Mercer

Government Human Services Consulting

Delaware External Quality Review

2023 Technical Report

State of Delaware
Division of Medicaid and Medical Assistance

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Contents

1. Introduction....1

2. External Quality Review Overview....3

- External Quality Review Objectives....3
- Technical Methods for Data Collection and Analysis....4
- Description of the Data Obtained....7
- Conclusions Based on the Data Analysis....7

3. Review of Compliance with Medicaid and CHIP Managed Care Regulations and Contract Standards....11

- Compliance Review....13
- Information Requirements, Benefit Information, Marketing, and Emergency and Post-Stabilization Services....23
- Advance Directives....29
- Availability of Services — Cultural Considerations, Delivery Network, Provider Selection, and Timely Access....29
- Program Integrity Requirements and Confidentiality....37
- Prohibited Affiliations with Individuals Debarred by Federal Agencies....37
- Grievance and Appeal Systems....38
- Sub-contractual Relations and Delegation....47
- Clinical Practice Guidelines and Coverage, and Authorization of Services....48

- Enrollment and Disenrollment 62
- Quality Assessment and Performance Improvement Program 62
- Coordination and Continuity — Primary Care and Special Health Care Needs 68
- Dental 90

4. Validation of Performance Measures 92
   - ACDE Performance Measures Overall Assessment 92
   - HHO Performance Measures Overall Assessment 105
5. Validation of Performance Improvement Projects 120
   - ACDE Performance Improvement Project Overall Assessment 120
   - HHO Performance Improvement Project Overall Assessment 137
6. Information Systems Capabilities Assessment 150
   - ACDE Overall Assessment 150
   - HHO Overall Assessment 152
   - Strengths 152
   - Opportunities 153
7. Delaware First Health Mid-Year Post-Implementation Review 154
   - Purpose 154

- On-site Review 154
- Overall Mid-Year Post-Implementation Assessment 155

8. NCI-AD Adult Consumer Survey 156

- NCI-AD Survey Overview 156
- NCI-AD Sample 156
- Survey Process in Delaware 157
- Survey Findings 157

Section 1

Introduction

The State of Delaware (Delaware or State) Division of Medicaid and Medical Assistance (DMMA), within the Department of Health and Social Services(DHSS), has provided healthcare services to its Medicaid population, including individuals with disabilities, through the Diamond State Health Plan (DSHP), the Delaware Healthy Children's Program (DHCP), and the State's Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act since 1996, operating under an 1115 Managed Care Waiver.

In April 2012, DMMA, working with its Managed Care Organizations (MCOs), the Centers for Medicare & Medicaid Services (CMS), sister agencies, such as the Division of Services for Aging and Adults with Physical Disabilities, providers, such as nursing facilities (NFs) and Home- and Community-Based Services (HCBS) providers, and community stakeholders, including NFs, patient advocates, members, and others, amended their Section 1115 waiver to include a Managed Long-Term Services and Support (MLTSS) program. The program serves individuals eligible for MLTSS (institutional and HCBS) and individuals living in the community who are dually eligible for Medicaid and Medicare; this program is referred to as DSHP Plus. DSHP Plus does not include individuals with developmental disabilities receiving institutional or community-based Long-Term Services and Supports (LTSS).

On January 1, 2015, the DSHP Plus Medicaid Managed Long-Term Care program was launched. In 2015, the DSHP program continued to evolve and, in addition to the integration of acute and LTSS services, the pharmacy benefit was "carved in" and DMMA integrated a new MCO, Highmark Health Options (HHO), into the Delaware market. In response to these changes, DMMA, with CMS approval, took an innovative approach to its quality review activities in 2015. This included an MCO implementation action plan review, technical assistance for the MCOs focused on MLTSS Case Management (CM) and Care Coordination (CC), development of Performance Improvement Project (PIP) topics, continued activities supporting compliance with the HCBS final rule, and an analysis of each MCOs compliance with existing network adequacy standards.

In 2017, DMMA issued a Request for Qualification (RFQ) to solicit innovative approaches to drive improvements in the delivery system and quality of services offered to DSHP and DSHP Plus members. DMMA provided formal notification to United Healthcare Community Plan of Delaware (UHCP), one of its incumbent MCOs, of its intent to not exercise the 2018 contract option year. DMMA opted to contract with AmeriHealth Caritas Delaware (ACDE) with a planned go-live date of January 1, 2018. Transition and continuity of care activities with UHCP occurred through December 2017 while readiness review activities for ACDE commenced in October 2017.

In an effort to deliver member-focused care, hold MCOs accountable, drive innovation and align with other State initiatives in delivering quality services to DSHP and DSHP Plus members, DMMA issued a Request for Proposal (RFP)on December 15, 2021. DMMA opted to contract with the two incumbent MCOs, ACDE and HHO as well as contract with a new plan, Delaware First Health

(DFH) with a planned go-live date of January 1, 2023. In preparation for DFH's go-live date, Mercer Government Human Services Consulting (Mercer) conducted a readiness review of DFH which was held November 15, 2022, through November 17, 2022. The Readiness Review comprised of 12 track teams (Administration and Organization, Network, Grievances and Appeals, Service Coordination, Utilization Management, CC, CM, Pharmacy, Dental, Quality Management and Quality Improvement, Information Technology and Claims Readiness and Claims and Encounters and Information Systems).

In March 2023 and June 2023, Mercer conducted a Post-Implementation Review and Mid-Year Post-Implementation Review of DFH which consisted of facilitating interviews with MCO leadership, supervisory, and management staff engaged with delivering benefits to DSHP and DSHP Plus members through the first six months of operations. The External Quality Review Organization (EQRO) focused on the delivery of services, ensuring progress had been made toward developing and implementing Delaware-specific policies and procedures (P&Ps) and resolving issues or concerns identified during the Readiness Review. The purpose of this review was to ensure that DFH was stabilizing operations, moving toward full compliance with contract expectations, and would be on sound footing for a comprehensive compliance review in 2024.

Additionally, in 2023, Mercer completed a corrective action plan (CAP) review of ACDE and HHO that encompassed the three mandatory activities, compliance review, validation of Performance Measures (PMs), and validation of Performance Improvement Projects (PIPs) for both MCOs; Mercer also completed a CAP Information Systems Capabilities Assessment (ISCA). In addition to the completion of mandatory activities, the EQRO conducted the following activities, detailed throughout the report:

- National Core Indicators–Aging and Disability Survey.

Section 2
External Quality Review Overview

External Quality Review Objectives

Mercer's objective for the 2023 External Quality Review (EQR) was to assess Delaware MCO performance toward achieving the Delaware Quality Strategy (QS) goals in place at the time of the review[1], which were:

1. To improve timely access to appropriate care and services for adults and children with an emphasis on primary, preventive, and behavioral health (BH) care, and to remain in a safe and least-restrictive environment.
2. To improve the quality of care (QOC) and services provided to Medicaid and CHIP enrollees.
3. To control the growth of health care expenditures.
4. To assure member satisfaction with services.

To achieve this objective, Mercer performed the mandatory EQR activities and conducted a CAP compliance review; this report presents the results as required by 42 CFR 438.364. The objectives of this review included:

- Assessing the implementation of CAP activities by the MCOs for those items that scored less than "Met" in 2022.
- Assessing the quality of services provided, the timeliness of services provided, and access to care and recommendations to the MCOs and DMMA for continued improvement.
- Comparison of MCO PM results with national benchmarks.
- Evaluation of PIPs.

The 2023 QS, submitted to CMS on September 29, 2023, will be the basis of the EQRO evaluation in 2024 and forward until Delaware updates or revises the document.

[1] The Delaware Quality Strategy was revised and submitted to CMS on September 29, 2023.

Technical Methods for Data Collection and Analysis

As a consulting firm, Mercer has access to individuals with expertise in a variety of fields. For this EQR process, Mercer chose a specifically designated team with a variety of specialties and talents that could meet the requirements of the EQR process.

The methodology used by Mercer, during this review process, was organized into five critical phases presented in the following diagram.

Standards Reviewed in the Current Reporting Cycle	
§438.56 Disenrollment Requirements and Limitations	§438.214 Provider Selection
§438.100 Enrollee Rights Requirements	§438.224 Confidentiality
§438.114 Emergency and Post-Stabilization Services	§438.228 Grievance and Appeal Systems
§438.206 Availability of Services	§438.230 Subcontractual Relationships and Delegation
§438.207 Assurances of Adequate Capacity of Services	§438.236 Practice Guidelines
§438.208 Coordination and Continuity of Care	§438.242 Health Information Systems
§438.210 Coverage and Authorization of Services	§438.330 Quality Assurance and Performance Improvement (QAPI)

Request for Information

Mercer used the MCO RFI, based on the CMS protocol and modified by Mercer to meet the needs of DMMA, to acquire information specific to all areas of the review. Mercer received information electronically and reviewed all documents submitted over a series of

weeks. The information was organized on the Mercer Connect SharePoint site into folders and subfolders, coordinating with the data request format. During the on-site review phase, additional information was collected; a small number of outstanding data needs remained. At the close of the on-site review process, Mercer summarized the outstanding information needs and the MCOs submitted additional information for further review and consideration following the on-site visit.

Review Tool

Mercer utilized a CAP EQR compliance review tool (tool) adapted from CMS protocols for the compliance section of the review. The tool design included State standards reflecting key issues and priorities of DMMA. The tool assisted the reviewers in logically coordinating the review process, consistent with the flow of Federal Regulations for Medicaid Managed Care (FRMMC) and State standards and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Mercer's desk review results helped to focus observations and interviews to gather additional information during the on-site review.

File Review Protocol

Mercer developed a file request Excel template containing the specific date range and data fields required for each of the file review areas. Additionally, Mercer provided the detailed file formats and content expected for each file review type. After receiving the universe file listing for the specified time period, Mercer selected a targeted random sample of 30 files for review. The final file selection was distributed to the MCO via the Mercer Connect SharePoint site, and the MCO was provided four weeks to upload the file contents to the Mercer Connect SharePoint site.

Mercer utilized the National Committee for Quality Assurance's (NCQA's) "8/30" rule for the evaluation of healthcare organization file reviews. The rule states that of a sample of 30 files if the initial eight pass the review, the entire sample of 30 is cleared. The additional 22 files undergo review if the reviewers discover issues in the first eight. The NCQA has evaluated this method to be "a cost-effective and statistically appropriate method of gathering data about the overall performance" of a health care organization. After discussion with DMMA for the purpose of all file reviews, Mercer employed a variant of the "8/30" rule and chose to review 10 files selected from a sample of 30. For file reviews in which there was not enough volume to reach the 10 or 30 file denominators, Mercer reviewed all files for that category. Mercer reviewed the files and posted the preliminary file findings prior to the on-site review to allow the MCO an opportunity to collect additional information to address file findings. Outstanding file findings were discussed during the on-site review, additional supporting documentation was requested and provided as available.

For scoring the file review, Mercer utilized a three-tiered system. This approach for quantitative scoring was determined as more appropriate than the five-tiered system (described below) used for regulatory and contractual compliance activities due to predictive constraints of the denominator size.

File Review Compliance Level Definitions	
Met	For file reviews, the MCO must have achieved 90.0% compliance or greater.
Partially Met	For file reviews that scored between 75.0% and 89.0% compliance.
Not Met	For file reviews that scored less than 74.0% compliance.

Analysis and Reporting

Information from all phases of the review process was gathered, and a comprehensive analysis was completed. The MCO-specific report sections present the topics reviewed, the MCO team members who participated in the review, as well as the metrics requiring a CAP as a result of the 2023 review (i.e., substantially met, partially met, minimally met, not met). Summary results of the analysis make up this report. The table below outlines the five-tiered system utilized to determine compliance findings.

Compliance Level Definitions	
Met	All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.
Substantially Met	After a review of the documentation and discussion with MCO staff, it is determined that the MCO has met most of the requirements required for the Met category.
Partially Met	MCO staff describes and verifies the existence of compliant practices during the interview(s), but the required documentation is incomplete or inconsistent with practice.
Minimally Met	After a review of the documentation and discussion with MCO staff, it is determined that although some requirements have been met, the MCO has not met most of the requirements.
Not Met	No documentation is present and MCO staff have little to no knowledge of processes or issues that comply with regulatory or contractual provisions.

Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures the MCOs reported were compiled and comparative results between MCOs and relative to national benchmarks are included. The following rating scale is used to present these results:

			
HEDIS rating met or exceeded the national benchmark for the 90th percentile.	HEDIS rating fell between the national benchmarks for the 75th and the 90th percentile.	HEDIS rating fell between the national benchmarks for the 50th and the 75th percentile.	HEDIS ratings fell below the national benchmark for the 50th percentile.

Description of the Data Obtained

The data obtained for the annual review included, but was not limited to:

- P&Ps, quality, utilization management (UM), and CM program descriptions.
- CC, CM, grievance, and appeal files.
- Enrollee and provider documents.
- Meeting minutes and data to support validation of PIPs and PMs.
- Quality and Care Management Measurement Report (QCMMR) reports.
- HEDIS results.
- CAHPS results.
- Provider satisfaction survey results.

In addition to the documentation and files reviewed, Mercer conducted interviews with MCO staff to assess the consistency of responses across operational areas and documentation the MCO provided.

Conclusions Based on the Data Analysis

Compliance review results are presented in Section 3 of the report and were assigned a domain of quality, timeliness, and/or access to care. MCOs were given a rating of Met, Substantially Met, Partially Met, Minimally Met, or Not Met for each standard (see Analysis and Reporting above for full definitions). Comparative summary results reveal that ACDE was fully compliant or “Met” all expectations in six of the 11 Subpart D and QAPI standards (availability of services, adequate capacity of services, provider selection, confidentiality, practice guidelines, and QAPI). The scores for the five standards that were not fully compliant for ACDE ranged from 60.0% to 97.8%. HHO was fully compliant in nine areas (availability of services, adequate capacity of services, coordination and continuation of care, coverage and authorization of services, provider selection, confidentiality, grievance and appeal (G&A) systems, practice guidelines, and QAPI). The scores for the two standards that were not fully compliant for HHO ranged from 97.7% to 98.4%, Additionally, the number of items across standards needing a CAP, that is scoring less than “Met,” was higher for ACDE (20) than HHO (4).

The areas of greatest opportunity for ACDE identified in the compliance review were related to CC and UM (12 and 3 items, respectively, requiring a CAP). By contrast, the areas of greatest opportunity for HHO were related to G&A and LTSS CM (1 and 3 items, respectively requiring a CAP).

Based upon the ISCA CAP review, ACDE continues to demonstrate effective partnership and collaboration between the local MCO and the enterprise ACFC teams, operations, and systems and, as such, continues to perform well in supporting the systems-related requirements of Delaware's managed Medicaid program. The insights gained from ACDE's ISCA CAP desk review and hybrid discussions confirmed a strong infrastructure, claims and encounters subject matter expertise, teamwork, and commitment to supporting Delaware's Medicaid programs. The desk and on-site reviews of the 2023 ISCA items resulted in 113 of the 117 desk review items (96.6%) receiving a review score of Met for ACDE.

HHO demonstrated their continued efforts to improve their claims processing operations and submission of encounter data to effectively support Delaware's Medicaid managed care program. At the same time, HHO made significant progress in its vendor oversight capabilities including enhanced processes, value-added dashboards and collaborative meetings. HHO has made substantial progress in claims remediation and audit activities with newly developed dashboards to support daily operations. The insights gained from HHO's ISCA desk review and on-site discussions confirmed HHO's efforts to improve the claims operations and underlying infrastructure to ensure accurate claims processing and timely encounter submission. As implied through their well-organized and thoughtful RFI response, HHO continued to exhibit strong process orientation, comprehensive understanding of DMMA requirements, and well-organized internal partnership. The desk and on-site reviews of the 2023 ISCA items resulted in 111 of the 117 desk review items (94.9%) receiving a review score of Met for HHO.

Both ACDE's and HHO's ongoing collaboration with DMMA and Gainwell to identify and remediate encounter data submission issues has been beneficial to stakeholders.

Both MCOs have processes in place to generate standardized PMs (e.g., HEDIS and CAHPS) to fulfill contractual obligations. However, the validation of PM results indicated room for improvement for one of the MCOs in State-specific reporting. The EQRO reported high confidence in all six State-specific measures for ACDE and high confidence in five State-specific measures and no confidence in one State-specific measure for HHO. A full description of the validation of PM results is in Section 4 of the report.

There is a significant opportunity for improvement in HEDIS results for both MCOs. Presented below are 34 select HEDIS measures across various domains of care. Of the 34 reported measures for ACDE, none were at or above the 90th percentile. Two measures, timeliness of prenatal care and well-child visits in the first 30 months of life (15–30 months) were at or above the 75th percentile. ACDE reported five measures where the HEDIS rate improved by one percentage point or greater, 28 measures where the HEDIS rate did not change by more than one percentage point, and one measure where the HEDIS rate declined by one percentage point or greater from 2022 to 2023. 22 of ACDE's HEDIS results for these 34 measures (64.0%) were below the 50th percentile. Of the 34 reported measures for HHO, one measure, lead screening in children, was at or above the 90th percentile. Nine measures, child and

adolescent well-care visits for all ages and in total, timeliness of prenatal care, cervical cancer screening, comprehensive diabetes care — HbA1C screening, and well-child visits in the first 30 months of life for both the first 15 months and 15–30 months, were at or above the 75th percentile. HHO reported five measures where the HEDIS rate improved by one percentage point or greater, 28 measures where the HEDIS rate did not change by more than one percentage point, and one measure where the HEDIS rate had declined by one percentage point or greater from 2022 to 2023. Fourteen of HHO's HEDIS results for these 34 measures (41.0%) were below the 50th percentile.

Through ongoing waiver and grant projects, as well as engagement with the provider community, DMMA supports the efforts of the MCOs to ensure that care is coordinated and managed appropriately with timely access to a stable and robust provider network that is providing high-quality care. However, the compliance and HEDIS results represent opportunities for continued collaborative work with the MCOs to achieve Goal 1 (to improve timely access to appropriate care and services for adults and children), and Goal 2 (to improve QOC and services provided to Medicaid and CHIP enrollees) detailed in the Quality Strategy.

ACDE demonstrated some improved CAHPS results from 2022 to 2023. ACDE's members gave the highest scoring (at or above the 90th percentile) for the measures: adult rating of health plan and children rating of all health care. ACDE's members gave the lowest scoring (below the 50th percentile) for the measures: children rating of specialist, children getting needed care, and children getting care quickly. ACDE improved its CAHPS performance year over year in seven categories. ACDE stayed stagnant in five categories, and ACDE's performance decreased in two categories. HHO demonstrated a slight decrease in CAHPS results from 2022 to 2023. HHO's members gave the highest scoring (at or above the 90th percentile) for the measures: adult rating of health plan, children rating of specialists, children rating of all health care, and children rating of health plan. HHO's members gave the lowest rating (below the 50th percentile) for the measures: adult rating of specialist, adult getting care quickly, adult how well doctors communicate, children getting needed care, children getting care quickly, and children how well doctors communicate. HHO improved its performance year over year in two categories. HHO was stagnant in nine categories, and HHO's performance declined in three categories. These results identify an opportunity for the MCOs and DMMA to work collaboratively toward improving results for Goal 4: To ensure member satisfaction with services, particularly related to getting needed care and getting care quickly.

A full description of the validation of PIP results can be found in Section 5 of the report. In the Quality Strategy in place during the 2023 EQR, DMMA has mandated that each MCO conduct a minimum of five PIPs covering specific topics. Of the five required PIPs, the State required the EQRO to validate three PIPs during the 2023 compliance review cycle. The first required PIP allows for a topic selected by the individual MCO that is relevant to its population and approved by DMMA. The second PIP was a State-mandated topic but MCO developed study questions (BH and PH integration). The third PIP allows for a topic selected by the individual MCO that is non-clinical or service-related and approved by DMMA. Both MCOs have met the requirements for PIPs based on the Delaware Quality Strategy and the EQRO has a high level of confidence in the reported results for all three validated PIPs. However, as an essential component of an MCO's quality program to identify, assess, and monitor improvement in processes or outcomes of care, both MCOs should assess opportunities across the spectrum of the organization and business units to identify and implement

PIPs. Including PIP topics that have an impact on a larger population and are active in driving improvement would help to accomplish this goal and drive toward continued improvement in both clinical and service matters for the Delaware Medicaid population.

Section 3

Review of Compliance with Medicaid and CHIP Managed Care Regulations and Contract Standards

At the request of the State, Mercer, DMMA's EQRO, conducted a CAP review of Delaware's MCOs, ACDE and HHO, assessing compliance with federal regulations. Below is a crosswalk of the standards reviewed by the EQRO to the standards in 42 CFR 438.56, 438.110, 438.114, 42 CFR subpart D, and 42 CFR 438.330, MCO scores, as well as the timeframe for the review.

Standard Reviewed by the EQRO	Standards	ACDE	HHO	Last Reviewed
Access and Availability	§438.56 Disenrollment Requirements and Limitations	100.0%	100.0%	Review Cycle 2023
	§438.100 Enrollee Rights Requirements	100.0%	100.0%	Review Cycle 2023
	§438.206 Availability of Services	100.0%	100.0%	Review Cycle 2023
	§438.207 Assurances of Adequate Capacity of Services	100.0%	100.0%	Review Cycle 2023
Care Management	§438.208 Coordination and Continuity of Care	92.1%	100.0%	Review Cycle 2023
Utilization Management (UM)	§438.114 Emergency and Post-Stabilization Services	100.0%	100.0%	Review Cycle 2023
	§438.210 Coverage and Authorization of Services	97.3%	100.0%	Review Cycle 2023
Provider Network	§438.214 Provider Selection	100.0%	100.0%	Review Cycle 2023
	§438.224 Confidentiality	100.0%	100.0%	Review Cycle 2023
	§438.230 Subcontractual Relationships and Delegation	60.0%	100.0%	Review Cycle 2023
Grievance and Appeals	§438.228 Grievance and Appeal (G&A) Systems	98.9%	97.7%	Review Cycle 2023
Quality Improvement and Assessment	§438.236 Practice Guidelines	100.0%	100.0%	Review Cycle 2023
	§438.242 Health Information Systems	97.8%	98.4%	Review Cycle 2023
	§438.330 QAPI	100.0%	100.0%	Review Cycle 2023

Mercer completed this review as part of the mandatory EQR required by federal law using applicable CMS EQR protocols, released in October 2019. Areas included in the assessments were:

- CAP review of MCO compliance with FRMMC, the CHIPRA, and State standards.
- CAP review of compliance with contract standards for:
  - DSHP and DSHP Plus CM.
  - DSHP All Member Level Coordination, Level 1 Resource Coordination (RC), and Level 2 Clinical Care Coordination (CCC).
- PIP validation.
- PM validation.

The purpose of this independent review was to assess the following:

- The ability of the MCO and its programs to achieve quality outcomes and timely access to health care services for Medicaid, CHIP, and DSHP Plus members.
- Compliance with all regulations and requirements related to the FRMMC and CHIPRA State-defined standards.
- The consistency of the MCO's internal policies, procedures, and processes, and to evaluate maintenance of effort for all previous corrective actions.

To kick off the EQR, Mercer developed and distributed to MCO staff a timeline that chronologically summarized the EQR deliverables and their due dates for 2023. The 2023 CAP review encompassed the MCO's calendar year 2022 operations and specifically focused the file review on the period of January 1, 2023 through March 31, 2023. The 2023 EQR process began on April 24, 2023, when Mercer delivered the Request for Information (RFI) to both MCOs. Mercer used a Health Insurance Portability & Accountability Act (HIPAA) compliant secure file transfer protocol site, Mercer Connect SharePoint, to allow a secure exchange of information among Mercer, DMMA, and the MCO. MCO materials were uploaded to the SharePoint site by May 19, 2023. The desk review was a CAP analysis of P&Ps and supporting documents related to FRMMC, CHIPRA, and State contract standards. In addition, Mercer reviewed the CC, CM, and G&A files and submitted preliminary findings to both MCOs to prepare for the on-site review.

The annual on-site review was conducted by Mercer, with DMMA staff in attendance, on June 13, 2023 through June 14, 2023, for ACDE and on June 15, 2023, for HHO. The documentation reviews and staff interviews were conducted to gain a more complete and accurate understanding of the operations of the MCOs and how those operations contribute to its compliance with federal and State regulations and requirements, consistency with internal P&Ps and processes, and adherence to contractual standards in the provision of health care services to its enrollees.

Compliance Review

This review was conducted based on information submitted by ACDE and HHO through the RFI and through on-site meetings. The table below provides a sense of the MCO's progress toward full compliance with expectations by review area.

MCO Corrective Action Plan						
EQRO Review Sections	ACDE			HHO		
	Number of CAP Items Identified in 2021	Number of CAP Items Identified in 2022	Number of CAP Items Identified in 2023	Number of CAP Items Identified in 2021	Number of CAP Items Identified in 2022	Number of CAP Items Identified in 2023
Administration and Organization	0	1 - Newly identified	1 - Newly identified	3	1 - Newly identified	0
CC	33	17	12	6	0	0
Dental	2	0	0	0	1 - Newly identified	0
G&As	0	0	1 - Newly identified	3	2	1 — Newly identified
LTSS CM	4	3	2	4	3	3
Pharmacy	1	0	0	2	0	0
Provider Network	4	2 - Newly identified	1	13	2 - Newly identified	0
Quality	3	1	0	13	3 (1 - Newly Identified)	0
UM	18	12 (5 - Newly Identified)	3	4	0	0
Total	**65**	**36**	**20**	**48**	**12**	**4**

2023 Findings and Recommendations for the State's Quality Strategy

Delaware's Medicaid managed care program focuses on providing quality care to the majority of DSHP (Medicaid and CHIP) and DSHP Plus eligible individuals in the State through increased access to and appropriate, timely utilization of health care services. The goals and objectives of the Quality Strategy provide a persistent reminder of program direction and scope. The following four goals equate to areas of focus for clinical quality improvement in Delaware as listed in the State's Quality Strategy:

Goal 1: To improve timely access to appropriate care and services for adults and children, with an emphasis on primary and preventive, and BH care, and to remain in a safe and least-restrictive environment.

Goal 2: To improve QOC and services provided to Medicaid and CHIP enrollees.

Goal 3: To control the growth of healthcare expenditures.

Goal 4: To ensure member satisfaction with services.

Below are tables with the EQRO's 2023 findings and recommendations for DMMA's Quality Strategy broken out by a goal.

Information from the 2018 Quality Strategy Goal: 1. To improve timely access to appropriate care and services for adults and children with an emphasis on primary and preventive, and BH care, and to remain in a safe and least-restrictive environment		
Quality Strategy Expectations	**EQRO Finding or HEDIS Rates**	**EQRO Suggestions for the State**
Availability of Services — cultural considerations, delivery network, provider selection, and timely access	The sample of grievance files reviewed identified a number of member grievances related to members being balance billed by providers.	If members, in the past, have been balance billed by a provider it may make them hesitant to seek out care. The State should continue to review reports of QOC and quality of service grievances, and when needed conduct file reviews, to assess any trends in inappropriate balance billing. The State should ensure effective MCO staff training and provider communication and education on member billing practices.

