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Diamond State Health Plan

Section 1115 CY 2020 1st Quarterly Report

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

Federal Fiscal Quarter 2- 2020:04/01/2020 – 06/30/2020

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

- Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS;
- Rebalancing Delaware's LTC system in favor of HCBS;
- Promoting early intervention for individuals with, or at-risk, for having, LTC needs;
- Increasing coordination of care and supports;
- Expanding consumer choices;
- Improving the quality of health services, including LTC services, delivered to all Delawareans;
- Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTSS services where appropriate;
- Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles;
- Improving overall health status and quality of life of individuals enrolled in PROMISE;
- Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population; and
- Increase enrollee access and utilization of appropriate SUD treatment services; decrease use of medically inappropriate and avoidable high-cost emergency and hospital services; increase

initiation of follow-up SUD treatment after emergency department discharge; and reduce SUD readmission rates.

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

In accordance with the STCs of the DSHP 1115 demonstration, the Delaware Division of Medicaid and Medical Assistance submits this second quarter report ending June 30, 2020, Demonstration Years 25.

Q2 Enrollment

Demonstration Populations	Current Enrollees (to date)	Disenrolled in Current Quarter
Population 1: Former AFDC Children less than 21 (DSHP TANF Children)	86,990	1,226
Population 2: Former AFDC Adults aged 21 and over (DSHP TANF Adult)	30,439	751
Population 3: Disabled Children less than 21 (DSHP SSI Children)	5,494	41
Population 4: Aged and Disabled Adults 21 and older (DSHP SSI Adults)	6,581	76
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.)	57,920	1,109
Population 7: Family Planning Expansion (FP Expansion)	None; program terminated in 2013	N/A
Population 8: DSHP-Plus State Plan	9,786	318
Population 9: DSHP-Plus HCBS	5,487	83
Population 10: DSHP TEFRA-Like	289	2

Population 11: Newly Eligible Group	9,964	326
Population 12: PROMISE	1,454	16
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 April 1, 2020 to June 30, 2020 period based on capitation claims and for the MC and PROMISE enrollment and eligibility files. Clients who were in more than one eligibility category during the quarter are reported based on their last status (most recent month). Age calculated as of the first day of the most recent month of enrollment, consistent with reporting of member months.*

Q2 Outreach and Innovative Activities

Q2 MCO and State Outreach Events, Special Topic Meetings and Workgroups

MCO Outreach

Due to the COVID-19 Public Health Emergency (PHE), our MCOs suspended in-person outreach. Both MCOs increased their website information to include COVID-19 information, especially telehealth information and community resources. Telehealth now includes telephone-only communication as well. The MCO Care Coordinators and Case Managers increased their telephonic outreach to their members.

Special Interest Meetings/Conferences

2020 Advancing States Virtual Spring Meeting - The 2020 ADvancing States Virtual Spring Meeting took place online, June 10-11th. This virtual meeting was attended by Kathleen Dougherty, current Vice President of Advancing States Board of Directors and DMMA Chief of Managed Care Operations. The conference was comprised of state Aging and Disabilities Directors, Medicaid LTSS directors, federal officials, MCOs, and other key service delivery partners. Participants joined 8 different virtual sessions focusing on: updates from CMS leadership; updates from ACL leadership; maximizing relationships with nursing facilities in times of crisis; partnering with health plans during emergencies; the challenges of integrating services for dual eligibles; how to best support family caregivers; providing services in rural settings; and lessons learned from COVID-19.

Delaware Family Voices - DE Medicaid continues to support Delaware Family Voices. Caring for children with special needs is often complex, and Delaware Family Voices and the Family to Family Health Information Center is in the unique position to help. This organization states that “We help families of children with special needs become informed, experienced, and self-sufficient advocates for their children and themselves.” DMMA and our MCOs participate in these monthly calls assisting families to navigate the complex healthcare field. There were three monthly calls this quarter: April 14, May 12 and June 9, 2020. DMMA stays in regular contact with Delaware Family Voices outside of scheduled calls to assist any Medicaid family in need.

