Mercer

Government Human Services Consulting

Delaware External Quality Review

2022 Technical Report

State of Delaware
Division of Medicaid and Medical Assistance

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Contents

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 health care 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 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 2022, Mercer Government Human Services Consulting (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 PIPs for both MCOs; Mercer also completed a CAP Information Systems Capabilities Assessment (ISCA). In addition to completion of mandatory activities, the External Quality Review Organization (EQRO) conducted the following activities, detailed throughout the report:

- Delaware First Health Readiness Review
- National Core Indicators–Aging and Disability Survey.

Section 2

External Quality Review Overview

External Quality Review Objectives

Mercer Government Human Services Consulting's (Mercer's) objective for the 2022 External Quality Review (EQR) was to assess Delaware Managed Care Organization (MCO) performance toward achieving the Delaware Quality Strategy goals, which are:

1. To improve timely access to appropriate care and services for adults and children with an emphasis on primary and preventive, and behavioral health (BH) care, and to remain in a safe and least-restrictive environment.
2. To improve quality of care (QOC) and services provided to Medicaid and Children's Health Insurance Program (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 corrective action plan (CAP) compliance review and this report presents the results as required by 42 CFR 438.364. The objectives of this review included:

- Assessing implementation of CAP activities by the MCOs for those items that scored less than "Met" in 2021.
- Assessing the quality of services provided, the timeliness of services provided, and access to care and recommendations to the MCOs and the State of Delaware (Delaware or State) Division of Medicaid and Medical Assistance (DMMA) for continued improvement.
- Comparison of MCO Performance Measure (PM) results with national benchmarks.
- Evaluation of Performance Improvement Projects (PIPs).

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	
§438.206 Availability of Services	§438.230 Subcontractual Relationships and Delegation
§438.207 Assurances of Adequate Capacity of Services	§438.228 Grievance and Appeal Systems
§438.208 Coordination and Continuity of Care	§438.236 Practice Guidelines
§438.210 Coverage and Authorization of Services	§438.242 Health Information Systems
§438.214 Provider Selection	§438.330 Quality Assurance and Performance Improvement (QAPI)
§438.224 Confidentiality	

Request for Information

Mercer used the MCO request for information (RFI), based on the Centers for Medicare & Medicaid Services (CMS) protocol and modified by Mercer to meet the needs of DMMA, to acquire information specific for 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 SharePoint site into folders and subfolders, coordinating with the data request format. During the virtual onsite review phase, additional information was collected; a small number of outstanding data needs remained. At the close of the virtual onsite review process, Mercer summarized the outstanding information needs and the MCOs submitted additional information for further review and consideration following the virtual onsite 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 coordinating the review process in a logical manner, consistent with the flow of Federal Regulations for Medicaid Managed Care (FRMMC) and State standards and 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 virtual onsite 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 detail 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 SharePoint site, and the MCO was provided three weeks to upload the file contents to the SharePoint site.

Mercer utilized the National Committee for Quality Assurance's (NCQA's) "8/30" rule for evaluation of health care 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 and only 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 denominator, Mercer reviewed all files for that category. Mercer reviewed the files and posted the preliminary file findings prior to the onsite review to allow the MCO an opportunity to collect additional information to address file findings. Outstanding file findings were discussed during the onsite review, additional supporting documentation was requested and provided as available.

For scoring the file review, Mercer has retained a three-tiered system. This approach for quantitative scoring was determined as more appropriate than the five-tiered system 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% compliance or greater.
Partially Met	For file reviews that scored between 75% and 89% compliance.
Not Met	For file reviews that scored less than 75% 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 2022 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 review of the documentation and discussion with MCO staff, it is determined that the MCO has met most of the requirements as required for the Met category.
Partially Met	MCO staff describes and verifies the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice.
Minimally Met	After 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 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:

- Policies and procedures (P&Ps), quality, utilization management (UM), and case management (CM) program descriptions
- Care coordination (CC), CM, pharmacy prior authorization (PA), grievance, appeal, credentialing, and recredentialing 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 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 AmeriHealth Caritas Delaware (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, subcontractual relationships and delegation, and grievance and appeal system). The scores for the five standards that were not fully compliant for ACDE ranged from 84.0% to 98.5%. Highmark Health Options (HHO) was fully compliant in seven areas (availability of services, adequate capacity of services, coordination and continuation of care, coverage and authorization of services, provider selection, confidentiality and practice guidelines). However, the number of items across standards needing a CAP, that is scoring less than “Met,” was higher for ACDE (36) than HHO (12).

The areas of greatest opportunity for ACDE identified in the compliance review were related to CC and UM (17 and 12 items, respectively, requiring a CAP). By contrast, the areas of greatest opportunity for HHO were related to provider network and quality (2 and 3 items, respectively requiring a CAP).

Based upon the Information Systems Capabilities Assessment (ISCA) review, ACDE continues to demonstrate effective partnership and collaboration between the local health plan and the enterprise AmeriHealth Caritas Family of Companies (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 desk review and virtual discussions confirmed a strong infrastructure, claims and encounters subject matter expertise, and teamwork and commitment to Delaware. The desk and onsite reviews of the 2022 ISCA items resulted in 89 of the 99 desk review items (97.4%) receiving a review score of Met for ACDE.

HHO demonstrated their continued efforts to improve their claims processing operations to effectively support Delaware's Medicaid managed care program. In the latter part of 2019, HHO brought the claims operations in-house from the delegate, Gateway Health, but continued to process claims on the same claims platform, Optimal System for Claims and Reimbursement (OSCAR). HHO has made substantial progress in claims remediation activities, as well as identifying and implementing process improvements that improve claims processing outcomes overall. The insights gained from HHO's ISCA desk review and virtual discussions confirmed HHO's efforts to improve the claims operations and underlying infrastructure to ensure accurate claims processing. The desk and onsite reviews of the 2022 ISCA items resulted in 91 of the 99 desk review items (97.4%) 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 both MCOs in State-specific reporting. The External Quality Review Organization (EQRO) reported low confidence in one State-specific measure for HHO and no confidence in two State-specific measures for ACDE. A full description of the validation of PM results is in Section 4 of the report.

There is significant opportunity for improvement in HEDIS results for both MCOs. Of the 36 reported measures for ACDE, no measures were at or above the 90th percentile. Two measures, timeliness of prenatal care, and mental health (MH) utilization (inpatient services), were at or above the 75th percentile. Twenty-six of ACDE's HEDIS results for these 36 measures (72%) were below the 50th percentile. Of the 36 reported measures for HHO, one measure, timeliness of prenatal care, was at or above the 90th percentile. Four measures, lead screening in children, cervical cancer screening, comprehensive diabetes care (HbA1C screening), and well-child visits in the first 30 months of life (15–30 months), were at or above the 75th percentile. Twenty-two of HHO's HEDIS results for these 36 measures (61%) 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.

Both ACDE and HHO demonstrated decreased CAHPS results from 2021 to 2022. ACDE's members gave the highest score for the measures All Health Care and Rating of Health Plan, which were above the 90th percentile on the child CAHPS survey. However, both the adult and child CAHPS surveys highlight a significant opportunity for improvement across Getting Needed Care and How Well Doctors Communicate measures with ratings falling below the 50th percentile in both categories. Five measures for the ACDE adult CAHPS survey and three measures for the child CAHPS survey fell below the 50th percentile. HHO's performance decreased only slightly with members giving the highest scoring to the Rating of All Health Care and Rating of Health Plan in adult and child surveys, and rating of Specialists on the child survey which were above the 90th percentile. HHO's child and adult CAHPS surveys highlight a significant opportunity for improvement across Getting Needed Care. Three measures for the HHO adult CAHPS survey and two measures for the HHO child CAHPS survey were below the 50th percentile. 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 current Quality Strategy, DMMA has mandated that each MCO conduct a minimum of five PIPs covering specific topics. HHO's Quality department has faced challenges in leadership and staffing over the past several years, including the review period of 2021 as evidenced by quantifiable measure results and the confidence in reported results. HHO now has the resources and team to focus efforts particularly as it relates to PIPs. Although there is a strong PIP team in place, the submitted documentation was contradictory which made validation of the three PIPs impossible. In 2021, ACDE has implemented a service related PIP in process; however, the MCO did not provide sufficient data for the baseline and measurement periods for this PIP. ACDE was asked for follow-up information but was unable to provide information for the reporting periods as well as the data for the numerator and denominator for the measures.

Section 3

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

At the request of the State of Delaware (Delaware or State), Mercer Government Human Services Consulting (Mercer), the Division of Medicaid and Medical Assistance's (DMMA's) External Quality Review Organization (EQRO), conducted a corrective action plan (CAP) review of Delaware's Managed Care Organizations (MCOs), AmeriHealth Caritas Delaware (ACDE) and Highmark Health Options (HHO), assessing compliance with federal regulations. Below is a crosswalk of the standards reviewed by the EQRO to the Subpart D and Quality Assurance and Performance Improvement (QAPI) Standards, MCO scores, as well as the timeframe for the review.

Standard Reviewed by the EQRO	Subpart D and QAPI Standard	ACDE	HHO	Last Reviewed
Access and Availability	§438.206 Availability of Services	100.0%	100.0%	Review Cycle 2022
	§438.207 Assurances of Adequate Capacity of Services	100.0%	100.0%	Review Cycle 2022
Care Management	§438.208 Coordination and Continuity of Care	84.4%	100.0%	Review Cycle 2022
Utilization Management (UM)	§438.210 Coverage and Authorization of Services	94.1%	100.0%	Review Cycle 2022
Provider Network	§438.214 Provider Selection	100.0%	100.0%	Review Cycle 2022
	§438.224 Confidentiality	100.0%	100.0%	Review Cycle 2022
	§438.230 Subcontractual Relationships and Delegation	100.0%	90.0%	Review Cycle 2022
Grievance and Appeals	§438.228 Grievance and Appeal (G&A) Systems	100.0%	98.9%	Review Cycle 2022
Quality Improvement and Assessment	§438.236 Practice Guidelines	84.0%	100.0%	Review Cycle 2022
	§438.242 Health Information Systems	97.4%	97.4%	Review Cycle 2022
	§438.330 QAPI	98.5%	87.8%	Review Cycle 2022

Mercer completed this review as part of the mandatory External Quality Review (EQR) required by federal law using applicable Centers for Medicare & Medicaid Services (CMS) EQR protocols, released in October 2019. Areas included in the assessments were:

- CAP review of MCO compliance with Federal Regulations for Medicaid Managed Care (FRMMC), with the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), and State standards.
- CAP review of compliance with contract standards for:
  - Diamond State Health Plan (DSHP) and DSHP Plus Case Management (CM).
  - DSHP All Member Level Coordination, Level 1 Resource Coordination (RC), and Level 2 Clinical Care Coordination (CCC).
- Performance Improvement Project (PIP) validation.
- Performance Measure (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, Children's Health Insurance Program (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 2022. The 2022 CAP review encompassed the MCO's calendar year 2021 operations and specifically focused the file review on the period of July 1, 2021 through December 31, 2021. The 2022 EQR process began on April 25, 2022, 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, SharePoint, to allow a secure exchange of information among Mercer, DMMA, and the MCO. MCO materials were uploaded to the SharePoint site by May 13, 2022. The desk review was a comprehensive analysis of policies and procedures (P&Ps) and supporting documents related to FRMMC, CHIPRA, and State contract standards. In addition, Mercer reviewed the care coordination (CC), case management (CM), provider and organizational provider credentialing/ recredentialing, provider termination, pharmacy prior authorization (PA), and grievance and appeal files and submitted preliminary findings to both MCOs to prepare for the onsite review.

The annual onsite review was conducted by Mercer, with DMMA staff in attendance, on June 14, 2022–June 15, 2022 for ACDE and on June 28, 2022–June 29, 2022 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 onsite 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 CAP Items Closed in 2022**	**Items Needing CAP from 2022 EQR**	**Number of CAP Items Identified in 2021**	**Number of CAP Items Closed in 2022**	**Items Needing CAP from 2022 EQR**
Administration & Organization	0	0	1 — Newly identified	3	3	1 — Newly identified
CC	33	16	17	6	6	0
Dental	2	2	0	0	0	1 — Newly identified
G&As	0	0	0	3	1	2
Long-Term Services and Supports (LTSS) CM	4	1	3	4	1	3
Pharmacy	1	1	0	2	2	0
Provider Network	4	4	2 — Newly identified	13	13	2 — Newly identified
Quality	3	2	1	13	11	3 (1 — Newly Identified)
UM	18	11	12 (5 — Newly Identified)	4	4	0
Total	**65**	**37**	**36**	**48**	**41**	**12**

2022 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. 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 behavioral health (BH) care, and to remain in a safe and least-restrictive environment

Goal 2: To improve quality of care (QOC) and services provided to Medicaid and CHIP enrollees

Goal 3: To control the growth of health care expenditures

Goal 4: To ensure member satisfaction with services

Below are tables with the EQRO's 2022 findings and recommendations for DMMA's Quality Strategy broken out by 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 Expectation	**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: • Home- and Community-Based Services (HCBS) level of care evaluation and completion of the Comprehensive Medical Report will need to be a focus area when the Public Health Emergency (PHE) is rescinded. • Follow-up after emergency department (ED) visit or hospital admission was lacking. • There is a need to focus on collaboration and an interdisciplinary approach to CC.		The State should continue to review contractually required quarterly clinical reports, and when needed conduct file reviews, to assess level of care evaluations and completion of a Comprehensive Medical Report as the PHE is unwinding. The State should assess the timeliness and effectiveness of ED visit follow-up provided to the DSHP Plus population. DMMA, in conjunction with partner divisions, should ensure a collaborative and interdisciplinary approach is pursued by the MCOs as well as between the State divisions. 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: 68.34% Ages 45–64: 79.56% Ages 65+: 80.91% **Total: 72.23%**	**HHO:** Ages 20–44: 74.79% Ages 45–64: 82.83% Ages 65+: 81.52% **Total: 77.45%**	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 Expectation	**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:	The State should continue to review contractually required quarterly clinical reports, and when needed conduct file reviews, to identify and trends in lower rates

Information from the 2018 Quality Strategy Goal: 2. To improve QOC and services provided to Medicaid and CHIP enrollees			
	• Identification and follow-up of member preventive health needs. • Coordination of care for members with BH diagnosis.		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 to receiving preventive services and BH services are coordinated across the health care spectrum.
Inpatient days/1000 MM*	**ACDE:** Maternity: 7.29 Medicine: 16.85 Surgery: 18.97 **Total Inpatient: 41.46**	**HHO:** Maternity: 5.49 Medicine: 16.45 Surgery: 16.45 **Total Inpatient: 36.85**	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: 3.09 Medicine: 5.35 Surgery: 11.08 **Total Inpatient: 6.20**	**HHO:** Maternity: 2.85 Medicine: 4.90 Surgery: 11.02 **Total Inpatient: 5.91**	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:** Blood Pressure Control (<140/90): 60.34% Eye Exams: 55.96% HbA1c Control (<8%): 46.96% HbA1c Testing: 80.29% Poor HbA1c Control: 45.74%	**HHO:** Blood Pressure Control (<140/90): 58.39% Eye Exams: 45.74% HbA1c Control (<8%): 55.47% HbA1c Testing: 88.32% Poor HbA1c Control: 35.04%	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.

Information from the 2018 Quality Strategy Goal: 3. To control the growth of health care expenditures			
Quality Strategy Expectation	**EQRO Finding or HEDIS Rates**		**EQRO Suggestions for the State**
ED Utilization per 1000 MM*	**ACDE**: 49.60	**HHO**: 45.59	Continue to identify areas of opportunity for alternative (non-ED) service settings.
Non-Elective Inpatient Discharges per 1000 MM*	**ACDE**: 6.69	**HHO**: 6.24	Continue to monitor UM reports to ensure appropriate management of care by the MCOs.
Plan All Cause Readmission Observed/Expected Ratio*	**ACDE**: 1.1063	**HHO**: 1.23	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 Expectation	**EQRO Finding or HEDIS Rates**		**EQRO Suggestions for the State**
CAHPS Rating of Personal Doctor Composite	**ACDE:** Adult: 63.80% Child: 80.0%	**HHO:** Adult: 68.80% Child: 82.10%	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: 61.90% Child: 78.40%	**HHO:** Adult: 67.40% Child: 82.50%	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: 50.40%	**HHO:** Adult: 60.30%	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			
	Child: 76.40%	Child: 79.80%	
CAHPS Getting Needed Care Composite	**ACDE:** Adult: 82.70% Child: 82.90%	**HHO:** Adult: 82.50% Child: 86.50%	Monitor grievance reports to identify opportunities for improved member satisfaction with timely access to high quality care.
CAHPS Getting Care Quickly Composite	**ACDE:** Adult: 81.90% Child: 87.50%	**HHO:** Adult: 82.80% Child: 87.30%	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: 92.60% Child: 92.10%	**HHO:** Adult: 92.20% Child: 95.90%	Monitor grievance reports to identify opportunities to ensure a continued level of high member satisfaction with care by providers.