Information from the 2018 Quality Strategy Goal: 1. To improve timely access to appropriate care and services for adults and children with an emphasis on primary and preventive, and BH care, and to remain in a safe and least-restrictive environment			
DSHP Plus CM File Compliance	The sample of DSHP Plus files reviewed identified the following areas for improvement: • Ensuring case manager compliance with standards for timely, complete, and accurate documentation. • Ensuring preventive care gaps are identified, and addressed in member care plans and members are offered applicable education. • Follow-up after emergency department (ED) visit or hospital admission was lacking.		The State should continue to review contractually required quarterly clinical reports, and when needed conduct file reviews, to assess the level of care evaluations and completion of member care plans. The State should assess the timeliness and effectiveness of ED visit follow-up provided to the DSHP Plus population. As part of ongoing oversight and monitoring, DMMA should continue monitoring DSHP Plus CM files through ongoing case file review to ensure all contractual requirements are met and members are receiving appropriate care in a safe and least restrictive environment.
Adult Access to Primary and Preventive Care Services*	**ACDE:** Ages 20–44: 65.97% Ages 45–64: 77.58% Ages 65+: 81.12% **Total: 70.01%**	**HHO:** Ages 20–44: 70.83% Ages 45–64: 80.91% Ages 65+: 84.65% **Total: 74.15%**	As part of the ongoing value-based purchasing strategy efforts, DMMA should continue to pursue initiatives, including network development (with a particular focus on primary care providers [PCPs]) for access and availability of services, to drive improved rates of utilization of primary and preventive care services.

**NCQA HEDIS Specifications*

Information from the 2018 Quality Strategy Goal: 2. To improve QOC and services provided to Medicaid and CHIP enrollees			
Quality Strategy Expectations	**EQRO Finding or HEDIS Rates**		**EQRO Suggestions for the State**
DSHP Plus CM File Compliance	The sample of DSHP Plus files reviewed identified the following areas for improvement: • Identification and follow-up of member preventive health needs. • Coordination of care for members with BH diagnosis.		The State should continue to review contractually required quarterly clinical reports, and when needed conduct file reviews, to identify trends in lower rates of DSHP Plus preventive care and any BH concerns. As part of ongoing oversight and monitoring, DMMA should continue monitoring DSHP Plus CM files through ongoing case file review to ensure case managers are pursuing all avenues for members receiving preventive services and BH services are coordinated across the health care spectrum.
Inpatient days/1000 MM*	**ACDE:** Maternity: 72.64 Medicine: 187.82 Surgery: 216.42 **Total Inpatient: 460.10**	**HHO:** Maternity: 59.98 Medicine: 195.11 Surgery: 196.83 **Total Inpatient: 436.02**	The State should continue to monitor MCO UM reports and work to identify areas of opportunity for alternative service settings.
Average Length of Stay (ALOS*)	**ACDE:** Maternity: 2.77 Medicine: 5.49 Surgery: 12.29 **Total Inpatient: 6.39**	**HHO:** Maternity: 2.89 Medicine: 5.11 Surgery: 11.51 **Total Inpatient: 6.18**	The State should continue to monitor MCO UM reports to ensure appropriate lengths of stay and management of care by the MCOs.
Comprehensive diabetes care*	**ACDE:** Eye Exams: 53.04% HbA1c Control (<8.0%): 47.69% Poor HbA1c Control: 43.55%	**HHO:** Eye Exams: 46.96% HbA1c Control (<8.0%): 58.64% Poor HbA1c Control: 31.14%	The State should ensure MCOs are engaging in best practices (e.g., Delaware Diabetes and Heart Disease Prevention and Control Program) and with community partners (e.g., Delaware Diabetes Coalition, Inc.) to drive improved quality of comprehensive diabetes care.

**NCQA HEDIS Specifications*

Information from the 2018 Quality Strategy Goal: 3. To control the growth of health care expenditures			
Quality Strategy Expectations	**EQRO Finding or HEDIS Rates**		**EQRO Suggestions for the State**
ED Utilization per 1000 MY*	**ACDE**: 591.58	**HHO**: 550.99	Continue to identify areas of opportunity for alternative (non-ED) service settings.
Non-Elective Inpatient Discharges per 1000 MY*	**ACDE**: 71.99	**HHO**: 70.55	Continue to monitor UM reports to ensure appropriate management of care by the MCOs.
Plan All Cause Readmission Observed/Expected Ratio*	**ACDE**: 1.2461	**HHO**: 1.21	Continue to monitor UM reports to ensure appropriate management of care by the MCOs.

**NCQA HEDIS Specifications*

Information from the 2018 Quality Strategy Goal: 4. To assure member satisfaction with services			
Quality Strategy Expectations	**EQRO Finding or HEDIS Rates**		**EQRO Suggestions for the State**
CAHPS Rating of Personal Doctor Composite	**ACDE:** Adult: 73.50% Child: 77.60%	**HHO:** Adult: 60.50% Child: 77.90%	Particularly in light of other provider issues identified (i.e., balanced billing), the State should monitor grievance reports to identify opportunities to ensure a continued level of high member satisfaction with care by providers.
CAHPS Rating of Specialist Composite	**ACDE:** Adult: 69.00% Child: 68.80%	**HHO:** Adult: 62.00% Child: 80.90%	Monitor grievance reports to identify opportunities to ensure a continued level of high member satisfaction with care by providers.
CAHPS Rating of All Health Care Composite	**ACDE:** Adult: 56.00% Child: 77.30%	**HHO:** Adult: 56.00% Child: 72.60%	Monitor grievance reports to identify opportunities to ensure a continued level of high member satisfaction with care by providers.

Information from the 2018 Quality Strategy Goal: 4. To assure member satisfaction with services			
CAHPS Getting Needed Care Composite	**ACDE:** Adult: 84.70% Child: 81.10%	**HHO:** Adult: 84.30% Child: 84.70%	Monitor grievance reports to identify opportunities for improved member satisfaction with timely access to high-quality care.
CAHPS Getting Care Quickly Composite	**ACDE:** Adult: 81.70% Child: 84.50%	**HHO:** Adult: 79.20% Child: 81.50%	Monitor grievance reports to identify opportunities for improved member satisfaction with timely access to high-quality care.
CAHPS How Well Doctors Communicate Composite	**ACDE:** Adult: 94.80% Child: 93.50%	**HHO:** Adult: 92.20% Child: 91.90%	Monitor grievance reports to identify opportunities to ensure a continued level of high member satisfaction with care by providers.

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
PIP Validation			
ACDE	ACDE has met the requirements for PIPs based on the Delaware Quality Strategy and the EQRO has a high level of confidence in the reported results for all three validated PIPs.	As an essential component of an MCO's quality program to identify, assess, and monitor improvement in processes or outcomes of care, ACDE should assess opportunities across the spectrum of the organization and business units to identify and implement PIPs. Including PIP topics that have an impact on a larger population and are active in driving improvement would accomplish this goal.	Quality, Access, Timeliness
HHO	HHO has met the requirements for PIPs based on the Delaware Quality Strategy and the EQRO has a high level of confidence in the reported results for all three validated PIPs.	As an essential component of an MCO's quality program to identify, assess, and monitor improvement in processes or outcomes of care, HHO should assess opportunities across the spectrum of the organization and business units to identify and implement PIPs. Including PIP topics	Quality, Access, Timeliness

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
		that have an impact on a larger population and are active in driving improvement would accomplish this goal.	

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
PM Validation			
ACDE	The EQRO has a high level of confidence in the validity of the PMs generated using NCQA-certified HEDIS software.	None.	Quality, Timeliness, Access
HHO	The EQRO has a high level of confidence in the validity of the PMs generated using NCQA-certified HEDIS software.	The EQRO has no confidence in HHO's 30-day Hospital Readmission Rate PM.	Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance Review			
ACDE	ACDE has updated UM P&Ps for pre-service and concurrent reviews. These P&Ps require the team to gather additional member information not included in InterQual, implemented in May 2023 to assist with whole person approach and discharge planning.	Customer Service Representatives (CSR) were not familiar with common DHSP and DSHP Plus grievance and appeals terms and processes. Specifically, a CSR did not know what a State Fair Hearing was and, even after reaching out to additional CSRs was unable to provide appropriate guidance to the member in response to the member's question. Additional training, specifically on G&A terms and processes, is needed. Documentation across the Clinical department	Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
		must be Delaware-specific, use Master Service Agreement (MSA) vernacular, and reflect the intent of DMMA's CC and CM programs.	
	ACDE has consistent and strong leadership in place for the CM program, provides strong and effective housing support, and is working to improve the quality of discharge and transition coordination for members receiving CM.	CC file reviews demonstrate a need for improved clinical case conceptualization beyond required tasks and improvement in successful outreach and maintaining engagement. Additionally, communication and coordination between the CC department and provider network management requires improvement to address timely access to primary care provider (PCP) and specialist visits.	Quality, Timeliness, Access
	The MCO has implemented extensive use of targeted and standard auditing processes of member case files. The MCO also developed an audit policy that identifies metrics and compliance goal rates for documentation standards including preventive health monitoring and timeliness of CM documentation.	Drive improvements in care plans for the LTSS population regarding identification and incorporation of preventive health care needs, and appropriate standards of documentation. Improve timely identification of Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) members, active collaboration with PROMISE care managers, and update the P&P to clarify that the MCO CM is primary.	Quality, Timeliness, Access
	There is strong leadership in the QM/QI department that is supported by senior leadership within ACDE. This leadership fosters a member-first mindset, trust among team members, and a continuous quality improvement mindset across the organization.		Quality

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
HHO	HHO has embraced the concept of the Provider Network Development and Management Plan (PNDMP) as a living document and demonstrates a continuous quality improvement (CQI) mindset in the enhancements and evolution of this document. HHO monitors its network adequacy monthly via cross-departmental meetings, conducts quarterly audits for panel openings, and has a Provider Account Liaison (PAL) designated for all geographic territories and provider types. The Provider Network team works collaboratively with the Quality Improvement, UM, Care Management, Credentialing, Claims, Member and Provider Services teams to satisfy both provider and member needs to maintain a healthy provider network. HHO has improved training for call center staff and providers in an effort to halt providers inappropriately billing members.	Specific grievance training around balance billing was identified and given in 2022 for call center staff. However, there is an opportunity to proactively outreach to all members assigned to a provider who has previously balance billed to ensure there are no additional members who received a bill. Communication to those members should include information about the grievance process and how to be reimbursed if the member paid the provider. A targeted effort to address providers who have directly billed members will assist in mitigating the practice and ensure all members are informed of their rights and, if appropriate, reimbursed for inappropriate billing.	Quality, Timeliness, Access
	HHO's training module for vendors and subcontractors was redesigned to provide more relevant material for external entities. This training, in combination with the organization's self-paced "Medicaid 101" e-module, is a quality training requirement for vendors. These two training modules are documented on the vendors' scorecard and included in the overall assessment of compliance.	HHO UM department's IRR audit tools are specific to InterQual®; it would be beneficial to develop and audit IRR specific to American Society of Addition Medicine (ASAM) IRR.	Quality, Timeliness, Access
	HHO has made significant advancements to the dashboard tools for monitoring health care disparities, HEDIS rates and PIP metrics.	CM files reflect opportunities to improve consistent and comprehensive care for members. This was shown through inconsistencies in follow up after emergency room visits and hospital admissions. Files also revealed an opportunity for additional Care Plan template training for CM staff in order to optimize development of specific, measurable, achievable, relevant, and time bound (SMART) Goals, document progress updates, and	Quality, Timeliness, Access

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
		appropriate use of long- and short-term goals. Based on the files reviewed there is inconsistent use of system-based prompts and triggers to identify and address preventive health needs. Additionally, detail and documentation of care plan updates and progress would be helpful when goals are carried over from year to year.	
	HHO has a thorough UM program description that details team member responsibilities, the process for objective UM and analysis of utilization of services. HHO's UM team is led by a strong leadership team that utilizes several mechanisms for mentoring and collaboration which enabled the UM department's audit scores to exceed the 90.0% compliance goal, the interrater reliability (IRR) scores to exceed the goal of 80.0% in July 2022 and 85.0% in November 2022.	HHO should assess opportunities across the spectrum of the organization and business units to identify and implement PIPs that have an impact on a larger portion of the MCO population and are active in driving improvement.	Quality, Timeliness, Access
	HHO has a strong and effective infrastructure for the CM program inclusive of processes, workflows, job aids, and desk-level procedures (DLPs). The training plan that is in place addresses both initial and ongoing training for case managers. The MCO has implemented extensive use of targeted and standard auditing processes of CM member case files and CC files to demonstrate consistent outreach and engagement. The MCO has implemented co-management for high-risk members between the assigned case manager and the Transition of Care (TOC) case manager with the TOC case manager following members when they are inpatient.	During the validation of performance measures, it was identified that data used in the DMMA standard report under review were incomplete for the second year in a row. Although HHO addressed the findings from the 2022 ISCA review, the new measure selected for the review this year was not in adherence to the stated specifications. This calls into question the regulatory review process detailed in the P&Ps, particularly around the review of results by the business owner. HHO presented and spoke of a robust process with report creation; however, the inaccurate application of specifications and integration of data revealed that critical elements of quality assurance should be enhanced.	Quality, Timeliness, Access
	HHO's GuidingCare platform and the Mobile Clinician App reflect a commitment to ensure effective		Quality

Plans	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
	collaboration and coordination of care; it is a user-friendly system that lends itself to an organized workflow and interdepartmental coordination.		
	CC collaboration and integration of services are supported through interdisciplinary rounds that include multiple departments. HHO added a dedicated housing coordinator position to assist with referrals, applications, and other housing needs. This additional position, which works collaboratively with clinical care coordinators, allows care coordinators to focus on closing gaps in care and addressing the identified clinical needs.		Quality, Timeliness, Access
	HHO contracted with a substance use disorder (SUD) provider (Wayspring) specific to Medicaid and CHIP. Wayspring's program uses internal algorithms to identify members for outreach with a focus on high-risk and high-need individuals. The program provides SUD services and is focused on meeting people where they are in their recovery and ensuring they receive treatment at the appropriate level of care. HHO meets weekly with Wayspring for rounds.		Quality, Timeliness, Access

Information Requirements, Benefit Information, Marketing, and Emergency and Post-Stabilization Services

ACDE 2023 Findings and Recommendations

Member Rights and Responsibilities

Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

Member Communication Requirements

Member call center operations continue to be handled out of the Philadelphia, Pennsylvania contact center and real-time monitoring of member calls is available from the Delaware office location. Over-flow calls can be load-balanced with the ACFC call center in Florida where back up staff have been trained on the Delaware line of business. During the last EQR CAP review (2022), the EQRO identified the need for targeted training to ensure CSRs identify providers directly billing members as grievances. Since these issues were not being identified as grievances, they were not sent to nor processed by the G&A team for proper investigation, tracking, trending, and ultimately provider education. During the 2023 EQR CAP review, this issue has been resolved with the implementation of additional trainings, and processes as well as member and provider education.

During the 2023 onsite review, Mercer and DMMA staff listened to four member calls. Member services operations were smooth and evidenced by happy customer-centric staff dedicated to assisting members to the best of their ability. Of particular note, during one call the CSR updated a member address, mailed out the member ID, and provided a warm transfer to Modivcare. In another call, the CSR respectfully informed the caller that ACDE was no longer their MCO and provided the member with a warm transfer to the Health Benefit Manager (HBM).

Although call center staff addressed member concerns well, there is an opportunity for ACDE to improve some internal processes. In particular, when assisting a mother who called in to find a PCP for her son, the CSR did not reference any gaps in care for the member. In another instance, CSRs were not familiar with common DHSP and DSHP Plus grievance and appeals terms and processes. The CSRs engaged in the call did not know what a State Fair Hearing was and were unable to provide appropriate guidance to the member in response to the member's question. Additional training and establishing clear processes for the call center staff are needed in these areas.

Emergency and Post-Stabilization Services

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

Marketing

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
Staff must be trained to respond to member questions on DSHP and DSHP Plus as described in 3.14.2.3.8.	Met	New Finding for 2023	Not Met	**2023 Finding:** As evidenced through member calls, CSRs are not familiar with common DHSP and DSHP Plus grievance and appeals terms and processes. The CSRs engaged in the call did not know what a State Fair Hearing was and were unable to provide appropriate guidance to the member in response to the member's question. There were no clear processes in place for the CSR to obtain missing information via a supervisor, CSR tools, or the MCO website.	**2023 Recommendation:** Provide evidence of CSR training, which includes details on the member's process for appeal. Provide details on the CSR process to access information when the CSR is not clear about how to address a member's question.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
MCO call center staff receive ongoing training at least quarterly and must receive immediate training regarding changes to service delivery and covered services. (3.14.2.3.9)	New Finding for 2022	Partially Met	Met	**2022 Finding:** The MCO's call center operations staff meets the requirement of receiving ongoing training; however, specific targeted training is needed as it relates to member grievances. As evidenced through member calls, customer service representatives (CSRs) did not identify providers directly billing members as a grievance. Since these issues were not identified as grievances, they were not processed through the G&A team for proper investigation, tracking, trending and ultimately provider education.	**2022 Recommendation:** Provide evidence of CSRs receiving additional grievance training which includes identifying a grievance, member's right to grievance filing, available assistance to a member when filing grievances, and proper submission of the identified grievance to ACDE's G&A department for investigation and processing.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

HHO 2023 Findings and Recommendations

Member Rights, Responsibilities, and Member Communication Requirements

Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

Member call center operations continue to be handled out of the Pittsburgh, Pennsylvania contact center and real-time monitoring of member calls is available from the Delaware office location. During the last EQR CAP review (2022), the EQRO identified the need

for targeted training to ensure Customer Service Representatives (CSRs) identify providers directly billing members as a grievance. Since these issues were not being identified as grievances, they were not sent to nor processed by the G&A team for proper investigation, tracking, trending, and ultimately provider education. During the 2023 EQR CAP review, this issue has been resolved with the implementation of additional training, processes, and member and provider education.

In 2022, the Member Services team held a “Delaware Day” for all CSR staff making G&As a priority. During these training sessions, real-life tracer scenarios were utilized with CSR staff and proper procedures were discussed for each scenario. New for 2022, was the addition of a G&A liaison who sits in Member Services and acts as the subject matter expert for all things related to G&A. New scripts have also been developed to ensure the CSRs are providing members with the appropriate information around provider billing. To ensure this message is also heard throughout the organization, the Grievance workgroup is working with the Provider Network team and the Marketing team to take the information from Member Services and find solutions for any trending issues. This workgroup is also developing a campaign to educate and remind members to present their identification cards at the time of their appointment and instruct members to contact the MCO if they have paid a bill from a provider. Lastly, the Provider Network team has been developing scenarios and presenting these scenarios to providers during on-site visits for education purposes.

During the 2023 on-site review, Mercer and DMMA staff listened in on three-member calls. Member Services operations were smooth and evidenced by happy customer-centric staff dedicated to assisting members to the best of their ability. Although call center staff addressed member concerns well, one member called stating that he received a call from the provider he was about to see informing him that his account was not active. The CSR handled the call well and ensured the member was able to see the provider at the scheduled appointment time. Ensuring HHO PALs engage with provider front desk staff, particularly discussing access standards and member eligibility, will reduce member abrasion and may lead to improved member satisfaction when scheduling appointments.

During the CAP review in 2023, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
MCO call center staff receive ongoing training at least quarterly and must receive immediate training regarding changes to service delivery and covered services. (3.14.2.3.9)	New Finding for 2022	Partially Met	Met	**2022 Finding**: The MCO's call center operations staff meets the requirement of receiving ongoing training; however, specific targeted training is needed as it relates to member grievances. As evidenced through	**2022 Recommendation**: Provide evidence of CSRs receiving additional grievance training, which includes identifying a grievance, member's right to grievance filing, available assistance to the member when

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
				member calls, CSRs did not identify providers directly billing members as a grievance. Since these issues were not identified as grievances, they were not sent nor processed to the G&A team for proper investigation, tracking, trending, and ultimately provider education.	filing grievances, and proper submission of the identified grievance to HHO's G&A department for investigation and processing.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation**: None.

Emergency and Post-Stabilization Services

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

Marketing

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

Advance Directives

ACDE 2023 Findings and Recommendations

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

HHO 2023 Findings and Recommendations

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

Availability of Services — Cultural Considerations, Delivery Network, Provider Selection, and Timely Access

ACDE 2023 Findings and Recommendations

Contractually in Delaware, ACDE is required to develop and maintain a Provider Network Development Plan (PNDMP). The PNDMP acts as the Network Management PD outlining the different populations served, goals, objectives, outcomes, and action steps taken to develop, monitor, and maintain ACDE's network of providers. While the expectation is that ACDE use the PNDMP as a living document, updating it as the year unfolds, annually the State requires an evaluation of the effectiveness of the PNDMP; the results of the evaluation should be used as the basis for the next year's plan. ACDE has robust reporting capabilities and utilizes geospatial analytics, grievance, and critical incident data as well as, member and provider experience information to evaluate the effectiveness of its PNDMP.

The Provider Network Account Executives (AEs) are assigned to providers and play a critical role in communicating ACDE policy, conducting training on new business processes, and providing technical assistance to their assigned provider community. ACDE AEs completed 1,064 site visits to participating providers during 2022, the site visits were a combination of both virtual and in-person visits based on the provider preference. During a visit, AEs provide a high-level claim summary, provide updates concerning P&Ps, explain the claim dispute process, provide a wellness program overview, explain the Quality Enhancement Program, assist with electronic funds transfer (EFT)/electronic remittance advice (ERA) set up, gather demographic requirements, and promote provider education and training opportunities.

ACDE maintains a large network of providers and offers a Wellness Registry, powered by Aunt Bertha™ that lists community-based support and service organizations; access to it is made available to members and providers. An overview of the ACDE network follows:

Provider Types	Number of Providers	Provider Types	Number of Providers
PCP	931	Dental	101
Specialty Care Physician	1,261	Vision	275
BH	1,241	Home- and Community-Based Services (HCBS)	119
Hospital	7	Atypical	77
Urgent Care	72	Home Health	32
Nursing Facility (NF)	42		

ACDE operates a provider website and contracts with NaviNet for its online provider portal. The NaviNet portal allows for claims status checks, eligibility verification, and prior authorization (PA) submission and response as well as provider complaint submission. ACDE has several cross-functional workgroups that review NaviNet trends, weekly denied claim reports, and provider complaints. The workgroups proactively engage with Provider Network Management and often reach out to providers to educate and remediate incorrect claim denials or billing issues before they become provider complaint.

Providers have access to training and education materials through the NaviNet portal and receive new provider orientation when entering the network. Links are available for cultural competency training and various online training opportunities for BH topics, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) training, Wellness Registry training, and webinars. Some information included as part of provider orientation materials was redesigned to encourage providers to display them in their offices. This included updating the font and layout of documents which provide information on culturally and linguistically appropriate services, balance billing, and cultural competency.

Network monitoring activities are outlined in the PNDMP and include geospatial analysis of the time/distance and provider ratio requirements outlined in the contract. Appointment availability monitoring is conducted quarterly and is a shared responsibility between the Delaware Medicaid MCOs. Network changes (additions and terminations) are monitored. Grievance and critical incident information is reviewed and, when necessary, providers are brought to the Peer Review committee for further evaluation and consideration of continued participation in the network. Provider satisfaction is monitored through annual surveys and through a review of trends related to provider complaints. There was evidence of linkages to Program Integrity, Quality, and other health plan operation areas as a routine part of day-to-day network management. Evidence of network opportunities by specialty and geography were identified by ACDE and plans to remediate the gaps were outlined in the PNDMP.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO has a clear P&P to evaluate a delegate, subcontractor, or sister entities' compliance with State contract and federal requirements including pre-delegation, ongoing monitoring and oversight, and annual audits. The policy should indicate the ability to terminate delegated arrangements including requests from the State for termination. (5.1.2.1)	New Finding in 2022	Substantially Met	Not Met	**2022 Finding:** The annual delegation review completed by ACDE in November 2021 found that the Dental Benefits Management (DBM) UM review (documented in the Skygen Executive Summary.pdf) scored lower than the 95.0% required due to improper/incorrect/inconsistent language in member letters. At the time of the EQRO review, the issue remained an open DBM CAP item.	**2022 Recommendation:** Document full resolution of outstanding DBM UM CAP items.
				2023 Finding: Per the Executive Summary SKYGEN USA, LLC Annual Review 2022, the dental benefits manager (DBM) remained on CAP for lack of readability of UM denial letters and an inaccurate policy (UM-2-4100 Denial and Approval Letter). The MCO must provide documentation (e.g., ad hoc audit results) that the vendor has resolved all outstanding areas of noncompliance identified in an audit and is compliant with all federal and contractual standards.	**2023 Recommendation**: Document full resolution of outstanding DBM UM CAP items.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO's provider training plan is offered throughout the State and at different times of day, identifies conditions indicating that a provider needs technical assistance, and includes training on all topics covered in the Provider Manual and may include training on: Medicaid, the conditions for participation, billing processes, the provider's responsibilities to the MCO and its members, and clinical issues. The MCO maintains records of training topics, attendance, and technical assistance activities. (3.9.6.5.2, 3.9.6.5.3, 3.9.6.5.6, 3.9.6.5.7)	New Finding in 2022	Minimally Met	Met	**2022 Finding**: There were a number of grievances filed related to balance billing members. Some “member balance due” grievances were turned over to a collections agency to pursue collecting payment. Unless a member signs an agreement to pay for services that may potentially not be covered by the MCO, balance billing cannot occur. Providers should be educated about inappropriate balance billing practices, grievances should be tracked and trended to identify patterns with providers related to balance billing, and if needed providers should be required to submit a CAP. ACDE should conduct a retrospective review of grievances to identify any members that were inappropriately balance billed and ensure funds are returned if members inappropriately paid the balance due.	**2022 Recommendation**: Provide evidence that providers are educated on appropriate and inappropriate billing practices. Track and trend grievances filed by members related to billing issues (particularly balance billing) to identify trends with providers. Conduct a retrospective analysis of member grievances to identify members who may have been inappropriately balance billed. Track resolution (potentially repayment) of members who were inappropriately balance billed.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

Provider Selection and the Credentialing File Review Process

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

Delegated Provider Network Development: Credentialing

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

Provider Terminations and the Provider Termination File Review Process

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

HHO 2023 Findings and Recommendations

In Delaware, by contract, HHO is required to develop and maintain a PNDMP. The PNDMP acts as the Network Management program description outlining the different populations served, goals, objectives, outcomes, and action steps taken to develop, monitor and maintain HHO's network of providers. While the expectation is that HHO uses the PNDMP as a living document, updating it as the year unfolds, annually the State requires an evaluation of the effectiveness of the PNDMP; the results are to be used as the basis for the next year's plan. The Provider Network team works collaboratively with QI, UM, Care Management, Credentialing, Claims, Member and Provider Services to satisfy both provider and member needs to maintain an adequate provider network.

In 2022, there was a total of 355 Goal Visits to providers (virtual and in-person) with an increase in in-person provider visits. Various provider forums are conducted throughout the year. Annual provider satisfaction, member experience surveys, and quarterly trending reports identifying providers with two or more grievances and appeals are used to inform network management and oversight activities. All of this information informs the annual strategic plan to identify challenges, barriers, and proposed strategies for provider engagement.

Delegation of network development and management activities occurs nationally with Davis Vision and United Concordia Dental (UCD) and locally with Christiana Care Health System, AmWell, and Nemours as credentialing delegates. The Provider Network team met with the Vendor Management Organization team to assess training needs, track training requirements, and update policies for vendors. Vendor subcontractor employees and downstream entities will receive training upon hire/assessment followed by annual refresher training.