Q2 Innovative Activities

Medicaid/CHIP Accountable Care Organization Program (Medicaid ACO Program) - DMMA, under the direction of DHSS, is developing a Medicaid ACO Program for the purpose of improving health outcomes while reducing costs through value based purchasing (VBP) arrangements which include downside financial risk for ACOs. The Medicaid ACO program is part of the strategies DMMA is pursuing to advance the adoption of participating Medicaid VBP models and total cost of care (TCOC) strategies. DMMA developed an application to allow qualified provider organizations to apply to become Medicaid ACOs and subsequently contract directly with our Medicaid MCOs in a TCOC payment arrangement. DMMA

believes that by working together, Medicaid ACOs and MCOs can better coordinate care for Delaware's Medicaid and CHIP members, providing better health outcomes and lower costs. The applications were due by May 15, 2020, but due to the ongoing COVID-19 response and related activities, DMMA extended the due date to Tuesday, June 30, 2020 at 1:00pm ET. DMMA is currently evaluating the applications received June 30, 2020.

Q2 Operational and Policy Issues

COVID-19 Impacts

The nation faced the COVID-19 pandemic in March, the third month of the first quarter of DY 25. The Governor issued a State of Emergency declaration on March 12, 2020 that became effective on March 13, 2020 ordering Delawareans to stay at home whenever possible and closing all non-essential businesses in Delaware to help fight the spread of COVID-19 and the President and HHS Secretary declared a public health emergency. The PHE and State of Emergency declarations were extended through Q2.

In response, DMMA took actions that included, but were not limited to:

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

Policy and Legislative developments

- **Medicaid Adult Dental Benefit** – On August 2019, Governor Carney signed S.S.1 for S.B. 92 into law, expanding Medicaid dental benefit to adults. This new benefit start date is scheduled for October 1, 2020. DMMA submitted a state plan amendment to CMS to add adult dental to the state plan will submit an 1115 waiver amendment in order to deliver the benefit through

mandatory managed care. Initially, adult dental services will be reimbursed through a non-risk payment arrangement with the MCOs.

DMMA continues to work with our system vendor and the MCOs on readiness, testing and preparing for implementing the new Adult Dental benefit. DMMA's system vendor has completed the system updates and is working with our MCOs on testing. The MCOs are sharing files and performing regression testing. DMMA has developed a series of scenarios to assist the MCOs in testing to assure our Stakeholders are ready for a go-live date of October 1, 2020 for this new benefit.

MCO Operational Issues

The MCOs continue their daily outreach to assist members during the COVID-19 crisis, with a strong emphasis on social determinants of health. COVID-19 Response Teams outreach positive members identified using the DHIN (the Delaware HIE) analytics, member self-reporting, claims and utilization management. Care coordinators ensure access to care, address social determinants 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 and SUD continues to be a focus for the MCO's, especially the homeless members that are residing in hotels. DMMA Managed Care Operations is facilitating weekly meetings with DSAMH and the MCOs to ensure safe transition and continued coordination of PH/BH/SUD.

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

The MCOs also noted that members were not following through with requests for appeals, due to the requirement for hardcopy/written signature after a verbal request. As a result, DMMA has sought additional relief under the DSHP 1115 waiver to address this operational issue.

DSHP 1115 Waiver Administration

- **Q1 2020 Budget Neutrality Report** – This report is delayed due to a COVID-19 related delay in the CMS-64 expenditure reporting. CMS has granted an extension for the expenditure reporting and the budget neutrality reporting will be submitted at the same time in July.

