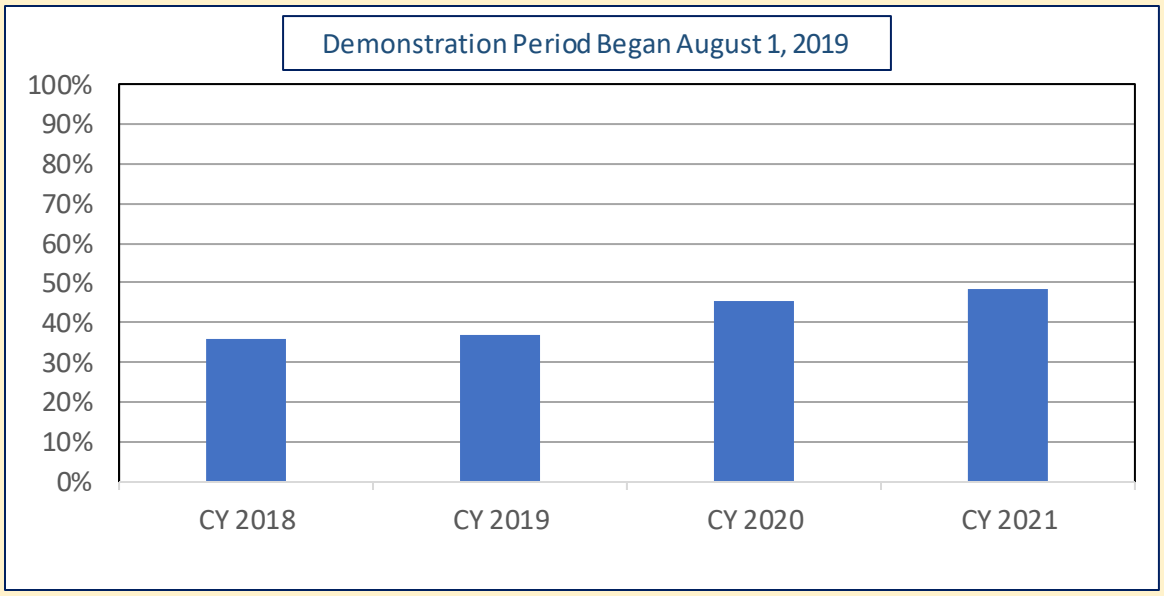
Desired Outcome: Decrease
Actual Outcome: Decrease
Statistical Review: T-test
Probability > [t]: 0.4187
Finding: Not Significant

Exhibit 48
Results for Interim Evaluation Measure #46
Follow-up After ED Visit for People with Multiple High-Risk Chronic Conditions

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

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

Results for the DSHP Plus Population in the Demonstration



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

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

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

Summary of Measures

Demonstration Goal #9 focuses on the PROMISE population. Eleven measures were computed to assess overall health status for PROMISE members. Two of the 11 measures are not being reported due to low sample size. Exhibit 49 on the next page summarizes the results of each measure. For the nine measures that are reported, for four measures the actual outcome was the desired outcome. For the other five measures, the opposite was true. Tests for statistical significance were conducted on five of the nine measures. In two of the five cases, the results were found to be statistically significant.

Individual Measure Results

HMA-Burns analyzed data from DSAMH, the division that processes PROMISE applications, to determine the percentage of applicants who are approved to enroll in PROMISE for the years CY 2018 to CY 2021 (refer to Exhibit 50). The enrollment rate increased from 30 percent in CY 2018 to 43 percent in CY 2021.

Many of the HEDIS measures that were computed for the DSHP and DSHP Plus populations were also computed specifically for the PROMISE population. The all-cause readmission rate (HEDIS PCR) remained steady at 48 percent for three of the four years, the exception being CY 2019 at 39 percent (Exhibit 51).

Whereas the rate of ED utilization decreased for DSHP and DSHP Plus members, the rate increased slightly in the first years of the demonstration for the PROMISE population, from a rate of 193.6 per 1,000 in CY 2018 to 200.2 per 1,000 in CY 2021 (refer to Exhibit 52). HMA-Burns also examined PROMISE members who are frequent users of the ED. The rate among members who presented at the ED more than five times in one year increased from 8.0 percent in CY 2018 to 9.7 percent in CY 2021.

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

Rates for the initiation and engagement of alcohol or other drug abuse dependence treatment (HEDIS IET) also decreased. The rate of initiation decreased from 54.9 percent in CY 2018 to 46.0 percent in CY 2021. The rate of engagement decreased from 25.0 percent in CY 2018 to 23.0 percent in CY 2021 (Exhibit 55).

The reduction in utilization for some services does not appear to correlate with the PROMISE provider network, since the network of providers has actually increased in the last four years from 318 to 377 providers (refer to Exhibit 56). Although PROMISE enrollment has also grown, the providers per 1,000 PROMISE members has increased 13.9 percent between CY 2018 and CY 2021.

Exhibit 49
Summary of Findings for Measures Mapped to Research Questions #10 and #12

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
Research Question #10: Does the level and trend of access to enhanced behavioral health services continue (or not worsen) in the curent waiver period?					
47	Rate of Identified Members Who Enroll in PROMISE	Increase	Increase	N/A	no test run
48	All-Cause Readmission, PROMISE Population	Decrease	Decrease	No	Chi-square
49	Follow-up After Hospitalization for Mental Illness (FUH), PROMISE Population	Increase	Decrease	No	Chi-square
50	Emergency Department Visits per 1000, PROMISE Population	Decrease	Increase	N/A	no test run
51	Emergency Department Visit Frequent Users Rate, PROMISE Population	Decrease	Increase	N/A	no test run
52	Follow-up After ED Visit for Mental Illness (FUM), PROMISE Population	Increase	Decrease	Yes	Chi-square
53	Initiation of AOD Dependence Treatment (IET), PROMISE Population	Increase	Decrease	No	Chi-square
54	Engagement of AOD Dependence Treatment (IET), PROMISE Population	Increase	Decrease	Yes	Chi-square

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

Follow-Up After Discharge from the Emergency Department for Alcohol or Other Drug (AOD) Dependence (FUA)	Denominator <100 in each year examined
Antidepressant Medication Management (AMM), 12 weeks and 6 months	Denominator <50 in each year examined

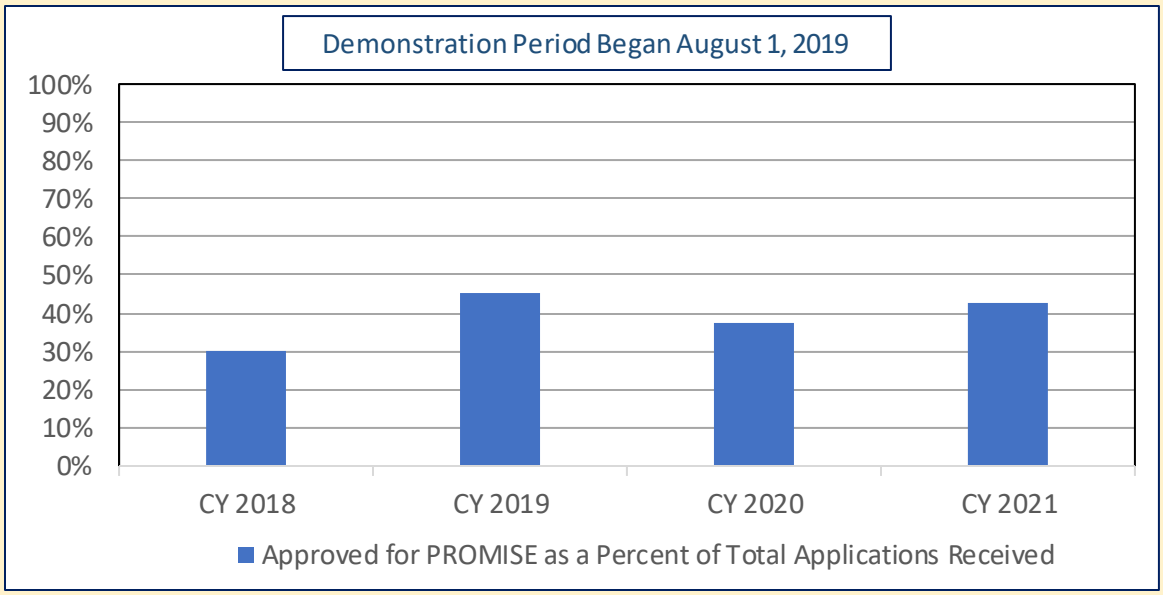
Research Question #12: Does the availability of PROMISE providers continue (or not worsen) the current waiver period?					
55	Number of Providers Delivering PROMISE Services per 1,000 PROMISE Members	Increase	Increase	N/A	no test run

Exhibit 50
Results for Interim Evaluation Measure #47
Rate of Identified Members Who Enroll in PROMISE

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

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

Results



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

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

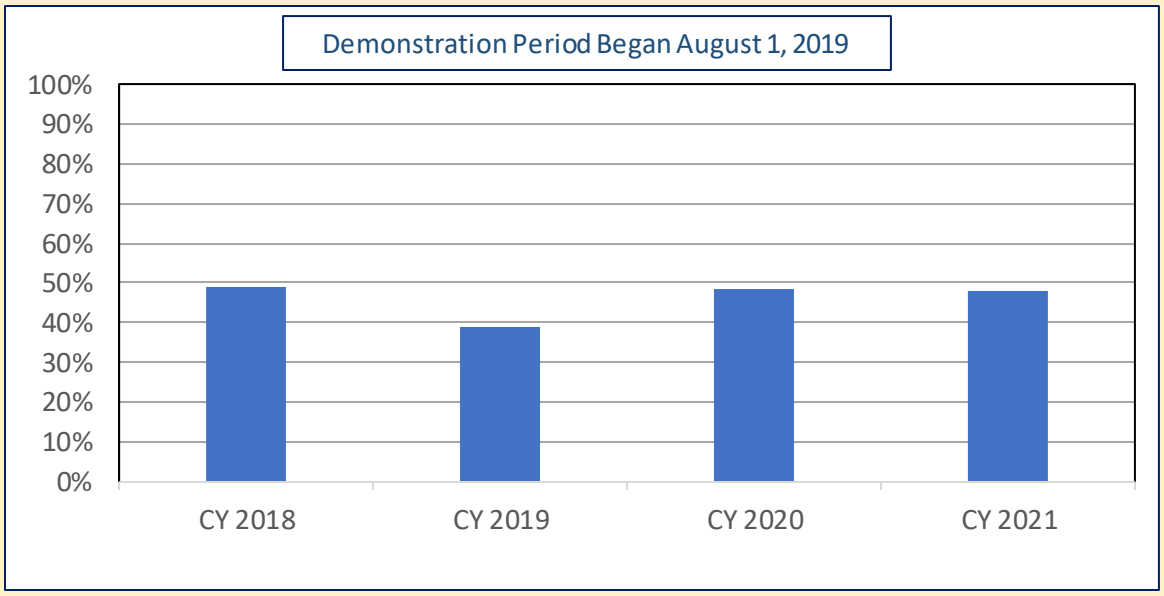
Desired Outcome: Increase
Actual Outcome: Increase

Exhibit 51
Results for Interim Evaluation Measure #48
Plan All-Cause Readmissions

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

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

Results for the PROMISE Population in the Demonstration



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

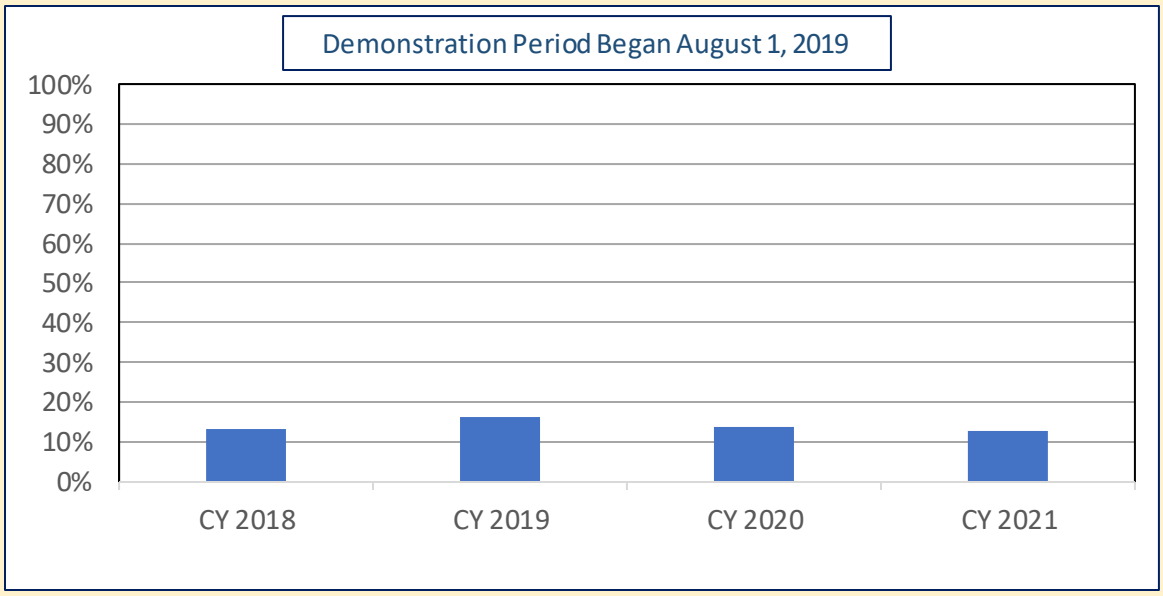
Desired Outcome: Decrease
Actual Outcome: Decrease
Statistical Review: Chi-Square
Probability: 0.7188
Finding: Not Significant

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

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

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

Results for the PROMISE Population in the Demonstration



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

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

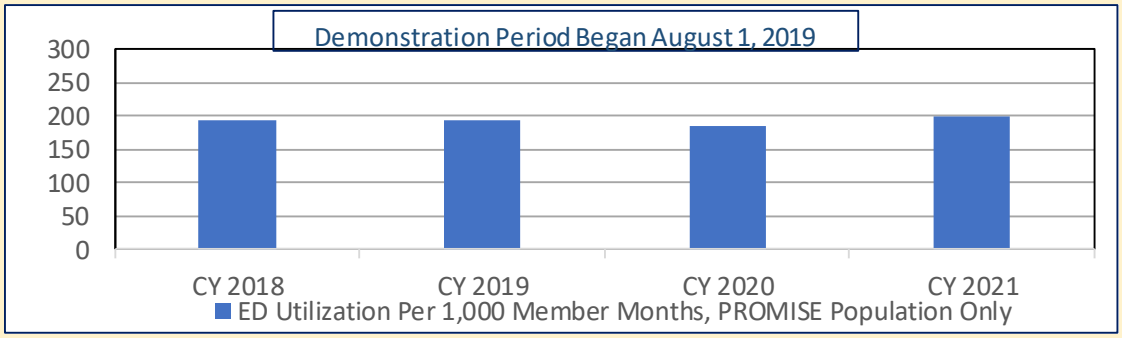
Exhibit 53
Results for Interim Evaluation Measures #50 and #51
Emergency Department Visits

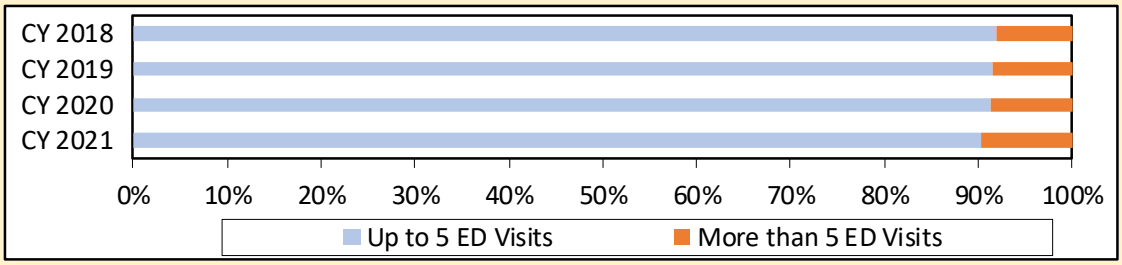
Hypothesis:
Trends in health outcomes will continue or improve in the current demonstration period for individuals enrolled in the PROMISE program.

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

Measure Steward: HMA-Burns

Results for the PROMISE Population in the Demonstration





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

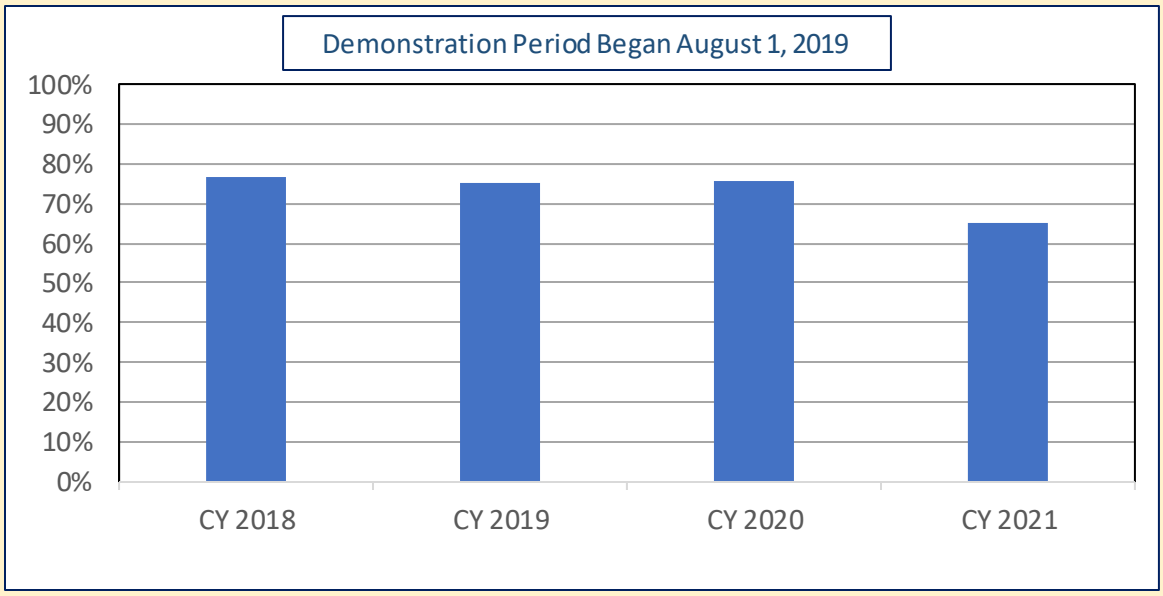
	ED Visits Per 1,000 PROMISE	Frequent ED Users PROMISE
Desired Outcome:	Decrease	Decrease
Actual Outcome:	Increase	Increase
Statistical Review:	T-test	Note that statistical testing was only conducted on the first measure, ED Visits Per 1,000
Probability > [t]:	0.5093	
Finding:	Not Significant	

Exhibit 54
Results for Interim Evaluation Measure #52
Follow-up After ED Visit for Mental Illness

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

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

Results for the PROMISE Population in the Demonstration



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

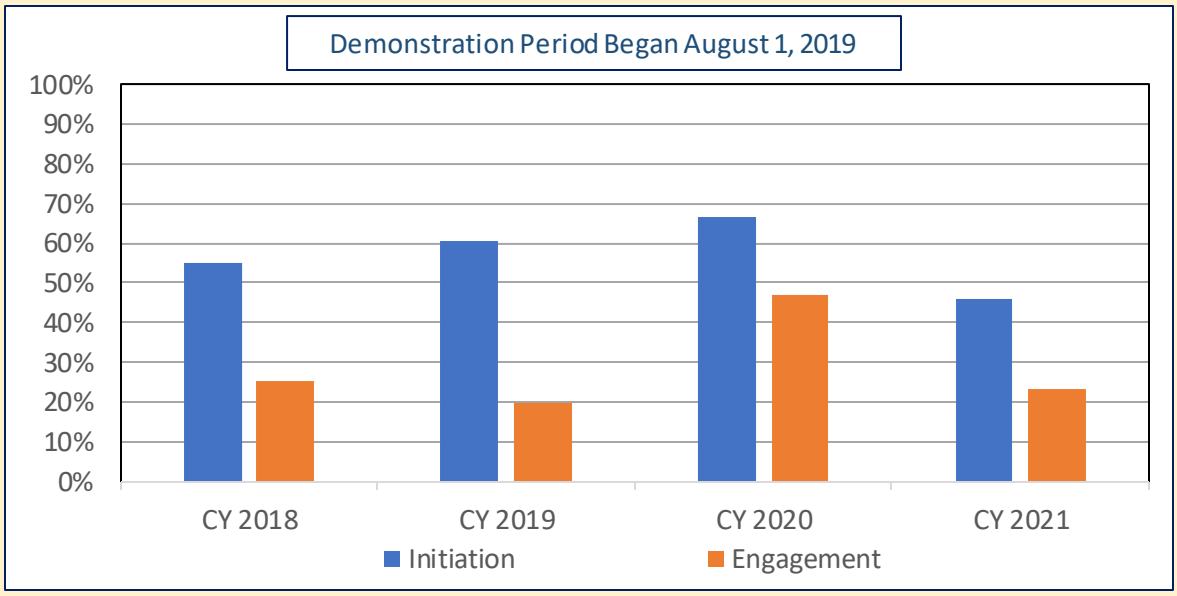
Desired Outcome:	Increase
Actual Outcome:	Decrease
Statistical Review:	Chi-Square
Probability:	0.0036
Finding:	Significant

Exhibit 55
Results for Interim Evaluation Measures #53 and #54
Initiation and Engagement of Alcohol or Other Drug Abuse Dependence Treatment

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

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

Results for the PROMISE Population in the Demonstration



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

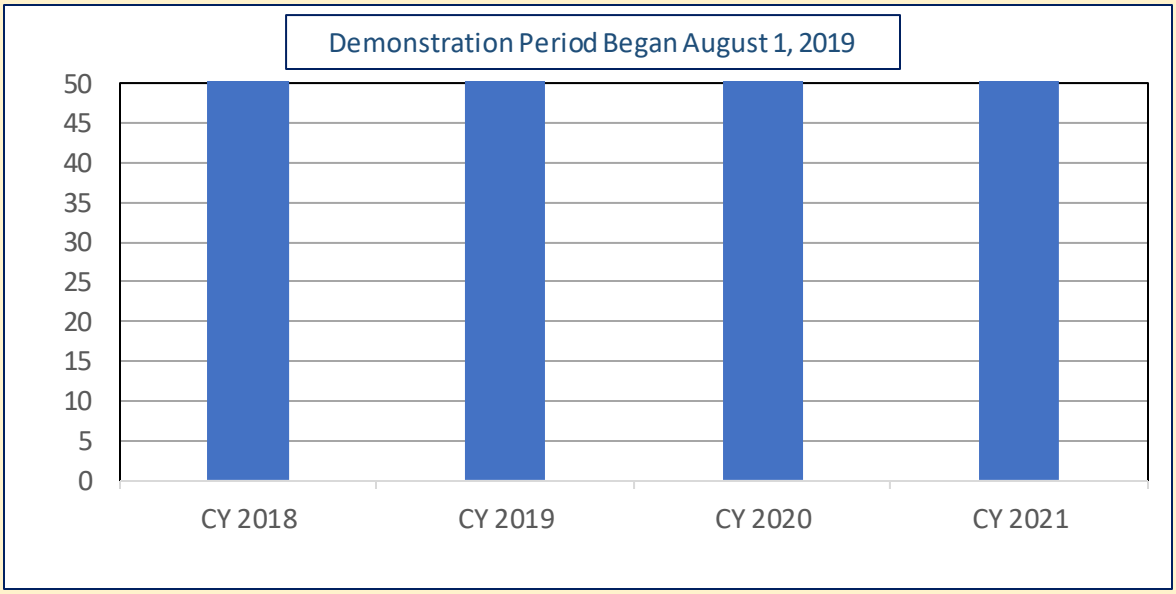
	Initiation	Engagement
Desired Outcome:	Increase	Increase
Actual Outcome:	Decrease	Decrease
Statistical Review:	Chi-Square	Chi-Square
Probability:	0.0688	0.7353
Finding:	Not Significant	Significant

Exhibit 56
Results for Interim Evaluation Measure #55
PROMISE Service Providers

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

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

Results for the PROMISE Population in the Demonstration



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

Desired Outcome: Increase
Actual Outcome: Increase

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

Summary of Measures

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

Exhibit 57
Summary of Findings for Measures Mapped to Research Question #3

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

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

Individual Measure Results

The results of each of these measures appears in Exhibit 58 on the next page. For all three measures, the same cohort population was examined for their use of primary care visits, dental visits, and ED visits. The percent of users was computed over four state fiscal year (SFY) periods from 2018 to 2021.

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

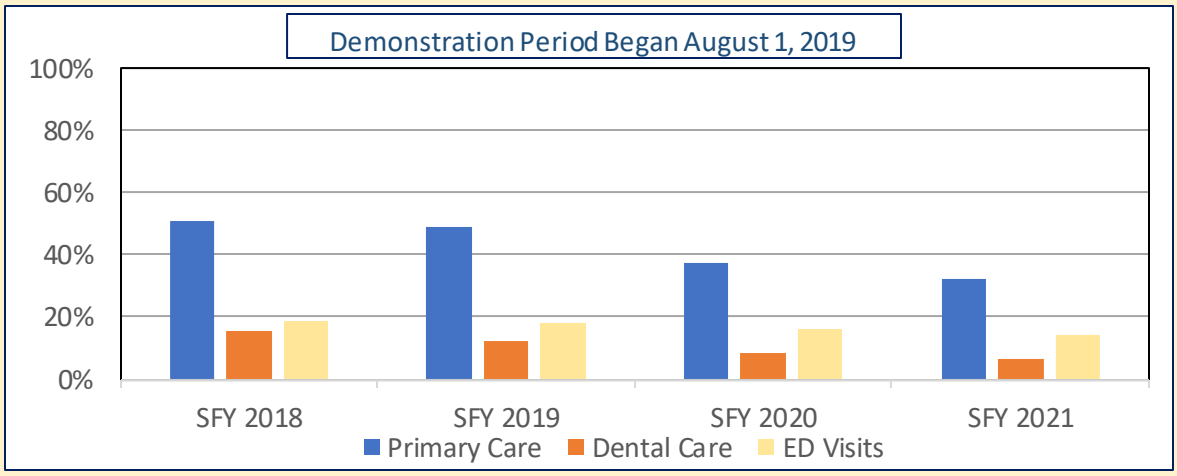
Exhibit 58
Results for Interim Evaluation Measures #56, #57 and #58
Utilization of Services for Former Foster Care Members

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

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

Measure Steward: HMA-Burns

Results for the Former Foster Care Population in the Demonstration



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

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

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

Summary of Measures

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

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

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

The eight measures where statistically significant improvement were found include:

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

The 11 measures where statistically significant declines were found include:

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

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

Summary of Measures

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

Exhibit 59
Summary of Findings for Measures Mapped to Research Question #13

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

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

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

Individual Measure Results

Detailed information, including the numerators and denominators for each measure, are shown in Exhibit 60 on the next page. HMA-Burns serves as the measure steward for three of the five measures. For the other two measures, the HMA-Burns team followed the specifications to compute results where the measure steward is the Dental Quality Alliance (EDV-A-A and EDF-A-A).

Exhibit 60
Results for Interim Evaluation Measures #59 through #63
Adult Dental Metrics

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

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

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

Results for the Adult Population in the Demonstration

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

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

SECTION G: Conclusions

Assessment of the Effectiveness of the Demonstration

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

1. **Maintain Continuity of Enrollment**

   Noteworthy positive impacts were found in the following areas:

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

2. **Maintain Access to Care**

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

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

3. **Maintain or Improve Health Outcomes**

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

   - The rate of adherence to antidepressant medication management improved at both the 12 week and six month mark.
   - The medication adherence rate, expressed as the proportion of days covered, saw a statistically significant increase among the DSHP Plus population.
   - Member grievances and appeals remain very low when measured on a per 1,000 member month basis.

- Among the DSHP Plus population, improvement was seen among all six LTSS CAHPS composite measures during the demonstration period thus far. The rate of critical incidents per 1,000 also decreased during the demonstration period.

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

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

   a. The utilization rate of HCBS services among DSHP Plus members.

   b. The PMPM expenditures for HCBS among DSHP Plus members increased 38.8 percent while the PMPM expenditures for institutional care decreased 15.9 percent.

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

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

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

When considering each of the demonstration goals, Delaware did see some success in each goal, albeit perhaps not as much as desired. Exhibit 61, which appears on the next page, summarizes all of the measures that were reviewed. Among the 63 measures, there were 39 measures where the desired outcome was met. Statistical tests were run for 28 of the 63 measures. Among these 28 measures, there are nine measures which have a statistically significant trend in the intended direction, nine measures which have a statistically significant trend in wrong direction, and 10 measures where the trend was found not to be statistically significant.

