DELAWARE HEALTH AND SOCIAL SERVICES

Division of Medicaid & Medical Assistance

Thomas Long
Division of Medicaid Expansion Demonstrations
State Demonstrations Group
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
Telephone: (410) 786-5019
Email: Thomas.Long@cms.hhs.gov

Diamond State Health Plan

Section 1115 2021 3rd Quarterly Report

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

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Kimberly Xavier
Social Service Chief Administrator
Planning & Policy
Division of Medicaid and Medical Assistance
Telephone: (302) 255-9628
Email: Kimberly.Xavier@delaware.gov

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Introduction

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

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

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

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

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

Additionally, this amendment expanded HCBS to include:

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

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

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

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

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

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

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

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

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

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

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

In accordance with the STCs of the DSHP 1115 demonstration, the Delaware Division of Medicaid and Medical Assistance submits this third quarter report (for the quarter ending September 30, 2021), Demonstration Year 26.

Enrollment Information and Enrollment Counts

Q3 2021 Enrollment

Demonstration Populations	Current Enrollees (to date)	Disenrolled in Current Quarter
Population 1: Former AFDC Children less than 21 (DSHP TANF Children)	101,015	12
Population 2: Former AFDC Adults aged 21and over (DSHP TANF Adult)	37,364	14
Population 3: Disabled Children less than 21 (DSHP SSI Children)	5,681	5
Population 4: Aged and Disabled Adults 21 and older (DSHP SSI Adults)	6,661	28
Population 5: Infants less than one year of age with income levels above 185 percent FPL through 200 percent FPL; optional targeted low income children (DSHP MCHIP)	N/A	N/A
Population 6: Uninsured Adults up to 100% FPL (DSHP Exp. Pop.)	69,295	134
Population 7: Family Planning Expansion (FP Expansion)	None; program terminated in 2013	N/A
Population 8: DSHP-Plus State Plan	10,128	140
Population 9: DSHP-Plus HCBS	5,920	99
Population 10: DSHP TEFRA-Like	299	0
Population 11: Newly Eligible Group	13,246	8
Population 12: PROMISE	1,472	77
Population 13: Former Foster Care Youth	0	0

Definition: "Current Enrollees (to date) is an unduplicated count of clients in the MCO for at least one day in the July 1, 2021 to September 30, 2021 period based on capitation claims and for the MC and PROMISE enrollment and eligibility files. Clients who were in more than one eligibility category during the quarter are reported based on their last status (most recent month). Age calculated as of the first day of the most recent month of enrollment, consistent with reporting of member months.

Outreach and Innovative Activities

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

Continued the Expansion of Home-Delivered Meals in Q3– Under the Appendix K authority provided in the DSHP 1115 Waiver, DMMA continued providing additional home-delivered meals to vulnerable clients served in the DSHP Plus HCBS Program. Highmark Health Options (HHO) and AmeriHealth Caritas DE performed extra outreach to DSHP Plus members to inform them of this extra benefit.

MCO Outreach – Below are examples of outreach conducted during Q3 by DMMA's MCO partners.

- **Highmark Health Options (HHO) Outreach Events**
- On Saturday, July 15th, 2021, from 10am to 1pm, two of the HHO Medicaid Member Advocates attended a Community Wellness Health Fair at Father Tucker Memorial Field in Wilmington, which was a day of fun and free health services for the entire family. Free Services included: COVID 19 Vaccines, wellness demonstrations, vision screenings, dental screenings, senior services and dietary & fitness programs.
- HHO held two Member Advisory Committee meetings in the third quarter. These meetings provide an opportunity for members to provide feedback that enables HHO to educate and better serve their members.

AmeriHealth Caritas Outreach Events

In July and August, AmeriHealth Caritas DE participated in several Back to School events in the community. AmeriHealth Caritas DE distributed information on health risk assessments, their 24/7 Nurse Call Line, pediatric care management, immunization reminders, mammogram scheduling, parenting classes, their GED program, health education, preventive screenings, Bright Starts, and care coordination. AmeriHealth Caritas DE also provided school backpacks and supplies to approximately 50 members.