- **Substance Use Disorder (SUD) Amendment** – DMMA continued working on the SUD Monitoring Protocol, Draft Evaluation Design and HIT Plan.
- **Retroactive Eligibility** - DMMA is required by STC #22 to provide retroactive coverage as of August 1, 2019 to pregnant women, women who are 60 days or less postpartum, infants under age 1, and individuals under age 19. This requirement must be operationalized by July 1, 2020 and must include a process for retroactive eligibility for individuals who would be eligible for retro-active coverage beginning August 1, 2019. DMMA worked on a variety activities to implement this STC including:
 - o On June 25, 2020, Delaware implemented an Integrated Eligibility IT system to support retroactive coverage for the new populations;
 - o Implemented processes to address retro-coverage for individuals who would have been eligible between August 1, 2019 and June 24, 2020;
 - o Implemented a process for claims payment for individuals eligible for retro-coverage;
 - o Implemented an outreach strategy to educate individuals, advocates and providers regarding retro-eligibility. This included a letter to each client who was eligible between August 1, 2019 and June 24, 2020 providing them with contact information so DMMA can work with the clients individually; and
 - o Changed the Integrated Eligibility application to add questions related to retro-coverage for new populations (both paper and on-line versions) to be completed in time for the start of the retro eligibility system on 6/25/2020.

Other Issues

- **NAMD Staff Survey** - DMMA partnered with the National Association of Medicaid Director's to survey our staff. The survey was prepared by NAMD and our staff were emailed a link to answer 13 questions as well as the ability leave comments. The focus of the survey explored various aspects of our work and environment during this unrepresented time. The survey received 87 replies and had an overall positive response. The comments we received were very informative and will enable the managers to have conversations with their staff about our new work environment
- **Support Act Grant** -DMMA was awarded a \$3.58 million planning grant from CMS to assess and expand our capacity to treat substance use disorder (SUD) in Medicaid. These funds will support an examination of our reimbursement system for SUD treatment providers, additional data analytic capacity to track SUD in the Medicaid population, and training for outpatient providers to increase the number of providers treating SUD.

During the second quarter of 2020, the SUPPORT Act Planning Grant Core Team continued to meet twice a month. The team participated in monthly 1003 calls with their CMS project officer and other relevant staff. The Core Team also executed four contracts with vendors for various staff roles and deliverables.

Other significant achievements include the identification of six experts to serve on our Subject Matter Expert Council, the completion of 20+ stakeholder interviews, and the convening of a stakeholder engagement webinar of individuals with lived experience with substance use disorders. The Core Team - in partnership with vendors - also commenced a number of research projects, including inventories of SUD care coordination models, Medications for Addiction Treatment incentive models, prescriber-to-prescriber technical assistance models, and existing Medicaid payments and rates.

- **Social Determinants of Health** - As the COVID-19 crisis became more urgent in Q2, DMMA adapted our SDOH strategy to address the immediate risk of food insecurity in our Medicaid population. DMMA began planning a partnership with the local Food Pantry, Logisiticare and the MCOs to deliver food boxes to certain MCO members. DMMA also began planning to increase the home-delivered meals benefit for DSHP-Plus (HCBS) members.
- **Medicaid/CHIP Accountable Care Organization Program (Medicaid ACO Program) Update** - DMMA continues to move forward with the Medicaid ACO initiative. ACO applications were due June 30 and the State's evaluation process will occur in July 2020. DMMA expects to announce approved Medicaid ACOs in early August which will permit our Medicaid MCOs to begin negotiating their own multi-year ACO agreements. It is expected that the Medicaid MCOs will contract with at least two of DMMA's approved Medicaid ACOs. The formal Medicaid ACO program will commence July 1, 2021, including payment from the MCOs based on total cost of care.
- **Program Integrity** - The Surveillance Utilization and Review Unit (SUR) was in a "stand down" status for the entire 2nd quarter of 2020 due to COVID-19. The unit halted all provider reviews, record requests, and collection efforts until July 15, 2020.

During the provider stand down, the SUR unit continued to identify strategies to combat fraud, waste, and abuse in the Delaware Medicaid Program. The unit reviewed policy, data analytics, and worked to develop strategies that will improve the unit's overall performance when normal audit activities resume. The unit hired two nurse reviewers, and one management analyst, bringing the team to a fully staffed status. The newest team members are currently being trained for their respective positions.

The SUR unit works closely with contractor IBM Watson to develop the most effective ways to utilize ranking reports to identify provider types to audit. The education provided by IBM Watson continues to be pivotal in assisting the team with creating reports that are efficient and easy for all members of the unit to utilize.