Exhibit 61
Summary of Measures Examined by Demonstration Goal

	Waiver Goals	Total Measures	Measures with Results Trending in the Intended Direction	Measures with Results Trending in the Wrong Direction	Total Measures Where Tests Were Run for Statistical Significance	Of these, the Total Where Trend in Intended Direction and Statistically Significant	Of these, the Total Where Trends in Wrong Direction and Statistically Significant	Of these, the Total Where There Was No Statistically Significant Change
	MEASURES FOR GOALS #1 - #10	**58**	**39**	**19**	**28**	**9**	**9**	**10**
1	Improve access to health care for the Medicaid population	13	10	3	7	3	3	1
2	Rebalance Delaware's LTC system in favor of HCBS	4	4	0	2	2	0	0
3	Promote early intervention for individuals with, or at risk, for having LTC needs	4	2	2	4	1	2	1
4	Increase coordination of care and supports	7	4	3	7	2	2	3
5	Expand consumer choices	8	5	3	0	0	0	0
6	Improve the quality of health services, including LTC services, delivered to all Delawareans	7	7	0	0	0	0	0
7	Create a payment structure that provides incentives for resources to shift from institutions to community-based long-term services and supports	0						
8	Improve coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles	3	3	0	3	1	0	2
9	Improve overall health status and quality of life of individuals enrolled in PROMISE	9	3	6	5	0	2	3
10	Increase and strengthen overall coverage of former foster care youth to improve health outcomes	3	1	2	0	0	0	0
11	Increase enrollee access and utilization of appropriate SUD treatment services	29	Results are shown in the SUD Independent Evaluation report.					
12	Increase access to dental services; decrease adult ED visits for non-traumatic conditions	5	CY2021 is the baseline year for the results for each measure.					

Assessment of Opportunities for Improvement

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

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

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

Policy Implications

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

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

Interactions with Other State Initiatives

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

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

State of Delaware Interpretations from the Evaluation Findings

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

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

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

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

SECTION I: Lessons Learned and Recommendations

Lessons Learned

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

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

Recommendations

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

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

APPENDIX: Approved Evaluation Design Plan

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

State Demonstrations Group

April 2, 2021

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

Dear Mr. Groff:

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

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

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

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

Sincerely,

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

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

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

Andrea J. Casart
Director
Division of Eligibility and Coverage Demonstrations

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

EVALUATION DESIGN PLAN FOR DELAWARE'S 1115 MEDICAID DEMONSTRATION WAIVER

FINAL DRAFT
FEBRUARY 25, 2021

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

Evaluation Team Members:

Mark Podrazik, Principal Investigator

Akhilesh Pasupulati
Ryan Sandhaus
Debbie Saxe
Barry Smith
Shawn Stack

TABLE OF CONTENTS

Listing of Exhibits

Abbreviations List

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

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

SECTION I: GENERAL BACKGROUND INFORMATION

I.A INTRODUCTION[1]

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

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

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

I.B NAME, APPROVAL DATE AND TIME PERIOD COVERED

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

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

I.C DEMONSTRATION GOALS[2]

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

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

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

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

The approved waiver has five demonstration components:

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

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

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

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

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

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

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

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

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

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

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

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

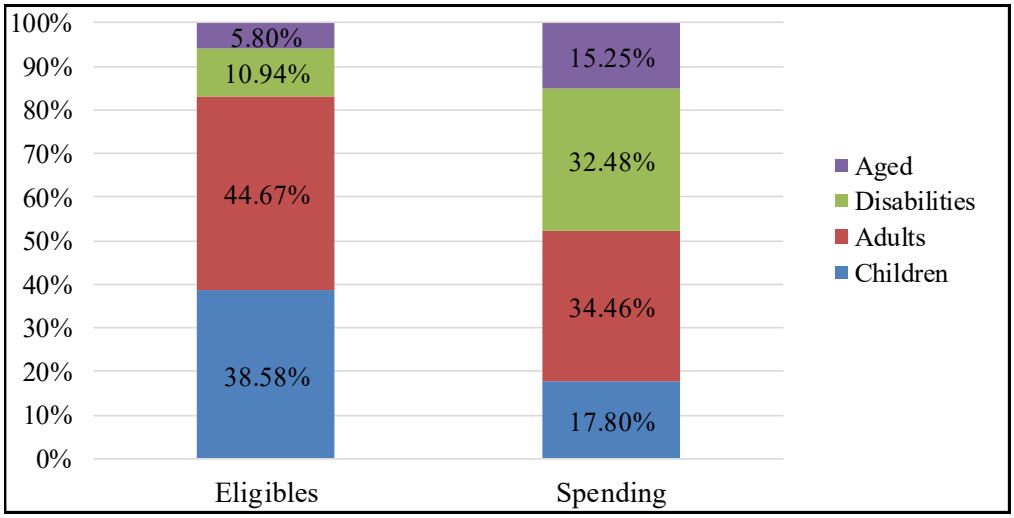
In June 2018, Delaware submitted a five-year demonstration extension and an amendment to provide the state with authority to provide high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an IMD. The demonstration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

I.E POPULATION GROUPS IMPACTED

Overview of Delaware's Medicaid Program

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Enrollment at a Glance

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

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

Exhibit I.4 Number of Unique Beneficiaries

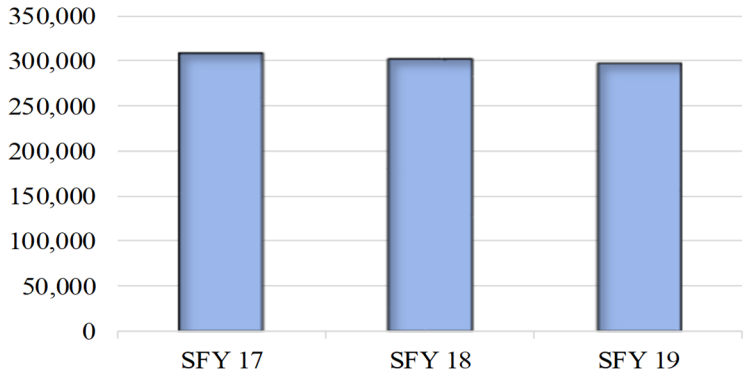
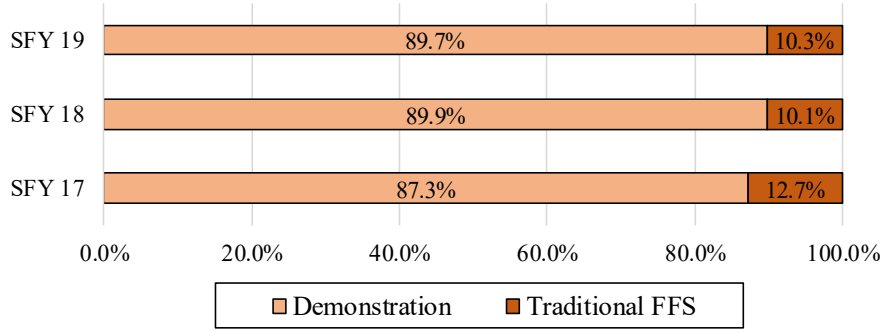


Exhibit I.5 Unique Beneficiaries by Delivery System



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

Exhibit I.6 Demonstration Population by Race

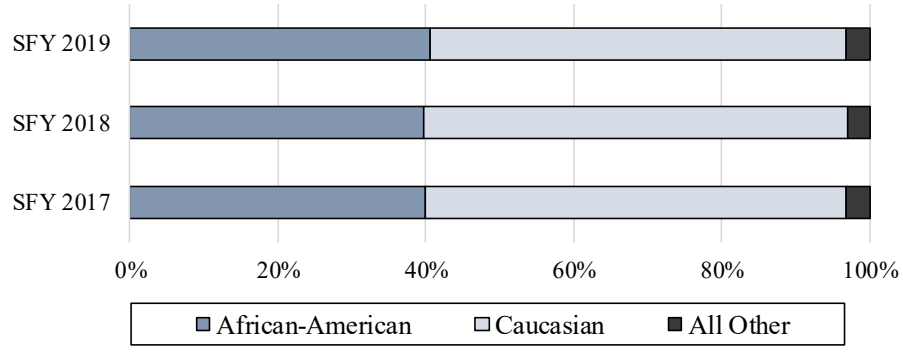
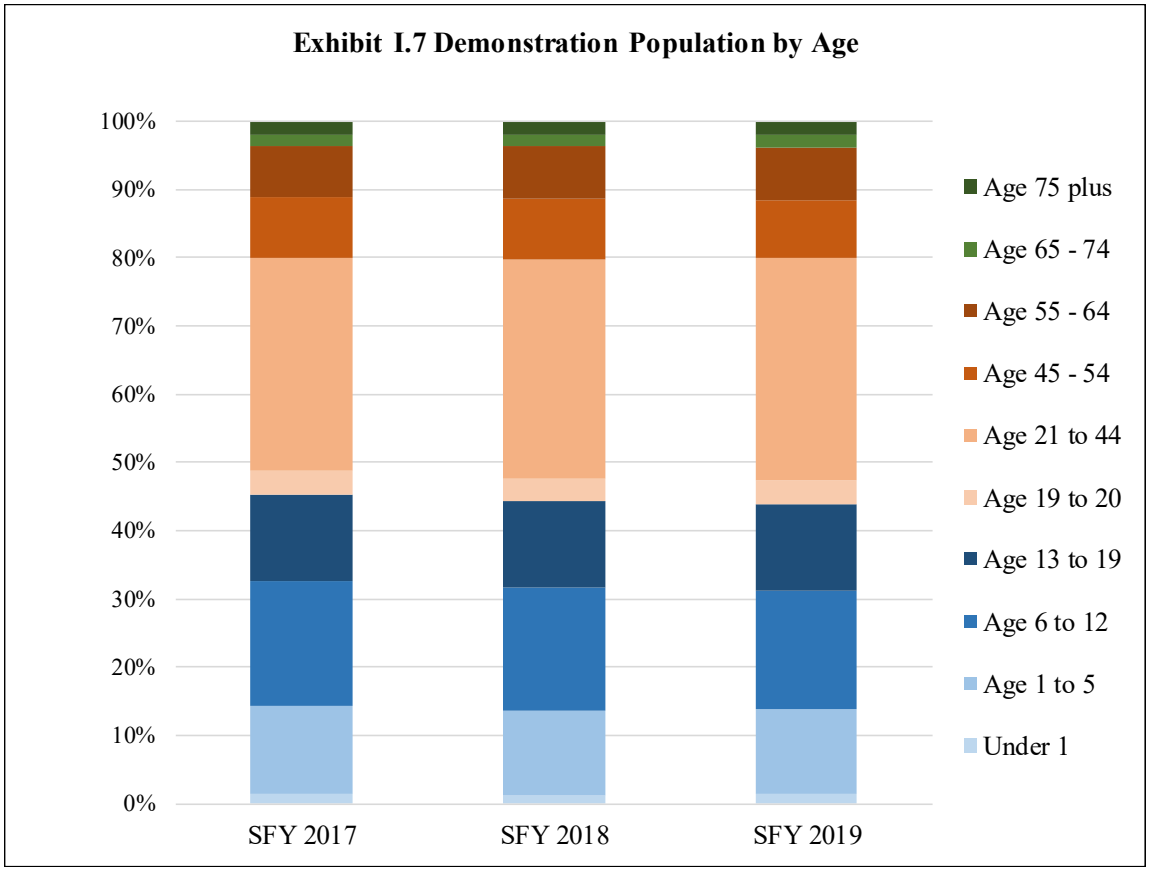


Exhibit I.7 distributes enrollment in the demonstration by the age of the members. In this exhibit, the blue colors represent different age groups among children while the peach/orange colors represent different age groups among adults age 64 and under. The green colors represent adults age 65 and older.



SECTION II: EVALUATION QUESTIONS AND HYPOTHESES

II.A Translating Demonstration Goals into Quantifiable Targets for Improvement

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

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

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

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

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

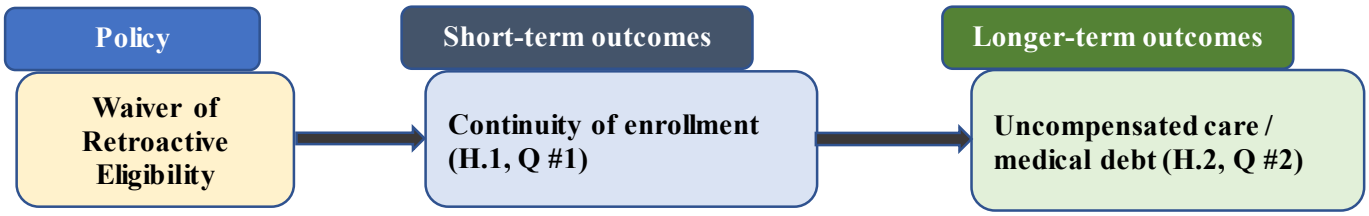
1. Maintain Continuity of Enrollment
2. Maintain Access to Care,
3. Maintain or Improve Health Outcomes, and
4. Rebalance Long-term Care Services and Supports (LTSS) in favor of Home and Community-based Services (HCBS).

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

Maintain Continuity of Enrollment

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

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

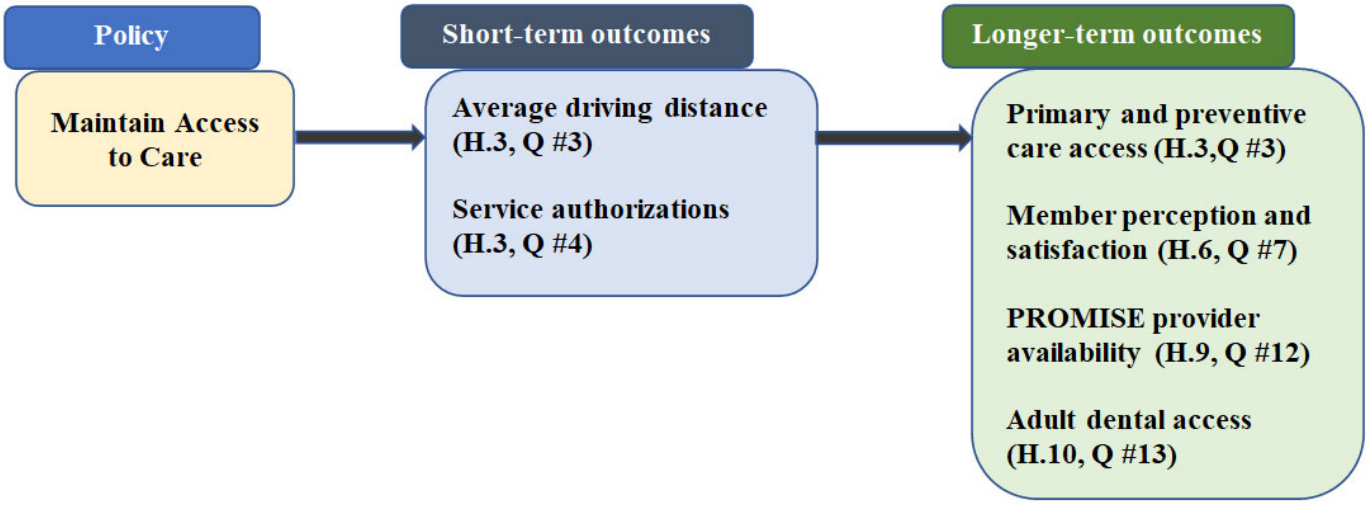


Maintain Access to Care

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

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

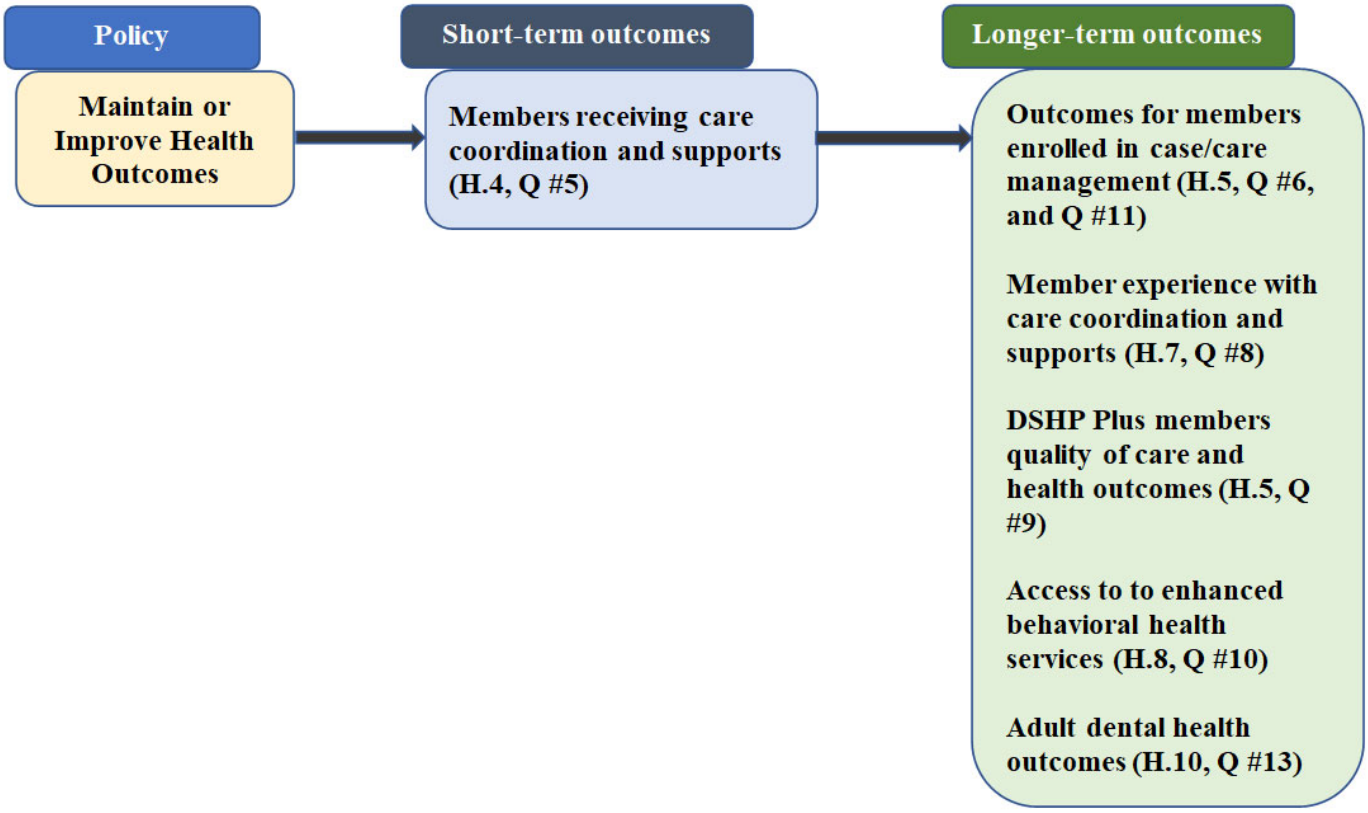
Exhibit II.3
Logic Model 2: Maintain or Improve Access



Maintain or Improve Health Outcomes

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

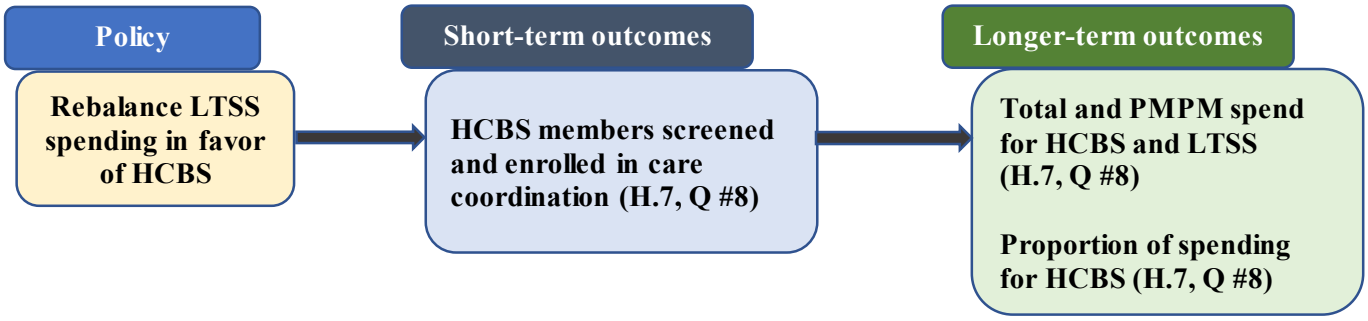
Exhibit II.4
Logic Model 3: Maintain or Improve Health Outcomes



Rebalance LTSS in favor of HCBS

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

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



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

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

II.C Hypotheses and Research Questions

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

Exhibit II.6
Hypotheses and Research Questions

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

II.D Alignment with Demonstration Goals

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

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

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

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

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

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

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

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

SECTION III: METHODOLOGY

III.A Evaluation Design

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

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

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

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

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

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

Exhibit III.1
Summary of Five Analytic Methods by Hypotheses

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

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

III.B Target and Comparison Populations

Target Population

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

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

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

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

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

Comparison Groups

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

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

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

III.C Evaluation Period

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

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

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

III.D Evaluation Measures

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

Exhibit III.2 Evaluation Measures by Domain

Quality

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

Access

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

Financial

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

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

III.E Data Sources

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

Delaware Medicaid Administrative Data

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

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

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

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

Survey and Facilitated Interview Data

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

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

Facilitated Interview Guides

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

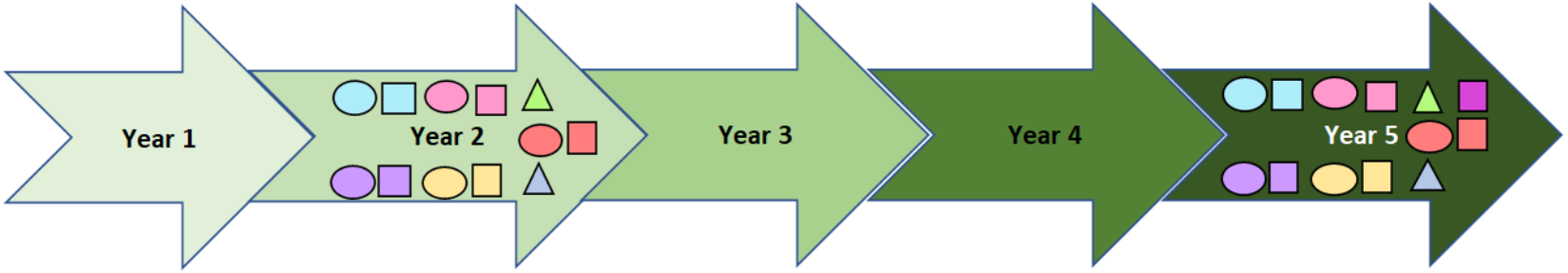
Whereas the Delaware Medicaid administrative data will be collected and used on a monthly basis throughout the waiver period and after the waiver concludes to produce the Summative Evaluation, B&A anticipates that data from our sources will be collected in CY 2021 and CY 2024 for use in evaluation activities.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

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

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

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

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



Hypotheses

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

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

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

III.F Analytic Methods

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

Method #1: Descriptive Statistics

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

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

COVID-19 Considerations

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

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

Method 2: Statistical Tests

T-test or Chi-square test

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

COVID-19 Considerations

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

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

T-test

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

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

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

The assumptions underlying the t-test include:

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

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

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

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

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

Chi-square test

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

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

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

The assumptions of the chi-square are:

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

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

Interrupted Time Series (ITS)

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

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

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

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

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

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

ITS Descriptive Statistics

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

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

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

Regression Analysis

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

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

Where: Y_t is the outcome

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

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

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

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

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

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

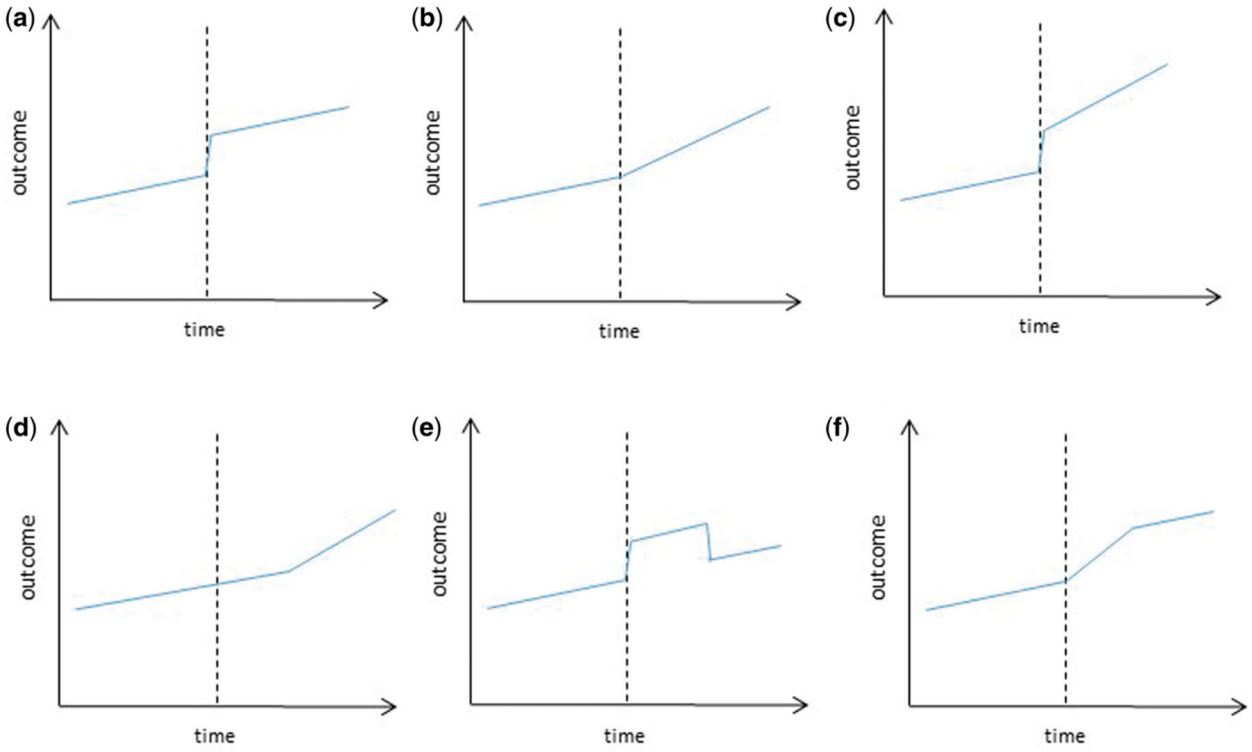
β_3 estimates the change in trend in the post-intervention segment

e_t estimates the error

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

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

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



Seasonality and Autocorrelation

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

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

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

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

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

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

Controls and Stratification

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

COVID-19 Considerations

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

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

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

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

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

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

Method #4: Desk Reviews

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

Method #5 Facilitated and/or Focus Group Interviews

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

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

III.G Other Additions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION IV: METHODOLOGICAL LIMITATIONS

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

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

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

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

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

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

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

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

ATTACHMENT A: INDEPENDENT EVALUATOR

Process

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

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

Vendor Qualifications

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

Assuring Independence

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

ATTACHMENT B: EVALUATION BUDGET

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

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

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

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

ATTACHMENT C: TIMELINE AND MILESTONES

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

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

The main sections of the work plan are as follows:

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

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

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

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

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

CONTRACT YEAR 1

Indicates ongoing work toward task

Indicates submission to CMS

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

CONTRACT YEAR 2

Indicates ongoing work toward task

Indicates submission to CMS

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

CONTRACT YEAR 3

Indicates ongoing work toward task

Indicates submission to CMS

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

CONTRACT YEAR 4

Indicates ongoing work toward task

Indicates submission to CMS

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

CONTRACT YEAR 5

Indicates ongoing work toward task

Indicates submission to CMS

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

CONTRACT YEAR 6

Indicates ongoing work toward task

Indicates submission to CMS

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

ATTACHMENT D: DETAILED EVALUATION DESIGN PLAN TABLE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Medicaid & Medical Assistance

Interim Evaluation of Delaware's Section 1115 Substance Use Disorder Demonstration for the Period August 1, 2019 to December 31, 2023

OCTOBER 31, 2022

HMA

HEALTH MANAGEMENT ASSOCIATES

Table of Contents

LISTING OF EXHIBITS

Number	Appears in	Exhibit Title
18	Section F	Concurrent Use of Opioids and Benzodiazepines
19	Section F	Summary of Findings for Measures Mapped to Milestone 4
20	Section F	Emergency Department Visits for SUD Per 1,000 Medicaid Beneficiaries
21	Section F	Inpatient Stays Per 1,000 Medicaid Beneficiaries
22	Section F	Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence
23	Section F	Summary of Findings for Measures Mapped to Milestone 5
24	Section F	Readmissions Among Beneficiaries with SUD
25	Section F	Case Management of SUD Clients
26	Section F	Transitions of Care for SUD Clients
27	Section F	Summary of Findings for Measures Mapped to Milestone 6
28	Section F	Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD
29	Section F	Summary of Findings for Other Measures Not Mapped to a Specific Milestone
30	Section F	Per Member Per Month Expenditures Among the SUD Population
31	Section G	Summary of Measures Examined by CMS Milestone

SECTION A: Executive Summary

Delaware's Diamond State Health Plan demonstration was approved for the period August 1, 2019 through December 31, 2023. This demonstration was originally approved in 1995. Prior to this most recent approval, the demonstration has been renewed five times.

