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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 1- 2020: 01/01/2020 – 03/31/2020

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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 first quarter report ending March 31, 2020, Demonstration Years 25.

Q1 Enrollment

Demonstration Populations	Current Enrollees (to date)	Disenrolled in Current Quarter
Population 1: Former AFDC Children less than 21 (DSHP TANF Children)	87,567	4,891
Population 2: Former AFDC Adults aged 21and over (DSHP TANF Adult)	30,077	2,272
Population 3: Disabled Children less than 21 (DSHP SSI Children)	5,439	169
Population 4: Aged and Disabled Adults 21 and older (DSHP SSI Adults)	6,576	192
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)	0	N/A
Population 6: Uninsured Adults up to 100% FPL (DSHP Exp. Pop.)	57,495	3,907

Population 7: Family Planning Expansion (FP Expansion)	None; program terminated in 2013	N/A
Population 8: DSHP-Plus State Plan	10,267	362
Population 9: DSHP-Plus HCBS	5,431	176
Population 10: DSHP TEFRA-Like	286	N/A
Population 11: Newly Eligible Group	9,528	1,116
Population 12: PROMISE	1,423	15
Population 13: Former Foster Care Youth	199	N/A

Definition: "Current Enrollees (to date) is an unduplicated count of clients in the MCO for at least one day in the January 1, 2020 to March 31, 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.

Q1 Outreach and Innovative Activities

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

Both MCOs participated in Delaware's Life Conference on January 29, 2020. The LIFE Conference is a joint effort of many Delaware organizations that serve persons with disabilities and their families, which addresses the topics of Legislation, Independence (through Assistive Technology), Family and Education. Over 500 people with disabilities, families and professionals attend the annual conference for educational and networking opportunities.

Highmark Health Options Outreach Events

Here are two examples of Highmark Health Options outreach events for this quarter:

Highmark Health Options participated in the 3rd Annual Strong Minds and Healthy Hearts event held at Bayard Middle School in Wilmington on February 1, 2020. This community event had several area agencies in attendance. There were workgroups, breakout sessions, health screenings and more. Highmark Health Options had an exhibitor table which included health & wellness education materials with a focus on healthy eating and the importance of exercise.

Highmark Health Options participated in the Opioid Resource Fair Hosted by DE State representative Ray Siegfried and the Claymont Community Center. This community event had several area agencies in attendance, providing information on resources and services that provide support to those affected by the opioid crisis. Highmark Health Options had an exhibitor table which included health & wellness education materials. Information on obtaining Substance Use Disorder treatment and counseling.

AmeriHealth Caritas Outreach Events

Here are two examples of AmeriHealth Caritas DE outreach events for this quarter.

29th Annual Brain Injury Association of Delaware "Joined Voices, Shared Journeys, Connection through the Continuum. AmeriHealth Caritas DE attended the Annual Conference at Dover Downs Casino and Convention Center, 1131 N DuPont Hwy, Dover, DE 19901 on March 5, 2020. There were break-out sessions; 2020 Concussion updates, learned about Robotic Therapies. Also, Rehabilitation, Survivors and Military panel discussions.

AmeriHealth Caritas DE participated in the March 7, 2020 Latin American Community Center health fair. There was vendor participation along with free health screenings. AmeriHealth Caritas focused on the importance of diabetic testing. Along with healthy eating education, rate your plate, choose healthier food options. They also distributed information on Depression, what causes depression and where to seek help.

Special Interest Meetings/Conferences

Maternal & Infant Health - Dr. Elizabeth Brown, Medical Director, is working to enhance DMMA's engagement with multiple stakeholders around maternal and infant health. During Q1, she attended the regional ACOG Maternal Health Awareness Day at the Medical Society of Delaware on Jan 23rd and a community meeting hosted by Black Mothers in Power at the Wilmington Library on Jan 27th. Dr. Brown has also established regular biweekly meetings with DPH's Maternal Child Health Unit. In addition, DMMA discussed the Medicaid claims and birth certificate linkage work being done in DPH to identify opportunities to learn from the linked data set in the future.

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 managed care organizations, Highmark Health Options and AmeriHealth Caritas DE participate in these monthly calls assisting families to navigate the complex healthcare field. There were three monthly calls this quarter: January 14, February 11 and March 10, 2020. DMMA stays in regular contact with Delaware Family Voices outside of scheduled calls to assist any Medicaid family in need.