The partnership with the Unified Program Integrity Contractor (UPIC), Safeguard Services (SGS), continues to be a valuable resource to the SUR team. Audit work plans for Medicaid credit balance reports and genetic testing are in the process of being finalized. Once fully developed and approved, post payment claims reviews will commence.

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

Q2 Expenditure Containment Initiatives

See description of Medicaid ACOs above.

Q2 Financial/Budget Neutrality/Issues

Due to COVID-19 related delays impacting the Delaware's CMS-64 expenditure reporting and a CMS-approved extension to the reporting deadline, DMMA continued to work on developing the Q1 report scheduled to be submitted to CMS in July.

Q2 Member Month Reporting and With-Waiver PMPMs

Q2 2020 Member Months

Eligibility Group	Month 4 April 2020 Member Months	Month 5 May 2020 Member Months	Month 6 June 2020 Member Months	Total Quarter ending June 30, 2020
DSHP TANF CHILDREN	85,215	86,365	86,990	258,570
DSHP TANF ADULT	29,241	29,999	30,439	89,679
DSHP SSI CHILDREN	5,392	5,430	5,494	16,316
DSHP SSI ADULTS	6,480	6,518	6,581	19,579
DSHP MCHP (Title XIX match)*	0	0	0	
DSHP ADULT GROUP	64,468	65,726	66,479	196,673
DSHP-Plus State Plan	9,956	9,848	9,786	29,590
DSHP-Plus HCBS	5,345	5,428	5,487	16,260
DSHP TEFRA-Like**	284	286	289	859
PROMISE	1,387	1,403	1,390	4,180

* 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)

Q2 2020 Member Months and WW PMPMs

Eligibility Group	Total Member Months for the Quarter	PMPM	Total Expenditures
DSHP TANF CHILDREN	258,570	\$416.92	\$107,802,658
DSHP TANF ADULT	89,679	\$626.29	\$56,165,219
DSHP SSI CHILDREN	15,000	\$2,491.34	\$38,616,299
DSHP SSI ADULTS	19,579	\$1,864.09	\$36,496,952
DSHP MCHP (Title XIX match)*	0	0	0
DSHP ADULT GROUP	196,673	\$701.54	\$137,973,999
DSHP-Plus State Plan	29,590	\$2,076.24	\$61,435,968
DSHP-Plus HCBS	16,260	\$6,908.89	\$112,338,514
DSHP TEFRA-Like**	816	\$2,491.34	\$2,032,437
PROMISE	4,180	\$10.93	\$45,708

* 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)

Q2 Consumer Issues

Children with Medical Complexity Advisory Council: Due to the Public Health Emergency (PHE) put in place by the State of Delaware as a result of the COVID-19 pandemic, the Children with Medical Complexity Advisory Committee (CMCAC) met remotely for the first time on April 15, 2020, for the second quarter council meeting. The CMCAC Chairman, Director Stephen Groff, shared updates with Committee members on what DMMA is doing in response to the pandemic and opened the meeting for comments, particularly from the families on how they are dealing with the PHE. The CMCAC will continue to hold the quarterly meetings remotely until the PHE is lifted.

Both workgroups also continue to meet remotely. The Skilled Home Health Nursing (SHHN) Workgroup continues to work on the Private Duty Nursing (PDN) Toolkit, which includes an Emergent Decision Care Tree, a link to DECLASI's website for the Temporary Custodian Healthcare Authorization, PDN Letters of Medical Necessity from both MCOs, and PDN guidelines from both MCOs. The SHHN workgroup plans to present the finalized Toolkit to the CMCAC at the 3rd quarter meeting for approval. The CMCAC Data Workgroup continues to work on the Year End Report for 2019 and plans to present the final report to the CMAC at the 3rd quarter meeting for approval.