2022 Quality, Timeliness, and Access to Care Strengths and Weaknesses

Plan	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
PIP validation			
ACDE	The EQRO has high confidence in ACDE's muscle relaxers and opioid concomitant use PIP.	DMMA has mandated that each MCO conduct a minimum of five PIPs covering specific topics. In 2021, ACDE has implemented a service related PIP in process; however, ACDE did not provide sufficient data for the baseline and measurement periods for this PIP. ACDE was asked for follow-up information after the onsite visit but was unable to provide information for the reporting periods as well as the data for the numerator and denominator for the measures.	Quality, Access, Timeliness
HHO	HHO now has the resources and team to focus efforts particularly as it relates to PIPs. Specifically, the Manager of Quality Improvement (QI), Regulatory, and Accreditation exhibited a strong base knowledge to identify PIP topics, develop an appropriate question, select quantifiable lead and lag measures, and implement and assess interventions all of which are supported by enhanced analytics.	The EQRO has low confidence in HHO's Health Risk Assessment (HRA) standards, BH/physical health (PH) CC, and LTSS reducing ED utilization PIPs.	Quality, Access, Timeliness

Plan	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 Healthcare Effectiveness Data and Information Set (HEDIS®) software.	The EQRO has no confidence in ACDE's number of Medicaid members with diabetes who received an oral exam (D0150, D0120, D0180), and use of pharmacotherapy for opioid use disorder (OUD) (Percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or dispensed an US Food and Drug Administration [FDA]-approved medication for the disorder during the measurement year).	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 low confidence in ACDE's number of Medicaid members with diabetes who received an oral exam (D0150, D0120, D0180) PM.	Quality, Timeliness, Access

Plan	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
Compliance review			
ACDE	Member services operations were smooth and evidenced happy, customer-centric staff dedicated to assisting members. Of particular note, Member Services Representatives were able to identify outstanding preventive care screenings and coordinate efforts with care coordinators and case managers.	Although ACDE's call center operations staff meet the requirement of receiving ongoing training, specific grievance training was identified as an opportunity area.	Quality, Timeliness, Access
	The MCO has a strong and effective infrastructure for the CM program inclusive of processes, workflows, job aids, and desk level procedures, which support ongoing	The MCO needs to develop an audit policy that identifies metrics and compliance goal rates for documentation standards including preventive	Quality, Timeliness, Access

Plan	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
	operations, and ensue contract requirements are met. A comprehensive training plan is in place and has been updated to leverage didactic, modeling, and coaching approaches. ACDE has implemented extensive use of targeted and standard auditing processes of member case files. The MCO has consistent and competent leadership in place for the CM program, provides strong and effective housing supports, and is working to improve the quality of discharge and transition coordination for members receiving CM. Nursing facility (NF) diversion and transition activities include facilitated caregiver forums and in-home nurse practitioner assessments and support.	health monitoring and timeliness of CM documentation. ACDE should continue its efforts specific to member case file audits in order to continue to drive improvements regarding assessment, addressing gaps in preventive health care, care planning, follow-up on identified member needs, and to ensure appropriate standards of documentation.	
		ACDE has struggled to meet contractual requirements to deliver a successful and comprehensive CC program. Challenges identified included, but were not limited to, turnover in the Health Services Director position; significant difficulty developing and validating a functional risk stratification plan and methodology; inability to maintain contractually required Level 2 CCC staff ratios; the absence of a formal Training Plan; failure to ensure integration of PH and BH, including substance use disorders (SUDs); inability to develop and implement member case file audit processes that evaluate both quantitative and qualitative aspects of CC provided to members; and failure to address longstanding non-compliance identified in EQR CAPs.	Quality, Timeliness, Access

Plan	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
	There is strong leadership in the Quality Management (QM)/QI department that is supported by senior leadership within ACDE. There is evidence of integration of quality throughout the organization as evidenced by quality assessment and performance improvement meeting minutes.		Quality, Access
	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. The MCO has robust reporting capabilities and utilizes geo-spatial analytics, grievance, and critical incident data as well as, member and provider experience information to evaluate the effectiveness of its Provider Network Development and Management Plan (PNDMP).	The MCO must improve the management, progress and reporting of PIPs as well as required PM reporting.	Quality, Timeliness, Access
HHO	HHO has undertaken significant transformation efforts and continues to focus on service excellence and harnessing technology to improve not only its service delivery, but to enhance its focus on member outcomes. HHO delivered system improvements (including Altruista GuidingCare Platform and Care Gap Tableau), hired a Lead Training Coordinator, developed new training offerings, and implemented facilitation of regular cross-functional training sessions.	HHO's call center operations staff meets the requirement of receiving ongoing training; however, specific grievance training was identified as being needed. Targeted training on the grievance process for all call center staff would enable potentially systemic issues to be caught up front. Allowing an issue to follow the grievance process gives the organization the ability to investigate, track, and trend, and ultimately find resolutions so these issues do not continue.	Quality, Timeliness, Access

Plan	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
	HHO has embraced the concept of the 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 meeting, conducts quarterly audits for panel openings, and has a Provider Account Liaison (PAL) designated for all geographic territories and provider type. 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 HHO, and plans and progress to remediate the gaps were outlined in the PNDMP and discussed during the interviews. HHO has also incorporated LTSS provider monitoring and oversight activities such as missed and late visit reports and alternative service wait times.	HHO should consider reviewing their P&Ps around oversight of delegated or subcontracted entities. During this review, evidence of a high rate of overturned appeals, before going to the Hearing committee, emerged. For instance, eviCore is granted initial UM decision-making authority for the approval of high-cost imaging services. Even though eviCore and HHO use the same clinical guidelines to determine medical necessity, there were a large number of files that exhibited overturned appeals by HHO. This would suggest a flaw in the initial UM decision-making process by eviCore and does not reflect the member and provider-centric intentions of the DMMA contract.	Quality, Timeliness, Access
	HHO developed a process to assess for the need for cultural considerations during the UM review process and communicate with either CC or CM when identified, to assist with coordination of service. Cultural competency elements were added to the UM audit tool and competency checklist in 2022. The need for inclusion of cultural considerations was identified by HHO as a priority, going beyond addressing language barriers.	DSHP Plus LTSS member files were reviewed for compliance with contract standards (particularly for timeliness) and to evaluate the extent to which the cases successfully met the domains identified on the standardized scoring tool. Member files reflect inconsistencies in follow-up after ED visits and hospital admissions. Some inconsistencies were noted regarding the system based prompts and triggers to identify and address preventive health needs. Additional detail and documentation of care plan updates and progress would be helpful when goals are carried over from year-to-year.	Quality, Timeliness, Access
	The MCO has a strong and effective infrastructure for the CM program inclusive of processes, workflows, job aids, and desk level procedures (DLPs), which support	CC file review revealed a recurrent issue of needs being identified on the initial call and then subsequent efforts to engage or reach the member	Quality, Timeliness, Access

Plan	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
	ongoing operations and ensure contract requirements are met. There is a strong training plan in place, addressing both initial and ongoing training. A focus on transition of care (TOC) is evidenced by adoption of the Coleman Model of care and implementation of a TOC team. The MCO also demonstrates a commitment to the provision of housing supports and to meeting LTSS member dental needs. HHO has implemented extensive use of targeted and standard auditing processes of member case files to ensure training efforts are reflected in CM documentation. Additionally, the MCOs implementation of GuidingCare and the Mobile Clinician App reflects a commitment to ensure effective collaboration and coordination of care.	are unsuccessful, leaving needs unaddressed. HHO may benefit from ensuring assistance is offered during the initial touch point to engage the member. While resources were provided when a need was identified in some cases, follow-up was not routinely provided to close the loop and ensure that the member had made contact with the resources provided and that the member's needs were met.	
	HHO has a strong and effective infrastructure for the CC program inclusive of processes, workflows, job aids, and DLPs, which support ongoing operations and ensure contract requirements are met. There is a comprehensive CC training plan that addresses both initial and ongoing training. HHO has maintained consistent and competent leadership for the CC program and HHO resource coordinators and clinical care coordinators demonstrate a commitment to improving the lives of Medicaid members.	Although a stronger PIP team has been put in to place, the submitted documentation was contradictory which made validation of the three PIPs impossible. The reporting periods, numerators, and denominators identified for baseline and measurement periods were not clearly stated for validation against supporting PIP documentation. The RFI and Quality Improvement Activity (QIA) Form submissions failed to provide clear specifications when attributing to the reporting periods, numerator, and denominator. The data for the reporting periods, numerator, and denominator in onsite follow-up documentation did not align with the MCO's RFI submission, so validation was unable to occur.	Quality
		During the validation of PMs, it was identified that data used in the report under review were incomplete; this calls into question the regulatory review process detailed in the P&Ps, particularly	Quality

Plan	Strengths	Weaknesses	Domain (Quality, Timeliness, or Access to Care)
		around review of results by the business owner. HHO presented and spoke of a robust process with report creating; however, some critical elements of quality assurance could be enhanced. Although the process overall for developing the reports appears comprehensive including a few layers of approval, the first step of quality assurance is missing. When data is entered manually, no peer review is completed to ensure accuracy and for non-HEDIS PMs, validation and extra review of the source code was not performed.	

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

ACDE 2022 Findings and Recommendations

Member Rights, Responsibilities, and Member Communication Requirements

Enrollee rights are published in the Member Handbook, Provider Manual, and AmeriHealth Caritas Family of Companies' (ACFC's) Notice of Privacy Practices (NPP). Members are advised of their rights and responsibilities (R&R) upon enrollment and annually. Upon enrollment, the member is mailed a new member enrollment packet which includes documents that instruct the member to access the Member Handbook, R&R, and NPP online via ACDE's website. These documents include information on how a member can receive a copy of the Handbook via mail at no charge by calling the toll-free Member Services number. Staff members are educated about enrollee rights as part of new hire orientation. Training emphasizes the requirements found in Section 1557 of the Patient Protection and Affordable Care Act which outlines the nondiscrimination provisions prohibiting discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Corporate P&Ps globally address member R&Rs and specifically address member requests for access to health records and the right to change information. This includes instances where access to and the right to change are denied along with due process and grievance pathways. Delegates, through contract, are required to follow all Delaware contract requirements. When necessary, and appropriate, ACDE/Corporate works with its delegates to provide training on key topics pertinent to the Delaware contract.

Information regarding enrollee rights and protections, available benefits, and how to access emergency versus urgent care are all contained within the Member Handbook, which is made available in English and Spanish. Alternative formats of the Member Handbook, including braille, audio tapes, TTY, and language translation services (including American Sign Language) are available to members at no cost. Members are advised, via the Member Handbook and ACDE website, to contact Member Services via ACDE's toll-free number to request translation assistance. ACDE indicated the Member Advocate can also provide assistance to the member in accessing these services or in accompanying the member to the provider's office.

A full list of covered benefits, including those not covered by ACDE, are available within the Member Handbook, which is accessible online via ACDE's website. Information on the types of conditions that constitute an emergency and how to access emergency services, versus when to use urgent or primary care, is shared via the Member Handbook and posted online. The Handbook addresses all contractually required elements. ACDE's new member enrollment packet includes information about available benefits, urgent care facilities, how to contact Member Services, how to file a grievance or appeal, State Fair Hearing, HRA incentive, and member portal information. All P&Ps are consistent with federal regulations and contractual 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 onsite review, Mercer and DMMA staff listened to four member calls. Member services operations were smooth and evidenced happy, customer-centric staff dedicated to assisting members to the best of their ability. Of particular note, in one call the Member Services Representative was able to identify an outstanding preventive care screening. ACDE stated that the Member Services system includes radio buttons, which enable red prompts to show on the screen to indicate missing preventive care services as well as if the member is assigned to a care coordinator or case manager. This gives the Member Services Representative the ability to remind and assist the member to make preventive services appointments during the time of the call and provide a warm transfer for the member to CC and/or CM.

Although ACDE's call center operations staff meet the requirement of receiving ongoing training, specific grievance training was identified as an opportunity area. One member called in regarding a bill they had received from a provider. The Member Services Representative researched the services and total charges and told the member to disregard the bill stating that a summary of the call discussion would be noted in the system. The member was not told that he/she had the right to file a grievance in this matter nor did the Member Services Representative forward this issue onto the Provider Network team for further research and possibly provider education. Targeted training on identifying a grievance and the grievance process for all call center staff would enable these types of issues to be caught up front when they are first identified. Allowing an issue to follow the grievance process gives the organization the ability to investigate, track, and trend, and ultimately find resolutions so these issues do not continue.

Emergency and Post-Stabilization Services

During the compliance review in 2021 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.

Marketing

During the compliance review in 2021 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 Score	2022 Review Score	Finding	Recommendation
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	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.	Provide evidence of CSRs receiving additional grievance training which includes identifying a grievance, member's right to grievance filing, available assistance to member when filing grievances, and proper submission of identified grievance to ACDE's G&A department for investigation and processing.

HHO 2022 Findings and Recommendations

Member Rights, Responsibilities, and Member Communication Requirements

Enrollee rights are published in the Member Handbook, Provider Manual, and on HHO's member portal. Members are advised of their R&Rs upon enrollment and annually. Upon enrollment, the member is mailed a new member welcome letter, which details instructions on accessing the member portal as well as the Member Handbook, both of which house the member's R&Rs. The welcome letter includes information on how a member can receive a copy of the Handbook via mail or request an alternate version of the Handbook at no charge by contacting Member Services at the toll-free number. Staff members are educated about enrollee rights as part of new hire orientation; training emphasizes the requirements found in Section 1557 of the Patient Protection and Affordable Care Act, which outlines the nondiscrimination provisions prohibiting discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Corporate P&Ps globally address member R&Rs and specifically address member requests for access to health records and the right to change information including instances where access to and the right to change are denied along with due process and grievance pathways. Delegates, through contract, are required to follow all Delaware contract requirements; when necessary and appropriate HHO corporate works with delegates to provide training on key topics pertinent to the Delaware contract.

Information regarding enrollee rights and protections, available benefits, telemedicine, and how to access emergency care are all contained within the Member Handbook, which is made available in English and Spanish for both the DSHP/the Delaware Healthy Children's Program (DHCP) and DSHP Plus populations. Alternative formats of the Member Handbook, including braille, audio CD, TTY, and language translation services (including American Sign Language) are available to members at no cost. Members are advised, via the Member Handbook and HHO website, to contact Member Services via HHO's toll-free number to request translation assistance. HHO indicated the Member Advocate can also provide assistance to the member in accessing these services or in accompanying the member to the provider's office.

A full list of covered benefits, including those not covered by HHO, are available within the Member Handbook, which is accessible online via HHO's website. Information on the types of conditions that constitute an emergency and how to access emergency services versus when to use urgent or primary care is shared via the Member Handbook and is also posted online. The Handbook addresses all contractually required elements. All P&Ps are consistent with federal regulations and contractual requirements.

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 onsite review, Mercer and DMMA staff listened in on four member calls. Member Services operations were smooth and evidenced happy, customer-centric staff dedicated to assisting members to the best of their ability. During the 2021 EQR review, it was discovered that HHO did not have mechanisms for identifying whether a member is engaged in CC/CM, if the member has any gaps in care, or if the MCO had been trying unsuccessfully to

engage with the member. These issues have now been resolved with the implementation of the Altruista GuidingCare platform which took place in October 2021 and the implementation of a Care Gap Tableau dashboard which took place in November 2021 as an interim solution. The GuidingCare system allows CSRs to obtain and access updated and accurate information on each members' case, including the assigned care coordinator and others involved in the care team for that member. This system also allows the CSR to see if the member has been "lost to contact" as well as allowing the CSR to send referrals to HHO's CC and CM groups. The Care Gap Tableau dashboard allows the CSR to identify gaps in care, address those gaps, and offer assistance while the member is on the line. The Care Gap Tableau dashboard is only an interim solution as HHO stated that the MCO plans on converting to a new system, SalesForce, in August 2022. The SalesForce system will enable the MCO to import key care gaps into the data feed and thereby populate these gaps on the member 360 view that the CSR will see on each interaction with a member.

Although HHO's call center operations staff meets the requirement of receiving ongoing training, specific grievance training was identified as being needed. One member called in to state that they had received a bill from a provider. The CSR researched the services and total charges and even put the member on hold to call the provider to inquire more but was unable to reach the provider. The CSR told the member that he/she would try the provider again and would call the member back. Although, the CSR went above and beyond to rectify the issue, the CSR did not state that member had the right to file a grievance in this matter nor did the CSR forward this issue onto the Provider Network team for further research and possibly provider education. Targeted training on the grievance process for all call center staff would enable these types of issues to be caught up front when they are first identified. Allowing an issue to follow the grievance process gives the organization the ability to investigate, track, and trend, and ultimately find resolutions so these issues do not continue.

Emergency and Post-Stabilization Services

During the compliance review in 2021 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.

Marketing

During the compliance review in 2021 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 Score	2022 Review Score	Finding	Recommendation
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	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, 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.	Provide evidence of CSRs receiving additional grievance training, which includes identifying a grievance, member's right to grievance filing, available assistance to member when filing grievances, and proper submission of identified grievance to HHO's G&A department for investigation and processing.

Advance Directives

ACDE 2022 Findings and Recommendations

During the compliance review in 2021 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.

