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Diamond State Health Plan

Section 1115 2022 1st Quarterly Report

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

Federal Fiscal Quarter 2: January 1 – March 31, 2022

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Introduction

Delaware's Diamond State Health Plan (DSHP) 1115 Demonstration Waiver was initially approved in 1995, and implemented beginning on January 1, 1996. The original goal of the demonstration was to improve the health status of low-income Delawareans by expanding access to healthcare to more individuals throughout the State; creating and maintaining a managed care delivery system with an emphasis on primary care; and controlling the growth of healthcare expenditures for the Medicaid population. The DSHP 1115 Demonstration was designed to mandatorily enroll eligible Medicaid recipients into managed care organizations (MCOs) and create cost efficiencies in the Medicaid program that could be used to expand coverage. Delaware achieved its objective of implementation of mandatory managed care focused on primary care in 1996 and invested the resulting waiver savings in Delaware's Medicaid eligibility coverage expansion to uninsured adults up to 100% of the federal poverty level (FPL). Long before Medicaid expansion under the Affordable Care Act, Delaware was a pioneer in coverage expansion for individuals who would otherwise not be eligible for Medicaid. Delaware built upon this success with the eventual expansion of coverage for family planning services, leading up to participating in Medicaid expansion under the Affordable Care Act (ACA) in 2014.

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

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

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

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

Additionally, this amendment expanded HCBS to include:

(1) cost-effective and medically necessary home modifications;
(2) chore services; and
(3) home-delivered meals.

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

The demonstration was amended in 2014 to authorize coverage for enhanced behavioral health services and supports for targeted Medicaid beneficiaries through a voluntary program called Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) starting in 2015. PROMISE enrollees include Medicaid beneficiaries who have a severe and persistent mental illness (SPMI) and/or a substance use disorder (SUD) and require HCBS to live and work in integrated settings.

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

In July 2019, the demonstration was extended for an additional five years and an amendment approved to provide the state with authority to provide high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD).

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

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

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

- Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTSS services where appropriate;
- Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles;
- Improving overall health status and quality of life of individuals enrolled in PROMISE;
- Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population;
- Increasing enrollee access and utilization of appropriate SUD treatment services; decrease use of medically inappropriate and avoidable high-cost emergency and hospital services; increase initiation of follow-up SUD treatment after emergency department discharge; and reduce SUD readmission rates; and
- Increasing access to dental services; decrease the percent of emergency department visits for non-traumatic dental conditions in adults; increase follow up with dentists after an emergency department visit for non-traumatic dental conditions in adults; and increase the number of adults with diabetes who receive an oral exam annually.

The DSHP demonstration includes five distinct components: 1) The DSHP Medicaid managed care program provides Medicaid state plan benefits through a comprehensive managed care delivery system to most recipients eligible under the state plan; 2) The DSHP Plus program provides long-term care services and supports (LTSS) to certain individuals under the State Plan, and to certain demonstration populations; 3) The PROMISE program provides enhanced behavioral health services fee-for-service (FFS) to Medicaid beneficiaries with a higher level of behavioral health needs and functional limitations who need HCBS to live and work in integrated settings; 4) Coverage for former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care at age 18 (or such higher age as elected by the state), were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid; and 5) Coverage for high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as IMDs.

In accordance with the STCs of the DSHP 1115 demonstration, the Delaware Division of Medicaid and Medical Assistance submits this first quarter report (for the quarter ending March 31, 2022) Demonstration Year 27.

Enrollment Information and Enrollment Counts

2022 Q1 Enrollment

Demonstration Populations	Current Enrollees (to date)	Disenrolled in Current Quarter
Population 1: Former AFDC Children less than 21 (DSHP TANF Children)	103,927	10
Population 2: Former AFDC Adults aged 21and over (DSHP TANF Adult)	39,120	18
Population 3: Disabled Children less than 21 (DSHP SSI Children)	5,685	3
Population 4: Aged and Disabled Adults 21 and older (DSHP SSI Adults)	6,541	25
Population 5: Infants less than one year of age with income levels above 185 percent FPL through 200 percent FPL; optional targeted low income children (DSHP MCHIP)	N/A	N/A
Population 6: Uninsured Adults up to 100% FPL (DSHP Exp. Pop.)	76,624	152
Population 7: Family Planning Expansion (FP Expansion)	None; program terminated in 2013	N/A
Population 8: DSHP-Plus State Plan	10,107	186
Population 9: DSHP-Plus HCBS	6,083	154
Population 10: DSHP TEFRA-Like	299	0
Population 11: Newly Eligible Group	14,962	20
Population 12: PROMISE	1,425	76
Population 13: Former Foster Care Youth	0	0