Q1 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 managed care organizations (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 is extending the due date to Tuesday, June 30, 2020 at 1:00pm ET.

Q1 Operational and Policy Issues

COVID-19 Impacts

The nation faced a 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 COVID-19 pandemic has required all Delawareans to take dramatic emergency actions to slow the transmission of the virus from person to person. This emergency impacts all individuals in the State, including our Medicaid beneficiaries and families, providers, advocates, state staff, contractors and more. While we have begun to note of the impact of COVID-19 on the DSHP 1115 in this Q1 report, we expect to be able to more effectively evaluate the impact on Q2 and future quarters.

Policy and Legislative developments

- **COVID-19 Disaster/Emergency Authorities** – Delaware developed and requested relief under Section 1135 waiver authority from Medicaid and Medicare requirements that pose issues or challenges for the health care delivery system in all counties in Delaware. CMS granted a partial approval on March 27, 2020.

- **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, effective April 2020. During Q1, DMMA submitted a state plan amendment to CMS to add adult dental to the state plan and will be submitting an 1115 waiver amendment in order to deliver the benefit through mandatory managed care.

  DMMA decided it was in the best interest of the members to delay the start of this project, allowing time for all stakeholders to implement their systems, establish their dental provider networks and properly test. The new benefit start date is scheduled for October 1, 2020.

  DMMA continues to work with our system vendor and the MCOs testing and preparing for implementing the new Adult Dental benefit.

- **Primary Care Collaborative**: Delaware continues to work on this collaborative, which focuses on primary care in Delaware and what support can be provided to the primary care practices in the state.

MCO Operational Issues

- **Managed Care and DDDS Lifespan Waiver Members -** DMMA Managed Care Operations and DDDS staff held readiness review follow-up meetings with both MCOs on February 18 and 19th. These reviews followed up on the readiness reviews conducted in 2019 prior to moving the Lifespan 1915(c) Waiver IID population into the DSHP MCOs for their state plan services on July 1, 2019. These reviews were a continued effort by DMMA and DDDS to assure oversight of quality management of care for these members. DMMA and DDDS commended both MCOs on their quality of care and dedication to their IID members. We noted opportunities for improvement but overall were satisfied with the progress to date. We will review the MCO performance with serving the Lifespan members again during this year's EQR review.

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 until the end of June for the expenditure reporting and the budget neutrality reporting will be submitted at the same time.

- **Substance Use Disorder (SUD) Amendment** – DMMA requested an extension for submittal of the draft SUD Monitoring Protocol to April 15, 2020.

- **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 is working on a variety activities to implement this STC including:

    - Changes to the Integrated Eligibility IT system to support retro-active coverage for the new populations;
    - Changes to the Integrated Eligibility application to add questions related to retro-coverage for new populations (both paper and on-line versions);
    - Development of processes to address retro-coverage for individuals who are eligible between August 1, 2019 and July 1, 2020 ;
    - Development of process for claims payment for individuals eligible for retro-coverage;
    - Development of outreach strategy to educate individuals, advocates and providers regarding retro-eligibility;
    - Development of education and outreach materials for individuals, advocates and providers including fact sheets and timelines.

Other 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. 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 first quarter of 2020, DMMA assembled the SUPPORT Act Grant Core team and met twice a month. The team participated in monthly 1103 calls with their CMS project officer and other relevant staff, developed a short and long term stakeholder engagement plan, and established a stakeholder interview protocol. The team also conducted ten stakeholder interviews and participated in Delaware's multi-agency Substance Use Disorder strategy meeting.

Other significant achievements include the hiring of a Project Director and Project Coordinator for the grant, the selection of vendors to execute grant deliverables, coordination calls with sister agencies (the Division of Substance Abuse and Mental Health and the Division of Public Health), and the convening of executives from sister agencies - within the State's Department of Health and Social Services - to develop cross-agency coordination strategy on opioid epidemic-related work.

Social Determinants of Health - DMMA has been developing a strategy to understand the social determinants of health and address social needs for our beneficiaries. Building off of information gathered during discussions with our managed care partners, providers in the community, and other state agencies, we have begun to implement a multi-pronged approach. DMMA added contract language which requires the MCOs to collect information on social determinants of health on health risk assessments and to include up-to-date information about community resources to address social needs in their resource directories.