The research team for the Family Focus Groups and Satisfaction Survey, had to change the work plan for the Survey due to the PHE. The Survey's titled was changed to the Family Satisfaction Survey, and the approach changed from gathering information in focus groups to conducting individual family interviews by phone. The research team, Vital Research, continues to gather data from the interview with a goal to have the interviews completed by the end of the 2nd quarter. DMMA began meeting with the University of Delaware Center for Disability Studies for contract negotiations for the PDN Workforce Capacity Study. The CMCAC's vision for both studies is to gain more insight of the gaps in care for private duty nursing for children with complex medical conditions from the family and the provider perspective.

Justice Involved Populations Steering Committee: DMMA was tasked with making a significant change to Medicaid for incarcerated individuals (aka the Justice-Involved Population). Previously, Medicaid benefits were terminated for individuals who were entering the prison system, and it took many hours or days to get the benefits reinstated once they were released from the Department of Correction (DOC). However, the new process will only suspend benefits during incarceration and individuals will have full benefit coverage at the time of their prison release. The project started January 1, 2020. The MCOs are able to see who is incarcerated and when they will be getting released, which allows for smooth transition of medical care for our Medicaid members. The MCOs are able to coordinate care with Department of Corrections, DOC Care team to provide the member with their plan of care upon release. Due to the COVID-19 emergency the MCOs had to suspend their in-person visits and switch to telephonic communication with DOCs Care Team to be able to provide medical care upon a member's release.

Medical Care Advisory Committee (MCAC): The MCAC met on April 28, 2020. Issues discussed included COVID-19 PHE flexibilities and trends, support for telehealth, and ACO application deadlines.

HBM (Enrollment Broker) Highlights: There were no notable consumer issues in the second quarter. During the COVID-19 PHE, the HBM staff were able to work from home and have full access to their telephone system, as such there was no impact to Delaware Medicaid Members.

Q2 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 April, the QII Taskforce met and focused on quality measurement and improvement during COVID-19. The group considered what measures are appropriate during a pandemic, what is scientifically acceptable, the feasibility of calculating the measure given the limitations of COVID-19, and how to implement quality improvement. The group also focused on revisions to the DSHP Quality Management approach. This work involves evaluating DMMA's processes, oversight and monitoring of critical incidents. It will also involve a full revision to the Quality Strategy and focusing on the quality improvement process and PIPs.

Case Management Oversight - Due to COVID-19, the MCOs began telephonic member assessments. The MCOs submit the member assessments to the DMMA oversight team for review. DMMA oversight clinical staff reviewed approximately 300 member assessments. DMMA staff meets with each MCO monthly to discuss telephonic member assessment findings and collaborates on ways to improve oversight of the Medicaid population.

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

Due to COVID-19 emergency there weren't any MCO Bi-Monthly meetings held in the 2nd quarter. DMMA was in constant communication with the MCOs on operational issues while instituting remote working

arrangements. The MCO bi-monthly meetings resumed July 21, 2020 and will be reported on during the 3rd quarter 1115 Waiver report.