Definition: "Current Enrollees (to date) is an unduplicated count of clients in the MCO for at least one day in the January 1, 2022 to March 31, 2022 period based on capitation claims and for the MC and PROMISE enrollment and eligibility files. Clients who were in more than one eligibility category during the quarter are reported based on their last status (most recent month). Age calculated as of the first day of the most recent month of enrollment, consistent with reporting of member months.

Outreach and Innovative Activities

2022 Q1 MCO and State Outreach Events, Special Topic Meetings and Workgroups

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

MCO Outreach – The MCOs were mostly virtual during Q1due to the COVID-19 pandemic surge. Below are examples of outreach conducted during Q1 by DMMA's MCO partners.

Highmark Health Options (HHO) Q1 Outreach Events

- January and February 2022 - Highmark Health Options participated in two Covid-19 Vaccine clinics at Kingswood Community Center, Wilmington, DE.

- February 22, 2022, Highmark Health Options participated in a food distribution event in Milford, DE. Highmark Health Options sent out postcards to their members residing in the surrounding zip codes. Highmark Health Options staff volunteered on the day of the event. They distributed food to 44 of their members.

AmeriHealth Caritas Delaware (ACDE) Outreach Events

- ACDE held several New Member Orientations in a variety of locations through out the State. They discussed member benefits and explained how to access services and ask questions to get the most out of their health benefits. ACDE reached 71 new members during Q1.

- On March 27, 2022, AmeriHealth Caritas participated in the Harper's Heart 1000 Diaper Giveaway, helping to distribute diapers and supplies to families in the Wilmington area. AmeriHealth was able to meet with 24 of their members during the event and provide information on a variety of health topics, including pregnancy and caring for a new baby.

DMMA Special Interest Meetings/Conferences

Delaware Family Voices – DMMA continues to support Delaware Family Voices. Caring for children with special needs is often complex, and Delaware Family Voices and the Family to Family Health Information Center is in the unique position to help. This organization states that "We help families of children with special needs become informed, experienced, and self-sufficient advocates for their children and themselves." DMMA and our MCOs participate in these monthly calls assisting families to navigate the complex healthcare field. There were three monthly calls this quarter: January 11th,

February 8th, March 8, 2022. DMMA stays in regular contact with Delaware Family Voices outside of scheduled calls to assist any Medicaid family in need.

Maternal Child Health – DMMA continues to prioritize efforts to improve maternal and child health outcomes. The findings from the Maternal Health Focus Study in Q4 were followed up in Q1. DMMA partnered with the EQRO to offer technical assistance to our MCOs to address opportunities for improvement in the maternal care coordination program. The MCH Workgroup continues to work on policy changes including postpartum expansion coverage, evidence-based home visiting, and doula coverage. In Q1, DMMA published its updated breast pump policy. This updated policy helps to ensure more equitable access to breast pumps for our members. DMMA continues to meet with doula stakeholders for their feedback on a Medicaid doula benefit design.

Through SUPPORT grant funds, DMMA offered SAMHSA's "Clinical Guidance Training for Treating Pregnant and Parenting People with Opioid Use Disorder and their Infants" in Q1. There were over 300 registrants for the training. This training was part of our ongoing work to improve the system of care for pregnant and postpartum people with substance use disorder. These efforts are part of DMMA's collaborative partnerships between DHSS Divisions, including DSAMH and DPH.

2022 Q1 Innovative Activities

Social Determinants of Health (SDOH) – In Q1, DMMA continued focusing on food insecurity in Medicaid resulting from the COVID-19 PHE. The postpartum Food Box Partnership Program continues to see an increased need for food box deliveries in Q1. An average of 320 boxes per week were delivered in Q1. This unique program is offered to our postpartum members less than 8 weeks postpartum. Members are also offered diapers and wipes to be included with their food box deliveries.

Operational/Policy Developments/Issues

Policy and Legislative developments

In Q1, DMMA continued seeking public input and developing policy initiatives, such as pediatric respite and direct service provider recruitment and retention payments, to be included in Delaware's Section 9817 HCBS Spending Plan.