Delaware's Section 1115 demonstration includes 12 goals. One of these goals is specific to substance use disorder (SUD):

> *Increase enrollee access and utilization of appropriate substance use disorder (SUD) treatment services; decrease use of medically inappropriate and avoidable high-cost emergency and hospital services; increase initiation of follow-up SUD treatment after emergency department discharge; and reduce SUD readmission rates.*

Delaware proposes to test whether it can enhance the effectiveness of the SUD treatment system in Medicaid by maintenance and expansion of SUD residential services as part of a coordinated and full continuum of care resulting in increased access and improved health outcomes for individuals with SUD.

Under the broader waiver demonstration goal stated above, as set forth in the SUD Implementation Plan, Delaware is aligning the six goals for the SUD waiver component with the milestones outlined by the Centers for Medicare and Medicaid Services (CMS) as follows:

1. Increased rates of identification, initiation, and engagement in treatment;
2. Increased adherence to and retention in treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
6. Improved access to care for physical health conditions among beneficiaries.

Delaware's Implementation Plan describes the planned activities in the waiver period organized by CMS milestone. Delaware identified its own milestones in its approved Implementation Plan which include:

1. Access to critical levels of care for opioid use disorder (OUD) and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including medication-assisted treatment (MAT);
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

Population Impacted by the Demonstration

Overall, Medicaid members with a SUD diagnosis represented 7.7 percent of the total Medicaid population in the fourth quarter of CY 2021. The evaluators used CMS's specifications for SUD Metric #3 (Medicaid Beneficiaries with SUD Diagnosis) to assess the trend in the Medicaid population most likely

to be impacted by the demonstration. Medicaid beneficiaries with a SUD diagnosis have remained steady during the three-year period examined, from 22,461 in Q1-2019 to 22,592 as of Q4-2021. The highest quarter reported was Q1-2020 with 23,483 beneficiaries with SUD.

Among the SUD beneficiaries in Q4-2021, only one percent of the population are adolescents and four percent are elderly. The remaining 95 percent are non-elderly adults. Dual eligibles represent 3.5 percent of the total SUD population. Pregnant women represent just 1.4 percent of the total SUD population. The mix between beneficiaries based on substances used is 40 percent with an opioid use disorder (OUD) and 60 percent some SUD.

Evaluation Questions and Hypotheses

Burns & Associates, a Division of Health Management Associates (HMA-Burns) is serving as the Independent Evaluator for this demonstration. HMA-Burns created a driver diagram with a focus on reducing opioid-related overdose deaths. HMA-Burns converted the primary and secondary drivers in the driver diagram into 11 hypotheses and five research questions. For each research question, measures were assigned as well as a targeted methodology.

At least one research question and one hypothesis is mapped to each of the CMS demonstration goals. As a means to answer the research questions posed, the results of 29 measures are reported on in this evaluation.

Methodology

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

Target Population

The target population is any Delaware Medicaid beneficiary with a diagnosis of SUD enrolled in the demonstration in the study period. HMA-Burns is using the CMS-defined specification for the individuals identified with an SUD. HMA-Burns has created flags to identify sub-populations within the demonstration population which include the following:

1. **Individuals with an OUD:** This flag was created to better understand the utilization and health outcomes of individuals with an OUD compared to other SUDs.
2. **Dual eligible**: Includes the population with an SUD who also meet criteria for being dually-eligible for both the Medicare and Medicaid population.
3. **Age Stratification**: Includes individuals with an SUD age 18 and younger, age 19 to 64, and age 65 and older.
4. **County stratification**: Includes the stratification of members with an SUD based on their home location in one of the three counties in Delaware: New Castle, Kent, or Sussex.
5. **MCO Stratification**: Includes the stratification of members with an SUD based on the MCO that they are enrolled with.

Evaluation Period

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

Data Sources

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

Results

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

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

A summary of the results of all 29 measures, by CMS milestone, appears in Exhibit 1 at the end of this section. Among 29 measures reviewed, there were 15 where the desired outcome was met. Of these, eight measures had an outcome that was statistically significant in the desired direction. For the 14 measures where the desired outcome was not met, 11 measures had a statistically significant change in the wrong direction.

The DMMA was also successful in large part in the activities it set out to do in its SUD Implementation Plan. Among the eight activities identified, five were completed in full and the remainder are in progress.

Conclusions

Delaware did not meet all of the desired outcomes outright but still saw many positive impacts due to the demonstration. The PHE likely had a confounding effect in enabling Delaware to fully meet these aims during the demonstration period. When considering the CMS Milestones, Delaware saw success in each milestone with the exception of Milestone 6, Improved Access to Care for Physical Health Conditions Among Beneficiaries

1. **Increased rates of identification, initiation, and engagement in treatment.** Delaware did not see an increase in the initiation or engagement in treatment during the initial years of the demonstration when compared to the pre-demonstration period. There has been a significant ramp up in the use of the state's Prescription Drug Monitoring Program, both in number of clinicians using it and the number of inquiries.
2. **Increased adherence to and retention in treatment**. The percentage of beneficiaries with a SUD diagnosis who used SUD services each month increased 11.3 percent during the initial years of the demonstration (CY 2019, CY 2020, and CY 2021). But the continuity of pharmacotherapy for OUD decreased during this time period.
3. **Reduction in overdose deaths, particularly those due to opioids.** While overdose deaths did increase in CY 2020, there were positive trends observed in the use of opioids at high dosage in persons without cancer and the rate of concurrent use of opioids and benzodiazepines.
4. **Reduced utilization of emergency department and inpatient hospital settings**. The rate of ED visits for SUD on a per 1,000 Medicaid beneficiary basis for the total population and for members ages 18-64 both declined. There were also declines in inpatient stays per 1,000 Medicaid beneficiaries for the total population and for members ages 18-64. When assessing trends in follow-up from the ED for a visit related to alcohol or other drug dependence, results were mixed (improvement at the 30-day mark but not at the 7-day mark).
5. **Fewer readmissions to the same or higher level of care**. The rate of readmissions among beneficiaries with SUD decreased during the initial years of the demonstration. Also, among SUD beneficiaries with an inpatient stay, the percentage that used the ED in the 12 weeks after their discharge was lower than the 12 weeks prior to admission. Utilization of intensive outpatient services and medication assisted treatment increased in the 12 weeks post hospital discharge.
6. **Improved access to care for physical health conditions among beneficiaries.** For individuals with an SUD diagnosis, access to preventive or ambulatory care decreased between the pre-demonstration period and the initial years of the demonstration.
7. **Reduce the cost of the SUD population in the demonstration period**. The per member per month expenditures for all services among SUD beneficiaries remained steady during the demonstration period, but expenditures for SUD services increased 24.8 percent while non-SUD service expenditures decreased 20.6 percent during the same time period.

Assessment of Opportunities for Improvement

Delaware saw progress towards its aim to expand SUD-specific services to its Medicaid population through the initial phase of the SUD demonstration period. This occurred through the expansion of coverage for short-term stays in residential and hospital inpatient treatment settings that qualify as institutions for mental disease (IMDs), new services added across the ASAM continuum, and a concentrated effort to increase access to existing SUD. Opportunities for continued improvement remain. HMA-Burns has identified eight opportunities for the DMMA to consider as it continues to enhance service delivery and access. Recommendations focus on reimbursement strategies to encourage greater provider participation, education to providers on ASAM criteria and authorization requests, and strategies to incentivize the MCOs to improve initiation and engagement in treatment for SUD beneficiaries.

Exhibit 1
Summary of Measures Examined by CMS Milestone

CMS Milestone		Total Measures	Measures with Results Trending in the Intended Direction	Measures with Results Trending in the Wrong Direction	Total Measures Where Tests Were Run for Statistical Significance	Of these, the Total Where Trend in Intended Direction and Statistically Significant	Of these, the Total Where Trends in Wrong Direction and Statistically Significant	Of these, the Total Where There Was No Statistically Significant Change
ALL MEASURES		**29**	**15**	**14**	**22**	**8**	**11**	**3**
1	Increased rates of identification, initiation, and engagement in treatment	13	3	10	8	0	8	0
2	Increased adherence to and retention in treatment	2	1	1	2	1	1	0
3	Reductions in overdose deaths, particularly those due to opioids	3	2	1	3	2	1	0
4	Reduced utilization of emergency departments and inpatient settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services	4	3	1	4	2	0	2
5	Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate	3	3	0	1	1	0	0
6	Improved access to care for physical health conditions among beneficiaries	1	0	1	1	0	1	0
	Cost-related measures not tied to a specfic milestone	3	3	0	3	2	0	1

SECTION B: General Background Information

Description of the Demonstration's Policy Goals

Delaware's Section 1115 demonstration includes 12 goals. One of these goals is specific to substance use disorder (SUD):

- to increase enrollee access and utilization of appropriate SUD treatment services by decreasing the use of medically inappropriate and avoidable high-cost emergency and hospital services;
- to increase initiation of follow-up SUD treatment after emergency department discharge; and
- to reduce SUD readmission rates. [1]

Delaware proposes to test whether it can enhance the effectiveness of the SUD treatment system in Medicaid by maintenance and expansion of SUD residential services as part of a coordinated and full continuum of care resulting in increased access and improved health outcomes for individuals with SUD.

Under the broader waiver demonstration goal stated above, as set forth in the SUD Implementation Plan, Delaware is aligning the six goals for the SUD waiver component with the milestones outlined by the Centers for Medicare and Medicaid Services (CMS) as follows:[2]

1. Increased rates of identification, initiation, and engagement in treatment;
2. Increased adherence to and retention in treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
6. Improved access to care for physical health conditions among beneficiaries.

Delaware's Implementation Plan describes the planned activities in the waiver period organized by CMS milestone. Delaware identified its own milestones in its approved Implementation Plan which include:

1. Access to critical levels of care for opioid use disorder (OUD) and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including medication-assisted treatment (MAT);
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

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

[2] State Medicaid Director Letter #17-003 Re: Strategies to Address the Opioid Epidemic, November 1, 2017, available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

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

Name: Delaware Diamond State Health Plan

Project Number: 11-W-00036/4

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

Time Period Covered by Evaluation: The demonstration covers the period from August 1, 2019 through December 31, 2023. This assessment covers the period with dates of service from August 1, 2019 through December 31, 2021.

Brief Description and History of Implementation

Delaware's Section 1115 Waiver Authority

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 to create cost efficiencies in the Medicaid program that could be used to expand coverage.

Since the initial approval, the demonstration has been renewed six times. Key changes over the course of these renewals include the following:

- In 2012, creation of the Diamond State Health Plan Plus (DSHP-Plus), which is Delaware's managed long-term services and supports (MLTSS) program. This amendment requires additional state plan populations to receive services through MCOs.
- In 2013, extending benefits to the low-income adult demonstration population with incomes up to 100 percent of the FPL until December 31, 2013 upon which these members would become part of a new adult eligibility group authorized under the ACA.
- In 2014, authorizing coverage for enhanced behavioral health services and supports for targeted Medicaid beneficiaries through a voluntary program called PROMISE (Promoting Optimal Mental Health for Individuals Through Supports and Empowerment) starting in 2015. PROMISE enrollees include Medicaid beneficiaries who have a severe and persistent mental illness (SPMI) and/or a SUD and require HCBS to live and work in integrated settings.
- In 2021, adding adult dental services to the services administered by the state's managed care system.

Administration of Delaware's Medicaid Program

The Division of Medicaid and Medical Assistance (DMMA) of the Delaware Department of Health and Social Services (DHSS) has responsibility for the administration and oversight of Delaware's Medicaid program under the waiver and state plan authorities. At the end of Calendar Year (CY) 2021, total Medicaid enrollment in Delaware was 292,548, or 29 percent of the total state population (July 2021

Census). By the end of CY 2021, 88 percent of eligibles were enrolled in managed care. Total enrollment has grown by 17.8 percent since the start of the public health emergency (PHE) at the end of Q1-2020.

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

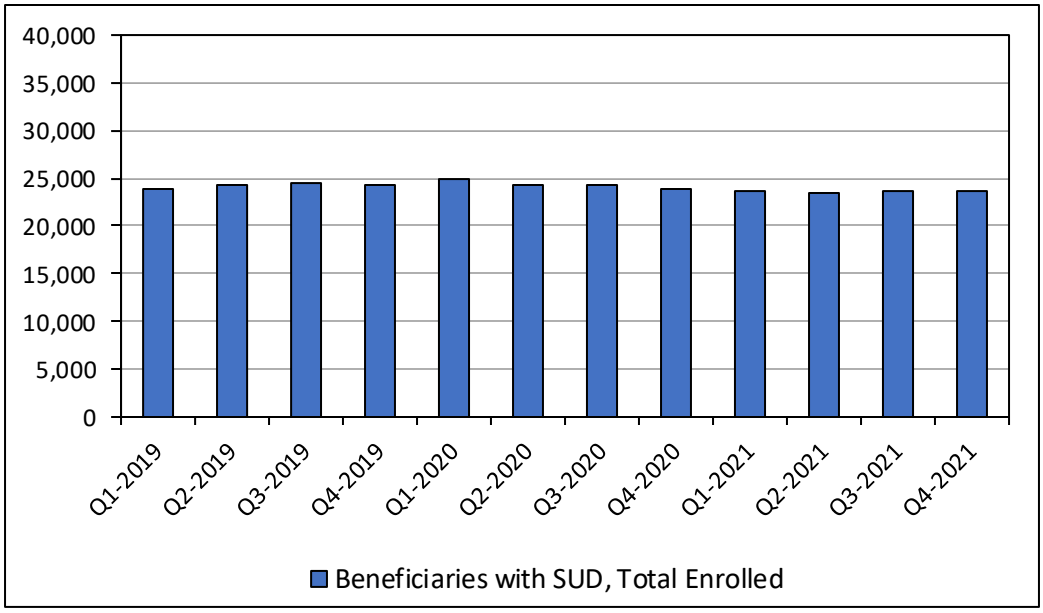
The MCOs under contract with DMMA currently are AmeriHealth Caritas Delaware and Highmark Health Options. The current DMMA contract with each MCO will expire December 31, 2022. The incumbent MCOs, with the addition of a new MCO (Delaware First Health), will enter into a new contract with DMMA effective January 1, 2023.

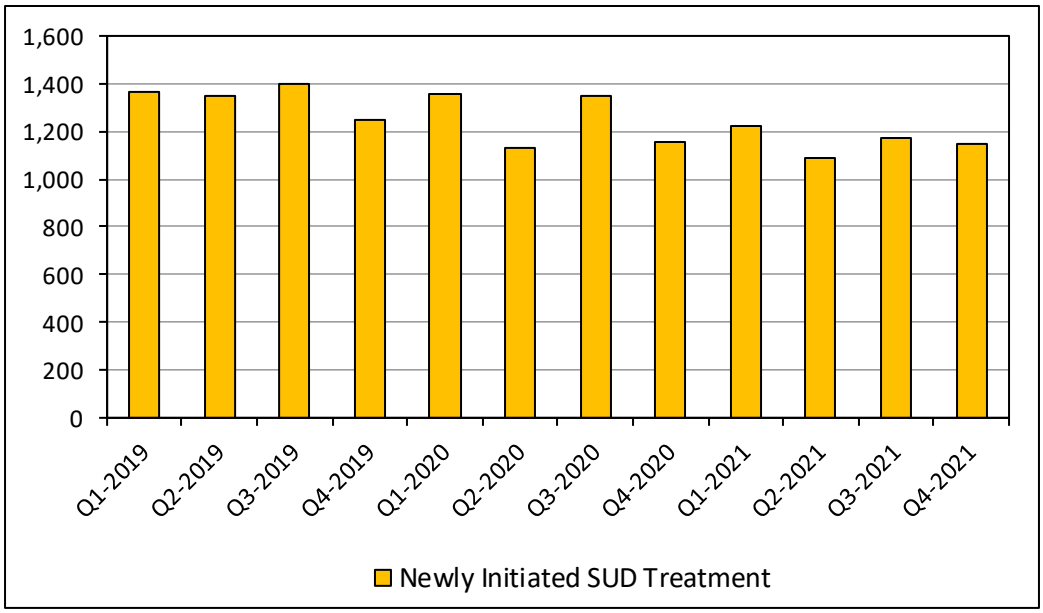
Population Groups Impacted by the Demonstration

The evaluators used CMS's specifications for SUD Metric #3 (Medicaid Beneficiaries with SUD Diagnosis) and Metric #2 (Medicaid Beneficiaries with Newly Initiated SUD Diagnosis) to assess the trend in the Medicaid population most likely to be impacted by the demonstration. Exhibit 2, which appears on the next page, shows the trend on both of these measures on a quarterly basis from Q1-2019 to Q4-2021.

Medicaid beneficiaries with a SUD diagnosis have remained steady during the three-year period examined, from 22,461 in Q1-2019 to 22,592 as of Q4-2021. The highest quarter reported was Q1-2020 with 23,483 beneficiaries with SUD. Since CMS's Metric #3 is dependent on utilization (claims) to count beneficiaries, the low fluctuation in the count of beneficiaries with SUD may be due to reduced utilization of SUD services at the start of the public health emergency (PHE). Individuals with a newly initiated SUD diagnosis has actually gone down since the start of the demonstration, again likely due to suppressed utilization in the early period of the PHE. The range for individuals with a newly initiated SUD diagnosis on average each quarter has been between 1,084 in Q2-2021 to 1,399 in Q3-2019 (the start of the demonstration).

Exhibit 2
Medicaid Beneficiaries with SUD, by Quarter, CY 2019 - CY 2021

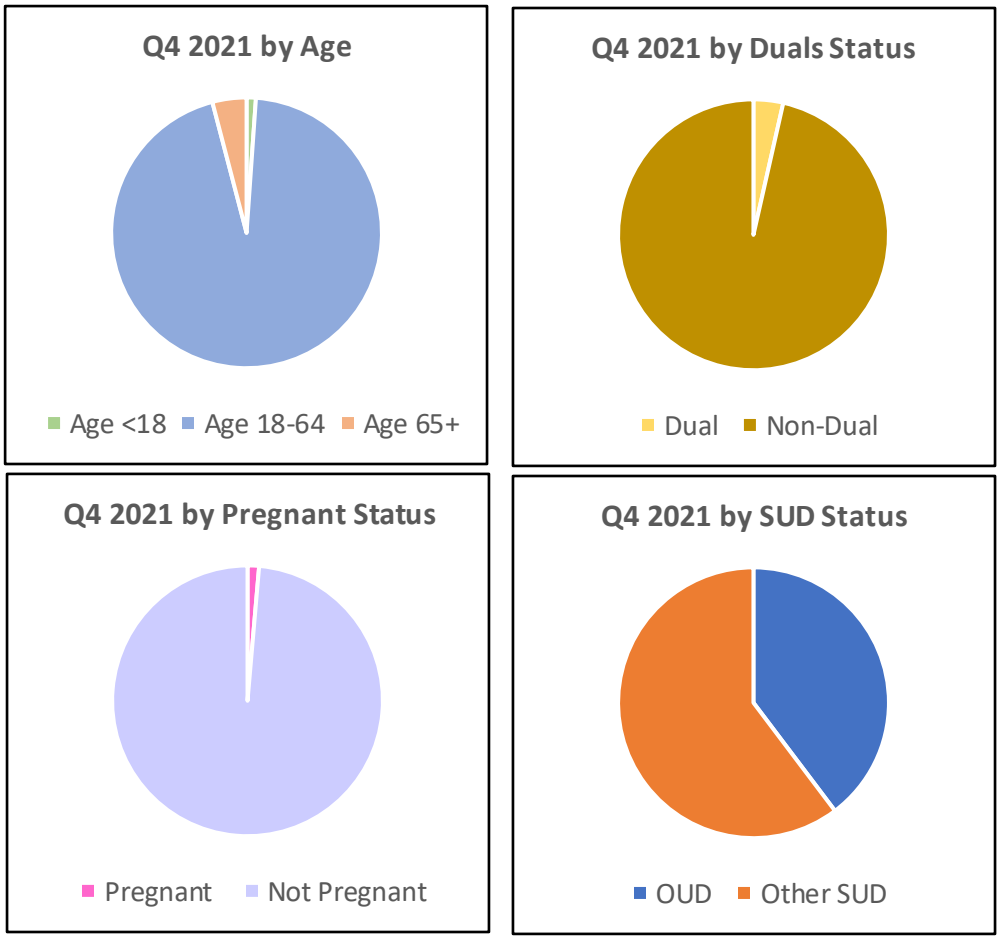




Overall, Medicaid members with a SUD diagnosis represented 7.7 percent of the total Medicaid population in the fourth quarter of CY 2021. Exhibit 3 on the next page shows attributes of the average enrollment of 22,592 beneficiaries with a SUD diagnosis. Only one percent of the total population are adolescents and four percent are elderly. The remaining 95 percent are non-elderly adults. Dual eligibles represent 3.5 percent of the total SUD population. Pregnant women represent just 1.4 percent of the total SUD population. The mix between beneficiaries based on substances used is 40 percent with an opioid use disorder (OUD) and 60 percent some SUD other than OUD.

Exhibit 3
Profile of Medicaid Members with SUD Diagnosis, 4th Quarter CY2021

Total Medicaid Enrollment, Average in Q4 2021	292,816
Total Enrollment with SUD Diagnosis in Q4 2021	22,592
Percent of Total Enrollment with SUD Diagnosis	7.7%



SECTION C: Evaluation Questions and Hypotheses

Defining Relationships: Aims, Primary Drivers and Secondary Drivers

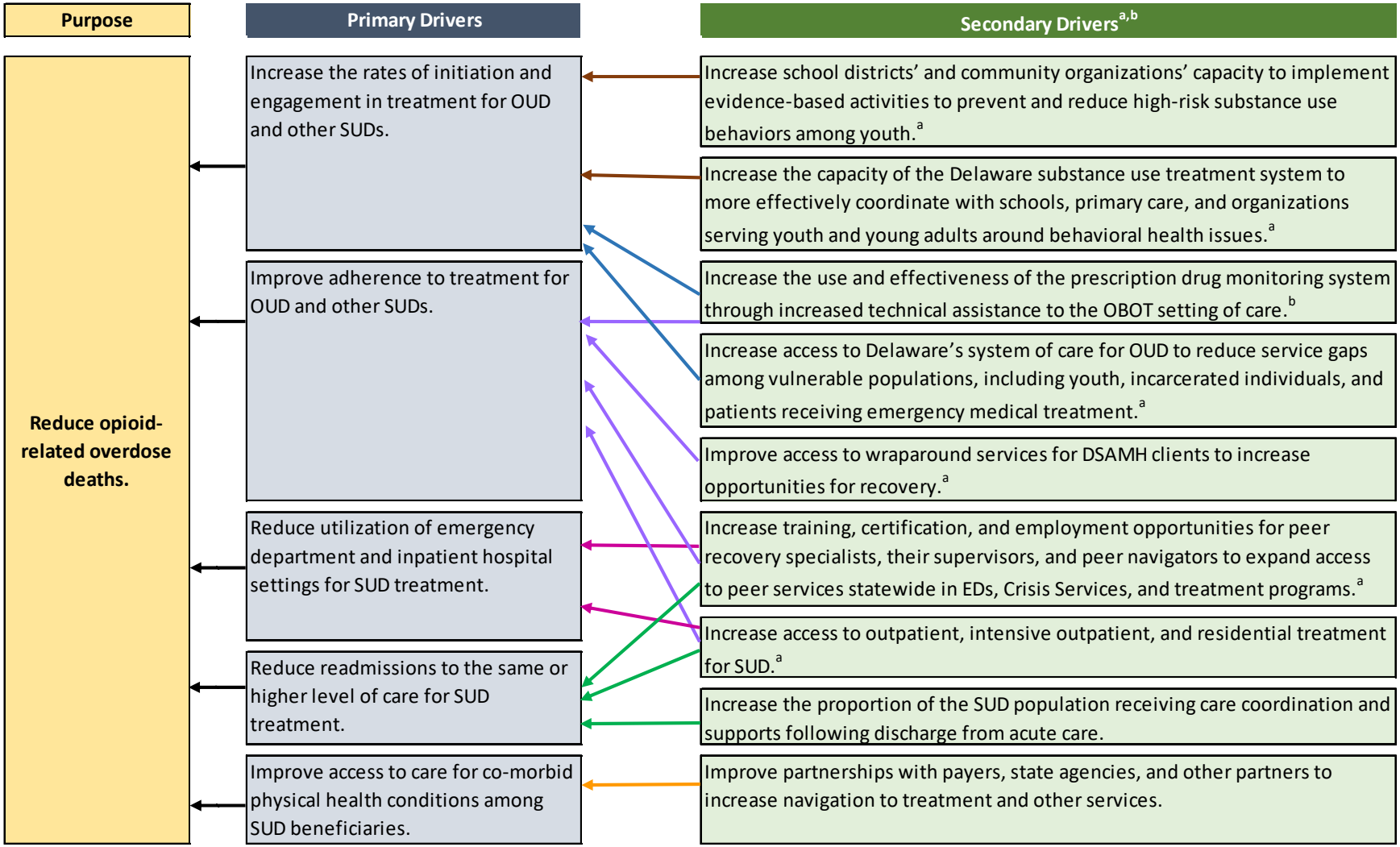
Burns & Associates, a Division of Health Management Associates (HMA-Burns) is serving as the Independent Evaluator for this demonstration. HMA-Burns examined the relationships between the CMS goals and DMMA's interventions included in the approved demonstration and SUD Implementation Plan. HMA-Burns constructed a driver diagram identifying primary and secondary drivers of the principal aim to reduce opioid-related overdose deaths. The driver diagram shown in Exhibit 4 on the next page is part of the approved Evaluation Design Plan.

HMA-Burns chose reduction in opioid-related overdose deaths as the primary aim because it is a measurable health outcome. CMS goals related to improved quality of care were determined to all have the potential to contribute to a reduction in overdose deaths and, therefore, are factored in as primary drivers. In turn, the specific actions described in the Implementation Plan which would be designed to improve these measures of quality of care were considered as secondary drivers.

In order to translate these aims as well as primary and secondary drivers into measurable results, HMA-Burns identified existing, nationally-recognized measures where available for the aims and primary drivers. This includes measures that CMS has defined for the quarterly monitoring reports that states with SUD demonstrations submit to CMS. HMA-Burns added custom measures where needed. The measures that have been identified are used to measure performance during the demonstration period against the pre-demonstration period.

Exhibit 4

Driver Diagram: Reduce Opioid-related Overdose Deaths



[a]Part of federal SOR evaluation and not specifically included in the scope of this evaluation.

[b]Part of federal SUD Capacity Planning evaluation and not specifically included in the scope of this evaluation.

Hypotheses and Research Questions

HMA-Burns converted the primary and secondary drivers shown above into a series of hypotheses and research questions. For each research question, measures were assigned as well as a targeted methodology. This is detailed further in Section D of the report.

In Exhibit 5 on the next page, HMA-Burns organized the hypotheses and research questions shown in the Evaluation Design Plan and mapped them to CMS's milestones. HMA-Burns then mapped each measure identified in the Evaluation Design to one of the research questions shown in Exhibit 5.