Q2 Managed Care Reporting Requirements

Q2 QCMMR and QCMMR Plus Reporting

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

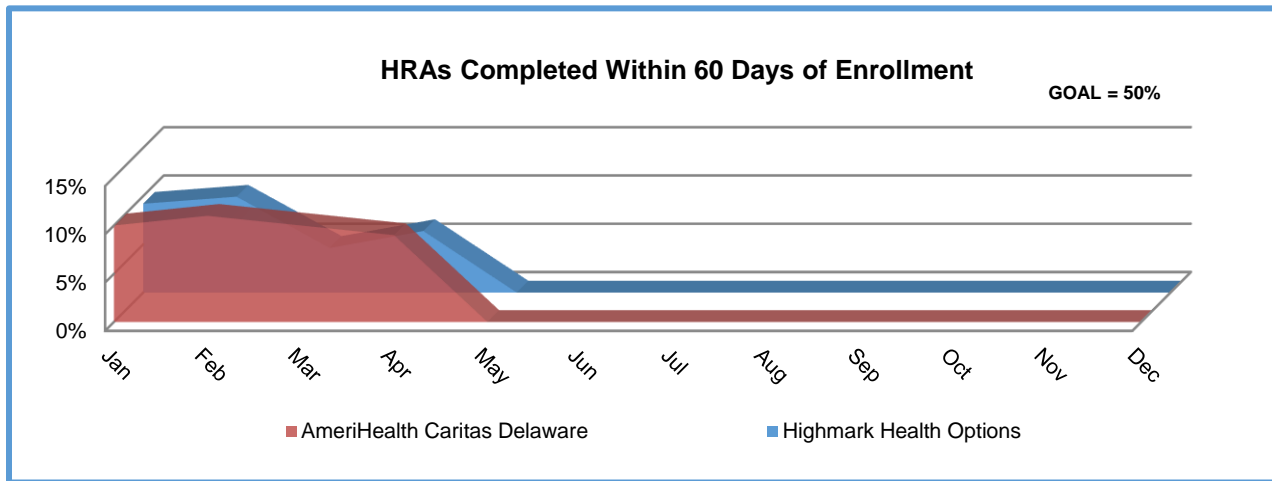
The DMMA Managed Care Operations unit developed the full circle approach to the QCMMR and QCMMR Plus reporting. The reports are reviewed by the Managed Care Operations team and an agenda is developed for our monthly meeting with each MCO to discuss the findings from the reports. Managed Care Operation's 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. DMMA is in the process of developing a new format for additional QCMMR data to be reported to CMS as part of the quarterly and annual reports.

QCMMR Reporting Examples

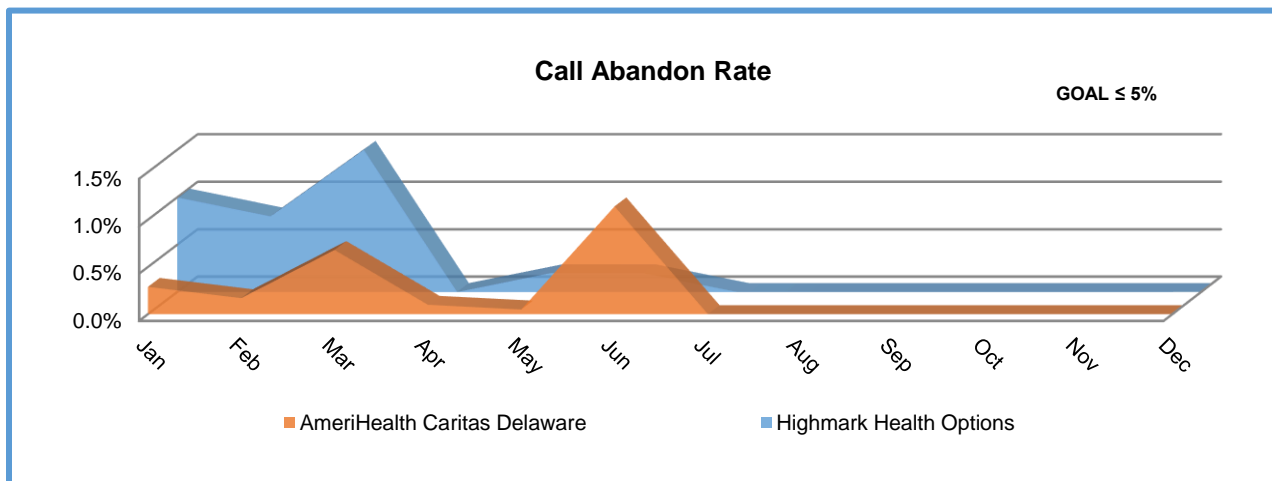
Q2 Health Risk Assessment (HRA) Completion Rate

HRAs serve as a key to identifying and engaging members in need of services early in their experience with an MCO. The MCOs are contractually required to complete HRAs with at least 50% of their newly enrolled members within 60 days of enrollment. May and June data will be included in the Q3 report. This metric has been a focus of the EQRO review.

