HMA

HEALTH MANAGEMENT ASSOCIATES

Mid-Point Assessment of Delaware's Section 1115 Substance Use Disorder Demonstration

PREPARED FOR

DELAWARE DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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SECTION A: General Background Information

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 2020 Annual Report, the State's Division of Forensic Science reported a total of 449 deaths from drug and alcohol intoxication, up approximately ten percent from the total of 400 in 2018[1] and up two percent from a total of 438 in 2019.[2] In 2019, Delaware experienced the highest year-over-year percentage increase in drug overdose death rates among states nationally with an increase of 4.2 percent. In 2019, the Centers for Disease Control reported that Delaware ranked 2nd among states nationally for drug overdose deaths per 100,000 population at a rate of 48.0. The national median value was 20.6.[3]

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 1, 2019 through December 31, 2023. As of November 2021, Delaware is one of 32 states to have received approval for SUD demonstrations under this waiver authority.[4]

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 June 30, 2021.

Description of the Demonstration's Policy Goals

Among the 13 goals stated for this demonstration, one of the goals is specific to SUD—namely,

- 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

[1] Division of Forensic Science 2019 Annual Report issued May 7, 2020, page 10, accessed at https://forensics.delaware.gov/resources/contentFolder/pdfs/2019%20DFS%20Annual%20Report.pdf?cache=1637901418152

[2] Division of Forensic Science 2020 Annual Report issued June 29, 2021, page 10, accessed at. https://forensics.delaware.gov/resources/contentFolder/pdfs/2020%20DFS%20Annual%20Report.pdf?cache=1637901152758

[3] State Policy Reports, Federal Funds Information for States, Volume 39, Issue 11, June 2021.

[4] Kaiser Family Foundation Issue Brief https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table5

- to reduce SUD readmission rates. [5]

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:[6]

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.

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 more than 10 years of experience with organizing its system around these principles.

[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

[6] 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

Background on the Delaware Medicaid Program

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.

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 (ACA), Delaware was a pioneer in coverage expansion for individuals who would otherwise not be eligible for Medicaid.

Since the initial approval, the demonstration has been renewed six times. Key changes over the course of these renewals include the following:

- 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.

- 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 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 (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.

- The most recent waiver renewal application provides 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.

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. Nearly one in four Delawareans, or 275,000 citizens, are covered by Medicaid in the state. Enrollment increased by 11.2 percent from the start of the public health emergency (PHE) in March 2020 to January 2021 alone due to the prohibition of disenrollment as mandated by the Families First Coronavirus Response Act.[7] In State Fiscal Year (SFY) 2020, children comprised 38.7 percent of Medicaid enrollees, non-aged or disabled adult 44.4% of enrollees, and the aged and disabled population comprised 16.9 percent of total enrollees.[8]

Delaware's Medicaid program provides access to healthcare through either a traditional fee-for-service (FFS) model and through managed care, but the majority of individuals eligible for Delaware Medicaid (over 86% in any month) are enrolled through one of the State's two risk-based managed care plans under the DSHP or DSHP-Plus benefit plan. The MCOs under contract with DMMA currently are AmeriHealth Caritas Delaware and Highmark Health Options. The current DMMA contract with each MCO has been in place since January 2018.

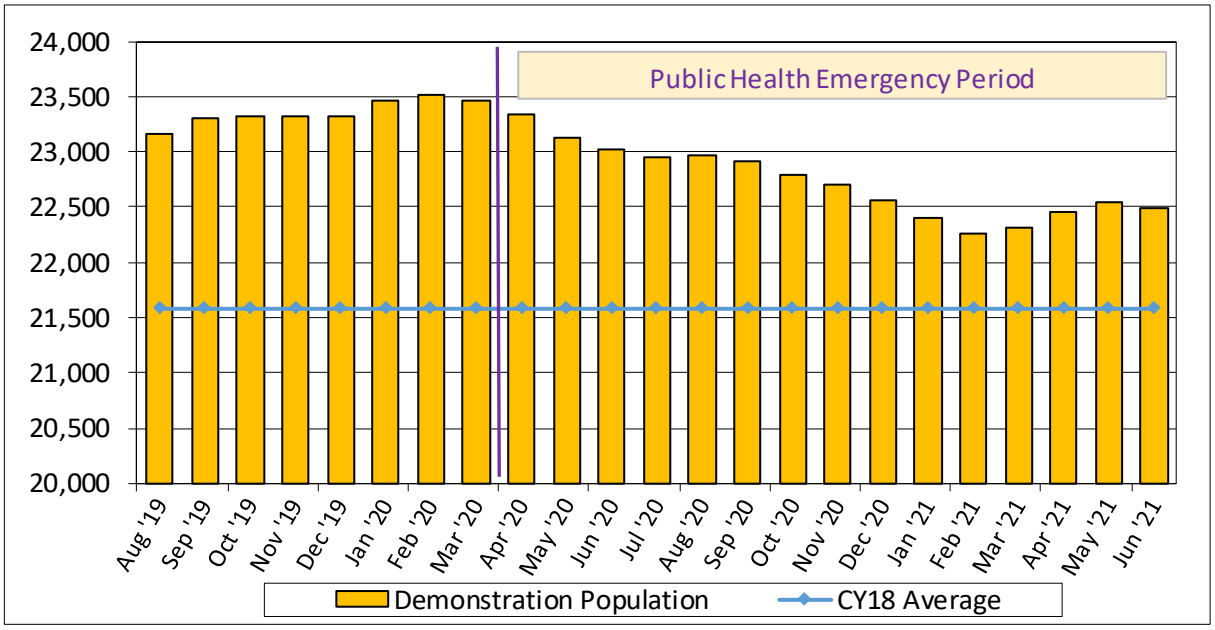
Delaware Medicaid Enrollees with SUD

Since the beginning of the current SUD demonstration period that began in August 2019, between 22,263 and 23,520 Medicaid enrollees have been identified with an SUD each month. Refer to Exhibit A.1 on the next page which details the count of members by month using CMS's SUD Metric #3 specification. The average number of enrollees identified with an SUD in Calendar Year (CY) 2018 was 21,582. With an average total enrollment in excess of 248,000 since the waiver period began, this means that between 8.0 and 9.5 percent of the total Medicaid enrollees have been identified with an SUD each month.

[7] Joint Finance Committee Hearing presentation by Stephen Groff, DMMA Medicaid Director, February 24, 2021 https://legis.delaware.gov/MeetingNotice/22357

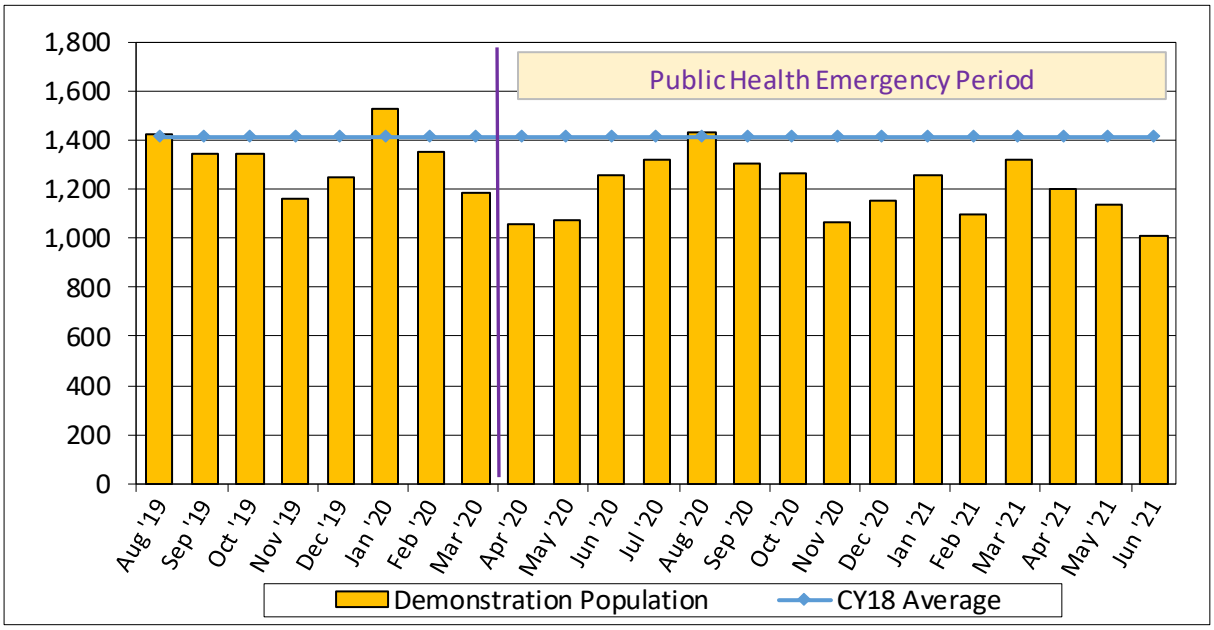
[8] Ibid.

Exhibit A.1
Count of Medicaid Beneficiaries with SUD Diagnosis, by Month
For Demonstration Population As Reported in Quarterly Monitoring Reports to CMS



Since the SUD demonstration period began in August 2019, between 1,010 and 1,525 Medicaid enrollees have been identified with a newly -initiated treatment or diagnosis for an SUD in each month. Exhibit A.2 below details the count of members by month using CMS's SUD Metric #2 specification. The average number of enrollees identified with an SUD in Calendar Year (CY) 2018 was 1,415.

Exhibit A.2
Count of Medicaid Beneficiaries with Newly Initiated SUD Treatment or Diagnosis, by Month
For Demonstration Population As Reported in Quarterly Monitoring Reports to CMS



SECTION B: Methodology Used in Assessment

This section describes the multiple modalities used by the independent assessment team, Burns & Associates, a Division of Health Management Associates (HMA-Burns) to conduct this Mid-Point Assessment of Delaware's SUD waiver demonstration. Data collection and analysis includes secondary sources such as fee-for-service claims, managed care encounters, Medicaid member and Medicaid provider enrollment files from the DMMA's data warehouse. Primary data collection includes information requested from MCOs regarding SUD-related service authorization requests and case management rosters. Qualitative information collection includes interviews with DMMA staff regarding SUD Implementation Plan activities and interviews with MCO and provider representatives. Due to the PHE, individual interviews with Medicaid beneficiaries were curtailed; however, a short survey was released for Medicaid members with SUD to complete on a voluntary basis.

Data Sources

The data sources used to report results in the Findings section are defined in the section below.

Critical Metrics

The information source to compute the metrics defined by and reported to CMS is the same as that used by DMMA to submit its SUD metrics to CMS in its quarterly SUD waiver monitoring report. The HMA-Burns team receives and intakes claim/encounter and enrollment data delivered from the State's Enterprise Data Warehouse (EDW) on a monthly basis. 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.

State-Specific Metrics

As part of the SUD Evaluation Design, the HMA-Burns team proposed metrics related to SUD service authorizations and transitions of care for SUD beneficiaries. These metrics were developed to answer evaluation questions developed in the Evaluation Design.

- Evaluation Question related to service authorizations: *Does the demonstration increase access to and utilization of SUD treatment services?*

  Metrics for examination include (1) Average turnaround time for authorization decisions, (2) Rate of approved and denied authorizations, and (3) Frequency and percentage of denial reason codes. The data source used to conduct this study is information collected directly from the MCOs. The template used to request SUD-related service authorizations from the MCOs appears in **Attachment 1**. The tool used in the review of the sample of service authorization cases appears in **Attachment 2**.

- Evaluation Question related to transitions of care: *Do enrollees who are receiving SUD services experience improved health outcomes?*

  The Metric for examination is the proportion of beneficiaries with SUD receiving care coordination following discharge from index hospital or residential stay. The template used to request case management rosters from the MCOs appears in **Attachment 3**.

Provider Availability Assessment Data

Although the DMMA Provider enrollment file was used as a starting point to assess provider availability, the HMA-Burns team ultimately used actual paid claims and encounters to assess which providers are actually delivering services.

One of the limitations of the DMMA Provider enrollment file is that it does not establish SUD providers as a specific provider type or category. The NPI field was also proven to not always be reliable. Instead, HMA-Burns identified the provider billing IDs attached to claims/encounters for the SUD services identified in CMS's metrics 7 through 12. Individual provider IDs were mapped to a Federal ID (FEIN) number on DMMA's provider file to count the number of unique providers.

Implementation Plan Action Items

HMA-Burns identified all of the items identified in DMMA's SUD Implementation Plan to determine where action had or had not yet been taken on each item. The assessment team conducted a desk review of materials released by DMMA prior to and after the waiver implementation date as well as reports released by DMMA's External Quality Review Organization. After review of these materials, interviews were conducted with key staff at DMMA, including the Medicaid Director, Deputy Director, Managed Care Director, and Chief of Policy and Planning to confirm our assessment of each of the planned implementation activities.

Qualitative Interviews with Key Stakeholders

While there were not fundamental changes to the delivery of SUD services with the introduction of the waiver, the HMA-Burns team collected feedback from a variety of stakeholders to gain perceptions about the implementation of the SUD waiver, as well as their perspectives related to SUD service delivery for Medicaid beneficiaries. All of the feedback was collected through in-person interviews that were conducted remotely via Zoom.

HMA-Burns used the list of the 24 community-based SUD providers developed as part of the SUPPORT Act Grant rate survey to request participation in a one-on-one interview with the assessment team. Additionally, HMA-Burns contacted the Ability Network of Delaware (a provider association) to gather their perspectives and request assistance with contact information for providers. Ultimately, five provider organizations agreed to participate. All interviews were conducted in-person via Zoom and completed between October 22 and November 11, 2021.

Appointments 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 two members. Each provider was sent the same set of questions in advance of their interview. Although the assessors 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. The list of questions sent to providers in advance of each interview appear in **Attachment 4**.

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 14 clients provided feedback.

The list of questions covered in the Medicaid client survey appear in **Attachment 5**.

HMA-Burns conducted one interview session with representatives from both MCOs that contract with DMMA on October 11, 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. The HMA-Burns assessment team members who conducted the provider interviews also conducted the MCO interview. There was equal participation and feedback from the representatives from both MCOs. The list of questions sent to the MCOs in advance of their interview appear in **Attachment 6**.

Analytic Methods

The HMA-Burns team used criteria defined by CMS for computing the critical metrics and our own criteria developed specifically for this assessment for the state-specific metrics. More information on each method, as well as our approach to tabulating stakeholder feedback, is described below.

Critical Metrics

The HMA-Burns team provides technical assistance to the DMMA in the computation of the SUD metrics reported to CMS each quarter. As such, the metrics reported in this Mid-Point Assessment are the same as those reported to CMS in the quarterly reports. It should be noted that, based on the timing of when CMS specifications were released, the results reported may use either Version 3 or Version 4 of CMS's specifications. For the data reported on all CMS-defined annual metrics, the Version 3 specifications were used to report the baseline and Mid-Point period results. For all data reported on CMS-defined monthly measures, the Version 3 specifications were used to report values in the baseline period whereas Version 4 specifications were used to report values in the defined Mid-Point period.