Exhibit 5
Mapping Hypotheses and Research Questions to Demonstration Goals

Hypothesis	Research Questions	Demonstration Goal
#1: The demonstration will increase or maintain the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDs.	Does the demonstration increase access to and utilization of SUD treatment services?	1
#2: The demonstration will increase or maintain adherence to and retention in treatment for OUD.		2
#3: Approved service authorizations improve appropriate utilization of health care services in the post-demonstration period.		1
#4: The demonstration will decrease the rate of emergency department and inpatient hospital visits within the beneficiary population for SUD.		4
#5: The demonstration will increase or maintain the percentage of beneficiaries with SUD who experience care forcomorbid conditions.	Do enrollees who are receiving SUD services experience improved health outcomes?	6
#6: Among beneficiaries receiving care for SUD, the demonstration will reduce or maintain readmissions to SUD treatment.		5
#7: The demonstration will decrease the rate of overdose deaths due to opioids.	Are rates of opioid-related overdose deaths impacted by the demonstration?	3
#8: The demonstration will increase or maintain the use of Delaware's Prescription Drug Monitoring Program.	Do activities post-implementation increase use of Delaware's Prescription Drug Monitoring Program?	1
#9: The demonstration will decrease or maintain per beneficiary per month costs.	How does the demonstration impact cost?	All
#10: The demonstration will increase or maintain per beneficiary per month costs for SUD services versus non-SUD services.		All
#11: The demonstration will decrease or maintain per beneficiary per month costs for SUD-related ED visits and hospital inpatient stays.		All

SECTION D: Methodology Used in Assessment

Evaluation Design

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

The five analytic methods used by the evaluators include:

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

Target and Comparison Population

The target population is any Delaware Medicaid beneficiary with a diagnosis of SUD enrolled in the demonstration in the study period. HMA-Burns is using the CMS-defined specification for the individuals identified with an SUD. HMA-Burns has created flags to identify sub-populations within the demonstration population which include the following:

1. **Individuals with an OUD:** This flag was created to better understand the utilization and health outcomes of individuals with an OUD compared to other SUDs.
2. **Dual eligible**: Includes the population with an SUD who also meet criteria for being dually-eligible for both the Medicare and Medicaid population.
3. **Age Stratification**: Includes individuals with an SUD age 18 and younger, age 19 to 64, and age 65 and older.
4. **County stratification**: Includes the stratification of members with an SUD based on their home location in one of the three counties in Delaware: New Castle, Kent, or Sussex.
5. **MCO Stratification**: Includes the stratification of members with an SUD based on the MCO that they are enrolled with.

Evaluation Period

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

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

The demonstration period is defined as follows:

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

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

Evaluation Measures

HMA-Burns is reporting on 29 measures, each of which has been mapped to a demonstration goal. The measures that have been analyzed in this Interim Evaluation utilize measures defined by CMS for the quarterly SUD monitoring reports that states submit to CMS as well as measures defined by the HMA-Burns team that are specific to Delaware's demonstration goals stewards. Many of the CMS measures leverage the specifications developed as part of the National Committee on Quality Assurance's (NCQA's) HEDIS®[3] measures. A summary of these measures, by demonstration goal, appears in Exhibit 6 on the next page.

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

Exhibit 6
Inventory of Measures Included in the Interim Evaluation, by CMS Milestone

CMS Milestone	Measures Defined by CMS*	Measures Defined by HMA-Burns	Total Measures
TOTAL	**19**	**10**	**29**
Increased rates of identification, initiation, and engagement in treatment	8	5	**13**
Increased adherence to and retention in treatment	2	0	**2**
Reductions in overdose deaths, particularly those due to opioids	3	0	**3**
Reduced utilization of emergency departments and inpatient settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services	4	0	**4**
Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate	1	2	**3**
Improved access to care for physical health conditions among beneficiaries	1	0	**1**
Other measures not associated to a specific milestone	0	3	**3**

* Part of the measures submitted quarterly to CMS as part of Monitoring Reports

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

Data Sources

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

- Service utilization reported on encounters with member and provider enrollment files from the Delaware Medicaid Enterprise System (DMES);

- Primary data collected by HMA-Burns from the MCOs for focus studies;
- Secondary data collected by DMMA from Vital Statistics;
- Secondary data from the Delaware Prescription Drug Monitoring Program; and
- Qualitative feedback collected from facilitated interviews.

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

Although managed care encounters are the primary source for computing measures, other measures use a combination of encounters, member enrollment, and provider enrollment files. An example of this is the development of maps that were included in the Mid-Point Assessment report. HMA-Burns plotted the home location of individuals with SUD on a map that displayed the provider locations of SUD providers as a way to visualize access to services.

For other measures defined by HMA-Burns, the evaluators used primary data collected from MCOs for Medicaid beneficiaries enrolled in managed care. This was completed for the analysis of SUD authorizations that was reported in the Mid-Point Assessment and that appears in measures under CMS Milestone #1 in this report. HMA-Burns also collected information from each MCO on the status of enrollment in the case management program offered at each MCO for beneficiaries with SUD.

HMA-Burns worked with the DMMA to facilitate the receipt of secondary data from other state agencies—namely, the Delaware Department of Public Health's Office of Vital Statistics and the Delaware Division of Professional Regulation's Prescription Drug Monitoring Program (PMP) database. The files from Vital Statistics were used to map individuals in their records to the Medicaid enrollment roster to compute the overdose death rate among Medicaid beneficiaries. The results from the PMP database were used to track the number of clinicians and number of inquiries into the PMP over time.

Qualitative feedback was collected through in-person interviews (conducted via Zoom) with the MCOs and SUD providers in October and November 2021. Medicaid beneficiary feedback was collected through a short survey (five minutes in length). Results of this feedback were reported on in Delaware's SUD Mid-Point Assessment. For the Summative Evaluation, facilitated interviews will be conducted again towards the end of the demonstration period with SUD providers, beneficiaries of SUD services, and the MCOs.

Analytic Methods

Descriptive Statistics

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

CY 2021. The baseline period is defined as CY 2018. The comparison year for the demonstration period is defined as CY 2021. The rate of change between the baseline and most recent demonstration period is shown.

Statistical Tests

Among the 29 measures examined, tests of significance were run on 22 measures. The test that was applied to assess statistical significance was either t-test or chi-square. For the Summative Evaluation, interrupted time series will be used to assess significance on all measures where t-test was applied in the Interim Evaluation and for many of the measures where chi-square was applied as well.

Onsite Reviews and Desk Reviews

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

Facilitated Interviews

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

For SUD providers, HMA-Burns solicited interest from the base of providers currently delivering SUD services to Medicaid beneficiaries. Interviews were conducted one-on-one with each provider and with staff from the provider's trade association. A total of six interviews were conducted. Appointments for each interview were set in advance so that the appropriate provider representatives could be present. Participation in each interview ranged from one to six representatives. The HMA-Burns assessment team consisted of the same two members that conducted the MCO interview. Each provider was sent the same set of questions in advance of their interview. Although the evaluation team used the interview guide to cover relevant topics, the providers were encouraged to provide feedback on any other topic important to them as well. Actual interviews were 60 to 90 minutes in duration.

When the initial appointments were made with providers, HMA-Burns also requested provider assistance, where possible, to coordinate gathering feedback from their Medicaid clients. Given the PHE, the feedback from Medicaid members who received SUD treatment were offered either through completion of a hardcopy or online survey. Clients were told upfront the questions that would be asked and that any feedback that they provided would be anonymous. A total of 43 clients provided feedback.

Feedback from all interviews and surveys were categorized into themes. In total, 15 themes resonated with stakeholders. This feedback was included in the SUD Mid-Point Assessment.

SECTION E: Methodological Limitations

Limitations

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

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

1. *Public health emergency*. The obvious limitation in this evaluation is the impact on service utilization and provider supply during the public health emergency period. The current demonstration began just seven months prior to the start of the PHE. Delaware, like most states, saw atypical results during the early period of the PHE both positively (e.g., lower emergency department visits) and negatively (e.g., lower rates on measures related to access to services or follow-up services). For the Summative Evaluation, in addition to adding results from CYs 2022 and 2023 to the analysis, the HMA-Burns team will assess trends not only between the pre-demonstration and current demonstration periods, but also the pace at which utilization and access measures improve as the PHE winds down.

2. *Data limitations in DMES*. There are some limitations in the data as reported in DMMA's data warehouse in the pre-demonstration period of CY 2016 and CY 2017. Information is available for both utilization and enrollment statistics for each Medicaid beneficiary for these two years, but some variables such as MCO assignment are incomplete. For this Interim Evaluation, therefore, results are shown for the years where this information is complete (CYs 2018 through 2021). For the Summative Evaluation, information will be reported using CY 2016 and CY 2017 for analyses such as interrupted time series, but these results may need to be more at the overall demonstration population level and not at the sub-population level.

3. *Small sample size*. For many sub-populations identified in the Evaluation Design Plan, the sample was too low to conduct meaningful evaluation. Because of this and the atypical utilization patterns during the PHE, the results for each measure are reported in this Interim Evaluation for the SUD demonstration population as a whole. For the Summative Evaluation, results at the sub-population level will be reported wherever feasible once more data is available for study.

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

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

SECTION F: Results

The findings from HMA-Burns' assessment of each of CMS milestone is shown in Section F. Each CMS milestone serves as a heading. There is a seventh heading at the end of Section F to report on measures that were included in the Evaluation Design Plan but cannot be mapped to a specific CMS milestone.

At the start of each heading in Section F, there is a summary table that lists each measure reviewed that was mapped to the CMS milestone. The table shows the desired outcome for each measure, if the desired outcome was met, and if the results were found to be statistically significant (when testing for significance was conducted). The test used for statistical significance is also shown, where applicable.

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

Milestone #1: Increased Rates of Identification, Initiation, and Engagement in Treatment

Summary of Measures

Thirteen measures were examined to assess the rates of identification, initiation, and engagement in treatment. In Exhibit 7 below, it shows that the desired outcome was met in three out of the 13 measures. A test for statistical significance was conducted on eight of the 13 measures. For seven of these eight measures, the outcome was statistically significant.

Exhibit 7
Summary of Findings for Measures Mapped to Milestone 1
Results Shown Below are for the Total Demonstration Population

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
	Initiation of Alcohol and Other Drug Dependence Treatment				
1	Alcohol Abuse Only	Increase	Decrease	Yes	Chi-square
2	Opioid Abuse Only	Increase	Decrease	Yes	Chi-square
3	Abuse Other than Alcohol or Opioid	Increase	Decrease	Yes	Chi-square
4	Total AOD Population	Increase	Decrease	Yes	Chi-square
	Engagement of Alcohol and Other Drug Dependence Treatment				
5	Alcohol Abuse Only	Increase	Decrease	Yes	Chi-square
6	Opioid Abuse Only	Increase	Decrease	No	Chi-square
7	Abuse Other than Alcohol or Opioid	Increase	Decrease	Yes	Chi-square
8	Total AOD Population	Increase	Decrease	Yes	Chi-square
9	Average Turnaround Time for Authorization Decisions	>90% within contract timelines	Not Met	N/A	no test run
10	Authorization Denial Rate for SUD Services	<5%	Met	N/A	no test run
11	SUD Authorization Denial Reasons	>90% due to lack of medical necessity	Not Met	N/A	no test run
12	Numer of Clinicians Accessing the PMP	Increase	Increase	N/A	no test run
13	Number of Queries to the PMP	Increase	Increase	N/A	no test run

Individual Measure Results

HMA-Burns utilized NQCA's specification for its HEDIS measure related to the initiation (refer to Exhibit 8) and engagement (refer to Exhibit 9) of alcohol and other drug dependence (AOD) treatment (HEDIS measure IET). For both initiation and engagement, HMA-Burns computed separate results for four populations: alcohol abuse only, opioid abuse only, abuse other than alcohol or opioid, and the total AOD population. Results were computed for measurement years CY 2018 through CY 2021. For the initiation measures, there was a reduction in initiation between the baseline period (CY 2018) and the latest demonstration period (CY 2021) for all four populations. In CY 2021, the initiation rate was similar for alcohol abuse only and for abuse other than alcohol or opioid (near 50%). The initiation rate was lower for opioid abuse only (43%).

The rates of engagement were also lower when comparing the baseline period to the latest demonstration period. However, unlike the initiation rates, the rate of engagement was higher for opioid abuse only than for the other populations (42% in CY 2021 compared to near 20% for alcohol only or abuse other than alcohol or opioid).

HMA-Burns conducted a focus study on SUD service authorizations to determine if the timing of authorization decisions and the rate of authorization requests denied may be contributing to issues related to access to SUD services. The results of this study appear on Exhibit 10. The period of study was all SUD provider authorization requests for the period September 1, 2018 through February 28, 2020 submitted to the MCOs for services requiring authorization by the MCO.

First, HMA-Burns examined the turnaround time for these authorization requests. For pre-service requests 70 percent of requests were determined within three days and 81 percent within 10 days. For concurrent review (e.g. residential treatment), 47 percent were determined within one day.

Second, the rate of approved and denied requests were examined. HMA-Burns found that the approval rate for inpatient hospital SUD stays was 96 percent; for residential treatment stays, it was 97 percent.

Lastly, when authorizations were denied, the reason for the denials was reviewed. For inpatient hospital stays, lack of medical necessity was the reason in more than nine out of ten occurrences. Conversely, for residential treatment, lack of medical necessity was the reason only 32 percent of the time and administrative denials were the remaining 68 percent.

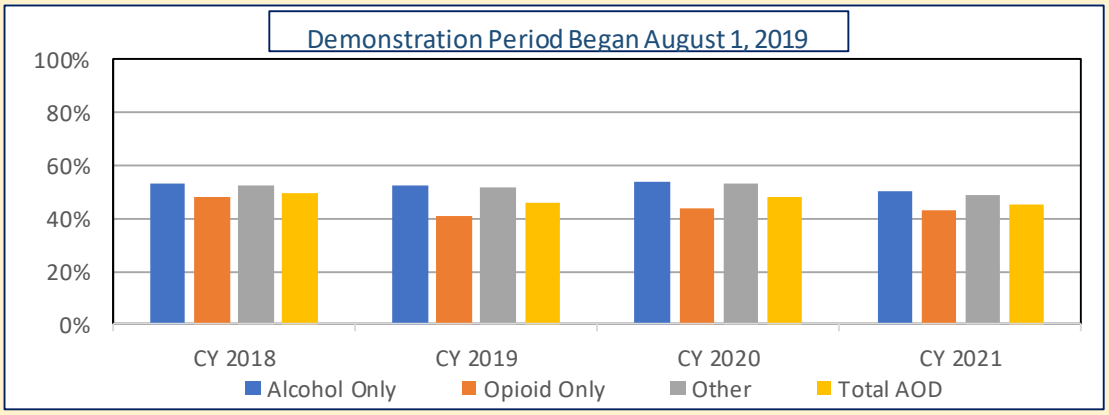
HMA-Burns also examined the use of Delaware's Prescription Drug Monitoring Program (Delaware uses the acronym PMP) over time (refer to Exhibit 11). Measures include the number of clinicians accessing the PMP and the number of queries to the PMP. From the start of CY 2019 to the end of CY 2021, the average number of clinicians accessing the PMP has grown more than four-fold. The number of queries has increased more than five-fold.

Exhibit 8
Results for Interim Evaluation Measures #1 through #4
Initiation of Alcohol and Other Drug Dependence Treatment

Hypothesis:
The demonstration will increase the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDs.

Measure Used to Test Hypothesis:
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Measure Steward: NCQA, National Quality Forum #0004 [CMS Monitoring Metric #15]

Results for the Demonstration Population



	Study Period	Numerator	Denominator	Rate	
Alcohol Abuse Only	CY 2018	1,732	3,252	53.3%	
	CY 2019	1,756	3,339	52.6%	
	CY 2020	1,725	3,200	53.9%	
	CY 2021	1,755	3,469	50.6%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-5.3%
Opioid Abuse Only	CY 2018	2,800	5,857	47.8%	
	CY 2019	1,988	4,850	41.0%	
	CY 2020	1,840	4,175	44.1%	
	CY 2021	1,922	4,457	43.1%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-10.9%
Abuse Other than Alcohol or Opioid	CY 2018	1,789	3,417	52.4%	
	CY 2019	1,689	3,269	51.7%	
	CY 2020	1,723	3,259	52.9%	
	CY 2021	1,700	3,458	49.2%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-6.5%
Total AOD Population	CY 2018	5,264	10,621	49.6%	
	CY 2019	4,417	9,660	45.7%	
	CY 2020	4,250	8,842	48.1%	
	CY 2021	4,348	9,562	45.5%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-9.0%

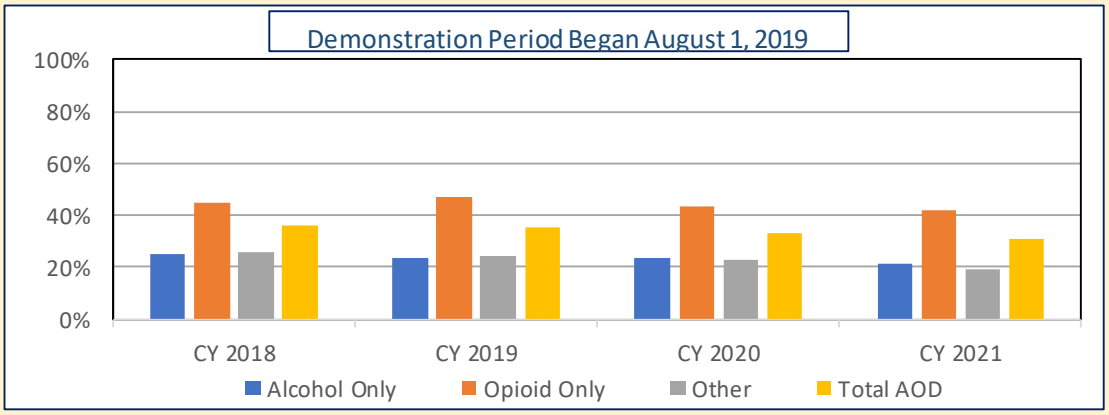
	Alcohol Only	Opioid Only	Other	Total AOD
Desired Outcome:	Increase	Increase	Increase	Increase
Actual Outcome:	Decrease	Decrease	Decrease	Decrease
Statistical Review:	Chi-Square	Chi-Square	Chi-Square	Chi-Square
Probability:	0.0287	<.0001	0.0081	<.0001
Finding:	Significant	Significant	Significant	Significant

Exhibit 9
Results for Interim Evaluation Measures #5 through #8
Engagement of Alcohol and Other Drug Dependence Treatment

Hypothesis:
The demonstration will increase the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDs.

Measure Used to Test Hypothesis:
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Measure Steward: NCQA, National Quality Forum #0004 [CMS Monitoring Metric #15]

Results for the Demonstration Population



	Study Period	Numerator	Denominator	Rate	
Alcohol Abuse Only	CY 2018	431	1,732	24.9%	
	CY 2019	413	1,756	23.5%	
	CY 2020	407	1,725	23.6%	
	CY 2021	381	1,755	21.7%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-14.6%
Opioid Abuse Only	CY 2018	1,251	2,800	44.7%	
	CY 2019	941	1,988	47.3%	
	CY 2020	801	1,840	43.5%	
	CY 2021	812	1,922	42.2%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-5.8%
Abuse Other than Alcohol or Opioid	CY 2018	458	1,789	25.6%	
	CY 2019	413	1,689	24.5%	
	CY 2020	390	1,723	22.6%	
	CY 2021	321	1,700	18.9%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-35.6%
Total AOD Population	CY 2018	1,893	5,264	36.0%	
	CY 2019	1,567	4,417	35.5%	
	CY 2020	1,412	4,250	33.2%	
	CY 2021	1,347	4,348	31.0%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-16.1%

	Alcohol Only	Opioid Only	Other	Total AOD
Desired Outcome:	Increase	Increase	Increase	Increase
Actual Outcome:	Decrease	Decrease	Decrease	Decrease
Statistical Review:	Chi-Square	Chi-Square	Chi-Square	Chi-Square
Probability:	0.0266	0.098	<.0001	<.0001
Finding:	Significant	Not Significant	Significant	Significant

Exhibit 10
Results for Interim Evaluation Measures #9 through #11
SUD Service Authorization Requests

Hypothesis:
Approved service authorizations improve appropriate utilization of health care services in the post-demonstration period.

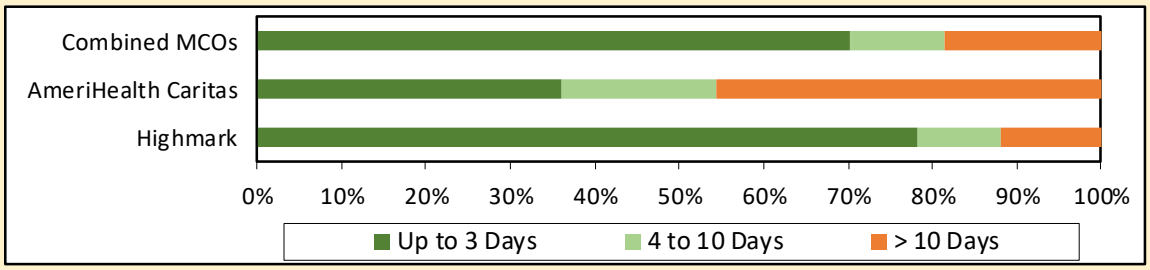
Measure Used to Test Hypothesis:
1. Average Turnaround Time for SUD Authorization Decisions
2. Authorization Denial Rate for SUD Services
3. SUD Authorization Denial Reasons

Measure Steward: HMA-Burns

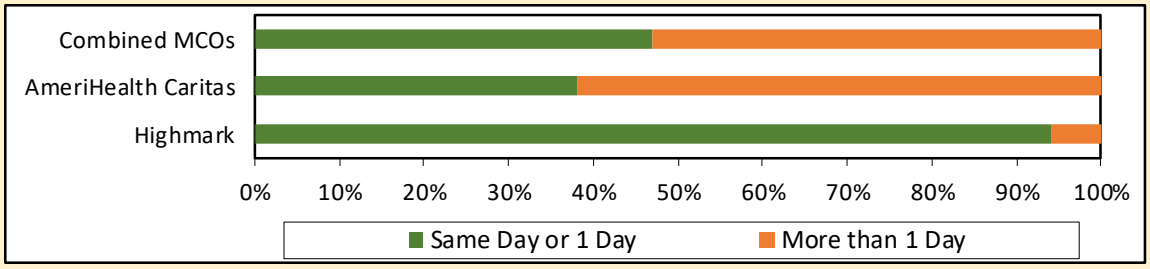
Data source: Data reported by Medicaid MCOs to the evaluators for SUD authorization requests for the period September 1, 2019 - February 28, 2020

Results for Turnaround Time for SUD Authorization Decisions

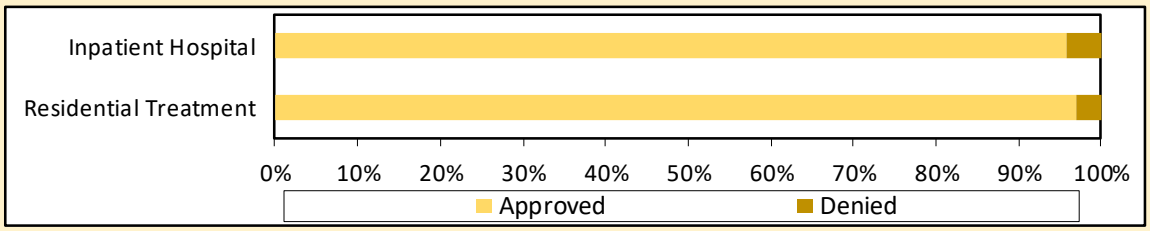
Pre-Service Requests for the Six Month Period (n = 3,188)



Concurrent Review Requests for the Six Month Period (n = 2,763)



Results for Denial Rate of SUD Authorization Decisions



Results for Reasons for Denials of SUD Authorization Decisions

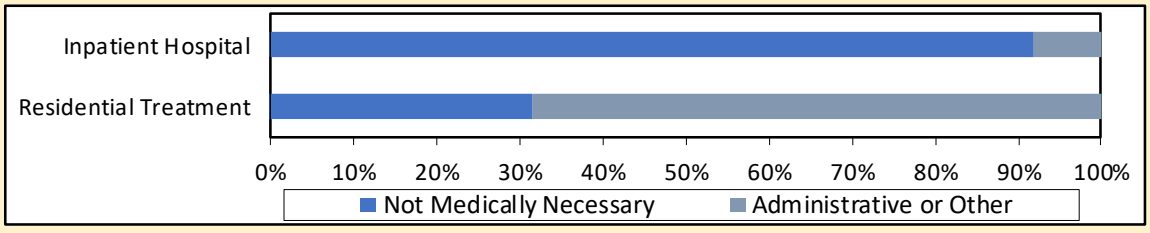


Exhibit 11
Results for Interim Evaluation Measures #12 and #13
Statistics on Use of Delaware's Prescription Drug Monitoring Program Database

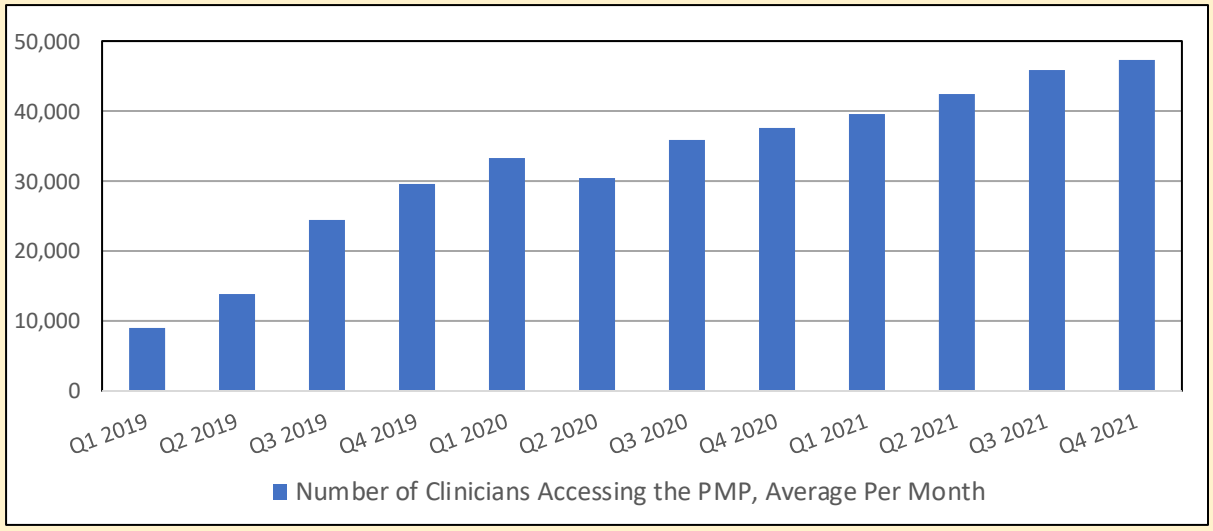
Hypothesis:
The demonstration will increase or maintain the use of Delaware's Prescription Drug Monitoring Program (in Delaware, the abbreviation used is PMP).

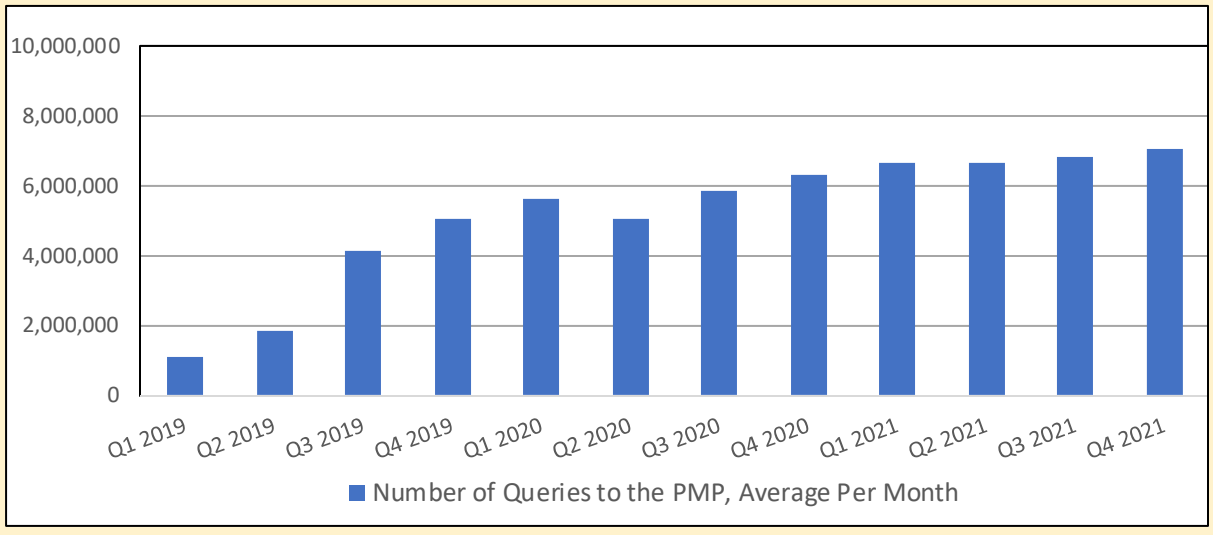
Measure(s) Used to Test Hypothesis:
1. Number of clinicians accessing the PMP
2. Number of queries to the PMP

Measure Steward: HMA-Burns
Data Source: Delaware Division of Professional Regulation submitted to DMMA https://dpr.delaware.gov/boards/pmp

Desired Trend:	Increase in number of clinicians accessing the PM	**Finding:**	Increased
Desired Trend:	Increase in number of queries to the PMP	**Finding:**	Increased

Results [Note: Data only available since January 2019]





Milestone #2: Increased Adherence to and Retention in Treatment

Summary of Measures

Two measures were examined to assess the adherence to and retention in treatment. In Exhibit 12 below, it shows that the desired outcome was met in one of the two measures. A test for statistical significance was conducted on both measures. The results were statistically significant in both measures.