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

Q3 Innovative Activities

Social Determinants of Health (SDOH) – With the continuation of the Public Health Emergency, DMMA continued to focus on addressing food insecurity in Medicaid through two initiatives. The first initiative

is focused on working with our MCOs (through Appendix K authority in the 1115 Waiver) to increase the availability of home-delivered meals to DSHP Plus members receiving HCBS services.

The second initiative, the Postpartum Food Box Partnership, expanded the program to all postpartum members <8 weeks postpartum in July. The number of food box deliveries continues to increase each week, currently averaging around 250 food boxes per week. DMMA has received positive feedback from members and program partners on the support the program offers.

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

DMMA reviewed MCO/ACO provider contracts submitted by MCOs to ensure that the program implementation aligns with the ACO program as designed and described in the DMMA application. DMMA is providing feedback on the MCO/ACO contracts but is not formally approving the arrangements.

DMMA Special Interest Meetings/Conferences

Delaware Family Voices – DMMA continues to support Delaware Family Voices. Caring for children with special needs is often complex, and Delaware Family Voices and the Family to Family Health Information Center is in the unique position to help. This organization states that "We help families of children with special needs become informed, experienced, and self-sufficient advocates for their children and themselves." DMMA and our MCOs participate in these monthly calls assisting families to navigate the complex healthcare field. There were two monthly calls this quarter: August 10, 2021 and September 14, 2021. DMMA stays in regular contact with Delaware Family Voices outside of scheduled calls to assist any Medicaid family in need.

Maternal Child Health – The Maternal Child Health (MCH) Workgroup continues to meet to evaluate policy and coverage changes around maternal health. The workgroup has updated DMMA's breast pump and lactation services policies to ensure our policies are equitable and promote access to all of our members. The workgroup is also focusing their efforts to prioritize financing of evidence-based home visiting, postpartum expansion coverage, and doula coverage.

Collaboration with other divisions and stakeholders is an on-going focus of DMMA's Maternal Child Health lead. DMMA has partnered with DSAMH and DPH to increase engagement with pregnant and parenting women with substance use disorders. DMMA's continued engagement in Delaware Perinatal Quality Collaborative (DPQC), Maternal Mortality Review (MMR) and Fetal and Infant Mortality Review (FIMR) has guided MCH workgroup discussions and focus of policy changes and implementation.

In Q3, the EQRO completed a Maternal Health Focus study at the request of DMMA. Final reports of findings are anticipated to be shared with DMMA in October.

Post-award Public Forum

The post-award public forum was held in August 2021 at the MCAC meeting and reviewed DMMA's progress to date with implementation of the waiver terms and conditions:

- Implementation of retroactive eligibility for all pregnant women and children (July 2019)
- Implementation of a Medicaid adult dental benefit (October 2020)
- Continued coverage for IMD stays for individuals with substance use disorders
- Implementation of flexibilities under the 1115 to enable MCOs to address the COVID-19 PHE
- Planning for DSHP MCO reprocurement

DMMA did not receive any public comments on the waiver implementation.

Operational/Policy Developments/Issues

Q3 Operational and Policy Issues

Policy and Legislative developments

No updates.

MCO Operational Issues

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

DSHP 1115 Waiver Administration

No updates.

Other Program Issues

Support Act Grant – DMMA was awarded a $3.58 million planning grant from CMS to assess and expand

our capacity to treat substance use disorder (SUD) in Medicaid. After a supplemental award in March 2021, the total grant award is now $3.67 million. During the July-September 2021 period, we completed the final quarter of our Office Based Opioid Treatment (OBOT) fellowship, developed recommendations for SUD Medicaid reimbursement rate changes, presented our planning grant findings to six stakeholder groups, developed use cases for our internal surveillance dashboards, and completed our final recommendations report.

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

Program Integrity – As of September 2021, the Surveillance Utilization and Review Unit (SUR) has adopted a hybrid work schedule, the team works both from home and in the office as needed.