State-specific Metrics

Method to Conduct the Review of SUD Service Authorizations

HMA-Burns included in its study all SUD-related authorization requests for the period September 1, 2019 to February 29, 2020 made to the two MCOs-- AmeriHealth Caritas Delaware (AHCDE) and Highmark Health Options (HHO). The specific SUD services in the study included inpatient, residential treatment, and intensive outpatient services. This data was delivered by the MCOs to the HMA-Burns team, as requested, in the pre-defined Excel format.

The HMA-Burns team conducted a desk review of these service authorizations to tabulate approval and denial rates by MCO/service type as well as the turnaround time to complete the authorization review.

It should be noted that in 2017, state Senate Bill 109 was enacted that guarantees the following scope of services if deemed medically necessary using ASAM criteria:

- Five days for inpatient withdrawal management
- Fourteen days for residential treatment

- Thirty days for intensive outpatient treatment

The intent appeared to be to ensure that there was not a gap in service between an authorization request and approval or denial. Even if an authorization is presumptively approved, however, the provider must still ultimately deliver information to prove medical necessity in order to be paid.

From the total authorization requests provided to HMA-Burns, a sample of 120 authorizations was selected for additional review (60 requests from each MCO). A combination of inpatient, residential treatment, and intensive outpatient requests was sampled that was proportional to each MCO's volume of these requests. By design, denied requests were oversampled such that each MCO had 10 denied requests and 50 approved requests in the sample. Each MCO was given their sample for additional review in advance of completion of the second portion of the study. All 120 cases in the sample were reviewed to verify MCO processes. The non-clinical members of the HMA-Burns team validated elements in each MCO's online authorization database to confirm items such as the disposition of the request, the MCO staff that reviewed and made decisions on the request, and the MCO turnaround time. Among the 120 cases, 34 cases (17 from each MCO) were selected for review by the HMA-Burns clinical representative to provide an opinion if he agreed with the medical necessity determination made by the MCO given the information submitted with the authorization request by the service provider.

The desk review of all SUD service authorizations was conducted in December 2020. The non-clinical review of the sample of 120 cases was conducted in January 2021. The clinical review of the sample of 34 cases was conducted in March 2021.

Method to Conduct the Review of Transitions of Care

HMA-Burns identified specific services received by Delaware Medicaid managed care enrollees which serve as the 'anchor' for the study of transitions of care:

- Individuals with an inpatient hospital stay for any SUD
- Individuals with a residential treatment stay in ASAM levels 3.1, 3.3, 3.5 or 3.7

Using encounters submitted by the MCOs, individuals with one of these anchor services during one of two time periods are included in the study:

- Time Period #1: Dates of service October 1, 2019 – March 31, 2020
- Time Period #2: Dates of service April 1, 2020 – September 30, 2020

If an individual received more than one of the anchor services during the study period, the individual will be counted only once using the anchor service closest to the end of the study time period.

Within each time period, an array of services was examined for each beneficiary individually. Counting from the dates of the anchor service, a beneficiary's service pattern was reviewed for the 12 weeks prior to admission for the inpatient hospital or residential treatment stay and for the 12 weeks after discharge from the inpatient hospital or residential treatment stay. This means that:

- For Time Period #1, services may be reviewed on a person-level basis going back as far as May 2019 and look forward to as late as June 30, 2020.
- For Time Period #2, services may be reviewed on a person-level basis going back as far as December 2019 and look forward to as late as December 31, 2020.

HMA-Burns created a person-specific episode for each member. Each individual was assigned to an MCO. The HMA-Burns team requested case/care management rosters from each MCO for the time period of the study in order to determine the percentage of SUD members enrolled with each MCO that had an anchor event during the study period were enrolled in case or care management with the MCO.

Provider Availability Assessment Data

HMA-Burns mapped the physical location where providers render services and the home address of individual Medicaid beneficiaries to show on a map the Medicaid members who received services within ten miles of their home location. This process was completed for residential SUD treatment and medication-assisted treatment (MAT) for Medicaid clients receiving these services during CY 2020.

Because the FEIN on file may have a provider entity's corporate office assigned and not individual locations where services are rendered, the HMA-Burns team conducted internet research of provider websites and conducted outreach to individual providers regarding the physical location where they render services to Medicaid beneficiaries. This process was completed because there is not a centralized provider service location directory stored.

Stakeholder Feedback Data

After each interview was conducted with the MCOs and each provider, HMA-Burns recorded the qualitative feedback from each meeting. Once all interviews were completed, this feedback was categorized into themes. In total, 15 themes resonated with MCO and provider stakeholders.

The feedback from the beneficiary survey was also captured and identified for themes. Some, but not all, of themes that resonated with MCOs and providers also resonated with beneficiaries. The themes that resonated with beneficiaries among the 15 themes identified were also tracked.

The HMA-Burns team mapped the 15 themes identified to the six milestones set out by the DMMA in its SUD waiver. The number and type of respondents that mentioned each theme in their feedback to the assessment team was summarized in a table.

Assessment of Overall Risk of Not Meeting Milestones

The HMA-Burns team utilized the methodology outlined by CMS in its Mid-Point Assessment Technical Assistance guidance from October 2021 for considering whether Delaware is at risk of not meeting any of its milestones in its SUD demonstration waiver. This criteria is shown in Exhibit B.1 on page 11. Although each element shown in the exhibit was assessed individually, the HMA-Burns team considered the assessment of all factors in totality when making its final assessment related to each milestone that is shown in Section D of this report.

Exhibit B.1
Considerations for Assessing Risk of Not Achieving Each Demonstration Milestone

	Overall Risk of Not Meeting Milestone		
Data Source	**Low**	**Medium**	**High**
Critical Metrics	All or nearly all (>75%) of the critical metrics are trending in the expected direction	Some (25% - 75%) of the critical metrics are trending in the expected direction	**Few (<25%) of the critical metrics are trending in the expected direction**
Implementation Plan Action Items	All or nearly all (>75%) of the action items completed	Some (25% - 75%) of the action items completed	**Few (<25%) of the action items completed**
Stakeholder Feedback	Few stakeholders identified risks; any risks can be easily addressed	Multiple stakeholders identified risks that may cause challenges meeting the milestone	**Stakeholders identified significant risks that may cause challenges meeting milestone**
Provider Availability	SUD provider availability is adequate	SUD provider availability is not yet adequate but is moving in expected direction	**SUD provider availability is not yet adequate and not moving in expected direction**

Limitations

The HMA-Burns assessment team identified two limitations with data sources while conducting this Mid-Point Assessment. Although the limitations of this data does not impact the overall findings of this assessment, evaluation activities will be enhanced in future reporting on Delaware's SUD waiver demonstration once this data becomes available.

- ***Lack of overdose death data***. At this time, the number of overdose deaths annually in Delaware is available from published reports within Delaware's state government. The number and rate of overdose deaths among Medicaid beneficiaries, however, is unknown. The DMMA has coordinated with Vital Statistics in the Department of Public Health to receive cause of death information on Medicaid beneficiaries in order to start reporting these metrics to CMS in the waiver quarterly monitoring report due to CMS on May 31, 2022.
- ***Additional 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. For this Mid-Point Assessment, fill-in surveys were conducted in lieu of interviews online. The evaluators will conduct face-to-face interviews with beneficiaries once the PHE has concluded and report beneficiary feedback in the Interim and Summative Waiver Evaluations.

SECTION C: Findings

The findings from HMA-Burns' assessment of Delaware's SUD demonstration waiver to date is summarized in five components:

1. Review of the critical monitoring metrics as defined by CMS in its SUD monitoring protocol;
2. Review of metrics examined in two focus studies conducted by the evaluation team with regards to SUD service authorizations and transitions of care for Medicaid members with SUD;
3. Status of the State's efforts to date in completion of the items identified in its SUD Implementation Plan;
4. Review of the availability of SUD providers; and
5. Feedback from stakeholders.

Critical Monitoring Metrics

Exhibit C.1 on page 13 summarizes the results of the critical monitoring metrics reported to CMS on an annual or quarterly basis. The data presented shows the value for each metric at the baseline period and at the Mid-Point period. For metrics that are reported with monthly values to CMS, the baseline period is defined as the three-month average of values for the service period of Quarter 2 (April, May, June) of CY 2019. This period is just prior to the demonstration start of August 2019. The Mid-Point period is defined as the three-month average of values for the service period of Quarter 2 of CY 2021. For metrics that are reported annually to CMS, the baseline period is defined as the CY 2019 value; the Mid-Point period is defined as the CY 2020 value since CY 2021 values are yet to be computed.

In its SUD Monitoring Plan, the DMMA indicated a target of "consistent" for the values of each metric shown in the exhibit. Per CMS guidance, if a state shows consistent values between the baseline and Mid-Point period, then progress has been shown.

For the 22 metrics shown, Delaware saw an increase or improvement on ten metrics between the baseline and the Mid-Point period, a decrease or worsened result on eight metrics, consistent results on three metrics, and one metric has been unassigned because the data is not yet available (CMS Metric #27 Overdose Death Rate among Medicaid Beneficiaries). It should be not that, for some metrics, the term "improved" is used instead of "increased" because a lower rate at the Mid-Point indicates improvement. Likewise, "worsened" is used instead of "decreased" because a higher rate at the Mid-Point indicates worsened status.

Based on these results, the HMA-Burns team has assigned 12 metrics as showing progress, nine metrics as not showing progress, and one metric that is unknown.

Some explanation is needed on the first metric presented, CMS Metric #7 Early Intervention. The values shown at the baseline and at the Mid-Point are zero due to the hierarchical nature of CMS's specification for computing the results for this measure. If the hierarchy is not applied, HMA-Burns computed the value at the baseline as 161 and at the Mid-Point as 107. Therefore, HMA-Burns gave the progress on this metric as "no".

Exhibit C.1

Findings from the Mid-Point Assessment of Critical Monitoring Metrics

Values shown below are for the entire Demonstration population

CMS Metric #	Metric Name	Value At Baseline	Value At Mid-Point	Absolute Change	Percent Change	State's Demon-stration Target	Directionality at Mid-Point	Progress	Milestone Risk Assess-ment
7	Early Intervention	0	0	0	0.0%	Consistent	Consistent	No	High
8	Outpatient Services	8,099	7,553	-546	-7.2%	Consistent	Decrease	No	
9	Intensive Outpatient and Partial Hosp.	464	252	-212	-84.1%	Consistent	Decrease	No	
10	Residential and Inpatient	569	432	-137	-31.7%	Consistent	Decrease	No	
11	Withdrawal Management	490	330	-160	-48.5%	Consistent	Decrease	No	
12	Medication-Assisted Treatment	5,773	5,784	11	0.2%	Consistent	Consistent	Yes	
22	Continuity of Pharmacotherapy for OUD	18.2%	19.0%	0.8%	4.2%	Consistent	Increase	Yes	
5	Medicaid Beneficiaries Treated in an IMD for SUD	412	363	-49	-13.5%	Consistent	Improved	Yes	Low
36	Average Length of Stay in IMDs	7.6	7.6	0	0.0%	Consistent	Consistent	Yes	
13	Provider Availability	688	665	-23	-3.5%	Consistent	Decrease	No	High
14	Provider Availability - MAT	40	30	-10	-33.3%	Consistent	Decrease	No	
18	Use of Opioids at High Dosage Persons w/o Cancer	72.9%	74.1%	1.2%	1.6%	Consistent	Worsened	No	Medium
21	Concurrent Use of Opioids and Benzodiazepines	8.9%	8.3%	-0.6%	-7.2%	Consistent	Improved	Yes	
23	ED Utilization for SUD per 1,000 Medicaid Beneficia	7.2	4.7	-2.5	-53.2%	Consistent	Improved	Yes	
27	Overdose Death Rate	not yet reported by state				Consistent		unknown	
15	Initiation of AOD Treatment	45.8%	48.1%	2.3%	4.8%	Consistent	Increase	Yes	Low
15	Engagement of AOD Treatment	36.0%	36.6%	0.6%	1.6%	Consistent	Increase	Yes	
17(1)	Follow-up After ED Visit for AOD, 7 day	10.2%	10.1%	-0.1%	-1.0%	Consistent	Decrease	No	
17(1)	Follow-up After ED Visit for AOD, 30 day	19.4%	19.7%	0.3%	1.5%	Consistent	Increase	Yes	
17(2)	Follow-up After ED Visit for Mental Illness, 7 day	18.1%	19.6%	1.5%	7.7%	Consistent	Increase	Yes	
17(2)	Follow-up After ED Visit for Mental Illness, 30 day	36.2%	36.7%	0.5%	1.4%	Consistent	Increase	Yes	
25	Readmissions Among Beneficiaries with SUD	25.9%	26.3%	0.4%	1.5%	Consistent	Worsened	No	

Time Period for Baseline:

For measures #7, #8, #9, #10, #11, #12, and #23 - average of the three months for service period Q2-2019

For measures #22, #5, #36, #13, #14, #18, #21, #15, #17(1), #17(2), and #25 - annual value for service period CY2019

Time Period for Mid-Point:

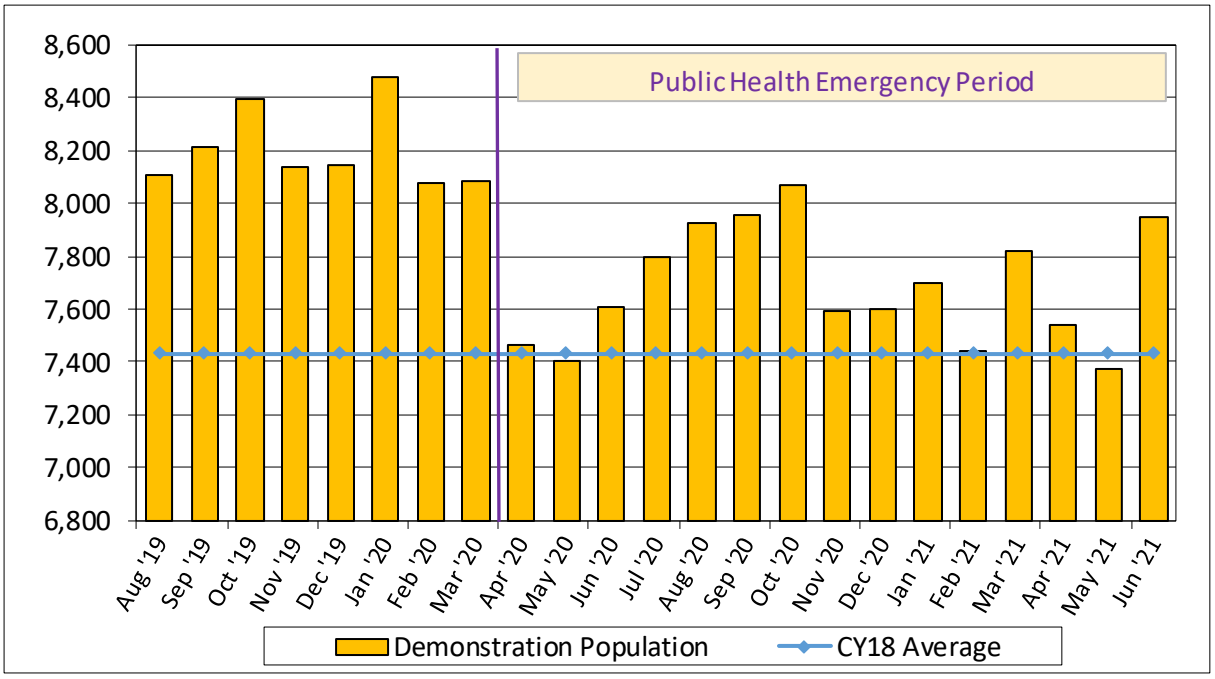
For measures #7, #8, #9, #10, #11, #12, and #23 - average of the three months for service period Q2-2021

For measures #22, #5, #36, #13, #14, #18, #21, #15, #17(1), #17(2), and #25 - annual value for service period CY2020

As was seen in Exhibit C.1, many of the metrics related to CMS Milestone #1, Access to Critical Levels of Care for SUD Treatment, have decreased from the baseline to the Mid-Point time periods. Understandably, for many metrics, this is an artifact of the PHE when access to many in-person services was curtailed. In an effort to provide more context on current trends, Exhibits C.2 through C.6 show the month-by-month trends for the count of Medicaid beneficiaries using each service. Data is shown from the start of the demonstration (August 2019) through the most recent period available (June 2021). For context, the value shown for each measure using the average count of users in CY 2018 is also displayed.