Exhibit 12
Summary of Findings for Measures Mapped to Milestone 2
Results Shown Below are for the Total Demonstration Population

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
14	Continuity of Pharmacotherapy for Opioid Use Disorder	Increase	Decrease	Yes	Chi-square
15	Percentage of Beneficiaries with a SUD Diagnosis Who Used SUD Services Per Month	Increase	Increase	Yes	T-test

Individual Measure Results

Exhibit 13 shows that the continuity of pharmacotherapy for opioid use disorder has decreased from 15.2 percent in CY 2018 to 11.5 percent in CY 2021.

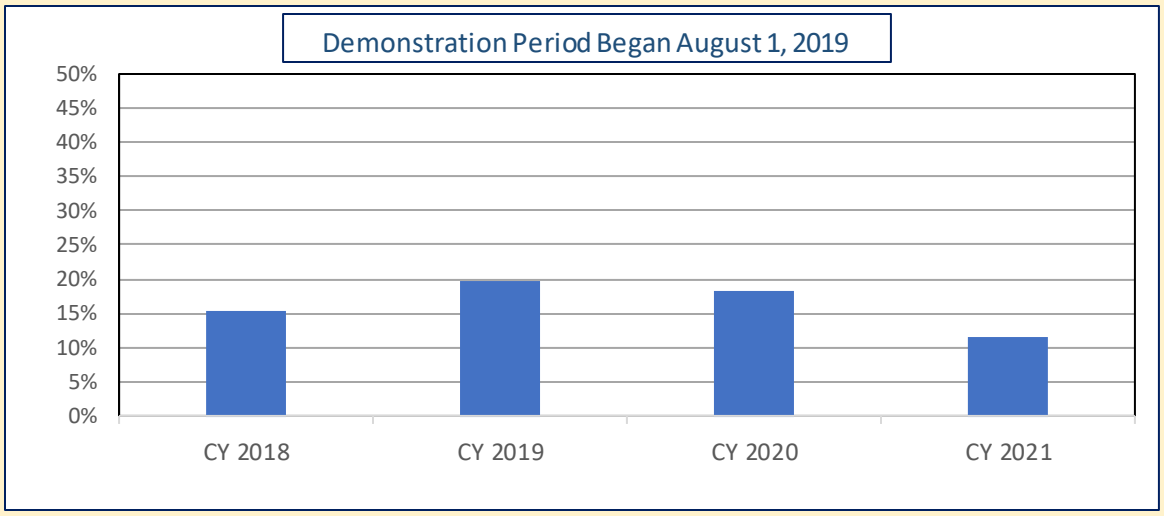
In Exhibit 14, HMA-Burns used the results from two CMS monitoring measures to compute the percentage of beneficiaries with a SUD diagnosis who used any SUD service in the month. The use of SUD services among this population increased steadily over the four-year period, from 44.1 percent of SUD members in CY 2018 to 49.7 percent in CY 2021. HMA-Burns used CMS Metric #6 as the definition of any SUD service.

Exhibit 13
Results for Interim Evaluation Measure #14
Continuity of Pharmacotherapy for Opioid Use Disorder

Hypothesis:
The demonstration will increase the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDs.

Measure Used to Test Hypothesis:
Continuity of Pharmacotherapy for Opioid Use Disorder
Measure Steward: National Quality Forum #3175 [CMS Monitoring Metric #22]

Results for the Demonstration Population



Study Period	Numerator	Denominator	Rate
CY 2018	196	1,287	15.2%
CY 2019	363	1,842	19.7%
CY 2020	400	2,181	18.3%
CY 2021	287	2,490	11.5%
Change Baseline (CY 2018) to Demonstration Period (CY 2021):			-32.1%

Desired Outcome:	Increase
Actual Outcome:	Decrease
Statistical Review:	Chi-Square
Probability:	0.0213
Finding:	Significant

Exhibit 14

Results for Interim Evaluation Measure #15

Percentage of Beneficiaries with a SUD Diagnosis Who Used Any SUD Service Each Month

Hypothesis:

The demonstration will increase the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDs.

Measures Used to Test Hypothesis:

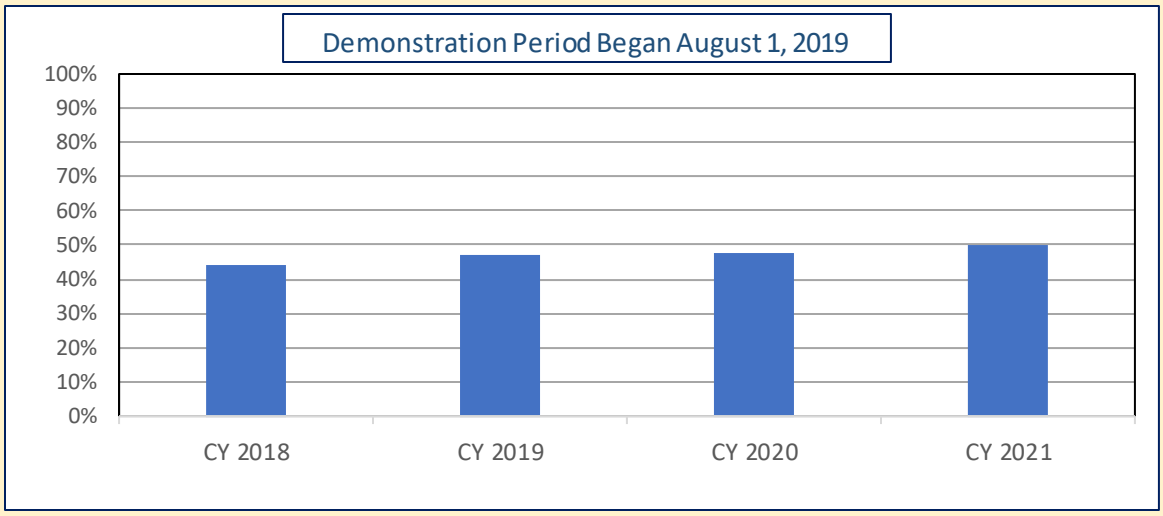
Numerator: Medicaid Beneficiaries with Any SUD Treatment

Measure Steward: CMS [CMS Monitoring Metric #6]

Denominator: Medicaid Beneficiaries SUD Diagnosis (monthly)

Measure Steward: CMS [CMS Monitoring Metric #3]

Results for the Demonstration Population



Study Period	Numerator	Denominator	Rate
CY 2018 Average	9,515	21,580	44.1%
CY 2019 Average	10,773	22,948	46.9%
CY 2020 Average	10,898	22,972	47.4%
CY 2021 Average	11,131	22,389	49.7%
Change Baseline (CY 2018) to Demonstration Period (CY 2021):			11.3%

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

Milestone #3: Reductions in Overdose Deaths, Particularly those Due to Opioids

Summary of Measures

Three measures were examined to assess the reductions in overdose deaths. In Exhibit 15 below, it shows that the desired outcome was met in two of the three measures. Tests for statistical significance were not conducted on all three measures and the results were statistically significant for all three measures.

Exhibit 15

Summary of Findings for Measures Mapped to Milestone 3

Results Shown Below are for the Total Demonstration Population

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
16	Rate of overdose deaths per 1,000 adult Medicaid beneficiaries	Decrease	Increase	Yes	Chi-square
17	Use of Opioids at High Dosage in Persons Without Cancer	Decrease	Decrease	Yes	Chi-square
18	Concurrent Use of Opioids and Benzodiazepines	Decrease	Decrease	Yes	Chi-square

Individual Measure Results

HMA-Burns examined data files submitted to the DMMA under agreement from the Delaware's Vital Statistics division to map cause of death information for Medicaid beneficiaries who expired. As of this report, data is only available through the end of CY 2020. HMA-Burns computed the overdose death rate among Medicaid beneficiaries using the specifications provided in CMS's Metric #27. The overdose death rate was steady near 9.5 deaths per 1,000 in CYs 2018 and 2019, but it increased to 12.0 deaths per 1,000 in CY 2020 (refer to Exhibit 16).

The use of opioids at high dosage in persons without cancer decreased significantly over the four years examined, from a rate of 9.3 percent in CY 2018 to 7.1 percent in CY 2021 (refer to Exhibit 17).

The rate of concurrent use of opioids and benzodiazepines also decreased significantly, from 11.2 percent in CY 2018 to 8.2 percent in CY 2021 (refer to Exhibit 18).

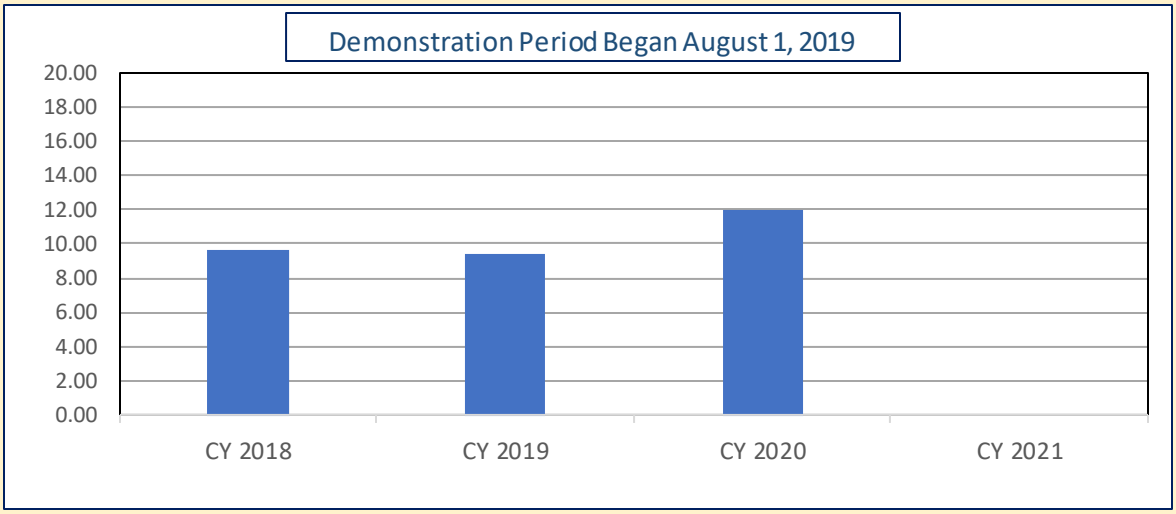
Exhibit 16
Results for Interim Evaluation Measure #16
Overdose Death Rate

Hypothesis:

The demonstration will decrease the rate of overdose deaths due to opioids.

Measure Used to Test Hypothesis:
Overdose death rate among Medicaid beneficiaries
Measure Steward: CMS [CMS Monitoring Metric #27]

Results



Study Period	Numerator	Denominator	Rate
CY 2018	2,873	298,293	9.631
CY 2019	2,817	298,421	9.440
CY 2020	3,531	293,482	12.031
CY 2021	Data not available yet from Vital Statistics		
Change Baseline (CY 2018) to Demonstration Period (CY 2020):			19.9%

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

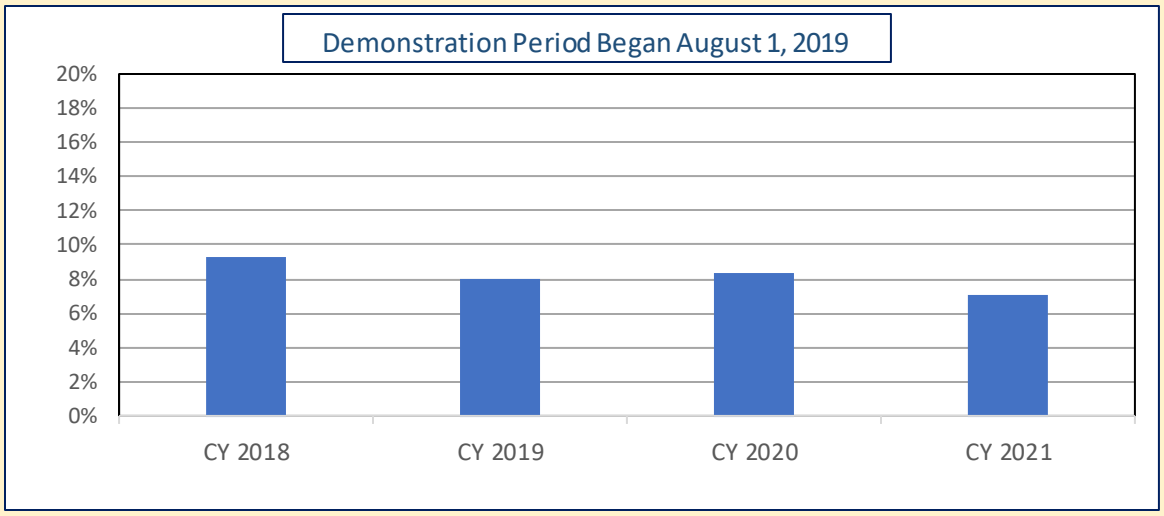
Exhibit 17
Results for Interim Evaluation Measure #17
Use of Opioids at High Dosage in Persons Without Cancer

Hypothesis:

The demonstration will decrease the rate of overdose deaths due to opioids.

Measure Used to Test Hypothesis:
Use of Opioids at High Dosage in Persons Without Cancer
Measure Steward: National Quality Forum #2940 [CMS Monitoring Metric #18]

Results for the Demonstration Population



Study Period	Numerator	Denominator	Rate
CY 2018	652	6,974	9.3%
CY 2019	401	5,034	8.0%
CY 2020	359	4,286	8.4%
CY 2021	301	4,256	7.1%
Change Baseline (CY 2018) to Demonstration Period (CY 2021):			-32.2%

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

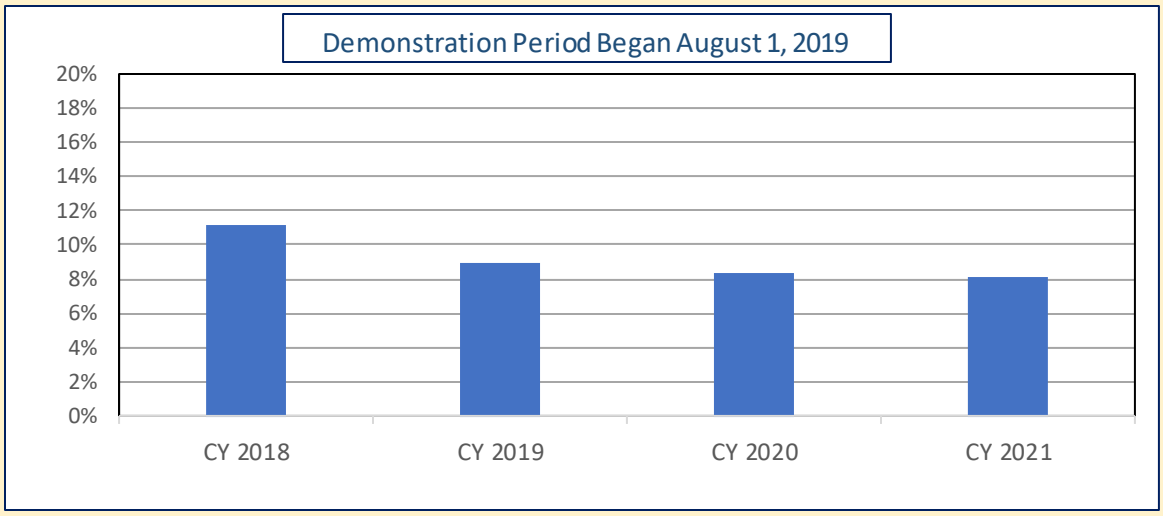
Exhibit 18
Results for Interim Evaluation Measure #18
Concurrent Use of Opioids and Benzodiazepines

Hypothesis:

The demonstration will decrease the rate of overdose deaths due to opioids.

Measure Used to Test Hypothesis:
Concurrent Use of Opioids and Benzodiazepines
Measure Steward: National Quality Forum #3389 [CMS Monitoring Metric #21]

Results for the Demonstration Population



Study Period	Numerator	Denominator	Rate
CY 2018	971	8,666	11.2%
CY 2019	539	5,999	9.0%
CY 2020	419	5,039	8.3%
CY 2021	402	4,918	8.2%
Change Baseline (CY 2018) to Demonstration Period (CY 2021):			-37.1%

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

Milestone #4: Reduced Utilization of Emergency Departments and Inpatient Settings for Treatment Where the Utilization is Preventable or Medically Inappropriate

Summary of Measures

Four measures were examined to assess inpatient hospital utilization, emergency department (ED) utilization, and follow-up from the ED. The desired outcome was met in three of the four measures examined. Tests for statistical significance were conducted on all four measures. Results were statistically significant in two of the four measures.

Exhibit 19
Summary of Findings for Measures Mapped to Milestone 4
Results Shown Below are for the Total Demonstration Population

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
19	Rate of emergency department visits for SUD per 1,000 Medicaid beneficiaries, Age 18-64	Decrease	Decrease	Yes	T-test
20	Inpatient Stays for SUD Per 1,000 Medicaid Beneficiaries, Age 18-64	Decrease	Decrease	Yes	T-test
21	Follow-up After Discharge from the Emergency Department for Alcohol or Other Drug Dependence, 7 days	Increase	Decrease	No	Chi-square
22	Follow-up After Discharge from the Emergency Department for Alcohol or Other Drug Dependence, 30 days	Increase	Increase	No	Chi-square

Individual Measure Results

HMA-Burns computed the rate of ED visits for SUD on a per 1,000 Medicaid beneficiary basis using CMS's Metric #23 specification. Because children are a significant portion of the total Medicaid population, the measure was computed for the total population and for members ages 18-64 only. The ED visit rate declined for both measures. Notably, the reduction was greater in the age 18-64 population, from a rate of 12.1 visits per 1,000 in CY 2018 to 10.5 visits per 1,000 in CY 2021. This reduction is a statistically significant improvement (refer to Exhibit 20).

Similar to the ED measure, HMA-Burns also computed the inpatient stays per 1,000 Medicaid beneficiaries for the total population and for members ages 18-64 only. There was a reduction found in inpatient utilization for both measures, but the reduction was more notable among members ages 18-64, from 8.8 per 1,000 in CY 2018 to 7.8 per 1,000 in CY 2021 (refer to Exhibit 21).

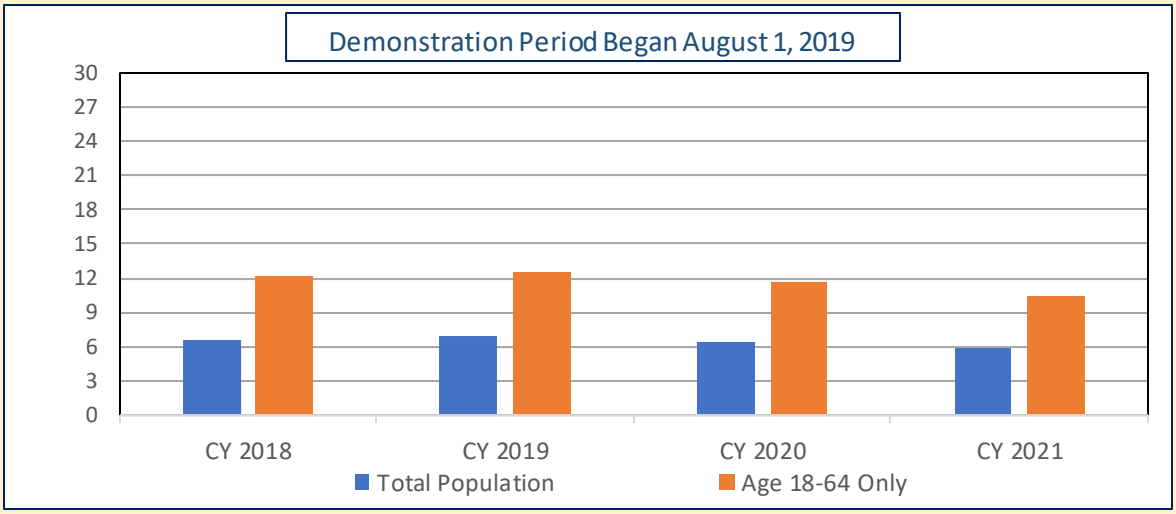
Follow-up after an ED visit for alcohol or other drug dependence was examined at the 7-day and 30-day thresholds. There was a slight decrease in the follow-up rate at seven days, but an improved follow-up rate at 30 days, from 16.5 percent in CY 2018 to 17.3 percent in CY 2021 (refer to Exhibit 22).

Exhibit 20
Results for Interim Evaluation Measure #19
Emergency Department Visits for SUD Per 1,000 Medicaid Beneficiaries

Hypothesis:
The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.

Measure Used to Test Hypothesis:
ED Visits for SUD Per 1,000 Medicaid Beneficiaries
Measure Steward: CMS [CMS Monitoring Metric #23]

Results



	Study Period	Numerator	Denominator	Rate	
Total Demon-stration Population	CY 2018	19,582	2,976,587	6.6	
	CY 2019	20,402	2,979,910	6.8	
	CY 2020	19,886	3,105,517	6.4	
	CY 2021	20,320	3,427,811	5.9	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-11.0%
Age 18-64 Only	CY 2018	18,870	1,558,332	12.1	
	CY 2019	19,612	1,554,083	12.6	
	CY 2020	19,267	1,643,160	11.7	
	CY 2021	19,712	1,884,817	10.5	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-15.8%

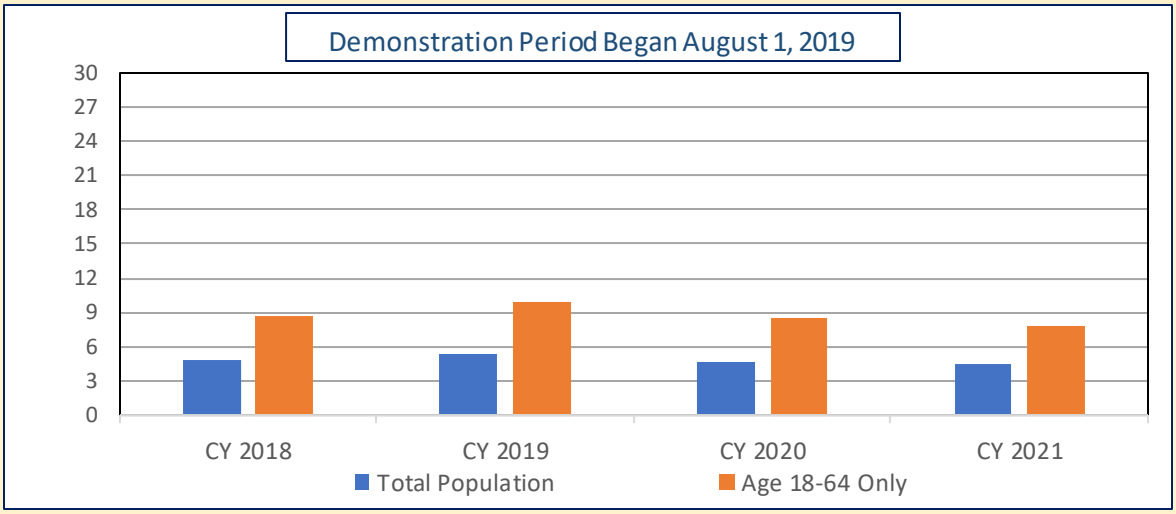
	Total Population	Age 18-64 Only
Desired Outcome:	Decrease	Decrease
Actual Outcome:	Decrease	Decrease
Statistical Review:	T-test	T-test
Probability > [t]:	0.0163	0.0029
Finding:	Significant	Significant

Exhibit 21
Results for Interim Evaluation Measure #20
Inpatient Stays Per 1,000 Medicaid Beneficiaries

Hypothesis:
The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.

Measure Used to Test Hypothesis:
Inpatient Stays Per 1,000 Medicaid Beneficiaries
Measure Steward: CMS [CMS Monitoring Metric #24]

Results



	Study Period	Numerator	Denominator	Rate	
Total Demonstration Population	CY 2018	14,130	2,976,587	4.7	
	CY 2019	15,956	2,979,910	5.4	
	CY 2020	14,607	3,105,517	4.7	
	CY 2021	15,376	3,427,811	4.5	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-5.8%
Age 18-64 Only	CY 2018	13,639	1,558,332	8.8	
	CY 2019	15,270	1,554,083	9.8	
	CY 2020	14,014	1,643,160	8.5	
	CY 2021	14,721	1,884,817	7.8	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-12.1%

	Total Population	Age 18-64 Only
Desired Outcome:	Decrease	Decrease
Actual Outcome:	Decrease	Decrease
Statistical Review:	T-test	T-test
Probability > [t]:	0.1893	0.0144
Finding:	Not Significant	Significant

Exhibit 22

Results for Interim Evaluation Measures #21 and #22

Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence

Hypothesis:

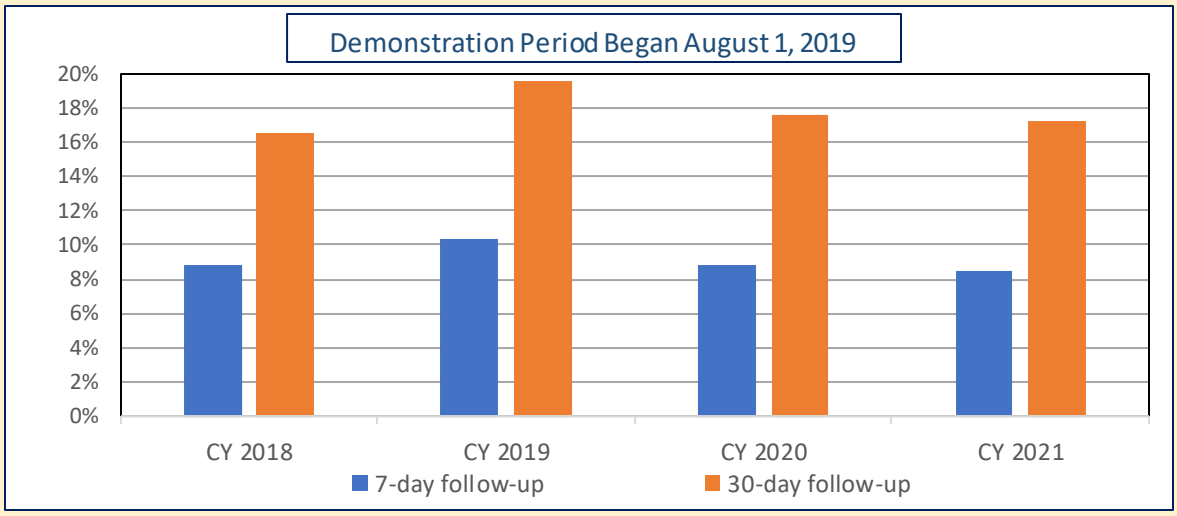
The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.

Measure Used to Test Hypothesis:

Follow-up After ED Visit for Alcohol or Other Drug Dependence

Measure Steward: NCQA, National Quality Forum #3488 [CMS Monitoring Metric #17(1)]

Results for the Demonstration Population



	Study Period	Numerator	Denominator	Rate	
7-day follow-up	CY 2018	159	1,813	8.8%	
	CY 2019	203	1,963	10.3%	
	CY 2020	174	1,968	8.8%	
	CY 2021	170	2,011	8.5%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-3.7%
30-day follow-up	CY 2018	299	1,813	16.5%	
	CY 2019	384	1,963	19.6%	
	CY 2020	347	1,968	17.6%	
	CY 2021	347	2,011	17.3%	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				4.4%

	7-day follow-up	30-day follow-up
Desired Outcome:	Increase	Increase
Actual Outcome:	Decrease	Increase
Statistical Review:	Chi-Square	Chi-Square
Probability:	0.7275	0.5294
Finding:	Not Significant	Not Significant

Milestone #5: Fewer Readmissions to the Same or Higher Level of Care Where the Readmission is Preventable or Medically Inappropriate

Summary of Measures

Three measures were examined to assess readmissions and related care coordination and transitions of care of members after a hospital admission for SUD. The desired outcome was met in all three measures. A test for statistical significance was conducted on one of the three measures and the outcome was statistically significant.