DMMA Operational Issues

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

In Q1, DMMA continued its efforts to prepare for "unwinding" Medicaid activities related to the COVID-19 PHE, including planning for eligibility redeterminations after the maintenance of eligibility

period ends.

DSHP 1115 Waiver Administration

In Q1, DMMA began developing an amendment to the DSHP 1115 waiver that will be submitted to CMS in July 2022.

Other Program Issues

SUPPORT Act Planning Grant and Demonstration Project - DMMA is now operating two SUPPORT Act initiatives -- the SUPPORT Act Planning Grant and SUPPORT Act Demonstration Project. During the January to March 2022 period, DMMA convened a conference (February 22 and February 24) on Clinical Guidance in Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants; participated in planning sessions with our sister agency -- the Division of Substance Abuse and Mental Health -- to launch a medications for opioid use disorder (MOUD) ECHO; and presented a "Medicaid 101" presentation to stakeholders at the State Opioid Response conference (March 30). DMMA also continued progress on other deliverables, such as their long-term SUD/OUD prevalence and workforce surveillance system, SUD data dashboards, and revisions to key other MOUD policy documents. Finally, DMMA developed preliminary rate SUD services models and introduced those models and associated assumptions to providers in a webinar on January 26.

Electronic Visit Verification – DMMA is working with our EVV vendor, Sandata, to implement a pilot with a few selected vendors in September 2022 with go live at the end of December 2022.

Program Integrity – In Q1, the Surveillance and Utilization Review Unit (SUR) worked diligently to identify, correct, and prevent fraud waste and abuse in the Delaware Medicaid Program. These efforts included continuing to identify ways to analyze Managed Care Organization (MCO) encounter data to ensure proper payment of claims. The SUR unit has completed two post payment Chiropractor reviews. IBM will be providing ongoing statistician services and analytical guidance to the SUR team. The unit worked diligently to train new staff members, including two new Management Analysts and Medicaid Surveillance Administrator. SUR is in the process of hiring two new Auditors and a Registered Nurse reviewer.

The SUR team used various data mining strategies to guide the post payment auditing and review efforts of the unit. Recent data mining projects have focused on chiropractic services, pharmacy claims and private duty nursing/personal care claims. The SUR management analysts collaborate regularly with both the MCO's and the Medicaid Fraud Control Unit (MFCU) to ensure that efforts are not duplicative but remain effective for fighting fraud. The SUR continues to strengthen its relationship with DMMA's NEMT provider, Modivcare, by facilitating monthly collaborative meetings designed to discuss areas of the program that may be vulnerable to fraud, waste, or abuse.

The Program Integrity section is working closely with SafeGuard Services LLC (NE UPIC contractor) to identify areas within the Delaware Medicaid program which may be vulnerable to fraud, waste, or abuse. Recent efforts have centered around genetic testing. Initial results showed little to no findings in

the areas of duplicate billing for the same recipient. SGS will continue reviewing the top billing providers for medical necessity and policy compliance.

The SUR dedicates a significant portion of its time overseeing the PERM audit. To date, all required data has been submitted to the PERM contractors. Initial results from the Q4 data have been positive so far. SUR will continue to work with the various PERM contractors to provide any additional data and to answer any questions that arise throughout the PERM cycle.

Throughout 2022, the Program Integrity section maintained its practice of holding monthly meetings with each MCO, as well as the joint quarterly sessions held in conjunction with our MFCU. This practice continues to be effective in identifying unusual billing patterns and provider misconduct within the Medicaid program. This collaborative approach is also helping to ease the transition of auditing encounter data, as MCO input is essential to the success of this effort.

Expenditure Containment Initiatives

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

No new activities in Q1. DHSS developed a Medicaid ACO Program for the purpose of improving health outcomes while reducing costs through value based purchasing (VBP) arrangements that include downside financial risk for ACOs. The Medicaid ACO program continues to be one of the strategies DMMA is pursuing to advance the adoption of participating Medicaid VBP models and total cost of care (TCOC) strategies. In 2019, DMMA developed an application allowing qualified provider organizations to apply to become Medicaid ACOs and subsequently contract directly with our Medicaid managed care organizations (MCOs) in a TCOC payment arrangement. The initial application cycle ended in 2020 and four Medicaid ACOs were approved. The MCO/ACO contracts will begin July 1, 2021. The inaugural group of Medicaid ACOs are authorized through December 31, 2024. In 2021, DMMA completed its work to add an additional Medicaid ACO for CY 2022 participation.