The SUR unit has experienced staffing changes, and is currently recruiting for data analysts and a nurse reviewer. Amidst all the staffing changes, the SUR unit has begun post payment reviews of Medicaid chiropractic services. The focus of the reviews is policy compliance and medical necessity. The chiropractic reviews will be the SUR unit's first time reviewing MCO encounter claims. The SUR unit is excited about the new endeavor and looks forward to working the MCOs to reduce fraud, waste, and abuse in the Delaware Medicaid Program.

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

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

The SUR unit dedicates a significant portion of its time overseeing the PERM audit and all required data has been submitted to the PERM contractors. The SUR unit will continue to work with the various PERM contractors to provide any additional data and to answer any questions that arise throughout the PERM cycle.

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

Expenditure Containment Initiatives

Q3 Expenditure Containment Initiatives

Medicaid/CHIP Accountable Care Organization Program (Medicaid ACO Program) –DMMA, under the direction of DHSS, developed a Medicaid ACO Program for the purpose of improving health outcomes

while reducing costs through value based purchasing (VBP) arrangements which include downside financial risk for ACOs. The Medicaid ACO program is part of the strategies DMMA is pursuing to advance the adoption of participating Medicaid VBP models and total cost of care (TCOC) strategies. DMMA developed an application to allow qualified provider organizations to apply to become Medicaid ACOs and subsequently contract directly with our Medicaid MCOs in a TCOC payment arrangement. DMMA believes that by working together, Medicaid ACOs and MCOs can better coordinate care for Delaware's Medicaid and CHIP members, providing better health outcomes and lower costs.

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

DMMA reviewed MCO/ACO provider contracts submitted by MCOs to ensure that the program implementation aligns with the ACO program as designed and described in the DMMA application. DMMA is providing feedback on the MCO/ACO contracts but is not formally approving the arrangements.

Financial/Budget Neutrality Development/Issues

Q3 Financial/Budget Neutrality/Issues

DMMA completed its reconciliation analysis and presented our findings to CMS in November. DMMA met with CMS to provide an overview of the major issues identified, the process used to identify the issues, and the impact on budget neutrality for the demonstration period covering CY 2014 – 2018. DMMA has scheduled several follow up meetings with CMS to walk through each DY and each adjustment to document the reconciliation process and to seek guidance from CMS on any adjustments within the financial reporting system (MBES/CBES) to address the reporting issues. DMMA has determined that the DSHP 1115 Waiver had a budget neutrality margin of $834 million dollars. CMS suggested an extension of STC 73(b) beyond the 12/31/21 reconciliation due date to allow CMS to work with Delaware to determine how best to effectuate the reporting corrections resulting from the completion of the reconciliation process.

Q3 2021 Member Month Reporting and With-Waiver PMPMs

Eligibility Group	Jul 2021 Member Months	Aug 2021 Member Months	Sep 2021 Member Months	Quarter ending 9/30/2021
DSHP TANF CHILDREN	98,847	99,455	99,952	**298,254**
DSHP TANF ADULT	36,107	36,454	36,750	**109,311**
DSHP SSI CHILDREN	5,577	5,566	5,563	**16,706**
DSHP SSI ADULTS	6,506	6,523	6,526	**19,555**
DSHP MCHP (Title XIX match)*	0	0	0	**0**
DSHP ADULT GROUP	79,122	79,869	80,300	**239,291**
DSHP-Plus State Plan	9,964	9,933	9,916	**29,813**
DSHP-Plus HCBS	5,737	5,787	5,832	**17,356**
DSHP TEFRA-Like**	294	293	293	**882**
PROMISE	**1,452**	**1,432**	**1,405**	**4,289**

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

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

Q3 2021 Member Months and WW PMPMs

Eligibility Group	Total Member Months for the Quarter	PMPM	Total Expenditures
DSHP TANF CHILDREN	298,254	$346.13	$103,235,139
DSHP TANF ADULT	109,311	$552.85	$60,432,833
DSHP SSI CHILDREN	16,706	$1,957.18	$32,696,598
DSHP SSI ADULTS	19,555	$1,687.51	$32,999,264
DSHP MCHP (Title XIX match)*	0	$0.00	
DSHP ADULT GROUP	239,291	$702.64	$168,136,064