Exhibit 23
Summary of Findings for Measures Mapped to Milestone 5
Results Shown Below are for the Total Demonstration Population

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
23	Readmissions Among Beneficiaries with SUD	Decrease	Decrease	Yes	Chi-square
24	Proportion of Beneficiaries with SUD Receiving Care Coordination Following Discharge from an Index Hospital Stay	Increase	Increase	N/A	no test run
25	Service Utilization After a Hospital or Residential Treatment Stay for SUD	Increase	Increase	N/A	no test run

Individual Measure Results

HMA-Burns used CMS's Metric #25 to examine the rate of readmissions among beneficiaries with SUD. The readmission rate decreased from 25.4 percent in CY 2018 to 23.9 percent in CY 2021 (refer to Exhibit 24).

HMA-Burns received case management rosters from both of the Medicaid MCOs for the period October 1, 2019 through September 30, 2020. Separately, individuals with an inpatient hospital stay for SUD were identified during this time period. HMA-Burns then matched the individual client with the SUD inpatient stays against the case management rosters to determine the percentage of members enrolled in case management at their MCO after discharge from the inpatient hospital stay. In Exhibit 25, the results are shown for two 6-month time periods. The percentage of members enrolled in case management after a SUD hospital stay is low, but it did improve from six percent of members in the first 6-month study period to eight percent of members in the second 6-month study period.

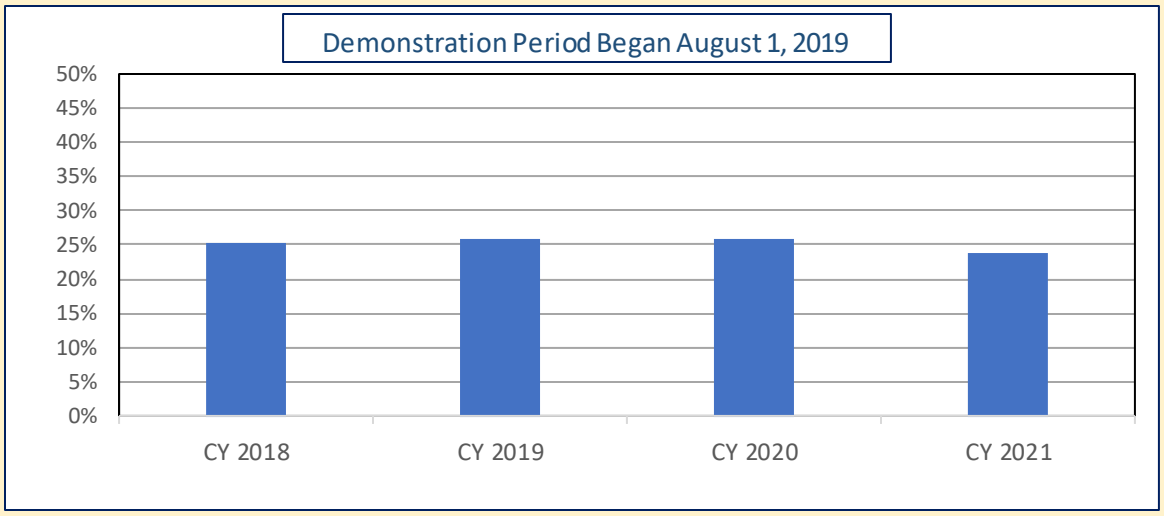
Using the same time periods and the same SUD inpatient hospital stays, HMA-Burns tracked the utilization of a number of services for members in the 12 weeks prior to admission to the hospital for their SUD-related stay and the 12 weeks post-discharge from this hospital stay (refer to Exhibit 26). When comparing utilization pre-admission and post-discharge, the percentage of members with an ED visit went down in their post-discharge from hospital 12-week period compared to their ED use in the pre-admission period. Utilization of intensive outpatient services for SUD and medication assisted treatment increased in the post-discharge hospital period for one of the 6-month study periods as well.

Exhibit 24
Results for Interim Evaluation Measure #23
Readmissions Among Beneficiaries with SUD

Hypothesis:
Among beneficiaries receiving care for SUD, the demonstration will reduce hospital readmissions.

Measure Used to Test Hypothesis:
Readmissions Among Beneficiaries with SUD
Measure Steward: CMS [CMS Monitoring Metric #25]

Results for the Demonstration Population



Study Period	Numerator	Denominator	Rate
CY 2018	2,748	10,834	25.4%
CY 2019	2,979	11,558	25.8%
CY 2020	2,897	11,225	25.8%
CY 2021	2,610	10,912	23.9%
Change Baseline (CY 2018) to Demonstration Period (CY 2021):			-6.0%

Desired Outcome:	Decrease
Actual Outcome:	Decrease
Statistical Review:	Chi-Square
Probability:	0.0134
Finding:	Significant

Exhibit 25
Results for Interim Evaluation Measure #24
Case Management of SUD Clients

Hypothesis:
Among beneficiaries receiving care for SUD, the demonstration will reduce hospital readmissions.

Measure Used to Test Hypothesis:
Proportion of beneficiaries with SUD receiving case management following discharge from an index inpatient stay

Measure Steward: HMA-Burns

Data source: Data reported by Medicaid MCOs to the evaluators of case management rosters for the period October 1, 2019 - September 30, 2020

Results for Enrollment in Case Management

	Both MCOs Combined	AmeriHealth Caritas	Highmark Health Options
Pre-PHE Study Population: Oct 1, 2019 – Mar 31, 2020			
Number of SUD Clients with an Inpatient Index Stay	1,360	639	721
Of these, Percent Enrolled in Case Management	6%	9%	3%
PHE Period: Apr 1, 2020 – Sept 30, 2020			
Number of SUD Clients with an Inpatient Index Stay	747	374	373
Of these, Percent Enrolled in Case Management	8%	14%	2%

Exhibit 26
Results for Interim Evaluation Measure #25
Transitions of Care for SUD Clients

Hypothesis:

Among beneficiaries receiving care for SUD, the demonstration will reduce hospital readmissions.

Measure Used to Test Hypothesis:
Proportion of beneficiaries with SUD receiving timely SUD services following discharge from an index inpatient stay (hospital or residential treatment)

Measure Steward: HMA-Burns

Data source: State encounter data and enrollment files

Results for Service Utilization After a Hospital or Residential Treatment Stay for SUD

	Pre-PHE Study Population: Oct 1, 2019 – Mar 31, 2020		PHE Study Population: April 1, 2020 – Sept 30, 2020	
	Both MCOs Combined		Both MCOs Combined	
	in the 12 weeks before anchor event	in the 12 weeks after anchor event	in the 12 weeks before anchor event	in the 12 weeks after anchor event
Total Denominator Population	**1,360**		**747**	
Percent of Individuals with				
ED Utilization	40%	**23%**	43%	**25%**
Outpatient Hospital, SUD service	53%	49%	60%	52%
Intensive Outpatient	23%	**28%**	29%	17%
Medication Assisted Treatment	30%	**33%**	37%	36%
Outpatient Hospital, NonSUD service	6%	9%	4%	**12%**
Professional Claim other than above	22%	**41%**	13%	**36%**

Percentages highlighted in green indicate an improvement in utilization for the service after discharge from the hospital or residential treatment stay compared to prior being admitted to the hospital or residential treatment stay.
For ED utilization, a lower percentage is preferred.

Milestone #6: Improved Access to Care for Physical Health Conditions Among Beneficiaries

Summary of Measures

One measure was examined to assess improved access to care for physical health conditions among SUD beneficiaries. The desired outcome was not met for this measure. The result was determined to be statistically significant.

Exhibit 27

Summary of Findings for Measures Mapped to Milestone 6

Results Shown Below are for the Total Demonstration Population

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
26	Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	Increase	Decrease	Yes	Chi-square

Individual Measure Results

HMA-Burns used NCQA's AAP HEDIS measure that CMS uses as SUD monitoring metric #32 to measure the access to preventive/ambulatory health services for adult Medicaid beneficiaries with SUD. The rate is high in each year studied, but the rate did go down from 91.9 percent in CY 2018 to 91.1 percent in CY 2021.

Exhibit 28

Results for Interim Evaluation Measure #26

Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD

Hypothesis:

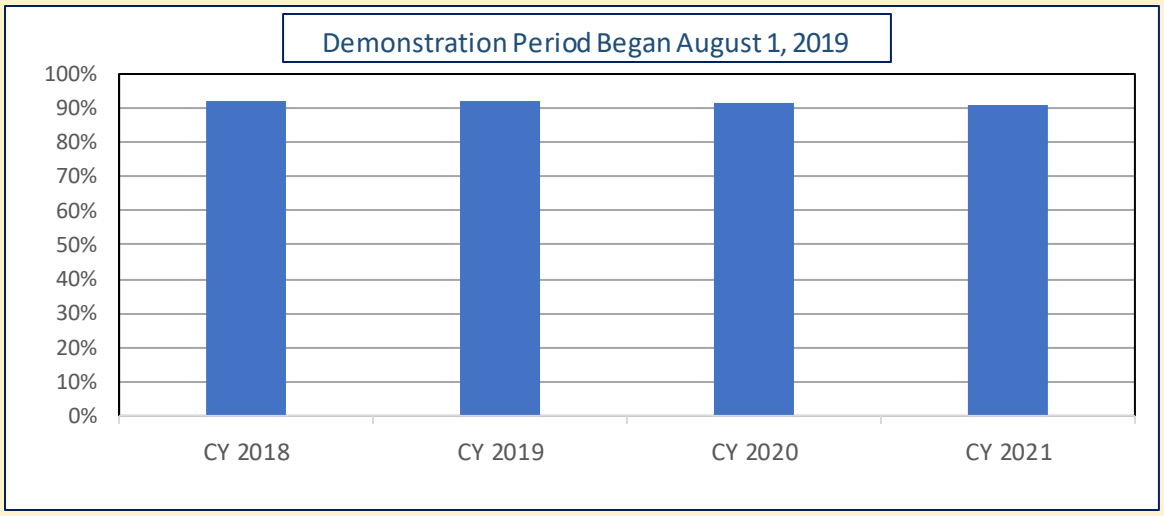
The demonstration will increase the percentage of beneficiaries with SUD who experience care for comorbid conditions.

Measure Used to Test Hypothesis:

Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD

Measure Steward: CMS [CMS Monitoring Metric #32]

Results for the Demonstration Population



Study Period	Numerator	Denominator	Rate
CY 2018	16,340	17,784	91.9%
CY 2019	17,344	18,852	92.0%
CY 2020	18,386	20,059	91.7%
CY 2021	19,235	21,122	91.1%
Change Baseline (CY 2018) to Demonstration Period (CY 2021):			-0.9%

Desired Outcome:	Increase
Actual Outcome:	Decrease
Statistical Review:	Chi-Square
Probability:	0.0042
Finding:	Significant

Cost-Related Measures in the Evaluation Design Plan

Summary of Measures

HMA-Burns also included three cost-related measures in the Evaluation Design Plan. So far in the demonstration, the desired outcome has been met for all three measures. A test for statistical significance was conducted on all three measures. The desired outcomes were found to be statistically significant in two of the three measures.

Exhibit 29

Summary of Findings for Other Measures Not Mapped to a Specific Milestone

Results Shown Below are for the Total Demonstration Population

	Measure Examined	Desired Outcome	Actual Outcome	Statistically Significant?	Statistical Test
27	Per member per month expenditures for all services among the SUD population	Stable or Increase	Stable	No	T-test
28	Per member per month expenditures for SUD services among the SUD population	Increase	Increase	Yes	T-test
29	Per member per month expenditures for non-SUD services among the SUD population	Decrease	Decrease	Yes	T-test

Individual Measure Results

All three of the cost measures appear in Exhibit 30 on the next page. HMA-Burns identified the individuals in the study using CMS monitoring metric #4 for the years CY 2018 through CY 2021. Total expenditures for services were accumulated for each member. The expenditures were then segregated between SUD services (using the definition for SUD services from CMS monitoring metric #28) and non-SUD services (all other services not defined as SUD services).

The per member per month expenditures for all services among SUD beneficiaries has remained steady, from $1,534 in CY 2018 to $1,538 in CY 2021. But the mix of expenditures has changed. The expenditures for SUD services per member per month has increased 24.8 percent, from $530 in CY 2018 to $705 in CY 2021. But the expenditures for non-SUD services per member per month has decreased 20.6 percent, from $1,005 in CY 2018 to $833 in CY 2021.

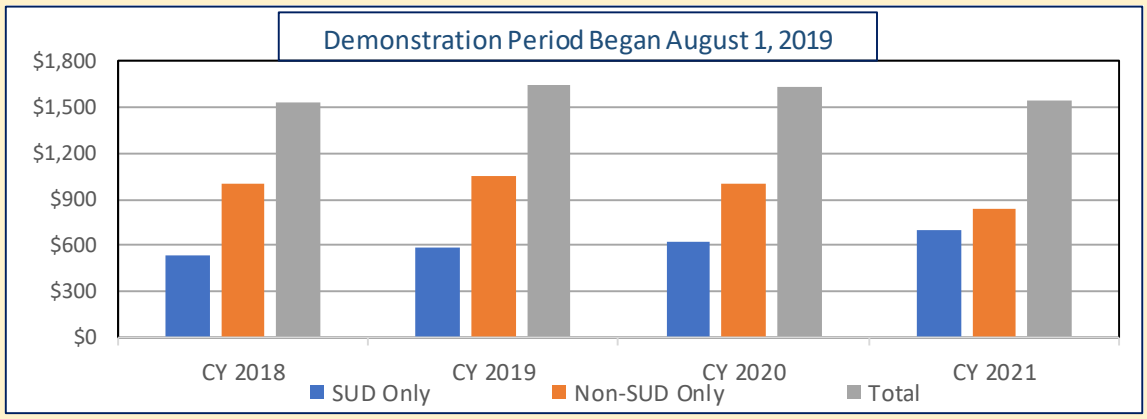
Exhibit 30
Results for Interim Evaluation Measures #27 through #29
Per Member Per Month Expenditures Among the SUD Population

Hypotheses:
1. The demonstration will increase/maintain per beneficiary per month total costs for SUD
2. The demonstration will decrease/maintain per beneficiary per month total costs for non-SUD
3. The demonstration will decrease/maintain per beneficiary per month total costs.

Measures Used to Test Hypothesis:
1. Per Member Per Month SUD Service Spending for Beneficiaries with SUD
2. Per Member Per Month non-SUD Service Spending for Beneficiaries with SUD
3. Per Member Per Month Total Spending for Beneficiaries with SUD

Measure Steward: HMA-Burns (numerator) and CMS (denominator)
Numerators computed from payments summed from Medicaid claims and encounters
Denominator for each month uses results from CMS Monitoring Metric #4

Results for the Demonstration Population



	Study Period	Numerator	Denominator	PMPM	
SUD Services Only	CY 2018	$142,133,543	268,186	$529.98	
	CY 2019	$167,743,497	283,950	$590.75	
	CY 2020	$179,158,715	284,912	$628.82	
	CY 2021	$195,175,562	276,824	$705.05	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				24.8%
Non-SUD Services Only	CY 2018	$269,429,055	268,186	$1,004.64	
	CY 2019	$300,515,232	283,950	$1,058.34	
	CY 2020	$286,926,905	284,912	$1,007.07	
	CY 2021	$230,559,025	276,824	$832.87	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				-20.6%
Total	CY 2018	$411,562,598	268,186	$1,534.62	
	CY 2019	$468,258,729	283,950	$1,649.09	
	CY 2020	$466,085,620	284,912	$1,635.89	
	CY 2021	$425,734,587	276,824	$1,537.93	
	Change Baseline (CY 2018) to Demonstration Period (CY 2021):				0.2%

	SUD Only	Non-SUD Only	Total
Desired Outcome:	Increase/Steady	Decrease/Steady	Decrease/Steady
Actual Outcome:	Increase	Decrease	Steady
Statistical Review:	T-test	T-test	T-test
Probability > [t]:	<.0001	0.0005	0.9248
Finding:	Significant	Significant	Not Significant

SECTION G: Conclusions

Assessment of the Effectiveness of the Demonstration

When considering the driver diagram shown in the Evaluation Design Plan, Delaware did not meet the specific aim identified outright but did see positive impacts due to the demonstration. The section below summarizes the trends related to each of the CMS milestones.

1. **Increased rates of identification, initiation, and engagement in treatment.** Delaware did not see an increase in the initiation or engagement in treatment during the initial years of the demonstration when compared to the pre-demonstration period. There has been a significant ramp up in the use of the state's Prescription Drug Monitoring Program, both in number of clinicians using it and the number of inquiries.
2. **Increased adherence to and retention in treatment**. The percentage of beneficiaries with a SUD diagnosis who used SUD services each month increased 11.3 percent during the initial years of the demonstration (CY 2019, CY 2020, and CY 2021). But the continuity of pharmacotherapy for OUD decreased during this time period.
3. **Reduction in overdose deaths, particularly those due to opioids.** While overdose deaths did increase in CY 2020, there were positive trends observed in the use of opioids at high dosage in persons without cancer (drop from 9.3% in CY 2018 to 7.1% in CY 2021) and the rate of concurrent use of opioids and benzodiazepines (drop from 11.2% in CY 2018 to 8.2% in CY 2021).
4. **Reduced utilization of emergency department and inpatient hospital settings**. The rate of ED visits for SUD on a per 1,000 Medicaid beneficiary basis for the total population and for members ages 18-64 both declined. Notably, the reduction was greater in the age 18-64 population, from a rate of 12.1 visits per 1,000 in CY 2018 to 10.5 visits per 1,000 in CY 2021.

   Similar to the ED measure, inpatient stays per 1,000 Medicaid beneficiaries for the total population and for members ages 18-64 both declined, but the reduction was more notable among members ages 18-64, from 8.8 per 1,000 in CY 2018 to 7.8 per 1,000 in CY 2021.

   When assessing trends in follow-up from the ED for a visit related to alcohol or other drug dependence, the follow-up rate decreased during the demonstration at the 7-day mark but increased at the 30-day mark.
5. **Fewer readmissions to the same or higher level of care**. The rate of readmissions among beneficiaries with SUD decreased from 25.4 percent in CY 2018 to 23.9 percent in CY 2021.

   When comparing utilization pre-admission and post-discharge from a hospital SUD-related stay, the percentage of members with an ED visit went down in the 12 weeks after they were discharged compared to their ED use in the 12-week period prior to admission. Utilization of intensive outpatient services for SUD and medication assisted treatment increased in the post-discharge hospital period for one of the 6-month study periods as well.
6. **Improved access to care for physical health conditions among beneficiaries.** For individuals with an SUD diagnosis, access to preventive or ambulatory care decreased between the pre-demonstration period and the initial years of the demonstration.

7. **Reduce the cost of the SUD population in the demonstration period**. The per member per month expenditures for all services among SUD beneficiaries has remained steady, from $1,534 in CY 2018 to $1,538 in CY 2021. But the mix of expenditures has changed. The expenditures for SUD services per member per month has increased 24.8 percent, from $530 in CY 2018 to $705 in CY 2021. But the expenditures for non-SUD services per member per month has decreased 20.6 percent, from $1,005 in CY 2018 to $833 in CY 2021.

The PHE likely had a confounding effect in enabling Delaware to fully meet these aims during the demonstration period.

When considering the CMS Milestones, Delaware saw success in each milestone with the exception of Milestone 6, Improved Access to Care for Physical Health Conditions Among Beneficiaries. Exhibit 31, which appears on the next page, summarizes the results of each of the measures by CMS milestone. Among 29 measures reviewed, there were 15 where the desired outcome was met. Of these, eight measures had an outcome that was statistically significant in the desired direction.

The DMMA was also successful in large part in the activities it set out to do in its SUD Implementation Plan. Among the eight activities identified, five were completed in full and the remainder are in progress.

Exhibit 31
Summary of Measures Examined by CMS Milestone

CMS Milestone		Total Measures	Measures with Results Trending in the Intended Direction	Measures with Results Trending in the Wrong Direction	Total Measures Where Tests Were Run for Statistical Significance	Of these, the Total Where Trend in Intended Direction and Statistically Significant	Of these, the Total Where Trends in Wrong Direction and Statistically Significant	Of these, the Total Where There Was No Statistically Significant Change
ALL MEASURES		**29**	**15**	**14**	**22**	**8**	**11**	**3**
1	Increased rates of identification, initiation, and engagement in treatment	13	3	10	8	0	8	0
2	Increased adherence to and retention in treatment	2	1	1	2	1	1	0
3	Reductions in overdose deaths, particularly those due to opioids	3	2	1	3	2	1	0
4	Reduced utilization of emergency departments and inpatient settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services	4	3	1	4	2	0	2
5	Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate	3	3	0	1	1	0	0
6	Improved access to care for physical health conditions among beneficiaries	1	0	1	1	0	1	0
	Cost-related measures not tied to a specfic milestone	3	3	0	3	2	0	1

Assessment of Opportunities for Improvement

Delaware saw progress towards its aim to expand SUD-specific services to its Medicaid population through the initial phase of the SUD demonstration period. This occurred through the expansion of coverage for short-term stays in residential and hospital inpatient treatment settings that qualify as institutions for mental disease (IMDs), new services added across the ASAM continuum, and a concentrated effort to increase access to services that had previously been covered. Despite these notable actions, there remain opportunities for continued improvement. The HMA-Burns evaluation team has identified the opportunities below for the DMMA to continue to build upon the strong foundation established during the initial SUD demonstration period.

1. The DMMA is encouraged to develop a mechanism for periodic review (e.g. annual or every two years) of the method used by high-volume SUD providers to determine how they assess patient need for SUD services. This may be a shared responsibility between the State agencies, DMMA and DSAMH, and/or a shared responsibility between the DHSS and its contracted MCOs.
2. The DMMA is encouraged to facilitate an educational session with the providers and the MCOs on the application of the tools commonly used to assess patient need for substance use treatment and how these tools align with ASAM. Additional focus of training could be targeted on the application of state Senate Bill 109 which relates to authorization of residential treatment days.
3. The DMMA should outreach to the existing provider base about its capacity and interest to be licensed at each Delaware ASAM level, including steps that could be taken to increase provider participation in Medicaid such as a value-based payment model. Specific areas of need to expand the provider base include services to adolescents and pregnant women and their children.
4. The DMMA should also outreach to existing providers and potential other entities about options to build a supportive housing network of providers statewide. In interviews conducted for the Mid-Point Assessment, both providers and members mentioned the need for supportive housing options for those receiving medication assisted treatment.
5. The DMMA should encourage or require its MCOs to implement a SUD-specific quality improvement program that focuses on one or more of the SUD-related measures, such as follow-up visits from the ED or the rate of initiation and engagement in treatment.
6. The DMMA should revise MCO reporting to collect SUD appeals and grievances to comply with the requirement to report this data in the waiver monitoring report to CMS.
7. The DMMA should consider both incentives and penalties for providers who do not participate with the MCOs in transitions of members across ASAM levels of care.
8. The DMMA should add accountability standards in its MCO contracts to ensure a higher level of documented transitions of its members across ASAM levels of care.

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

Policy Implications

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

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

Interactions with Other State Initiatives

During the initial SUD demonstration period, the DMMA undertook other initiatives that had a direct impact on the demonstration. As it continues in its demonstration renewal, the DMMA will be mindful of these initiatives as well as new initiatives as they relate to the provisions of SUD services.

1. DMMA was awarded a SUPPORT Act planning grant to assess and expand capacity to treat substance use disorder (SUD) in Medicaid. One direct result of the work under this grant was engagement with providers on the costs to deliver each SUD service. The rates paid for many SUD services will increase significantly starting January 1, 2023. This is the first rate increase in over six years.
2. DMMA developed a Medicaid accountable care organization (ACO) program for the purposes of improving health outcomes while reducing costs through value based purchasing arrangements. Four health care provider groups were authorized as ACOs in September 2020. The ACOs are authorized to contract directly with each MCO under contract with the DMMA, provided that the ACO has participation from at least 5,000 Medicaid enrollees.

State of Delaware Interpretations from the Evaluation Findings

Over the past several years, DMMA has worked to create coverage policies that ensure access to SUD treatment. Even prior to the SUPPORT Act requirements, we covered all forms of medications for opioid use disorder (MOUD) with no prior authorization and had naloxone available with no copay. Delaware's persistently high overdose rates, however, indicated that we needed to do more.

Through our SUD 1115 demonstration and the SUPPORT Act planning grant, and through partnerships with DSAMH, our MCOs, and other stakeholders, DMMA has taken additional steps to improve the continuum of care available. Under the planning grant, we conducted a rate study that included SUD

provider input and developed proposed rates for SUD services. As we continue to work with providers on the implementation of those rates, we will assess readiness and willingness of providers to expand to other levels of care. We have opportunities to provide technical assistance under both SUPPORT Act and State Opioid Response grant (SOR) funding on topics such as the ASAM criteria, Senate Bill 109, office-based opioid treatment (OBOT) implementation, and early intervention. Residential treatment services, including those that target specific populations such as adolescents, will require partnering with DSAMH and the Department of Services for Children & their Families (DSCYF). As part of our SUPPORT Act demonstration project, we have created a provider directory with information about availability across levels of care, including opioid treatment programs (OTP) and OBOTs. All of these efforts will help DMMA and our partners to monitor our existing system and evaluate our efforts to expand services such as early intervention and residential treatment.

Specific DMMA comments to address HMA-Burns recommendations by CMS Milestone are below.

Regarding ***access to critical levels of care for SUD treatment***, Delaware's persistently high overdose death rate has catalyzed cross-agency efforts to improve access to care.

- DMMA's contracts with the MCOs require that the plans use ASAM criteria for utilization management, and DMMA expects that the plans have the same expectations of providers. Through a focus study or EQRO compliance review we can assess how well the MCOs are monitoring the use of ASAM. We also plan to collaborate with DSAMH on credentialing and licensing requirements for providers.
- Under the SOR grant, DSAMH is providing funding and technical assistance to a large number of providers to begin universal screening for SUD. We plan to partner with DSAMH to engage this cohort and help us to better understand what their barriers are to providing early intervention.

Regarding the ***use of evidence-based SUD-specific patient placement criteria***, both the SOR grant to DSAMH and the SUPPORT demonstration project have resources reserved for technical assistance. Education on ASAM criteria and the application of Senate Bill 109 can be topics of some of that assistance. Between the DMMA and DSAMH divisions, we will be able to educate the majority of providers in the state.

Regarding the ***use of nationally recognized SUD-specific program standards for residential treatment***, residential treatment services were highlighted in our SUPPORT act planning grant rate study as an area of concern. As we work with DSAMH on potential rate changes, we can collaboratively review the state standards for credentialing and licensing.

Regarding ***sufficient provider capacity at critical levels of care***, DMMA is engaged in a number of activities to grow the base of SUD providers:

- The development of a provider directory that includes ASAM levels was a deliverable from the SUPPORT demonstration project.
- As part of the SUPPORT planning grant rate study, DMMA engaged with providers on the costs to deliver SUD services and solicited feedback both informally (in meetings) and formally (through a public notice) prior to finalizing the rates that will become effective January 1, 2023.
- Housing insecurity is a concern statewide and at various levels of government. DMMA has engaged with CSH, an organization with supportive housing expertise, to assess the

opportunities for Medicaid funding for housing supports in Delaware. We are engaged in efforts both internally and externally to increase supportive housing for a variety of populations.

- The DSCYF is our partner in delivering Medicaid-funded SUD services to adolescents. DMMA will continue to work with DSCYF to ensure adequate treatment availability for adolescents who need SUD care, including residential services.
- DMMA has a variety of efforts to encourage value-based payment (VBP), such as bundled services. The new MCO contracts effective in January 2023 have specific provisions related to expanding the use of VPB in provider reimbursement.

Regarding the ***implementation of comprehensive treatment and prevention strategies to address opioid abuse***, DMMA is already developing a SUD- and pregnancy-related PIP to encourage low barrier MOUD for those who need it. We are currently in the development phase, but plan to ask the MCOs to design and implement interventions that lead to increased engagement with MOUD in pregnancy. Additionally, expanding the availability of OBOT services was a major focus of our SUPPORT demonstration project. Activities included supporting providers in developing functioning OBOT models via technical assistance, enhanced reimbursement, and strengthening referral networks.

Regarding ***improved care coordination and transition between levels of care***,

- DMMA revised the reporting specifications for the MCOs in the January 2023 contract to include in the next version of the MCO reporting manual.
- DMMA has worked with the MCOs to increase their capacity for internal chart audits, with the expectation of raising care coordination standards and creating uniformity in the care received by complex members. In future EQRO reviews, we plan to examine a sample of care coordination records where there is a known SUD diagnosis.

SECTION I: Lessons Learned and Recommendations

Lessons Learned

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

1. Data systems can often inhibit the effective implementation of new program initiatives. Gaining a thorough understanding of systems changes is important when standing up new programs as well as an appreciation for the time commitment involved. This held true with the rate changes that will be implemented for SUD services in January 2023.
2. Enhancing the linkages between state agencies for citizens who are eligible for multiple programs is important for both continuity of care and for health outcomes. The DMMA has added language to its managed care contracts to ensure proper linkages for individuals that are eligible for Medicaid and other publicly-funded programs in the state as well as for the justice-involved population.