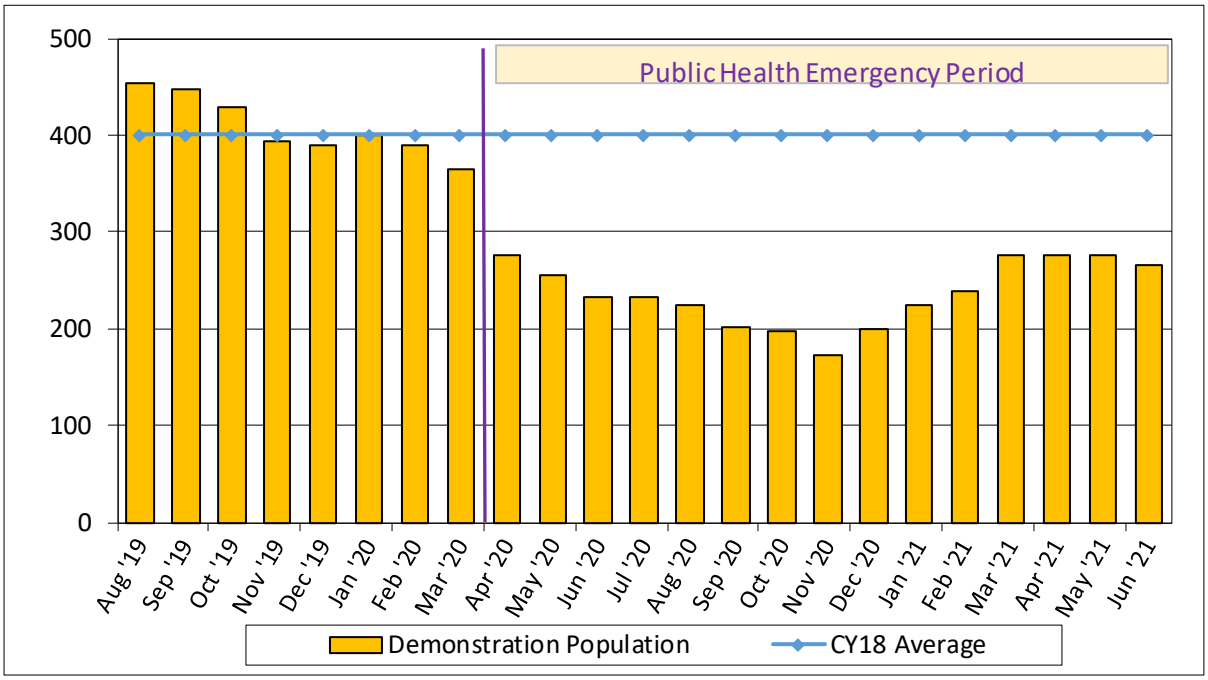
For CMS Metric #8, Outpatient Services, in the initial demonstration months prior to the PHE, the count of users by month was increasing or steady. After a sharp decrease at the start of the PHE, usage started to increase toward the end of CY 2020. The count of users declined again starting in November 2020 but is picking up in the most recent period.

Exhibit C.2
Count of Medicaid Beneficiaries with Outpatient Services, by Month
For Demonstration Population As Reported in Quarterly Monitoring Reports to CMS



For CMS Metric #9, Intensive Outpatient or Partial Hospitalization, the count of users was above the CY 2018 average in the first few months of the demonstration. The number of users started to wane even prior to the PHE, but then fell almost 50 percent from CY 2018 counts at the start of the PHE. Use of IOP in particular has started to gradually increase in the months of CY 2021, but it is still at 70 percent of CY 2018 levels.

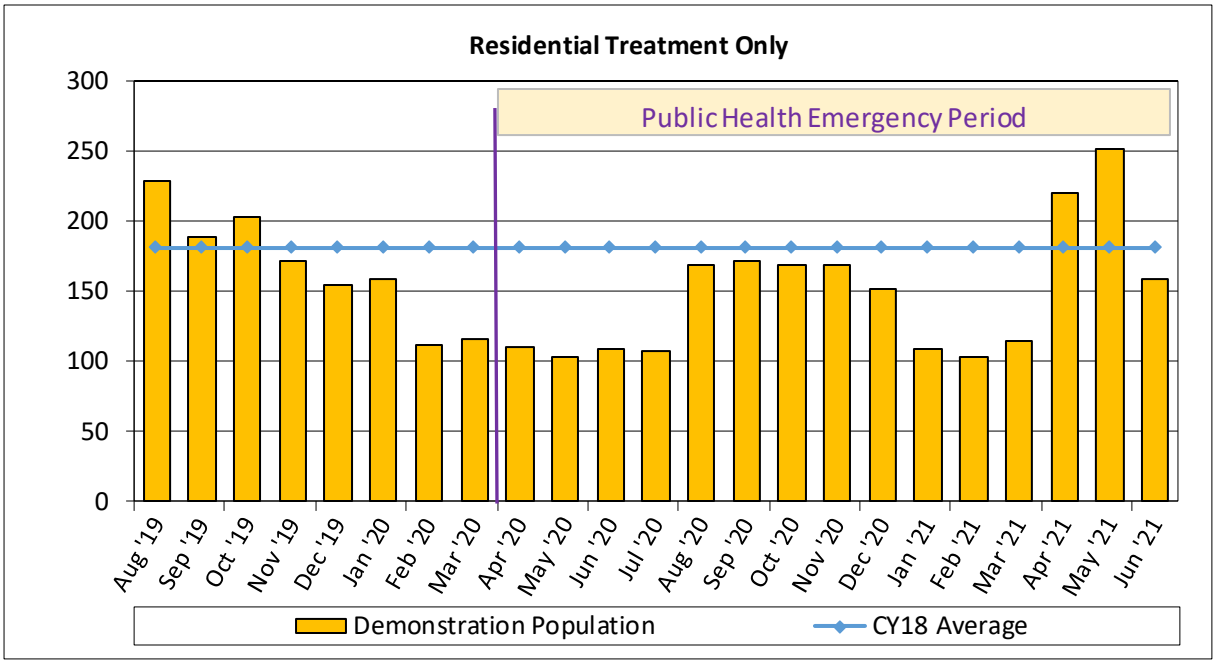
Exhibit C.3
Count of Medicaid Beneficiaries with Intensive Outpatient or Partial Hospitalization, by Month For Demonstration Population As Reported in Quarterly Monitoring Reports to CMS

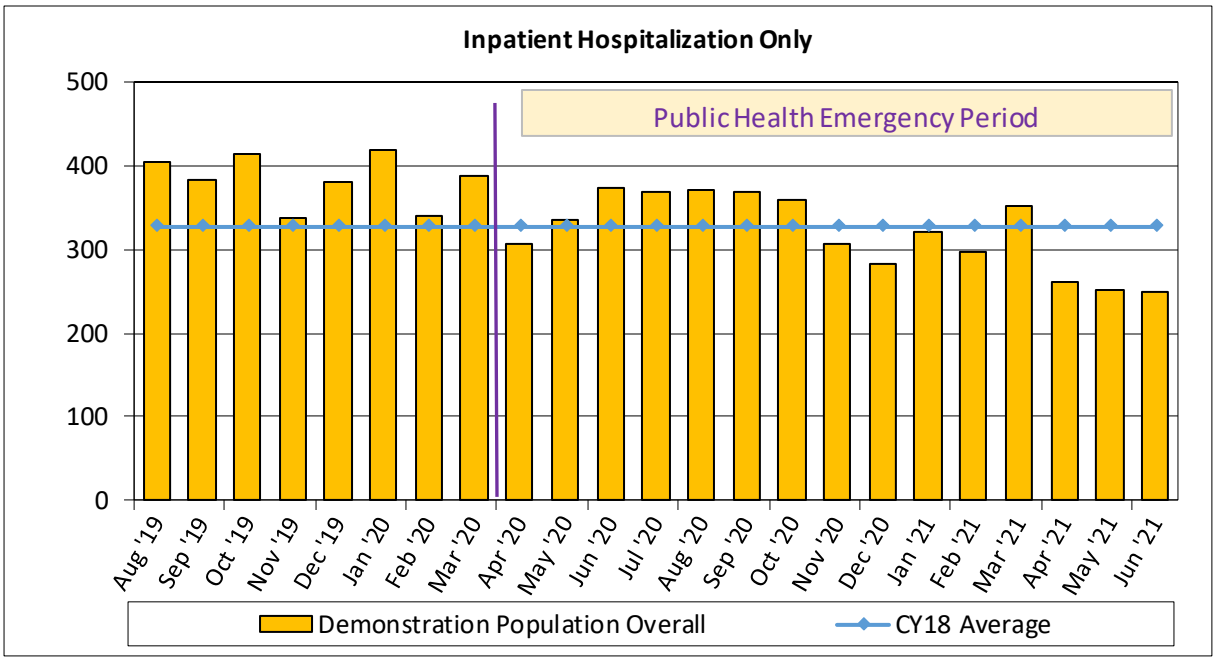


For CMS Metric #10, Inpatient Hospitalization and Residential Treatment, the HMA-Burns team split the reporting of count of Medicaid users between the two services. Exhibit C.4 shows the trends for both services. For residential treatment, the trend observed was similar to what was found for intensive outpatient. That is, there is a modest increase at the start of the demonstration, then a decrease even prior to the PHE. At the start of the PHE, the count of users of residential treatment was almost 50 percent of CY 2018 values. Usage started to increase at the end of CY 2020, but then decreased in early CY 2021 and is rebounding once again.

The trend for users of inpatient hospitalization has been steadier since the start of the demonstration. In fact, for most months, the count of Medicaid users for this service is above the CY 2018 average. The lower counts in the April to June 2021 period may still be attributable in part to claims submission lag.

Exhibit C.4
Count of Medicaid Beneficiaries with Residential Treatment or Inpatient Stays, by Month
For Demonstration Population As Reported in Quarterly Monitoring Reports to CMS





For CMS Metric #11, Withdrawal Management, there was an increase in use by Medicaid clients in the initial months of the demonstration, then a decline even prior to the start of the PHE. During the PHE period, however, usage was higher than the CY 2018 average even in the initial PHE period.

CMS Metric #12, Medication Assisted Treatment (MAT), is the metric that is the exception to the rule so far in this demonstration for the access to care measures. The count of Medicaid clients using MAT has

been higher than the CY 2018 in every month since the demonstration period began. The count of users is steadily increasing as well.

Exhibit C.5
Count of Medicaid Beneficiaries with Withdrawal Management Services, by Month
For Demonstration Population As Reported in Quarterly Monitoring Reports to CMS

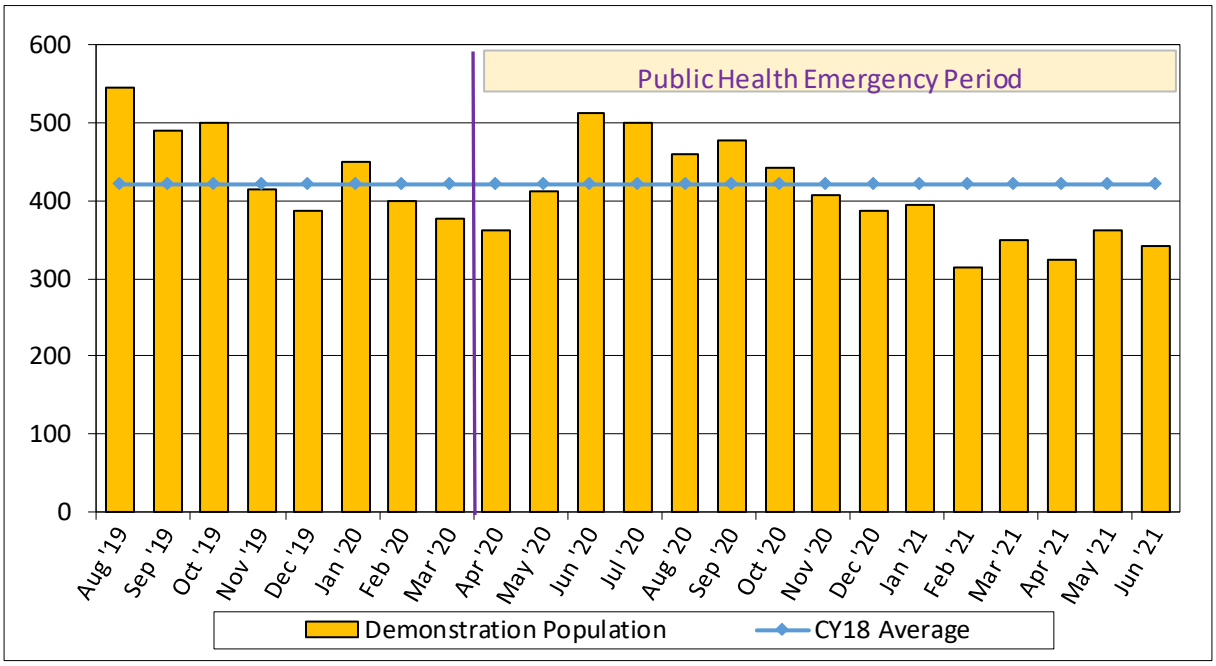
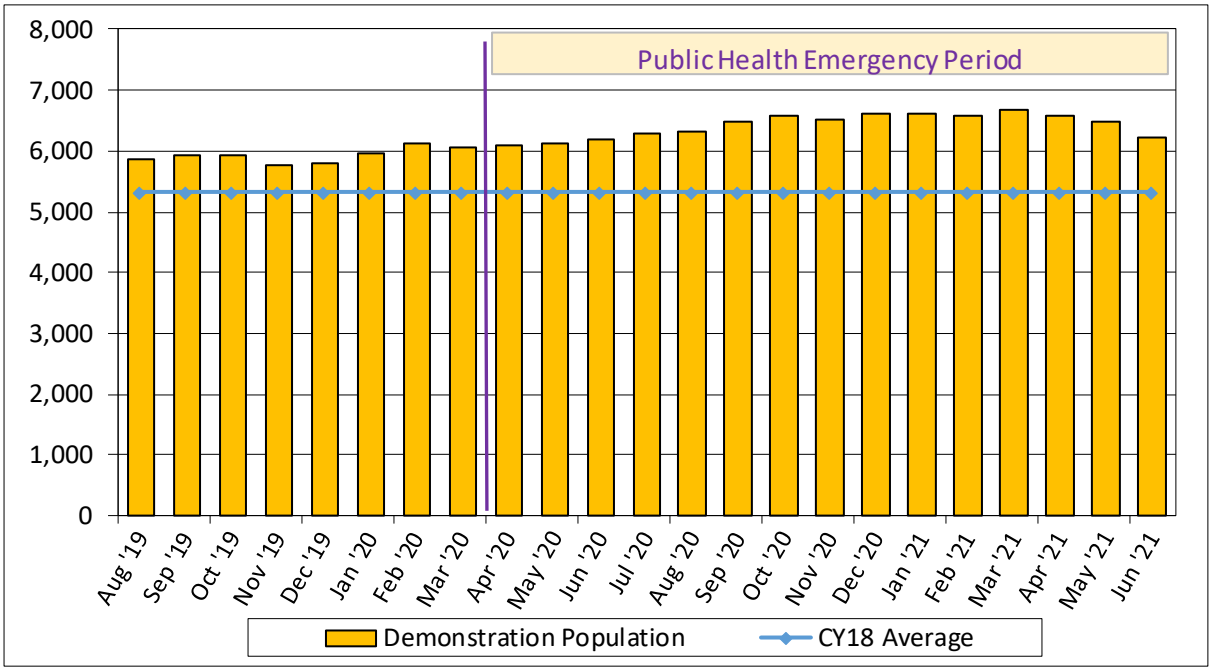