DSHP-Plus State Plan	29,813	$1,464.69	$43,666,743
DSHP-Plus HCBS	17,356	$6,310.03	$109,516,947
DSHP TEFRA-Like**	882	$1,951.10	$1,720,874
PROMISE	**4,289**	**$103.47**	$443,767

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

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

Consumer Issues

Q3 Consumer Issues

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

HBM (Enrollment Broker) Update –Automated Health System, AHS, our Health Benefits Manager, continues to assist our members with health information questions regarding the two MCOs.

A total of 16,794 calls were received in Q3, with an average of 5,598 per month. New enrollments totaled 1,387 and transfers totaled 79. Mailings continued for the program, totaling 13,695. Customer Surveys began in January to ensure quality and satisfaction continues. As consumers navigate their MCO choices prior to open enrollment, the HBM continues engage and educate families regarding their options.

Children with Medical Complexity Advisory Council –The Children with Medical Complexity Advisory Council (Advisory Council) met remotely for the 3rd Quarter Advisory Council meeting, which convened on July 13, 2021. The research team for the Family Satisfaction Survey presented their findings to the Advisory Council. The Private Duty Nursing Workforce Capacity Study has concluded and data analysis is in progress. The research team for the PDN study will present their findings at the next Advisory Council meeting in January 2022. The Skilled Home Health Nursing (SHHN) Workgroup presented the NASHP Care Coordination Standards of Practice to the Advisory Council for endorsement. Both the SHHN and DME/Supplies workgroups continue to meet remotely. The SHHN Workgroup also finalized the PDN Welcome and What to Expect letters. The DME/Supplies Workgroup identified issues related to the priority authorization process, appeals, denials and care coordination. Both MCOs gave formal presentations on the prior authorization process. The DME/Supplies Workgroup discussed the potential development of an MCO Care Coordinator training specific to DME/Supplies requests.

Quality Assurance/Monitoring Activity

Q3 Quality Assurance/Monitoring Activity

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

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

QII Activity – During Q3:

- Over the course of the quarter, an internal workgroup has been meeting weekly to maintain momentum.

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

    - CMS QTAG: July 21, 2021 – Spotlight Topic: 2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit
    - MAC QX: No July 2021 Meeting
    - CMS QTAG: No August 2021 Meeting
    - MAC QX: No August 2021 Meeting
    - CMS QTAG: September 16, 2021 - Discussion of 2022 Child and Adult Core Set Annual Review Stakeholder Workgroup Recommendations
    - MAC QX: No September 2021 Meeting

The Quality Improvement Initiative (QII) Task Force held the quarterly meeting on July 22, 2021. DMMA invited Jacob Bowling of Bowling Business Strategies to present on Substance Use Disorders and Delaware's Support Act Planning Grant. The guest presentation included:

- What is the Support Act Planning Grant?
- Goals of the Support Act Planning Grant, including:
    - Ongoing assessment of the SUD treatment needs of Delaware Medicaid beneficiaries;
    - Improving reimbursement for, and expansion of the number or treatment capacity of Medicaid primary care and specialty providers; and
    - The recruitment, training and technical assistance for Medicaid providers offering SUD/OUD treatment or recovery services.
- Key Support Act Deliverables, Preliminary findings, and Preliminary recommendations.
- An interactive Question and Answer session with the MCOs and the presenter.

Case Management Oversight - Due to the COVID-19 PHE, MCO case management was primarily provided telephonically since March 2020. In Q3 2021, The MCO increased face to face visits. The MCOs submit weekly telephonic case management files for the DMMA clinical staff to review. DMMA clinical staff reviewed approximately 576 telephonic/virtual reviews in Q3 2021 which is a combination of care coordination and LTSS case management. DMMA communicates with the MCOs areas of concern or need for improvement that our oversight team finds.