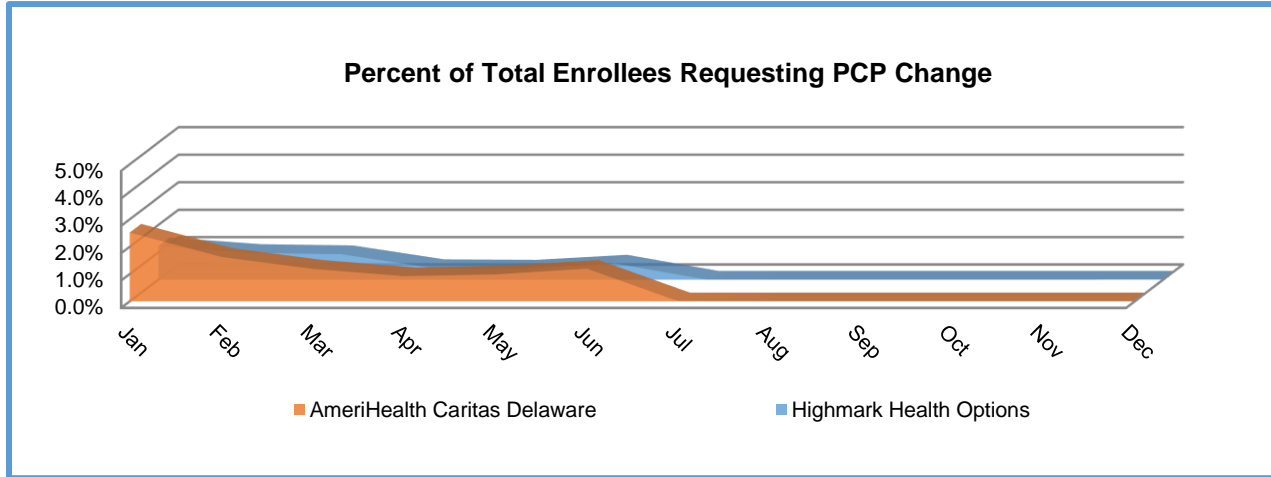


Q2 Customer Service

Both MCOs met the goal for average speed of answer, percent answered within 30 seconds, call abandon rate and had similar percentages of PCP change requests during the first quarter.



Percent of Total Enrollees Requesting PCP Change



Grievances and Appeals in Q2

DSHP Grievances and Appeals

For DSHP, there were 147 grievances for Q2 and the distribution across MCOs was an expected result given the differences in membership between the MCOs. The breakdown across areas is described below:

- Access and availability: 15
- Benefits: 4
- Billing and/or claims: 30
- Cultural competency: 1
- MCO staff issue: 1
- Quality of care: 35
- Quality of service: 47
- Transportation to medical appointment: 2
- Other: 12

Appeals are documented in the month in which they are filed, and any appeals resolved are marked within the month in which they have been resolved. The two MCOs reported a total of 103 appeals. The number of appeals withdrawn and overturned are higher than those upheld.

DSHP Plus Grievances and Appeals

For DSHP Plus, the MCOs reported a total of 36 grievances for Q2, down from 69 in Q1 of 2020. Listed below are the categories for grievances:

- Access and availability: 4
- Benefits: 0
- Billing and/or claims: 5
- Cultural competency: 1
- MCO staff issue: 1
- Quality of care: 3
- Quality of service: 6
- Transportation to medical appointment: 3
- Other: 3
- Case management (HCBS and institutional experience): 10

Appeals should be documented in the month in which they are filed, and any appeals resolved should be reported within the month in which they have been resolved. The overall number of appeals is low, with one MCO reporting 27 appeals during Q2 2020, 8 of which were overturned (30%); and the second MCO reporting 10 appeals, 6 of which were overturned (60%).

Critical Incident Reporting in Q2

There were 30 critical incidents reported in Q2, down from 44 in Q1. Listed below are the categories for Q2 critical incidents:

- Unexpected deaths: 2
- Physical, mental, sexual abuse or neglect: 19
- Theft or exploitation: 6
- Severe injury: 3
- Medication error: 0
- Unprofessional provider: 0

Q2 External Quality Review Reporting

No updates for Q2.

Q2 Demonstration Evaluation Activities

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

Enclosures/Attachments

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

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