HHO maintains a large network of providers and offers a Wellness Registry, powered by Aunt Bertha™ that lists community-based support and service organizations; access is made available to providers via the HHO Community Resources page. An overview of the HHO network is as follows:

Provider Type	Number of Providers	Provider Types	Number of Providers
Primary Care Physician (PCP)	1,293	Day Habilitation	3
Specialty Care Provider	6,364	Home Delivered Meals	6
BH	1,668	Homemaker Chore Services	25
Hospital	13	Home Health	10
Home- and Community-Based Services (HCBS)	1046	Adult Day Care	8
Urgent Care	8	In-Home Respite Care	23
Nursing Facility (NF)	41	Inpatient Respite	1
Dental	169	Attendant Care	44
Vision	587	Personal Emergency Response System	13
Assisted Living Facility	12	Support for Self-Directed Attendant Care Service	4
Minor Home Modifications	5		

HHO maintains a provider directory, which contains all contractually required elements. HHO has created separate directories for different provider types including one specific to HCBS providers. A third-party vendor, Atlas Systems, sends questionnaires to providers and engages in telephonic outreach every 90 days to confirm the accuracy of provider data. In addition, each HHO PAL has an individualized plan to engage in ongoing provider education to their assigned providers. PALs educated providers on cultural competency training options and the cultural competency toolkit to increase provider completion of cultural competence training. In 2022, 40.0% of Delaware PCPs attested to completing cultural competency training. During annual Goal Visits with providers, PALs also verify practice demographics, panel status, age limits, and caseloads. HHO conducted multiple trainings in 2022 to educate providers on appropriate and inappropriate billing practices. In order to strengthen the connection between member services and the grievance department, for full-circle knowledge and understanding of member issues and concerns, monthly touch point meetings are taking place between departments.

Providers have access to training and education materials through the NaviNet portal and receive new provider orientation when entering the network. Provider forums were hosted in 2022 and saw a 63.7% increase in attendance over 2021. In addition, HHO implemented a Provider Forum and Training Workgroup to review the needs for upcoming 2023 forums, training, and other provider-facing education plans. This workgroup meets monthly to share ideas for upcoming forums and other educational initiatives. HHO saw a 74.5% increase in total provider visits as a result of extensive efforts to engage providers in virtual and on-site participation.

Network monitoring activities are outlined in the PNDMP and include geospatial analysis of the time/distance, open/closed panels, and provider ratio requirements outlined in the contract. Appointment availability monitoring is conducted quarterly and is a shared responsibility between the Delaware Medicaid MCOs. HHO conducts a monthly internal review of network changes per DMMA standards and NCQA requirements. Reports are reviewed internally by the Provider Network team and the QI Subcommittee; they are shared with the HHO Network Adequacy Workgroup, reviewed and attested to by the Director of Provider Experience, and results are presented to the QI UM Committee. Grievance and critical incident information is reviewed and, when necessary, providers are brought to the Peer Review committee for further evaluation and consideration of continued participation in the network.

Provider satisfaction is monitored through annual surveys and through a review of trends related to provider complaints. 96.6% of PCPs, Specialists, and BH Providers surveyed in 2022 would recommend HHO to other physician practices; maintained from 2021.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
Submitted audit tools and quarterly reports demonstrate timely completion and an approach with content sufficient to ensure the delegated entity's compliance with State and federal requirements. (5.1.2.3.4)	New Finding in 2022	Partially Met	Met	**2022 Finding:** All MSA standards must flow through the MCO to delegated entities for the functions they conduct. The DBM Medicaid Fraud Allegations policy (SIU.VI.H — DE MEDICAID FRAUD ALLEGATIONS) indicates that an initial assessment and analysis of suspected fraud, waste, and abuse (FWA) will be conducted prior to notifying the Delaware HHO Special Investigation Unit (SIU). However, contractually the DMMA Program Integrity Unit and Medicaid Fraud Control Unit (MFCU) should be notified of any and all cases of suspected FWA within two business days of discovery.	**2023 Recommendation:** Assess and update as-needed delegate audit tools to ensure all MSA requirements for functions delegated are included. Require the DBM to update the Medicaid Fraud Allegations policy to inform the Delaware HHO SIU within two business days of discovery.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

Provider Selection and the Credentialing File Review Process

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

Delegated Provider Network Development: Credentialing

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

Provider Terminations and the Provider Termination File Review Process

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

Program Integrity Requirements and Confidentiality

ACDE 2023 Findings and Recommendations

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

HHO 2023 Findings and Recommendations

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

Prohibited Affiliations with Individuals Debarred by Federal Agencies

ACDE 2023 Findings and Recommendations

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

HHO 2023 Findings and Recommendations

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

Grievance and Appeal Systems

ACDE 2023 Findings and Recommendations

The grievance system follows standard processes. Grievances can be received from members, member representatives, or providers orally through Member Services or through an ACDE staff member (e.g., the member advocate), or be written (i.e., filling out a form on the ACDE website and submitting it). If a grievance is received orally, the Grievance Coordinator completes the Contact Center Grievance & Appeals Service Form and begins documenting the process using the EXP MACESS system. This system is a repository for all member grievances received via Member Services, member advocates, LTSS case managers, and the Pharmacy department. There are eight FTEs dedicated to the Delaware line of business for grievance management.

Appeals are handled out of the local ACDE office, using the Jiva medical management documentation system; there are six FTEs dedicated to appeal adjudication. At the time of the review, all positions were filled.

Grievance staff facilitates the grievance investigation, send acknowledgment letters to members, and coordinate investigations with other impacted business units. For example, the Provider Network Management team will be sent quality of service grievances or a CM may be engaged due to member concerns about an assigned case manager. Any information that is sent to other units of ACDE for investigation is returned to the grievance unit along with the investigatory findings. EXP MACESS was defined as the “source of truth” for grievance resolution and is used for tracking the timeliness of resolution and housing all grievance documentation. QOC issues and other clinical issues are sent to the ACDE QM department for further investigation and resolution by the Clinical Quality Performance Specialist (QPS). At the completion of the QOC investigation, the Clinical QPS sends an outcome letter to the provider (within one week of determination) and the QOC Grievance Member Resolution letter to the member (within two business days of the resolution). The Clinical QPS then uploads the QOC Grievance Member Resolution letter and documents that the letter was sent in EXP MACESS and Jiva (within two business days of the resolution of the grievance).

In instances where a pharmacy-related grievance is received via phone, the member is warm transferred to the MCO’s pharmacy benefit manager, PerformRx. The grievance file universe list did not include any pharmacy-related grievances. It is unclear whether PerformRx is identifying and capturing member grievances according to the MCO’s policies and whether they are appropriately accounted for in the MCO’s reporting or represented in overall QI efforts. The MCO should review the process by which PerformRx identifies, investigates, and reports member grievances to ensure they are included in continuous QI activities.

Grievances are an opportunity to identify areas of improvement in the complete system of care. A greater number of grievances related to provider balance billing of members was identified by the MCO, and a process was established to assist a member in resolving the issue. However, if no grievance was filed by a member, no outreach is or has been made to alert members that they are not responsible for a balance bill should they receive one. There remains an opportunity for the MCO to evaluate the root cause of members being balance billed for services and ensure that members are reminded that they are not responsible for bills received for covered services and their right to file a grievance if a bill is received.

Similar to grievances, standard appeals are accepted both orally (through Member Services) or in writing (appeals form can be found on the ACDE website or the last page of the member's NOABD letter) and sent to ACDE via US mail, fax, or email. If an appeal is filed by a member, written consent is not required. Appeals filed by a provider or member representative, on behalf of the member, require written member consent within 10 days of the initial filing. The appeal start date is the date the member files the appeal (orally or written), or the date member's written consent is received if the appeal is filed on a member's behalf. If member written consent is not received as part of the initial written appeal filed on their behalf, the appeals analyst calls the member to inform them an appeal has been filed on their behalf and asks if they would like to proceed with the appeal. If the member responds in the affirmative, the appeal is transitioned to a member appeal, thus eliminating the need for written consent. The appeals files reviewed contain notes that indicate member oral consent was received and show the provider (or representative) initiated the appeal, creating confusion on the resolution timeline. The MCO's intention in this process is to minimize unnecessary burden for the member by not requiring written consent for an appeal filed on their behalf. There is an opportunity for the MCO to improve these processes by ensuring adequate documentation within the appeal file.

During the on-site review, Mercer listened to member calls. During one call, neither the rapid response representative nor the CSR was able to assist a member with understanding the purpose of a State Fair Hearing or the appeals process in general. There is an opportunity for the MCO to ensure that all MCO staff who interact with members are appropriately trained on the appeal process and how and when they should use desk-level tools and other resources available during member calls.

Appeals staff are responsible for sending out member correspondence including the initial acknowledgment letter, letters requesting additional information, and the resolution letter, as well as calling and/or faxing providers. If continuity of care is requested in the appeal, the analyst verifies the member request is within the required timeframe. If an appeal hearing is requested, the member, member representative, and/or member advocate is invited to attend in person or by phone to present the appeal and respond to questions. The case is deliberated, and a decision is issued and communicated to the member within two business days.

In general, the G&A system appears to function well. All of the required Final Rules and contract standards were met according to policies and handbooks. However, the appeal files reviewed show a potential disconnect between policies and actual working processes.

Grievance File Review

The grievance file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 grievance files was selected for review, representing Medicaid, CHIP, and DSHP Plus membership. Grievance subjects included categories such as access/availability of care, communication/relationships, transportation, QOC, and others. The files were assessed for compliance with Final Rule regulations, State contract requirements, and ACDE internal policy standards. The following elements were included in the review:

- Documentation of member correspondence and grievance details.
- Accuracy of classification and named provider.
- Grievance investigation and resolution.
- Timely acknowledgement.
- Timely resolution.
- Timely notification of resolution.
- File completeness.
- CC/continuity of care.

The assessment of the grievance files consisted of a review of the member's original grievance, internal notes and documents, letters produced by ACDE, and other documents supporting the investigation. Overall, the EQRO continues to see an increase in the number of member grievances captured and investigated by the MCO. However, nearly 63.0% (85 out of 135) grievances included in the MCO's file universe related to providers balance billing members. The files reviewed were found to have greater than 90.0% compliance in the required elements.

Appeal File Review

The appeal file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 appeals files was selected for review, representing Medicaid, CHIP, and DSHP Plus membership. The sample contained appeals that were upheld, overturned, and withdrawn following or prior to the Appeals Committee meeting. The files were assessed for compliance with Final Rule regulations, State contract requirements, and ACDE internal policy standards. The following elements were included in the review:

- Documentation of NOABD, member appeal, member consent, and supplemental information submitted by member or member's provider.
- Timely filing based on the NOABD date.
- Timely acknowledgement.
- Timely resolution.
- Timely notification of resolution.
- File completeness.

The assessment of the appeals files consisted of a review of NOABD letters, internal notes and documents, letters produced by ACDE, and other documents supporting the appeal investigation. Overall, the files reviewed met the 30-day resolution requirement. Denial letters consistently (100.0%) contained inaccurate language stating: "If you file your appeal by telephone, you must follow-up your call with a written, signed appeal letter within 10 days. ACDE must have the signed appeal letter to process your appeal". Additionally, there are inconsistencies in the documentation of the date the appeal was received, and the date noted in the resolution letter. Of note, 40.0% of appeals were overturned, 33.0% were withdrawn, 20.0% were upheld, and 7.0% were partially upheld.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
Member Handbook, MCO website, Provider Manual, and any additional new member/provider orientation materials have consistent language on the process for filing an appeal: • Following receipt of notification of an adverse benefit determination by an MCO, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), a member has 60 calendar days from the date on the notice in which to file a request for an appeal. • Member may request an appeal either orally or in writing. (42 CFR 438.402(c)(2-3) and 3.15.1.8).	Met	New Finding for 2023	Partially Met	**2023 Finding**: The MCO's member materials (NOABDs) do not reflect consistent language on the process for filing an appeal. The language shown in the file review indicates that if a member files an appeal orally, the member must follow-up with written consent to have the appeal processed, which does not align with federal regulations.	**2023 Recommendation**: Update and submit member materials containing accurate language that aligns with federal regulations for when a member files an appeal orally.

HHO 2023 Findings and Recommendations

The grievance system follows standard processes. Grievances can be received from members, member representatives, or providers orally through Member Services or an HHO staff member (e.g., the Member Advocate), or be written (i.e., filling out a form on the HHO website and sending it in). If a grievance is received orally, the Grievance coordinator completes a member grievance form and begins documenting the process. In October 2021, HHO implemented a new platform (GuidingCare) that, in addition to other functions, allows for easier interdepartmental collaboration to investigate and resolve grievances in a timely manner. The GuidingCare platform also captures all member information, including G&As file documentation and progress notes in a centralized spot that is accessible by any MCO staff member. In December 2021, HHO added vendor grievances to the vendor's scorecard to aid oversight activities. Appeals were added to the vendor's scorecard in July 2022.

Grievance staff takes the lead on investigations, sending acknowledgment letters to members, sending letters and faxes and/or making calls to providers to obtain information regarding the grievance. Depending upon the nature of the grievance, other HHO

departments may be involved in the investigation and resolution process. For instance, Provider Relations will be sent quality of service grievances and Provider Contracting will be sent vision grievances; the Quality department will be sent QOC issues and other clinical issues. If multiple grievances are identified (e.g., QOC, quality of service, billing) in the original grievance, a service form is created to capture and track each issue through the investigation and resolution process. Each grievance is tied to the member ID number in the GuidingCare system. When a member calls HHO regarding the receipt of a bill for covered services, the CSR attempts to resolve the issue at the time of the call. If the member is satisfied with the results during the initial call, the grievance is noted as "telephonically resolved" and included in tracking and trending reports to identify providers that continue to balance bill members; based on a pattern of balance billing members, a provider may be referred to FWA. The practice of telephonically resolved grievances appears to be effective in providing members with a satisfactory resolution. However, there is a lack of consistency in the process (e.g., if/when an acknowledgement or resolution letter is sent) seen in billing-related grievance files. HHO should review its process for handling telephonically resolved billing grievances and identify areas of improvement to ensure proper handling.

Similar to grievances, standard appeals are accepted both orally (through Member Services) or in writing (through a form on the HHO website or through the form on the last page of the member's NOABD letter) and sent to HHO. Appeals filed on the member's behalf (by providers or member representatives) are required to have written member consent within 10 calendar days to move forward with the appeal process. Following CMS updates to the Final Rule effective December 14, 2020, HHO no longer requires written member consent for appeals filed by the member. However, appeals files that were reviewed consistently included adverse benefit determination letters that indicate a written appeal is required within 10 days of filing an oral appeal. The appeal process start date is the date the appeal is received from the member or the date the written member consent is received for appeals filed on their behalf.

Appeals analysts are responsible for sending out member correspondence including the initial acknowledgment letter, letters requesting additional information, and the resolution letter, as well as calling and/or faxing providers. If continuation of current services is requested by the member, the analyst verifies the member request is within the required timeframe. If an appeal hearing is requested, the member or member representative is invited to attend in person or by phone to present the appeal and respond to questions. The Member Advocate also attends, along with the standing appeals committee. The case is deliberated, and a decision is made and communicated to the member within two business days.

Grievance File Review

The grievance file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 grievance files was selected for review, representing Medicaid, CHIP, and DSHP Plus membership. Grievance subjects included categories such as access/availability of care, communication/relationships, transportation, QOC, and others. The files were assessed for compliance with Better Business Administration (BBA) regulations, State contract requirements, and HHO internal policy standards. The following elements were included in the review:

- Documentation of member correspondence and grievance details.

- Accuracy of classification and named provider.
- Grievance investigation and resolution.
- Timely acknowledgement.
- Timely resolution.
- Timely notification of resolution.
- File completeness.

The assessment of the grievance files consisted of a review of the member's original grievance, internal notes and documents, letters produced by HHO, and other documents supporting the investigation and resolution. Six files reviewed were not compliant with timeliness standards for acknowledgment, decision, and notification of grievances. Overall, the files reviewed were found to have less than 87.0% compliance with the required elements.

Appeal File Review

The appeal file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 appeals files were selected for review, representing Medicaid, CHIP, and DSHP Plus membership. The sample contained appeals that were upheld, overturned, and withdrawn following or prior to the Appeals Committee hearing. An expedited appeal was also reviewed. The files were assessed for compliance with BBA regulations, State contract requirements, and HHO internal policy standards. The following elements were included in the review:

- Documentation of NOABD, member appeal, member consent, and supplemental information submitted by member or member's provider.
- Timely filing based on the NOABD date.
- Timely acknowledgement.
- Timely resolution.
- Timely notification of resolution.
- File completeness.

The assessment of the appeals files consisted of a review of NOABD letters, internal notes and documents, letters produced by HHO, and other documents supporting the appeal investigation. All of the files reviewed met timeliness requirements for appeal resolution. Seven of the 30 appeals files (23.0%) were found to have incorrect language in two areas of the NOABD letters. The first area is regarding the member's right to file an appeal verbally; the second area is the timeline for a member to request a State Fair Hearing. Other aspects of the file review evidenced that of the 30 case files reviewed, 15 were overturned (50.0%), three were upheld (10.0%), three were withdrawn (10.0%), and 9 were dismissed (30.0%).

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
P&Ps clearly identify that a member can file a grievance, appeal, or request a State Fair Hearing either orally or in writing. Policies clearly identify that the member's provider, acting on behalf of the member, may file an appeal either orally or in writing. (42 CFR 438.402(c)(3) and 3.15.1.1)	Partially Met	Substantially Met	Met	**2022 Finding:** MCO policies, procedures, and workflows demonstrate knowledge of the regulation. However, 11 of 30 appeals files reviewed contained notation from the appeals analyst of attempts to obtain member oral consent for appeals filed on their behalf.	**2022 Recommendation:** Provide additional training to G&A staff to ensure the MCO is compliant with the federal regulation requiring written approval from a member when an appeal is filed on their behalf. Provide evidence that training has occurred, including training program, dates of training, and staff trained.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO has a process to ensure that all QOC and quality of service grievances are fully investigated prior to issuing a final grievance resolution. (3.13.3)	Partially Met	Substantially Met	Met	**2022 Finding:** The MCO has a process using the GuidingCare system that identifies open items and those at risk of becoming non-compliant with timelines. However, GA.05 MBU-AGR-POL-1006 Interdepartmental Grievance Policy 3.2022 contains language that contradicts the intention of the Grievance system.	**2022 Recommendation:** Review and update policies that reflect the MCO's intention to collect grievance data as part of continuous program improvement efforts.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.
Content of the adverse benefit determination must include explanations of the following: • The adverse benefit determination the MCO has	Met	New Finding for 2023	Not Met	**2022 Finding:** During the comprehensive review in 2021, Mercer found that federal regulations and contract requirements were met in this area.	**2022 Recommendation:** None.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
taken or intends to take, reasons for the adverse benefit determination, including the right and process to appeal MCO decision, direct access to State fair hearing, availability of expedited resolution. • Right to benefits pending resolution, how to request benefit continuation, member may be required to pay the costs of services. (438.404(b) and 3.15.2.3)				**2023 Finding:** Appeals files contain incorrect language in NOABD letters including the need for a written appeal within 10 days when a member files verbally and an incorrect timeline for a member to request a State Fair Hearing. Training documents submitted after the on-site review include instructions to gain written appeal after verbal filing.	**2023 Recommendation:** Update member and provider materials, and MCO staff training resources to ensure consistency with the DMMA contract for information contained in the NOABD.

Sub-contractual Relations and Delegation

ACDE 2023 Findings and Recommendations

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

HHO 2023 Findings and Recommendations

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

Clinical Practice Guidelines and Coverage, and Authorization of Services

ACDE 2023 Findings and Recommendations

The ACDE UM organizational chart illustrates all UM positions are currently filled. Of note, the current UM manager has taken another position within the company and a replacement has been hired but the new UM manager had not started at the time of this review. The UM department consists of staff dedicated to Delaware as well as staff functioning within corporate shared services. The ACDE Chief Medical Officer (CMO) has direct oversight of the UM department for both shared services and those specific to Delaware Medicaid. ACDE added a UM operations oversight manager to the team; this position reports directly to the CMO and assists with project management of UM. ACDE contracts with four subcontractors with delegation for UM:

- Avēsis Third Party Administrators, Inc. (Avēsis) for UM of vision services.
- NIA for radiology UM.
- Perform Rx is the Pharmacy Benefit Management.
- SKYGEN USA, LLC delegated for management of the Adult Dental Benefit Administration.

There are separate sections of this report for both Dental and Pharmacy that will review SKYGEN USA, LLC and Perform Rx. This UM section provides a review of Avēsis and NIA.

Mercer completed a review of updated UM P&Ps which included: Delaware Concurrent Review, Non-urgent and Urgent Prior (Pre-service) Authorization, and Delaware UM Criteria. These P&Ps were updated to include instructions for gathering additional information for improved coordination and discharge planning. In addition, the Corporate Clinical Audit Policy has been updated to include the number of audits performed for CC, UM, UM medical directors, UM per diem associates, Medicaid provider appeals (per level of appeal), and Medicare UM (for DSHP Plus members).

During this review, several of ACDE's previous UM CAP items were successfully resolved. Below is a summary of the changes instituted to bring these CAP items into compliance:

- Submission of an organization chart reflecting that the CMO has oversight of all aspects of UM and that the UM manager reports directly to the CMO.
- Submission of staffing plans for ACDE, as well as UM delegates, that include a mechanism to assess staffing needs relative to UM and decision-making.

- Development of an updated P&P clearly explaining the ability of members to have direct access to a women's health specialist. This policy was updated to reflect reimbursement of non-participating providers for family planning services rendered to members per contractual requirements for DSHP, but not including DHCP.
- Development of a process to evaluate the training program of ACDE delegates responsible for UM decision-making.
- Updates to the provider handbook to provide a clear explanation of routine and expedited service requests, specific to the requirement for a 72-hour timeframe for timeliness of expedited organization determinations. While the provider handbook has been updated and approved, it was recommended that ACDE review the updated language to ensure it conveys clear and precise guidance to providers.
- Development of the audit process outlining coordination for transition and discharge planning.
- Updates to the process to review and approve both PH and BH care regardless of setting and provide an integrated UM approach. The UM manager and UM supervisor review the inpatient (IP) census to identify any members with BH co-morbidity for proactive integrated treatment. UM team members attend CC huddles as needed. Monthly audits are completed and shared during team meetings and 1:1 with team members with a focus on an integrated approach.
- Integration of Clinical Practice Guidelines within the scope of UM functions. This includes provider education on best practices.

For the 2023 on-site review, there were three identified UM CAP items related to delegation of UM functions to NIA. It is important that delegates used by ACDE are held to the same quality standards, and contract requirements, and present in a seamless manner to members and providers. During the 2021 comprehensive EQRO review, areas of concern were identified due to the high incidence of NIA denial of services, and the lack of coordination with providers and communication with members. ACDE lacked evidence of oversight and understanding of the role required when delegating services.

Since that comprehensive review, ACDE has put additional oversight activities in place. On a weekly basis, five NIA denials are reviewed by the UM manager and the CMO. The review identifies the reason for the denial, and any service and/or provider trends. Any review findings are shared with NIA and discussed during monthly meetings with NIA. Beginning in September 2022, a process was initiated where files are reviewed for interrater reliability (IRR) by the ACDE National Medical Review (NMR) which provides a review by a matching specialty for the specific requested service. There was an approximate 60.0% correlation between NIA and NMR. ACDE found that NIA's overall denial average for ACDE members is between 23.0%–25.0%. ACDE searched for a national average denial rate for radiology services but did not find one; Mercer has previously researched denial rates and not found a published average denial rate. The majority of denials rendered were due to lack of, or insufficient information provided. To address denial rates with the provider network, the top five providers with the most frequent denials were identified. These providers were

outreached jointly by NIA and ACDE Provider Relations AEs. The top 10 requested procedures and the top 10 denied procedures were identified and tip sheets were created with the criteria and documentation required for review and approval of these procedures. These tip sheets will be distributed to the entire provider network.

Currently, there is not an automatic trigger for ACDE to receive notifications for denied (or authorized) services by NIA within the Jiva system. This is an identified barrier for the coordination of care; ACDE is investigating possible solutions.

The file submission of NIA denials illustrated continued concerns with NIA requests and denials of service. Expectations for the file review include the requested service with the medical director note submissions, review with medical necessity criteria (MNC), alternative services or interventions offered to meet the member's needs, and proper member and provider communication. The initial file submission did not include the identified alternative service(s) or follow-up on members with a denial of service. During this review, the EQR requested that the ACDE provide "gold star" files for review to allow the MCO to spotlight work that has been put into place since last year's review. The "gold star" records that were submitted did not represent progress from the previous review.