Financial/Budget Neutrality Development/Issues

2022 Q1 Monthly Member Months

Eligibility Group	Jan 2022 Member Months	Feb 2022 Member Months	Mar 2022 Member Months	Quarter ending 03/31/2022
DSHP TANF CHILDREN	101,530	101,893	102,023	305,446
DSHP TANF ADULT	37,622	37,915	38,099	113,636
DSHP SSI CHILDREN	5,584	5,590	5,571	16,745
DSHP SSI ADULTS	6,403	6,393	6,371	19,167
DSHP MCHP (Title XIX match)*	0	0	0	0
DSHP ADULT GROUP	87,408	88,191	88,960	264,559
DSHP-Plus State Plan	9,988	9,889	9,832	29,709
DSHP-Plus HCBS	5,932	5,939	5,993	17,864
DSHP TEFRA-Like**	294	294	293	881
PROMISE	1,418	1,395	1,330	4,143

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

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

2022 Q1 Member Months and WW PMPMs

Eligibility Group	Total Member Months for the Quarter	PMPM	Total Expenditures
DSHP TANF CHILDREN	305,446	$370.00	$113,014,720
DSHP TANF ADULT	113,636	$626.95	$71,243,622
DSHP SSI CHILDREN	16,745	$2,062.01	$34,528,437
DSHP SSI ADULTS	19,167	$1,762.03	$33,772,813
DSHP MCHP (Title XIX match)*	0	$0.00	
DSHP ADULT GROUP	264,559	$752.99	$199,209,272
DSHP-Plus State Plan	29,709	$1,400.15	$41,596,952
DSHP-Plus HCBS	17,864	$6,359.60	$113,607,976
DSHP TEFRA-Like**	881	$2,062.75	$1,817,286
PROMISE	4,143	$169.70	$703,053

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

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

Financial/Budget Neutrality/Issues

DMMA completed its reconciliation analysis and presented our findings to CMS in November 2021. DMMA met with CMS to provide an overview of the major issues identified, the process used to identify the issues, and the impact on budget neutrality for the demonstration period covering CY 2014 through 2018. DMMA scheduled several follow up meetings with CMS to walk through each DY and

each adjustment to document the reconciliation process and to seek guidance from CMS on any adjustments within the financial reporting system (MBES/CBES) to address the reporting issues. DMMA has determined that the DSHP 1115 Waiver had a budget neutrality margin of $834 million dollars.

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

Quality Assurance/Monitoring Activity

2022 Q1 Quality Assurance/Monitoring Activity

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

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

QII Activity – During Q1:

- DMMA actively participated in multiple opportunities for technical assistance and cross-state learning with CMS, Mathematica and AcademyHealth, including:
    - CMS QTAG: January 19, 2022 – CMCS's Strategic Vision and Priorities for 2022
    - MAC QX: January 27, 2022 – How Do You Measure the Quality of Telehealth Services in Medicaid and CHIP?
    - CMS QTAG: February 16, 2022 - Promoting Quality Measurement and Improvement of Care Provided to Dually Eligible Individuals
    - MAC QX: February 24, 2022 - Promoting Whole-Person Care in Medicaid and CHIP: Implications for Quality Measurement and Improvement

- CMS QTAG: March 16, 2022 - Overview of the Colorectal Cancer Screening (COL)

The Quality Improvement Initiative (QII) Task Force held the quarterly meeting on January 27, 2022. DMMA invited Atnre Alleyne, founder of The Proximity Project to present on Health Equity. His presentation, titled, "The Power of Proximity in Healthcare," included;

- Activities Leaders can do now to take organizational Justice, Equity, Diversity, and Inclusion to the next level
- Minority Experiences in the Healthcare System
- Diversity vs Leadership Proximity
- An Introduction to "The Proximity Project"

Case Management Oversight – The MCOs submit weekly telephonic case management files for the DMMA clinical staff to review. DMMA clinical staff reviewed approximately 803 telephonic/virtual reviews in Q1 2022, which is a combination of Care Coordination, LTSS case management and Nursing Facility. Each MCO receives a quarterly report and DMMA meets with each MCO to go over review findings and areas identified needing improvement to meet contractual standards.