HHO 2022 Findings and Recommendations

During the compliance review in 2021 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.

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

ACDE 2022 Findings and Recommendations

In Delaware, by contract, ACDE 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 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 geo-spatial analytics, grievance, and critical incident data as well as, member and provider experience information to evaluate the effectiveness of its PNDMP.

Provider Network Account Executives (AEs) are assigned to providers continue to provide virtual visits due to the PHE. AEs play a critical role in communicating ACDE policy, conducting training on new business processes, and providing technical assistance to their assigned provider community. Various provider forums are conducted at different locations and times throughout the year. AEs completed 1,371 virtual site visits to participating providers in 2021. During a visit, AEs provide plan updates concerning P&Ps, an overview of the wellness program, Quality Enhancement Program, a high level claim summary, explain the claim dispute process, electronic funds transfer/electronic remittance advice set up, provider directory demographic requirements, and share information on provider education and training opportunities. ACDE also continues to conduct annual provider satisfaction and member experience surveys, using the results to inform network management and oversight activities.

Delegation of network development and management activities occurs using both national (Avēsis Third Party Administrators, Inc. [Avēsis] and Skygen) and local (Christiana Care Health System [CCHS], Delaware Chiropractic Services Network [DCSN], TidalHealth Peninsula, and Nemours) contracted vendors. ACDE's network management team has partnered with delegates to ensure a clear understanding of Delaware Medicaid contract requirements, and participates in ongoing monitoring and oversight to ensure compliance with key indicators and service level agreements. ACDE has also contracted with recognized Medicaid Accountable Care Organizations (ACOs) and is actively engaged in the development and proliferation of alternative payment models and value-based contract relationships.

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 Type	Number of Providers	Provider Type	Number of Providers
PCP	931	Dental	101
Specialty Care Physician (SCP)	1,261	Vision	275
BH	1,41	HCBS	119
Hospital	7	Atypical	77
Urgent Care	72	Home Health	32
NF	42		

ACDE operates a provider website and contracts with NaviNet for its online provider portal. The NaviNet portal allows for claims status check, eligibility verification, and PA submission and response as well as provider complaint submission. The provider contract templates meet all contract requirements. Submitted P&Ps demonstrate compliance with providing women with direct access to a women's health practitioner in addition to their PCP of record, allow for a second opinion, and demonstrate the use of single case agreements and out-of-network (OON) authorizations to ensure members received medically necessary care when such care or specialty is not available in-network. ACDE has updated its P&P for utilizing specialists as PCP to incorporate the State required language allowing an individual undergoing dialysis to use their nephrologist as a PCP.

Providers have access to training and education materials through the NaviNet portal and receive new provider orientation when entering the network. Two virtual provider forums were hosted in the last quarter of 2021 and quarterly newsletter and monthly provider bulletins were disseminated. The Provider Manual is a critical resource document for providers and their office staff; it is made available electronically. ACDE updated the Provider Manual to include language around the 45-day period to file a non-claim related complaint.

ACDE maintains a provider directory, which contains all contractually required elements. On a quarterly basis, ACDE conducts verification on a statistically valid sample of the provider types contained within the directory. Verification of provider data can occur through many different mechanisms but pertinent information such as a provider's race, ethnicity, language (REL), and completion of cultural competency training is captured and evaluated, along with address, phone, hospital affiliation, etc. A spreadsheet of provider REL information is maintained in the Member Contact Center and is available to CSRs to respond to member requests. Access and accommodation for individuals with physical or mental disabilities is reviewed and information on handicap access and accommodation for vision and hearing impairment are assessed by the Provider Account Representatives and included in the directory. Translation services, including American Sign Language, is available with advanced notice to the MCO.

Network monitoring activities are outlined in the PNDMP and include geo-spatial 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 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 (PRC) for further evaluation and continued participation in the network. As noted in the table below, an opportunity exists for ACDE to improve the process for using grievance data for enhanced and targeted, provider education. Provider satisfaction is monitored through annual surveys and through 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 and progress discussed during the interviews. An overview of membership demographics as well as incorporating BH and LTSS provider monitoring and oversight activities has been added to the PNDMP.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
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	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% 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.	Document full resolution of outstanding DBM UM CAP items.
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	New Finding in 2022	Minimally Met	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	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

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
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)			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.	members who may have been inappropriately balance billed. Track resolution (potentially repayment) of members who were in appropriately balance billed.

Provider Selection and the Credentialing File Review Process

Credentialing support is provided by the ACFC and is conducted in accordance with NCQA standards and modified as necessary for Delaware specific requirements and NCQA COVID-19 accommodations. ACDE maintains written P&Ps outlining its provider selection activities, which comport with federal and State specific requirements. ACDE's internal policy for provider selection includes nondiscrimination language and providers are also required to practice nondiscrimination in their approach to patient selection and treatment planning. Recredentialing follows a three-year cycle except for LTSS provider types who are recredentialed annually. Peer review activities and the Credentialing committee are operated at the local level by the Chief Medical Officer (CMO) or designee and follow all confidentiality protections, including a code of conduct for non-employee committee participants.

Delegated Provider Network Development: Credentialing

ACDE currently delegates credentialing and recredentialing of practitioners, in the local market, to CCHS, DCSN, TidalHealth Peninsula, and Nemours. Delegation oversight of these credentialing entities includes review of standards and review of credentialing files. The credentialing file review was performed using the File Review Protocol methodology outlined in Section 3. File review encompassed initial and recredentialing activities for organizational providers and independent practitioners. A sample of 30 credentialing files (15 initial and 15 recredential) were selected, including LTSS provider types. In total 10 practitioner and

10 institutional files were selected for initial review, with files split between initial and recredentialing. 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:

- Credentialing entity
- Verification of medical licensure, board certification, Drug Enforcement Administration licensure (if applicable), and malpractice insurance coverage
- Documentation of National Practitioner Data Bank and/or Office of Inspector General queries:
  - List of Excluded Individuals and Entities, System of Award Management, Excluded Parties List System, and Social Security Administration Death Master File (SSA DMF)
- Signed and dated provider attestation
- Date of previous credentialing for recredentialing, if applicable
- Logs of attempts to reach providers for credentialing, if applicable
- Documentation of internal quality review, if applicable (excludes peer review documentation)
- Documentation of decision and decision date

Overall, the practitioner and institutional files reviewed demonstrated compliance with DMMA's required 45-day turnaround time for all initial applications. Recredentialing activities occurred within the one-year cycle for LTSS providers and three-years for all other practitioners and institutions. Evidence of sanction and debarment checks, social security death master file review, collection of Clinical Laboratory Improvement Amendments waivers, and provider disclosure forms were included in the file review or supported by P&P. Interview sessions dedicated to file review demonstrated consistency with ACDE's submitted written response. Files reviewed were found to have greater than 90% compliance in the required elements.

Provider Terminations and the Provider Termination File Review Process

When a provider is terminated from an MCO network, members who had an established relationship or who had an ongoing plan of care can experience disruption in access and availability. To decrease the impact to members, MCOs are to alert members to the impending provider termination and provide assistance to transfer medical records and/or locate a new provider. ACDE's provider termination P&Ps reflect the decision making of terminating providers, appropriate look-back periods to determine established

relationships, and consider open service authorizations to limit disruption to members. Letters are sent to members and members are encouraged to call Member Services should they need assistance with locating a new provider. ACDE updates the system that feeds the Provider Directory to ensure that all known network changes are processed within the required 30-day window. Additionally, ACDE monitors its monthly provider termination reports along with the access and availability reports to gauge any deficiencies in the Provider Network.

Avēsis is ACFC's national vendor for vision benefit services and is used in the Delaware market by ACDE to provide vision benefits to its membership. Avēsis is responsible for developing ACDE's Optometry and Vision Service Provider Network. As part of its network management functions Avēsis is required to operate a provider call center, implement a provider complaint system, and process provider terminations from the network. The call center is subject to requirements outlined in ACDE's Master Service Agreement (MSA) with the State. Skygen USA, is ACDE's adult dental benefit administrator and retains overall accountability for all activities performed on behalf of ACDE and to notify ACDE of provider terminations.

The provider termination file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 provider termination files were selected for review; sampling included practitioners and institutional providers representing ACDE and delegated credentialing entities. The following elements were included in the review:

- Provider demographics
- All provider communication received and sent, including mailings (with postmark), electronic communication, and phone logs, including date
- Documentation of termination decision and justification, with date
- Documentation of termination of all applicable contracts, with date
- Notification to provider and members, if applicable

At Mercer's request, ACDE submitted a Universe file listing of all terminated providers in the last half of 2021 (July 1–December 31). A total of 265 terminated providers were identified. Termination reasons appeared primarily voluntary in nature: non-response for recredentialing, provider no longer at practice, at the provider's request, or provider not practicing/retiring. For provider types, a total of 31 PCPs were identified in the termination files. Among provider specialties, the most common were nurse practitioners and physical therapists.

There were some issues identified in the file review process, but none that rose to the level requiring corrective action. However, there is opportunity for ACDE to review its provider data quality as a result of a termination. For example, in one case the provider file (31026203), the documentation did not show the date when termination was requested from the provider or when ACDE received the

termination. This missing information hinders auditing the files as it is difficult to determine if ACDE is compliant with standards. In all PCP provider files reviewed, there was no evidence of member notification of termination of the provider. A delay in notifying provider termination could impact member access to the provider or disrupt the execution of plan of care. While no CAP is required based on the results of the file review, Mercer would encourage ACDE to review both its provider data QM practices associated with the term process to avoid unnecessary delays. Overall, the files reviewed were found to have greater than 90% compliance in the required elements.

HHO 2022 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, and monitor and maintain HHO's network of providers. While the expectation is that HHO 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 to be used as the basis for the next year's plan. HHO has embraced the concept of the PNDMP and demonstrates a CQI mindset in the enhancements and evolution of this document. HHO monitors its network adequacy monthly via cross-departmental meeting, conducts quarterly audits for panel openings, and has a PAL designated for all geographic territories and provider type.

In 2021 the Provider Training and Outreach Plan (PTOP) was incorporated into the PNDMP. Goals were tracked for each PAL using a new system 'Archer' to capture additional data fields and improve reporting. PALs play a critical role in communicating HHO policy, conducting training on new business processes, and providing technical assistance to their assigned provider community. They are beginning to take a more active role in remediating practice set up issues, educating on standards, conducting secret shopper audits, and supporting corrective action. In 2021, provider visits were primarily virtual but efforts are underway to increase in-person visits in 2022. A total of 768 visits were completed in 2021. Various provider forums are conducted throughout the year. Annual provider satisfaction and member experience surveys are conducted and results 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 CCHS, AmWell, and Nemours as credentialing delegates. HHO's Network Management team has partnered with delegates to ensure a clear understanding of Delaware Medicaid contract requirements, and participates in ongoing monitoring and oversight to ensure compliance with key indicators and service level agreements. HHO has also contracted with recognized Medicaid ACOs and is actively engaged in the development and proliferation of alternative payment models and value-based contract relationships. HHO's Alternative Payment program is geared towards primary care and incorporates the DMMA quality PMs and other quality indicators.

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 Type	Number of Providers
PCP	1,246	Minor Home Modifications	5
SCP	6,038	Home Delivered Meals	7
BH	1,204	Homemaker Chore Services	25
Hospital	12	Home Health	19
HCBS	176	Adult Day Services	10
Urgent Care	8	In Home Respite Care	24
NF	50	Personal Assistance Service Agencies	47
Dental	182	Personal Emergency Response System	14
Vision	342	Support for Self Directed Attendant Care Service	3
Assisted Living Facility	16		

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 accuracy. In addition, HHO PALs verify practice demographics, panel status, age limits, and caseload during annual goal visits with providers. HHO also reviews grievances for impacts to network. Verification of provider data can occur through many different mechanisms but pertinent information such languages spoken, wheelchair accessibility, and open panel status is captured and evaluated, along with address, phone, and specialty. In 2021, questions were added to the provider survey to assess accommodation for individuals with physical or mental disabilities. In addition, PALs educated providers on cultural competency training options and the cultural competency toolkit to increase provider completion of cultural competence training.

HHO contracts with NaviNet for its online provider portal. The NaviNet portal allows for claims status check, eligibility verification, and PA submission and response, as well as provider appeals and claims disputes/complaint submission. HHO is working to introduce a new provider portal experience in 2023. Among other things, the change will improve LTSS authorization. However, in transition, LTSS plan of care attestations and appeals/claims disputes functions were turned off in October 2021. An email work around has been established in the interim while a process to simplify the practice for providers is under development.

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 2021 and saw a 23% increase in attendance over 2020. Newsletters and provider bulletins are disseminated as necessary. The Provider Manual is a critical resource document for providers and their office staff; it is made available electronically. HHO's Provider Manual includes specificity around appointment availability standards and has been updated to incorporate the managed long-term services and supports (MLTSS) alternative service wait time standards and to capture missed or late visit reporting requirements for certain MLTSS provider types as required by contract. HHO has addressed concerns raised in past reviews regarding missing Delaware specific requirements in the Provider Directory.

Network monitoring activities are outlined in the PNDMP and include geo-spatial 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 Medicaid MCOs. Network changes (additions and terminations) are monitored monthly. Grievance and critical incident information is reviewed and, when necessary, providers are brought to the PRC for further evaluation and continued participation in the network. Provider satisfaction is monitored through annual surveys and through 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 HHO, and plans and progress to remediate the gaps were outlined in the PNDMP and discussed during the interviews. HHO has also incorporated LTSS provider monitoring and oversight activities such as missed and late visit reports and alternative service wait times.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
Submitted audit tools and quarterly reports demonstrate timely completion and an approach with content sufficient to ensure delegated entity's compliance with State and federal requirements. (5.1.2.3.4)	New Finding in 2022	Partially Met	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	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.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
			Medicaid Fraud Control Unit (MFCU) should be notified of any and all cases of suspected FWA within two business days of discovery.	

Provider Selection and the Credentialing File Review Process

Credentialing support is provided by Highmark Shared Services and is conducted in accordance with NCQA standards and modified as necessary for Delaware specific requirements and NCQA COVID-19 accommodations. Highmark Shared Services is responsible for coordinating the National Credentials Committee while the HHO CMO is responsible for chairing the PRC. Findings and recommendations from the PRC are communicated to the National Credentialing Committee. HHO maintains written P&Ps outlining its provider selection activities, which comport with federal and, at times, State specific requirements. HHO's internal guidance documents for provider selection include non-discrimination language and providers are also required to practice non-discrimination in their approach to patient selection and treatment planning. The MSA requires written P&Ps that demonstrate compliance with DMMA's provider selection requirements — many of the submitted documents lack specificity. Recredentialing follows a three-year cycle except for LTSS provider types, which are recredentialed annually. Peer review activities are operated at the local level by the CMO or designee and follow all confidentiality protections, including a code of conduct for non-employee committee participants.

Delegated Provider Network Development: Credentialing

HHO currently delegates credentialing and recredentialing of practitioners, in the local market, to CCHS and Nemours. Delegation oversight of these credentialing entities includes review of standards and review of credentialing files. In 2020, CCHS was under a CAP focused on ensuring more rapid exchange of delegate rosters that will allow HHO to maintain its compliance with the State's requirement (complete credentialing application and enter into the billing system in 45-days). Both CCHS and Nemours were approved for continued delegation and as of the time of the review all CAPs had been closed.

HHO's newly created CMO works with Functional Business Owner (FBO), Quality, and Compliance units to ensure oversight of delegated credentialing to national partners Davis Vision, UCD, and AmWell. The 2021 annual oversight audits were completed and each vendor was recommended for continued delegation.

The credentialing file review was performed using the File Review Protocol methodology outlined in Section 3. File review encompassed initial credentialing activities for organizational providers and independent practitioners. A sample of 30 credentialing

files (15 initial and 15 recredential) were selected, including LTSS provider types. The files were assessed for compliance with Balanced Budget Act (BBA) regulations, State contract requirements, and HHO internal policy standards. The following elements were included in the review:

- Credentialing entity
- Verification of medical licensure, board certification, Drug Enforcement Administration licensure (if applicable), and malpractice insurance coverage
- Documentation of National Practitioner Data Bank and/or Office of Inspector General queries:
  - List of Excluded Individuals and Entities, System of Award Management, Excluded Parties List System, and SSA DMF
- Signed and dated provider attestation
- Date of previous credentialing for recredentialing, if applicable
- Logs of attempts to reach providers for credentialing, if applicable
- Documentation of internal quality review, if applicable (excludes peer review documentation)
- Documentation of decision and decision date

Overall, the practitioner and institutional files reviewed demonstrated compliance with DMMA's required 45-day turnaround time for all initial applications. Recredentialing activities occurred within the one-year cycle for LTSS providers and three-years for all other practitioners and institutions. Evidence of sanction and debarment checks, social security death master file review, collection of Clinical Laboratory Improvement Amendments waivers, and provider disclosure forms were all evidenced in the file review or supported by P&P. Interview sessions dedicated to file review demonstrated consistency with HHO's submitted written response. Overall, files reviewed were found to have greater than 90% compliance in the required elements.