Exhibit C.6
Count of Medicaid Beneficiaries with Medication Assisted Treatment, by Month
For Demonstration Population As Reported in Quarterly Monitoring Reports to CMS



State-Specific Metrics Developed by the Evaluators

SUD Authorizations Study

Exhibits C.7 through C.9 show the findings related to the metrics examined in the focus study of SUD authorizations requested by providers to the MCOs during the service period September 1, 2019 to February 29, 2020. A total of 5,951 authorization requests were made for SUD services.

The results for turnaround time for authorization requests were usually found to be in compliance with the DMMA's contractual requirements and national standards for turnaround time. Exhibit C.7 shows that for pre-service authorization requests, the turnaround time was within seven days for 86 percent of requests. Further, 77 percent of these requests were completed within three days. There is some distinction in the turnaround times between the two MCOs. AmeriHealth Caritas had fewer requests with a turnaround time in excess of seven days.

For concurrent review requests, the national standard for turnaround time is within one day. This threshold was met for 92 percent of all concurrent review requests. The two MCOs had similar results for this metric.

Exhibit C.7
MCO Turnaround Time on SUD Authorization Requests

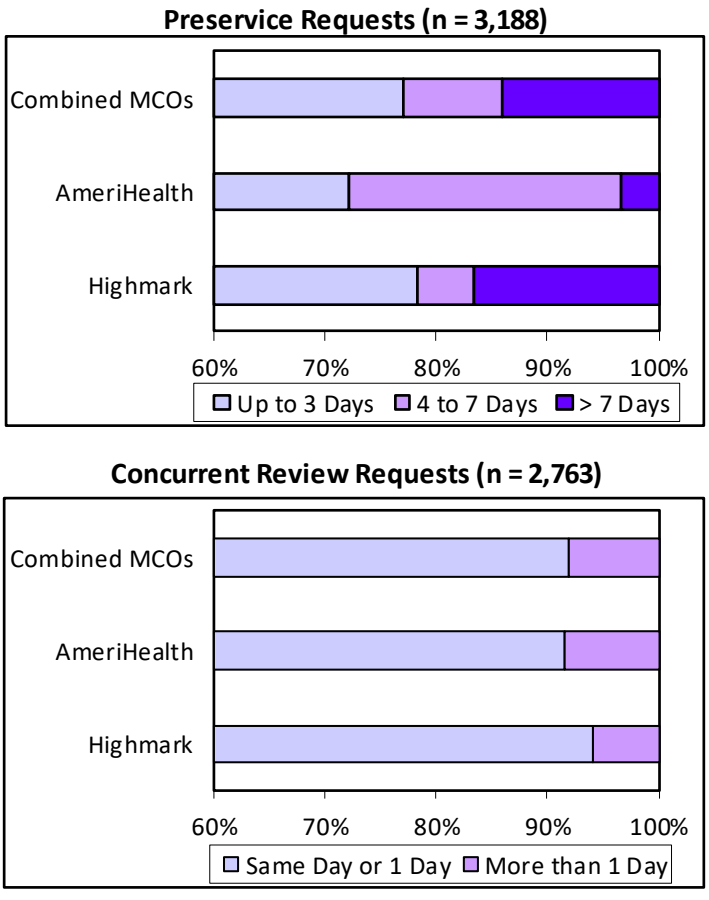


Exhibit C.8
Authorization Disposition Status

	Approved	Denied
All SUD Authorizations		
Both MCOs	97.0%	3.0%
AmeriHealth	97.1%	2.9%
Highmark	96.9%	3.1%
Inpatient Hospital Authorizations Only		
Both MCOs	95.9%	4.1%
AmeriHealth	97.6%	2.4%
Highmark	94.9%	5.1%
Residential Treatment Authorizations Only		
Both MCOs	96.9%	3.1%
AmeriHealth	96.1%	3.9%
Highmark	98.3%	1.7%

On the disposition of the authorization requests, the two MCOs had similar results. The approval rate for both MCOs was 97 percent. For SUD-related inpatient hospital requests, the approval rate was 96 percent; for residential treatment stays, the approval rate was 97 percent.

Exhibit C.9
Denial Reasons Stated for SUD Auth Requests

	Administrative	Not Medically Necessary	Other
Inpatient Hospital Authorizations Only			
Both MCOs	6.1%	91.9%	2.0%
AmeriHealth	28.6%	61.9%	9.5%
Highmark	0.0%	100.0%	0.0%
Residential Treatment Authorizations Only			
Both MCOs	54.4%	31.6%	14.0%
AmeriHealth	67.4%	15.2%	17.4%
Highmark	0.0%	100.0%	0.0%

In the few instances where authorizations were denied, there was variation in the reason for the denial between the two MCOs. For Highmark, the reason provided for the denial was always lack of medical necessity. For AmeriHealth Caritas, administrative or other reasons were sometimes cited for the denial in addition to lack of medical necessity.

With few exceptions, among the 120 sample cases reviewed, the attribution of the type of authorization, the disposition status, and the turnaround time matched what was given to HMA-Burns in the self-reported spreadsheets. Among the 120 sample cases reviewed (of which 100 were denied), in 20 cases there was a reconsideration requested by the provider. Also, in 20 cases a peer-to-peer consult was requested.

Overall, the MCOs appear to be following standard practices when reviewing for medical necessity. However, there were some inconstancies noted in the level of clinical documentation supplied and the number and timing of days approved and operational processes. While only three percent of all SUD authorization requests were denied in the study period, there appears to be an opportunity for process improvement surrounding the timing of peer-to-peer and communication of final denial decisions.

Transitions of Care Study

In the transitions to care focus study conducted by the HMA-Burns team, there were 1,360 Medicaid beneficiaries in the first study period (anchor event during the time period October 1, 2019 – March 31, 2020) and 747 beneficiaries in the second study period (anchor event during the time period April 1 – September 30, 2020). An anchor event was defined as either a SUD-related inpatient hospital stay, or a residential treatment stay.

Exhibit C.10 shows the percentage of members in each study period that were enrolled in case or care management with the MCO that he/she is enrolled with. Overall, it was found that only seven percent of members in the study were enrolled in case/care management with their MCO. This varied for nine to 14 percent of AmeriHealth Caritas members and two to three percent for Highmark members.

Exhibit C.10
Percent of Medicaid Beneficiaries with a SUD Inpatient Hospital or Residential Stay that were Enrolled in Case/Care Management

	Both MCOs Combined	AmeriHealth Caritas	Highmark Health Options
Pre-PHE Study Population: Oct 1, 2019 – Mar 31, 2020	1,360	639	721
Pct Enrolled in Case Management	6%	9%	3%
PHE Period: Apr 1, 2020 – Sept 30, 2020	747	374	373
Pct Enrolled in Case Management	8%	14%	2%

Exhibit C.11, which appears on the next page, compares utilization of selected services for the individuals in the study in the 12 weeks prior to and 12 weeks after their anchor event. Key findings shown in this exhibit include the following:

- Emergency department utilization was lower for SUD members after their anchor event than prior to their anchor event. This was true in both study period (pre-PHE and during PHE) as well as for both MCOs.
- Withdrawal management was also lower in the post-anchor event period than the pre-anchor event period in both study periods and for both MCOs.
- Intensive outpatient services increased modestly for Medicaid members after their anchor event during the pre-PHE period studied, but utilization was less after the anchor event in the during-PHE period studied.
- The use of medication assisted treatment was steady in the period before and after a member's anchor event. This was true for both study periods examined and for both MCOs.
- Medication assisted treatment was utilized by one-third of the members in both study periods.
- Services delivered in an outpatient hospital setting that were related to SUD treatment were also consistent in the pre-anchor and post-anchor event periods.

Exhibit C.11

Percent of Medicaid Beneficiaries and their Service Use Before & After an Inpatient Hospital or Residential Stay ("anchor event")

Pre-PHE Period: Oct 1, 2019 – Mar 31, 2020	Both MCOs Combined		AmeriHealth Caritas		Highmark Health Options	
	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	in the 12 weeks before anchor event	in the 12 weeks after anchor event
Total Denominator Population	**1,360**		**639**		**721**	
Percent of Individuals with						
ED Utilization	40%	23%	40%	25%	40%	21%
Outpatient Hospital, SUD service	53%	49%	50%	47%	55%	51%
Withdrawal Management	45%	20%	39%	20%	49%	20%
Residential Treatment, SUD	33%	11%	45%	16%	22%	7%
Intensive Outpatient	23%	28%	19%	20%	26%	35%
Medication Assisted Treatment	30%	33%	31%	32%	30%	34%
Outpatient Hospital, NonSUD service	6%	9%	5%	9%	7%	8%
Professional Claim other than above	22%	41%	28%	52%	17%	31%

PHE Period: Apr 1, 2020 – Sept 30, 2020	Both MCOs Combined		AmeriHealth Caritas		Highmark Health Options	
Total Denominator Population	**747**		**374**		**373**	
Percent of Individuals with						
ED Utilization	43%	25%	45%	28%	40%	22%
Outpatient Hospital, SUD service	60%	52%	61%	49%	58%	54%
Withdrawal Management	51%	23%	49%	24%	53%	22%
Residential Treatment, SUD	39%	11%	55%	17%	22%	5%
Intensive Outpatient	29%	17%	26%	12%	32%	22%
Medication Assisted Treatment	37%	36%	36%	36%	38%	36%
Outpatient Hospital, NonSUD service	4%	12%	4%	10%	4%	14%
Professional Claim other than above	13%	36%	16%	47%	9%	25%

SUD Implementation Plan Action Items

Of the eight action items in the Implementation Plan, DMMA has completed five, with the other three in an ongoing status. Exhibit C.12 below lists each of the action items along with the current status.

Exhibit C.12

Findings from the Mid-Point Assessment of Implementation Plan Action Items

Item Number	Action Item Description	Date to be Completed	Current Status
1	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.)	Aug 2021	**Completed**. Note, however, that the EQRO did not perform study; DMMA opted to use independent evaluator SUD Authorizations focus study.
2	DMMA's EQRO will perform a focus study to assess MCO performance on Care Coordination and Transitions between Levels of Care for individuals with OUD and other	Aug 2021	**Completed**. Note, however, that the EQRO did not perform study; DMMA opted to use independent evaluator SUD Authorizations focus study.
3	CMS awarded Delaware a SUPPORT Act Planning Grant to assess the mental health and SUD treatment needs of the State and to determine the extent to which additional providers are needed to address unmet need.	Sept 2021	**Open**. Assessment is ongoing. In April 2020, DMMA proposed to add Licensed Chemical Dependency Professionals (LCDP) to list of behavioral health practitioners but it was never finalized or submitted as a state plan amendment.
4	The State will estimate the number and percentage of OUD and other SUD among Medicaid beneficiaries, and OUD and other SUD treatment and recovery needs.	Dec 2020	**Completed**
5	The State will complete a workforce assessment to determine SUD provider and service capacity for Medicaid beneficiaries.	Dec 2020	**Completed**
6	The State will conduct a gaps analysis to determine service gaps to treat OUD and other SUD needs.	Dec 2020	**Completed**
7	Delaware will report on future planned Prescription Drug Monitoring Program (PDMP) query capabilities within six months of CMS approval of the SUD HIT Plan.	July 2021	**Open**. HIT reporting began with SUD DY3 Q3 Monitoring Report
8	Delaware will provide and update a description of the future state of enhancements to its PDMP within six months of CMS approval of the SUD Implementation Plan.	July 2021	**Open**. HIT reporting began with SUD DY3 Q3 Monitoring Report

Note: An additional action Item that relates to mental health was listed in the SUD Implementation Plan but will be addressed in Delaware's 1115 waiver Interim Evaluation. Statement: "DMMA will determine if additional policies to ensure coordination of care for co- occurring physical and mental health conditions are needed".

Provider Availability

In order to assess provider capacity at different levels of care, the HMA-Burns team plotted the physical location of where SUD treatment is currently being delivered to Medicaid beneficiaries. The home locations of Medicaid beneficiaries who received each service reviewed were also plotted. The maps that appear in Exhibits C.13 through C.16 on the following pages show the Medicaid members that are within 10 miles of a Medicaid SUD provider for each service reviewed. The Medicaid member may not have received the service from the closest provider to their home, but the green circles on each map show the proximity to an available Medicaid provider.

A summary of the findings from each exhibit appears below.

- In Exhibit C.13, it was found that residential treatment providers are less prevalent in Sussex County, the southern part of the state.
- In Exhibit C.14, it was found that there are medication assisted treatment providers in all portions of the state, but Medicaid members in Sussex County had to travel further to receive this service than members in the northern counties.
- In Exhibit C.15, it was found that members in southern New Castle County and most of Sussex County have to travel further than other Medicaid members in the state to receive intensive outpatient services.
- In Exhibit C.16, it was found that office based opioid treatment is available in all portions of the state. Most Medicaid members do not have to travel more than ten miles to receive this service.