NIA representatives were present during the on-site discussion of the NIA file review. There was contradicting information provided by NIA regarding documentation required from a provider for PA of a service. In addition, files were reviewed where NIA stated there was not a definitive reason for either approval or denial; clinical judgment was used, which was not always consistent. The NIA on-site representatives could not definitively defend the PA decision based on MNC. File review findings included the following:

- Approximately one-third of the files did not include any follow-up for additional information prior to the denial of service.
- Two of the records contained excellent documentation of engagement and communication with members by the resource coordinator.
- Files included identification by the UM manager for follow-up needs; however, timely follow-up by CC was not evident.
- Member advocates reach out to a member following the PA denial to explain the member's appeal rights. However, there appear to be opportunities for ACDE to provide a more holistic approach to addressing the member's current condition or assisting in obtaining services to ensure good care/outcomes for the member.
- CC notes were present in files but there was no mention of a NIA denial, and no follow-up on alternative services.
- Follow-up file documentation included confirmation that the requested service took place, but lacked an explanation of how or why the service was approved following an initial denial.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO has an Organizational Chart for the UM program that includes the names of senior and departmental management, the number of FTEs per department/position, the staff supporting the Delaware population, including those shared across other State programs (if applicable), and notes staff situated in Delaware and identifies any open positions. The Organizational Chart clearly indicates the UM coordinator reports directly to the CMO; the CMO has ultimate responsibility for the UM activities. (3.12.2.1.3, 3.12.2.1.11)	New Finding for 2022	Partially Met	Not Met	**2022 Finding**: ACDE submitted an updated Delaware UM Organizational Chart 2022 that depicts the Delaware manager (identified as the "UM Coordinator" per contract) as directly reporting to the Corporate UM directors. There is a dotted line that turns into a solid line from the Delaware CMO to the Delaware manager. There is a solid line that turns into a dotted line between the BH manager and the Delaware manager. This updated chart does not clearly identify the reporting organization. Typically, a solid line indicates a direct reporting relationship and a dotted line indicates an indirect reporting relationship.	**2022 Recommendation**: Identify the reporting relationships within the UM departments, specifically noting the following: 1. The Delaware Manager appears to report to Corporate UM directors; provide clarification if this is more than one person, and if so, a description of the shared supervisory duties of the Corporate UM directors and the process. 2. Clarify the Delaware manager reporting relationship to the Delaware CMO. 3. Clarify the Delaware BH UM manager reporting relationship to the Delaware CMO as the initial desk review Organizational Chart submission depicted the BH UM manager as reporting to the Corporate Director of UM. 4. Provide a description of coordination if there is a matrix reporting relationship.
				2023 Finding: ACDE did not submit an updated organizational chart for UM; only organizational charts for Avēsis, NIA, and SKYGEN USA, LLC were submitted	**2023 Recommendation**: Provide an updated ACDE UM organization chart

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO and its delegates have a process for assessing its staffing needs relative to UM and decision- making. (3.21.2.1.11)	Minimally Met	Partially Met	Met	**2022 Finding:** ACDE provided the Avēsis staffing plan. The NIA staffing plan for Delaware Medicaid was not present.	**2022 Recommendation:** Provide the NIA staffing plan to support Delaware Medicaid and metrics.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO has a P&P that allows for reimbursement of non-participating providers for family planning services rendered to members as long as the following conditions are met: provider is qualified to provide family planning services based on the licensed scope of practice and is a Delaware Medical Assistance Program (DMAP)-enrolled provider; electronic claims are submitted using HIPAA standard transactions; medical records sufficient for MCO CC activities are provided; if a member refuses the release of medical information the non-participating provider must submit documentation of such refusal; informed consent is obtained for all contraceptive methods including sterilization consistent with requirements of 42 CFR 441.257 and 42 CFR 258. Note: DHCP members may not utilize OON Family Planning providers. (3.4.1.4.2.3)	New Finding for 2022	Substantially Met	Met	**2022 Finding:** ACDE submitted an update to the policy: UM.401DE Direct Access to Obstetrics and Gynecology (OB/GYN). Members are not required to access participating providers for family planning services with the exception of DHCP members who are required to use participating providers. To clarify the requirement to utilize OON Family Planning providers does not apply to DHCP members. This policy will be reviewed as noted during the next P&P committee meeting for review and approval.	**2022 Recommendation:** Submit the final approved Direct Access to OB/GYN policy.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO has a process to evaluate the training program of its delegates responsible for UM decision-making, this may include results of delegation oversight audits and/or agendas, minutes, or reports presented at a Joint Operating/Delegation Oversight committee. (5.1.2.3.1)	Minimally Met	Partially Met	Met	**2022 Finding:** The document NIA ACDE 2021–2022 UM Training contains the following attestation*: I certify on behalf of my organization that I have received and made available the following AmeriHealth Caritas Delaware-specific materials to all of the organization's employees and subcontractors who currently service the Delaware contract:* • *Member rights and responsibilities information included in the member handbook.* • *Utilization Management — Key Information ACDE — Subcontractor Training* The submission did not include the process that ACDE utilizes to confirm that training takes place with all NIA team members to understand Delaware contract needs.	**2022 Recommendation:** Provide the oversite process utilized by ACDE to confirm training of NIA team members takes place for Delaware Medicaid needs extending past the signed employee attestation.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO has a process to evaluate a delegated entity's compliance with federal requirements set forth under 42 CFR 438.210 which includes: UM, program structure, coverage, authorization of service, NOABD (standard authorization and expedited), and the compensation for utilization activities. (42 CFR 438.210)	Partially Met	Partially Met	Partially Met	**2022 Finding:** The number of NIA denials for Delaware Medicaid members has been a focus and concern. The document, NIA 2022 ACDE EQR Narrative reports that NIA conducts outreach to high-volume providers with denial rates of 30.0% or greater, they note that they do not include administrative denials. During the on-site review, files chosen were reviewed and concern regarding the decision of medical necessity criteria was discussed. A deep dive of clinical presentation, review of records, and outcome was requested.	**2022 Recommendation:** Provide a report of NIA denial rates by provider and the process to define high-volume providers within Delaware Medicaid. Provide a deep dive review of services requested and inter-rater reliability (IRR) of NIA decisions utilizing the 30 file reviews submitted for the EQR CAP review. Include follow-up that has taken place by ACDE.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
				2023 Finding: The MCO developed a process for care coordinators, case managers, and member advocates to use when following up with members who received a PA denial from NIA. The process is designed to ensure members understand the denial process and are informed of the recommended alternative service and offered assistance to receive the service or to appeal the denial. The documentation in the NIA file submission demonstrated that follow-up was identified but not completed, or was untimely, and did not reflect an exploration of the member's condition and understanding of the denial and recommended service.	**2023 Recommendation:** Provide fidelity of NIA denial follow-up through ongoing file review reports that include the NIA denied service, the alternative service recommendation, and ACDE follow-up.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO has a process to evaluate the compliance of its delegates responsible for UM decision-making. Delegation oversight tools and file review should clearly demonstrate evaluation of the delegate's UM program for compliance with requirements set forth under 42 CFR 438.210 and Delaware contract standards. (42 CFR 438.210)	Partially Met	Not Met	Partially Met	**2022 Finding:** The submitted document: 2022 EQRO Follow Up_Subcon states to refer to the document: Vendor_Delegate Mgt 2021–2022 CAP report.xls for Avēsis, NIA, PerformRx, SKYGEN CAPs, however this document was not provided in the UM desk audit submission, during the EQRO on-site, or as part of the UM follow-up submission. The document: Vendor and Delegate Oversight Auditing Process described the process that ACDE follows, however the supporting documents were not included.	**2022 Recommendation:** Provide details of subcontractors/delegates that have been issued CAPs. Include the ACDE follow-up requirements.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
				2023 Finding: The MCO provided a response to the previous EQRO findings of higher-than-expected NIA denials and concerns that recommendations are not being clearly communicated to the member. The MCO developed a like-specialty IRR process, achieving results of approximately 60.0%. While NIA representatives were present for the on-site EQRO review, consistent application of and decision-making based on MNC was not clearly described during the discussion of member files.	**2023 Recommendation:** Report oversight of denials by tracking, trending, and finding with outcomes. Provide ACDE/NIA IRR findings and progress toward the target benchmark.
The MCO has a process to monitor and ensure UM decisions for routine and expedited service requests meet required timeframes and that requests for extension, regardless of the requestor, are clearly documented and available to DMMA or its designee for review. (3.12.6.5.2)	Partially Met	Partially Met	Met	**2022 Finding:** The Provider Handbook available on the ACDE website did not include the required timeframe updates.	**2022 Recommendation:** Update the Provider Handbook to include the 72-hour timeframe for timeliness of expedited organization determinations.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO has a process to ensure that decisions for UM, member education, coverage of services, and other areas to which the practice guidelines apply are consistent with the guidelines. (42 CFR 438.236(d) and 3.13.6.3)	Partially Met	Partially Met	Met	**2022 Finding:** The online availability is not clear, the links provided do not take the user directly to the Clinical Practice Guideline (CPG) listed.	**2022 Recommendation:** Provide details on the mechanism used to educate providers on CPGs, particularly for guidelines with recent updates. Develop an upgrade to the online CPG resource that allows the user to access the CPG listed.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.
The MCO has a process to ensure that UM decision criteria/clinical guidelines are reviewed at least annually and are made available to providers. (3.12.2.1.1, 3.12.2.1.5)	New Finding for 2022	Partially Met	Met	**2022 Finding:** The listing of ACDE CPGs includes all US Preventative Services Task Force A and B recommendations. This listing is fluid and changing. This does not allow ACDE the ability to review annually those measures included and provide guidance and education to providers on these CPGs.	**2022 Recommendation:** Provide a process that ACDE utilities to monitor any changes to updates of the Delaware CPGs, including the review process internally, the internal training on updates, and the provider education process.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO demonstrates, through chart reviews, tracer scenarios, and other activities that UM and Transition and Discharge planning staff work together to support the members' needs during the hospitalization and post-discharge. (3.12.2.1.13)	New Finding for 2022	Not Met	Met	**2022 Finding:** ACDE submitted the document "ACDE UM Team Audits" however, this document does not support verification through audits of coordination of care. Many of the audit findings are N/A. For example, the following fields have a significant number of N/A entries. 25. For BH, a Discharge Planning Follow-Up Activity is created. 26. If applicable, the CC Trigger Assessment and/or CM referral to the appropriate department/individual is completed. 27. PA — If outpatient services were denied for LTSS/CCC members, was an activity sent to the appropriate worklist? 28. Did CC follow-up on the activity?	**2022 Recommendation:** Provide clear audit process and results for coordination with Transition and Discharge Planning.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO has a policy and procedure to allow female enrollees direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not the women's health specialist. (42 CFR 438.206(b)(2))	New Finding for 2022	Substantially Met	Met	**2022 Finding:** ACDE submitted an update to the policy: UM.401DE Direct Access to OB/GYN. Members are not required to access participating providers for family planning services with the exception of DHCP members who are required to use participating providers. To clarify the requirement to utilize OON Family Planning providers does not apply to DHCP members. This policy will be reviewed as noted during the next P&P committee meeting for review and approval.	**2022 Recommendation:** Submit the final approved Direct Access to OB/GYN policy.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.
The MCO has a process to ensure PH and BH UM decisions are coordinated and that the authorization process is consistent and seamless for members and/or providers. (3.4.1.2)	Substantially Met	Not Met	Met	**2022 Finding:** The process to review and approve both PH and BH care regardless of setting was not submitted.	**2022 Recommendation:** Provide the UM process for authorizations when a member is inpatient for a PH condition and BH services are also needed.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

HHO 2023 Findings and Recommendations

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

Enrollment and Disenrollment

ACDE 2023 Findings and Recommendations

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

HHO 2023 Findings and Recommendations

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

Quality Assessment and Performance Improvement Program

ACDE 2023 Findings and Recommendations

There is a strong QM/QI department that is supported by senior leadership within ACDE. There is evidence of integration of quality throughout the organization as evidenced by QI/UM committee meeting minutes. The 2022 Quality Improvement Program Evaluation includes a description of the QI activities and initiatives throughout 2022, including, but not limited to, the quality and safety of clinical care and quality of service activities. The evaluation includes a summary of the overall QI program effectiveness. The analysis included evaluation of committee accomplishments, service indicators, provider satisfaction, evaluation of clinical care, evaluation of the MRRs, and audit activities. The annual evaluation included a number of data analyses with conclusions and recommendations for improvement in 2023.

Beginning November 2022, ACDE transitioned the frequency of their Provider Forums from an annual to a monthly schedule. The Provider Forums held in 2022 included, but were not limited to, focusing on educating providers about HEDIS and gaps in care (i.e., breast cancer screening, cervical cancer screening, lead screening, etc.), telehealth, member incentives, and wellness programs. ACDE stated that the topic of balanced billing is also an agenda item for these forums.

During the last EQR CAP review (2022), the EQRO identified one item that required a CAP. The CAP item was identified during the EQRO's validation of PMs. ACDE submission of source code did not follow the required specifications. Specifically, the MCO was required to identify members with diabetes using diagnoses codes as well as pharmacy codes for the denominator. The source code did not include any pharmacy programming associated with diabetes. To rectify this, ACDE's regulatory reporting team expanded their validation efforts to include outputs that reflect key criteria have been implemented and accounted for. In fall 2022, the regulatory reporting team conducted a review of the logic for all reporting measures with the appropriate business owners and key stakeholders. ACDE will continue to perform at a minimum an annual review of the measures and logic for accuracy. ACDE has hired additional staff (one manager and two associates) to act as Quality Specialists responsible for this initiative. P&Ps were updated to outline these new efforts in detail. The CAP item has been resolved.

During the CAP review in 2023 Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO creates, reviews, and approves all contractually required reports that ensure accuracy and timely submission. (Note: Review passed year Quality and Care Management Measurement Report [QCMMR] and clinical reports to identify ongoing areas of inaccuracy.) (3.21.1.2)	Partially Met	Partially Met	Met	**2022 Finding:** The 2021 finding regarding reporting and preparation for discussing information reported during quarterly meetings has improved. However, a new finding was uncovered as the EQRO validated the PMs. The source code submitted did not follow the required specifications. Specifically, the MCO was required to identify members with diabetes using diagnoses codes as well as pharmacy codes for the denominator. The source code did not include any pharmacy programming to identify pharmacy codes associated with diabetes. This error calls into question ACDE's process for internal review of programming for contractually required reports.	**2022 Recommendation:** Identify and rectify the gap in the documented process for reviewing the QCMMR dental utilization reports. Provide a report of the most recent date of validation of all required (non-HEDIS) PMs.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

HHO 2023 Findings and Recommendations

In previous EQRO cycles (e.g., 2019–2022), there was significant concern about the lack of leadership and progress in quality initiatives. During the 2022 review, the HHO Quality department began to show progress toward meeting contractual requirements and a more robust approach to driving improvement in the health and wellness of the members. The support of HHO leadership and

the progress within the Quality department resulted in a strong performance in each of the quality areas assessed during the 2023 review.

There is evidence of integration of quality throughout the organization as evidenced by QI/UM committee meeting minutes. The 2022 QI/UM Annual Program Evaluation includes a description of the QI activities and initiatives throughout 2022; including, but not limited to the quality and safety of clinical care and quality of service activities. The evaluation includes a summary of the overall QI program effectiveness. The analysis included evaluation of service indicators, provider satisfaction, evaluation of clinical care, evaluation of the LTSS program, and audit activities. The annual evaluation included a number of data analyses with conclusions and recommendations for improvement in 2023.

With the addition of the Learning Advisor position in HHO in 2022, many methods of the Quality department have been treated as best practices in the development of an overall learning and education plan for the organization. The QI department management now participates in meetings with the Learning Advisor and other trainers in the organization to strategize on improvements and streamlining of quality training throughout HHO.

In 2022, the training module for vendors and subcontractors was redesigned to provide more relevant material for external entities. This training, in combination with the organization's self-paced "Medicaid 101" e-module, is a quality training requirement for vendors. These two training modules are documented on the vendors' scorecard and included in the overall assessment of compliance. HHO has continued to make significant advancements to the dashboard tools for monitoring health care disparities, HEDIS rates and PIP metrics. Additional dashboard development and improvements specifically in the areas of critical incidents and QOC are also a goal for 2023.

During the last EQR CAP review (2022), the EQRO identified three items that required a CAP. Two of the items were related to duplication and incorrect information in Primary Care Practice Portfolio Report policies. HHO updated the policy with appropriate language which now demonstrates compliance. The third CAP item was related to performing appropriate quality assurance reviews for manual entry reports as well as performing appropriate validation of code/data received from other entities. HHO has developed policies and desk-level procedures instructing Business Owners to use source/base data reports to validate the information that has been manually populated. HHO also updated policies to include incorporating review and approval of code received from other entities into the annual Vendor Scorecard process. The vendor code will be reviewed, at minimum, on an annual basis. The code will also be reviewed if the Vendor has had any system changes, as new or updated regulatory reporting specifications are received from DMMA, and as needed if the data coming from the vendor comes into question by the Business Owner. All three CAP items have been resolved.

During the CAP review in 2023, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO provider practice analysis includes the implementation of a CAP, if necessary. (3.13.7.1.3)	Partially Met	Substantially Met	Met	**2022 Finding:** The MCO has developed a policy that includes the implementation of a CAP, if necessary, based on provider practice results. However, there are two Primary Care Practice Portfolio (PCPP) Report policies MBU-QI-POL-503 and MBU-QI-POL-060 that contain the same language. Additionally, the policy has duplicative language in the description of action taken when a third occurrence of outlier reporting occurs in the portion of the policy.	**2022 Recommendation:** Correct the numbering of duplicative PCPP Report policies MBU-QI-POL-503 and MBU-QI-POL-060.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO provider practice analysis includes the development of policy recommendations to maintain or enhance the QOC provided to members. (3.13.7.1.4)	Partially Met	Substantially Met	Met	**2022 Finding:** The MCO has developed a policy that includes the implementation of a CAP, if necessary, based on provider practice results. However, there are two PCPP Report policies MBU-QI-POL-503 and MBU-QI-POL-060 that contain the same language. Additionally, the policy has duplicative language in the description of action taken when a third occurrence of outlier reporting occurs in the portion of the policy.	**2022 Recommendation:** Correct the numbering of duplicative PCPP Report policies MBU-QI-POL-503 and MBU-QI-POL-060.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO creates, reviews, and approves all contractually required reports that ensure accuracy and timely submission. (Note: Review past year QCMMR and clinical reports to identify ongoing areas of inaccuracy.) (3.21.1.2)	New Finding for 2022	Partially Met	Met	**2022 Finding:** Although the process for developing reports appears comprehensive with layers for approval, the first step is missing. There are no quality assurance steps performed, such as peer review, to ensure manual entry is accurate. During the review, HHO stated that HHO received the code for the extraction of dental data. It was evident during the review that no validation of this code was performed.	**2022 Recommendation:** Develop a process to validate the manual entry of data for reporting before these reports are submitted for approval. Develop a process of code review for data extraction to be used in the regulatory reports that would include HHO review and approval of the code received from other entries.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

Coordination and Continuity — Primary Care and Special Health Care Needs

ACDE 2023 Findings and Recommendations

All ACDE CC positions are full-time and dedicated solely to Delaware Medicaid. ACDE leadership meets weekly to review current staffing and make adjustments as needed. ACDE CC staff recruitment efforts and staffing retention continue to be a priority to ensure compliance with caseload requirements and timely outreach. The entire ACDE population is stratified monthly basis; stratification results are then used to analyze future staffing needs. With the implementation of the 2023 MSA, ACDE projected an increase in members eligible for CC, and in turn updated their staffing plan in the first quarter of 2023. ACDE added 89 CC positions which included two additional CC supervisors, 27 permanent care coordinators, and 40 temporary care coordinators (22 temporary care coordinators were hired at the time of the EQR on-site review). Permanent and temporary resource coordinators, temporary CSRs,

and permanent care connectors were positions that were created with the temporary positions being implemented due to the potential membership fluctuation. The temporary staff received comprehensive CC orientation and detailed training for the particular area where they were assigned. Addressing the 2022 Death Investigation Alerts (DIA) CAP, ACDE hired two additional supervisors and 34 community health navigators (CHNs) to outreach, within the community, substance use disorder (SUD) members who that are unable to be reached. The supervisors will oversee the process to outreach and engage SUD members, as well as perform some direct care and provide supervision to the navigators.

ACDE submitted an updated risk stratification plan to DMMA in Quarter 4 (Q4) 2022, which was approved and implemented in January 2023. Currently, the supervisors manually assign cases, but a Jiva enhancement is being explored to auto-assign cases from the monthly stratification. The CC team continues to utilize daily huddles, care review rounds, and UM rounds to discuss members, identify needs, and develop strategies to address care gaps and health-related social needs (HRSN). Challenges continue with the efforts to ensure coordination and collaboration with PROMISE members. There are data discrepancies between ACDE and DMMA lists of PROMISE members with new members not being identified or updates made on the daily file in a timely manner. ACDE stated that they are working on a solution and in the interim can reconcile the list by checking the State website.

Submitted documents validate compliance with both CC caseloads not exceeding 1:50 for CCC and 1:40 for MCC, as well as supervisory ratios of 1:15. File review showed that timely outreach is occurring upon member identification for CC. ACDE has worked to ensure consistent application of criteria for ending CC services or closing cases to ensure caseloads are reasonable and serving active and eligible members. These efforts included developing care plan goals with projected timeframes for completion, ensuring goals are person-centered and created in collaboration with the member and other identified team participants, and routinely re-evaluating and revising goals and timeframes to reflect the current situation and progress. Outreach frequency to members is determined collaboratively with care coordinators and supervisors reviewing cases at six-month intervals to evaluate ongoing CC services.

ACDE offers numerous options for members to complete HRAs. These include a web-based interface, a kiosk at the Community Wellness Center, and contracting with Icario for telephonic outreach to members to complete HRAs. Performance has been lower than expected utilizing Icario and ACDE has followed up to identify barriers and interventions to improve performance. Ramping up live agent outreach, implementing technology to allow web platforms to save partially completed assessments, and improving the member experience by facilitating transfer to a live agent are all interventions that were implemented. Based on previous performance, Icario’s performance is now monitored on a weekly basis by the manager of Population Health Vendor Solutions. Rates in 2023 to date include:

Month	Members Contacted Successfully	HRA Completed	Rate of Completion
January	578	534	92.3%
February	425	374	88.0%
March	438	397	90.6%
April	650	559	86.0%

ACDE has struggled to demonstrate that CC policies, procedures, and workflows are being followed as written. In particular, integrated CC has been a repeated area in need of improvement. Efforts have focused on provider education about CC programs and benefits; however, the overall programmatic approach must emphasize the benefits CC by the MCO offers to providers and members. Webinars and training for providers were implemented after the 2022 EQR on-site review, but initial attendance was limited. It improved in November 2022 and December 2022, with an average of 40 providers in attendance. All dental providers were added to ACDE's fax distribution list to receive educational documents about CC. In addition, ACDE developed a high-level dental needs a standard operating procedure (SOP) to educate CC staff on the adult dental benefit and improve CC efforts with dental providers.

Policies and checklists outline the requirements for assisting members with securing appointments and documenting network adequacy standards, as well as the process to escalate concerns to provider relations/leadership. However, file review results reveal provider waitlists and that providers are not accepting new members. ACDE reports that at the time of this review, BH specialties, such as Autism spectrum or dialectical behavioral therapy (DBT) may be difficult to find but if provider relations/leadership is notified they will contact providers in an OON or look for providers out-of-state. Provider network management reported that the secret shopper rate for timely appointments for PCPs and other PH specialists, like high-risk obstetrics (Obs), was 100.0%. ACDE stated that when they moved beyond the frontline scheduler to the nurse line, they were able to schedule an appointment in a timely manner; however, this means of accessing a timely appointment had not been shared with the CC team or ACDE members.

ACDE has a documented process to identify and close gaps in care. This process is routinely audited with scores reported in the range of 88.0%–100.0% in Q1 2023. File reviews completed by the EQR demonstrate fairly consistent identification of gaps but there was little documented evidence of these gaps being addressed or closed.

ACDE continues efforts to comply with contractual standards to identify and outreach individuals with low-acuity non-emergent (LANE) ED utilization. Members are identified daily using the top 25 LANE diagnoses and a weekly report is generated as a safeguard to capture members who did not trigger the admission, discharge, and transfer list. The goal is to conduct outreach within 48 hours of the ED visit, perform a diversion survey and coordinate appropriate follow-up. The diversion survey is an effort to gather information about why the member chose the ED as opposed to an alternative setting (e.g., urgent care or PCP). In addition to outreach phone calls, postcards are sent to educate members on alternative settings. Other enhancements to LANE ED utilization

include the addition of Spanish-speaking staff and a report to monitor the percentage of members who receive a PCP appointment within seven, 14, and 30 days of a LANE ED visit. LANE ED reports are developed for all accountable care organizations and providers in VBP arrangements and are presented at the Joint Operations Committee meetings.

The ACDE Corporate clinical auditor conducts monthly CC file audits. A minimum of two random cases are selected per care coordinator and the passing score is 95.0%. The auditing tool is designed to evaluate the required checklist activities and clinical appropriateness of the case. During the monthly 1:1 meetings with the supervisor, audit results are reviewed with the care coordinator along with caseload reviews and outreach timelines, face-to-face attempts, and assessments. Additional coaching is provided to address identified opportunities for performance improvement. The reported audit scores in December 2022 ranged from 89.0%–97.0% by care coordinator and pod. ACDE has implemented strategies for improvement that include hiring additional supervisors, promoting staff to senior care coordinators to assist with training and precepting new staff, and working with the corporate training team to develop an enhanced care planning training (expected finalization June 2023).

Care Coordination File Review

Mercer completed a review of 30 CCC files, 15 low-risk maternity and 15 high-risk MCC files using the File Review Protocol outlined in Section 3. Mercer requested that ACDE identify the “gold standard” files that demonstrate excellent CC in accordance with the MSA standards.

Many files could not be scored completely due to the lack of successful outreach and engagement documented in the file. Sixteen CCC, eight high-risk maternity, and 11 low-risk files were fully scored. The EQR file review audits demonstrated missed opportunities for outreach, lack of member engagement, lack of follow-up to identified care gaps, incomplete assessments and quarterly reassessments, and undeveloped and out-of-date person-centered plans of care.

Members are identified for CC from numerous sources including stratification, ED reports, UM and ONAF forms (for Bright Start). The reason for the assignment to CC is not always clearly identified nor are the high-risk factors overtly addressed in many cases. For instance, a high-risk maternity member was referred due to hypertension but the plan of care did not include a plan of monitoring blood pressure or warning signs of eclampsia/preeclampsia. Most cases did show consistent and timely attempts at outreach, though significant challenges remain in reaching members via phone attempts. As described above, gaps in care were identified but rarely addressed or resolved. Plans of care were routinely shared with other providers, but actual collaboration was very limited. Some cases appeared to be appropriate for PROMISE referral or other BH/SUD services but the linkage to BH/SUD services was not made.

The EQRO recognizes that the review of a flat file has some limitations; however, there appeared to be a lack of case conceptualization and limited exploration of the member’s situation and needs beyond asking the required questions. For instance, in maternity cases, it was at times difficult to determine the para/gravida status as well as the identified supports, including the father of the baby in the flat file. Additionally, during the on-site session when numerous cases were discussed a lack of case conceptualization was still noted. Live call monitoring, already in use by the ACDE, may be helpful in evaluating the care coordinator’s

ability to establish rapport with the member, demonstrate the value of program participation, and result in better case conceptualization.

The following table displays the strengths and weaknesses broken down by domains. Please consider that not all sections of the case files could be scored as the numerator of outreached and engaged members was very small.

Review Area	Strengths	Opportunities
Outreach and Engagement (for all levels)	Cases are being assigned in a timely manner and initial telephonic outreach is timely and consistent.	While following P&P for case assignment and outreach, there are missed opportunities to outreach members who were hospitalized, or those routinely seeking treatment, such as at opioid treatment programs (OTPs) or OB appointments. Call monitoring is recommended to evaluate program offerings.
Screening (for low-risk MCC)	Members were routinely provided with resources to receive a breast pump and other services.	Some members had risk factors that warranted discussion or referral to high-risk MCC.
	A high-risk maternity case was appropriately elevated to Level 2.	Some files demonstrated missed opportunities to offer a referral to PROMISE. Many files lack completed assessments.
Assessment (for CCC and high-risk maternity)	Gaps in care were routinely documented and discussed with the member.	The reason for referral to CC was not always evident. Gaps in care were not usually closed.
Plan of Care (for CCC and high-risk maternity)	Members are included in the plan of care development and receive a copy, as do providers.	Plans of care did not always address the reason for referral to CC.
CC Activities (for all levels)	Members are routinely given lists of providers, such as dentists or PCPs and offers are made to schedule appointments.	Follow-up is limited to determine if appointments are ever scheduled and kept.