Provider Terminations and the Provider Termination File Review Process

When a provider is terminated from an MCO network, members who had an established relationship or who had an ongoing plan of care can experience disruption in access and availability. To decrease the impact to members, MCOs alert members to the impending provider termination and provide assistance to transfer medical records and/or locate a new provider. HHO's provider termination P&Ps reflect the appropriate lookback periods to determine established relationships and consider any open service authorizations to limit disruption to members. Letters are sent to members and members are encouraged to call Member Services

should they need assistance with locating a new provider. To minimize further disruption, if the provider was part of a large practice and other providers within the practice are a part of the MCO, HHO does not send the member a notice of provider termination. HHO updates the system that feeds the Provider Directory to ensure that all known network changes are processed within the required 30-day window.

Davis Vision is Highmark's national vendor for vision benefit services and is used in the Delaware market by HHO to provide vision benefits to its members. Davis Vision is responsible for developing HHO's optometry and vision service provider network. As part of its network management functions Davis Vision is required to operate a provider call center, implement a Provider Complaint system, and process provider terminations from the network. The call center is subject to requirements outlined in HHO's MSA with the State. Delegate oversight information demonstrates that HHO has been working with Davis Vision to address identified compliance issues. UCD, is HHO's adult dental benefit administrator and retains overall accountability for all activities performed on behalf of HHO and to notify HHO of provider terminations.

The provider termination file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 provider termination files were selected for review; sampling included practitioners and institutional providers representing HHO and delegated credentialing entities. The following elements were included in the review:

- Provider demographics
- All provider communication received and sent, including mailings (with postmark), electronic communication, and phone logs, including date
- Documentation of termination decision and justification, with date
- Documentation of termination of all applicable contracts, with date
- Notification to provider and members, if applicable

At Mercer's request, HHO submitted a Universe file listing of all terminated providers in the last half of 2021 (July 1–December 31). A total of 265 terminated providers were identified. Termination reasons appeared primarily voluntary in nature; non-response for recredentialing, provider no longer at practice, at the provider's request, or provider not practicing/retiring. For provider types, a total of 33 PCPs were identified in the termination files. Among provider specialties, the most common were certified registered nurse practitioners and clinical social workers.

There were some issues identified in the file review process, but none that rose to the level requiring corrective action. However, there is opportunity for HHO to review its provider data quality as a result of a termination. For example, in all PCP provider files reviewed, there was no evidence of member notification of termination of the provider or indicator that the PCP is in a large practice.

A delay in notifying provider termination could impact member access to the provider or disruption in execution of plan of care. While no CAP is required based on the results of the file review, Mercer would encourage HHO to review both its provider data QM practices associated with the term process to avoid unnecessary delays. Overall, the files reviewed were found to have greater than 90% compliance in the required elements.

Program Integrity Requirements and Confidentiality

ACDE 2022 Findings and Recommendations

During the compliance review in 2021 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.

HHO 2022 Findings and Recommendations

During the compliance review in 2021 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.

Prohibited Affiliations with Individuals Debarred by Federal Agencies

ACDE 2022 Findings and Recommendations

During the compliance review in 2021 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

HHO 2022 Findings and Recommendations

During the compliance review in 2021 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

Grievance and Appeal Systems

ACDE 2022 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 five full-time equivalents (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 three FTEs dedicated to appeal adjudication, and one open FTE.

Grievance staff facilitate the grievance investigation, sending acknowledgement letters to members, and coordinating investigations with other impacted business units. For example, the Provider Network Management team will be sent quality of service grievances; 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). Grievances are an opportunity to identify areas of improvement in the complete system of care. A greater number of grievances related to member billing was identified by the MCO, and a process was established to assist the member in resolving the issue. There is an opportunity for the MCO to evaluate the root cause of members being billed for services, and in several instances being sent to a collection agency.

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 on the last page of the member’s Notice of Adverse Benefit Determination [NOABD] letter) and sent to ACDE via US mail, fax, or email. If an appeal is filed by the 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 initial filing. The appeal start date is the date the member files the appeal (orally or written) or the date member written consent is received if filed on their behalf.

Appeals staff are responsible for sending out member correspondence including the initial acknowledgement 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 checks to ensure the proper steps have occurred and timelines are met. If an appeal hearing is requested, the member or member representative is invited to attend in person or via phone as well as the Member Advocate. Hearings are held on a weekly basis and the member or member representative has the opportunity to present the case and answer any questions. The case is deliberated, and a decision is issued and communicated to the member within two business days.

All of the required Final Rule and contract standards were met according to policies and handbooks. In general, the Grievance system appears to function well. ACDE has a strong leadership team in place for both the G&A teams. Both teams have shown great ability to identify issues within their system and change processes to rectify these situations.

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, there was an increase in the number of grievances captured and investigated over the 2021 EQR. The files reviewed were found to have greater than 90% 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 and the denial and acknowledgement of appeal letters contained appropriate and consistent language. Of note, 50% of appeals were overturned/withdrawn and 50% were upheld.

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.

HHO 2022 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 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 grievance and appeals 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 a scorecard to aid oversight activities. Appeals will be added to the scorecard in July 2022.

Grievance staff takes the lead on investigations, sending acknowledgement letters to members, and 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.

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 representative) 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. 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 acknowledgement letter, letters requesting additional information, and the resolution letter, as well as calling and/or faxing providers. If continuation of current services is requested while the appeal is pending, the analyst checks to ensure the proper steps have occurred and timelines are met. If an appeal hearing is requested, the member or member representative is invited to attend in-person or by phone. The Member Advocate also attends, along with the Standing committee. Hearings are held on a weekly basis and the member or member representative may present the case and answer questions. The case is deliberated, and a decision is made and communicated to the member within two business days.

In addition to the opportunities listed below, HHO should consider reviewing their P&Ps around oversight of delegated or subcontracted entities. During this review, evidence of a high rate of overturned appeals, before going to the Hearing committee, emerged. For instance, eviCore is granted initial UM decision making authority for the approval of high cost imaging services. Even though eviCore and HHO use the same clinical guidelines to determine medical necessity, there were a large number of files that exhibited overturned appeals by HHO. This would suggest a flaw in the initial UM decision making process by eviCore and does not reflect the member and provider-centric intentions of the DMMA contract.

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 were 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 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
- 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 HHO, and other documents supporting the investigation. After investigation is complete, cases are labeled as either substantiated or unsubstantiated based on findings of the investigation. While this delineation is not a violation of the MCO's contract with the State, it is recommended that HHO re-evaluate the use of these terms as they imply devaluation of a member's expression of dissatisfaction. Overall, the files reviewed were found to have >87% 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 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 appeals resolutions. Eleven of 30 appeals files were found to be missing written consent from the member when a provider or representative filed an appeal on the member's behalf. During the interviews with the MCO, it was explained that policy changes were made during the PHE which eliminated the need for obtaining written consent temporarily. After further investigation it has not been determined that policy changes were put into effect and therefore this does not align with federal regulations and the MCO must adhere to what is federally required. Other aspects of the file review evidenced that of the 30 case files reviewed, 15 were overturned (50%), and six were upheld (20%). Additionally, seven out of 10 appeal cases that were processed based on the subcontractor eviCore guidelines were overturned prior to Appeals committee hearing. Overall, the files reviewed were found to have less than 75% compliance in the required elements.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
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	MCO policies, procedures, and work flows 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.	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, include training program, dates of training, and staff trained.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
The MCO has a process to ensure that all QOC and quality of service grievances are fully investigated prior to issuing final grievance resolution. (3.13.3)	Partially Met	Substantially Met	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.	Review and update policies that reflect the MCO's intention to collect grievance data as part of continuous program improvement efforts.

Sub-contractual Relations and Delegation

ACDE 2022 Findings and Recommendations

During the compliance review in 2021 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.

HHO 2021 Findings and Recommendations

Changes to HHO's delegation oversight program were in process in 2020 and continued throughout 2021. In part, these changes are a result of HHO transitioning responsibilities from Gateway back to HHO and represent the creation of a Medicaid specific Vendor Management Oversight (VMO) team housed in HHO's new Medicaid Business Unit (MBU). Additionally, contracts previously held by Gateway or other operating entities have been moved to Highmark contracts with Delaware Medicaid addendums or onto HHO owned contracts; the exception is pharmacy benefits which continue to be held by Gateway. The following paragraphs provide a programmatic overview of HHO's VMO structure and approach. For the remainder of this section vendor and delegate are used synonymously.

HHO's MBU provides support to HHO for oversight of its vendors (i.e., delegates) via its VMO team. Delegate oversight occurs in a matrixed fashion involving the VMO, Compliance, Quality, and FBOs (e.g., UM, credentialing, etc.). The VMO acts as the liaison with the delegate from an oversight perspective and works with the Compliance unit to ensure the VMO framework is compatible with the contract. FBOs are identified within each business unit and aligned with the delegate's scope of services. FBOs are responsible for

the day-to-day operations and overall delegate relationship management including performing operational oversight, training, and audits. Results of delegate oversight activities are shared through the Quality committee structure (QI/UM Committee). All delegated activities follow NCQA standards and consist of a signed agreement documenting the delegated responsibilities and other pertinent contract elements, including any flow-downs from the MSA HHO has signed with DMMA. HHO ensures that all delegates undergo a pre-delegation audit, ensures routine reporting and evaluation of performance vis-à-vis the vendor scorecard, and ensures an annual delegation audit occurs within the required timeframe. Delegation oversight audit tools have been developed to capture both NCQA and Delaware-specific requirements. Audit results are reported out at the NCQA and Delaware-specific requirement levels and CAPs are requested when results fall below established thresholds. CAP oversight is shared between the FBO and VMO. HHO retains the final determination on decisions affecting delegated relationships.

After review and evaluation of HHO's delegation oversight program the EQRO found that HHO was compliant in how it conducted delegate oversight activities in 2021. The creation of the VMO unit resulted in several process improvements including development of a delegate scorecard to track delegate compliance and performance, the implementation of the semi-annual delegate attestation process, establishment of the Vendor Oversight Governance Board, and rigorous oversight of Davis Vision's implementation progress of its CAPs all demonstrate HHOs commitment to building a strong and outcomes-oriented delegate oversight model.

During the 2020 review, it was identified that HHO was not able to consistently identify the services delegated to each vendor. These inconsistencies made it difficult to ensure VMO activities conducted comported with the actual delegation scope of work assigned to each vendor and in turn HHO was issued one CAP in this area. During the 2021 review, HHO provided evidence that it has rectified the inconsistencies and now is compliant in this area.

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

Clinical Practice Guidelines and Coverage, and Authorization of Services

ACDE 2022 Findings and Recommendations

ACDE continues to have strong internal leadership with a focus on CQI to processes. For UM decision making, automation of the intake process for PA has been developed and implemented Quarter 3 2021. This allows cases to be built when a request is submitted, decreasing the time taken to build the case and increasing the time for the UM reviewer to make a determination. As decisions made outside of the turnaround times result in an administrative authorization, this process improvement has the capacity to ensure that service requests are meeting the appropriate level of care, decreasing unjustified services. Turnaround times for UM decision making is audited monthly with the expectation to have increased compliance. In 2021, a neonatal intensive care unit (NICU) team was created to review for this highly specialized population and a triggered referral is made to Level 2 CC for all NICU

admissions. Another improvement put into place is assigning a single point of contact (typically the UM manager or UM supervisor) for high volume facilities, such as CCHS, Bayhealth, Nemours, and St. Francis. At the start of this initiative ACDE had regularly scheduled meetings with the facilities; this early relationship building improved communications and the meetings are no longer needed (ACDE is available to meet if requested by the facilities).

Ongoing clinical support is available to the UM reviewers through various avenues. The UM supervisors (both for PH and BH) meet with UM reviewers to review audit findings and discuss areas of success/opportunities. Supervisors as well as peers are available for case discussion. Dedicated UM medical director reviewers are in place and rounds are held on any cases that do not meet medical necessity. If the determination is that the case does not meet medical necessity, then the medical director takes over the review.

The 2021 UM Program Description, UM Work Plan, and the 2020 UM Program Evaluation were submitted and met the contractual requirements. These documents are submitted for review and approval to the QAPI committee. Specific UM reporting is reviewed as well in the QAPI committee. The committee meets at a minimum every quarter and attendance includes the CMO and BH CMO as well as leadership from the following departments: QM, LTSS, UM, Provider Network Management (PNM), Population Health Management, HEDIS, Appeals, Member Services, Member Engagement, Pharmacy, Compliance, and Delegation. Selected in-network providers attend each QAPI committee.

The ACDE Organizational Chart depicted key positions within the UM department both on a local and corporate level. The Regional President and Corporate Director of UM Operations positions provide corporate leadership and oversight to the local MCO positions, during the 2021 EQR, it was reported there were plans to create a local director position, however this change has not occurred. The UM staff consist of 28 individuals performing duties allocated as 19.5 FTEs for Delaware Medicaid. The non-clinical intake supervisors, the BH manager, and the BH supervisor all function as 0.5 FTE for Delaware Medicaid while supporting another line of business. There are seven non-clinical intake staff that are trained on Delaware Medicaid, with 0.5 FTE of this unit allocated to Delaware Medicaid. The BH UM department is not local to Delaware Medicaid, but rather managed at the corporate level. The remainder of the UM staff work in Delaware, most remotely, while the UM manager and the UM supervisor are Delaware office based. The UM supervisor position was added and filled in 2021.

ACDE contracts with three separate delegated entities for UM activities, Avēsis for vision benefits, National Imaging Associates (NIA) for radiology, and Skygen for adult dental benefit administration. Monitoring and oversight of delegated UM activities has been a focus of ACDE. Beginning with 2021 audits, the ACDE Delegation Oversight team had followed the “8/30” NCQA file review methodology; however as of 2022 auditing, 30 approval and 30 denial files for each subcontractor will be reviewed. Review of monthly approval, denial, and appeal rates were part of the RFI submission. Avēsis had less than 1% of services denied, NIA denied approximately 22% of services, and Skygen denied approximately 50% of services. Dental services were reviewed by a separate track team with details included in Section 11 of this report. Of the number of services denied by NIA, a small portion are appealed, many though are overturned. ACDE has performed delegation oversight particularly in response to EQRO and DMMA concerns of

NIA review process. From this review, ACDE determined that the NIA system was built for speed and not quality, as a result NIA made system upgrades allowing a pended request to gather additional information prior to making a determination. ACDE has found a reduction of the number of appeals. A file review on services reviewed by NIA revealed clinically driven concerns of members presenting with concerning conditions that received denied services. NIA additional comments were submitted as follow-up to the 2022 EQR, however follow-up on members with denied services was not evident in the file review or follow-up documentation and is recommended.

From the 2021 EQR, there were 18 CAP items identified, 12 were met and closed and six remain open. There were four new CAP items identified. The remaining six CAP items are described in the table below along with the four new CAP items.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
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 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	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 to the BH manager from 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.	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.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
				4. Provide description of coordination if there is a matrix reporting relationship.
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	ACDE provided the Avēsis staffing plan. The NIA staffing plan for Delaware Medicaid was not present.	Provide the NIA staffing plan to support Delaware Medicaid and metrics.
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 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	New Finding for 2022	Substantially Met	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 that 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.	Submit the final approved Direct Access to OB/GYN policy.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
utilize OON Family Planning providers. (3.4.1.4.2.3)				
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	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.	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.
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	Partially Met	Partially Met	The number of NIA denials for Delaware Medicaid members have 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% or greater,	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

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
expedited), and the compensation for utilization activities. (42 CFR 438.210)			they note that they do not include administrative denials. During the onsite 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.	CAP review. Include follow-up that has taken place by ACDE.
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	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 onsite, 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.	Provide details of subcontractors/delegates that have been issued CAPs. Include the ACDE follow-up requirements.
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 requestor, are clearly documented and available to	Partially Met	Partially Met	The Provider Handbook available on the ACDE website did not include the required timeframe updates.	Update the Provider Handbook to include the 72 hour timeframe for timeliness of expedited organization determinations.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
DMMA or its designee for review. (3.12.6.5.2)				
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	The online availability is not clear, the links provided do not take the user directly to the Clinical Practice Guideline (CPG) listed.	Provide detail on the mechanism used to educate providers on CPGs, particularly for guidelines with recent updates. Develop upgrade to the online CPG resource that allows the user to access the CPG listed.
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	The listing of ACDE CPGs include all US Preventative Services Task Force A and B recommendations. This listing is fluid, changing. This does not allow ACDE the ability to review annually those measures included and provide guidance and education to providers on these CPGs.	Provide 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.
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	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, Discharge Planning Follow-Up Activity is created. 26. If applicable, the CC Trigger Assessment and/or CM referral to appropriate department/individual is completed.	Provide clear audit process and results for coordination with Transition and Discharge Planning.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
			27. PA — If outpatient services were denied for LTSS/CCC member, was an activity sent to the appropriate worklist. 28. Did CC follow-up on the activity?	
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	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 that 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.	Submit the final approved Direct Access to OB/GYN policy.
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	The process to review and approve both PH and BH care regardless of setting was not submitted.	Provide the UM process for authorizations when a member is inpatient for a PH condition and BH services are also needed.