Exhibit C.13
Plot of Medicaid Members Using Residential Services in CY 2020

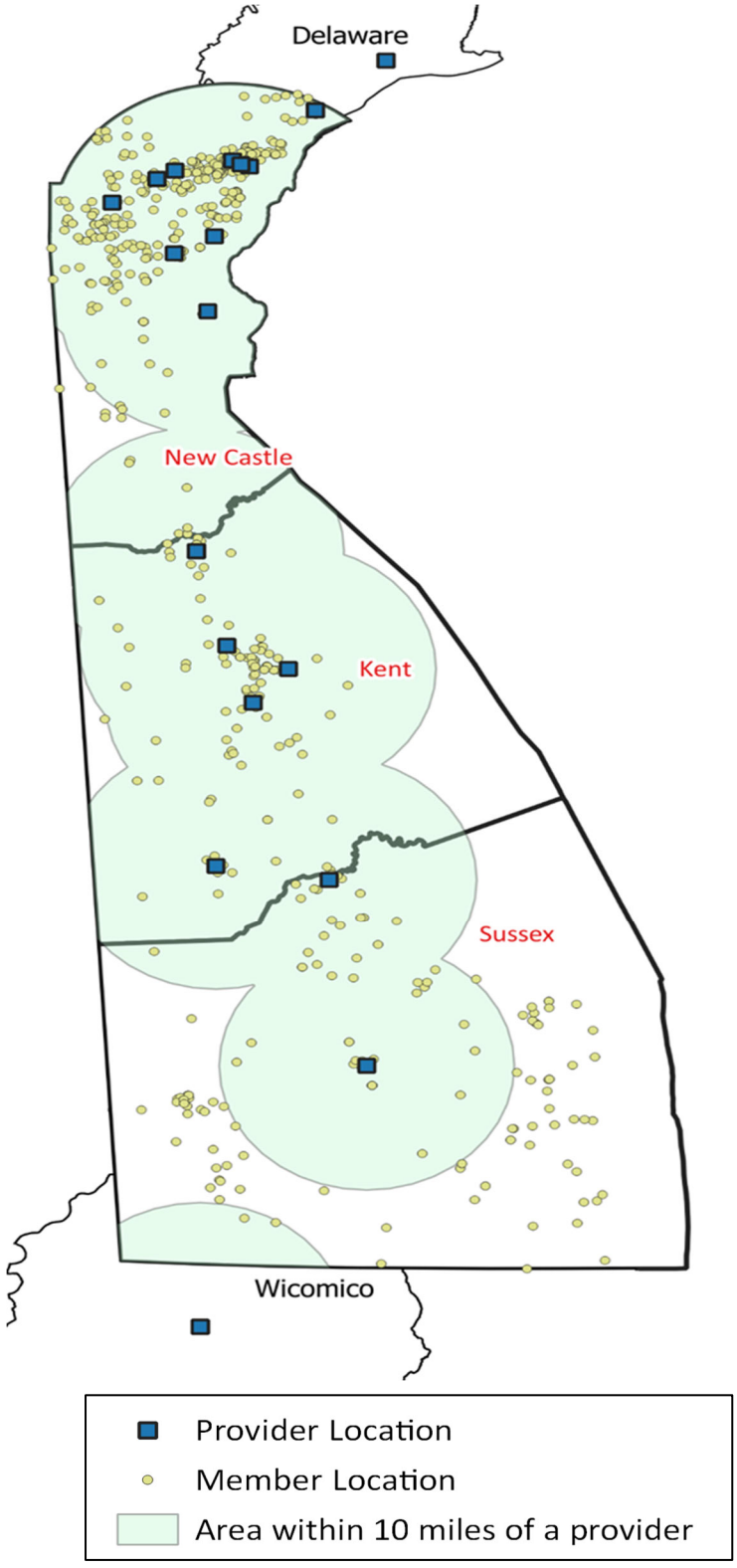


Exhibit C.14
Plot of Medicaid Members Using Medication-Assisted Treatment in CY 2020

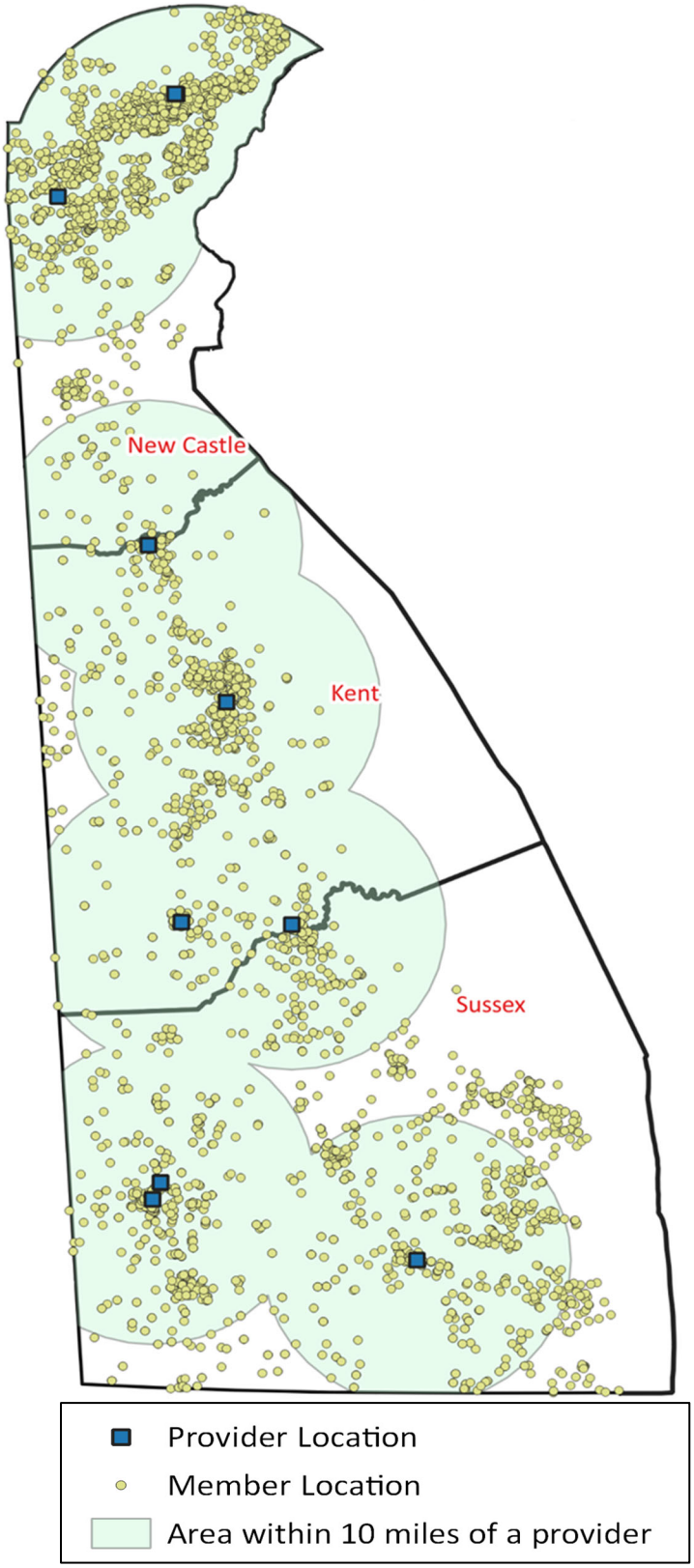


Exhibit C.15

Plot of Medicaid Members using Intensive Outpatient Service in CY 2020

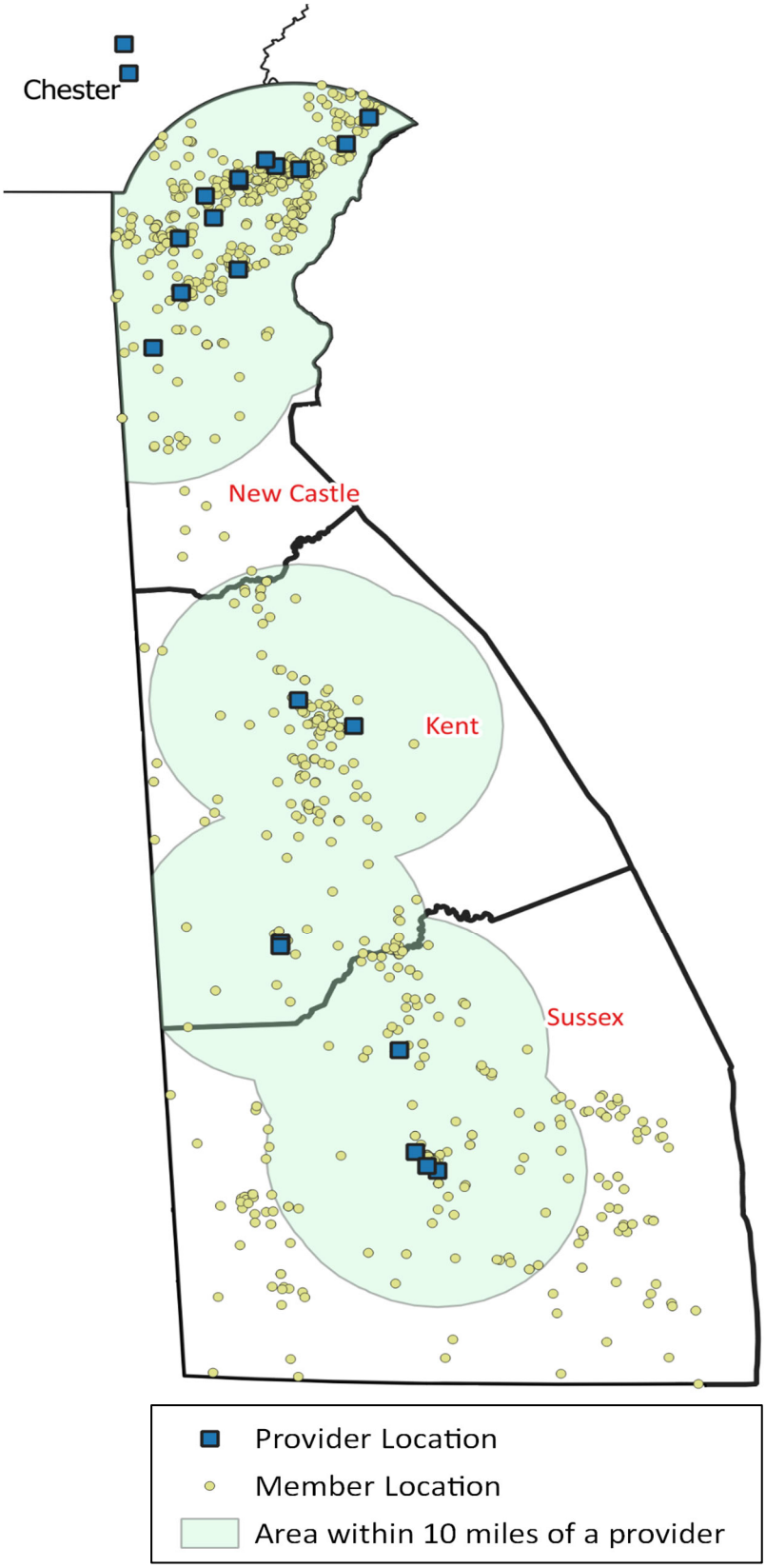
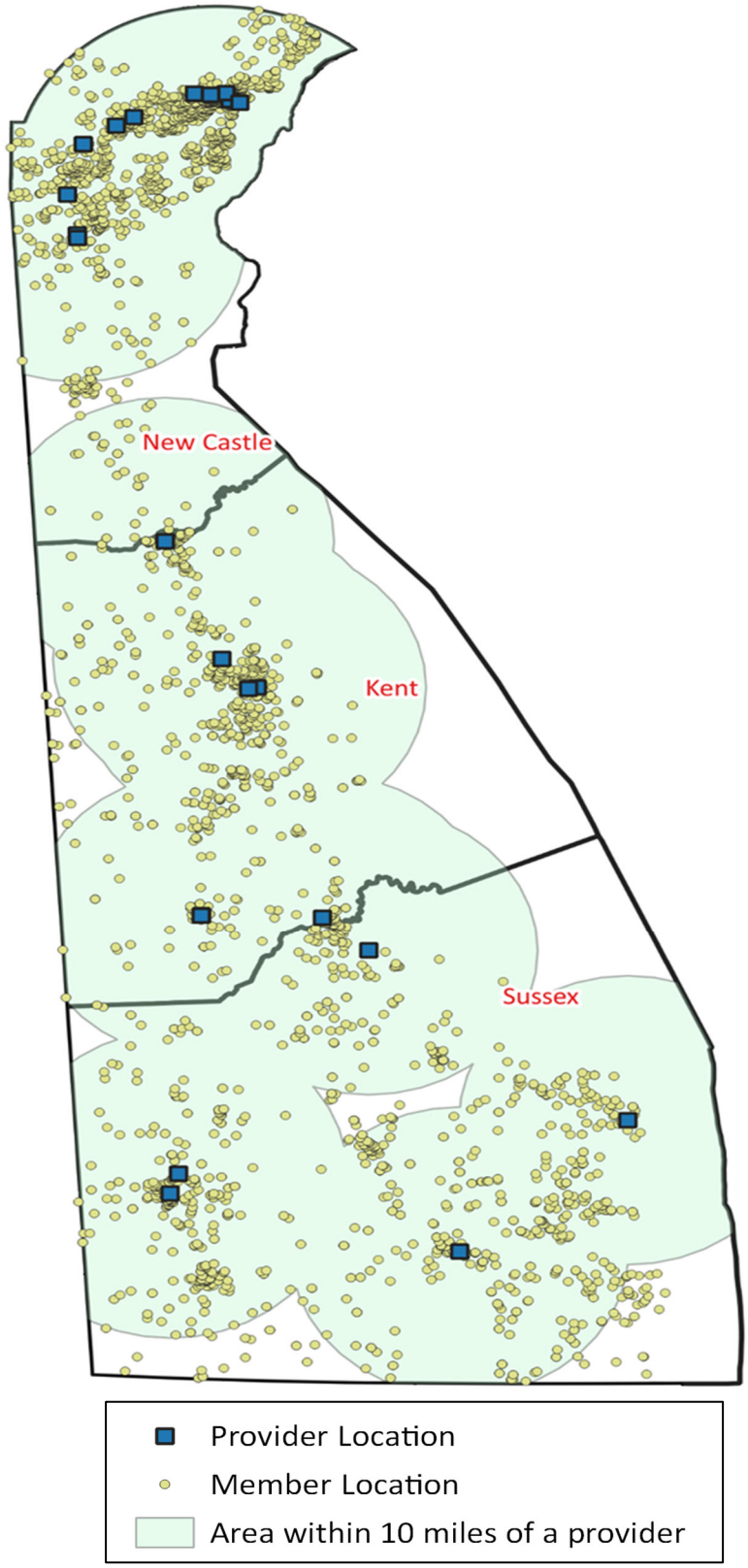


Exhibit C.16

Plot of Medicaid Member Using Office Based Opioid Treatment Providers in CY 2020



Stakeholder Feedback

This section summarizes the feedback received by the two Medicaid MCOs, from five SUD providers, and from 43 Medicaid beneficiaries. Themes mentioned by stakeholders are organized by each of the CMS milestones. After the summary section, more detailed feedback is described related to each milestone. A notation is given if the feedback reported is from the MCOs, from providers, and/or from beneficiaries.