As part of a DHSS-wide effort, DMMA is exploring what information we as a department have on social needs in the community and for our individual members and are considering ways to use existing data to connect families with resources that may be preventing them from achieving optimal health. Finally, DMMA is in the planning stages of a potential pilot program that will provide incentives to the MCOs to develop deeper relationships with community-based organizations and collaborate on a project to address problems with unstable housing or food insecurity in their population.

During January and February 2020, DMMA was finalizing the details of a pilot program that would have provided incentives to the MCOs to develop deeper relationships with community based organizations and collaborate on a project to address problems with unstable housing or food insecurity in their population. However, as the COVID-19 crisis became more urgent and the likelihood of both short term and long term economic consequences became clear, we put this planning on hold. The incentive program we developed will likely need to change to adapt to the

real and immediate needs created by COVID-19.

Vital Research - January 28th & 29th, 2020, DMMA and DSAAPD hosted Vital Research in preparation for our 2020 Advancing States National Core Indicators – Aging and Disabilities, NCI-AD survey. NCI-AD is a voluntary effort by State Medicaid, Aging, and Disability agencies to measure and track their own performance. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families from both agencies. There was training for the interviewers who will conduct the face to face surveys in February thru May 2020. We are surveying members in nursing facilities and community settings who received DSAAPD or Medicaid LTSS services.

State Testing Collaborative – DMMA and our MCO partners are working with Mathematica as part of a State Testing Collaborative around quality measure specifications. This effort is in preparation for the development of MCO Quality Rating Scales, which will eventually be required by CMS. As a test state, we will be running standardized computer code provided by Mathematica to calculate a measure on the quality of care for diabetes. The goal is to understand whether measurement can be more uniform if all states can implement the same code.

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 managed care organizations (MCOs) in a TCOC payment arrangement. These applications were scheduled to be due by May 15, 2020 but the deadline has been extended to June 30th. 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.

External Quality Review Organization (EQRO) Contract Reprocurement – In January, DMMA released a Request for Proposal for our EQRO contract. The EQRO tasks may include, but are not limited to the following:

- Annual Managed Care Compliance Review
- Validation of Performance Measures (PM)
- Validation of Performance Improvement Projects
- Validating network adequacy
- MCO encounter data validation.
- Information Systems Capabilities Assessment (ISCA)
- Technical Assistance
- Quality Strategy
- Special Projects, such as assistance with MCO readiness reviews.

Program Integrity – The Surveillance Utilization and Review Unit (SUR) continues to work diligently to identify strategies to combat fraud, waste, and abuse in the Delaware Medicaid Program. These efforts include policy reform, data analytics, and overpayment recovery. Despite the challenges of the first quarter associated with staffing and COVID-19, the SUR continued to conduct post payment reviews to identify and recover inappropriate payments.

As a result of comprehensive analytical and algorithm training the SUR Team data analyst is now able to begin in-house claims universe establishment and claims sampling. The team is working to secure statistician services to meet the current CMS guidelines as outlined in the latest Program Integrity Manual.

In Q1, the SUR held training supported by contractor staff to help educate staff on the most effective ways to utilize ranking reports to identify provider types to review and create reports that are specific to the needs of the SUR.

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 being developed. 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.

Q1 Expenditure Containment Initiatives

See description of Medicaid ACOs above.

Q1 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, Delaware has requested until June 30th to submit the corresponding 1115 budget neutrality reports for Q1.

Q1 Member Month Reporting and With-Waiver PMPMs

Q1 2020 Member Months

Eligibility Group	Month 1 January 2020 Member Months	Month 2 February 2020 Member Months	Month 3 March 2020 Member Months	Total Quarter ending March 31, 2020
DSHP TANF **CHILDREN**	83,718	84,008	83,706	**251,432**
DSHP TANF ADULT	28,508	28,599	28,578	**85,685**
DSHP SSI CHILDREN	5,319	5,355	5,380	**16,054**
DSHP SSI ADULTS	6,455	6,459	6,478	**19,392**
DSHP MCHP (Title XIX match)*	0	0	0	
DSHP ADULT GROUP	53,389	53,394	53,714	**160,497**
DSHP-Plus State Plan	10,025	9,987	9,951	**29,963**
DSHP-Plus HCBS	5,237	5,259	5,321	**15,817**
DSHP TEFRA-Like**	280	282	283	**845**
PROMISE	1,359	1,360	1,364	**4,083**