HHO 2022 Findings and Recommendations

The HHO Utilization department has a solid foundation and provides clear guidance for processes within the department as well as collaboration with various internal departments. Thoughtful inclusion of UM team member input and feedback provided accountability for the program at various levels.

HHO submitted a well written Delaware Medicaid specific UM program description that includes required elements from the Delaware MSA. The UM program description, includes the process for Interdepartmental Integration, the staffing roles and structure for UM decision making, coordination for UM functions across BH-PH-LTSS, and access to UM staff, including the availability of UM on-call staff. The UM program description outlines the QI/UM committee structure; HHO also provided a detailed description of the QI/UM committee, including members, voting practice, activities, and functions. HHO submitted a Delaware Medicaid specific and fluid work plan that describes and tracks the department initiatives in place. The HHO 2021 UM Program Evaluation provided a review of PH, BH, and LTSS UM findings and highlights from the 2021 year.

HHO has a comprehensive suite of P&Ps in place, specific to the needs for management of Delaware Medicaid. The P&Ps were accompanied by numerous MBU specific DLP that are specific to Delaware Medicaid, well written, and included UM team member input.

HHO has implemented GuidingCare as a new Electronic Health Record (EHR) system. GuidingCare has elevated opportunities and advantages to HHO processes. Specifically for the UM department, GuidingCare provides the following:

1. Allows for coordination within various department as UM, CC, CM, and G&A all use GuidingCare for documentation. This allows the UM team members access to current notes and to share information. Prior to GuidingCare, the UM staff had to use a separate CC module.
2. Both InterQual and American Society of Addition Medicine (ASAM) medical necessity criteria are embedded within the EHR, allowing efficiency while reviewing and eliminating the need to use hard copy references.
3. HHO included user facing team members in the development of GuidingCare and surveyed feedback from team members once DLPs were drafted. The inclusion of feedback from team members using the system not only enhanced the overall product but supported the team which is integral to the change process.
4. DLPs were created to provide consistent processes for the UM staff to navigate GuidingCare.

HHO supported training four UM reviewers through Change Healthcare on InterQual criteria; three of those trained became Certified InterQual Trainers (one for BH, one for PH, and one to support both PH and BH.) To support CQI, the IRR target has been increased from 80% to 85%.

As of February 1, 2021, HHO's Cardiology/Radiology UM vendor changed from NIA to eviCore. As part of the transition plan, NIA managed resolution of all cases opened through January 31, 2021. eviCore sent trainers to provider locations for training and an opportunity to answer questions, allowing for in-person interaction. During the onsite review, eviCore had compliance staff members present to participate in the review and address specific outstanding questions.

HHO provided a thorough oversight and monitoring plan for eviCore. The eviCore Clinical Certification of Services include State-specific requirements as well as Delaware MSA specific language. The MCO's submission included eviCore 2020 Annual Training documents and the staff members that attended trainings.

Within the eviCore UM Delegation Oversight Plan, follow-up is required on all members who are denied services. The UM manager receives a report that provides the number of services requested, approved, and denied, and the G&A department provides the number of radiology appeals. Follow-up takes place through CC or CM outreach (or Member Advocate if member is not engaged in CC or CM) as well as an interactive voice response (IVR) call with the option of a call back from the Member Advocate. An ongoing focus is the number of denials that are overturned. The overall number of denial overturns is low, however the percentage of overturns is high.

HHO utilizes a scorecard to document oversight findings. The March 2022 eviCore scorecard included Service Level Agreement Key Performance Indicators for monthly and year-to-date results that were "at risk". A financial penalty ($1000 per month) was enforced December 2021–March 2022 and a PIP was created. HHO's process for determining if a vendor is required to develop a PIP versus a CAP sits with the department providing oversight. This leads to potential inconsistency across departments. A recommendation for HHO is to develop a system wide process for vendor oversight, specific to determining the need for PIPs and/or CAPS.

Following the 2021 EQR review, there were four UM areas requiring a CAP. One of the items was related to clarification of Davis Vision as a UM delegate. This CAP item was closed following the initial MCO technical assistance session as HHO clarified that Davis Vision does not perform UM duties for the benefits assigned to them. When services are not granted by Davis Vision for members, the case is referred to HHO UM for further determination. HHO provided the policy and DLP to support this process.

The remaining three open CAP items were related to internal audit findings within the following focused areas:

- Coordination with Transition and Discharge Planning
- State Provided Benefits

- Cultural Considerations

HHO has put into place focused audits in response to the EQRO findings and developed a new comprehensive audit tool for UM from implementation of GuidingCare. Audit scores have improved and met the 85% threshold during Quarter 1 and Quarter 2 2022, thus the remaining CAP items have been closed. HHO will continue to perform quarterly UM audits.

HHO developed a process to assess for the need for cultural considerations during the UM review process and communicate with either CC or CM when identified to assist with coordination of service. Cultural competency elements were added to the UM audit tool and competency checklist in 2022. The need for inclusion of cultural considerations was identified by HHO as a priority, going beyond addressing language barriers.

The HHO UM department has put in place a robust training program. Focus on supporting new hires has supported staff retention. Assigning a mentor/preceptor allowed for training on UM for those that came into HHO without UM experience as well as spotlighted the UM team members with exemplary performance and knowledge. HHO UM submitted training documents from 2021 trainings that took place. This included an annual boot camp and specific UM modules by Athena Forum, https://theathenaforum.org.Training took place in various settings, including pod meetings, town hall meetings, and through internal employee newsletters.

Enrollment and Disenrollment

ACDE 2022 Findings and Recommendations

During the compliance review in 2021 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.

HHO 2022 Findings and Recommendations

During the compliance review in 2021 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.

Quality Assessment and Performance Improvement Program

ACDE 2022 Findings and Recommendations

There is strong leadership in the QM/QI department that is supported by senior leadership within ACDE. There is evidence of integration of quality throughout the organization as evidenced by QAPI meeting minutes. The 2021 QI Program Evaluation includes a description of the QI activities and initiatives throughout 2021, including but not limited to the quality and safety of clinical care and quality of service activities. The evaluation includes a summary of 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 2022.

Cross-functional teams as well as three providers are used to support integration of QM/QI throughout the organization. Annual QM training is required for all and the curriculum includes specific examples to demonstrate how individual roles impact quality. The QAPI committee met five times in 2021. The committee recommended and approved P&Ps, annual program documents, clinical care reports, quality of service reports, and member experience reports.

While the Peer Review subcommittee is part of the QM/QI committee structure the review in 2021 showed it lacked a process for routine peer reviews of participating provider practice methods and patterns, including quality outcomes, prescribing patterns, morbidity/mortality rates, and QOC/quality of service grievances. Based on the 2021 EQRO findings, ACDE established a set meeting schedule for the PRC. In 2022, the PRC has met quarterly with the first meeting occurring in the first quarter 2022. The PRC reviews emerging provider practice performance concerns, data, and trends.

ACDE demonstrated evidence of a P&P for initiation or approval of a member request to amend or correct the medical record. The Compliance department manages the full process when appropriate for amendment or correction of the medical record, but all member facing staff were trained on the supporting procedure.

Previously, the quarterly clinical reports lacked data accuracy and completeness as well as staff knowledge in being able to fully respond to questions in regards to the data results. Subsequent to last year's review, ACDE developed a workflow for submission of the quarterly clinical reports and discussions during the ongoing quarterly meetings has improved. The results have not necessarily improved, but the process for reporting and responding to questions has improved.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
The MCO creates, reviews, and approves all contractually required reports that ensures 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	The 2021 finding regarding reporting and preparation for discussing information in 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.	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.

HHO 2022 Findings and Recommendations

The QM/QI department of HHO has faced significant challenges throughout the past several years. Early in 2020, HHO hired a Quality director, fulfilling the contractual requirements for this position. Throughout 2020, the Quality director assessed the QM/QI department staff and operations, assessed the need for additional staff, and approaches to quality initiatives. Throughout 2021 the QM/QI department hired additional Quality staff and implemented the improved quality processes identified in the 2021 Quality Program description. As noted in the previous EQRO report, innovation, successful implementation, and management of initiatives are key to achieving the results the MCO anticipates. With the additional staff, training approach, and the current direction of the QM/QI department and committees described below, the HHO QM/QI department appears to be improving and focused on CQI in their internal processes as well as improved outcomes for HHO members.

The QI training program has grown over the past two years. Prior to 2021, the Quality team had no official training program in place; since then, the team has sourced internal and external resources, seminars, and other modules and tools to add to the team's training library. A training policy has been developed and is reviewed at least annually. The Quality team management rebuilt the training program to anticipate the needs of new and existing staff alike, and all departmental staff has received the necessary training. The team completed the development of training materials that covers fundamental QM concepts and CQI methodologies. In 2021, the team continued to add training opportunities to staff. Monthly trainings now occur. Other, more specialized trainings may be required for some staff based on their role and expertise, but the entire team is also provided the opportunity for these specific events.

In 2020 and 2021, improvements were made to the functioning of the QI/UM committee and its subcommittees, the Internal QI subcommittee, and PRC. In Quarter 3 2021, the team chose for all three committees to meet monthly; this allowed for the team to have more meaningful discussion, versus working through a quarter's worth of data and reporting. The increased meeting frequency has allowed participating provider members to keep a better pulse on HHO activities and thus are able to make more pertinent recommendations to HHO at the QI/UM committee, while for HHO staff at the Internal QI subcommittee, teams have found a reliable and valuable source of discussion and insight.

- A significant change in 2021 was the function of the PRC. The HHO QI/UM PRC serves to:
  - Define, evaluate, and make recommendations regarding quality of patient care and services delivered to members by the provider network.
  - Perform physician advisory functions, in peer review, for QI.
  - Oversee peer review of QOC concerns and evaluate cases that may need further action, such as an explanation of the occurrence/incident or a CAP.
  - Evaluate the PCP profile report results. Outlier data will be evaluated, and further action will be determined (i.e., CAP, policy recommendations, etc.). This review will occur at least on a quarterly basis (as the report is generated), and on an ad-hoc basis, as needed.

The MCO conducted the Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS), Child CAHPS, and a CC satisfaction survey to assess member satisfaction with the MCO and health care services. The top three Adult CAHPS results for HHO were Customer Service, Rating of Personal Doctor, and Rating of Health Plan. The bottom three results in need of improvement were Coordination of Care (also in the bottom three in 2020), Getting Care Quickly, and How Well Doctors Communicate. The top three 2021 Child CAHPS survey scores were Rating of Health Plan, Rating of Health Care, and Coordination of Care. The bottom

three measures were Getting Needed Care, Getting Care Quickly (both in the bottom three in 2020), and How Well Doctors Communicate.

HHO evaluates member experience with its Care Management program by obtaining feedback from members and analyzing member complaints. Health Options evaluates overall satisfaction with its CC program. It is a measure of the ability of Health Options care coordinators to provide member/caregiver education, assist with member self-management, provide supportive counseling, offer practitioner education, and support members who have complex health care needs. Health Options Management and Executive Leadership set a performance goal of an 85% positive rating with the overall Care Management program and on each satisfaction survey question rating care manager's effectiveness. The HHO member's average overall satisfactions with the Health Options Care Management program is 89.8% exceeding the benchmark of 85%. This is a decrease from the previous year's rating of 90.5%. The lowest score of satisfaction is at 82.7% in the elemental question How helpful was the Highmark Health Options Manager in providing referrals to community resources (e.g., housing, food bank, etc.), if requested?

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
The MCO provider practice analysis includes implementation of a CAP, if necessary. (3.13.7.1.3)	Partially Met	Substantially Met	The MCO has developed a policy that includes 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.	Correct the numbering of duplicative PCPP Report policies MBU-QI-POL-503 and MBU-QI-POL-060.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
The MCO provider practice analysis includes development of policy recommendations to maintain or enhance the QOC provided to members. (3.13.7.1.4)	Partially Met	Substantially Met	The MCO has developed a policy that includes 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.	Correct the numbering of duplicative PCPP Report policies MBU-QI-POL-503 and MBU-QI-POL-060.
The MCO creates, reviews, and approves all contractually required reports that ensures accuracy and timely submission. (Note: Review passed year QCMMR and clinical reports to identify ongoing areas of inaccuracy.) (3.21.1.2)	New Finding for 2022	Partially Met	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 extraction of dental data. It was evident during the review that no validation of this code was performed.	Develop a process to validate 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.

Coordination and Continuity — Primary Care and Special Health Care Needs

ACDE 2022 Findings and Recommendations

ACDE has struggled to meet contractual requirements to deliver a successful and comprehensive CC program. Challenges identified included, but were not limited to, turnover in the Health Services director position; significant difficulty developing and validating a functional risk stratification plan and methodology; inability to maintain contractually required Level 2 CCC staff ratios; the absence of a formal training plan; failure to ensure integration of PH and BH, including SUDs; inability to develop and implement member case file audit processes that evaluate both quantitative and qualitative aspects of CC provided to members; and failure to address longstanding on-compliance identified in EQR CAPs.

The 2021 EQR resulted in 33 CAP areas for CC. ACDE submitted regular updates to the CAP and demonstrated progress in certain areas but challenges remain in core program areas. Following the 2022 review 16 CAP areas fully met the requirements and were closed, while 17 remained out of compliance resulting in continued CAP monitoring. A focused review of the Bright Start Maternal Health program was conducted in 2021 with a report issued in October 2021. Monitoring of the recommendations occurred during 2022. The Bright Start program is now included as part of CC.

The Health Services director position was filled August 30, 2021. Organizational Charts demonstrate a fully staffed leadership team, although it is not clear from the Organizational Chart who the Director of CC reports to or if there is any corporate support. The CC pods are included and reflect a 1:15 supervisory ratio. All positions are full-time and reside in Delaware.

Recruitment efforts and staffing retention were prioritized resulting in the MCO making substantial hiring additions in 2021 including care coordinators, resource coordinators, managers, supervisors, and a director. Allocated positions at the time of review included 22 resource coordinators, one senior resource coordinator, three maternal health resource coordinators, 52 care coordinators, two senior care coordinators, two care coordinator managers, seven care coordinator supervisors, 10 maternal health care coordinators, one maternal health care coordinator supervisor, one BH clinical manager, and one director of CC. Submitted documentation reflected a supervisor to staff ratio meeting the requirement of 1:15. Caseload ratios were reported to be in compliance with the 50 and under requirement; however, during a file review presentation it was discovered that members were being placed on a waiting list for Level 2 and outreach was not occurring in a timely manner. This was a significant finding that had not been reported during any of the technical assistance sessions or the quarterly clinical reporting meetings.

Staffing also reflects that the CC team includes 65% BH specialists in the RC clinical care coordinators and leadership staff. Members are assessed and triaged based on their needs using a High BH, High PH, and High BH and PH model. Written workflows support use of screening tools and referral to Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE).

A comprehensive new hire orientation and ongoing training plan was developed. All new hires are assigned a preceptor and are provided with checklists of required trainings and competencies. New hire training is expected to be completed within the first 30 days of employment. Trainings are completed via anytime learning, clinical systems training, and with the supervisor and preceptor. Completion of training and application of the content is included in the employee development plan.

ACDE revised the CC program description and strategy. The model uses a population health management framework to match members to the level of support they require to address PH, BH, and health-related social needs (HRSNs). The CC team includes nurses, social workers, BH clinicians, and non-clinical care connectors. Programs include Complex CCC, Bright Start Maternity, and Pediatric/Adolescent preventive health and disease management.

An integrated Pod team approach was implemented February 28, 2022, which includes BH and PH specialists and RC. Each team has a 20 minute daily huddle designed to function as a staff check in, discuss concerns, and review high-risk members. There is not an established process to ensure case discussion and recommendations from huddles are documented into the case file and plan of care.

The risk stratification logic was revised. The criteria for Level 1 and Level 2 members are clearly defined. The entire membership is restratified on a monthly basis. Members who are leveled down from Level 2 to Level 1 or from Level 1 to an all member level are reviewed by the CMO and/or the Chief BH Officer to ensure appropriate clinical stratification. Members who are leveled up from Level 1 to Level 2 are also reviewed as well as new members who stratify to Level 2.

All CC staff were trained on the Care Management Society of America (CMSA) standards of CM practice. Care coordinators utilize clinical pathways for different conditions including asthma, diabetes, maternal health, substance use, and general CC. Linguistic needs are managed through a bilingual Member Advocate and interpreter services and translation of written materials.

ACDE has demonstrated improvement in meeting requirements related to inpatient and transition of care. A daily inpatient census report is generated and shared with the team. An integrated Pod team model was developed in 2021 and includes a transition of care team that focuses on inpatient and ED visits. CC staff are embedded in a number of PH and BH facilities. Outreach is expected within one to two business days of the admission and is monitored through Jiva call tracking. Care coordinators can meet with members, attend team meetings, coordinate with UM, and assist with referrals and services for members. Care coordinators use a discharge planning checklist to guide the member interaction and case auditing is used to monitor required activities related to transition of care.

ACDE document submission was not clear and concise related to the requirement it is intended to demonstrate. The desk review materials included multiple and repetitive documents without specific reference to the intended demonstrated requirement. The case file submission documentation was confusing to follow, the notes were not always sequential, and the case status was unclear.