Summary of Findings

Although all of the providers expressed appreciation for the funds available to Medicaid beneficiaries, their feedback about the waiver, delivery of SUD services and more current day-to-day operations was mixed. HMA-Burns asked for specific examples of what was working well (or had improved since the initial rollout) and where there were items that continue to be of concern.

Much of the concerns expressed by providers were related to the delivery of SUD services than the waiver itself. All of the providers interviewed are contracted with both of the MCOs. The positive and negative feedback about MCOs was mostly consistent across the providers; that is, most providers had positive feedback about the same MCOs, while the other MCO received mixed reviews.

Many of the topics that were covered by HMA-Burns in the provider interviews were also covered with the MCOs, but the feedback obtained was from the MCO perspective. The MCOs highlighted the varying levels of knowledge across the base of providers delivering SUD services. Early challenges that the MCOs expressed were often not even specific to SUD; rather, it was educating SUD providers about working with Medicaid in areas such as seeking authorizations and billing requirements, mostly the result of confusion surrounding State Senate Bill 109.

The feedback from beneficiaries (Medicaid members) was obtained through a survey (offered online or hard copy to fill out) which was made available to them by their treating providers. The specific items asked of beneficiaries included:

1. Ease of finding treatment options or access to services;
2. Opinion on what could help others in the future who are seeking out SUD treatment; and
3. Identification of services not available (actual or perceived) to the client.

Exhibit C.17 on the next page summarizes the themes mentioned by stakeholders. The themes are mapped to the CMS Milestones. An indication is given in parentheses as to which stakeholder (or stakeholders) mentioned the theme as well as how often the theme was mentioned.

Exhibit C.17
Summary of Themes Mentioned by Stakeholders

Theme Number	Description of Theme	Stakeholder Responding (P)rovider, (M)CO, (B)eneficiary	# Stakeholders Who Mentioned Theme (out of 50)
Milestone 1: Access to Critical Levels of Care for SUD Treatment			
1	Clients do not ask about their benefits if they are enrolled in an MCO	P	5
2	Beneficiaries find out about treatment mostly from a friend	P, M, B	23
3	It was not hard to figure out where to get treatment	P, M, B	31
Milestone 2: Use of Evidence-Based, SUD-specific Patient Placement Criteria			
4	MCO authorization processes are similar	P	5
5	There are some challenges with billing, contracting, authorizations	P	3
6	Senate Bill 109 has caused confusion among providers regarding authorization requirements	M	2
Milestone 3: Use of Nationally Recognized SUD Program Standards for Residential Treatment			
7	Peer support credentialing criteria is an issue	M	2
8	Credentialing with MCOs can be problematic and lengthy	P	3
Milestone 4: Sufficient Provider Capacity at Critical Levels of Care			
9	Staffing requirements and low reimbursement rates are barriers to residential treatment capacity	P	4
10	Residential treatment services cited as the service least available	P, M, B	19
11	Provider network for residential treatment is not extensive enough, particularly lower ASAM levels	P, M	7
Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse			
12	Perceived lack of urgency regarding SUD treatment services in Delaware	P	3
13	DMMA could have asked for more in its SUD waiver request to enhance the service continuum	P	3
Milestone 6: Improved Care Coordination and Transitions Between Levels of Care Opioid Abuse			
14	Care coordination activities by MCOs with providers is limited	P	3
15	Providers would like help with discharge and after care planning	P	3

Feedback on Milestone #1: Access to Critical Levels of Care for SUD Treatment

Client perceptions

- *Clients do not ask about their benefits if they are enrolled in an MCO (providers).* All of the providers stated that clients believe that they have SUD services available to them as part of their benefit package if they are enrolled in an MCO. Access to residential treatment, sober living and, in particular, facilities that would take someone on medication assisted treatment (MAT) with methadone were expressed as concerns.

- *(beneficiaries)* Many of the members responding to the survey said that they found out about treatment primarily from a friend. Other methods were from a health care provider, family member or as a result of going through the criminal justice system.

Access to services

- *(beneficiaries)* Most members stated that it was not hard to figure out where to get treatment, although they mentioned difficulties getting treatment in a residential treatment center when they needed to.

Feedback on Milestone #2: Use of Evidence-Based, SUD-specific Patient Placement Criteria

The prior authorization process, overall and specific situations

- *MCO authorization processes are similar, but one MCO is easier to work with (providers).* All of the providers uniformly expressed difficulties with the same MCO.

Perception of provider knowledge base on the SUD benefit or Medicaid processes

- *Senate Bill 109 has caused confusion among providers (MCOs).* MCOs mention that this bill has contributed to provider confusion around coverage and medical necessity requirements. Additionally, the MCOs mentioned that providers are not billing for assessments and SBIRT when they are able to and noted that provider education was needed.

Feedback Related to Milestone #3: Use of Nationally Recognized SUD-specific Program Standards for Residential Treatment

Delaware SUD ASAM provider requirements

- *Issues with peer support credentialing criteria (MCOs).* Both MCOs expressed that peer support is an important part of the recovery process and is limited, in part, by credentialing criteria.

Onboarding providers

- *Issues with credentialing and onboarding with MCOs (providers).* Some, but not all, of the providers expressed that they had issues with credentialing and onboarding with one particular MCO. This is impacting their ability to serve patients due to scarce clinical resources for treatment.

Feedback on Milestone #4: Sufficient Provider Capacity at Critical Levels of Care

Ease of finding treatment options

- *(beneficiaries)* Almost all members stated that it was not hard to figure out where to get treatment.

Identification of services not available (actual or perceived) by the client

- *(beneficiaries)* Services most often mentioned included: residential treatment, outpatient treatment, psychiatrist, psychologist, primary care doctor and transportation.

Provider network is not deep enough

- *Staffing requirements and low reimbursement rates are barriers to growing residential treatment sites in the state (providers).* Four of the providers expressed that the State's staffing requirements at the lower ASAM residential levels in particular make it cost prohibitive to offer services at the lower levels.

- *(providers)* All providers mentioned that more residential treatment providers are needed. Specific services cited include: level 3.1 facilities; facilities specific for women and children; facilities that will take members who are on methadone at 100 milligrams and above; and supportive housing, in particular that can support members on MAT.

- *(MCOs)* Expressed concern with the low counts of: outpatient; MAT; supportive/sober living; and peer support that is transportable across agencies. In particular, the MCOs noted the need for more ASAM level 3.1, intensive outpatient, and residential treatment providers at ASAM level 2.1 and 2.5 in western Sussex and Kent counties specifically. The MCOs also mentioned that there is a need for halfway houses and that they would like to see Medicaid cover it instead of it being funded through DSAMH (the State mental health agency).

Feedback on Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse

Waiver did not go far enough

- *Lack of urgency regarding SUD treatment services in Delaware (providers).* Three of the five providers specifically mentioned that there appears to be a lack of urgency regarding SUD in Delaware at higher levels within State government. All three referenced that Delaware has one of the highest rates of SUD related deaths.

- *DMMA could have asked for more in the waiver (providers).* The majority of the providers interviewed expressed disappointment that the waiver did not include additional services and funding which could have been used to shore up the SUD provider network. Specific examples mentioned include sober living services.

Other communications

- *Targeted outreach (beneficiaries)* via social media, AA/NA meetings, homeless shelter and healthcare providers were the top four forms of communication that beneficiaries thought would help them or others who are seeking treatment to find out about how they can find providers to help them.

Feedback on Milestone #6: Improved Care Coordination and Transitions Between Levels of Care

MCO care coordination activities with providers

- *Care coordination activities with providers are limited (providers).* Most of the providers indicated limited interaction with the MCOs on care coordination, with only one MCO mentioned specifically as being more engaged and wanting to help. All providers with interactions indicated that members were not interested in speaking with the MCO care coordinator and that instead they serve as a resource to provider care coordination that is already embedded in their processes.

- *Providers would like help with discharge and after care planning (providers).* Most providers mentioned that it would be helpful to have the MCOs locate the next level of care for members with co-occurring conditions, in particular, complex medical and behavioral health conditions.

SECTION D: Assessment and Recommendations

Assessment of Overall Risk of Not Meeting Milestones

Exhibit D.1, which appears on the next three pages, summarizes the HMA-Burns team's assessment of DMMA's ability to meet the SUD milestones it agreed to in its demonstration waiver. To complete this assessment, the HMA-Burns team factored in the results to date of the critical metrics comparing results at the Mid-Point against the baseline, the status of DMMA's activities in its SUD Implementation Plan, a review of SUD provider availability, and feedback from stakeholders.

The HMA-Burns team met with DMMA on the results of this assessment and offered recommendations related to each CMS Milestone. The State's response to this assessment and the recommendations offered also appears in Exhibit D.1.

Assessment of State's Capacity to Provide SUD Services

Based on the assessment conducted, the HMA-Burns team believes that most community-based SUD services are available within reasonable proximity to most Medicaid beneficiaries. The exception to this is residential treatment services in the following areas in particular:

- ASAM level 3.1
- Programs for adolescents
- Programs for pregnant women and new mothers and their children

Recommendations for ways to increase the provider base in this area includes an increase to the per diem rate of payment, researching the option for a global payment instead of a per diem payment, and review of the staffing guidelines for residential treatment, particularly at the lower ASAM levels of care.

Overall provider capacity for SUD services has seen disruption in the state since the start of the demonstration, but DMMA has been able to mitigate changes in the provider base. The State team is actively looking for additional sites for methadone administration and the addition of new office based opioid treatment (OBOT) providers.

Next Steps Identified by the State

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 waiver 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, SB109, 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 will create 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.

Exhibit D.1

Assessment of State's Ability to Meet Milestones at Mid-Point of SUD Waiver

Milestone	Action Items in Implementation Protocol	Critical Monitoring Metric Goals	Key Themes from Stakeholder Feedback	Risk Level
	# and % Completed	# and % Goal Met		
#1 Access to Critical Levels of Care for SUD Treatment	N/A (none identified)	28% (2 / 7)	1. Clients do not ask about their benefits if they are enrolled in an MCO. 2. Beneficiaries find out about treatment options from a friend. 3. It was not hard to determine where to get treatment.	**Medium**
Independent Assessor Recommendations				
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, in coordination with its MCOs, should conduct a root cause analysis of why early intervention services utilization is low. For example, determine if the cause is lack of knowledge by providers that the services are covered, the services are being rendered but coded differently from the CMS specification, or providers are not delivering the services for other reasons.				
3 The DMMA should leverage the work completed under the SUPPORT Act grant assessing SUD provider rates and CMS access to care measures to identify and target rate adjustments to areas with the most need as a means to potentially increase access to services throughout the state.				
State's Response	Delaware's persistently high overdose death rate has catalyzed cross-agency efforts to improve access to care. 1) DMMA's contracts with the MCOs require that the plans use ASAM criteria for utilization management, and DMMA expects that the MCOs 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. 2) 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. 3) DMMA is collaborating with DSAMH on a plan for staged implementation of rate changes proposed under the SUPPORT Act planning grant rate study.			

Exhibit D.1 (continued)
Assessment of State's Ability to Meet Milestones at Mid-Point of SUD Waiver

Milestone	Action Items in Implementation Protocol # and % Completed	Critical Monitoring Metric Goals # and % Goal Met	Key Themes from Stakeholder Feedback	Risk Level
#2 Use of Evidence-Based SUD-specific Patient Placement Criteria	0% (0 / 1)	100% (2 / 2)	1. MCO authorization processes are similar. 2. There are some billing and authorizations challenges with the MCOs. 3. Senate Bill 109 has caused confusion among providers regarding authorization requirements.	**Low**
Independent Assessor Recommendations				
4 Given the confusion on SB 109 on authorizations and ASAM levels of care, 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				
5 In conjunction with the MCOs, the DMMA should provide regular training opportunities, including development of a provider toolkit, on ASAM criteria to providers.				
State's Response	Both the SOR grant to DSAMH and the SUPPORT demonstration project have resources reserved for technical assistance. ASAM criteria and the application of SB109 can be topics of some of that TA. By working through both DMMA and DSAMH, we will be able to educate the majority of providers in the state.			
#3 Use of Nationally-Recognized SUD-specific Program Standards for Residential Treatment	N/A (none identified)	none to report	1. Peer support credentialing is an issue. 2. Credentialing with the MCOs can be problematic and lengthy.	**Low**
Independent Assessor Recommendations				
6 The DMMA should review the staffing requirements in the state's regulations to see if the provider feedback merits reconsideration related to delivery of residential treatment services along the ASAM continuum of care.				
State's Response	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.			

Exhibit D.1 (continued)
Assessment of State's Ability to Meet Milestones at Mid-Point of SUD Waiver

Milestone	Action Items in Implementation Protocol	Critical Monitoring Metric Goals	Key Themes from Stakeholder Feedback	Risk Level
	# and % Completed	# and % Goal Met		
#4 Sufficient Provider Capacity at Critical Levels of Care	75% (3 / 4)	0% (0 / 2)	1. Staffing requirements and low reimbursement rates are barriers to residential treatment capacity. 2. Residential treatment services cited as the service least available. 3. Provider network for residential treatment is not extensive enough, particularly lower ASAM levels.	**High**
Independent Assessor Recommendations				
7 The DMMA is encouraged to develop a report that tracks beds by provider and ASAM level, with a specific focus on who currently accepts Medicaid clients.				
8 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.				
9 The DMMA should also outreach to existing providers and potential other entities about options to build a supportive housing network of providers statewide. Both providers and members mentioned the need for supportive housing options for those receiving medication assisted treatment.				
10 The DMMA should consider financial and/or non-financial incentives (e.g., reduced administrative requirements) to incentivize providers to develop residential treatment programs specifically for adolescents.				
11 The DMMA may consider piloting a bundled payment model for selected residential programs to encourage participation. A bundled payment could reduce administrative burden and allow for more predictable cash flow for smaller-size providers.				
State's Response	7) A provider directory that includes ASAM levels is a planned deliverable from the SUPPORT TA project. 8) As part of the SUPPORT planning grant rate study, DMMA will be engaging with providers on the study's findings. That can serve as an opportunity to assess interest in expanding ASAM levels available via existing providers. 9) 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 internal and external to DHSS to increase supportive housing for a variety of populations. 10) The Department of Children, Youth and Families 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 potentially residential services. 11) DMMA has a variety of efforts to encourage value-based payment, such as bundled services. In addition to general requirements to move all expenditures toward higher levels of VBP arrangements over time, DMMA plans to work on alternative payment models as part of the SUPPORT demonstration.			

Exhibit D.1 (continued)
Assessment of State's Ability to Meet Milestones at Mid-Point of SUD Waiver

Milestone	Action Items in Implementation Protocol	Critical Monitoring Metric Goals	Key Themes from Stakeholder Feedback	Risk Level
	# and % Completed	# and % Goal Met		
#5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse	N/A (none identified)	67% (2 / 3)	1. Perceived lack of urgency regarding SUD treatment services in Delaware. 2. DMMA could have asked for more in its SUD waiver request to enhance the service continuum.	**Medium**
Independent Assessor Recommendations				
12 The DMMA should encourage or require a SUD-specific quality improvement program from each of its MCOs that focuses on one or more of the SUD-related measures. Examples could include a study of the root cause analysis of barriers for follow-up after ED visits.				
13 The DMMA should track access to both OTP and OBOT and identify strategies to support the increased use of OBOT and buprenorphine waivered clinicians.				
14 The DMMA should confirm that cause of death records from Vital Statistics will be provided in early 2022 to meet the May 31, 2022 reporting deadline.				
State's Response	12) 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. 13) Expanding the availability of OBOT services is a major focus of our SUPPORT demonstration project. We plan to support providers in developing functioning OBOT models via technical assistance, enhanced reimbursement, and strengthening referral networks. 14) DMMA leadership is in direct contact with the Department of Public Health about this topic.			