The preliminary findings were reviewed with DMMA and ACDE at the on-site interview and five member records were reviewed in the ACDE CC system.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO and its delegates have a process for assessing its staffing needs relative to mandated caseload requirements and CC decision-making. (Note: Assess staffing approach and caseloads to address all three levels of CC.) (3.6.3.4.3.4)	Minimally Met	Not Met	Substantially Met	**2022 Finding:** The MCO reported a process of placing members identified as meeting Level 2 criteria on a waiting list, resulting in delays in outreach, assessment, and interventions.	**2022 Recommendation:** Provide an analysis of the members referred to Level 2 CCC in 2021 and 2022. Include the number of members placed on a waiting list, the start date for this process, the end date for this process, and the corrective action process to ensure members identified as Level 2 receive contractually and clinically required intervention. Provide the plan to coordinate with DMMA on staffing crisis needs and remediation.
				2023 Finding: The MCO is hiring two DIA supervisors to oversee the process of outreach and engaging members with SUD as well as oversee CHNs. The job description submitted for DIA supervisors was incorrect and included the job description for a CC supervisor.	**2023 Recommendation:** Provide the DIA supervisor specific-job description.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO has field-based staff allocated by county and can adjust based on membership thresholds to support appointment referral and linkage requirements. Clinical care coordinator caseloads should not exceed a ratio of 1:50. The job responsibilities and qualifications by position are appropriate and certification standards are met where appropriate. Staffing should reflect the assignment of a nurse and social worker as care coordinators to any member receiving more than eight hours of private duty nursing. (3.6.3.2.2.3.1, 3.6.3.4.3.2, 3.6.3.4.3.4, 3.7.1.5.3)	Minimally Met	Not Met	Met	**2022 Finding:** The MCO submitted documentation that demonstrated caseloads between eight and 50 for 52 FTE. A file review demonstration revealed a process of placing members identified as meeting Level 2 criteria on a waiting list.	**2022 Recommendation:** Conduct a staffing analysis to determine adequate staffing needs to comply with contractual requirements.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area	**2023 Recommendation:** None.
The MCO provided data regarding HRA completion, evidence compliance with 60-day outreach standard, and demonstrated active outreach and engagement within the first 30 days. (3.6.2)	Partially Met	Partially Met	Substantially Met	**2022 Finding:** The number of completed HRAs continued to fall below the goal of 40.0% in 2021. The submitted documentation for 2022 also contained rates below the goal which was attributed to the use of an incorrect member listing for outreach. Completion rates were also submitted for future dates. (July 2022).	**2022 Recommendation:** Provide narrative for the HRA completion rates reported for EQR and QCMMR including member count month and submission month. Provide updates related to the transition from Pursuant to Icario, including the data transfer process to avoid delays or missed assessments.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
				2023 Finding: The MCO submitted documentation that shows 60-day HRA completion rates of 47.0%, 60.0%, 51.0%, and 53.0% for 2022. The goal in 2022 was 40.0%. The MCO reports that Icario is producing lower-than-expected rates but has implemented a technology change, live agent outreach, and ways to reduce member abrasion.	**2023 Recommendation:** Provide monitoring updates on Icario's HRA completion rate, improved processes, and performance**.**
The MCO has an integrated CC program that eliminates fragmentation in care and promotes education, communication, and access to health information for members and providers to optimize QOC and member health outcomes. The CC program is based on risk stratification and rooted in a population health model, touches members across the entire care continuum, promotes healthy behaviors, provides face-to-face (or virtual) CC as needed, and is supported by evidence-based medicine and national best practices. (3.6.1.1, 3.6.1.2)	Minimally Met	Partially Met	Partially Met	**2022 Finding:** The program description and strategy were revised. An integrated Pod team was implemented on February 28, 2022, which includes BH, PH, and RC representation. The teams meet daily for 20-minute huddles to discuss concerns and review high-risk cases. Team members are alerted to HRSN concerns and care gaps via the population health portal.	**2022 Recommendation:** Provide the process and evidence to include case discussion and recommendations from huddles are documented in the CC notes and plan of care. Provide evidence of the functionality of the widget for HRSN that alerts the team member to both HRSN concerns and care gaps as they are displayed in the population health portal.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
				2023 Finding: The MCO CC PD was reported as still in draft and was not submitted; completion estimated for June 30, 2023.	**2023 Recommendation:** Provide the final CC PD with relevant findings highlighted or summarized.
The MCO has a well-defined process to ensure comprehensive CC to all members based on member's risk level. CC efforts incorporate pharmacy, BH providers, the Division of Substance Abuse and Mental Health (DSAMH), and other community-based entities including school-based wellness centers. The process should address the coordination of PH and BH conditions and social determinants of health needs. (3.6.1)	Minimally Met	Minimally Met	Met	**2022 Finding:** Written materials outline a seamless transition from one level of the program to another and the Jiva platform is designed to integrate UM, CC, and pharmacy functions but the file reviews do not consistently provide evidence that this is occurring.	**2022 Recommendation:** Demonstrate fidelity to an integrated CC process through file audit findings. Re-evaluate the provider education model to ensure targeted providers are receiving the training as intended.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO's CC program provides identification of and assistance with securing an ongoing source of primary care including access to a specialist, if appropriate. Care coordinators can identify primary care panel status and make referrals to the network unit when provider information is inaccurate and requires correction. (3.6.3.4.6.2)	Not Met	Partially Met	Substantially Met	**2022 Finding:** Resource coordinators assist with coordinating PCP or specialist appointments, including identifying a provider, scheduling the appointment (via three-way if needed), and securing transportation to the appointment. During the on-site, barriers to securing appointments were identified including wait times of 30 days or longer.	**2022 Recommendation:** Provide a standalone P&P or checklist for RC and CC to coordinate with provider relations on barriers in meeting network adequacy standards.
				2023 Finding: The MCO reports that in the last year, the response rate for secret shopper access appointments was 100.0%. The MCO determined that appointment access was timely when the nurse line was contacted versus the frontline scheduling. Both the care coordinator and resource coordinator checklists include the requirement of identification and assistance with securing an appointment for the member as needed.	**2023 Recommendation:** Provide evidence including file audit results, meeting minutes, or other correspondence to demonstrate that care coordinators and resource coordinators are informed of findings and suggestions from provider network access activities.
The MCO has a documented process to identify and track gaps in care inclusive of all elements of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and applicable	Partially Met	Partially Met	Partially Met	**2022 Finding:** A process for identifying, tracking, and closing gaps in care is documented but case file reviews do not support the process is consistently followed.	**2022 Recommendation:** Provide evidence, based on focused audits of CC member records, demonstrating fidelity to the process for identifying, tracking, and addressing gaps in care.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
HEDIS measures. (3.4.6.3.4, 3.6.3.4.6.2.7)				**2023 Finding:** The MCO has a documented process for identifying, tracking, and closing gaps in care. File reviews demonstrate fairly consistent identification of gaps in care but the MCO is not compliant with the expectation to close gaps in care.	**2023 Recommendation:** Provide evidence of fidelity to the contractual requirements of the CC program which include timely outreach; member engagement; identifying, tracking, and closing gaps in care; completing an assessment and quarterly reassessments; and developing and updating a person-centered plan of care.
The MCO has created a threshold for high rates of low-acuity, non-emergent **(**LANE) ED utilization, which determines the members identified for outreach and engagement in the primary care setting. The MCO has a process to actively outreach and engage members who have reached the threshold of having LANE ED utilization and has taken steps to identify and remove barriers as well as coordinate linkage to primary care services to mitigate further LANE ED utilization. (3.6.3.3.2, 3.6.3.3.2)	Partially Met	Partially Met	Met	**2022 Finding:** Members are identified daily using the top 25 LANE diagnoses. A weekly report is generated as a safeguard to identify members who did not trigger the Admission, Discharge, and Transfer list. The goal is to reach members within 48 hours of the ED visit, perform a diversion survey, and coordinate a follow-up visit. The percentage of members who receive a PCP visit within seven, 14, and 30 days of the ED visit is monitored.	**2022 Recommendation:** Provide updated LANE policy and results of the number of members successfully contacted within 48 hours. Provide audit findings of members receiving a timely follow-up visit post ED visit.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO has a process to actively engage PCPs whose members have reached the established threshold for LANE ED utilization that incorporates other business units such as quality and/or provider services to identify barriers and influence PCP behavior, as appropriate. (3.6.3.3.2)	Not Met	Substantially Met	Met	**2022 Finding:** A LANE task force between CCHS and the Joint Operations Committee was formed. Tasks include determining criteria for high ED utilization and developing a plan to share information with PCPs.	**2022 Recommendation:** Provide updates on the task force and plans to extend efforts beyond CCHS.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.
The MCO has a process to monitor and oversee non-clinical resource coordinators, including appropriate supervisor-to-staff ratios, conducting IRR and file audits, taking action on identified gaps in knowledge, and variance from approved processes. (3.6.3.3.1)	Minimally Met	Minimally Met	Partially Met	**2022 Finding:** The supervisor-to-staff ratios of RC meet the 1:15 requirement. Monthly file audits are conducted however the goal of 95.0% was not met from September 2021 to December 2021 and the findings were difficult to interpret. File reviews demonstrate missed opportunities for outreach, lack of follow-up to identified care gaps, and delays in outreach.	**2022 Recommendation:** Provide audit results including a numerator and denominator of the number of staff audited, the opportunities for improvement, and the actions taken to address the deficiencies.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
				2023 Finding: Resource coordinators are supervised by a care coordinator supervisor who is a licensed registered nurse (RN) or licensed clinical social worker (LCSW). The supervisory ratio is 1:15. Audits are performed at least monthly, and RC completes IRR. File reviews demonstrate missed opportunities for outreach, lack of follow-up to identified care gaps, and delays in outreach. The MCO is not compliant with the expectation to engage members and close gaps in care.	**2023 Recommendation:** Provide evidence of fidelity to the contractual requirements of the CC program which include timely outreach; member engagement; identifying, tracking, and closing gaps in care; completing an assessment and quarterly reassessments; and developing and updating a person-centered plan of care.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO has P&Ps that indicate all initial outreach occurs within 15 days of the member being identified as eligible; with a minimum of five attempts made within the first 90 days, including at least one documented face-to-face (or virtual) attempt. If after 90 days or member declines participation, the clinical care coordinator notes all outreach attempts and can close the case. If the member is identified as high-risk, BH, or SUD, the MCO outreaches to DMMA, DSAMH, Division of Developmental Disabilities Services (DDDS), or other agencies or providers prior to closing the case. (3.6.3.4.4.2)	Partially Met	Not Met	Partially Met	**2022 Finding:** ACDE has P&Ps that outline outreach and engagement strategies and standards. Level 2 CCC file review findings indicate there are significant challenges in reaching members and engaging members. Through the case file presentations, the team described a process of placing members identified as meeting Level 2 criteria on a waiting list. Many of the files submitted for review represented cases where the member was not ultimately reached and/or engaged in CC.	**2022 Recommendation:** Provide evidence, based on focused audits of CC case files, demonstrating fidelity to the policy for outreach standards. For each member stratified as Level 2 and placed on a waiting list, provide member-level detail related to the: • Identification • Assignment • Outreach (e.g., attempts, successful outreach, last contact) • Assessment • Completed plan of care • Dates of inpatient and ED visits • Current status Include an analysis to describe if the members were included in the CC quarterly reports.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
				2023 Finding: The MCO provided documentation in policy and audit tools that outline the specific expectations that the care coordinator reaches out within two to five business days of the initial contact and there must be five outreach attempts (including one face-to-face) within the first 90 days of identification. File reviews reflected challenges with outreach and engagement. The MCO is not compliant with the expectation to engage members.	**2023 Recommendation:** Provide evidence of fidelity to the contractual requirements of the CC program which include timely outreach; member engagement; identifying, tracking, and closing gaps in care; completing an assessment and quarterly reassessments; and developing and updating a person-centered plan of care.
The MCO's P&Ps require clinical care coordinators to outreach to eligible members within 30 calendar days to complete a comprehensive assessment (e.g., PH, BH, social, environmental, cultural, and psychological needs) including input from the member's caregivers, family, PCP, and other providers, as appropriate. All	Partially met	Partially Met	Partially Met	**2022 Finding:** ACDE has P&Ps that outline assessment standards. Numerous assessments are available for use by the CC and the appropriate assessment is determined by the HRA findings, a checklist, and a reference guide. File reviews demonstrate very little member engagement and subsequently completed assessments.	**2022 Recommendation:** Provide evidence, based on focused audits of CC member records, demonstrating fidelity to the process for meeting assessment standards.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
outreach and coordination efforts are documented within the member's file and demonstrate active and good-faith efforts to incorporate provider involvement in CC activities. (3.6.3.4.5.1-3.6.3.4.5.3)				**2023 Finding:** The MCO provided documentation in policy and audit tools that outline the specific expectations that an assessment and plan of care be developed within 30 days of the member agreeing to CC. File reviews demonstrate challenges in engaging members and completing assessments. The MCO is not compliant with the expectation to engage members and complete assessments.	**2023 Recommendation:** Provide evidence of fidelity to the contractual requirements of the CC program which include timely outreach; member engagement; identifying, tracking, and closing gaps in care; completing an assessment and quarterly reassessments; and developing and updating a person-centered plan of care.
The MCO's P&Ps, file reviews, and/or tracer scenarios evidence person-centered planning processes. All plans of care include at minimum prioritized goals and actions, the effective and comprehensive transition of care plan, a communication plan with PCP and other providers, a list of providers delivering services to the member, a listing of other services received by programs other than those provided by the MCO (to avoid duplication), evidence of referral to the	Partially Met	Partially Met	Partially Met	**2022 Finding:** ACDE has P&Ps that outline care planning standards. ACDE reports that as of June 15, 2022, 93.9% of members have an active, open care plan. Audit results indicate this is an area for improvement with 314 opportunities identified for the indicator “development of care management plans, including prioritized goals.” File reviews demonstrate very few care plans are completed. Goals are not always clearly defined or actionable.	**2022 Recommendation:** Develop or update the audit tool to monitor the required components for the care plan. Provide audit results demonstrating compliance with contractual requirements.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
community or social support services, HRSNs, frequency of ongoing member contacts, and identification and plans to close gaps in care. Documentation demonstrates that a member receives a copy of their plan of care. (3.6.3.4.6.2)				**2023 Finding:** The MCO provided documentation in policy and audit tools that outline the specific expectations that a person-centered plan of care is developed within 30 days of the member agreeing to care coordination. File reviews demonstrate challenges in engaging members and completing and updating individualized plans of care.	**2023 Recommendation:** Provide evidence of fidelity to the contractual requirements of the CC program which include timely outreach, member engagement, identifying, tracking, and closing gaps in care, completing an assessment and quarterly reassessments, and developing and updating a person-centered plan of care by providing the following each month: Five member files which must include a mix of maternity and CC cases submitted in a HIPAA compliant manner and the MCO audit results with associated scoring sheets for these five files.
The MCO has a process to monitor care plans and initiate updates and revisions to member's plans of care, as necessary. This includes a minimum of one face-to-face/virtual contact every six months with members enrolled in Level 2 CCC and requires documentation of all outreach attempts. (3.6.3.4.7)	Partially Met	Partially Met	Partially Met	**2022 Finding:** ACDE has P&Ps that outline standards for care plan updates and revisions. File reviews demonstrate very few care plans are completed and continued challenges in reaching members limit the number of six-month updates.	**2022 Recommendation:** Document ACDE's process to provide oversight that care coordinators are initiating updates and revisions to the member's plan of care, as necessary. Provide information detailing oversight activities conducted to ensure face-to-face or virtual contacts are made every six months for members enrolled in Level 2 CCC.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
				2023 Finding: The MCO provided documentation in policy and audit tools that outline the specific expectations that a quarterly reassessment is completed, and a face-to-face visit will be conducted at least every six months. File reviews demonstrate challenges in engaging members and completing quarterly assessments. The MCO is not compliant with the expectation to engage members and complete quarterly assessments.	**2023 Recommendation:** Provide evidence of fidelity to the contractual requirements of the CC program which include timely outreach; member engagement; identifying, tracking, and closing gaps in care; completing an assessment and quarterly reassessments; and developing and updating a person-centered plan of care.
Supervisors and Level 2 CCC staff receive reports to monitor timeliness of outreach efforts and consistency with outreach and contact timeframes and develop staff and/or departmental corrective actions, if necessary. (3.21.6.1.3)	Minimally Met	Minimally Met	Met	**2022 Finding:** Jiva reports are used to measure staff productivity. Each CCC has a monthly 1:1 and audit results are reviewed, a caseload review, outreach timelines, and face-to-face attempts within 30 days, and assessments completed per month. The case file reviews also revealed delayed outreach due to members being assigned to a waiting list.	**2022 Recommendation:** Document the process to ensure timeliness of outreach and compliance with contract timeframes are met and no waiting lists are utilized.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
The MCO has tools and processes to conduct IRR and Level 2 CCC file audits, taking action on identified gaps in knowledge, and variance from approved processes. The file audit tool assesses the completeness of the plan of care addressing member needs and personal goals. The goals must be specific and measurable with achievement timeframes and desired outcomes. (3.6.3.4.6.3, 3.6.3.4.6.4)	Partially Met	Partially Met	Partially Met	**2022 Finding:** Clinical audits are completed monthly by the Corporate Clinical auditor. A minimum of two random cases are audited per CCC and the passing score is 95.0%. The auditing is designed to evaluate checklist activities and clinical appropriateness. The Level 2 audits had a 92.0% average for 2021 and the 95.0% goal was not met from May 2021 through December 2021. The audit findings were listed for the Level 2 State and NCQA audit form and the GHR; however, the findings were difficult to interpret. For instance, opportunities were numerically defined by indicator, but no denominator was identified. The MCO has an IRR policy and CC supervisors conduct IRR on a quarterly basis using a Survey Monkey platform that allows for scoring, data analysis, and record keeping of staff completing the exercise. A score of 90.0% is required for passing. The IRR assessments determine the level of consistency of CC and the development of a person-centered care plan.	**2022 Recommendation:** Provide comprehensive audit results and continue to submit audit results until the 95.0% goal is met for three consecutive months. Provide results of the IRR reviews and actions to address any identified opportunities.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
				2023 Finding: The MCO provided evidence in policy and reports to demonstrate the completion of audits and IRR. File reviews did not consistently reflect case conceptualization and the high audit scores reported by the MCO were incongruent with the EQRO file review findings. The MCO is not compliant with the expectation for robust case conceptualization to be documented in the member file.	**2023 Recommendation:** Provide evidence of fidelity to the contractual requirements of the CC program which include timely outreach; member engagement; identifying, tracking, and closing gaps in care; completing an assessment and quarterly reassessments; and developing and updating a person-centered plan of care.
The MCO has a process to evaluate the success of the Level 2 CCC program, which includes metrics and benchmarks for performance, activities to close identified gaps or variances, and incorporates CQI activities. (3.6.2.3, 3.21.6.2)	Partially Met	Partially Met	Partially Met	**2022 Finding:** The CC program is evaluated annually. Depression, asthma, and hypertension are the three most common diagnoses for the population. A lack of screening and referral for depression was noted in the CC file audits and the EQRO case file review. Training on referral to PROMISE continues. 2021 activities included updating workflows, checklists, and evaluation tools. The maternity blood pressure cuff initiative was highlighted with an expected distribution start date of June 2022.	**2022 Recommendation:** Demonstrate how the program evaluation is translated into actionable items to address the noted deficiencies found in the program.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
				2023 Finding: The MCO CC PD was reported as still in draft and was not submitted; completion estimated for June 30, 2023.	**2023 Recommendation:** Provide the final CC PD with relevant findings highlighted or summarized.

HHO 2023 Findings and Recommendations

The HHO CC department is structured to include a director, managers, supervisors, an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coordinator, care coordinators, service coordinators, compliance coordinators, and administrative staff. A dedicated housing coordinator position was added in 2022 as well as a maternity care coordinator with specific experience in BH and SUDs. The department currently has a Triage and Outreach Pod which is designed to increase outreach and engagement. Other pods include BH, transition of care, PDN/Division of Developmental Disabilities Services (DDDS), and maternity/pediatrics/EPSDT. All pods include both care coordinators and service coordinators. After-hours coverage, including weekends and holidays, is staffed by departmental managers and supervisors so members always have access to a clinician.

All positions are full-time and dedicated to Delaware. At the time of the on-site, there were no open positions for CC or service coordination, and staffing was meeting the required ratios to not exceed 1:50 for CCC and 1:40 for maternity care coordination (MCC). Supervisors assess daily CC caseload volumes through reports and the GuidingCare platform. CC supervisory ratios were in compliance with the requirement to not exceed 1:15.

HHO provided programmatic updates to enhance the CC program:

- A new SUD program, Wayspring, opened in July 2022 in Wilmington, Delaware. This program is intended to serve Medicaid and CHIP members who are not enrolled in PROMISE. Wayspring uses internal algorithms and outreaches members to try and engage them in treatment. Although there are weekly rounds with HHO and daily files of action plans are shared with the care coordinators, action plans and documentation reside outside of HHO's GuidingCare platform. These action plans can be uploaded into GuidingCare.
- HHO is in the process of developing a dashboard for the transition of care that will be color-coded, which will provide the rapid in-reach team member a quick visual of the number of admissions.

The MCC program was restructured to improve the program and to ensure compliance with the 2023 MSA requirements. The risk stratification was updated to include pregnant and post-partum members considered to be high-risk and low-risk. The MCC caseloads are lower than other pods with the ratio set at 1:40.

HHO has a robust internal CC monitoring program. Auditing efforts include monthly case file audits, call audits, and field visit audits. Program supervisors' complete audits which are reviewed during monthly supervision, corporate compliance conducts audits as well. Audit score benchmarks are set at 90.0% and in 2022 both call audits and charts audits exceeded the goal every quarter. Focused audits on care planning, discharge planning and ED follow-up were also conducted and results ranged from 73.0%–92.0%. IRR audits are completed on a quarterly basis and involve the audit team completing a review of a chart the supervisor has scored, using the same tool. The audit (i.e., IRR) scores have been comparable in each quarter. Highmark Enterprise Risk and Governance began monitoring specific contractual compliance items on a monthly basis in Quarter 3 (Q3) 2022. Audited items include outreach timeliness, PDN assignment, member assessment timeliness, face-to-face visit timeliness, and staffing and caseload ratios. Audit scores ranged from 96.6% to 100.0% each quarter.

All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.

Care Coordination File Reviews

Mercer completed a review of 30 CCC files, 15 low-risk maternity, and 15 high-risk MCC files using the File Review Protocol outlined in Section 3. Mercer requested that HHO identify the "gold standard" files that demonstrate excellent CC in accordance with the MSA standards.

Overall, the files were well-organized and easy to follow. For those members who were reachable, the outreach and engagement were consistent and timely. The clinical interventions were not always specific or robust, though this was largely a function of the dropdown selections in GuidingCare and while care plans were routinely shared with PCPs and Obstetrician/Gynecologists there was little evidence of actual collaboration. At times, the reason for referral to CC was not readily evident.

Of the 30 CC files, four members were unreachable or opted out of CC and could not be scored beyond the outreach activity. The remaining files were fully scored on the outreach, assessment, plan of care, and CC activities. Seventeen files were scored at 100.0% and the remaining files were scored between 50.0%–88.0%.

Eight of the 15 low-risk maternity files were able to be scored on all activities. Scores ranged between 50.0%–80.0%. The remaining seven were unreachable or declined CC.

For the high-risk maternity files, 10 of the 15 files were scored on all activities and the scores ranged from 50.0%–100.0%. Five members were unreachable or declined CC.

Dental

ACDE 2023 Findings and Recommendations

During the CAP review in 2022, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions. This area did not require additional review in 2023.

HHO 2023 Findings and Recommendations

UCD is HHO's Dental Benefits Manager (DBM) and has been delegated provider call center functions, provider network management, UM, claims processing and payment, and provider appeals and complaints. Overall, HHO, in partnership with UCD, has appropriate processes, policies, and procedures in place to continue the successful management of the adult dental benefit. An example of this partnership is the inclusion of dental health questions in health risk assessments. This allows care coordinators trained in dental benefits to assist with the coordination of care between dental and medical providers. Periodontal services generally require prior authorization; however, members with a chronic condition or who are pregnant are approved to use the emergency/extended benefit, if needed. In support of this effort toward a holistic approach to care, HHO plans to review the utilization of dental services for the diabetic population to determine opportunities for additional oral health initiatives.

During the 2022 EQR CAP review, one CAP item was identified. The CAP item was in relation to the DBM having only an internal guideline, but not a formalized process, to identify potential member care disruptions when a provider leaves the network so the DBM can notify the affected members. This CAP item has been resolved with HHO's submission of the DBM's formalized P&P documenting the process to conduct member outreach, advising them of provider terminations, and their options to engage with a new provider.

During the CAP review in 2023, Mercer found all required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provided evidence of compliance with regulatory or contractual provisions.

Regulation/Contract Standard Not Fully Compliant	2021 Review Scores	2022 Review Scores	2023 Review Scores	Findings	Recommendations
MCO has P&Ps to notify the State and members if a provider's contract is terminated. (3.9.18.3.2)	New Finding for 2022	Partially Met	Met	**2022 Finding:** The DBM has an internal guideline to identify potential member care disruptions so they can be notified but does not have a formal process.	**2022 Recommendation:** Develop or formalize a process to appropriately notify members of provider terminations.
				2023 Finding: During the CAP review in 2023, Mercer found that federal regulations and contract requirements were met in this area.	**2023 Recommendation:** None.

Section 4
Validation of Performance Measures

The Performance Measure (PM) review process included a review of the written desk policies and procedures (P&Ps) that are followed when the reports and measure scores are generated. As a cornerstone of the review, the assessment and applicability of the CMS protocol entitled “Validating Performance Measures” was completed. This protocol’s goal was to guide the assessment of compliance with identified specifications applicable to each PM. The measures reviewed for 2022 included a combination of CMS adult and pediatric core measures, as well as Quality and Care Management Measurement Report (QCMMR) measures. To assess compliance, some of the adult and pediatric core measures selected relied on the hybrid method to calculate the scores.

Compliance Findings

High Confidence	Moderate Confidence	Low Confidence	No Confidence
All required documentation is present, managed care organization (MCO) staff provides responses that are consistent with each other and with the documentation, or a State-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.	After a review of the documentation and discussion with MCO staff, it is determined that the MCO has met most of the requirements required for the Met category.	MCO staff describes and verifies the existence of compliant practices during the interview(s), but the required documentation is incomplete or inconsistent with practice.	After a review of the documentation and discussion with MCO staff, it is determined that although some requirements have been met, the MCO has not met most of the requirements.

ACDE Performance Measures Overall Assessment

Overall Assessment

ACDE has processes in place to generate standardized reports to fulfill contractual obligations. These processes differ between HEDIS reporting (a corporate shared service) and reports and measures generated for DMMA-specific regulatory reporting. For both types of reports, ACDE developed and depends on internal processes to assess data quality and integrity to ensure the required data are complete, accurate, and timely. The process of report development requires a collaborative effort by multiple internal teams such as regulatory, compliance, reporting, analytics, and management. These teams manage the reports and/or products that enhance the overall performance of the business and monitor adherence to the timelines of regulatory reporting. All reporting generated by

Regulatory Reporting is reviewed by analysts and the business owner as well as the COO, who provides final sign-off of the reports. The standard review process includes verifying that all requested data elements are provided, data are within the reporting period requested, and that all data fit the specific criteria requested. Where possible, reports are checked for reasonableness through benchmarking and/or trend analysis. When summary and detailed files are available (dependent on the type of report), the two are reconciled to each other.

ACDE (i.e., corporate through shared services) utilizes the NCQA-certified HEDIS software, Inovolon, for calculating all HEDIS PMs and non-HEDIS core measures. Monthly, ACDE loads HEDIS data into the HEDIS software for interim and, later, final reporting. The reports rely on the data from primary (ACDE and its vendors systems) and supplemental (health information exchange [HIE], electronic health record [EHR], etc.) sources and include, but are not limited to, medical claims, pharmacy claims, lab results, dental claims, vision claims, and medical records. The data used for reporting are extracted from the ACDE data warehouse.

The EQRO has a high level of confidence in the validity of the PMs generated using NCQA-certified HEDIS software.