In many areas, there are inconsistencies between ACDE written policies, procedures, and workflows and the member file reviews.

The policies, procedures, and workflows outline a seamless transition from one level of program to another, and the Jiva platform is designed to integrate UM, CC, and Pharmacy department functions. However, the file reviews do not consistently provide evidence that an integrated approach is occurring. For example, findings included: delays in outreach when members transition from one program to another, BH and HRSNs are not consistently addressed and include follow-up, and plans of care are not consistently completed and/or are not comprehensive. Outreach, assessment, and care planning activities are other examples of the policy.

Provider Network Management implemented biweekly provider training sessions to educate and engage providers in the Bright Start program on May 2, 2022, at the time of the onsite review no providers had joined the live sessions.

The formal QI process does not appear to adequately evaluate the extent to which the CC is meeting State, MCO, and member goals and objectives. The process should address how member case file reviews are conducted to ensure files reflect appropriate outreach, assessment, care planning (when appropriate), follow-up to member identified needs, and fidelity to generally accepted medical record documentation standards.

All Member Level Coordination

ACDE continued to fall short of the 40% HRA completion goal for new members within 60 days of enrollment in 2021. Several initiatives were put into place to meet this contractual obligation, this included increasing the member monetary incentive, implementation of a “Make Every Call Count” culture to all member facing teams to ensure HRA’s are addressed regardless of reason for the inbound or outbound call, expansion of days and hours for outbound calls, web based improvements for member portal, and use of race, ethnicity, and language data to align members with bilingual team members.

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 HRA, confirmation of a PCP is reviewed and assistance provided when a lack of a PCP is identified. RC identified barriers to securing appointments which included wait times of 30 days or longer, which is out of compliance with network standards. Network management does conduct monthly Access and Availability call monitoring and while no deficiencies have been reported, there is no formal mechanism for RC to communicate to Network Management when primary care access is limited.

Members are identified for Wellness programs through the HRA, risk stratification, provider, and self-referral as well as other outreach efforts. Referrals to Wellness programs are tracked via the Wellness program survey in Jiva.

Level I Resource Coordination

ACDE has updated the risk stratification model and the criteria for RC are clearly defined. Restratification occurs monthly and any members who are “leveled down” from Level 2 to Level 1 are reviewed to ensure the clinical assignment is appropriate. Resource coordinators were trained on the use of a checklist that includes criteria for elevating a case to Level 2.

The supervisor to resource coordinator ratio is compliant and does not exceed 1:15. Monthly supervision is held and monthly file audits are conducted by the corporate auditing team for enhanced objectivity. IRR is conducted on a quarterly basis via a Survey Monkey platform which allows for scoring, data analysis, and record keeping. The submitted audit findings were difficult to interpret. The goal of 95% was not met from September 2021 thru December 2021, and numerators and denominators of the indicators were not always identified. Opportunities included completing the survey within the required timeframe, identifying unmet needs, completing screenings including the HRSN, Patient Health Questionnaire (PHQ), and Edinburgh depression and following up on linkages.

Level 1 Resource Coordination File Review

Mercer completed a review of 15 Level 1 RC files. The files were reviewed for compliance with contract standards and to evaluate the extent to which the cases successfully met the four domains identified on the standardized scoring tool: Outreach and Engagement, Coordination of Care, Condition Management and BH/SUD, and HRSNs. Domains were scored as “substantially met” when all or most of the expectations for RC were reached and documented appropriately. Domains were scored as “partially met” when documentation reflected that some RC activity was present. Domains were scored as “not met” when documentation demonstrated that RC expectations were not reached. For members who were reached and declined RC, the Outreach and Engagement domain was the only domain that could be assessed, so all subsequent domains were scored as “Not Applicable” (N/A). For the members who were unable to be reached, the only domain that was able to be scored was Outreach and Engagement, so all subsequent domains were scored as N/A.

The preliminary findings were reviewed with DMMA and ACDE at the onsite interview and four member records were reviewed including Bright Start members in the ACDE CC system. An additional session was required in order to review more cases due to concerns with RC.

Of the 15 Level 1 RC case files reviewed, nine were outreached, engaged, and able to be fully scored and evaluated. Five members were never reached, and one was initially reached and then agreed to the program but was lost to care. Of the 9 fully scored cases, scores ranged from 30% to 100%.

The case file review supported the audit findings and demonstrated missed opportunities for outreach, lack of follow-up care, and assignment of a case to a non-working queue, resulting in delays in outreach. The path of the member in CC was also difficult to follow in the case file submission.

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	Resources coordinators generally made outreach calls per protocol and outreached pharmacies and other providers to obtain accurate contact information.	Multiple files display gaps in outreach. There were missed opportunities to outreach hospitalized members or those routinely seeking treatment. There were missed opportunities to engage unable to reach members who made inbound inquiry calls. Call monitoring is recommended to evaluate program offering.
Coordination of Care	A Bright Start case file demonstrated notification to the OB/GYN about the member's Edinburgh depression score.	Multiple opportunities were identified to outreach providers to engage in a care plan to address care gaps and identified needs.
Condition Management/BH SUD	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.
HRSNs	A Bright Start case file demonstrated referral to programs, linkages to services such as diaper and food banks, and conducted follow-up.	While resources were provided when a need was identified in some cases, follow-up was not routinely provided to close the loop and ensure that the member had made contact with the resources provided and that the member's needs were then met.

Level 2 Clinical Care Coordination

ACDE has updated policies, procedures, and workflows with the goal of improved processes, however audit results and file reviews continue to demonstrate inconsistencies in practice. The Level 2 audit results in 2021 had a 92% average and from May 2021 through December 2021 the 95% goal was not met. Opportunities were identified in following HIPAA guidelines, completing the initial assessment, completing depression screening and referral for positive depression screens, evaluation of community resources, development of a care management plan, scheduling follow-up, completing plans of care, and identifying high priority goals.

Interventions include 1:1 coaching that includes review of a job aide, refresher training on care plan requirements, and weekly and monthly supervisory oversight.

Level 2 Clinical Care Coordination File Review

Mercer completed a review of 15 Level 2 CCC files. The files were reviewed for compliance with contract standards and to evaluate the extent to which the cases successfully met the five domains identified on the standardized scoring tool: Outreach and Engagement, HRSNs, Assessment, Coordination of Care, and Care Plan Development. Domains were scored as “substantially met” when all or most of the expectations for CC were reached and documented appropriately. Domains were scored as “partially met” when documentation reflected that some CC activity was present. Domains were scored as “not met” when documentation demonstrated that CC expectations were not reached. For members who were reached and declined CC, the Outreach and Engagement domain was the only domain that could be assessed, so all subsequent domains were scored as N/A. For the members who were unable to be reached, the only domain that was able to be scored was Outreach and Engagement, so all subsequent domains were scored as N/A.

Of the 15 Level 2 CCC case files reviewed, nine were outreached, engaged, and able to be fully scored and evaluated. One member agreed and then was lost to care, and five were never reached. Of the nine fully scored cases, scores ranged from 48% to 100%. More robust CC was noted in documentation in 2022.

File reviews demonstrate that very few care plans are completed. Level 2 CCC file review findings indicate there are significant challenges in reaching members and engaging members and, as a result, it was difficult to assess the extent to which MCO care coordinators are conducting comprehensive assessments.

The preliminary findings were reviewed with DMMA and ACDE at the onsite interview and six member records were reviewed in the ACDE CC system. Maternity cases were included in the review. An additional session was required in order to review more cases due to concerns with CCC. This included a review of one member identified through G&As and another through the Information Systems Capabilities Assessment review.

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	Member who were reached were largely agreeable to engage in CC.	Delayed outreach was noted as a result of members being assigned and placed on a waiting list. One case was assigned to the wrong queue resulting in outreach delays. Care coordinators communicated with family members and guardians but there was no documentation of signed release of information. There continue to be significant challenges in reaching members or maintaining engagement with members. There were missed opportunities for outreach during member hospitalizations.
HRSNs	When screenings were completed, CCC offered resources.	While resources were provided when a need was identified in some cases, follow-up was not routinely provided to close the loop and ensure that the member had made contact with the resources provided and that the member's needs were then met.
Assessment	One file notes an appropriate referral to LTSS.	Many scored cases had incomplete assessments due to inconsistent contact with members.
Coordination of Care	One file notes coordination of care with ACT team and PROMISE. One file demonstrates CC with OB/GYN for postpartum depression.	Missed opportunities for BH and SUD referrals.
Care Plan Development	One file demonstrates the assessment findings incorporated into the care plan.	Most scored cases had incomplete plans of care due to inconsistent contact with the member.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
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	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.	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.
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 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	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.	Conduct a staffing analysis to determine adequate staffing needs to comply with contractual requirements.
The MCO provided data regarding HRA completion, evidences compliance with 60-day outreach standard, and demonstrates active	Partially Met	Partially Met	The number of completed HRAs continued to fall below the goal of 40% in 2021. The submitted documentation for 2022 also contained rates below the goal which was attributed to use of an	Provide narrative for the HRA completion rates reported for EQR and QCMMR including member count month and submission month.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
outreach and engagement within the first 30 days. (3.6.2)			incorrect member listing for outreach. Completion rates were also submitted for future dates. (July 2022).	Provide updates related to the transition from Pursuant to Icario, include the data transfer process to avoid delays or missed assessments.
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	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.	Provide the process and evidence to include case discussion and recommendations from huddles are documented into 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.
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, Division of Substance Abuse and Mental Health (DSAMH), and other community-based entities including school-based wellness centers. The process should address coordination of PH and BH conditions and social determinants of health needs. (3.6.1)	Minimally Met	Minimally Met	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.	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.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
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	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 onsite, barriers to securing appointments were identified including wait times of 30 days or longer.	Provide standalone P&P or checklist for RC and CC to coordinate with provider relations on barriers of meeting network adequacy standards.
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 HEDIS measures. (3.4.6.3.4, 3.6.3.4.6.2.7)	Partially Met	Partially Met	A process for identifying, tracking, and closing gaps in care is documented but case file reviews do not support the process is consistently followed.	Provide evidence, based on focused audits of CC member records, demonstrating fidelity to the process for identifying, tracking, and addressing gaps in 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 into 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	Partially Met	Partially Met	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 outreach members within 48 hours of 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	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.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
LANE ED utilization. (3.6.3.3.2, 3.6.3.3.2)			30 days of the ED visit is monitored.	
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	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.	Provide updates on task force and plans to extend efforts beyond CCHS.
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	The supervisor to staff ratios of RC meet the 1:15 requirement. Monthly file audits are conducted however the goal of 95% 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.	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.
The MCO has P&Ps that indicate all initial outreach occurs within 15 days of 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	Partially Met	Not Met	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	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

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
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)			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.	• 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.
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, psychological needs) including input from the member's caregivers, family, PCP, and other providers, as appropriate. All 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)	Partially met	Partially Met	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.	Provide evidence, based on focused audits of CC member records, demonstrating fidelity to the process for meeting assessment standards.
The MCO's P&Ps, file reviews, and/or tracer scenarios evidence person-centered planning processes. All plans of care include at a minimum prioritized goals and actions, effective and	Partially Met	Partially Met	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	Develop or update the audit tool to monitor the required components for the care plan. Provide audit results demonstrating compliance with contractual requirement.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
comprehensive transition of care plan, a communication plan with PCP and other providers, list of providers delivering services to the member, listing of other services received by programs other than those provided by the MCO (to avoid duplication), evidence of referral to 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)			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.	
The MCO has a process to monitor care plans and initiate updates and revisions to member's plan 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	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.	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.
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	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, assessments completed per month.	Document the process to ensure timeliness of outreach and compliance with contract timeframes are met and no waiting lists are utilized.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
			The case file reviews also revealed delayed outreach due to members being assigned to a waiting list.	
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 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	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%. The auditing is designed to evaluate checklist activities and clinical appropriateness. The Level 2 audits had a 92% average for 2021 and the 95% goal was not met from May 2021 thru 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% is required for passing. The IRR assessments determine the level of consistency of CC	Provide comprehensive audit results and continue to submit audit results until the 95% 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 Score	2022 Review Score	Finding	Recommendation
			and development of a person-centered care plan.	
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	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.	Demonstrate how the program evaluation is translated into actionable items to address the noted deficiencies found in the program.

HHO 2022 Findings and Recommendations

HHO has a strong and effective infrastructure for the CC program inclusive of processes, workflows, job aids, and DLPs, which support ongoing operations and ensure contract requirements are met. There is a comprehensive CC training plan that addresses both initial and ongoing training. HHO has maintained consistent and competent leadership for the CC program and HHO resource coordinators and clinical care coordinators demonstrate a commitment to improving the lives of Medicaid members.

HHO transitioned its EHR system from Electronic Health System (EHS) to GuidingCare Platform on October 25, 2021. The GuidingCare Platform was designed to significantly enhance CC by facilitating interdepartmental referral and communication, building in required activities and timeframes, utilizing assessment tools that populate to care plans, supporting a Mobile Clinician feature which allows for upload of documentation without internet access, increasing reporting accuracy and providing oversight tools. The transition to GuidingCare also involved updates to policies, procedures, and DLPs as well as changes to the CC assessments and

care plan template. Through the onsite review and demonstration HHO provided evidence of the platform improvements and employee satisfaction with the platform was evident.

HHO implemented a dedicated Transition of Care team in October 2021 and the team was trained on the Coleman model. This includes using pre- and post-assessment tools, meeting the member face-to-face during the hospitalization and focusing on medication self-management, use of a personal health record, identifying red flags, and attending timely follow-up care. The 2022 first quarter discharge planning audits show higher scores using the Coleman model as compared to the Level 2 discharge planning audits.

The Maternal Health program underwent significant updates including the program guide, P&Ps, updated assessments in GuidingCare, and efforts to improve interdepartmental collaboration. CC staff were offered trainings relevant to pregnant members including substance use and HRSNs. The updated risk stratification includes the addition of a postpartum cohort.

All Member Level Coordination

HHO hired four part-time employees focused on HRA completion and referrals to resources in addition to using Icario, who is delegated for HRA completion. HRA completion rates demonstrated improvement in 2021 with results as follows: Quarter 1 32.42%; Quarter 2 40.91%; Quarter 3 48.02%; and Quarter 4 45.56%.

HHO developed a Wellness Program Provider Training Plan though a collaborative interdepartmental workgroup that included representation from provider network, CC, member experience, pharmacy, business solutions, and quality. The Wellness Program is focused on PH and BH conditions and HRSNs. Provider training and education is offered through multiple approaches including in-person, newsletters, portal, and webinars. HHO utilizes a platform called Brainshark that allows for the creation of training modules. HHO tested the Brainshark platform with a module on Culturally Competent Care to a pilot group of providers with plans to distribute to a larger audience later in the year. The Provider Relations team is monitoring the volume of providers receiving education and training and will revise the materials as the programs are updated. HHO evaluates the Provider Wellness training plan through the Annual Provider Satisfaction survey and the Annual Network Program evaluation.

Level I Resource Coordination

HHO’s risk stratification model was revised to apply Predictive Modeling to all transition of care members considering co-morbidities and complex needs. A daily report is utilized to ensure members are appropriately stratified and can be “leveled up” to Level 2 if their needs and conditions are too complex for Level 1. HHO has written guidelines to determine when a member would benefit from Level 2 CCC.

Focused monthly audits are occurring to ensure members being discharged from inpatient are being assigned to the appropriate level of CC. Results in the first quarter of 2022 are 97% or above.

Level 1 Resource Coordination File Review

Mercer completed a review of 15 Level 1 RC files. The files were reviewed for compliance with contract standards and to evaluate the extent to which the cases successfully met the four domains identified on the standardized scoring tool: Outreach and Engagement, Coordination of Care, Condition Management and BH SUD, and HRSNs. Domains were scored as "substantially met" when all or most of the expectations for RC were reached and documented appropriately. Domains were scored as "partially met" when documentation reflected that some RC activity was present. Domains were scored as "not met" when documentation demonstrated that RC expectations were not reached. For members who were reached and declined RC or who were unable to be reached, the Outreach and Engagement domain was the only domain that could be assessed, so all subsequent domains were scored as N/A. The member files were submitted in a well-organized format that was concise and easy to follow.

The preliminary findings were reviewed with DMMA and HHO at the onsite review. During the interview, three member records were reviewed in the HHO GuidingCare system.

The file review demonstrated robust outreach attempts, but eight members were unreachable, initially reached and then unable to be contacted, or declined CC. Two members were appropriately referred to Level 2. Of the five fully scored cases, one scored 53%, one scored 78%, one scored 88%, one score 93%, and the highest score was 100%. Many of the members had significant medical or BH conditions but there was limited evidence of referral to BH, substance use or PROMISE.

The following table displays the findings by domains, identifying strengths and opportunities. Please consider that not all sections of the case files could be scored as some members were unable to be reached or declined to participate in RC, thus the numerator of outreached and engaged members was very small.