In Q3 2021, DMMA's oversite team completed Q2 case file reviews with each MCO virtually. DMMA staff reviewed approximately 100 random files to review for contractual compliance by MCO's in areas of Care Coordination, Case Management and Nursing Facility Transitions. DMMA reviews the findings with each MCO's and discusses areas needing improvement in Care Coordination and LTSS Case Management for our Medicaid population.

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

DMMA Managed Care Operations met with both MCOs and DMMA Long Term Care Unit, LTC on September 20, 2021. During the meeting we discussed at length the PASRR rules for Medicaid Certified Nursing Facilities. We reviewed contact information for all parties to exchange information with all parties. The meeting was well received by all participants, we had very useful conversations and discussions on procedures and best practices.

Q3 Incident Management System - DMMA continued the review and development of the work plan to operationalize improvement recommendations for the incident management system process for DSHP and DSHP-Plus. The Quality unit continues to intake, track and facilitate the reporting of Critical Incidents into the department using the current technology solutions.

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

Managed Care Reporting Requirements

Q3 QCMMR and QCMMR Plus Reporting

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

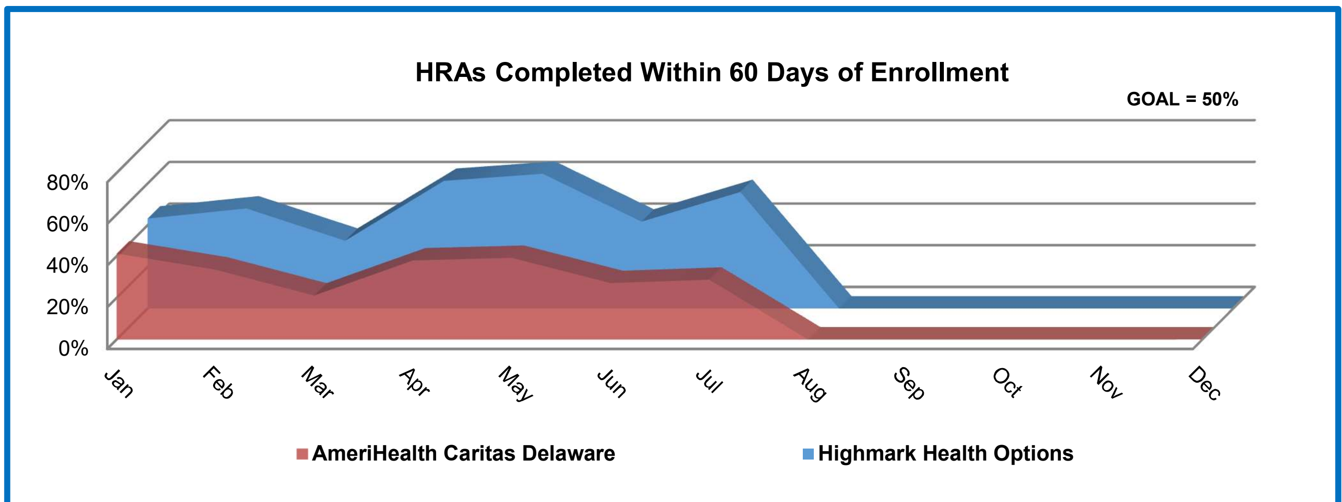
contract.