The Regulatory Reporting Department follows a multi-step process for each report completed within the unit. The assigned associate develops the report following the P&P specific to the report and the business owner (director/manager) assists in addressing issues identified during the development phase. During this review, the report is checked for accuracy and reasonableness of the data. As appropriate, a report may be reviewed with other internal departments. ACDE developed a robust process of data governance focused on data quality and integrity as well as established an internal team tasked with annual review of the reports to ensure continued compliance with the specifications and applicable changes based on the Current Procedural Terminology (CPT) codes, provider taxonomies, and other health care nomenclature.

Overall Results

PM	Confidence in Reported Results
PM 1: Number of Medicaid members with diabetes who received an oral exam (D0150, D0120, D0180)	High Confidence
PM 2: 30-day Hospital Readmission Rate (QPM)	High Confidence
PM 3: Controlling High Blood Pressure	High Confidence
PM 4: Comprehensive Diabetes (Control <8.0%)	High Confidence
PM 5: Childhood Immunization Status CIS-CH	High Confidence
PM 6: Risk of Continued Opioid Use (COU)	High Confidence

Number of Medicaid Members with Diabetes who received an Oral Exam (D0150, D0120, D0180)

1. Overview of PM

MCP Name: AmeriHealth Caritas Delaware

PM Name: PM 1: Number of Medicaid members with diabetes who received an oral exam (D0150, D0120, D0180)

Measure Steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☐ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☒ No measure steward, developed by State/EQRO
☐ Other measure steward (specify): _____

Is the PM part of an existing measure set? (check all that apply)
☐ HEDIS®
☐ CMS Child or Adult Core Set
☒ Other (specify): QCMMR and QCMMR Plus Reporting Requirements

What data source(s) was used to calculate the measure? (check all that apply)
☐ Administrative Data (describe):
☐ Medical Records (describe): _____
☒ Other (specify): Claims Data within Facets and the Enterprise Data Warehouse (EDWH). Facets is the business operating system for ACFC. EDWH is utilized to capture subcontractor claims data.

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not Applicable (hybrid method not used)

Definition of Denominator (describe):
Number of Medicaid members with a diabetes diagnosis.

Definition of Numerator (describe):
Number of Medicaid members with diabetes who received an oral exam (D0150, D0120, D0180).

Program(s) included in the measure: ☐ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☒ Medicaid and CHIP

Measurement Period (start/end date): January 2022–December 2022

2. PM Results (If measure contains more than one rate, add columns to the table)				
PM	**Rate 1**	**Rate 2**	**Rate 3**	**Rate 4**
Numerator	302	275	287	263
Denominator	16,895	17,257	17,431	17,781
Rate	2.0%	2.0%	2.0%	1.0%

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There are no deviations from the technical specifications.

Describe any findings from the Information Systems Capabilities Assessment (ISCA) or other information systems audit that affected the reliability or validity of the PM results.
☐ Not Applicable (ISCA not reviewed)
ISCA review did not identify any findings specific to this measure.

Describe any findings from the medical record review that affected the reliability or validity of the PM results.
☒ Not Applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
During the 2022 review, ACDE was not compliant with the QCMMR technical specifications and was not reporting the data accurately. ACDE did not select the full population expected for the denominator nor did it include the pharmacy data to identify the members with diabetes. During the year, ACDE corrected the issue, supplied the corrected code used to extract the data and confirmed that the measure was revised and is in accordance with the listed technical specifications.

Validation Rating: ☒ High Confidence ☐ Moderate Confidence ☐ Low Confidence ☐ No Confidence
"Validation Rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:
None.

30-day Hospital Readmission Rate (QPM)

1. Overview of PM

MCP Name: AmeriHealth Caritas Delaware

PM 2: 30-day Hospital Readmission Rate (QPM)

1. Overview of PM

Measure Steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☐ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☒ No measure steward, developed by State/EQRO
☐ Other measure steward (specify): _____

Is the PM part of an existing measure set? (check all that apply)
☐ HEDIS®
☐ CMS Child or Adult Core Set
☒ Other (specify): PM7.D_Readmission_Specification

What data source(s) was used to calculate the measure? (check all that apply)
☐ Administrative Data (describe):
☐ Medical Records (describe): _____
☒ Other (specify): IP claims data.

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not Applicable (hybrid method not used)

Definition of Denominator (describe):
The discreet count of admission events, regardless of diagnosis, age, sex, and/or “qualifying” facility type (IP only). The date of admission should be the primary variable used to identify an admission event. If an admission event occurred within the study period, regardless of whether the date of discharge was within the study period (calendar year), it should be counted within the Denominator.

Definition of Numerator (describe):
The readmission event must occur within 30 days of discharge from a prior Qualifying Admission Event.

Program(s) included in the measure: ☐ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☒ Medicaid and CHIP

Measurement Period (start/end date): January 2022–December 2022

2. PM Results (If measure contains more than one rate, add columns to the table)				
PM	**Rate 1**	**Rate 2**	**Rate 3**	**Rate 4**
Numerator	264	577	905	1,256
Denominator	2,583	5,265	7,948	10,920
Rate	10.2%	11.0%	11.4%	11.5%

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
BH providers using bill type code 11x code while the services provided are outpatient or residential treatment are excluded for both numerator and denominator.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
☐ Not Applicable (ISCA not reviewed)
ISCA review did not identify any findings specific to this measure.

Describe any findings from the medical record review that affected the reliability or validity of the PM results.
☒ Not Applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
N/A

Validation Rating: ☒ High Confidence ☐ Moderate Confidence ☐ Low Confidence ☐ No Confidence
"Validation Rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:
None.

Controlling High Blood Pressure

1. Overview of PM

MCP Name: AmeriHealth Caritas Delaware

PM Name: PM 3: Controlling High Blood Pressure

1. Overview of PM

Measure Steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify): _____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS®
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative Data (describe): Facets claims (Core Claims Processing) and PerformRx claims (Pharmacy).
☒ Medical Records (describe): MRR was conducted, as this measure is reported via the hybrid method to find the percentage of members 18–85 years old who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the MY.
☒ Other (specify): Supplemental Data, including DHIN, JIVA, CCHS, United Medical, Athena and UHC.

If the hybrid method was used, describe the sampling approach used to select the medical records:

Systematic sampling was performed per the NCQA HEDIS MY2022 Volume 2 Technical Specifications for Health Plans, Controlling High Blood Pressure (CBP) measure.

☐ Not Applicable (hybrid method not used)

Definition of Denominator (describe):

The denominator was identified per the NCQA HEDIS MY2022 Volume 2 Technical Specifications for Health Plans, CBP measure.

High level: Members between 18–85 as of December 31, 2022, with two visits on different dates of service with a diagnosis of hypertension between January 1, 2021 and June 30, 2022.

Definition of Numerator (describe):

The numerator was identified per the NCQA HEDIS MY2022 Volume 2 Technical Specifications for Health Plans, CBP measure.

High level: Identify the most recent blood pressure taken during the measurement year which excludes blood pressures from an acute IP setting and the ED. The blood pressure must be after the second diagnosis of hypertension. Adequate control is the goal of the measure.

Program(s) included in the measure: ☒ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☐ Medicaid and CHIP

Measurement Period (start/end date): January 1, 2022–December 31, 2022

2. PM Results (If measure contains more than one rate, add columns to the table)	
PM	**Rate 1**
Numerator	248
Denominator	411
Rate	60.34%

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There were no deviations from the NCQA HEDIS MY2022 Volume 2 Technical Specifications for Health Plans, CBP measure.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
☐ Not Applicable (ISCA not reviewed)
ISCA review did not identify any findings specific to this measure.

Describe any findings from the medical record review that affected the reliability or validity of the PM results.
☒ Not Applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
N/A

Validation Rating: ☒ High Confidence ☐ Moderate Confidence ☐ Low Confidence ☐ No Confidence
"Validation Rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:
None.

Comprehensive Diabetes (Control <8.0%)

1. Overview of PM

MCP Name: AmeriHealth Caritas Delaware

PM Name: PM 4: Comprehensive Diabetes (Control <8.0%)

1. Overview of PM

Measure Steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify): _____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS®
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative Data (describe): FACETS claims (Core Claims Processing) and PerformRx claims (Pharmacy).
☒ Medical Records (describe): MRR was conducted, as this measure is reported via the hybrid method to find the percentage of members 18–75 years old who had a diagnosis of diabetes and whose A1c was adequately controlled, < 8.0%) during the MY.
☒ Other (specify): Supplemental Data, including Labcorp, i2i, Delaware Health Information Network (DHIN), Jiva, Christiana Care Health System (CCHS), United Medical, and Athena.

If the hybrid method was used, describe the sampling approach used to select the medical records:

Systematic sampling was performed per the NCQA HEDIS MY2022 Volume 2 Technical Specifications for Health Plans, Hemoglobin A1c Control for Patients with Diabetes (HBD) measure.

☐ Not Applicable (hybrid method not used)

Definition of Denominator (describe):

The denominator was identified per the NCQA HEDIS MY2022 Volume 2 Technical Specifications for Health Plans, HBD measure.

High level: Members between 18–75 as of December 31, 2022, who were diagnosed with diabetes in the MY or year prior, or who were dispensed insulin or hypoglycemic/antihyperglycemics during the MY or the prior year.

Definition of Numerator (describe):

The numerator was identified per the NCQA HEDIS MY2022 Volume 2 Technical Specifications for Health Plans, HBD measure.

High level: Identify the most recent A1c taken during the measurement year.

Program(s) included in the measure: ☒ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☐ Medicaid and CHIP

Measurement Period (start/end date): January 1, 2022–December 31, 2022

2. PM Results (If measure contains more than one rate, add columns to the table)	
PM	**CBP (Total) Rate 1**
Numerator	196
Denominator	411
Rate	47.69%

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There were no deviations from the NCQA HEDIS MY2022 Volume 2 Technical Specifications for Health Plans, HBD measure.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
☐ Not Applicable (ISCA not reviewed)
ISCA review did not identify any findings specific to this measure.

Describe any findings from the medical record review that affected the reliability or validity of the PM results.
☒ Not Applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
N/A

Validation Rating: ☒ High Confidence ☐ Moderate Confidence ☐ Low Confidence ☐ No Confidence
"Validation Rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:
None.

Childhood Immunization Status CIS-CH

1. Overview of PM

MCP Name: AmeriHealth Caritas Delaware

PM Name: PM 5: Childhood Immunization Status CIS-CH

1. Overview of PM

Measure Steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify): _____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS®
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative Data (describe): Facets claims (Core Claims Processing.
☒ Medical Records (describe): MRR was conducted, as this measure is reported via the hybrid method to find the percentage of two-year-old members who were vaccinated for diphtheria, tetanus, pertussis (DTaP), polio (IPV), measles, mumps, and rubella (MMR), Haemophilus influenzae type b (HiB), hepatitis B (HepB), Varicella Zoster Virus (VZV), pneumococcal conjugate vaccine (PCV), hepatitis A (HepA), rotavirus vaccine (RV), and flu by their second birthday.
☒ Other (specify): Supplemental Data, including DHIN, Athena, and i2i.

If the hybrid method was used, describe the sampling approach used to select the medical records:
Systematic sampling was performed per the NCQA HEDIS MY2022 Volume 2 Technical Specifications for Health Plans, Childhood Immunizations (CIS) measure.
☐ Not Applicable (hybrid method not used)

Definition of Denominator (describe):
The denominator was identified per the NCQA HEDIS MY2022 Volume 2 Technical Specifications for Health Plans, CIS.
High Level: Members who are two years old in the MY.

Definition of Numerator (describe):
The numerator was identified per the NCQA HEDIS MY2022 Volume 2 Technical Specifications for Health Plans, CIS measure.
High level: Identify the vaccines given within the time frame during the MY.

Program(s) included in the measure: ☐ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☒ Medicaid and CHIP

Measurement Period (start/end date): January 1, 2022–December 31, 2022

2. PM Results (If measure contains more than one rate, add columns to the table)													
PM	**DTaP**	**IPV**	**MMR**	**HiB**	**HepB**	**VZV**	**PCV**	**HepA**	**RV**	**Flu**	**Combo 3**	**Combo 7**	**Combo 10**
Numerator	316	374	366	368	372	367	321	356	308	182	295	260	150
Denominator	411	411	411	411	411	411	411	411	411	411	411	411	411
Rate	76.89%	91.00%	89.05%	89.54%	90.51%	89.29%	78.10%	86.62%	74.94%	44.28%	71.78%	63.26%	36.50%

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There were no deviations from the NCQA HEDIS MY2022 Volume 2 Technical Specifications for Health Plans, CIS measure.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
☐ Not Applicable (ISCA not reviewed)
ISCA review did not identify any findings specific to this measure.

Describe any findings from the medical record review that affected the reliability or validity of the PM results.
☒ Not Applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
N/A

Validation Rating: ☒ High Confidence ☐ Moderate Confidence ☐ Low Confidence ☐ No Confidence
"Validation Rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:
None.

Risk of Continued Opioid Use (COU)

1. Overview of PM

MCP Name: AmeriHealth Caritas Delaware

PM Name: PM 6: Risk of Continued Opioid Use (COU)

1. Overview of PM

Measure Steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify): _____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS®
☐ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative Data (describe): FACETS claims (Core Claims Processing) and PerformRx claims (Pharmacy).
☐ Medical Records (describe): _____
☐ Other (specify): No data sources have yet been used. CMS Adult Core Set Specifications were not released until April 2022. Preliminary rates (with an indication of sources used) will not be available until August 2022, and final audited rates until November 2022.

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not Applicable (hybrid method not used)

Definition of Denominator (describe):
The denominator was identified per the NCQA HEDIS MY2022 Volume 2 Technical Specifications for Health Plans, Risk of COU
High level: Members 18 and older who have a new episode of opioid use from November 1, 2021–October 31, 2022.

Definition of Numerator (describe):
The numerator was identified per the NCQA HEDIS MY2022 Volume 2 Technical Specifications for Health Plans, Risk of COU measure.
High level: Identify the opioid medication dispensing events within the time frame.

Program(s) included in the measure: ☒ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☐ Medicaid and CHIP

Measurement Period (start/end date): November 1, 2021–October 31, 2022

2. PM Results (If measure contains more than one rate, add columns to the table)						
PM	**Aged 18–64 have >= 15 days coverage**	**Aged 18–64 have >= 31 days coverage**	**Aged 65 & older have >= 15 day coverage**	**Aged 65 & Older have >= 31 day coverage**	**Total Members have >= 15 days coverage**	**Total Members have >31 days coverage**
Numerator	321	241	1	0	322	4,110
Denominator	4,101	4,101	9	9	4,110	241
Rate	7.83%	5.88%	11.11%	0.00%	7.83%	5.86%

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There were no deviations from the NCQA HEDIS MY2022 Volume 2 Technical Specifications for Health Plans, Risk of COU measure.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
☐ Not applicable (ISCA not reviewed)
ISCA Review did not identify any findings specific to this measure.

Describe any findings from the medical record review that affected the reliability or validity of the PM results.
☒ Not Applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

Validation Rating: ☒ High Confidence ☐ Moderate Confidence ☐ Low Confidence ☐ No Confidence
"Validation Rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation:
None.

HHO Performance Measures Overall Assessment

Overall Assessment

HHO has processes in place to generate standardized reports to fulfill contractual obligations. These processes differ between HEDIS reporting (a corporate shared service) and reports and measures generated for DMMA-specific regulatory reporting. For both types of reports, HHO developed and depends on internal processes to assess data quality and integrity to ensure the required data are

complete, accurate, and timely. The process of report development requires a collaborative effort by multiple internal teams such as regulatory, compliance, reporting, analytics, and management. These teams manage the reports and/or products that enhance the overall performance of the business and monitor adherence to the timelines of regulatory reporting. All reporting generated by the Regulatory Reporting department is reviewed by analysts and the business owner as well as the Chief Operations Officer, who provides final sign-off for the reports. The standard review process includes verifying that all requested data elements are provided, data are within the reporting period requested, and that all data fit the specific criteria requested. Where possible, reports are checked for reasonableness through benchmarking and/or trend analysis. When summary and detailed files are available (dependent on the type of report), the two are reconciled to each other.

HHO (i.e., corporate through shared services) utilizes the NCQA-certified HEDIS software, Inovolon, for calculating all HEDIS PMs and non-HEDIS core measures. Monthly, HHO loads HEDIS data into the HEDIS software for interim, and later, final reporting. The reports rely on data from the primary (HHO and its vendor's systems) and supplemental (Health Information Exchange, Electronic Health Records, etc.) sources and include, but are not limited to, medical claims, pharmacy claims, lab results, dental claims, vision claims, and medical records. The data used for reporting are extracted from the HHO data warehouse. For HEDIS MY2022, HHO continued to contract with PalmQuest for medical record review services.

The EQRO has a high level of confidence in the validity of the PMs generated using NCQA-certified HEDIS software.

The Regulatory Reporting Department follows a multi-step process for each report completed within the unit. The assigned associate develops the report following the P&P specific to the report; the business owner (Director/Manager) assists in addressing issues identified during the development phase. A review session is then held within the department to review in detail a final draft of the report. During this review, the report is checked for accuracy and reasonableness of the data. As appropriate, a report may be reviewed with other internal departments. For consistency, each data element used in reporting should have clear definitions, acceptable value domains, a clear owner, and a defined purpose and use. Additionally, on a regular basis (e.g., annually) all reports and data elements should be reviewed to ensure no changes are required to the report, such as adding new Current Procedural Terminology codes, provider taxonomies, and other health care nomenclature. Moreover, the review of the reports and data elements would allow HHO to determine if any updates based on system changes (i.e., upgrades and enhancements) necessitate report modifications.

During the review, it was identified that data used in a DMMA standard report was incomplete for the second year in a row. Although HHO addressed the finding from the 2022 ISCA review for a specific measure, the new measure selected for this year's review did not adhere to the stated specifications. This calls into question the regulatory review process detailed in the P&Ps, particularly around the review of results by the business owner. HHO presented and spoke of a robust process to create reports; however, critical elements of quality assurance should be enhanced. Although the process overall for developing the reports appears comprehensive, including layers of approval, it was evident that even when issues are identified they are not fixed and the need for remediation is not shared with DMMA. HHO stated that in September 2022, a discrepancy in how the data were extracted and reported compared to the

DMMA specifications was identified. However, there was no communication with DMMA and when reporting the measure this year, HHO stated that there were no variances between the measure specifications and data extraction and reporting even when HHO was aware of the issue for several months.

Mercer recommends that HHO develop a process to validate the manual entry of data before reports are submitted for approval, as well as enhance the process of code review for data extraction to be used in the regulatory reports. This process should include HHO review and approval of any code received from other entities.

PM	Confidence in Reported Results
PM 1: Number of Medicaid members with diabetes who received an oral exam (D0150, D0120, D0180)	High Confidence
PM 2: 30-day Hospital Readmission Rate	No Confidence
PM 3: Controlling High Blood Pressure	High Confidence
PM 4: Comprehensive Diabetes (Control <8.0%)	High Confidence
PM 5: Childhood Immunization Status (CIS-CH)	High Confidence
PM 6: Risk of Continued Opioid Use (COU)	High Confidence

Number of Medicaid Members with Diabetes who Received an Oral Exam (D0150, D0120, D0180)

1. Overview of PM
MCP Name: Highmark Health Options
PM Name: PM 1: Number of Medicaid members with diabetes who received an oral exam (D0150, D0120, D0180)
Measure Steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☐ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☒ No measure steward, developed by State/EQRO ☐ Other measure steward (specify): _____

1. Overview of PM

Is the PM part of an existing measure set? (check all that apply)

☐ HEDIS®
☐ CMS Child or Adult Core Set
☒ Other (specify): QCMMR and QCMMR Plus Reporting Requirements

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative Data (describe): Claims data.
☐ Medical Records (describe): _____
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not Applicable (hybrid method not used)

Definition of Denominator (describe):

Unduplicated number of Medicaid members with diabetes.

Definition of Numerator (describe):

Unduplicated number of Medicaid members with diabetes who received a comprehensive (D0150) or periodic oral evaluation (D0120), or comprehensive period members with diabetes who received a comprehensive (D0150) or periodic oral evaluation (D0120), or a comprehensive periodontal evaluation (D0180).

Program(s) included in the measure: ☐ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☒ Medicaid and CHIP

Measurement Period (start/end date): January 1, 2022–December 31, 2022

2. PM Results (If measure contains more than one rate, add columns to the table)

PM	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022
Numerator	73	78	81	93	99	82	66	97	85	103	163	122
Denominator	5,979	5,972	5,931	6,352	6,344	6,306	6,658	6,629	6,590	6,828	9,672	9,644
Rate	1.22%	1.31%	1.37%	1.46%	1.56%	1.30%	0.99%	1.46%	1.29%	1.51%	1.69%	1.27%

3. PM Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). There are no deviations from the report specifications outlined in the 2022 QCMMR Reporting Guide.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. ☐ Not Applicable (ISCA not reviewed) ISCA review did not identify any findings specific to this measure.
Describe any findings from the medical record review that affected the reliability or validity of the PM results. ☒ Not Applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the PM calculation. During the 2022 review, HHO was not compliant with the QCMMR technical specifications and was not reporting the data accurately. During the year, HHO corrected the issue, supplied the corrected code used to extract the data, and confirmed that the measure is revised and is in accordance with the listed technical specifications. The measure is valid and there are no findings or recommendations requiring a corrective action plan.
Validation Rating: ☒ High Confidence ☐ Moderate Confidence ☐ Low Confidence ☐ No Confidence "Validation Rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.
EQRO recommendations for improvement of PM calculation: None.

30-Day Hospital Readmission Rate

1. Overview of PM
MCP Name: Highmark Health Options
PM Name: 30-day Hospital Readmission Rate
Measure Steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☐ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☒ No measure steward, developed by State/EQRO ☐ Other measure steward (specify): _____

1. Overview of PM

Is the PM part of an existing measure set? (check all that apply)

☐ HEDIS®
☐ CMS Child or Adult Core Set
☒ Other (specify): Not part of measure set rather chosen as a QPM for MY2022.

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative Data (describe): Claims-based.
☐ Medical Records (describe): _____
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not Applicable (hybrid method not used)

Definition of Denominator (describe):

The discreet count of admission events, regardless of diagnosis, age, sex, and/or "qualifying" facility type. The date of admission should be the primary variable used to identify an admission event. If an admission event occurred within the study period, regardless of whether the date of discharge was within the study period (calendar year), it should be counted within the Denominator.

Definition of Numerator (describe):

Readmission event occurring within 30 days of discharge from a Qualifying Admission Event.

Program(s) included in the measure: ☐ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☒ Medicaid and CHIP

Measurement Period (start/end date): January 1, 2022–December 31, 2022

2. PM Results (If measure contains more than one rate, add columns to the table)

PM	30-Day Readmission Rate 1
Numerator	3,162
Denominator	19,190
Rate	16.48%

3. PM Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). There are no deviations from the report specifications outlined in the QPM specifications.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. ☐ Not Applicable (ISCA not reviewed) ISCA review did not identify any findings specific to this measure.
Describe any findings from the medical record review that affected the reliability or validity of the PM results. ☒ Not Applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the PM calculation. HHO was not compliant with the technical specifications and is reporting the data inaccurately. The specifications list specific codes used to identify patient status codes for the qualifying admission event. HHO did not adhere to the specifications and included codes that were not listed and excluded codes that were listed in the specifications.
Validation Rating: ☐ High Confidence ☐ Moderate Confidence ☐ Low Confidence ☒ No Confidence "Validation Rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.
EQRO recommendations for improvement of PM calculation: Correct the measure source code to include the correct patient status codes for the qualifying admission event per the technical specifications.

Controlling High Blood Pressure

1. Overview of PM
MCP Name: Highmark Health Options
PM Name: PM 3: Controlling High Blood Pressure
Measure Steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by State/EQRO ☐ Other measure steward (specify): _____

1. Overview of PM

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS®
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative Data (describe): Claims data
☒ Medical Records (describe): HEDIS hybrid data medical record review campaign.
☒ Other (specify): Provider EMR data files.

If the hybrid method was used, describe the sampling approach used to select the medical records:

Sampling-based on HEDIS MY 2022 Specifications
☐ Not Applicable (hybrid method not used)

Definition of Denominator (describe):

Members 18–85 years of age who had a diagnosis of hypertension. Other elements of denominator compliance are in accordance with HEDIS MY2022 Specifications.

Definition of Numerator (describe):

The member is numerator compliant if the blood pressure (BP) is <140/90 mm Hg. Other elements of numerator compliance are in accordance with HEDIS MY2022 Specifications.

Program(s) included in the measure: ☒ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☐ Medicaid and CHIP

Measurement Period (start/end date): January 1, 2022–December 31, 2022

2. PM Results (If measure contains more than one rate, add columns to the table)

PM	BP <140/90 mm Hg Rate 1
Numerator	275
Denominator	411
Rate	66.91%

3. PM Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). There were no deviations from the technical specifications.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. ☐ Not Applicable (ISCA not reviewed) ISCA review did not identify any findings specific to this measure.
Describe any findings from the medical record review that affected the reliability or validity of the PM results. ☒ Not Applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the PM calculation. N/A
Validation Rating: ☒ High Confidence ☐ Moderate Confidence ☐ Low Confidence ☐ No Confidence "Validation Rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.
EQRO recommendations for improvement of PM calculation: None.

Hemoglobin A1c Control for Patients with Diabetes; HbA1c Control (<8.0%)

1. Overview of PM
MCP Name: Highmark Health Options
PM Name: PM 4: Hemoglobin A1c Control for Patients With Diabetes; HbA1c Control (<8.0%)
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by State/EQRO ☐ Other measure steward (specify): _____
Is the PM part of an existing measure set? (check all that apply) ☒ HEDIS® ☐ CMS Child or Adult Core Set ☐ Other (specify):

1. Overview of PM

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative Data (describe): Claims data.
☒ Medical Records (describe): HEDIS hybrid data medical record review campaign.
☒ Other (specify): Provider EMR data files and vendor data file.

If the hybrid method was used, describe the sampling approach used to select the medical records:

Sampling-based on HEDIS MY2022 Specifications.
☐ Not Applicable (hybrid method not used)

Definition of Denominator (describe):

Members 18–75 years of age with type 1 or type 2 diabetes. Other elements of denominator compliance are in accordance with HEDIS MY2022 Specifications.

Definition of Numerator (describe):

Member with a most recent HbA1c level of <8.0%. Other elements of numerator compliance are in accordance with HEDIS MY2022 Specifications.

Program(s) included in the measure: ☒ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☐ Medicaid and CHIP

Measurement Period (start/end date): January 1, 2022–December 31, 2022

2. PM Results (If measure contains more than one rate, add columns to the table)

PM	HbA1c (Control <8.0%) Rate 1
Numerator	241
Denominator	411
Rate	58.64%

3. PM Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). There were no deviations from the technical specifications.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. ☐ Not applicable (ISCA not reviewed) ISCA review did not identify any findings specific to this measure.
Describe any findings from the medical record review that affected the reliability or validity of the PM results. ☒ Not Applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the PM calculation. N/A
Validation Rating: ☒ High Confidence ☐ Moderate Confidence ☐ Low Confidence ☐ No Confidence "Validation Rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.
EQRO recommendations for improvement of PM calculation: None.