Review Area	Strengths	Opportunities
Outreach and Engagement	The files demonstrated a great deal of outreach activities including reviewing claims and outreaching providers and pharmacies in order to obtain accurate contact information. Outreach was largely conducted within the two business day requirement.	There is a recurrent issue of needs being identified on the initial call and then subsequent efforts to engage or reach the member are unsuccessful, leaving needs unaddressed. HHO may benefit from ensuring assistance is offered during the initial touch point to engage the member. Call audits may be useful to evaluate the RC program offering. HHO should assess whether HIPAA verification measures are occurring at the initiation of calls.

Review Area	Strengths	Opportunities
Coordination of Care	Preventative care gaps are frequently identified and discussed with the members. One file demonstrated robust coordination between HHO, Division of Family Services (DFS), and the facility. Translation services were secured for members to ensure communication needs were met.	The files did not contain evidence of outreach to providers, notifying them of the gaps in care.
Condition Management and BH SUD	The 24 hours a day, seven days a week Nurse Line and Member Services phone number were provided to several members.	A member with a recent opioid dependence would have benefited from a SUD referral.
HRSNs	In one case the care coordinator assisted the member with an application to Women, Infants, and Children (WIC), postpartum food supports, and diaper pantries. Supports and resources were offered even if member declined CC.	While resources were provided when a need was identified in some cases, follow-up was not routinely provided to close the loop and ensure that the member had made contact with the resources provided and that the member's needs were then met.

Level 2 Clinical Care Coordination

HHO has improved the process for evaluating compliance with contractual timelines for outreach and assessment. DLPs clearly define the requirements. The GuidingCare Platform is designed to assign activities with due dates that meet the contractual requirements. Outreach timeliness is monitored using a tableau report that provides case age and outreach attempts and through monthly clinical auditing and HHO Government Compliance monthly monitoring. Timeliness to complete a comprehensive assessment is monitored through HHO Government Compliance monthly monitoring and clinical corporate auditing using a focused tool. The focused audits began in December 2021 and scores were 100% through April 2022, with the exception of January 2022 which had a score of 93%.

Level 2 Clinical Care Coordination File Review

Mercer completed a review of 15 Level 2 CCC files. The files were reviewed for compliance with contract standards and to evaluate the extent to which the cases successfully met the five domains identified on the standardized scoring tool: Outreach and Engagement, HRSNs, Assessment, Coordination of Care, and Care Plan Development. Domains were scored as "substantially met" when all or most of the expectations for CC were reached and documented appropriately. Domains were scored as "partially met" when documentation reflected that some CC activity was present. Domains were scored as "not met" when documentation

demonstrated that CC expectations were not reached. For members who were reached and declined CC, the Outreach and Engagement domain was the only domain that could be assessed, so all subsequent domains were scored as N/A. For the members who were unable to be reached, the only domain that was able to be scored was Outreach and Engagement, so all subsequent domains were scored as N/A.

Cases were reviewed during the onsite review which provided clarity to the care plan template. A particularly challenging case was reviewed which demonstrated significant effort by the care coordinator to collaborate with the member, his family, hospitals, PROMISE, and DSAMH in order to provide appropriate treatment to ensure his and other's safety.

Of the 15 Level 2 CCC case files reviewed, 12 were outreached, engaged, and able to be fully scored and evaluated. One member declined CC, and two were never reached. Several people agreed to the program and completed assessments but were lost to follow-up before the next assessment and treatment plan update. Of the 12 fully scored cases, scores ranged from 53% to 100%.

The following table displays the findings by domains, identifying strengths and opportunities.

Review Area	Strengths	Opportunities
Outreach and Engagement	The files demonstrated a great deal of outreach activities, including outreach to hospitalized members.	Evaluate opportunities to offer more supports, referrals, and resources on the initial calls as several members were lost to care. Documentation does not always reflect HIPAA disclosures on calls or completion of a release of information if someone is speaking on behalf of a member.
HRSNs	One case demonstrated case conferences with DDDS, the member, and caregivers to discuss housing options. File reviews included documentation that referrals were made to food stamps, Modivcare.	In one case where the member suffered a gunshot wound the mother answered "no" to the question do you feel safe in this neighborhood and this was not explored.
Assessment	Most files for engaged members showed completed assessments including initial assessments, PHQ 2, maternity, and postpartum.	Utilize the GuidingCare functionality to link assessments to care plans.

Review Area	Strengths	Opportunities
Coordination of Care	Robust Collaboration was noted with providers, facilities, and the interdisciplinary team. In one case, referrals were made to Spanish speaking counselors. Documentation reflects that care plan was shared with the OB/GYN. One member was appropriately referred to LTSS.	Evaluate opportunities for continued provider engagement as in some cases only a message was left for the provider.
Care Plan Development	One file noted the closure of care gaps related to cervical screening and education was provided on chronic obstructive pulmonary disease and an asthma action plan.	Utilize the GuidingCare functionality to create targeted and individualized care plans. It was unclear if plan of care was shared with member or providers in some cases.

HHO demonstrated commitment to serving Delaware Medicaid membership through a variety of process improvements and oversight activities within the CC department; a well-developed response to the 2021 EQR findings and recommendations were evident. HHO had six CC CAP items identified, all of which have been met and closed. The following is a summary of the 2021 CAP items and the activities HHO put into place to meet these requirements.

The HHO risk stratification plan had met DMMA contract requirements with the exception of risk stratification for members who are being discharged from inpatient PH and BH admissions. An updated risk stratification was submitted in June 2022 that includes enhancements to identify high-risk pregnant and postpartum members through the use of Lucina and Wayspring vendors. A new risk stratification was approved November 17, 2021 and went into effect February 14, 2022.

The DMMA approved Wellness Program Provider Training Plan was not submitted as part of the 2021 EQR review. HHO developed a Wellness Program Provider training which was approved. Provider education and training is offered in a variety of modalities including: in-person, webinars, mailed, provider portal, and Brainshark. Provider relations will revise any education and trainings as they are updated by the clinical team.

During the 2021 EQR review, member case file review findings suggested some members with multiple co-morbidities and/or complex conditions were assigned to Level 1 CC. Focused audits have demonstrated improvement in member assignment to the appropriate level of CC. HHO has written guidelines to determine when a member would benefit from Level 2 CCC.

HHO had provided information during the 2021EQR review that member case file audits focused on ensuring timeliness of outreach efforts, but indicated there is not a formal monitoring or reporting process in place to evaluate the extent to which outreach efforts comply with contract timeframes. DLPs clearly outline these requirements. The new GuidingCare Platform configures outreach activities aligned with contractual due dates. Compliance is monitored in real time through the outreach tracker in tableau and also through audits. The DLPs clearly outline this requirement.

HHO provided information during the 2021 EQR review about the process and tools used to evaluate compliance with contract requirements for timely completion of member assessments. However, member case file review findings suggested there is a need to further assess the extent to which assessments are appropriately dated and completed within prescribed timeframes. The GuidingCare Platform configures assessment activities aligned with contractual due dates. Compliance is monitored through clinical and corporate audits.

HHO provided information during the 2021 EQR review about member case file audits focused on ensuring timeliness of outreach efforts, but indicated there is not a formal monitoring or reporting process in place to evaluate the extent to which outreach efforts comply with contract timeframes. Monitoring occurs through the GuidingCare Platform produces a report that shows outreach activities and case age. The Level 2 outreach tracker report auditing conducted by HHO Government Compliance, supervisors, and clinical corporate auditing.

There were no new CC CAP items identified through this review.

Dental

ACDE 2022 Findings and Recommendations

On September 21, 2020, Mercer conducted a readiness review of ACDE's ability to effectively delivery a new dental benefit for the State's adult Medicaid population. A post-implementation review was planned for Quarter 1 2021. To complete a more comprehensive post-implementation review, DMMA requested that Mercer conduct the review as part of the annual EQR in 2021. Skygen is delegated provider call center functions, provider network management, UM, claims processing and payment, and provider appeals and complaints.

On June 15, 2022, Mercer performed a corrective action review, with a particular focus on areas of opportunity identified during the post-implementation review as part of the 2021 EQR. One issue remains open from the 2020 readiness review: Skygen to finalize and implement third-party liability (TPL) P&Ps regarding member claims and recoupment efforts. Overall, Mercer found minor issues regarding the MCO's ability to manage the adult dental benefit. ACDE demonstrates appropriate oversight of their DBM evidenced by the 2021 Annual Delegation Review Executive Summary and Outstanding Items Tracker.

An opportunity for improvement exists with ACDE's delegation oversight, specifically around UM and TPL. More information on these issues can be found in Section 6. Additionally, a discrepancy was noted between the number of service authorizations denied (1,640) and the number of notices sent (978). None of these issues rose to the level of requiring a CAP.

HHO 2022 Findings and Recommendations

On September 21, 2020, Mercer conducted a readiness review of HHO's ability to effectively delivery a new dental benefit for the State's adult Medicaid population. A post-implementation review was planned for Quarter 1 2021. To complete a more comprehensive post-implementation review, DMMA requested that Mercer conduct the review as part of the annual EQR in 2021. UCD is delegated provider call center functions, provider network management, UM, claims processing and payment, and provider appeals and complaints.

On June 29, 2022, Mercer performed a corrective action review, with a particular focus on areas of opportunity identified during the 2021 EQR. HHO had no outstanding issues from the 2021 review. However, a new finding for 2022, related to member notification of provider terminations, is noted below. Overall, Mercer found minor issues regarding the MCO's ability to manage the adult dental benefit.

An opportunity for improvement exists with HHO's delegation oversight, specifically around FWA. More information on this issue can be found in Section 6. Additionally, HHO should consider missed opportunities to educate members of community-based resources to receive dental services that are not a covered benefit, or have exhausted the annual benefit limit.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	2022 Review Score	Finding	Recommendation
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	The DBM has an internal guideline to identify potential member care disruptions so they can be notified, but does not have a formal process.	Develop or formalize a process to appropriately notify members of provider terminations.

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 Centers for Medicare & Medicaid Services (CMS) protocol entitled "Validating Performance Measures" was completed. This protocol's goal was guiding the assessment of the 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 the 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 review of the documentation and discussion with MCO staff, it is determined that the MCO has met most of the requirements as required for the Met category.	MCO staff describes and verifies the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice.	After 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

AmeriHealth Caritas Delaware (ACDE) has a process in place to generate standardized reports to fulfill contractual obligations required by the Division of Medicaid and Medical Assistance (DMMA). These processes differ between Healthcare Effectiveness Data and Information Set (HEDIS®) required reporting and reports and measures generated for regulatory reporting that are DMMA specific. For both types of the reports, ACDE developed and depends on internal processes to assess data quality and integrity to

ensure the selected data are accurate and timely. The process of report development requires multiple internal teams such as regulatory, compliance, reporting, analytics, and management to collaborate together. 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 management as well as the Chief Operating Officer (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 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 utilizes the National Committee for Quality Assurance (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 includes, but is 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 External Quality Review Organization (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 leadership (director/manager) assists in addressing issues identified during the completion 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. Given the vast number of the reports, changes within the health care industry as well as changes within the ACDE organization, developing a robust process of data governance, as noted during the Information Systems Capabilities Assessment (ISCA), could greatly benefit the MCO operation. For consistency, each data element used in the reporting, should have clear definitions, acceptable value domains, a clear owner, and 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 (CPT) codes, provider taxonomies, and other health care nomenclature. Moreover, the review of the reports and data elements would allow ACDE to determine if any changes based on system changes (i.e., upgrades and enhancements) necessitate report modifications to account for these transformations.

During the review, it was identified that data used in the report under review were incomplete; this calls into question the regulatory review process detailed in the P&Ps, particularly around review of results by the business owner.

Overall Results

PM	Confidence in Reported Results
PM 1: Number of Medicaid members with diabetes who received an oral exam (D0150, D0120, D0180)	No confidence
PM 2: Number of members receiving American Society of Addition Medicine (ASAM) level III (ASAM 3.1, 3.3 & 3.5 included, 3.7 is not covered) residential inpatient substance use disorder (SUD) services	High confidence
PM 3: Asthma medication ratio	High confidence
PM 4: Prenatal and postpartum care	High confidence
PM 5: Immunizations for adolescents	High confidence
PM 6: Use of pharmacotherapy for opioid use disorder (OUD) (Percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or dispensed an US Food and Drug Administration [FDA]-approved medication for the disorder during the measurement year [MY])	No confidence

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

1. Overview of PM
Managed Care Plan (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): _____

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):
Medical records (describe): _____
☒ Other (specify): Claims Data within Facets and the Enterprise Data Warehouse (EDWH). Facets is the business operating system for AmeriHealth Caritas Family of Companies (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 2021–December 2021

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	162	211	235	244
Denominator	14,643	15,700	16,239	16,700
Rate	1%	1%	1%	1%

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 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 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: ACDE was not compliant with the QCMMR technical specifications and is not reporting the data accurately. ACDE did not select the full population expected for the denominator nor does it include the pharmacy data to identify the members with diabetes. The specification states that when using claims data to determine service receipt, include both paid and unpaid claims (including pending, suspended, and denied claims). ACDE does not include all required claims. Data were inaccurate over an extended period of time under the review; this calls into question the regulatory review process detailed in the Regulatory Reporting P&Ps, particularly around review of results by the business owner. ACDE must correct the denominator population selection per measure specifications to ensure correct rate calculation, including the pharmacy claims. ACDE must develop a standardized means for documenting measure specifications to ensure correct rate calculation by including all status of the claim including pending, suspended, and denied claims. ACDE should assess compliance with internal P&Ps for review of the report results by the business owner.

Number of Members receiving ASAM Level III (ASAM 3.1, 3.3 & 3.5 included, 3.7 is not covered) Residential Inpatient SUD Services

1. Overview of PM
MCP name: AmeriHealth Caritas Delaware
PM name: PM 2: Number of members receiving ASAM level III (ASAM 3.1, 3.3 & 3.5 included, 3.7 is not covered) residential inpatient SUD services

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): 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 Facet. Facets is the business operating system for ACFC.
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 members with a behavioral health (BH) diagnosis.
Definition of numerator (describe): Number of members receiving ASAM level III (ASAM 3.1, 3.3 & 3.5 included, 3.7 is not covered) residential inpatient SUD services.
Program(s) included in the measure: Medicaid (Title XIX) only CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date): January 1, 2021–December 31, 2021

2. PM Results (If measure contains more than one rate, add columns to the table)												
PM	**Rate 1**	**Rate 2**	**Rate 3**	**Rate 4**	**Rate 5**	**Rate 6**	**Rate 7**	**Rate 8**	**Rate 9**	**Rate 10**	**Rate 11**	**Rate 12**
Numerator	67	63	83	132	142	174	183	189	183	182	176	158
Denominator	11,249	11,551	11,842	12,178	12,330	12,445	12,364	12,282	12,204	12,384	12,584	12,524
Rate	1%	1%	1%	1%	1%	1%	1%	2%	1%	1%	1%	1%

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 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 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.

Asthma Medication Ratio

1. Overview of PM

MCP name: AmeriHealth Caritas Delaware

PM name: PM 3: Asthma medication ratio

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): Supplemental Data, including DHIN & I2I EMR data, and historical claims (United Health care).

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 MY 2021 Volume 2 Technical Specifications for Health Plans, Asthma Medication Ratio (AMR) measure.

High Level: The percentage of members 5–64 years of age who were identified as having persistent asthma during the MY and the year prior to the MY, and who had asthma controller or reliever medications prescribed during the MY.

Definition of numerator (describe):

The numerator was identified per the NCQA HEDIS MY 2021 Volume 2 Technical Specifications for Health Plans, AMR measure.

High Level: The number of members who have a medication ratio of 0.50 or greater during the MY.

1. Overview of PM

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

Measurement period (start/end date): January 1, 2021–December 31, 2021

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

PM	Asthma Medication Ratio (5–11)	Asthma Medication Ratio (12–18)	Asthma Medication Ratio (19–50)	Asthma Medication Ratio (51–64)	Asthma Medication Ratio (Total)
Numerator	67	48	248	107	470
Denominator	104	125	564	224	1,017
Rate	64.42%	38.40%	43.97%	47.77%	46.21%

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 MY 2021 Volume 2 Technical Specifications for Health Plans, AMR 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 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.

Prenatal and Postpartum Care

1. Overview of PM

MCP name: AmeriHealth Caritas Delaware

PM name: PM 4: Prenatal and postpartum care

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 Medical Claims Processing System).
☒ Medical records (describe): Medical record review was conducted, as this measure is reported via the hybrid method to find the percentage of deliveries that received a prenatal visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. Medical records review will also be used to find the percentage of deliveries that had a postpartum visit on or between seven and 84 days after delivery.
☒ Other (specify): Year round medical record abstraction.

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

Systematic sampling was performed per the NCQA HEDIS MY 2021 Volume 2 Technical Specifications for Health Plans, Prenatal and Postpartum Care (PPC) measure.

☐ Not applicable (hybrid method not used)

Definition of denominator (describe):

The denominator was identified per the NCQA HEDIS MY 2021 Volume 2 Technical Specifications for Health Plans, PPC measure.

High Level: The deliveries of live births on or between October 8, 2020 and October 7, 2021.