** 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)*

Q1 2020 Member Months and WW PMPMs

Eligibility Group	Total Member Months for the Quarter	PMPM	Total Expenditures
DSHP TANF CHILDREN	251,432	$319	**$ 80,171,218**
DSHP TANF ADULT	85,685	$543	**$ 46,516,513**
DSHP SSI CHILDREN	16,054	$1,674	**$ 26,882,394**
DSHP SSI ADULTS	19,392	$1,392	**$ 26,993,540**
DSHP MCHP (Title XIX match)	0		
DSHP ADULT GROUP	160,497	$799	**$ 128,241,486**
DSHP-Plus State Plan	29,963	$2,189	**$ 65,580,928**
DSHP-Plus HCBS	15,817	$6,824	**$ 107,927,477**
DSHP TEFRA-Like	845	$1,674	**$ 1,414,863**
PROMISE	**4,083**	$**219**	**$ 893,624**

Q1 Consumer Issues

Children with Medical Complexity Advisory Council: The CMC Advisory Committee met in the first quarter of 2020 on January 15th, and its workgroups continue to meet biweekly. The Advisory Committee and its workgroups began practicing the social distancing policies put in place by the State of Delaware as a result of the COVID-19 pandemic since March 15, 2020 and have been meeting remotely ever since. The Advisory Committee set priorities for the 2020 work plan and continues to work towards set goals. For example, the Advisory Committee is working on publishing an Emergent Care Decision Tree Tool to help guide families during emergency situations in maintaining care for their medically complex children, as well as completion of Workforce Capacity and Family Focus Group Survey studies for a clearer picture of the gap in care issues surrounding children with medical complexity in Delaware.

Justice Involved Populations Steering Committee: DMMA was commissioned to make a significant change to Medicaid benefits 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 prior to the member's release.

Medical Care Advisory Committee (MCAC): The MCAC met on January 14, 2020. Issues discussed included the Interagency Pharmaceuticals Purchasing Study Group, the Pharmacy Reimbursement Task Force, the DHSS Reorganization Committee, the pending adult dental benefit, the ACO regulation, and the justice-involved population initiative.

HBM (Enrollment Broker) Highlights for Q1 2020

There were no notable consumer issues in the first quarter. We expect to report on the impact of COVID-19 on consumers and the enrollment broker in the second quarterly report.

Q1 Quality Assurance/Monitoring Activity

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

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

QII Activity – During February, DMMA's quality unit became part of the Medical Director's office and DMMA began recruitment for a new Quality Director. With the office transition and personnel changes, the Quarter 1 QII meeting was cancelled, to be reconvened in Q2. The team spent this time reviewing the status of our quality management activities, including critical incidents tracking, performance improvement project oversight, and the quality management strategy.

State Testing Collaborative – Medical Director, Dr. Elizabeth Brown reports DMMA and our MCO partners are working with Mathematica as part of a State Testing Collaborative around quality measure specifications. This effort is in preparation for the development of MCO Quality Rating Scales, which will eventually be required by CMS. As a test state, we will be running standardized computer code provided by Mathematica to calculate a measure on the quality of care for diabetes. The goal is to understand whether measurement can be more uniform if all states can implement the same code. In March, both MCOs submitted results from the provided source code.

Case Management Oversight - In the 1st quarter 2020, DMMA oversight staff completed approximately 144 joint visits with the MCOs which included nursing facilities and community-based settings. DMMA meets with each MCO quarterly to discuss joint visit findings and collaborates on ways to improve. Due to COVID- 19, DMMA staff and the MCOs stopped face-to-face visits, which account for the reduction in this quarter's joint visits from 224 visits in Q4 of 2019. DMMA oversite staff began telephonic oversite reviews in late March 2020.

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.

DMMA met with the MCOs on January 21, 2020 and discussed a variety of topics. We discussed the IID Lifespan/DDDS members, who are relatively new to the MCOs. These members began enrollment into the MCOs in July 2019. There were no reported issues with this transition in the MCO discussions.

DMMA also discussed the new initiative for Justice-involved Medicaid members that went into effect January 1, 2020. DMMA is sharing files with our Department of Corrections to locate all our Medicaid members who are currently incarcerated. We will suspend their Medicaid benefit instead of closing their benefits which will allow our members to go directly back into their MCO and receive services on the first day of release. It also allows the MCOs the ability to assist with client care prior to release.