Exhibit D.1 (continued)
Assessment of State's Ability to Meet Milestones at Mid-Point of SUD Waiver

Milestone	Action Items in Implementation Protocol # and % Completed	Critical Monitoring Metric Goals # and % Goal Met	Key Themes from Stakeholder Feedback	Risk Level
#6 Improved Care Coordination and Transition Between Levels of Care	0% (0 / 2)	71% (5 / 7)	1. Care coordination activities by MCOs with providers is limited. 2. Providers would like help with discharge and after care planning.	**Medium**
Independent Assessor Recommendations				
15 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.				
16 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.				
17 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.				
State's Response	15) DMMA will be revising the reporting specifications for the MCOs in the next year and plan to include this in the next version of the reporting manual. 16) DMMA can encourage additional provider involvement in transitions through PIPs or value-based payment metrics. 17) 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.			

ATTACHMENTS

Independent Assessor Description

The HMA-Burns team met with the leadership of DMMA on September 14, 2021 to discuss the requirements of the content of the Mid-Point Assessment report and to review a draft report outline. The DMMA team asked questions about the approach that the HMA-Burns team would take to conduct the assessment, but DMMA honored the independence of the assessment team and allowed the HMA-Burns team to conduct its work unhindered.

The HMA-Burns team gave a status report to the DMMA team on November 10, 2021 on the progress to date in conducting the assessment. At this time, the HMA-Burns team notified DMMA that they would be required to offer a response to the assessment and the recommendations put forth.

The draft version of the Mid-Point Assessment was delivered to DMMA on November 29, 2021. A meeting was held with DMMA leadership on December 7, 2021 to review the report contents, key findings, and recommendations. After this meeting, the DMMA convened internally to discuss how to write the state response to the findings and recommendations. Later, a follow-up meeting was held between DMMA and HMA-Burns to discuss the state response and to incorporate it into the body of the Mid-Point Assessment report. The State's response to this Mid-Point Assessment appears on page 33, "Next Steps Identified by the State" and in the green boxes that are shown in Exhibit D.1.

Attestation

As the Project Director of this engagement, I am providing assurances there is no conflict of interest between the team members that conducted this Mid-Point Assessment and DMMA or its contracted managed care organizations.

Mark Podrazik

Mark Podrazik, Managing Director
Burns & Associates, a Division of Health Management Associates
December 28, 2021

Data Collection Tools

Refer to the pages that follow for the six collection tools utilized by the HMA-Burns team in this assessment:

1. Template used to request SUD-related service authorizations from the MCOs
2. Tool used in the review of the sample of service authorization cases
3. Template used to request case management rosters from the MCOs
4. Provider interview questions
5. Medicaid beneficiary interview questions
6. MCO interview questions

Attachment 1

Instructions and Guide to MCOs Related to SUD Authorization Requests

Guide to Focus Study on Service Authorizations

As part of the two Section 1115 waiver evaluations for Delaware (Medicaid managed care and substance use disorder services specifically), the Burns & Associates team from Health Management Associates (B&A) will be conducting a review of service authorizations in the managed care program. This focus study is intended to address one of the 12 Evaluation Questions posed in the 1115 waiver evaluation design and a component of one of the 5 Evaluation Questions posed in the SUD waiver evaluation design.

From the Section 1115 waiver evaluation design document to CMS:

Evaluation Question #4: Do service authorizations provide an effective tool in the appropriate utilization of health care services in the current waiver period?

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.

From the SUD waiver evaluation design document to CMS:

Evaluation Question #1: Does the demonstration increase access to and utilization of SUD treatment services?

Evaluation Hypothesis #1.3: Approved service authorizations improve appropriate utilization of health care services in the post-waiver period.

Measures examined: (both 1115 and SUD)

- Average turnaround time for authorization decisions
- Rate of approved and denied authorizations
- Frequency and percentage of denial reason codes

Approach

The specific service categories under review are services for individuals with SUD. The time period under review is for authorizations requested for services rendered from September 1, 2019 to February 29, 2020. This is the first of two reviews of service authorizations. A second review is expected to be conducted in a similar manner as this one during Calendar Year 2023.

The service authorizations study will examine:

- MCO process flows for SUD service authorization determinations
- Staffing at each MCO for the service authorization function specific to SUD or other behavioral health services
- Training and monitoring of staff performing service authorization functions specific to SUD
- The volume of SUD authorization requests, by type of service, and the MCO's determination related to each request

B&A's review will include the following components:

- An interview to discuss policies and procedures related to these authorization categories;
- A quantitative analysis (desk review) of service authorization requests in these two categories made to each MCO during the six-month study period; and
- A review of a sample of service authorizations to review procedures used and the information considered in the MCO's determination of the authorization request. At this time, it is anticipated that the sample drawn for each MCO will be 30 SUD authorization requests. The sample will be inclusive of approved and denied authorization requests. Due to pandemic restrictions, we would like to discuss with each MCO the feasibility of conducting this review via Zoom.

The B&A team that will participate in this review include Mark Podrazik (HMA Managing Director) Director), Debbie Saxe (HMA Principal), Shawn Stack (HMA Senior Consultant), Akhilesh Pasupulati (HMA SAS Programmer), Barry Smith (HMA Analyst), and Dr. Craig Thiele (HMA Principal).

Steps of Review

1. The B&A team will meet with each MCO in a 1-on-1 session via Zoom on **November 12, 2020**. The meeting is expected to be two hours but broken into segments. The purpose of this meeting is three-fold:
    a. Interview MCO staff with knowledge of the MCO's authorization process for SUD and behavioral health-related service requests. Refer to Appendix A (at the end of this file) for the questions that will be asked of each MCO during this session. *90 minutes*
    b. Review the data request that will be made of each MCO. Refer to Appendix B (in the separate Excel file) for the draft of the data request related to SUD -related service authorizations. *15 minutes*
    c. Obtain a sneak preview of the software used by the MCO (sample screens) to capture authorization request information. Determine the feasibility of viewing this information via a Zoom meeting under the direction of MCO staff. *15 minutes*

2. B&A anticipates that there may be a need to revise the data request template after consultation with each MCO. A final data request will be released to each MCO by **November 20, 2020**. The due date for submission of the data to the B&A team will be **December 8, 2020**.

3. B&A's data analyst will intake, compile and analyze the service authorizations form each MCO. A sample of cases will be drawn from each MCO's total pool of authorizations during the study period. This sample will be given to each MCO by **December 18, 2020**.

4. B&A will create a review tool to capture information about each service authorization that will be reviewed in the sample.

5. The sessions to review the sample cases are scheduled for **the week of January 11**. It is our intent that Debbie Saxe, Shawn Stack and our clinical expert Dr. Craig Thiele will attend these sessions. Sessions will be set up in coordination with each MCO. There may be one longer session or multiple smaller sessions. One session will be specific to the non-clinical component of SUD services and will be conducted by Debbie Saxe and Shawn Stack. The other session will be specific to the clinical component and will be conducted by our clinical expert Dr. Thiele. The non-clinical team will review the cases for process-related items. The clinician will provide

an opinion if he concurs or not with the MCO's decision based on the information provided and the guideline(s) applied.

The results of the quantitative analysis, the qualitative review, and the review of sample cases will be summarized in a report specific to this focus study. Each MCO will be provided feedback on the overall findings and, if necessary, MCO-specific feedback.

Appendix A
MCO Interview Questions Related to Service Authorizations for SUD Services

1. Describe the composition of the team that reviews service authorization requests for (a) SUD services and (b) other behavioral health services.

    a. Are they a specialized unit in your PA group or could all PA staff review the requests in these categories?
    b. If it is a separate unit, how many individuals work in it (admin, nurse reviewers, physician/other professionals)?
    c. Where are they located?
    d. What days and times of the week is the SUD services and PROMISE services group(s) staffed to process and respond to authorization requests submitted by providers?
    e. Do you delegate and/or sub-contract the any of this function? If so, to whom?

2. What modes can providers submit service authorization requests? What is the most common? What are the days and hours in which each of these modes are operational? Is there a recommended mode for 'after-hours' authorization requests?

3. Please provide details on activities within each step of the service authorization intake and review process: (to initial clinical review to final clinical review/determination).

    a. Initial intake, include any verifications completed
    b. Administrative approvals/denials
    c. Initial clinical review
    d. Final clinical review/determination

4. When considering SUD-related services, which services do **not** require prior authorization?

5. What documentation is required to complete a service authorization request for SUD?

    a. Does the information request vary if the request is pre-service vs. concurrent review?

6. Is there follow-up with a provider if the authorization request submission is incomplete? Or does it go immediately to administrative denial?

7. For SUD services, how are the majority of requests categorized—pre-service, concurrent, or retrospective? Does this vary between inpatient, residential treatment, and outpatient?

8. Do you follow NCQA guidelines for turnaround time or does DMMA require something different?

9. Describe the process of final determination and provider notification related to denied authorization requests.

10. Who is authorized to do denials due to lack of medical necessity for SUD services?

11. What clinical criteria do you utilize for SUD authorizations? Does the criteria differ based on the type of authorization request (e.g. inpatient vs. other services?)

12. What is your opinion of the utility of the ASAM criteria with respect to service authorization determinations?

13. If you use/consider ASAM criteria, are there certain elements within the six dimensions that carry more weight in the decision-making process for SUD authorization requests than others?

14. How would you characterize the level of appeals from providers (members) for SUD denied authorization—more, less or about the same as other non-SUD services?

15. Do you track and trend providers from the perspective of frequency of denials/appeals/hearings?

16. What, in your opinion, has been the greatest challenge (if any) pertaining to working with providers on SUD authorization requests?

17. Has there been other guidance/direction from DMMA of significance not mentioned above that the waiver evaluators should be aware of with respect to SUD-related services?

18. Are there any other pertinent points you want to convey to the waiver evaluators specific to the service authorization process not covered already?

Instructions for Submitting Data Elements Related to SUD Service Authorization Requests

This tab provides the working definitions for the data elements requested in the tab called "Auths template".

Instructions on Submission

The Burns & Associates team at HMA, B&A (HMA), is requesting an itemized listing of all SUD auths received by the MCO from September 1, 2019 to February 29, 2020, regardless of the final determination date.
If multiple requests (lines) are on the same auth, be sure to enter each line separately on the template. B&A recognizes that when this occurs, it may be that multiple lines on the spreadsheet will have the same internal auth ID.

For purposes of this study, "auths" include pre-service, concurrent and retrospective authorizations.

The order in which the auths are listed in your output file is not important. For example, the auths do not need to be listed in chronological order by Date Requested if it is easier for the MCO to output in some other manner.

Please submit back to the HMA SharePoint site no later than ***Tuesday, December 8, 2020.***
Place this file under SharePoint folder for (*enter MCO specific folder link on SharePoint*).
For questions on this data request, please call Debbie Saxe, B&A (HMA) at (614) 582-4189.

Definitions of Data Elements Requested

Column		
A	Date Auth Requested	Indicate the initial date that the request was made for pre-service, or the date assigned for concurrent or retrospective authorizations. B&A (HMA) recognizes that the initial date does not necessarily indicate the date that all information was received for the MCO to make an authorization determination.
B	Internal or Case ID for the Auth	The unique ID assigned by the MCO for the authorization request. This ID will be used by B&A (HMA) to communicate back to the MCO the final sample of auths that will be reviewed for this project.
C	Line ID for Auth	Delineates multiple requests (lines) associated with one authorization
D	Requisition Number for Auth	Requisition number associated with the Case ID, if applicable. **optional field**
E	Requesting (Service) Provider ID	Enter either the DMES Provider ID or an MCO internal provider ID assigned to the provider.
F	Crosswalk to DMES Provider ID	If the MCO did not enter the Service Provider's DMES Provider ID in the previous column, then please crosswalk your internal provider ID to the DMES ID.
G	Member Medicaid ID	The ID of the member that the service authorization is being requested on behalf of. If the DMMA-assigned Medicaid ID is not readily available, please use the MCO internal member ID assigned to the member.
H	Auth Type	Indicate if this authorization was Pre-Service, Concurrent, or Retrospective.
I	Service Type	Using the dropdown list, enter the ASAM level that relates to the service being requested for SUD. Leave blank if the ASAM level is not recorded as part of the SUD authorization, and submit a crosswalk from HCPCS/CPT code to ASAM level by email directly to Debbie Saxe at HMA.
	ASAM 1	Outpatient services
	ASAM 2.1	Intensive outpatient services
	ASAM 2.5	Partial hospitalization
	ASAM 3.1	Clinically managed low-intensity residential services
	ASAM 3.3	Clinically managed population-specific high-intensity residential services
	ASAM 3.5	Clinically managed high-intensity residential services
	ASAM 3.7	Medically monitored intensive inpatient services
	ASAM 4.0	Medically managed intensive inpatient services
J	CPT or HCPCS	Enter the specific CPT or HCPCS related to this auth (note this is not necessary for inpatient hospital SUD requests).
K	Modifier #1	Enter Modifier #1 billed with the CPT or HCPCS code, if applicable
L	Modifier #2	Enter Modifier #2 billed with the CPT or HCPCS code, if applicable
M	Modifier #3	Enter Modifier #3 billed with the CPT or HCPCS code, if applicable
N	Administrative Review Only	Indicate Yes or No if the authorization was only reviewed by administrative staff.
O	Reviewed by RN, LPN, BH/SUD	Indicate Yes or No if the authorization was reviewed by an RN, LPN, BH/SUD professional at any time.