In Q1 2022, DMMA's oversite team completed Q4, 2021 case file reviews with each MCO virtually. DMMA staff reviewed approximately 100 random files for contractual compliance of the MCO's in areas of Care Coordination, Case Management and Nursing Facility Transitions. DMMA reviews the findings with each MCO and discusses areas needing improvement in Care Coordination and LTSS Case Management for our Medicaid population.

DMMA/MCO Managed Care Meetings - The Bi-Monthly Managed Care meetings are a forum to discuss issues in a collaborative manner. The meetings are used to collaborate on common practices, identify issues, plan resolutions and establish connections to our sister agencies for coordination of care. March 8, 2022, DMMA had a joint meeting with both MCOs and our Long Term Care Operations Unit to discuss common issues. We discussed PASRR rules and the need for PASRRs to be completed prior to nursing home admission.

Q1 Incident Management System - DMMA continued the review and development of the work plan to operationalize improvement recommendations for the incident management system process for DSHP and DSHP-Plus. The Quality unit continues to intake, track and facilitate the reporting of Critical Incidents into the department using the current technology solutions.

DMMA continues to be looking for a software/database solution that will allow the department to address recommendations and improvements identified after reviewing the current process and system being utilized. One of the central focuses is to improve reporting capabilities and align DMMA systems with our sister agencies in DHSS. DMMA intends to improve this reporting as an HCBS Spending Plan initiative.

2022 Q1 Consumer Issues

HBM (Enrollment Broker) Update – Q1– The HBM continues to support our members, providing information on the two managed care organizations delivering our Medicaid Medical benefit to our members.

Children with Medical Complexity Advisory Council – Q1– The Children with Medical Complexity (CMC) Advisory Committee convened remotely on January 25, 2022. The group reviewed 2021 accomplishments, heard quarterly reports from the Skilled Home Health Nursing Workgroup and the Durable Medical Equipment (DME) and Supplies Workgroup, provided an update on DMMA's private duty nursing workforce capacity study, and reviewed priorities for 2022.

Medical Care Advisory Council (MCAC) – Q1 –The MCAC met on February 16, 2022. Discussion included the status of DMMA's HCBS Spending Plan, SUD Provider Rate study, SUD Prevalence Study EVV update, and the MCO reprocurement.

Managed Care Reporting Requirements

2022 Q1 QCMMR and QCMMR Plus Reporting

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

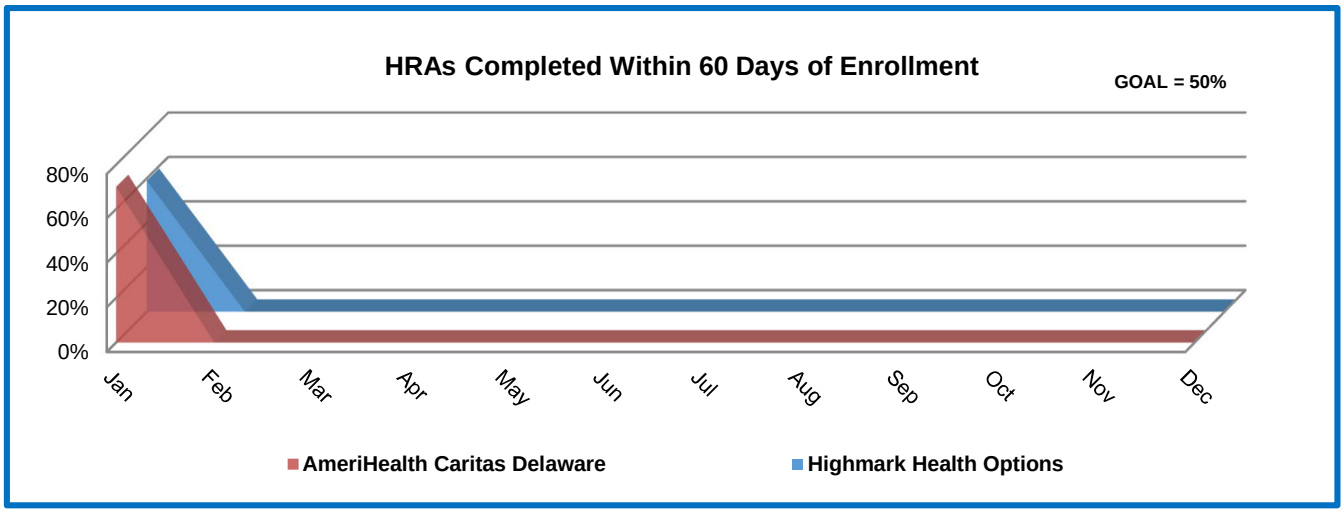
DMMA Managed Care Operations unit developed the full circle approach to the QCMMR and QCMMR Plus reporting. The reports are reviewed by the Managed Care Operations team and an agenda is developed for our monthly meeting with each MCO to discuss the findings from the reports. Manage Care Operation's goal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

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

DMMA is in the process of developing a new format for additional QCMMR data to be reported to CMS as part of the quarterly and annual reports.