Q1 Managed Care Reporting Requirements

Q1 QCMMR and QCMMR Plus Reporting

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

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

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:

<u>Q1 Health Risk Assessment (HRA) Completion Rate</u>

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. Neither of the MCOs has met this goal. Based on January and February data, one MCO reported an average of 11% completion while the second MCO submitted January data and reported a 9% completion rate. This metric has been consistently not met throughout 2019 and has been a focus within the EQRO review as well.

<u>Q1 Customer Service</u>

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.

Access in Q1 – Timely Appointments and Network

The MCOs report in alternating quarters on the metric for timely appointments. For Q1, the reporting MCO was unable to meet the goal of 100% access in all but six areas measured. Of particular concern is the lack of access for maternity appointments, where the scores ranged from 20% for high risk pregnancy access to 50% for second trimester pregnancy access. The reporting MCO stated that providers who failed to meet the standards will receive a report card and corrective action plan by April.

The two MCOs have very similar size primary care provider (PCP) networks. For DSHP Plus, the number of providers for Home Health and Day Service for both MCOs are similar. For Home and Community-Based Services (HCBS) and Behavioral Health providers, one MCO has more than double the number of providers than the second MCO. For Atypical providers, one MCO has a robust number while the second MCO lacks providers in Kent, New Castle and Sussex counties.

Grievances and Appeals in Q1

DSHP Grievances and Appeals

For DSHP, there were 171 grievances for Q4 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: 11
- Benefits: 2
- Billing and/or claims: 38
- Cultural competency: 5
- MCO staff issue: 9
- Quality of care: 39
- Quality of service: 43
- Transportation to medical appointment: 12
- 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 128 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 69 grievances for Q1, down from 81 in Q4 of 2019. Listed below are the categories for grievances:

- Access and availability: 2

- Benefits: 1
- Billing and/or claims: 3
- Cultural competency: 0
- MCO staff issue: 1
- Quality of care: 5
- Quality of service: 17
- Transportation to medical appointment: 5
- Other: 2
- Case management (HCBS and institutional experience): 33

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 17 appeals, 6 of which were overturned (35%) and the second MCO reporting 9 appeals, 6 of which were overturned (67%).

Critical Incident Reporting in Q1

There were 44 critical incidents reported in Q1. Listed below are the categories for Q1 critical incidents:

- Unexpected deaths: 3
- Physical, mental, sexual abuse or neglect: 19
- Theft or exploitation: 15
- Severe injury: 4
- Medication error: 1
- Unprofessional provider: 2

Q1 External Quality Review Reporting

During Q1, DMMA reviewed the annual external quality review technical report submitted by the EQRO for the two DSHP MCOs for 2019.

During 2019, Delaware's EQRO completed a comprehensive compliance review of the two DSHP MCOs that encompassed the three mandatory activities, compliance review, validation of Performance Measures (PMs) and validation of Performance Improvement Projects (PIPs) for both MCOs. The EQRO identified a number of strengths and opportunities for improvement for both MCOs.

The EQRO also completed a comprehensive ISCA. The Performance Measure Reporting ISCA items for both MCOs resulted in 13 of the 13 items receiving a score of "Met." There were no concerns identified with any processes for integrating Medicaid claims, encounter, membership, provider,

subcontractor and other data to calculate Medicaid PMs.

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

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

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

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

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

- Technical assistance with QCMMR. The QCMMR acts as an early alert system to address potential, emerging concerns about the quality, access and timeliness of care management operations of the State-contracted MCOs. As an early alert system, the report relies on self-reported data from the MCOs which is submitted monthly via a secure file transfer protocol

site using standardized data-submission templates in Microsoft Excel. When variance in expected results occurs, the MCOs are expected to provide a brief description of the corrective action or steps taken to remediate the variance. The EQRO provides technical assistance to the MCOs to ensure the data submitted to DMMA are complete, accurate and reliable. Trends regarding the data are analyzed quarterly and comparisons are made within each MCO and across MCOs, and when changes in trends are identified, the MCOs are asked to provide a response.

Q1 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 intends to submit separate evaluation design plans for the SUD component of the DSHP 1115 and the waiver as a whole. These draft evaluation design plans are due to CMS by June 1, 2020.

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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