Instructions for Submitting Data Elements Related to SUD Service Authorization Requests

P	Reviewed by MD/DO or BH/SUD	Indicate Yes or No if the authorization was reviewed by a physician, licensed BH professional or addictions specialist at any time.
Q	Date of Determination	Indicate the date that final determination was made for the auth request. B&A understands that there may be a significant number of days between the Determination Date and the Date Auth Requested if all of the information was not provided by the Requesting Provider in a timely manner.
R	Disposition Code	Enter one of the letters A, D, P, C or W that stand for Approved, Denied, Pending, Cancelled or Withdrawn. Note that Cancelled includes requests deleted by the MCO and Withdrawn includes requests cancelled by the provider.
S	Denial Reason Code	When Disposition = Denied, select the most appropriate reason code from the drop-down list below. If your MCO has pre-set denial reason codes, you may use these. Send the mapping of codes with descriptors directly to Debbie Saxe at HMA.
	1	Non-covered service
	2	Untimely filing of initial request
	3	Request filed timely, but failure to submit requested documentation timely
	4	Not medically necessary
	5	Other

REPORT #1 All SUD Authorizations Requested from 09/01/19 - 02/29/20

A	B	C	D	E	F	G	H	I	J
Date Auth Requested [mm/dd/yy]	Internal or Case ID for the Auth	Line ID for Auth (if applicable)	Requisition Number for Auth (if applicable)	Requesting (Service) Provider ID	Crosswalk to DMES (only fill in if Column E is not the DMES ID)	Member Medicaid ID	Auth Type P = Preservice; C = Concurrent; R = Retrospective	Service Type Enter the ASAM Level (refer to crosswalk)	Specific CPT or HCPCS (if applicable)

K	L	M	N	O	P	Q	R	S
Modifier #1	Modifier #2	Modifier #3	Auth Reviewed by Administrative Staff Only? Enter Yes or No	Reviewed by RN, LPN, or BH/SUD? Enter Yes or No	Reviewed by MD/DO or BH/SUD? Enter Yes or No	Date of Determination of the Auth [mm/dd/yy]	Disposition Code A = Approved; D = Denied; P = Pending; C = Cancelled; W = Withdrawn	Denial Reason Code

Attachment 2

SUD Authorization Review Tool

SUD AUTHORIZATION REVIEW TOOL

B&A Reviewer Initials _____ Date B&A Reviewed _____

MCO Case or Auth ID _____ Member MID _____

MCO Auth Line ID _____ MCO Requisition # _____

1. Indicate MCO
   ☐ AmeriHealth ☐ Highmark

2. Record relevant dates related to this authorization (mm/dd/yy)
   a. Date Auth was Requested _____ b. Date of Final Determination _____

3. Mode of Initial Auth Request? (place an X in only 1 box)
   ☐ Fax ☐ Phone ☐ Portal ☐ Cannot be determined

4. Type of Auth Request? (place an X in only 1 box)
   ☐ Pre Service ☐ Concurrent Review ☐ Retrospective ☐ Cannot be determined

5. Place an X in the most appropriate box to indicate the service category for auth request.
   ☐ Inpatient hospital ☐ Residential treatment ☐ Any outpatient service ☐ Other

   5a. If Inpatient, # of days requested _____ If any were approved, how many? _____

   5b. If RTC, # of days requested _____ If any were approved, how many? _____

   5c. If Outpatient, enter CPT code _____ If no CPT code, write description _____

6. Who is the highest level staff member to reviewed the Auth Request? (place an X in only 1 box)
   ☐ Administrative staff *only* ☐ Nurse/Mid Level BH Prof ☐ Physician/MH Professional ☐ Cannot be determined

7. Clinical documentation was supplied with the initial auth request by the provider (either via fax or by phone and recorded by MCO)
   ☐ Yes ☐ No ☐ Cannot be determined

8. What was the *Initial* Determination for the Auth Request? (place an X in only 1 box)
   ☐ Approved ☐ Denied ☐ Pending ☐ Cannot be determined
   ☐ Cancelled ☐ Withdrawn

9. ☐ Check if evidence in file that requesting provider asked for reconsideration after initial detemination was made.

10. ☐ Check if evidence in file that a physician peer-to-peer was conducted (either before or after determination made).

11. If answer to #9 or #10 is Yes, what was the *Final* Determination for the Auth Request? (place an X in only 1 box)
    ☐ Approved ☐ Denied ☐ Pending ☐ Cannot be determined

Complete Questions 12-16 only if the authorization request was denied or pending.

12. Denial Reason: ☐ Admin untimely filing ☐ Admin any other reason ☐ Not Medically Necessary
    ☐ Other (describe) _____

13. If reason for denial was "not deemed medically necessary", what criteria was used to justify this? (check all that apply)
    ☐ Milliman (MCG) ☐ InterQual ☐ MCO Clinical Guidelines ☐ ASAM

14. Who signed the denial/modified disposition letter to the requesting provider? (Check only 1) ☐ No written letter found
    ☐ MD or BH professional ☐ Nurse or BH mid-level ☐ No signature (generic such as "from Medical Management")

15. Indicate the level of detail provided in the letter pertaining to clinical criteria. ☐ Language from MCO guideline
    ☐ Specific citation for MCG, InterQual or ASAM stated ☐ Specific citation not provided, just general reference

16. Clinician's independent review. Given the information presented in the file for this authorization requested, was the denial appropriate?
    ☐ Yes
    ☐ No Why? _____
    ☐ Unable to determine Why? _____

Attachment 3

Instructions and Template to MCOs For Case Management Rosters

Delaware Transitions to Care Focus Study

MCO Name:

Active Enrollees in Case Management or Care Coordination for BH Conditions, SUD Conditions, Pregnancy, or HCBS Service Coordination

Notes:

1. Please provide the names of each individual actively enrolled in Case Management or Care Coordination at any time between Oct 1, 2019 and Dec 31, 2020.
   "Actively enrolled" is defined as: (1) identified for case or care management AND (2) member accepted enrollment into case/care management AND
   If enrolled in Case Management, a care plan was developed for the member
   If enrolled in Care Coordination, there was at least one contact with the member after they accepted participation in Care Coordination.
2. Individual members can be shown on more than one line in this report if:
   The member moved up from care coordination to case management and you track the duration of these events separately.
   The member moved down to care management from case management and you track the duration of these events separately.
   There was a gap during the study period when the member was in case or care management, disenrolled, then re-enrolled later.
3. For Column F, it is expected that some Date Began Enrollment dates will be earlier in CY 2019.
4. For Column G, it is expected that some Date Disenrolled dates will be in CY 2021. If the member is still enrolled as of 12/31/20, enter "Still Enrolled".

Please submit back to the HMA SharePoint site no later than close of business Monday, ***October 25, 2021.***

Place this file in the SharePoint folder using the MCO specific *link provided by HMA IT* .

For questions on this data request, please call Debbie Saxe, HMA-Burns at (614) 582-4189.

A	B	C	D	E	F	G	H	I	J
			CC = care coord CM = case mgmt			Place an X in every column that is applicable to the member for the condition(s) of interest that pertain to why the member is in Case Management or Care Coordination.			
Medicaid MID (not MCO's unique ID)	Member Last Name	Member First Name	Type (CC or CM)	Date Began Enrollment mm/dd/yy	Date Disenrolled mm/dd/yy	SUD	Pregnancy	HCBS	MCO specific BH Condition(s)

Attachment 4

Questions for Facilitated Interviews with SUD Providers

Facilitated Discussion with Provider Representatives
Delaware 1115 SUD Waiver Mid-Point Assessment

When the State applied for the Substance Use Disorder (SUD) waiver to gain additional state authorities and additional federal matching dollars, it made assurances to CMS that it would have independent evaluations conducted throughout the waiver period. Burns & Associates, a Division of Health Management Associates (HMA-Burns) was hired to conduct these evaluations. There are three specific deliverables that HMA-Burns is responsible for:

- An ***Interim Evaluation***. This is required by CMS to assess if meaningful change is occurring with respect to the waiver's goals. This is completed at the half-way point of the 5-year waiver period. HMA-Burns is scheduled to complete this deliverable December 31, 2022.
- A ***Summative Evaluation***. This will be completed by HMA-Burns at the end of the SUD waiver period. We will look at all measures that CMS and the State have defined over multiple years as a way to assess if meaningful change has occurred. This evaluation is not due until 2025.
- A ***Mid-Point Assessment***. This is the reason for our meeting with you. The Mid-Point Assessment is meant for us to assess the State's progress-to-date on waiver goals. HMA-Burns is specifically asked to obtain feedback from stakeholders related to what they perceive to be working/not working, what has improved/what still needs to be improved, and the greatest successes/greatest challenges thus far in the waiver. We greatly appreciate that your organization has agreed to provide feedback to the HMA-Burns team to assist them with completion of this task.

To that end, members of the HMA-Burns team will lead a facilitated discussion. The team members assigned to your organization are Mark Podrazik and Debbie Saxe. We ask that you review the questions below that will be covered in the discussion so that you have had an opportunity to think through your responses. All feedback provided will be verbal and will not be attributed to an individual or organization by name.

Facilitated Discussion with Provider Representatives
Delaware 1115 SUD Waiver Mid-Point Assessment

1. Were you given any guidance by DMMA or the MCOs about the SUD waiver, when it would start, what it means to you as a provider? If yes, what is your opinion about the guidance provided to you? In hindsight, could DMMA or the MCOs have done more related to some items? What specifically?

2. Is there anything that you believe the DMMA could still do to improve guidance related to SUD waiver implementation efforts or SUD service delivery more broadly?

3. What do you think about the adequacy of the provider network across the spectrum of DE ASAM levels of care? If you think improvements are needed, where specifically (e.g., certain ASAM levels, certain regions of the state)?

4. What is your opinion of the prior authorization processes established by the Medicaid MCOs?
    a. Do you perceive meaningful difference in the process that you are asked to complete between the two?
    b. Do you perceive a meaningful difference in the authorization determinations between the two?
    c. What improvements, if any, would you suggest to the authorization process itself?

5. How would you assess your interactions with the MCOs regarding billing for SUD services? Is one MCO easier to work with than the other? If there are differences, what do you see?

6. How would you assess your interactions with the MCOs regarding care coordination for members? Do the MCOs assist you with coordinating care for members? If you think improvements are needed, where specifically?

7. Do you perceive that there is still confusion on the part of members about covered services for SUD? If yes, what specifically?

8. What, in your opinion, has improved in the delivery of treatment for SUD with the implementation of the waiver August 1, 2019? Has any particular item gotten worse?

9. Are there unexpected positive outcomes that you can cite that resulted from this waiver?

10. Are there unexpected negative outcomes that you can cite that resulted from this waiver?

11. Do you have recommendations to HMA-Burns related to the delivery of treatment for SUD that you would like communicated in the Mid-Point Assessment?

Attachment 5

Survey Tool for Medicaid Members Receiving SUD Treatment

Delaware 1115 SUD Waiver Mid-Point Assessment
Member Questionnaire

Hello. Our company, Health Management Associates, was hired by the State of Delaware to review services for people seeking treatment for alcohol and drugs. The State is trying to expand services available for treatment throughout Delaware. The federal government is providing money to Delaware to help them do that. In return, the federal government wants to hear from citizens of Delaware getting treatment and providers delivering treatment to see how it is going.

We wanted to ask you four questions to see what you think. This will take about 5 minutes for you to complete the questionnaire. **You do not need to give us your name or other personal details on the survey**. Your service provider will be giving you a link to submit this survey to us online. We wanted you to see this hard copy of the survey so that you know in advance the questions that you will be asked.

Place a ☑ in the boxes below that best matches your answer to each question.

1. How did you find out about where you could get treatment? Please check all that apply to you.
   - a. Family member ❒
   - b. Friend ❒
   - c. Sponsor ❒
   - d. Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings ❒
   - e. Healthcare provider (doctor, nurse, physician assistant, hospital, clinic) ❒
   - f. Court/jail/prison/law enforcement/parole office ❒
   - g. Website ❒
   - h. Homeless shelter ❒

2. Was it hard to figure out where to get treatment? ❒Yes ❒ No
   If you answered Yes, please check all of the reasons why that apply to you.
   - a. Could not find a provider near my home ❒
   - b. Found a provider, but they have a waiting list ❒
   - c. Provider won't take Medicaid ❒

3. What do you think would help you or others who are seeking treatment about how they can find providers to help them? Please check all that you think would help.
   - a. Social media ❒
   - b. Radio or television ❒
   - c. Billboards ❒
   - d. AA/NA meeting locations ❒
   - e. Healthcare provider (doctor, nurse, physician assistant, hospital, clinic) ❒
   - f. Court/jail/prison/law enforcement/parole office ❒
   - g. Targeted outreach (e.g., schools) ❒
   - h. Government offices (e.g., WIC, welfare, county) ❒
   - i. Homeless shelter ❒
   - ❒

4. Are there services that you need but you cannot find help for? Please provide feedback for all services that apply to you and how much of a problem it is to find the type of provider.

	Type of provider	Big Problem	Small Problem	No Problem	Doesn't Apply to Me
a.	Primary Care Doctor	❑	❑	❑	❑
b	Psychiatrist	❑	❑	❑	❑
c.	Psychologist	❑	❑	❑	❑
d	Counselor	❑	❑	❑	❑
e.	Residential treatment	❑	❑	❑	❑
f.	Outpatient treatment	❑	❑	❑	❑
g.	Medication assisted treatment (MAT)	❑	❑	❑	❑
h.	Methadone	❑	❑	❑	❑
i.	Suboxone/Subutex	❑	❑	❑	❑
j.	Detoxification	❑	❑	❑	❑
k.	Transportation	❑	❑	❑	❑

Attachment 6

Questions for Facilitated Interview with Delaware Medicaid MCOs

Facilitated Discussion with MCO Representatives for SUD Waiver Mid-Point Assessment

October 11, 2021 (11:30 am to 1:00 pm)

Zoom Conference Call

As the State's independent evaluator, the Burns & Associates team at Health Management Associates (HMA-Burns) will facilitate this MCO stakeholder group discussion to gain feedback that can be included in the Mid-Point Assessment of Delaware's SUD waiver that will be submitted to CMS by December 31, 2021.

One of HMA-Burns' requirements in the Mid-Point Assessment is to obtain feedback from stakeholders specifically related to what they perceive to be working/not working, what has improved/what still needs to be improved, and the greatest successes/greatest challenges thus far in the waiver.

To that end, Mark Podrazik and Debbie Saxe from the HMA-Burns team will lead a facilitated discussion. We ask that you review the questions below that will be covered in the discussion so that you have had an opportunity to think through your responses. All feedback provided will be verbal and will not be attributed to an individual by name.

1. We recognize that there were not fundamental changes to the delivery of SUD services with the introduction of this waiver. But from a broader perspective related to SUD service delivery for Medicaid beneficiaries, what is your opinion on the guidance provided to you by DMMA related to SUD service delivery and any specific MCO responsibilities related to the waiver itself? Were you given any specific guidance about the waiver?

2. Is there anything that you believe the DMMA could still do to improve guidance related to SUD waiver implementation efforts or SUD service delivery more broadly?

3. What do you perceive the MCOs were asked to do related to the waiver implementation? Did the expectations change over time? If yes, how so?

4. What is your opinion of the adequacy of the provider network across the spectrum of Delaware ASAM levels of care? If you think improvements are needed, where specifically (e.g., certain DE ASAM levels, certain regions of the state)?

5. How would you assess provider compliance with contracting, authorization or billing rules today? How does this compare to the period in CY2018?

6. Do you perceive that there is confusion on the part of providers about covered services for SUD? If yes, what specifically?

7. Do you perceive that there is confusion on the part of providers about processes for SUD (e.g., authorization submissions, billing)? If yes, what specifically?

8. What, in your opinion, has improved in the delivery of treatment for SUD since CY2019 ? Has any particular item gotten worse since then?

9. Are there unexpected positive outcomes that you can cite that resulted from this waiver?

10. Are there unexpected negative outcomes that you can cite that resulted from this waiver?

11. Do you have recommendations to HMA-Burns related to the delivery of treatment for SUD that you would like communicated in the Mid Point Assessment?