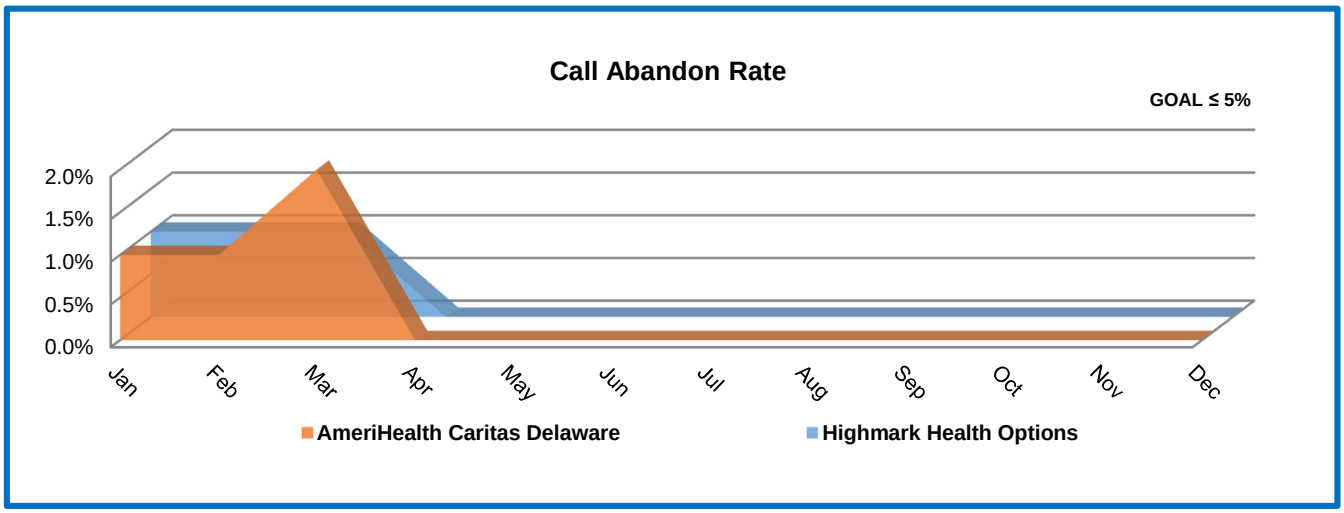
QCMMR Reporting Examples:

Health Risk Assessment (HRA) Completion Rate



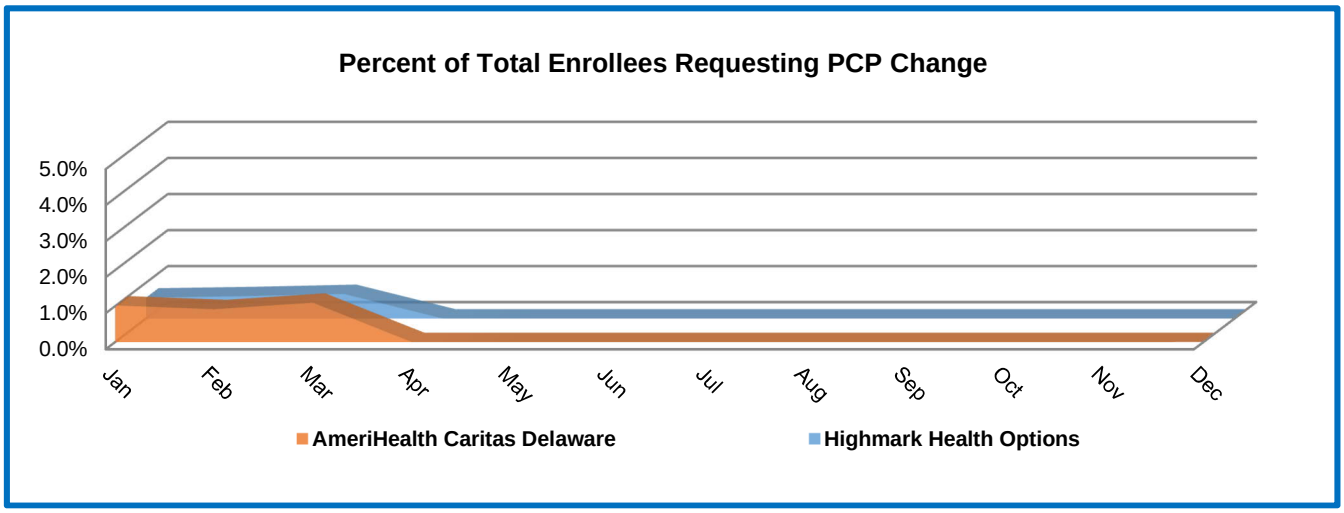
Health risk assessment data are submitted on a 60-day lag. For Q1, the MCOs submitted January 2022 data. Both MCOs exceeded the goal of completing health risk assessments for at least 50% of new Medicaid enrollees within 60 days of enrollment. ACDE reported a rate of 70% completion and HHO reported a rate of 59% completion. This is an increase from the 2021 average reported by ACDE of 33% completion and 48% completion 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 Q1.