Recommendations

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

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

APPENDIX: Approved Evaluation Design Plan

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

State Demonstrations Group

April 2, 2021

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

Dear Mr. Groff:

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

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

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

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

Sincerely,

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

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

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

Andrea J. Casart
Director
Division of Eligibility and Coverage Demonstrations

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

EVALUATION DESIGN PLAN FOR DELAWARE'S 1115 SUBSTANCE USE DISORDER (SUD) WAIVER

FINAL DRAFT
FEBRUARY 25, 2021

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

Evaluation Team Members:

Mark Podrazik, Principal Investigator
Ryan Sandhaus
Debbie Saxe
Shawn Stack
Kara Suter

TABLE OF CONTENTS

LISTING OF EXHIBITS

Abbreviations List

Abbreviation	Meaning
ASAM	American Society for Addiction Medicine
CMS	Centers for Medicare and Medicaid Services
B&A	Burns & Associates, Inc.
CY	Calendar Year
DHSS	Delaware Department of Health and Social Services
DMES	Delaware Medicaid Enterprise System
DMMA	Division of Medicaid and Medical Assistance
DR	Desk Review
DS	Descriptive Statistics
DSAMH	Division of Substance Abuse and Mental Health
DSHP	Diamond State Health Plan
DSHP-Plus	Diamond State Health Plan Plus
DXC	DXC Technologies
EDW	Enterprise Data Warehouse
E&M	Evaluation & Management
ED	Emergency Department
EQRO	External Quality Review Organization
FFS	Fee-For-Service
FG	Focus Groups

Abbreviation	Meaning
FI	Facilitated Interviews
ITS	Single Segment Interrupted Time Series
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MLTSS	Managed Long-Term Services and Supports
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
OR	Onsite Reviews
OUD	Opioid Use Disorder
PDMP	Prescription Drug Monitoring Program
PROMISE	Promoting Optimal Mental Health for Individuals through Supports and Empowerment
RCT	Randomized Control Trials
SFY	State Fiscal Year
SPMI	Severe and Persistent Mental Illness
ST	Statistical Tests
START	Substance Use Treatment and Recovery Transformation
STC	Special Terms and Conditions
SUD	Substance Use Disorder

SECTION I: GENERAL BACKGROUND INFORMATION

I.A Introduction

Like many states, the opioid epidemic has led Delaware's policymakers and providers to rethink the way in which it addresses substance use disorder (SUD) treatment more broadly. According to its 2019 Annual Report, the Division of Forensic Science reported a total of 438 deaths from drug and alcohol intoxication, up approximately 10 percent from the total of 400 in 2018.[1]

On June 29, 2018, the state submitted an amendment to its waiver demonstration intended to expand SUD services by including expenditure authority for services in institutions for mental diseases (IMD) as well as maintaining existing non-SUD services for beneficiaries. Delaware received approval of its request on July 31, 2019 with an effective period from August l, 2019 through December 31, 2023. As of April 2020, Delaware is one of 28 states to have received approval for SUD demonstrations under waiver.[2]

Exhibit I.1 provides a brief background on the waiver demonstration.

Exhibit I.1
Delaware's Current Section 1115 Waiver

The Delaware Diamond State Health Plan demonstration was initially approved in 1995 and implemented on January l, 1996. The demonstration mandatorily enrolls most Medicaid beneficiaries into managed care organizations (MCOs) to create efficiencies in the Medicaid program and enable the expansion of coverage to certain individuals who would otherwise not be eligible for Medicaid. Some population and service categories remain fee for service (FFS). In 2014, the demonstration was amended to expand eligibility for individuals with incomes up to and including 133 percent of the Federal Poverty Level (FPL) and to provide long- term care services and support (LTSS) to eligible individuals through a mandated managed care delivery system, entitled Diamond State Health Plan Plus (DSHP-Plus) program. In 2015, the state implemented a program called Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE), which enhanced behavioral health services and supports for recipients with severe and persistent mental illness (SPMI).

Under this demonstration, one of the 12 goals is to increase enrollee access and utilization of appropriate SUD treatment services by decreasing the 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. Delaware proposes to test whether it can enhance the effectiveness of the SUD treatment system in Medicaid by maintenance and expansion of SUD residential services as part of a coordinated, full continuum of care resulting in increased access and improved health outcomes for individuals with SUD.[3]

[1] Division of Forensic Science 2019 Annual Report issued May 7, 2020, page 10. https://forensics.delaware.gov/contentFolder/pdfs/2019%20DFS%20Annual%20Report.pdf
[2] Kaiser Family Foundation Issue Brief https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/
[3] Delaware Diamond State Health Plan 1115(a) Demonstration Special Terms and Conditions, accessed at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/de/de-dshp-ca.pdf

Under the broader waiver demonstration goal stated above, as set forth in the Implementation Plan, Delaware is aligning the six goals for the SUD waiver component with the milestones outlined by CMS as follows:[4]

1. Increased rates of identification, initiation, and engagement in treatment;
2. Increased adherence to and retention in treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
6. Improved access to care for physical health conditions among beneficiaries.

In accordance with CMS guidance contained in SMD #17-003, Delaware submitted an Implementation Plan in draft form to CMS on October 30, 2019. The Plan describes the planned activities in the waiver period organized by CMS milestone. In cooperation with CMS, Delaware identified its own milestones in its approved Implementation Plan which include:

1. Access to critical levels of care for opioid use disorder (OUD) and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including medication-assisted treatment (MAT);
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

I.B Delaware Context

Unlike other states who are seeking to adopt the use of the American Society for Addiction Medicine (ASAM) levels of care for both assessments, placement and provider criteria of care, Delaware has almost 10 years of experience with organizing its system around these principles. In April 2017, DHSS Secretary Dr. Kara Odom Walker asked Johns Hopkins University to conduct a review of Delaware's addiction treatment system. In July 2018, the Johns Hopkins team issued a 33-page report that proposed four main strategies[5]:

1. Increase the capacity of the treatment system,
2. Engage high-risk populations in treatment,
3. Create incentives for quality care, and
4. Use data to guide reform and monitor progress.

Recent action relates to strategies to address the recommendations generated from the SUD system review conducted by Johns Hopkins in 2018. Both the Section 1003 capacity planning grant and the State's Substance Use Treatment and Recovery Transformation (START) initiative address specific

[4] State Medicaid Director Letter #17-003 Re: Strategies to Address the Opioid Epidemic, November 1, 2017, available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf
[5] https://news.delaware.gov/2018/07/24/14-month-review-johns-hopkins-team-releases-major-recommendations-strengthening-delawares-substance-use-disorder-treatment-system/

recommendations from the system assessment. Delaware's specific context requires consideration when evaluating the effect of the SUD demonstration waiver monitoring with other ongoing federal initiatives.

Exhibit I.2 summarizes the specific actions identified by Delaware. These actions are categorized by CMS SUD monitoring milestone in the State's approved SUD implementation plan.

Exhibit I.2
Summary of Actions by Monitoring Milestone and Special Term and Condition (STC)
(excerpted from the State's Implementation Plan)

MILESTONE AND STC	SUMMARY OF ACTIONS NEEDED
1. Access to Critical Levels of Care for OUD and other SUDs (STC #31(a)(i))	There are no anticipated actions needed by DMMA for fulfillment of this milestone.
2. Use of Evidence-based, SUD-specific Patient Placement Criteria and Patient Placement (STC #31(a)(ii and iii)	In conjunction with Milestone #6, DMMA's EQRO will perform a focus study to assess MCO and provider application of the ASAM criteria in 2021 (for review of 2020 activities.) Expected report release by August 2021.
3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities and Standards of Care (STC #31(a)(iv)-(vi))	There are no anticipated actions needed by DMMA for fulfillment of this milestone.
4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (STC #31(a)(vii))	By December 2020, as described in Delaware's SUPPORT ACT Project Planning Grant, Delaware will: 1.Estimate the number and percentage of OUD and other SUD among Medicaid-beneficiaries, and OUD and other SUD treatment and recovery needs. 2. Complete a workforce assessment to determine SUD provider and service capacity for Medicaid beneficiaries. 3. Conduct a gaps analysis to determine service gaps to treating the OUD and other SUD needs of Medicaid-covered SUD treatment and recover services.
5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (STC #31(a)(viii))	There are no anticipated actions needed by DMMA for fulfillment of this milestone.
6. Improved Care Coordination and Transitions between Levels of Care (Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities.) (STC #31(a)(x))	DMMA will assess MCO performance on Care Coordination and Transitions between Levels of Care for individuals with OUD and other SUD.
7. SUD HIT Plan (STC #31(a)(ix))	There are no anticipated actions needed by DMMA for fulfillment of this milestone.

SECTION II: EVALUATION QUESTIONS AND HYPOTHESES

II.A Defining Relationships: Aims, Primary Drivers, and Secondary Drivers

Burns & Associates, a division of Health Management Associates (B&A), the State's Independent Evaluator, examined the relationships between the CMS goals and Delaware Medicaid interventions included in the demonstration waiver, the approved Implementation Plan, and other activities already underway in Delaware as part of other federal initiatives and grants. As part of the examination of the relationships between goals and the interventions, B&A constructed a driver diagram to identify the primary and secondary drivers of a principle aims: reduce overdose deaths. The driver diagram is shown in Exhibit II.1 on the next page.

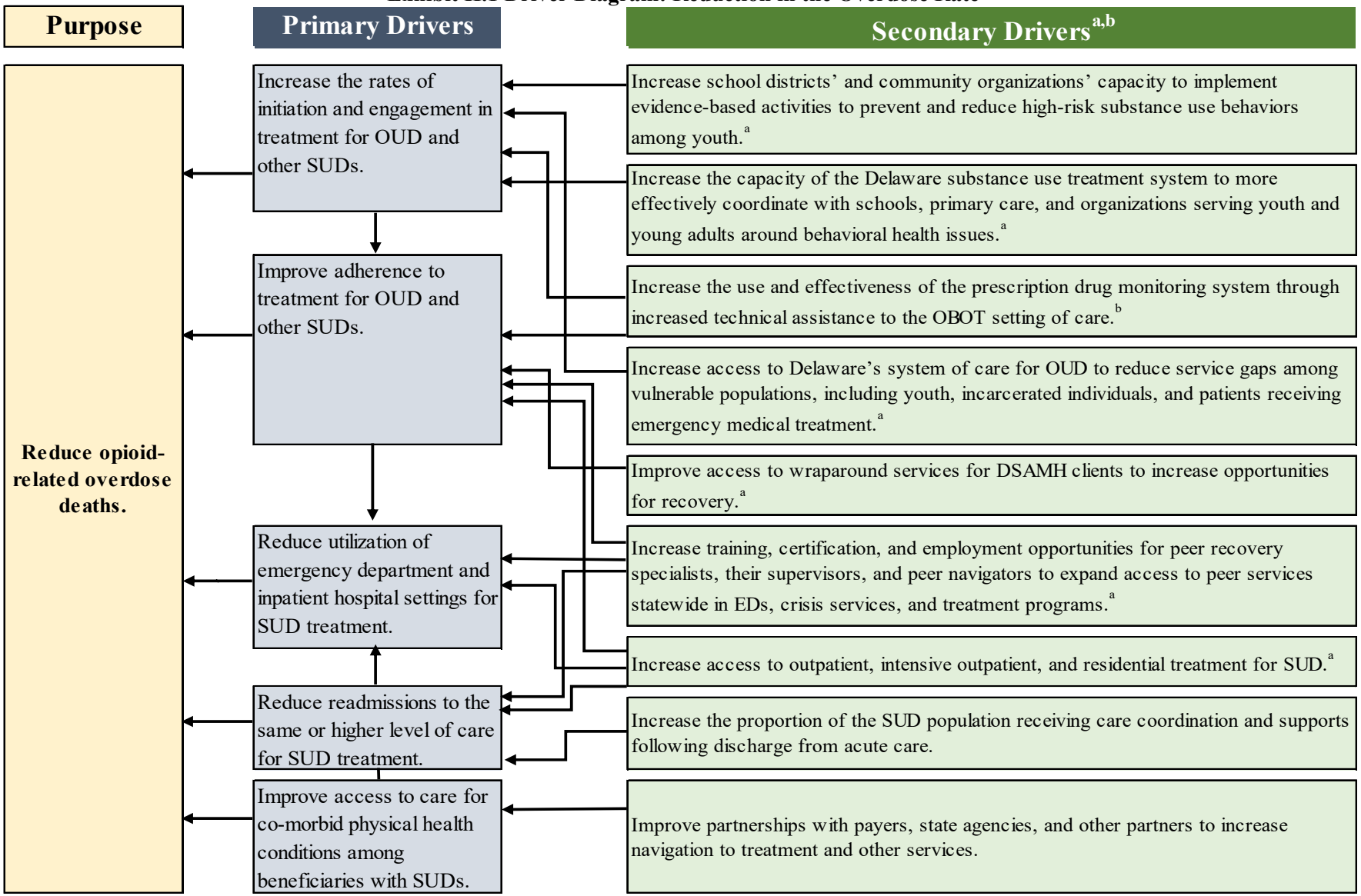
Overdose deaths is an important measurable health outcome of interest and, therefore, is the aim of the driver diagram. CMS's goals represent primary drivers all of which identified as having the potential to contribute to a reduction in overdose deaths. The specific actions described in the concurrent federal initiatives and grants are considered secondary drivers.

The aim and primary drivers were matched with metrics to aid in the assessment of performance and the development of meaningful findings. Where possible, B&A adopted the same metrics used as part of the State's monitoring protocol. These measures, in the post-waiver implementation period, will be used as targets such that performance in the post-waiver period will be considered positive should changes occur in the post- versus pre-waiver period. Use of the state's prescription drug monitoring website (PDMP) was identified as a secondary driver of interest. If more providers use the PDMP, then more beneficiaries would be potentially engaged in treatment.

Reductions or maintenance of per beneficiary costs in the SUD population is also of interest to CMS and the State. B&A plans to follow the three-part approach described in Appendix C of CMS's Technical Guidance to examine the relationships between waiver implementation and spending. The three analyses will attempt to answer whether investments in SUD services, made as part of the waiver, result in demonstrable reductions in non-SUD services spending. Further, the drivers of any non-SUD savings in the post-waiver period will be examined.

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

Exhibit II.1 Driver Diagram: Reduction in the Overdose Rate



a Secondary driver is part of federally-required SOR evaluation and not specifically included as part of the scope of the 1115 waiver evaluation.

b Secondary driver is part of federally-required SUD Capacity Planning evaluation and not specifically included as part of the scope of the 1115 waiver evaluation.

II.B Hypotheses and Research Questions

In quantitative research, testing of hypotheses is a commonly-used technique to operationalize a research question. It is a technique to find out if support for a formulated hypothesis is supported by the data.

Five research questions and eleven hypotheses in the evaluation design were developed around the six CMS-stated goals:

1. Increased rates of identification, initiation, and engagement in treatment;
2. Increased adherence to and retention in treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
6. Improved access to care for physical health conditions among beneficiaries.

Hypotheses and Research Questions

Exhibit II.2 on the next page summarizes the five research questions and eleven hypotheses included in the evaluation design plan with a reference to the CMS goal that each hypothesis relates to.

Exhibit II.3
Eleven Hypotheses and Corresponding CMS Goal, by Research Question

CMS Goal	R or H #	Five Research Questions (blue shading) and Eleven Hypotheses
	Q 1	**Does the demonstration increase access to and utilization of SUD treatment services?**
#1	H 1.1	• The demonstration will increase or maintain the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDs.
#2	H 1.2	• The demonstration will increase or maintain adherence to and retention in treatment for OUD.
#1	H 1.3	• Approved service authorizations improve appropriate utilization of health care services in the post-waiver period.
#4	H 1.4	• The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.
	Q 2	**Do enrollees who are receiving SUD services experience improved health outcomes?**
#6	H 2.1	• The demonstration will increase or maintain the percentage of beneficiaries with SUD who experience care for comorbid conditions.
#5	H 2.2	• Among beneficiaries receiving care for SUD, the demonstration will reduce or maintain readmissions to SUD treatment.
	Q 3	**Are rates of opioid-related overdose deaths impacted by the demonstration?**
#3	H 3.1	• The demonstration will decrease the rate of overdose deaths due to opioids.
	Q 4	**Do activities post-implementation increase use of Delaware's Prescription Drug Monitoring Program?**
#1	H 4.1	• The demonstration will increase or maintain the use of Delaware's PDMP.
	Q 5	**How does the demonstration impact cost?**
All	H 5.1	• The demonstration will decrease or maintain per beneficiary per month costs.
All	H 5.2	• The demonstration will increase or maintain per beneficiary per month costs for SUD services versus non-SUD services.
All	H 5.3	• The demonstration will decrease or maintain per beneficiary costs for SUD-related ED visits and inpatient stays.

SECTION III: METHODOLOGY

III.A Evaluation Design

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

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

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

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

Exhibit III.1
Summary of Five Analytic Methods by Hypotheses

		Method					Analytic Method Examples
	Hypothesis Description	DS	ST	OR	DR	FI	
H1.1	The demonstration will increase the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDs.	X	X	X	X	X	**DS**: trends in frequencies and percentages. **ST**: chi-square or t-test of significance. ITS completed in Summative Evaluation. **OR**: Care Coordination and Transitions to Care focus studies (2 rounds for each). **FI**: Interviews with Medicaid MCOs. Data sources: claims and enrollment data from state data warehouse, care coordination data from MCOs
H1.2	The demonstration will increase or maintain adherence to and retention in treatment for OUD.	X	X	X	X	X	
H1.3	Approved service authorizations improve appropriate utilization of health care services in the post-waiver period.	X	X	X	X	X	**DS**: trends in frequencies and percentages. **ST**: chi square or t-tests of significance. **OR**: Service Authorizations focus studies (2 rounds). Data sources: claims and enrollment data, authorization records submitted by MCOs (validated by B&A)
H1.4	The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population.	X			X		**DS**: trends tracked separately for subpopulations defined in the SUD Monitoring Protocol. ITS completed in Summative Evaluation. Data sources: claims, reports submitted by MCOs
H2.1	The demonstration will increase the percentage of beneficiaries with SUD who experience care for comorbid conditions.	X	X		X	X	**DS**: trends in frequencies and percentages. **ST**: chi-square or t-test of significance. ITS completed in Summative Evaluation. **FI**: Interviews with Medicaid MCOs. Data sources: claims and enrollment data from state data warehouse
H.2.2	Among beneficiaries receiving care for SUD, the demonstration will reduce readmissions for SUD treatment.	X	X		X		**DS**: trends in frequencies and percentages. **ST**: ITS will be completed in Summative Evaluation. **FI**: chi-square or t-test of significance. Data sources: claims and enrollment data from state data warehouse
H3.1	The demonstration will decrease the rate of overdose death due to opioids.	X	X		X		**ST**: chi square or t-tests of significance comparing target population to baseline. ITS will be completed in Summative Evaluation. Data sources: claims and enrollment data from state data warehouse
H4.1	The demonstration will increase the use of Delaware's PDMP.	X			X		**DS**: trends in frequencies and percentages. Data sources: information from the state's PDMP
H5.1	The demonstration will decrease or maintain per beneficiary per month costs.	X	X		X		**DS**: trend rates stratified by subpopulation identified in the SUD Monitoring Protocol. **ST**: ITS will be completed in the Summative Evaluation. Data sources: claims, member enrollment data.
H5.2	The demonstration will increase or maintain per beneficiary per month costs for SUD services versus non-SUD services.	X	X		X		
H5.3	The demonstration will decrease or maintain per beneficiary costs for SUD-related ED visits and inpatient stays.	X	X		X		

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

III.B Target and Comparison Populations

Target Population

The target population is any Delaware Medicaid beneficiary with a diagnosis of Substance Use Disorder (SUD) in the study period. B&A will use the approved specification, described in the CMS-approved Monitoring Plan, for identification of beneficiaries with SUD. Having a positive SUD Indicator Flag will serve as an indicator of exposure to the changes in the waiver.

While the key study population is the overall SUD population, a standardized set of sub-populations will be identified and examined. B&A will sub-set the SUD population, at minimum, by common demographic groups, by delivery system (i.e., managed care or FFS), and by geographic region. In addition, there are nuances in the 1115 waiver changes which warrant identification and stratification of the data into a number of sub-populations. See Figure 2 in Section I of the evaluation plan for a summary of the waiver policy changes.

- ASAM Levels: (specifically, levels 2.1; 3.1; 3.5; 4; OTP; and RS). It is possible that outcomes may differ among the SUD population based on their access to services. B&A will examine the outcomes by those accessing a particular level of care for differences in health outcomes or cost in the post-waiver period compared to the pre-wavier period.

- Risk Scores: Similarly, outcomes may differ among the SUD population for some types of clinically similar groups compared to others. Therefore, B&A will examine outcomes by categorized groups of clinically-similar beneficiaries to examine whether there are differences in health outcomes or cost among clinically-similar groups of SUD beneficiaries.

- IMD Services: IMD coverage is expanding beyond the existing availability through specialized waiver services (e.g., PROMISE). B&A will flag those individuals who previously had access to IMD coverage.

- Opioid Use Disorder (OUD): It is likely that those beneficiaries with OUD, compared to those with other types of SUD, may have different health outcomes and access a different mix of services. Therefore, it is possible that the waiver impacts these populations differently; therefore, the OUD beneficiaries will be identified and examined as a sub-population. B&A will use the specification for OUD described in the CMS-approved Monitoring Plan.

- New Member/COVID: Beneficiaries who became newly eligible for Medicaid due to the financial impact of the pandemic will be separately identified. A combination of aid category and time of enrollment will be used to identify this population.

Comparison Groups

Two ideal comparison groups described in the CMS technical advisory guidance on selection of comparison groups include another state Medicaid population and/or prospectively collected information prior to the start of the intervention.[6] Specifically, a SUD population with similar demographics, in another state without those waiver flexibilities described in Delaware, would be an ideal comparator. However, identifying whether such a state exists or the ability to obtain data from another state given the sensitivity of SUD privacy concerns as it relates to data sharing is not feasible; therefore, it is outside the

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

scope of this evaluation. Similarly, the other example of a control group described in the design guide is to collect prospective data. To our knowledge, there is no known prospective data collection on which to build baselines.

Given the lack of an available and appropriate comparison group, B&A will use an analytic method which creates a pre-waiver and current waiver (intervention) group upon which to compare outcomes. See Section III.F for more details on the analytic methods.

III.C Evaluation Period

Monthly Metrics

For those metrics which are computed monthly, the pre-waiver period will be defined as a three year period before waiver approval. The pre-waiver period is defined as enrollment or dates of service from August 1, 2016 through July 31, 2019. The post-waiver period is defined as enrollment or dates of service from August 1, 2019 through December 31, 2023.

Annual Metrics

For those metrics which are computed as annual metrics, particularly those with national measure stewards, B&A will assign calendar year 2019 data into the pre-waiver period since only five months of CY 2019 are in the post-waiver period. Before making a final decision on this matter, B&A will conduct tests to determine the sensitivity to change whether CY 2019 is included in the pre-waiver period or is omitted entirely from the evaluation. If the results of models are sensitive to including CY2019 annual metric in the pre-waiver period, it will be omitted from any statistical modeling—although it will be depicted descriptively.

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

III.D Evaluation Measures

The measures included in the evaluation plan directly relate to the aims and the primary and secondary driver described in Section II. The measures include those with national measure stewards, those specified by CMS, and evaluator-derived metrics. The metrics will be computed monthly, quarterly and annually and reported per the CMS technical specifications. The majority of the measures are also included in Delaware's monitoring protocol.

Exhibit III.2 on the next page of the evaluation design summarizes the list of measures included in the evaluation plan. A comprehensive list of measures as well as a description of numerators and denominators can be found in the detailed matrices in Section III.G.

Exhibit III.2 Summary of Metrics and Steward, by Research Question and Hypothesis

Q/H #	Measure Steward	Research Question and Metric(s)
Q 1		**Does the demonstration increase access to and utilization of SUD treatment services?**
H 1.1	NQF #0004	• Initiation and engagement of alcohol and other drug dependence treatment
H 1.2	NQF #3175	• Continuity of pharmacotherapy for OUD
H 1.2	CMS	• Percentage of beneficiaries with a SUD diagnosis who used SUD services per month
H 1.3	B&A	• Average turnaround time for authorization decisions
H 1.3	B&A	• Rate of approved and denied authorizations
H 1.3	B&A	• Frequency and percentage of denial reason codes
H 1.4	CMS	• Emergency department visits for SUD-related diagnoses and specifically for OUD
H 1.4	CMS	• Inpatient admissions for SUD and specifically OUD
H 1.4	NCQA	• Follow-up after discharge from the emergency department for alcohol or other drug (AOD) dependence
Q 2		**Do enrollees who are receiving SUD services experience improved health outcomes?**
H 2.1	NCQA	• Access to preventive/ ambulatory health services for adult Medicaid beneficiaries with SUD
H 2.2	CMS	• Plan all-cause readmissions
H 2.2	B&A	• The proportion of beneficiaries with SUD receiving care coordination following discharge from index hospital stay
H 2.2	NQF #3453	• Continuity of care after inpatient or residential treatment from SUD
Q 3		**Are rates of opioid-related overdose deaths impacted by the demonstration?**
H 3.1	NQF #2940	• Use of opioids at high dosage in persons without cancer
H 3.1	B&A	• Rate of overdose deaths, specifically overdose deaths due to any opioid
H 3.1	PQA	• Concurrent use of opioids and benzodiazepines
Q 4		**Do activities post-implementation increase the use of the Delaware's Prescription Drug Monitoring Program?**
H 4.1	B&A	• Number of clinicians accessing the PDMP
H 4.1	B&A	• Number of queries to the PDMP
Q 5		**How does the demonstration impact cost?**
H 5.1	CMS	• Per beneficiary per month spending: total and by service category
H 5.2	CMS	• Per beneficiary per month spending: SUD, IMD and non-SUD
H 5.3	CMS	• Per beneficiary per month spending: SUD treatments by category of service

III.E Data Sources

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

Delaware Medicaid Administrative Data

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

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

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

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

Delaware Vital Statistic Data

In collaboration with DMMA, vital statistics cause of death data will be transferred from the Department of Health to the evaluators for purposes of calculating overdose rates. More information on vital statistics can be found at: https://dhss.delaware.gov/dhss/dph/ss/vitalstats.html.

Delaware Prescription Drug Monitoring Program (PDMP) Data

In accordance with state guidelines, the states PDMP collects information on queries and unique users which will be provided by the Division of Financial Regulation in collaboration from DMMA. Where possible, data available in the public domain via quarterly reports will be collected and used. Information on the Delaware's PDMP can be found at: https://dpr.delaware.gov/boards/pmp/.

Facilitated Interview Data

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

III.F Analytic Methods

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

Method #1: Descriptive Statistics

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

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

COVID-19 Considerations

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

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

Method 2: Statistical Tests

T-test or Chi-square test

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

COVID-19 Considerations

For those metrics where simple statistics (chi square or t-test) is the appropriate quantitative methodology, the evaluators propose testing two separate post years to baseline to estimate the treatment effects before, during and after the pandemic. In both cases, members who became newly-eligible for Medicaid as a result of COVID will be identified by aid category and benefit plan and treated as a subpopulation in the analysis. By doing this, B&A will be able to continue to include other newly-eligible members for which enrollment in Medicaid is unrelated to the pandemic (e.g., aged, blind and disabled, pregnant women, newborns).

T-test

The t test is a type of inferential statistics. It is used to determine whether there is a significant difference between the means of two groups. Conceptually, it represents how many standardized units of the means of the pre- and post-populations differ. There are generally five factors to contribute whether a statistically significant difference between the pre- and post-periods will be considered significant:[7]

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

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

The assumptions underlying the t-test include:

- The samples have been randomly drawn from their respective population.
- The scores in the population are normally distributed.

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

- The scores in the populations have the same variance (s1=s2). A different calculation for the standard error may be used if they are not.

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

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

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

Chi-square test

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

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

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

The assumptions of the chi-square are:

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

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

Interrupted Time Series (ITS)

Interrupted time series (ITS) is a quasi-experimental method used to evaluate health interventions and policy changes when randomized control trials (RTC) are not feasible or appropriate.[8,9,10] As it would not be ethical or consistent with Medicaid policy to withhold services resulting from waiver changes from a sub-set of beneficiaries for purposes of evaluation, an RTC is therefore, not possible. Per CMS technical guidance, the ITS is the preferred alternative approach to RTC in the absence of an available, adequate comparison group for conducting cost-related evaluation analyses. The ITS method is particularly suited for interventions introduced at the population level which have a clearly defined time period and targeted health outcomes.[11,12,13]

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

While there are no fixed limits regarding the number of data points because statistical power depends on a number of factors like variability of the data and seasonality, it is likely that a small number of observations paired with small expected effects may be underpowered.[14] The expected change in many outcomes included in the evaluation are likely to be small; therefore, the evaluators will use 72 monthly observations where possible and 24 quarterly observations where monthly data are not deemed reliable.