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

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

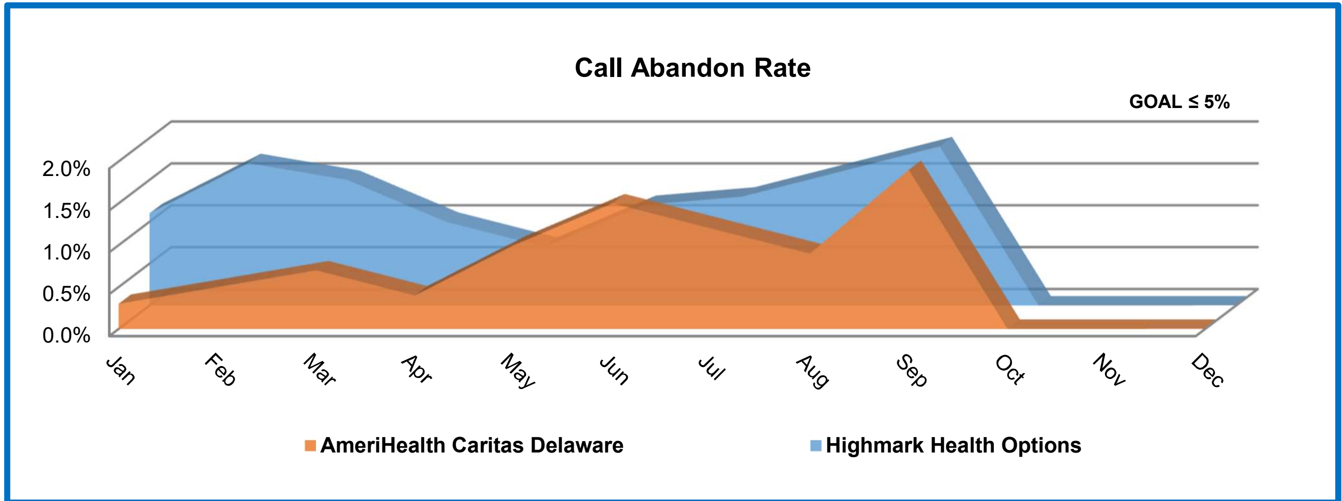
QCMMR Reporting Examples:

Health Risk Assessment (HRA) Completion Rate

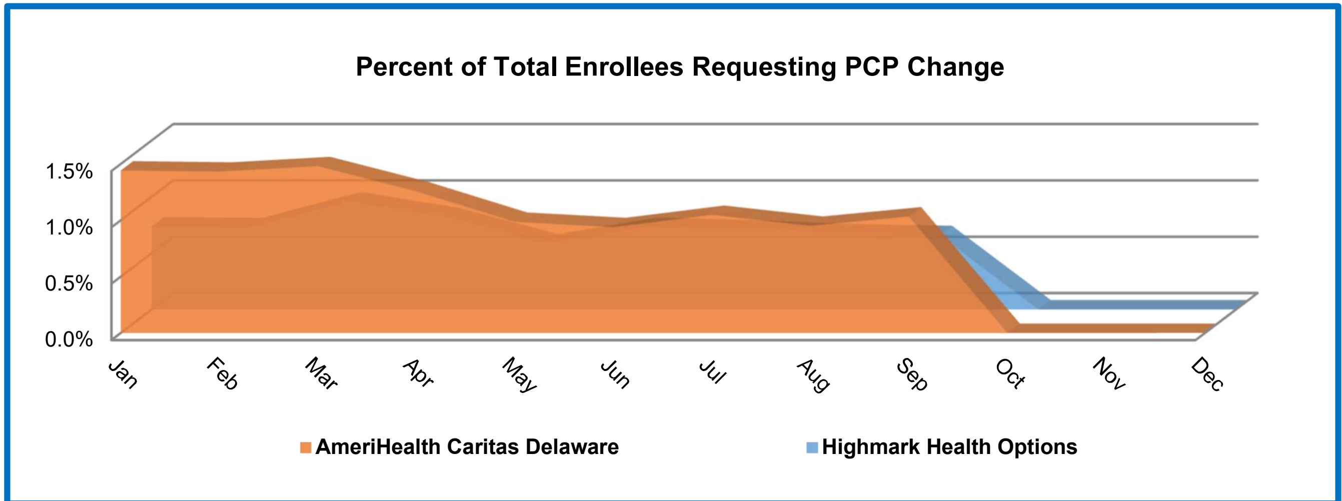


HRAs serve as a key to identifying and engaging members in need of services early in their experience with an MCO. The MCOs are contractually required to complete HRAs with at least 50% of their newly enrolled members within 60 days of enrollment. DMMA has placed each MCO on a corrective action plan (CAP), which requires incremental increases as a way of working toward contractual goals.