Percent of Enrollees Requesting a Change in Primary-Care Provider



Access in Q1 – The MCOs report in alternating quarters on this metric. For Q1, the reporting MCO met the goal of 100% access in 6 of the 20 areas measured (30% compliance). The MCO reported the lowest percentages were in the area of specialty care provider access, both routine and urgent. The MCO reported that all practices that failed were re-educated in March and re-audited. Practices that failed the re-audit are expected to provide a corrective action plan. Reasons for non-compliance in PCP practices included staffing shortages and training while reasons for non-compliance in specialty practices included appointments filling up fast, lack of urgent or emergent appointments, providers not having availability for routine care appointments for several months, as well as calls not being answered and directed to voicemail.

For DSHP Plus, the monthly average number of providers for Home and Community-Based Services (HCBS) are similar with a few exceptions. For Home Health providers, one MCO has a slightly higher monthly average of 76 providers compared to second MCO's monthly average of 30.

Q1 Grievances – For DSHP, there were 267 grievances, up from 228 in Q4. The breakdown across areas is described below:

- Access and availability: 14
- Benefits: 4
- Billing and/or claims: 70
- Cultural competency: 0
- MCO staff issue: 18
- Quality of care: 55
- Quality of service: 79

- Transportation to medical appointment: 14
- Other: 13

For DSHP Plus, there were 148 grievances for Q4, down from 196 in Q4. The breakdown across areas is described below:

- Access and availability: 8
- Benefits: 0
- Billing and/or claims: 15
- Cultural competency: 2
- MCO staff issue: 4
- Quality of care: 28
- Quality of service: 36
- Transportation to medical appointment: 10
- Other: 14
- Case management (HCBS and institutional experience): 31

Q1 Appeals
For DSHP, appeals are documented in the month in which they are filed, and any appeals resolved are marked within the month they are resolved. One MCO reported 29 appeals and the second MCO reported 66 appeals. The number of appeals withdrawn and overturned are higher than those upheld for both MCOs.

For DSHP Plus, appeals are documented in the month in which they are filed, and any appeals resolved should be reported within the month in which they have been resolved. The overall number of appeals is low, with one MCO reporting 5 appeals during Q1 2022 and the second MCO reporting 9 appeals.

Q1 Critical Incident Reporting – For Q1 there were 36 total critical incidents (CIs), up from 30 in Q4. The distribution of CIs heavily concentrates on HCBS versus institutional services. Listed below are the categories for CIs for Q1:

- Unexpected deaths: 8
- Physical, mental, sexual abuse or neglect: 14
- Theft or exploitation: 6
- Severe injury: 4
- Medication error: 0
- Unprofessional provider: 4

Q1 External Quality Review (EQR) Reporting

The EQRO continued to provide technical assistance on DMMA's Quality Strategy and assistance with QCMMR.

Demonstration Evaluation

During Q1, the independent evaluator received and read 2022 monthly extracts. In accordance with the approved Evaluation Design Plan, work continued on the following activities: continue coding for annual established quality measures; update PROMISE focus study analytics; develop Dental Focus Study baseline guide and analytics; and planning for the Interim Evaluation.

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