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

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[8] Bonell CP, Hargreaves J, Cousens S et al.. Alternatives to randomisation in the evaluation of public health interventions: Design challenges and solutions. J Epidemiol Community Health 2009;65:582-87.

[9] Victora CG , Habicht J-P, Bryce J. Evidence-based public health: moving beyond randomized trials. Am J Public Health 2004;94:400–05.

[10] Campbell M , Fitzpatrick R, Haines A, Kinmonth AL, Sandercock P, Spiegelhalter D, et al. . Framework for design and evaluation of complex interventions to improve health. BMJ 2000;321:694.

[11] Soumerai SB. How do you know which health care effectiveness research you can trust? A guide to study design for the perplexed. Prev Chronic Dis 2015;12:E101.

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

[13] James Lopez Bernal, Steven Cummins, Antonio Gasparrini; Interrupted time series regression for the evaluation of public health interventions: a tutorial, International Journal of Epidemiology, Volume 46, Issue 1, 1 February 2017, Pages 348–355, https://doi.org/10.1093/ije/dyw098

[14] James Lopez Bernal, Steven Cummins, Antonio Gasparrini; Interrupted time series regression for the evaluation of public health interventions: a tutorial, International Journal of Epidemiology, Volume 46, Issue 1, 1 February 2017, Pages 348–355, https://doi.org/10.1093/ije/dyw098

ITS Descriptive Statistics

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

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

Regression Analysis

Wagner et al. described the single segmented regression equation as[15]:

$$\hat{Y}_t = \beta_0 + \beta_1 * \text{time}_t + \beta_2 * \text{intervention}_t + \beta_3 * \text{time\_after\_intervention}_t + e_t$$

Where: Y_t is the outcome

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

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

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

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

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

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

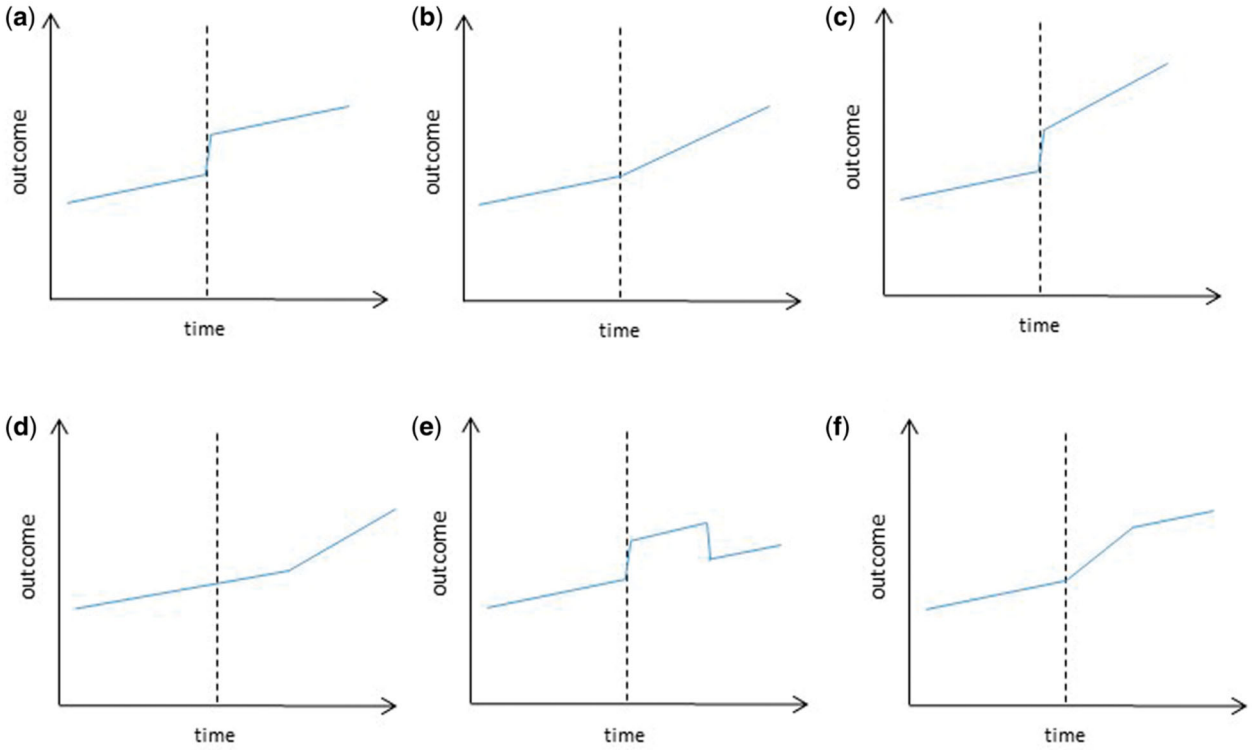
β_3 estimates the change in trend in the post-intervention segment

e_t estimates the error

Visualization and interpretation will be done as depicted in the Exhibit III.3. Each outcome will be assessed for one of the following types of relationships in the pre- and post-waiver period: (a) Level change; (b) Slope change; (c) Level and slope change; (d) Slope change following a lag; (e) Temporary level change; (f) Temporary slope change leading to a level change.

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

Exhibit III.3 Illustration of Potential ITS Relationships[16]



Seasonality and Autocorrelation

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

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

Other assumptions of linear regression are that data are linear and that there is constant variance in the errors versus time. Heteroscedasticity will be diagnosed by examining a plot of residuals verses predicted values. If the points are not symmetrically distributed around a horizontal line, with roughly constant variance, then the data may be nonlinear and transformation of the dependent variable may be warranted.

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

Heteroscedasticity often arises in time series models due to the effects of inflation and/or real compound growth. Some combination of logging and/or deflating may be necessary to stabilize the variance in this case.

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

Controls and Stratification

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

COVID-19 Considerations

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

Method #3: Onsite Reviews

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

- Care Coordination and Transitions to Care
- Service Authorization

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

Method #4: Desk Reviews

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

Method #5 Facilitated and/or Focus Group Interviews

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

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

III.G Other Additions

Starting on the next page, a matrix summarizing the methods for each hypothesis and research question described in Section III.A – III.F is presented.

Driver	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #1: ***Does the demonstration increase access to and utilization of SUD treatment services?***						
Demonstration Goal #1: Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.						
Evaluation Hypothesis #1.1: The demonstration will increase the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDs.						
Primary Driver (Increase the rates of initiation and engagement for OUD and other SUDs)	Initiation and engagement of alcohol and other drug dependence treatment	NQF #0004	Initiation: number of patients who began initiation of treatment through an inpatient admission, outpatient visits, intensive outpatient encounter or partial hospitalization within 14 days of the index episode start date	Patients who were diagnosed with a new episode of alcohol or drug dependency during the first 10 and ½ months of the measurement year	Claims data	***For both measures***: Descriptive statistics (frequencies and percentages); chi square tests or t-tests of significance comparing target population in the post-period to the baseline pre-period. ITS will be conducted in the Summative Evaluation.
	Initiation and engagement of alcohol and other drug dependence treatment	NQF #0004	Engagement: Initiation of treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any alcohol or drug diagnosis within 30 days after the date of the initiation encounter	Patients who were diagnosed with a new episode of alcohol or drug dependency during the first 10 and ½ months of the measurement year	Claims data	
Demonstration Goal #2: Increased adherence to and retention in treatment.						
Evaluation Hypothesis #1.2: The demonstration will increase the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDs.						
Primary Drivers (Increase the rates of initiation and engagement in treatment for OUD and other SUDs.)	Continuity of pharmacotherapy for OUD	NQF #3175	Number of participants who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days	Individuals who had a diagnosis of OUD and at least one claim for an OUD medication	Claims data	Descriptive statistics; chi square or t-tests of significance comparing target population in the pre- and post- periods. ITS in the Summative Eval.
	Percentage of beneficiaries with a SUD diagnosis (including beneficiaries with an OUD diagnosis) who used SUD services per month	CMS-specified	Number of enrollees who receive a service during the measurement period by service type	Number of enrollees	Claims data	Descriptive statistics; chi square or t-tests of significance comparing target population in the pre- and post- periods. ITS in the Summative Eval.

Driver	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Demonstration Goal #1: Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.						
Evaluation Hypothesis #1.3: Approved service authorizations improve appropriate utilization of health care services in the post-waiver period.						
Primary Drivers (Increase the rates of initiation and engagement in treatment for OUD and other SUDs.)	Average turnaround time for authorization decisions	Burns & Associates	Total number of days turnaround time for monthly authorizations for SUD, residential and inpatient requests	Total number of monthly SUD authorizations requests (approved and denied), residential and inpatient requests	MCO-submitted report	Descriptive statistics (frequencies and percentages)
	Rate of approved and denied authorizations	Burns & Associates	Number of monthly (1) approvals and (2) denials for SUD authorizations, residential and inpatient requests	Total number of monthly SUD authorizations requests, residential and inpatient	MCO-submitted report	Descriptive statistics (frequencies and percentages)
	Frequency and percentage of denial reason codes	Burns & Associates	Count of monthly denied SUD authorization requests, by denial reason code, residential and inpatient	Total number of monthly denied authorizations requests for SUD, residential and inpatient	MCO-submitted report	Descriptive statistics (frequencies and percentages)
Demonstration Goal #4: Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.						
Evaluation Hypothesis #1.4: The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.						
Primary Driver (Reduced utilization of emergency department and inpatient hospital settings for SUD treatment)	Emergency department visits for SUD-related diagnoses and specifically for OUD	CMS-specified	The number of ED visits with a SUD diagnosis present during the measurement period	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	Claims data	***For all measures***: Descriptive statistics (frequencies and percentages); chi square tests or t-tests of significance comparing target population in the post-period to the baseline pre-period. ITS in the Summative Eval.
	Inpatient admissions for SUD and specifically OUD	CMS-specified	The number of inpatient admissions with (1) a SUD primary diagnosis and (2) an OUD primary diagnosis	Total number of beneficiary member months (result of this formula then expressed as per 1,000 member months)	Claims data	
	Follow-Up After Discharge from the Emergency Department for Alcohol or Other Drug (AOD) Dependence	NCQA	1. Members who had a follow-up visit to an ED visit with a SUD indicator within 7 days of discharge within the previous rolling 12 months.	Individuals with an ED visit (with SUD indicator) within the previous rolling 12 months	Claims data	
		NCQA	2. Same as above for members who had a follow-up visit within 30 days.	Individuals with an ED visit (with SUD indicator) within the previous rolling 12 months	Claims data	

Driver	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #2: ***Do enrollees who are receiving SUD services experience improved health outcomes?***						
Demonstration Goal #6: Improved access to care for physical health conditions among beneficiaries.						
Evaluation Hypothesis #2.1: The demonstration will increase the percentage of beneficiaries with SUD who experience care for comorbid conditions.						
Primary Driver (Improve access to care for co-morbid physical health conditions among beneficiaries with SUD)	Access to preventive/ ambulatory health services for adult Medicaid beneficiaries with SUD	NCQA	Number of beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period	Number of beneficiaries with a SUD diagnosis	Claims data	Descriptive statistics (frequencies and percentages); chi square tests or t-tests of significance comparing target population in the post-period to the baseline pre-period. ITS in the Summative Eval.
Demonstration Goal #5: Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.						
Evaluation Hypothesis #2.2: Among beneficiaries receiving care for SUD, the demonstration will reduce readmissions to SUD treatment.						
Primary Driver (Reduce readmissions to the same or higher level of care for SUD)	Plan All-Cause Readmissions	CMS-specified	At least one acute unplanned readmission for any diagnosis within 30 days of the date of discharge from the index hospital stay, that is on or between the 2nd day and end of the measurement year	Medicaid beneficiaries age 18 and older with a discharge from an acute inpatient stay on or between January 1 and December 1 of the measurement year	Claims data	Descriptive statistics (frequencies and percentages); chi square tests or t-tests of significance comparing target population in the post-period to the baseline pre-period. ITS in the Summative Eval.
Secondary Driver (Increase the proportion of the SUD population receiving care coordination and supports following discharge from acute care.)	The proportion of beneficiaries with SUD receiving care coordination following discharge from index hospital stay	Burns & Associates	Number of beneficiaries within 30 days of the date of discharge from the SUD-related index hospital stay who received care coordination and supports.	Number of beneficiaries with a SUD-related index hospital stay.	MCO-submitted report with follow-up validation by evaluators	Descriptive statistics (frequencies and percentages)
	Percentage of discharges from inpatient or residential treatment for SUD for Medicaid beneficiaries, ages 18-64, which were followed by a SUD treatment. Two rates are reported, continuity within 7 and 14 days after discharge.	NQF	Number of beneficiaries within 7 and 14 days who received a SUD treatment following discharge from an inpatient or residential SUD provider in a 12-month period.	Number of beneficiaries with an inpatient or residential SUD stay in 12-month period.	Claims data	*Interim Evaluation*: Descriptive statistics (frequencies and percentages); chi square or t-tests of significance comparing target population in the pre- and post-period. *Summative Evaluation*: ITS

Driver	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #3: ***Are rates of opioid-related overdose deaths impacted by the demonstration?***						
Demonstration Goal #3: Reductions in overdose deaths, particularly those due to opioids.						
Evaluation Hypothesis #3.1: The demonstration will decrease the rate of overdose deaths due to opioids.						
Aim (Reduce opioid related overdose deaths)	Use of opioids at high dosage in persons without cancer	NQF #2940	Number of beneficiaries with opioid prescription claims where the morphine equivalent dose for 90 consecutive days or longer is greater than 120 mg	Number of beneficiaries with two or more prescription claims for opioids filled on at least two separate dates, for which the sum of the days' supply is greater than or equal to 15	Claims and administrative data	Descriptive statistics (frequencies and percentages); chi square tests or t-tests of significance comparing target population in the post-period to the baseline pre-period. ITS in the Summative Eval.
	Rate of overdose deaths, specifically overdose deaths due to any opioid	Burns & Associates	Number of overdose deaths per month and per year	Total number of beneficiary member months (result of this formula then expressed as per 1,000 member months)	Vital statistics, claims data	Descriptive statistics (frequencies and percentages); chi square tests or t-tests of significance comparing target population in the post-period to the baseline pre-period. ITS in the Summative Eval.
	Concurrent use of opioids and benzodiazepines	PQA	Number of beneficiaries with concurrent use of prescription opioids and benzodiazepines	Number of beneficiaries with two or more prescription claims for opioids filled on two or more separate days, for which the sum of the supply is 15 or more days	Claims data	Descriptive statistics (frequencies and percentages); chi square tests or t-tests of significance comparing target population in the post-period to the baseline pre-period. ITS in the Summative Eval.

Driver	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question #4: ***Do activities post-implementation increase the use of Delaware's Prescription Drug Monitoring Program?***						
Demonstration Goal #1: Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.						
Evaluation Hypothesis #4.1: The demonstration will increase or maintain the use of Delaware's PDMP.						
Primary Driver (Increase the rates of initiation and engagement for OUD and other SUDs)	Number of clinicians accessing the PDMP	Burns & Associates	Number of clinicians accessing the PDMP monthly	N/A	PDMP data	Descriptive statistics (frequencies and percentages)
	Number of queries to the PDMP	Burns & Associates	Number of queries accessing the PDMP monthly	N/A	PDMP data	Descriptive statistics (frequencies and percentages)
Evaluation Question #5: How d*oes the demonstration impact cost?*						
Evaluation Hypothesis #5.1: The demonstration will decrease or maintain per beneficiary per month costs.						
All	Per beneficiary per month costs in total and by categories of service in the SUD population	CMS-specified	Total monthly costs for SUD beneficiaries. Categories include inpatient, outpatient, pharmacy, long term care, IMDs and other.	1. Total member months for beneficiaries with an SUD diagnosis. 2. Total member months for all enrolled beneficiaries.	Claims data	Descriptive statistics; chi square tests or t-tests of significance comparing target population in pre- and post-period. ITS in the Summative Eval.
Evaluation Hypothesis #5.2: The demonstration will increase or maintain per beneficiary per month costs for SUD services.						
All	Per beneficiary per month costs for SUD services, IMDs, and non-SUD services in the SUD population	CMS-specified	Total costs for SUD beneficiaries. Categories include SUD-IMDs, other SUD, non-SUD.	1. Total member months for beneficiaries with an SUD diagnosis. 2. Total member months for all enrolled beneficiaries.	Claims data	Descriptive statistics; chi square tests or t-tests of significance comparing target population in pre- and post-period. ITS in the Summative Eval.
Evaluation Hypothesis #5.3: The demonstration will decrease or maintain per beneficiary costs for SUD-related ED visits and inpatient stays.						
All	Per beneficiary per month costs in total SUD treatment costs, by categories of services in the SUD population	CMS-specified	Total costs for SUD treatment. Categories include inpatient, ED visits, non-ED outpatient, pharmacy and long term care.	1. Total member months for beneficiaries with an SUD diagnosis. 2. Total member months for all enrolled beneficiaries.	Claims data	Descriptive statistics; chi square tests or t-tests of significance comparing target population in pre- and post-period. ITS in the Summative Eval.

SECTION IV: METHODOLOGICAL LIMITATIONS

There are inherent limitations to both the study design and its specific application to the SUD waiver evaluation. That being said, the proposed design is feasible and is a rational explanatory framework for evaluating the impact of the SUD waiver on the SUD population. Moreover, to fill gaps left by the limitations of this study design, a limited number of qualitative methods are proposed to provide a more holistic and comprehensive evaluation.

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

While CMS may prefer comparator group from another state, in the last two years, the proliferation of the SUD waiver authority across the country renders few comparable states to Delaware. Moreover, this would require significantly more resources and cooperation with another state on sharing data. Therefore, B&A is recommending using statistical tests comparing the pre- and post-waiver period to test hypotheses in the absence of a control group.

Another limitation is the length of time of the evaluation period. In some cases, the time period may be insufficient to observe descriptive or statically significant differences in outcomes in the SUD population. Therefore, it is expected that not all outcomes included in the study will show a demonstrable change descriptively, although we do expect some process measures to show a change during this time frame.

Moreover, with any study focused on the SUD population and potentially rare outcome measures, such as overdose rates, insufficient statistical power to detect a difference is a concern. For any observational studies, especially if the exposures and the outcomes being assessed are rare, it is difficult to find statistically significant results. It is not unexpected, therefore, that many of the outcome measure sample sizes will be too small to observe statistically significant results.

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

Section V, Special Considerations, will summarize the unique challenges in this study

SECTION V: SPECIAL METHODOLOGICAL CONSIDERATIONS

Delaware's SUD waiver is new. There are no identified implementation delays or any other outstanding concerns. Therefore, the proposed Evaluation Design Plan provides more than adequate rigor in the observational study design, especially when considering the range of supplemental evaluation methods proposed for inclusion. As described in detail in Section IV, Methodological Limitations, the study mitigates known limitations to the extent feasible drawing upon the range of options to fill gaps in the observational study design. Moreover, this Evaluation Design Plan is consistent with, and expands upon, CMS approved 1115 demonstration waiver SUD evaluation plans available on the CMS State Waivers List.[17]

An important special consideration in Delaware is the narrow focus of the SUD waiver and the State's above average performance on some metrics when compared to other states. Given the sophistication of Delaware's SUD system in the pre-waiver period compared to other states, there may be less room for improvement and, hence, less demonstrable changes in some metrics. For example, Delaware already adopted the use of ASAM criteria and other SUD system improvements in the pre-waiver period.

Also, observed changes in outcome metrics in the current waiver period will be difficult, if not impossible, to attribute to one specific demonstration component or activities outside the demonstration itself but occurring simultaneously (e.g., activities supported through federal grants) given the interrelationship of the components themselves. For many outcome measures, changes in the post-waiver period will be difficult, if not impossible, to attribute to coinciding related activities resulting from the combination of waiver, planning grant, and START initiative activities. Therefore, it will be important to use statistical tests of significance so that findings are properly put into context.

Lastly, the evaluators recognize that the utilization patterns that will occur relatively early in this demonstration period will be severely disrupted due to the COVID-19 pandemic. The predictability of future utilization patterns remains uncertain as of the date of this document. The evaluators are prepared to work with CMS in the event that guidance is provided to states for all waiver evaluations as to options that CMS will offer with respect to how to account for the acute period of the pandemic. The initial plan for handling COVID-19 effects are addressed in Section III. Methodology.

[17] Medicaid State Waivers List can be accessed at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html

ATTACHMENT A: INDEPENDENT EVALUATOR

Process

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

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

Vendor Qualifications

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

Assuring Independence

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

ATTACHMENT B: EVALUATION BUDGET

As part of the procurement process, Burns & Associates, a Division of HMA, (B&A) was required to submit a cost proposal that presents the level of effort to complete all deliverables associated with the independent evaluation of Delaware's SUD waiver. The DMMA asked B&A to propose the level of effort to complete the deliverables due by the independent evaluator as well as the effort to provide technical assistance to compute the metrics due to CMS from the State each quarter as part of waiver updates. Presently, the State only has the authority to contract with B&A through February 28, 2022, and there are deliverables due to CMS after February 28, 2022 which are reflected in the evaluation budget.

In an effort to show the complete level of effort that would be proposed to complete all deliverables, Exhibit B.1 Proposed Hours for SUD Waiver Evaluation found on page B-2 enumerates the proposed staffing and level of effort by labor category for each component of the evaluation. Likewise, Exhibit B.2 Proposed Costs for SUD Waiver Evaluation as found on page B-3 summarizes the total amount to complete all deliverables associated with the independent evaluation for each deliverable due to CMS. The total estimated cost for the independent evaluation of Delaware's SUD Demonstration Waiver is $1,688,220 to complete all deliverables through June 30, 2025.

EXHIBIT B.1 PROPOSED HOURS FOR SUD WAIVER EVALUATION							
Mark Podrazik	Kara Suter	Debbie Saxe	Ryan Sandhaus	Shawn Stack	Akhilesh Pasupulati	Barry Smith	TOTAL
Project Director	Project Informatics	Project Manager	Statistician	Senior Consultant	SAS Programmer	Consultant	
749	2,028	834	2,767	154	112	734	7,378

Task	Task Name							
SECTION A: PROJECT MANAGEMENT		**138**	**97**	**170**	**263**	**26**	**0**	**8**	**702**
1	Kickoff Meeting	10	12	12	6	0	0	0	40
2	Project Management	90	36	158	26	26	0	0	336
3	Obtain and Read in Data for Project	38	49	0	231	0	0	8	326
SECTION B: MONITORING ACTIVITIES		**177**	**902**	**256**	**1914**	**0**	**0**	**438**	**3687**
4	Build and Maintain Data Warehouse for Project	16	64	0	136	0	0	20	236
5	Produce Monitoring Protocol	17	92	26	12	0	0	2	149
6	Create Monitoring Reports	144	746	230	1766	0	0	416	3302
	One-time activities	*16*	*42*	*6*	*38*	*0*	*0*	*0*	*102*
	Ongoing activities each quarter	*128*	*704*	*224*	*1728*	*0*	*0*	*416*	*3200*
SECTION C: EVALUATION ACTIVITIES		**434**	**1029**	**408**	**590**	**128**	**112**	**288**	**2989**
7	Develop Evaluation Design	21	124	33	30	0	0	0	208
8	Produce Mid Point Assessment	176	175	135	76	86	44	110	802
9	Prepare Interim Evaluation	96	372	89	256	0	68	98	979
10	Prepare Summative Evaluation	141	358	151	228	42	0	80	1000

PROPOSED COSTS FOR SUD WAIVER EVALUATION							
Mark Podrazik	Kara Suter	Debbie Saxe	Ryan Sandhaus	Shawn Stack	Akhilesh Pasupulati	Barry Smith	TOTAL
Project Director	Project Informatics	Project Manager	Statistician	Senior Consultant	SAS Programmer	Consultant	
$250.00	$230.00	$230.00	$230.00	$230.00	$215.00	$200.00	
$187,250	$466,440	$191,820	$636,410	$35,420	$24,080	$146,800	$1,688,220

Task	Task Name							
SECTION A: PROJECT MANAGEMENT		**$34,500**	**$22,310**	**$39,100**	**$60,490**	**$5,980**	**$0**	**$1,600**	**$163,980**
1	Kickoff Meeting	$2,500	$2,760	$2,760	$1,380	$0	$0	$0	$9,400
2	Project Management	$22,500	$8,280	$36,340	$5,980	$5,980	$0	$0	$79,080
3	Obtain and Read in Data for Project	$9,500	$11,270	$0	$53,130	$0	$0	$1,600	$75,500
SECTION B: MONITORING ACTIVITIES		**$44,250**	**$207,460**	**$58,880**	**$440,220**	**$0**	**$0**	**$87,600**	**$838,410**
4	Build and Maintain Data Warehouse for Project	$4,000	$14,720	$0	$31,280	$0	$0	$4,000	$54,000
5	Produce Monitoring Protocol	$4,250	$21,160	$5,980	$2,760	$0	$0	$400	$34,550
6	Create Monitoring Reports	$36,000	$171,580	$52,900	$406,180	$0	$0	$83,200	$749,860
	One-time activities	*$4,000*	*$9,660*	*$1,380*	*$8,740*	*$0*	*$0*	*$0*	*$23,780*
	Ongoing activities each quarter	*$32,000*	*$161,920*	*$51,520*	*$397,440*	*$0*	*$0*	*$83,200*	*$726,080*
SECTION C: EVALUATION ACTIVITIES		**$108,500**	**$236,670**	**$93,840**	**$135,700**	**$29,440**	**$24,080**	**$57,600**	**$685,830**
7	Develop Evaluation Design	$5,250	$28,520	$7,590	$6,900	$0	$0	$0	$48,260
8	Produce Mid Point Assessment	$44,000	$40,250	$31,050	$17,480	$19,780	$9,460	$22,000	$184,020
9	Prepare Interim Evaluation	$24,000	$85,560	$20,470	$58,880	$0	$14,620	$19,600	$223,130
10	Prepare Summative Evaluation	$35,250	$82,340	$34,730	$52,440	$9,660	$0	$16,000	$230,420

ATTACHMENT C: TIMELINE AND MILESTONES

As part of the procurement process, Burns & Associates (B&A) was required to submit a work plan, including major tasks and milestones, to complete the entire scope of work. Presently, the State only has the authority to contract with B&A through February 28, 2022. There are deliverables due to CMS after February 28, 2022. In an effort to show the complete level of effort that would be proposed to complete all deliverables, B&A is showing a work plan that covers the entire evaluation period.

B&A has built a work plan that is constructed around the development of each deliverable identified as part of CMS required deliverables and the State's obligations related to monitoring and evaluation (M&E) activities. A summary of the work plan is shown beginning on the next page. Tasks are further detailed out by sub-task for internal tracking as well. Tasks are scheduled out by month.

The main sections of the work plan are as follows:

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

- Section B, ***Monitoring Activities***, includes Tasks 4, 5 and 6. It is anticipated that the work in this section will start immediately upon contract execution and continue until March 31, 2024.
    - Deliverable in this section:
        - Creation and maintenance of the analytic data warehouse specific to this project
        - Final Monitoring Protocol (April 30, 2020)
        - Quarterly/Annual Reports to CMS, in particular completion of CMS SUD Monitoring Reports Part A and B.
            - Quarterly reports due 60 days after each demonstration quarter
            - Annual reports due 90 days after each demonstration quarter
            - 16 deliverables in all—6 for quarters Q42020 – Q12022, then 10 additional quarters after this time period

- Section C, ***Evaluation Activities***, includes Task 7 through 10. It is expected that the work in this section will start immediately upon contract execution and continue until June 30, 2025.
    - Deliverable in this section:
        - Evaluation Design (Draft due May 15, 2020, Final due May 31, 2020)
        - Draft Version of Mid-Point Assessment (November 15, 2021)
        - Final Version of Mid-Point Assessment (December 31, 2021)
        - Detailed outline of the Interim Evaluation (August 31, 2022)
        - Draft Version of Interim Evaluation (November 30, 2022)
        - Final Version of Interim Evaluation (December 31, 2022)
        - Detailed outline of the Summative Evaluation (December 31, 2024)
        - Draft Version of Summative Evaluation (May 15, 2025)
        - Final Version of Summative Evaluation (June 30, 2025)

Attachment C – Budget Neutrality Spreadsheets

Reserved for budget neutrality Excel spreadsheets.