Customer Service: Call Abandon Rate



Percent of Enrollees Requesting a Change in Primary-Care Provider



Access in Q3 – DSHP Timely Appointments and Network

The MCOs report in alternating quarters on this metric. For Q3, the reporting MCO met the goal of 100% access in 14 of the 20 areas measured, which is an increase from Q1. All practices found non-compliant with an appointment received outreach and education by Provider Relations following the audit on appointment standards. Non-compliant practices will be re-audited in Q4 to ensure compliance.

The Q3 reported numbers for provider networks are consisted with the MCOs' Q2 submission.

Q3 Grievances – For DSHP, there were 271 grievances, up from 247 grievances in Q2. The breakdown across areas is described below:

- Access and availability: 18
- Benefits: 6
- Billing and/or claims: 63
- Cultural competency: 6
- MCO staff issue: 8
- Quality of care: 45
- Quality of service: 88
- Transportation to medical appointment: 16
- Other: 21

For DSHP Plus, there were 161 grievances for Q3, up from 147 (including case management). The breakdown across areas is described below:

- Access and availability: 8
- Benefits: 3
- Billing and/or claims: 9
- Cultural competency: 1
- MCO staff issue: 3
- Quality of care: 23
- Quality of service: 39
- Transportation to medical appointment: 16
- Other: 13
- Case management HCBS and institutional experience: 46

Q3 Appeals –

DSHP Appeals are documented in the month in which they are filed, and any appeals resolved are marked within the month they are resolved. Both MCOs reported a lower number of appeals in Q3

(98) compared to Q2 (152). The number of appeals overturned prior to appeals committee were higher than those upheld for one MCO and the number of appeals withdrawn and overturned prior to appeals committee were higher than those upheld for the second MCO.

For DSHP Plus, the overall number of appeals is low. There were 16 appeals in Q3.

Dental appeals in DSHP are documented in the month in which they are filed, and any appeals resolved are marked within the month are resolved. There were 18 dental grievances and three dental appeals.

Dental appeals in DSHP Plus are documented in the month in which they are filed, and any appeals resolved are marked within the month are resolved. There were 3 grievances and 1 dental appeal.

Pharmacy appeals in DSHP are documented in the month in which they are filed, and any appeals resolved are marked within the month they are resolved. There were 66 pharmacy grievances and 105 pharmacy appeals. The number of pharmacy appeals overturned and withdrawn for both MCOs are higher than those upheld.

Pharmacy appeals in DSHP Plus are documented in the month in which they are filed, and any appeals resolved are marked within the month they are resolved. The overall number of appeals is low. There were 15 pharmacy grievances and 5 pharmacy appeals.

Q3 Critical Incident Reporting – For Q3, there were 31 total critical incidents (CIs), up from 26 in Q2. The distribution of CIs heavily concentrates on HCBS versus institutional services. Listed below are the categories for CIs for Q2:

- Unexpected deaths: 5
- Physical, mental, sexual abuse or neglect: 11
- Theft or exploitation: 9
- Severe injury: 4
- Medication error: 0
- Unprofessional provider: 2

Q2 External Quality Review (EQR) Reporting

- No additional updates.

Demonstration Evaluation

Q3 Demonstration Evaluation Activities

During the reporting period, the independent evaluator received and read in 2021 monthly extracts. In

accordance with the approved Evaluation Design Plan, work continued on the following activities: continue coding for annual established quality measures; update Transitions to Care focus study analytics; and develop PROMISE enrollee analytics.

State Contacts

Kimberly Xavier
Social Service Chief Administrator
Planning & Policy
Division of Medicaid and Medical Assistance Delaware Health and Social Services
1901 N. DuPont Highway, Lewis Building New Castle, DE 19720
Phone: 302-255-9628
Fax: 302-255-4481
Kimberly.Xavier@delaware.gov

Kathleen Dougherty
Social Service Chief Administrator
DSHP/DSHP-Plus Operations
Division of Medicaid and Medical Assistance Delaware Health and Social Services
1901 N. DuPont Highway, Lewis Building New Castle, DE 19720
Phone: 302-255-9937
Fax: 302-255-4481
Kathleen.Dougherty@delaware.gov