Childhood Immunization Status

1. Overview of PM
MCP Name: Highmark Health Options
PM Name: PM 5: Childhood Immunization Status CIS-CH
Measure Steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by State/EQRO ☐ Other measure steward (specify): _____
Is the PM part of an existing measure set? (check all that apply) ☒ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify):

1. Overview of PM

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative Data (describe): Claims data.
☒ Medical Records (describe): HEDIS hybrid data medical record review campaign.
☒ Other (specify): Provider EMR data files and DelVax data files.

If the hybrid method was used, describe the sampling approach used to select the medical records:

Sampling-based on HEDIS MY2020 and MY2021 Specifications.
☐ Not Applicable (hybrid method not used)

Definition of Denominator (describe):

Children who turn two years of age during the MY. Other elements of denominator compliance are in accordance with HEDIS MY2022 Specifications.

Definition of Numerator (describe):

Any of the CIS-specified vaccinations given on or before the child's second birthday meet numerator criteria for that vaccination. Other elements of numerator compliance are in accordance with HEDIS MY2022 Specifications.

Program(s) included in the measure: ☐ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☒ Medicaid and CHIP

Measurement Period (start/end date): January 1, 2022–December 31, 2022

2. PM Results (If measure contains more than one rate, add columns to the table)

PM	DTaP Rate 1	IPV Rate 2	MMR Rate 3	HiB Rate 4
Numerator	319	379	369	375
Denominator	411	411	411	411
Rate	77.62%	92.21%	89.78%	91.24%

PM	Hepatitis B Rate 1	VZV Rate 2	Pneumococcal Conjugate Rate 3	Hepatitis A Rate 4
Numerator	382	369	323	358
Denominator	411	411	411	411
Rate	92.94%	89.78%	78.59%	87.10%

PM	Rotavirus Rate 1	Influenza Rate 2	Combo 3 Rate 3	Combo 7 Rate 4	Combo 10 Rate 13
Numerator	321	206	306	275	168
Denominator	411	411	411	411	411
Rate	78.10%	50.12%	74.45%	66.91%	40.88%

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
☐ Not Applicable (ISCA not reviewed)
ISCA review did not identify any findings specific to this measure.

Describe any findings from the medical record review that affected the reliability or validity of the PM results.
☒ Not Applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
N/A

Validation Rating: ☒ High Confidence ☐ Moderate Confidence ☐ Low Confidence ☐ No Confidence
"Validation Rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Risk of Continued Opioid Use (COU)

1. Overview of PM

MCP Name: Highmark Health Options

PM Name: Risk of Continued Opioid Use (COU)

1. Overview of PM

Measure Steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify): _____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS®
☐ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative Data (describe): Claims data.
☐ Medical Records (describe): _____
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not Applicable (hybrid method not used)

Definition of Denominator (describe):
Members 18 years of age and older who have a new episode of opioid use. Other elements of denominator compliance are in accordance with HEDIS MY2022 Specifications.

Definition of Numerator (describe):
Members dispensed an opioid medication from the list provided in technical specifications for either: 15 days dispensed in a 30-day period -OR- 31 days dispensed in a 62-day period. Other elements of numerator compliance are in accordance with HEDIS MY2022 Specifications.

Program(s) included in the measure: ☒ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☐ Medicaid and CHIP

Measurement Period (start/end date): November 1, 2021–October 31, 2022

2. PM Results (If measure contains more than one rate, add columns to the table)		
PM	**15 Days of Prescription in 30-Day Period Rate 1**	**31 Days of Prescription in 62-Day Period Rate 2**
Numerator	355	240
Denominator	5,536	5,536
Rate	6.41%	4.34%

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
☐ Not Applicable (ISCA not reviewed)
ISCA review did not identify any findings specific to this measure.

Describe any findings from the medical record review that affected the reliability or validity of the PM results.
☒ Not Applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
N/A

Validation Rating: ☒ High Confidence ☐ Moderate Confidence ☐ Low Confidence ☐ No Confidence
"Validation Rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Section 5

Validation of Performance Improvement Projects

PIPs are required by CMS as an essential component of an MCO's Quality program and are used to identify, assess, and monitor improvement in processes or outcomes of care. DMMA has mandated that each MCO conduct a minimum of five PIPs; the PIP topics must cover the following:

- Oral health of the LTSS population (this PIP is prescriptive in nature) (retired by DMMA on February 2, 2021).
- Behavioral Health (BH) and Physical Health (PH) Integration.
- Pediatric Population.
- LTSS Population.
- Non-Clinical or Service-Related.

Confidence in Reported Results			
High	**Moderate**	**Low**	**No Confidence**
Fully compliant with standard protocol.	Substantially validated and only minor deviations from standard protocol.	Deviated from a protocol such that the reported results are questionable.	Deviated from a protocol such that reported results are not validated.

ACDE Performance Improvement Project Overall Assessment

Of the five required PIPs, the State required the EQRO to validate three PIPs during the 2023 compliance review cycle. The first required PIP allows for a topic selected by the individual MCO that is relevant to its population and approved by DMMA. ACDE's selected topic focused on the impact of provider education on clinical practice guidelines for attention deficit hyperactivity disorder (ADHD) and member compliance with medication and outpatient (OP) therapy. The second PIP was a State-mandated topic but MCO developed study questions (BH and PH integration). The third PIP allows for a topic selected by the individual MCO that is non-clinical or service-related and approved by DMMA. ACDE's selected topic focused on the impact of targeted education of ACDE member-facing staff on the ACDE Wellness Program Referral Process to increase the number of member referrals.

The PIPs and the specifications to be applied included:

- ADHD clinical practice guidelines, medication, and therapy — MCO-developed specifications.
- Muscle relaxers and opioids concomitant use — MCO-developed specifications.
- Wellness program — MCO-developed specifications.

Overall Results

The State required the EQRO to validate three PIPs during the 2023 compliance review cycle. ACDE has met the requirements for PIPs based on the Delaware Quality Strategy and the EQRO has a high level of confidence in the reported results for all three validated PIPs. However, as an essential component of an MCO's quality program to identify, assess, and monitor improvement in processes or outcomes of care, ACDE should assess opportunities across the spectrum of the organization and business units to identify and implement PIPs. Including PIP topics that have an impact on a larger population and are active in driving improvement would accomplish this goal.

PIP	Confidence in Reported Results
PIP 1: ADHD clinical practice guidelines, medication, and therapy	High Confidence
PIP 2: Muscle relaxers and opioids concomitant use	High Confidence
PIP 3: Wellness Program	High Confidence

ADHD Clinical Practice Guidelines, Medication, and Therapy

1. General PIP Information
Managed Care Plan (MCP) Name: AmeriHealth Caritas Delaware
PIP Title: Increase in compliance with the American Academy of Pediatrics Clinical Practice Guidelines for ADHD
PIP Aim Statement: Will Pediatric PCPs, Nurse Practitioners, Psychologists, Psychiatrists, Licensed Professional Counselors and LCSWs, and Neurologists educated on the American Academy of Pediatrics (AAP's) Clinical Practice Guidelines for ADHD increase member compliance to both stimulant medication and OP BH therapy at least once every four weeks in the six to 12 years old population of AmeriHealth Caritas membership?
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) ☐ State-Mandated (State-required plans to conduct a PIP on this specific topic.) ☐ Collaborative (Plans worked together during the planning or implementation phases.) ☐ Statewide (The PIP was conducted by all MCOs and/or PIHPs within the State.) ☒ Plan Choice (State allowed the plan to identify the PIP topic.)

1. General PIP Information

Target age group (check one):
☒ Children Only (ages 0–17)* ☐ Adults Only (age 18 and over) ☐ Both Adults and Children
***If PIP uses a different age threshold for children, specify the age range here**: Children 6–12 years of age

Target population description, such as duals, LTSS, or pregnant women (please specify):
N/A

Programs: ☐ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- This is a provider-focused PIP. There were no member interventions for this PIP in 2022.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- Quarter 1 2022:
  - None.
- Quarter 2 2022:
  - The decision was made not to distribute the Lead 1 provider education mailer for calendar year 2022. Provider educational letters were sent yearly for the three previous years: 2019, 2020, and 2021.
- Quarter 3 2022:
  - The decision was made not to distribute the Lead 2 prescriber education mailer for calendar year 2022. Prescriber educational letters were sent in June 2021.
- Quarter 4 2022:
  - None.

2. Improvement Strategies or Interventions (Changes tested in the PIP)

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

- Quarter 1 2022:
  - None.
- Quarter 2 2022:
  - None.
- Quarter 3 2022:
  - Completed analysis of Telehealth visits for impact of Telehealth since the COVID-19 pandemic.
  - Updated statistical significance from <0.000 to <0.0001 for more accurate reporting.
- Quarter 4 2022:
  - None.

3. PMs and Results (Add rows as necessary)

PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Lag 1: Percentage of members diagnosed with ADHD ages six to 12 years old that did **not** receive OP BH therapy at least once every four weeks and were **not** prescribed stimulants within 45 days after seeing an ACDE contracted PCPs, Nurse Practitioners, Psychiatrists, Neuropsychiatrists, Psychologists, Neuropsychologists, Licensed Professional Counselors, Social Workers, or Neurologists who was educated about AAP's Clinical Practice Guidelines for ADHD.	2018	Sample Size: 756 Rate: 27.8%	2022	Sample Size: 1,279 Rate: 24.6%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.1076

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lag 2: Percentage of members diagnosed with ADHD ages six to 12 years old that **did** receive OP BH therapy at least once every four weeks and **were** prescribed stimulants within 45 days after seeing an ACDE contracted PCPs, Nurse Practitioners, Psychiatrists, Neuropsychiatrists, Psychologists, Neuropsychologists, Licensed Professional Counselors, Social Workers, or Neurologists that was educated about the importance of the AAP's Clinical Practice Guidelines for ADHD.	2018	Sample Size: 756 Rate: 16.7%	2022	Sample Size: 1,279 Rate: 26.7%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 3: Percentage of members diagnosed with ADHD aged six to 12 years old that did **not** receive OP BH therapy at least once every four weeks and **were** prescribed stimulants within 45 days after seeing an ACDE contracted PCPs, Nurse Practitioners, Psychiatrists, Neuropsychiatrists, Psychologists, Neuropsychologists, Licensed Professional Counselors, Social Workers, or Neurologists educated about the importance of the AAP's Clinical Practice Guidelines for ADHD.	2018	Sample Size: 756 Rate: 46.4%	2022	Sample Size: 1,279 Rate: 19.1%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lag 4: Percentage of members diagnosed with ADHD aged six to 12 years old that **did** receive OP BH therapy at least once every four weeks and were **not** prescribed stimulants within 45 days after seeing an ACDE contracted PCPs, Nurse Practitioners, Psychiatrists, Neuropsychiatrists, Psychologists, Neuropsychologists, Licensed Professional Counselors, Social Workers, or Neurologists educated about the importance of the AAP's Clinical Practice Guidelines for ADHD.	2018	Sample Size: 756 Rate: 9.1%	2022	Sample Size: 1,290 Rate: 29.7%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 5: Percentage of members who had a PCP, Nurse Practitioner, Psychiatrist, Neuropsychiatrist, Psychologist, Neuropsychologist, Licensed Professional Counselor, Social Worker, or Neurologist **second** provider follow-up visit within 30 days from initial diagnosis of ADHD.	2020	Sample Size: 141 Rate: 14.2%	2022	Sample Size: 59 Rate: 20.3%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.2789

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lag 6: Percentage of members who had a PCP, Nurse Practitioner, Psychiatrist, Neuropsychiatrist, Psychologist, Neuropsychologist, Licensed Professional Counselor, Social Worker, or Neurologist provider two follow-up visits (a **second and third visit**) in 30 days and 60 days from initial diagnosis of ADHD.	2020	Sample Size: 141 Rate: 16.3%	2022	Sample Size: 59 Rate: 5.1%	☐ Yes ☒ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
Lag 7: Percentage of members who had a PCP, Nurse Practitioner, Psychiatrist, Neuropsychiatrist, or Neurologist **prescribing provider** follow-up visit (**at least one**) within 30 days from filling a new prescription for a stimulant. A new prescription is defined as never having been prescribed stimulants previously or a gap of 12 months (365 days) since a prescription for a stimulant was filled. For multiple-provider practices, the prescribing provider is defined as the prescriber or another provider from the same practice.	Quarter 1 2021	Sample Size: 13 Rate: 38.5%	2022	Sample Size: 46 Rate: 21.7%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.2215

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lag 8: Percentage of members who had a **second** PCP, Nurse Practitioner, Psychiatrist, Neuropsychiatrist, or Neurologist **prescribing provider** follow-up visit between 31 to 90 days from filling a new prescription for a stimulant. A new prescription is defined as never having been prescribed stimulants previously or a gap of 12 months (365 days) since a prescription for a stimulant was filled. For multiple-provider practices, the prescribing provider is defined as the prescriber **or** another provider from the **same** practice.	2021	Sample Size: 5 Rate: 0.0%	2022	Sample Size: 10 Rate: 10.0%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.4642

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP Submitted for Approval ☐ Planning Phase ☒ Implementation Phase ☐ Baseline Year

☐ First Re-Measurement ☐ Second Re-Measurement ☒ Other (specify):

In the previous year, Lead Measure 1 and 2 rates were reported. In calendar year 2022, there was no Re-Measurement reported for Lead Measures 1 and 2; therefore, only Lag Measure 1-8 rates were reported. **Validation Rating**: ☒ High Confidence ☐ Moderate Confidence ☐ Low Confidence ☐ No Confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP:

None.

Opioids and Muscle Relaxers Use

1. General PIP Information

MCP Name: AmeriHealth Caritas Delaware

PIP Title: Opioids and Muscle Relaxers Use

PIP Aim Statement: Does education of providers and members on the risks of opioids and muscle relaxers decrease the number of members receiving muscle relaxers and opiates concurrently and decrease ED visits?

Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)

☐ State-Mandated (State-required plans to conduct a PIP on this specific topic.)

☐ Collaborative (Plans worked together during the planning or implementation phases.)

☐ Statewide (The PIP was conducted by all MCOs and/or PIHPs within the State.)

☒ Plan Choice (State allowed the plan to identify the PIP topic.)

Target age group (check one):

☐ Children Only (ages 0–17)* ☐ Adults Only (age 18 and over) ☒ Both Adults and Children

***If PIP uses a different age threshold for children, specify the age range here**: N/A

1. General PIP Information

Target population description, such as duals, LTSS, or pregnant women (please specify):
Members whose pharmacy claims are processed through PerformRx identified via real time claims review of pharmacy data as receiving concurrent opioid and muscle relaxer therapy. For calendar year 2022, Lag Measures 1 and 2 were based on members identified via pharmacy claims data Quarter 3 2021.

Programs: ☐ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- Quarter 4 2022:
  - Distributed a member education on chronic pain management and discussion of alternative therapy via the member newsletter.
  - The decision was made not to distribute a direct member mailing.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- Quarter 4 2022:
  - The decision was made not to distribute the provider mailings.

2. Improvement Strategies or Interventions (Changes tested in the PIP)

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

- Quarter 1 2022:
  - Reviewed data and outcomes for Lag Measures.
  - It was determined that members who were included in the 2020-member mailing that remained on concurrent therapy at the end of Quarter 4 2021 were medically appropriate as the member's prescribing provider did not change the treatment plan. These members will be removed from the Lag Measure data.
  - Data for 2022 will reflect outcomes for new 290 unique members who received the Quarter 4 2021 mailing.
- Quarter 2 2022:
  - Analysis of ED claims Quarter 1 2021 through Quarter 3 2021 to ensure capturing appropriate data. Analysis showed ED claims with opioid and SUD-related diagnosis codes which validated the technical specifications.
- Quarter 3 2022:
  - Analysis of provider prescribing 2020, 2021, 2022, and if prescribers are occurring on multiple mail lists and/or recurring years.
  - Identified a new member cohort of 239 new unique members receiving concurrent therapy. Hold on mailing until further review of provider prescribing patterns.
- Quarter 4 2022:
  - Continued analysis of provider prescribing patterns focusing on providers who were prescribing both opioids and muscle relaxers to the same members. The analysis included credentialing, practice area, and a number of members impacted. Special Investigations Unit completed a claims analysis for providers prescribing concurrent therapy to three or more individual members during the calendar year 2022.

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lag 1: Percentage of members in the member cohort who had prescriptions filled for muscle relaxers and opioid(s) following the education.	2020	Sample Size: 438 Rate: 100.00%	2022	Sample Size: 266 Rate: 37.3%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 2: Percentage of members in the member cohort who had ED visits.	2020	Sample Size: 438 Rate: 23.1%	2022	Sample Size: 266 Rate: 25.4%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP Submitted for Approval ☐ Planning Phase ☒ Implementation Phase ☐ Baseline Year

☐ First Re-Measurement ☒ Second Re-Measurement ☐ Other (specify):

In the previous year, Lead Measure 1-4 rates were reported. In calendar year 2022, there was no re-measurement reported for Lead Measures 1-4; therefore, only Lag Measure 1 and 2 rates were reported.

Validation Rating: ☒ High Confidence ☐ Moderate Confidence ☐ Low Confidence ☐ No Confidence

"Validation Rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP:

None.

Wellness Program

1. General PIP Information
MCP Name: AmeriHealth Caritas Delaware
PIP Title: Wellness Program
PIP Aim Statement: Increase the number of member referrals to Wellness programs through standardized education of ACDE member-facing staff on the ACDE Wellness Program Referral Process.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) ☐ State-Mandated (State-required plans to conduct a PIP on this specific topic.) ☐ Collaborative (Plans worked together during the planning or implementation phases.) ☐ Statewide (The PIP was conducted by all MCOs and/or prepaid inpatient health plans [PIHPs] within the State.) ☒ Plan Choice (State allowed the plan to identify the PIP topic.)
Target age group (check one): ☐ Children Only (ages 0–17)* ☐ Adults Only (age 18 and over) ☒ Both Adults and Children ***If PIP uses a different age threshold for children, specify the age range here**: N/A
Target population description, such as duals, LTSS, or pregnant women (please specify): DSHP, DSHP Plus, DSHP Plus DDDS, DSHP DDDS.
Programs: ☐ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

Quarter 1 2022:

- Developed Member Wellness Program Flyer. DMMA approval was received on March 31, 2022.
- Updated ACDE Wellness Resources website landing page.
- Ongoing member-facing staff outreach and discussion with members to identify opportunities for referrals to Wellness programs.

Quarter 2 2022:

- Ongoing member-facing staff outreach and discussion with members to identify opportunities for referrals to Wellness programs.

Quarter 3 2022:

- Ongoing member-facing staff outreach and discussion with members to identify opportunities for referrals to Wellness programs.

Quarter 4 2021:

- Ongoing member-facing staff outreach and discussion with members to identify opportunities for referrals to Wellness programs.
- Wellness Program Member Flyer updated.
- Updated ACDE Wellness Resources website landing page.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- No Provider-focused interventions implemented as this is a member and plan- focused PIP.

2. Improvement Strategies or Interventions (Changes tested in the PIP)

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

- Quarter 1 2022:
  - Aligned and updated Wellness program documents (SOP, outreach strategy, definition, workflow, and training PowerPoint). Added data validation and auditing process to the SOP.
  - Completed first quarter Wellness program training for member-facing staff on March 8, 2022.
  - Continued to refine technical specifications and reporting structures.
  - Rapid Response and Outreach Team, CC, and QM implemented updated Wellness program training for new hires.
  - Implemented a quarterly email reminder to member-facing staff for the Wellness Program Referral process.
  - Reviewed and updated Business Requirements Document/Functional Requirements Document (BRD/FRD) for reporting.

2. Improvement Strategies or Interventions (Changes tested in the PIP)

- Quarter 2 2022:
  - Aligned and updated Wellness program study questions and PIP Lead and Lag Measures after DMMA/EQRO feedback in June 2022.
  - Lead Measure 2: The original Lead Measure 2 was removed as it was duplicative. Lag Measure 4 was reviewed and identified as a Lead Measure. This is now Lead Measure 2. Verbiage was revised to focus on compliance with documentation and the referral process. Reports for referral tracking are directly pulled from the Jiva Medical Management system and audits ensure complete and accurate information is documented. The goal was updated to reflect the corporate standard of 90.0% score for compliance. Defined Sampling methodology.
  - Lead Measures 3 and 4: Removed based on internal discussion regarding the focus of the PIP and EQRO feedback. These measures did not meet the focus of the PIP.
  - Lag Measure 1: Clarified that this measures the rate of All-Member Level population referrals to a Wellness program provided by ACDE or within the community. Clarified the denominator for this measure for more accurate reporting. Removed previously reported data pending new validation processes.
  - Lag Measures 2 and 3: Clarified that these measures reference types of referrals, not members. Goals were updated for more relevant analysis and are independent of each other. Trending of referrals ensures that ACDE member-facing staff understand resources available to the All-Member Level population. Removed previously reported data pending new validation processes.
  - Continued collaboration with Analytics to review and refine the Delaware CC Wellness report and complete validation.
  - Finalized BRD/FRD for Delaware CC Wellness report.
  - Completed second quarter Wellness program training for member-facing staff on May 12, 2022.
  - Completed quarterly email reminders to member-facing staff for the Wellness Program Referral process.
  - Finalized Wellness Program Audit Tool for documentation compliance.

2. Improvement Strategies or Interventions (Changes tested in the PIP)

- Quarter 3 2022:
  - Restated performance rate data for Lag 1, Lag 2, and Lag 3 for Quarter 3 2021–Quarter 2 2022 due to an error in calculation identified. Prior data reflected unique members referred. Updated Lag Measure definitions as of June 2022 QIA, includes noted changes indicating these Lag Measures are measuring referrals, not members.
  - Completed third quarter Wellness program training for member-facing staff on September 13, 2022. Training included updates focused on frequently missed documentation requirements identified during audits.
  - Completed third quarter email reminder to member-facing staff for the Wellness Program Referral process on September 15, 2022. Email included updates focused on frequently missed documentation requirements identified during audits.
  - Identified Wellness program super users and held super user meetings on July 20, 2022 and August 18, 2022. The goal of super user meetings is to identify and support super users for the Wellness Programs Referral process to support departmental teams. The role of the super user is to provide support for end users in member-facing departments to ensure ongoing support of staff comprehension and implementation of the Wellness Program Referral process leading to increasing referrals to Wellness programs for all members.
  - Wellness program PIP work plan finalized and approved.
- Quarter 4 2022:
  - Lag 2 and Lag 3 goals realigned to measure updates in Quarter 2 2022 reflecting a goal based on referrals.
  - Completed fourth quarter Wellness program training for member-facing staff on November 16, 2022 and December 7, 2022. Training included updates focused on frequently missed documentation requirements identified during audits. Two trainings were held to provide additional opportunities for attendance due to scheduled Wellness program staff training being independent of departmental availability.
  - Completed fourth quarter email reminder to member-facing staff for the Wellness Program Referral process on November 28, 2022. Email included updates focused on frequently missed documentation requirements identified during audits.
  - Wellness program training slide deck provided to all member-facing departments for use in departmental training on November 10, 2022.
  - Quarter 3 2022 Wellness Program Workflow Documentation Audit results sent to member-facing department managers on December 16, 2022, for use in department-specific training.
  - Delaware Wellness program survey enhancements live in Jiva on December 29, 2022. Updates included additional questions to meet 2023 contractual requirements, updated Wellness program list, and flags on questions for process reminders such as adding activities for member follow-up and updating answers to questions upon follow-up with members.

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lead 1: The percentage of ACDE member-facing staff educated on ACDE's Wellness Program Referral process and ACDE Wellness Program survey. (Annual cumulative measure/rate).	Quarter 4 2021	Sample Size: 117 Rate: 76.92%	Quarter 4 2022	Sample Size: 219 Rate: 85.39%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): .0520
Lead 2: Percentage of unique ACDE Wellness Program Referrals audited that were documentation compliant.	Quarter 4 2021	Sample Size: 100 Rate: 27.0%	Quarter 4 2022	Sample Size: 100 Rate: 59.0%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 1: The percentage of All-Member Level population referrals to a Wellness program provided by either ACDE or within the community.	Quarter 3 2021	Sample Size: 95,806 Rate: 0.29%	Quarter 4 2022	Sample Size: 104,171 Rate: 0.72%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 2: Percentage of All-Member Level population referrals to a Wellness program provided by ACDE.	Quarter 3 2021	Sample Size: 275 Rate: 3.27%	Quarter 4 2022	Sample Size: 753 Rate: 30.94%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 3: Percentage of All-Member Level population referrals to a Wellness program within the community.	Quarter 3 2021	Sample Size: 275 Rate: 96.73%	Quarter 4 2022	Sample Size: 753 Rate: 69.06%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation Phase (check all that apply): ☐ PIP Submitted for Approval ☐ Planning Phase ☒ Implementation Phase ☐ Baseline Year ☒ First Re-measurement ☐ Second Re-Measurement ☐ Other (specify): **Validation Rating**: ☐ High Confidence ☐ Moderate Confidence ☒ Low Confidence ☐ No Confidence "Validation Rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: None.

HHO Performance Improvement Project Overall Assessment

Of the five required PIPs, the State required the EQRO to validate three PIPs during the 2023 compliance review cycle. The first PIP allows for a topic selected by the individual MCO that is relevant to its population and approved by DMMA. HHO's selected topic focused on improving the rate of completion of Health Risk Assessment (HRA) within 60 days. The second PIP was a State-mandated topic, but MCO developed study questions (BH and PH integration). The third required PIP allows for a topic selected by the individual MCO that is relevant to its population and approved by DMMA. HHO's selected topic focused on the impact of outreach efforts from the Rapid Response Team (RRT) in reducing ED utilization of LTSS HCBS members.

The PIPs and the specifications to be applied included:

- HRA Standards — State-Developed Specifications.
- PH and BH CC — MCO-Developed Specifications.
- LTSS Utilization — MCO-Developed Specifications.

Overall Results

DMMA has mandated that each MCO conduct a minimum of five PIPs covering specific topics. HHO has met the requirements for PIPs based on the Delaware Quality Strategy and the EQRO has a high level of confidence in the reported results for all three validated PIPs. However, as an essential component of an MCO's quality program to identify, assess, and monitor improvement in processes or outcomes of care, HHO should assess opportunities across the spectrum of the organization and business units to

identify and implement PIPs. Including PIP topics that have an impact on a larger population and are active in driving improvement would accomplish this goal.

PIP	Confidence in Reported Results
PIP 1: HRA Standards	High Confidence
PIP 2: BH/PH CC	High Confidence
PIP 3: LTSS Reducing ED Utilization	High Confidence

HRA Standards

1. General PIP Information
Managed Care Plan (MCP) Name: Highmark Health Options
PIP Title: HRA Standards
PIP Aim Statement: Would the addition of an experienced HRA vendor with a multi-channel outreach approach within 60 days to newly enrolled members lead to an increase in overall completion rates within the 2021–2023 plan year?
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) ☐ State-Mandated (State-required plans to conduct a PIP on this specific topic.) ☐ Collaborative (Plans worked together during the planning or implementation phases.) ☐ Statewide (The PIP was conducted by all MCOs and/or PIHPs within the State.) ☒ Plan Choice (State allowed the plan to identify the PIP topic.)
Target age group (check one): ☐ Children Only (ages 0–17)* ☐ Adults Only (age 18 and over) ☒ Both Adults and Children ***If PIP uses a different age threshold for children, specify the age range here**: N/A
Target population description, such as duals, LTSS, or pregnant women (please specify): N/A
Programs: ☐ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) Members are offered gift card incentives for HRA completion.

2. Improvement Strategies or Interventions (Changes tested in the PIP)
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) PIP-focused Provider forum presented in December 2022.
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools) • Quarter 1 2022: – The HRA vendor was put on a performance improvement plan for lack of proper reporting and quality of calls to members. Four part-time member advocates were hired to complete HRAs. Additional assistance is provided to members by the Member Advocates when Health Related Social Needs are identified. • Quarter 2 2022: – The Director of Member Experience developed a business case to increase HHO outreach staffing and bring most vendor functions to internal HHO staff. • Quarter 3 2022: – Specific answers on the HRA will trigger an automatic letter response with resources for members. This will also allow us to track what is done for members with specific diagnoses. • Quarter 4 2022: – Additional CC assessments, similar to the HRA form, this will count as an HRA completion.

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [NQF] number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lead 1: The percentage of HHO members who were reached by the HHO outreach team within 60 days of enrollment.	2021	Sample Size: 4,572 Rate: 33.57%	Quarter 4 2022	Sample Size: 4,278 Rate: 35.88%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
Lead 2: The percentage of HHO members who were reached by the HHO outreach team within 60 days of enrollment.	2021	Sample Size: 4,572 Rate: 20.43%	Quarter 4 2022	Sample Size: 3,466 Rate: 92.18%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 1: The percentage of HHO members who received outreach from the vendor and completed an HRA within 60 days of enrollment.	2021	Sample Size: 1,535 Rate: 48.99%	Quarter 4 2022	Sample Size: 1,535 Rate: 75.37%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 2: The percentage of HHO members who were reached by the HHO outreach team who completed an HRA within 60 days of enrollment.	2021	Sample Size: 934 Rate: 77.94%	Quarter 4 2022	Sample Size: 3,359 Rate: 28.88%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

4. PIP Validation Information
Validation Phase (check all that apply): ☐ PIP Submitted for Approval ☐ Planning Phase ☐ Implementation Phase ☐ Baseline Year ☐ First Re-Measurement ☒ Second Re-Measurement ☐ Other (specify): Third Re-Measurement **Validation Rating**: ☒ High Confidence ☐ Moderate Confidence ☐ Low Confidence ☐ No Confidence "Validation Rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: None.

Behavioral Health/Physical Health Care Coordination

1. General PIP Information
MCP Name: Highmark Health Options
PIP Title: BH/PH CC
PIP Aim Statement: Does coordination of care for adult members 18 years–64 years of age with a schizophrenia diagnosis who also have a diabetes diagnosis, increase the number of members who had both the LDL-C test and an HbA1c test during the 2021-2023 plan years?
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) ☐ State-Mandated (State-required plans to conduct a PIP on this specific topic.) ☐ Collaborative (Plans worked together during the planning or implementation phases.) ☐ Statewide (The PIP was conducted by all MCOs and/or PIHPs within the State.) ☒ Plan Choice (State allowed the plan to identify the PIP topic.)
Target age group (check one): ☐ Children Only (ages 0–17)* ☒ Adults Only (age 18 and over) ☐ Both Adults and Children ***If PIP uses a different age threshold for children, specify the age range here**: N/A
Target population description, such as duals, LTSS, or pregnant women (please specify): Adult members with a diagnosis of both diabetes and schizoaffective disorders. LTSS is included.
Programs: ☒ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) • Quarter 1 2022: — Care Management staff resumed face-to-face visits allowing the team to perform education and encourage BH members with diabetes to complete their LDL and A1c testing with their doctor. • Quarter 2 2022: — To ensure accurate reporting and reduce member abrasion, identified incorrect utilization of guiding care activities and renamed the activities in care managements system of documentation. Enhanced referral process for those members who require additional education, four or more chronic conditions and/or without an assigned care coordinator are referred to a dedicated care coordinator who will outreach those members. • Quarter 3 2022: — Members were educated through an article in the Spring edition of the member newsletter. • Quarter 4 2022: — Identified the process to refer members to a registered dietician and identified a new gym program that will be available to offer to our members called: The Lean Healthy Weight Program through the YMCA will Kick off January 1, 2023, and will also include nutrition counseling.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) • Quarter 1 2022: — Workgroup developed a survey that was sent out to all providers identified as administering care to patients with a diagnosis of Schizophrenia and diabetes. The survey was conducted to identify interventions to enrich provider and care management collaboration and how the HHO team can assist the providers in increasing continued compliance among our members. • Quarter 2 2022: — Workgroup reviewed the surveys received from the providers and the survey focused on how providers are educating their patients and ways HHO can improve the collaboration between the providers and the care management team. Although the response was low the providers that responded stated they utilize multiple methods to educate their patients regarding A1c and LDL from verbal, brochures, and written materials. Some providers also found the collaboration with the care management team helpful. Twenty out of thirty-three providers responded to these questions with ideas for improvement such as Dietician consults, scheduling brief meetings, consolidating the information, and incorporating email communication into the outreach and or follow-up. Providers were educated about the BH/PH PIP during the Provider Forums. • Quarter 3 2022: — Provider education through the Summer Provider newsletters.

2. Improvement Strategies or Interventions (Changes tested in the PIP)

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

- Quarter 1 2022:
  - The methodology for data collection was revised to exclude the assumptions that were implemented in Q3 2021. Statistical testing was conducted for this PIP in Q1 2023 utilizing the Chi-square test and the Outcome measured. The following barriers were identified in Q1 2022: Face-to-face visits were suspended from December 2021 to Mid-February 2022, but resumes in Q2 2022. The new HEDIS measures excluded dual members from the population which is about 2,000 members that will be affected by this new measure. The 2022 population will only focus on those members that have Medicaid as Primary. This change affects the LTSS population.
  - The PIP workgroup developed a survey that was sent out to all providers identified as administering care to patients with a diagnosis of Schizophrenia and diabetes. The survey was conducted to identify interventions to enrich provider and care management collaboration and how the HHO team can assist the providers in increasing continued compliance among our members. Identification of a new fishbone barrier analysis was conducted to focus on increasing provider collaboration which will in turn increase the number of members who complete their A1c and LDL testing in a MY.

2. Improvement Strategies or Interventions (Changes tested in the PIP)

- Quarter 2 2022:
  - The workgroup reviewed the surveys received from the providers and the survey focused on how providers are educating their patients, and ways HHO can improve the collaboration between the providers and the care management team. Although the response was low the providers that responded stated they utilize multiple methods to educate their patients regarding A1c and LDL from verbal, brochures, and written materials. Some providers also found the collaboration with the care management team helpful. Twenty out of thirty-three providers responded to these questions with ideas for improvement such as Dietician consults, scheduling brief meetings, consolidating the information, and incorporating email communication into the outreach and or follow-up. The workgroup is actively reviewing the recommendations provided and determining how we can improve on each item.
  - The workgroup collaborated with the HHO Member Engagement Enablement Team (MEET) department to develop a news article for the provider newsletter which will be featured in Quarter 3 2022 edition. In May 2022, a provider forum was conducted to provide education regarding the BH-PH PIP, barriers, and how the providers can help improve the PIP. Providers also requested literature to give to their patients, and provide in-services and education sessions for members.
  - The workgroup identified incorrect utilization of the assigned BH-PH guiding care PIP activities. The workgroup decided to rename the guiding care activities to ensure correct usage by the staff and maintain data accuracy.
  - The continued success of the PIP is attributed to the CC, LTSS CM, and Community Health Worker (CHW) consistent outreach efforts to educate and outreach those members via the outreach list sent out each month. With the inclusion of outreaching to the providers as well to help close the care gaps.

2. Improvement Strategies or Interventions (Changes tested in the PIP)

- Quarter 3 2022:
  - The CHW team went down by one full-time equivalent (FTE) and there is currently one FTE CHW completing all responsibilities as it relates to the CHW role. The CHW identified there are members who appear month over month who have refused to have their A1c and LDL labs completed.
  - The workgroup identified the need for nutrition counseling and engagement at the provider and member level concerning the identified intervention. The workgroup is currently collaborating with the MEET department to develop an article to go out in the provider and member newsletters in Quarter 4 2022.
  - This success can be attributed to the work of the care management team, provider and member collaboration, and educational materials.
- Quarter 4 2022:
  - The CHW team remains down one FTE and the hiring of a new full-time CHW is currently on hold until 2023. With further research and investigation, we found that members who do not have home health services are able to receive nutritionist services. A prior authorization would be needed for the service to be covered. The Lean Healthy Weight Program through the YMCA will Kick off January 1, 2023, and will also include nutrition counseling.
  - The workgroup identified that LDL screening was not included in Tableau. The Medicaid Analytics team collaborated to ensure the information reflected on Tableau matched the BH-PH member outreach list.
  - For the members Fall 2022 newsletter the following was published: “Does your medicine cause weight gain? What can you do?”. For the provider Fall 2022 newsletter the following was published: “Providers can partner with HHO for wellness programs and linkage to services.”

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lead 1: Percentage of adult members 18–64 years of age with a schizophrenia diagnosis, who have diabetes who were outreached and educated on the importance of LDL-c and A1c.	2021	Sample Size: 153 Rate: 98.69%	Quarter 4 2022	Sample Size: 235 Rate: 93.62%	☐ Yes ☒ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
Lag 1: Percentage of adult members 18-64 years of age with a schizophrenia diagnosis who completed their LDL-C test.	2021	Sample Size: 151 Rate: 80.79%	Quarter 4 2022	Sample Size: 220 Rate: 82.73%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.6
Lag 2: Percentage of adult members 18-64 years of age with a schizophrenia diagnosis who completed their HbA1c test.	2021	Sample Size: 151 Rate: 84.77%	Quarter 4 2022	Sample Size: 220 Rate: 86.82%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.6
Lag 3: Percentage of adult members 18-64 years of age with a schizophrenia diagnosis who completed both their HbA1C and LDL-C diabetic screeners.	2021	Sample Size: 151 Rate: 75.50%	Quarter 4 2022	Sample Size: 220 Rate: 74.09%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.8

4. PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP Submitted for Approval ☐ Planning Phase ☐ Implementation Phase ☐ Baseline Year ☐ First Re-Measurement ☒ Second Re-Measurement ☐ Other (specify): **Validation Rating**: ☒ High Confidence ☐ Moderate Confidence ☐ Low confidence ☐ No Confidence "Validation Rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: None.

LTSS Reducing ED Utilization

1. General PIP Information
MCP Name: Highmark Health Options
PIP Title: LTSS Reducing ED Utilization
PIP Aim Statement: Does outreach efforts from the RRT reduce high ED utilization of LTSS HCBS members identified as having three or more ED visits in a quarter within 2021-2023 measurement years?
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) ☐ State-Mandated (State-required plans to conduct a PIP on this specific topic.) ☐ Collaborative (Plans worked together during the planning or implementation phases.) ☐ Statewide (The PIP was conducted by all MCOs and/or PIHPs within the State.) ☒ Plan Choice (State allowed the plan to identify the PIP topic.)
Target age group (check one): ☐ Children Only (ages 0–17)* ☒ Adults Only (age 18 and over) ☐ Both Adults and Children ***If PIP uses a different age threshold for children, specify the age range here**: N/A
Target population description, such as duals, LTSS, or pregnant women (please specify): LTSS only
Programs: ☒ Medicaid (Title XIX) Only ☐ CHIP (Title XXI) Only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- Quarter 1 2022:
  - Transition of Care (TOC) Pod was established and is using the Coleman Model. A DLP was developed for post ED visits. In the year of 2022, there was an Eliza Emergency Room Avoidance campaign through Cotiviti implemented to all members who recently had a preventable ED visit.
- Quarter 2 2022:
  - Internal collaboration with the LTSS Pods to move members for increased support for those members open greater than 90 days. Identified home visiting providers/specialists. Joint visits with the member at provider appointments.
- Quarter 3 2022:
  - Team reviewed top 10 reasons LTSS members visit the ED.
- Quarter 4 2022:
  - Found that sepsis and COVID-19 are the top two reasons LTSS members visited the ED.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

- None.

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

- Quarter 1 2021:
  - Enriched provider collaboration with member initiatives the workgroup developed a provider survey for feedback on enhanced collaboration.
- Quarter 3 2022:
  - Education on working with the TOC Team was sent out via the provider update.
- Quarter 4 2022:
  - Education on urgent care use was sent out via the provider update.

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Lead 1: The percentage of DSHP Plus LTSS HCBS members identified as having three or more ED visits per quarter, who received an intervention outreach from the RRT.	2021	Sample Size: 78 Rate: 24.36%	Quarter 4 2022	Sample Size: 96 Rate: 66.67%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 1: The percentage of DSHP Plus LTSS HCBS members identified as having three or more ED visits per quarter, who received an intervention outreach from the RRT and have reduced their number of ED visits per quarter.	2021	Sample Size: 19 Rate: 84.21%	Quarter 4 2022	Sample Size: 64 Rate: 75.56%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.7518
Lag 2: The percentage of the number of ED visits for LTSS HCBS members with three or more visits/quarter.	2021	Sample Size: 1,006 Rate: 36.38%	Quarter 4 2022	Sample Size: 1,160 Rate: 40.86% *Inverse Measure	☐ Yes ☒ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.0328

4. PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP Submitted for Approval ☐ Planning Phase ☐ Implementation Phase ☐ Baseline Year ☐ First Re-Measurement ☒ Second Re-Measurement ☐ Other (specify): Third Re-Measurement **Validation Rating**: ☒ High confidence ☐ Moderate confidence ☐ Low Confidence ☐ No Confidence "Validation Rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: None.

Section 6

Information Systems Capabilities Assessment

At the request of the DMMA, Mercer conducted the EQR ISCA CAP review of ACDE and HHO for the time period of January 2022 through December 2022. This independent review of the MCO's information systems was conducted as an enhancement to the EQR mandatory activity outlined in 42 CFR § 438.358. To complete this assessment Mercer utilized the current version of the CMS EQR Protocol Appendix A, along with comprehensive enhancements to the ISCA to reflect State-specific regulations, standards, and requirements communicated to the managed care organization (MCO) through the contract with DMMA. Mercer's EQR ISCA process included a review of submitted materials and information, as well as interviews and live systems demonstrations. The annual ISCA evaluation was conducted by Mercer, with DMMA staff in attendance in-person and via video conference on April 20, 2023 through April 21, 2022 for ACDE and April 17, 2023 through April 18, 2023 for HHO and focused on the core information systems listed below:

- Claims systems processing procedures, training, and personnel.
- Reporting and analytics procedures, training, and personnel
- Encounter data processing procedures, training, and personnel
- Core systems — eligibility/enrollment, claims, provider, encounters, and data warehouse
- Claims and encounter data reporting
- Claims systems configuration, claims edits, and claims requiring manual intervention.
- Claims and encounters subcontractor oversight

ACDE Overall Assessment

Based upon the ISCA CAP review, ACDE continues to demonstrate effective partnership and collaboration between the local MCO and the enterprise ACFC teams, operations, and systems and, as such, continues to perform well in supporting the systems-related requirements of Delaware's managed Medicaid program. The insights gained from ACDE's ISCA CAP desk review and hybrid discussions confirmed a strong infrastructure, claims and encounters subject matter expertise, teamwork, and commitment to supporting Delaware's Medicaid programs.

ACDE has made strong progress in data governance by completing the installation of the Informatica Data Governance platform including data catalog and dictionary, and data profilers. Additionally, ACDE made progress in the standardization of data governance processes by identifying data analytics council members and approving the enterprise data policy for ACDE team members to follow.

As implied through their well-organized and thoughtful RFI response as well as effective and efficient on-site reviews, ACDE continued to exhibit strong process orientation and mature systems capabilities, along with a deep understanding of DMMA requirements. ACDE's strong process orientation is evident in the high-performance metrics shared during the meeting including credentialing and utilization management in which ACDE takes great pride.

ACDE Strengths

Based on the documentation submitted and the hybrid on-site review, Mercer identified the following strengths in ACDE systems, operations, and leadership capabilities:

- The progress made on data governance implementation demonstrates ACDE's commitment to data quality necessary for reporting, quality improvement initiatives, and accurate and timely encounter submissions.
- ACDE has made great strides in addressing issues with its Pharmacy Benefit Manager (PBM), including those related to over-the-counter (OTC) drugs, coordination of benefits, and quantity limits.
- ACDE has shown its commitment to a high-quality and stable technology environment by developing, implementing, and following strong change management processes including quality assurance processes, testing, and the release to production.
- DMMA and Gainwell consider ACDE a great partner in the work on the enhancement of the Medicaid Management Information System (MMIS) system by collaborating on key technology-dependent projects such as Electronic Visit Verification and 21st Century Cures Act, as well as preparation for the Public Health Emergency (PHE) Unwinding.

ACDE Opportunities

The review also identified areas below where ACDE could strengthen its commitment to excellence:

- Although ACDE made strong progress in subcontractor oversight, including executive-level leadership meetings with the subcontractors, ACDE needs to set clear expectations and outline consequences if the expectations are not met.
  - During the vision claims review, it was evident that the files ACDE received from subcontractors contained multiple inaccuracies, which limited the EQRO team's ability to assess the subcontractor claims systems and the accuracy of payments. ACDE should provide clear direction, oversight, and validation of the data submitted by subcontractors. It is ACDE's responsibility to ensure all submissions to Mercer for EQR are accurate and complete.

  - Medicaid is a payer of last resort and systems and manual processes should be designed to comply with this requirement. ACDE lacked appropriate oversight of the dental subcontractor claims; manually processed dental claims resulted in overpayment. ACDE should evaluate the instances of overpayment and collaborate with the subcontractor to develop mitigation strategies that could include reporting, system configuration changes, etc. and recoupment of overpayment when necessary.

- ACDE developed and implemented processes for annual audits of subcontractor claims by selecting 30 paid claims and 30 denied claims for audit. Although the subcontractors have internal audit processes and procedures and completed audits, ACDE does not have a process to review findings from subcontractors' internal claims audit. ACDE should consider enhancing its internal subcontractor audit processes until there is confidence in the accuracy of subcontractor claims payments. ACDE should also closely monitor subcontractor internal audit results to ensure all the findings are properly addressed.

HHO Overall Assessment

HHO demonstrated their continued efforts to improve their claims processing operations and submission of encounter data to effectively support Delaware's Medicaid managed care program. At the same time, HHO made significant progress in its vendor oversight capabilities including enhanced processes, value-added dashboards, and collaborative meetings.

HHO has made substantial progress in claims remediation and audit activities with newly developed dashboards to support daily operations. The insights gained from HHO's ISCA desk review and on-site discussions confirmed HHO's efforts to improve the claims operations and underlying infrastructure to ensure accurate claims processing and timely encounter submission.

As implied through their well-organized and thoughtful RFI response, HHO continued to exhibit strong process orientation, a comprehensive understanding of DMMA requirements, and a well-organized internal partnership.

Strengths

Based on the documentation submitted and hybrid on-site review, Mercer identified the following strengths in the HHO systems, operations, and leadership capabilities:

- HHO's development, implementation, and use of the vendor dashboards with built-in logic based on quantitative data can serve as an example of a best-in-class approach to monitoring vendor performance. The dashboards allow HHO to act quickly if a deviation from the expected performance is noted, develop a comprehensive response, and monitor changes.

- HHO's continuity of staff dedicated to the DMMA program allows wide-ranging coordination between teams built on trust and the common goal of a *"member first"* approach. This collaboration manifests in resolving multi-team concerns quickly by working together instead of in silos.

- HHO's leadership is committed to the *"member first"* approach, ensuring that systems, policies, and the entire HHO team concentrate on the effort of the member experience and health quality. To support this approach, HHO includes members from its member advisory council as part of systems release and testing for changes that impact members and listens to member feedback.
- HHO is committed to improving the quality of data used for reporting, including pharmacy files. In the last year, HHO began to require its pharmacy vendor to submit data quarterly. This proactive approach allows HHO to identify any issues in data early and develop solutions, if necessary. This process also demonstrates to HHO's vendors that quality data are very important to the organization and HHO will dedicate the necessary resources for oversight.

Opportunities

The review also identified the following areas where HHO could strengthen its commitment to excellence:

- Although HHO has an audit process that has been developed and implemented successfully, the process for the follow-up on the audit findings related to the errors in claims processing should be established to ensure audit findings are reviewed and claims are corrected.
- HHO has change request processes; however, there was no formal process to log requests received via email and change request processes were not consistently implemented by staff members. HHO should complete a gap analysis of the current processes to identify vulnerabilities that contributed to a request for change being entirely overlooked. HHO should revisit the approval process for new requests and clearly identify business owners responsible for the timely completion of requests.

Section 7

Delaware First Health Mid-Year Post-Implementation Review

Purpose

Delaware's DMMA, requested its contracted EQRO, Mercer Government Human Services Consulting (Mercer), complete a mid-year post-implementation review DFH. DMMA requested that the EQRO facilitate interviews with MCO leadership, supervisory, and management staff engaged with delivering benefits to DSHP and DSHP Plus members. The EQRO focused on the delivery of services, ensuring progress has been made toward developing and implementing Delaware-specific P&Ps and resolving issues or concerns identified during the Readiness Review, which was held November 15, 2022, through November 17, 2022, and the initial post-implementation review, which was held on March 21, 2023 through March 22, 2023. The mid-year post-implementation review process began on April 21, 2023, when Mercer delivered a request for information (RFI) to DFH. Mercer used a Health Insurance Portability and Accountability Act (HIPAA) compliant secure file transfer protocol site, SharePoint, to allow a secure exchange of information among Mercer, DMMA, and the MCO. MCO materials were uploaded to the SharePoint site by May 19, 2023. The desk review was a post-implementation analysis of P&Ps and supporting documents related to FRMMC, CHIPRA, and State contract standards. In addition, Mercer reviewed the CC, MCC, CM, and grievance and appeal (G&A) files and submitted preliminary findings to DFH to prepare for the on-site review.

The mid-year post-implementation on-site review was conducted by Mercer, with DMMA staff in attendance, on June 16, 2023, at the DFH offices located in Newark, Delaware. The documentation reviews and staff interviews were conducted to gain a more complete and accurate understanding of the operations of DFH and how those operations contribute to its compliance with federal and State regulations and requirements, consistency with internal P&Ps and processes, and adherence to contractual standards in the provision of health care services to its enrollees. Mercer would like to recognize DFH for its timely response to the RFI, as well as its open exchange of information during the review.

On-site Review

The mid-year post-implementation on-site review took place at the DFH offices located in Newark, Delaware, utilizing web-based video and telephonic technology to link on-site and remote EQRO, DMMA, and DFH participants. The on-site review began with an introductory session, with Mercer, DMMA representatives, and appropriate DFH staff present in person or in attendance via teleconference.

Overall Mid-Year Post-Implementation Assessment

Through the first six months of operation, DFH successfully implemented activities to manage the care of Medicaid members in Delaware. At the time of the on-site review, DFH had all the key personnel positions filled, with the exception of the LTSS CMO who had an offer pending, had a sufficient network of providers, was receiving and paying claims, and was providing CM and CC services to members as appropriate. The MCO was making progress on updating corporate P&Ps to be branded as DFH and ensuring that all contractual expectations were integrated and implemented as expected.

The level of membership afforded the MCO the opportunity to keep CM and CC ratios low; this allowed case manager and care coordinator supervisors to provide close oversight and coaching to remediate any deficiencies in team performance.

Initiatives in place for specific populations included weekly PROMISE case conferences, biweekly meetings for review of high-risk Department of Corrections re-entry members, and an MCC Interdisciplinary Care team. These meetings provided an opportunity for the team to discuss barriers identified for specific cases or to note trends and work through next steps.

CM caseloads were building and remained lower than the identified limits, which was anticipated during the initial enrollment of members. All HCBS members were seen in person except a few who were unable to be reached (UTR) and one who requested a telephonic assessment. CM staff were actively engaged with completing assessments face-to-face for NF members.

DFH developed a comprehensive panel of quality-related training that was presented or planned for leadership, QI/QM staff, and staff from other departments. MCO-wide quality training includes topics such as addressing critical incidents, G&As, and quality of care.

DHF should review claims on a regular basis, include an analytic approach to identify outlier claims, and develop processes to address any identified deficiencies in claims processing. The MCO should also employ the review of claims as a means to ensure members receive appropriate benefits, providers are paid correctly and if the claim is denied, the appropriate messages are included to help identify the issues that providers need to address.

Section 8
NCI-AD Adult Consumer Survey

The DMMA, in partnership with ADvancing States and Human Services Research Institute (HSRI), implemented the 2022–2023 National Core Indicators Aging and Disabilities (NCI-AD) Adult Consumer Survey in the Delaware. DMMA recognizes the need for an independent assessment of HCBS as well as all services provided under MLTSS. Delaware uses data from the survey to strengthen MLTSS policy, inform quality assurance activities, evaluate managed care performance and compliance, and improve the quality of life of MLTSS participants. To allow for year-to-year comparison of the data, Delaware plans to continue to implement NCI-AD in future years.

NCI-AD Survey Overview

The NCI-AD Adult Consumer Survey is designed to measure outcomes across 19 broad domains comprising approximately 80core indicators. Indicators are the standard measures used across states to assess the outcomes of services provided to individuals, including respect and rights, service coordination, CC, employment, health, safety, person-centered planning, etc. An example of an indicator in the Service Coordination domain is the “Percentage of people whose services meet their needs and goals”.

While most indicators correspond to a single survey question, a few refer to clusters of related questions. For example, the indicator “Percentage of people who have needed home modifications” in the Access to Needed Equipment domain is addressed by several survey questions that ask about the person’s need for various types of home modifications.

NCI-AD Sample

The total number of NCI-AD Adult Consumer Surveys conducted in Delaware for DSHP Plus members in 2023 and included for analysis was 761 (Total N=761).

DSHP Plus: Delaware’s Medicaid managed care program, comprised of DSHP and DSHP Plus, is authorized under the authority of a Section 1115 Demonstration waiver. This program provides improved access to community-based long-term care services and increased flexibility to address individual needs more effectively, and to better control rising long-term care costs significantly impacting Medicaid. Two types of service settings were included in the sample strategy: facility-based (i.e., [NF]) and HCBS. All service recipients were enrolled in one of two MCOs: ACDE and HHO.

Survey Process in Delaware

Mercer contracted with Vital Research, a national survey group, to hire and manage local interviewers to conduct the NCI-AD Adult Consumer Survey. Along with Vital Research, Mercer worked with the State to identify individuals to be NCI-AD interviewers and have them appropriately trained. DMMA, Mercer, Vital Research, ADvancing States, and HSRI staff conducted a mandatory three-day in-person training with these interviewers on March 14–16, 2023. The training consisted of a detailed review of the NCI-AD Survey tool, an overview of the NCI-AD project, general, and population-specific surveying techniques; procedures for scheduling interviews and obtaining written consent; guidance for follow-up in cases of unmet needs and/or abuse, neglect, or exploitation; mock interviewing practice sessions; and data entry procedures. Delaware used NCI-AD's optional module on person-centered planning and chose to add three additional State-specific questions to the standard NCI-AD Survey. Interviews began on March 14, 2023, and Vital Research sent the final data from the interviews to HSRI on June 28, 2023.

Survey Findings

At the time of this report, HSRI has not released findings from the 2022–2023 survey cycle.

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