1. Overview of PM

Definition of numerator (describe):

The numerator was identified per the NCQA HEDIS MY 2021 Volume 2 Technical Specifications for Health Plans, PPC measure.

High Level: The number of deliveries that received a prenatal visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. The number of deliveries that had a postpartum visit on or between seven and 84 days after delivery.

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

NOTE: No CHIP members met the denominator specifications.

Measurement period (start/end date): October 8, 2020–October 7, 2021

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

PM	Rate 1	Rate 2
Numerator	241	226
Denominator	270	270
Rate	89.26%	83.70%

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 MY 2021 Volume 2 Technical Specifications for Health Plans, PPC 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 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.

3. PM Validation Status
EQRO recommendations for improvement of PM calculation: None.

Immunizations for Adolescents

1. Overview of PM
MCP name: AmeriHealth Caritas Delaware
PM name: PM 5: Immunizations for adolescents
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): Medical record review was conducted, as this measure is reported via the hybrid method, to find meningococcal/tetanus, diphtheria toxoids and acellular pertussis (Tdap)/human papillomavirus (HPV) vaccines. ☒ Other (specify): Supplemental Data, including Delaware State immunization registry, Delaware Health Information Network (DHIN) immunization data, I2I immunization and electronic medical record (EMR) data, and historical claims (UnitedHealthcare).
If the hybrid method was used, describe the sampling approach used to select the medical records: Systematic sampled was performed per the NCQA HEDIS MY 2021 Volume 2 Technical Specifications for Health Plans, Guidelines for Calculations and Sampling, Systematic Sampling Methodology. ☐ Not applicable (hybrid method not used)

1. Overview of PM

Definition of denominator (describe):
The denominator was identified per the NCQA HEDIS MY 2021 Volume 2 Technical Specifications for Health Plans, Immunizations for Adolescents (IMA) measure.
High-level: Adolescents 13 years of age.

Definition of numerator (describe):
The numerators was identified per the NCQA HEDIS MY 2021 Volume 2 Technical Specifications for Health Plans, IMA measure.
High-level: One dose of meningococcal vaccine, one Tdap vaccine, and have completed the HPV vaccine series by their thirteenth birthday. The measure calculates a rate for each vaccine and two combination rates.

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

Measurement period (start/end date): January 1, 2021–December 31, 2021

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

PM	Meningococcal	Tdap	HPV	Combo 1	Combo 2
Numerator	272	300	146	270	126
Denominator	411	411	411	411	411
Rate	66.18%	72.99%	35.52%	65.69%	30.66%

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 MY 2021 Volume 2 Technical Specifications for Health Plans, IMA 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 medical record review that affected the reliability or validity of the PM results.
☒ Not applicable (medical record review not conducted)

3. PM Validation Status
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.

Use of Pharmacotherapy for Opioid Use Disorder (OUD) (Percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year)

1. Overview of PM
MCP name: AmeriHealth Caritas Delaware
PM name: PM 6: Use of Pharmacotherapy for Opioid Use Disorder (OUD) (Percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year)
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

☐ 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 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 will be defined per the CMS Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2022 Reporting, Use of Pharmacotherapy for OUD measure.

High-Level: The number of members 18–64 years of age who had at least one encounter with a diagnosis of opioid abuse, dependence, or remission at any time during the MY.

Definition of numerator (describe):

The numerator will be defined per the CMS Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2022 Reporting, Use of Pharmacotherapy for OUD measure.

High Level: Percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder 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, 2021–December 31, 2021

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

PM	Total	Buprenorphine	Oral Naltrexone	Long-Acting, Injectable Naltrexone	Methadone
Numerator	3,198	1,341	134	172	2,046
Denominator	4,517	4,517	4,517	4,517	4,517
Rate	70.80%	29.69%	2.97%	3.81%	45.30%

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). CMS Adult Core Set Specifications were not released until April 2022. Preliminary rates will not be available until August 2022, and final audited rates until November 2022. There are no planned deviations from the recently released 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 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. This measure was not accessed during the review as the data were not available.
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: This measure was not accessed during the review as the data were not available.

HHO Performance Measures Overall Assessment

Overall Assessment

Highmark Health Options (HHO) has processes in place to generate standardized reports to fulfill contractual obligations required by DMMA. These processes differ between HEDIS required reporting and reports and measures generated for regulatory reporting that is DMMA specific. For both types of the reports, HHO developed and depends on internal processes to assess data quality and integrity to ensure the selected data are accurate and timely. The process of report development requires multiple internal teams such as regulatory, compliance, reporting, analytics, and management to collaborate together. 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 management as well as the COO, 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 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 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 the data from primary (HHO and its vendors systems) and supplemental (HIE, 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 HHO 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 leadership (director/manager) assists in addressing issues identified during the completion 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. Given the vast number of the reports, changes within the health care industry as well as changes within the HHO organization, developing a robust process of data governance, as noted during the ISCA, could greatly benefit the MCO operation. For consistency, each data element used in the reporting, should have clear definitions, acceptable value domains, a clear owner, and 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 CPT codes, provider taxonomies, and other health care nomenclature. Moreover, the review of the reports and data elements would allow HHO to determine if any changes based on system changes (i.e., upgrades and enhancements) necessitate report modifications to account for these transformations.

During the review, it was identified that data used in the report under review were incomplete; this calls into question the regulatory review process detailed in the P&Ps, particularly around review of results by the business owner. HHO presented and spoke of a robust process with report creating; however, some critical elements of quality assurance could be enhanced. Although the process overall for developing the reports appears comprehensive including a few layers of approval, the first step of quality assurance is missing. When data is entered manually no peer review is completed to ensure accuracy. HHO stated that they received the code for extraction of dental data and it was evident that no validation and extra review of the code was performed.

Mercer recommends that HHO develop a process to validate the manual entry of data before reports are submitted for approval as well as enhancing the 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.

PM	Confidence in Reported Results
PM 1: Number of Medicaid members with diabetes who received an oral exam (D0150, D0120, D0180)	Low confidence
PM 2: Number of members receiving ASAM level III (ASAM 3.1, 3.3 & 3.5 included, 3.7 is not covered) residential inpatient SUD services	High confidence

PM	Confidence in Reported Results
PM 3: Asthma medication ratio	High confidence
PM 4: Prenatal and postpartum care	High confidence
PM 5: Immunizations for adolescents	High confidence
PM 6: Use of pharmacotherapy for opioid use disorder (OUD) (Percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the MY)	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): _____

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):

1. Overview of PM

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 2021–December 2021

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

PM	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021
Numerator	5,108	5,106	5,100	5,419	5,412	5,392	5,648	5,621	5,581	5,867	5,840	5,798
Denominator	64	53	70	56	62	77	62	55	57	57	71	64
Rate	1%	1%	1%	1%	1%	1%	1%	2%	1%	1%	1%	1%

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 2021 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 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

3. PM Validation Status

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:

HHO was not compliant with the QCMMR technical specifications and is not reporting the data accurately. The specification states that when using claims data to determine service receipt, include both paid and unpaid claims (including pending, suspended, and denied claims). HHO does not include all required claims. HHO was also unable to demonstrate and explain how the full pharmacy claims are selected. In one particular instance, only one dental code (D0150) was selected when the corresponding code narratives explained that all three expected codes were selected. Lastly, data were inaccurate over an extended period of time under the review; this calls into question the regulatory review process detailed in the Regulatory Reporting P&Ps, particularly around review of results by the business owner.

HHO must develop a standardized means for documenting measure specifications to ensure correct rate calculation by including all status of the claim including pending, suspended, and denied claims. HHO must correct the numerator population selection per measure specification to ensure correct rate calculation, including expected dental claims. HHO should assess compliance with internal P&Ps for review of the report results by the business owner.

Number of Members receiving ASAM Level III (ASAM 3.1, 3.3 & 3.5 included, 3.7 is not covered) Residential Inpatient SUD Services

1. Overview of PM

MCP name: Highmark Health Options

PM name: PM 2: Number of members receiving ASAM level III (ASAM 3.1, 3.3 & 3.5 included, 3.7 is not covered) residential inpatient SUD services

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

1. Overview of PM

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):
Number of members with a BH diagnosis.

Definition of numerator (describe):
Number of members receiving ASAM level III (ASAM 3.1, 3.3 & 3.5 included, 3.7 is not covered) residential inpatient SUD services.

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

Measurement period (start/end date): January 1, 2021–December 31, 2021

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

PM	Rate 1	Rate 2	Rate 3	Rate 4	Rate 5	Rate 6	Rate 7	Rate 8	Rate 9	Rate 10	Rate 11	Rate 12
Numerator	47	50	48	62	48	45	57	64	54	77	81	74
Denominator	26,982	24,978	27,633	27,925	26,042	29,731	25,618	25,502	27,965	25,941	26,130	28,392
Rate	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	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 report specifications outlined in the 2021 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.

3. PM Validation Status
Describe any findings from 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.

Asthma Medication Ratio

1. Overview of PM
MCP name: Highmark Health Options
PM name: PM 3: Asthma medication ratio
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):

1. Overview of PM

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):
Denominator compliance is applied in accordance with HEDIS MY 2020 & MY 2021 specifications.

Definition of numerator (describe):
Numerator compliance is applied in accordance with HEDIS MY 2020 & MY 2021 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, 2021–December 1, 2021

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

PM	Rate 1 Ages 5–11	Rate 2 Ages 12–18	Rate 3 Ages 19–50	Rate 4 Ages 51–64	Rate 5 All Ages 5–64
Numerator	437	384	554	234	1,609
Denominator	620	630	905	357	2,512
Rate	70.48%	60.95%	61.22%	65.55%	64.05%

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 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

3. PM Validation Status
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.

Prenatal and Postpartum Care

1. Overview of PM
MCP name: Highmark Health Options
PM name: PM 4: Prenatal and postpartum care
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): HEDIS hybrid data medical record review campaign. ☐ Other (specify):
If the hybrid method was used, describe the sampling approach used to select the medical records: Sampling based on HEDIS MY 2020 & MY 2021 specifications ☐ Not applicable (hybrid method not used)

1. Overview of PM

Definition of denominator (describe):
Denominator compliance is applied in accordance with HEDIS MY 2020 & MY 2021 specifications.

Definition of numerator (describe):
Numerator compliance is applied in accordance with HEDIS MY 2020 & MY 2021 specifications.

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

Measurement period (start/end date): October 8, 2020–October 7, 2021

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

PM	Rate 1 Timeliness of Prenatal Care	Rate 2 Postpartum Care	Rate 3 Met All Criteria
Numerator	324	264	252
Denominator	348	348	348
Rate	93.10%	75.86%	72.41%

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 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.

3. PM Validation Status
EQRO recommendations for improvement of PM calculation: None.

Immunizations for Adolescents

1. Overview of PM
MCP name: Highmark Health Options
PM name: PM 5: Immunizations for adolescents
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): HEDIS hybrid data medical record review campaign. ☐ Other (specify):
If the hybrid method was used, describe the sampling approach used to select the medical records: Sampling based on HEDIS MY 2020 & MY 2021 specifications. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): Denominator compliance is applied in accordance with HEDIS MY 2020 & MY 2021 specifications.

1. Overview of PM

Definition of numerator (describe):
Numerator compliance is applied in accordance with HEDIS MY 2020 & MY 2021 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, 2021–December 31, 2021

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

PLEASE NOTE: HEDIS MY2021 Rates are not final until June 15, 2022. Rates shown are preliminary only.

PM	Rate 1 Meningococcal	Rate 2 Tdap	Rate 3 HPV	Rate 4 Combo 1	Rate 5 Combo 2
Numerator	316	340	213	314	194
Denominator	411	411	411	411	411
Rate	76.89%	82.73%	51.82%	76.40%	47.20%

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 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.

3. PM Validation Status

EQRO recommendations for improvement of PM calculation:
None.

Use of Pharmacotherapy for Opioid Use Disorder (OUD) (Percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year)

1. Overview of PM

MCP name: Highmark Health Options

PM name: PM 6: Use of Pharmacotherapy for Opioid Use Disorder (OUD) (Percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year)

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)

1. Overview of PM

Definition of denominator (describe):
Denominator compliance is applied in accordance with CMS Adult Core Set MY 2021 specifications.

Definition of numerator (describe):
Numerator compliance is applied in accordance with CMS Adult Core Set MY 2021 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, 2021–December 1, 2021

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

PM	Rate 1 Total Rate	Rate 2 Buprenorphine	Rate 3 Oral Naltrexone	Rate 4 Long-Acting, Injectable Naltrexone	Rate 5 Methadone
Numerator	3,983	1,805	104	149	2,390
Denominator	6,209	6,209	6,209	6,209	6,209
Rate	64.15%	29.07%	1.67%	2.40%	38.49%

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 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

3. PM Validation Status
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

Performance Improvement Projects (PIPs) are required by the Centers for Medicare & Medicaid Services (CMS) as an essential component of a managed care organization's (MCO's) Quality program and are used to identify, assess, and monitor improvement in processes or outcomes of care. The Division of Medicaid and Medical Assistance (DMMA) has mandated that each MCO conduct a minimum of five PIPs; the PIP topics must cover the following:

- Oral health of the long-term services and supports (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 protocol such that the reported results are questionable.	Deviated from protocol such that reported results are not validated.

ACDE Performance Improvement Project Overall Assessment

Of the five required PIPs, the State required the External Quality Review Organization (EQRO) to validate three PIPs during the 2022 compliance review cycle. The first PIP allows for a topic selected by the individual MCO that is non-clinical or service related and approved by DMMA. AmeriHealth Caritas Delaware's (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 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. 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 therapy.

The PIPs and the specifications to be applied included:

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

Overall Results

DMMA has mandated that each MCO conduct a minimum of five PIPs covering specific topics. In 2021, ACDE has implemented a service related PIP in process; however, ACDE did not provide sufficient data for the baseline and measurement periods for this PIP. ACDE was asked for follow-up information after the onsite visit but was unable to provide information for the reporting periods as well as the data for the numerator and denominator for the measures. ACDE should develop clear processes and a formal mechanism to ensure data collected for baseline and measurement periods are provided, accurate, and compliant.

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

Wellness Program

1. General PIP Information
Managed Care Plan (MCP) Name: AmeriHealth Caritas Delaware
PIP Title: Wellness Program
PIP Aim Statement: Does targeted education to ACDE member facing staff on ACDE's Wellness Program Referral Process, including ACDE's Wellness Program Survey tool, increase the number of Wellness Program referrals?

1. General PIP Information

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 different age threshold for children, specify age range here**: N/A

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

All-Member Level population as defined in section 3.6.1.2.1 of the Master Service Agreement (MSA); Diamond State Health Plan (DSHP), DSHP Plus, DSHP Plus Division of Developmental Disabilities Services (DDDS), and 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 received on March 31, 2022.
  - Updated ACDE Wellness Resources website landing page.
- Quarter 4 2021:
  - Incorporated discussion of ACDE Wellness Program information at the St. Francis Community Event on November 6, 2021.
  - Initiated development of Wellness Program flyer for members.
  - Review of ACDE website for education to members regarding Wellness Resources. Identified opportunity to expand Wellness Resources landing page to include information on ACDE Wellness Programs in alignment with information provided in the Member Wellness Program flyer.

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:
  - Developed Provider Wellness Program flyer.
  - Included flyer in Provider Newsletter.

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

- Account Executives (AEs) began use of flyer in virtual site visits.

- Quarter 4 2021:
  - Wellness Program education included in provider forum. Provider forums held on October 26, 2021 and October 27, 2021.
  - Initiated development of Wellness Program flyers for distribution to providers during site visits/virtual site visits and newsletters.
  - AEs began education on Wellness Programs during virtual site visits.

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 2 2022:
  - Aligned and updated Wellness Program documents (e.g., Standard of Practice [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.
- Quarter 4 2021:
  - Reviewed and updated ACDE's Wellness Program definition.
  - Developed Wellness Program SOP for referral processes, data reporting and validation, and training and education.
  - Reviewed and updated Wellness Programs resources to include new category for women and children.
  - Updated Delaware Wellness Program survey for accurate reporting of referrals, updated version live in Jiva on November 3, 2021.
  - Reviewed and updated Wellness Program workflow in alignment with Wellness Program SOP.
  - Developed and implemented targeted new Wellness Program training for ACDE member facing staff on Wellness Program, Wellness Program referral process, and documentation. Three trainings held on November 18, 2021, December 2, 2021, and December 13, 2021 with 76.9% participation rate.
  - Developed Wellness Program Technical Specifications/Business Requirements for Lead and Lag Measures.

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: Percentage of ACDE member facing staff educated on ACDE's Wellness Program Referral process and ACDE Wellness Program survey.	Quarter 4 2021	Sample Size: 117 Rate: 76.92%	Quarter 1 2022	Sample Size: 141 Rate: 62.41%	☐ Yes ☒ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
Lead 2: Percentage of unique ACDE Wellness Program referrals audited that were documentation compliant.	N/A	Sample Size: Rate:	Implementation Phase	Sample Size: Rate:	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lag 1: Percentage of All Member Level population referred to a Wellness Program provided by either ACDE or within the community.	N/A	Sample Size: Rate:	Implementation Phase	Sample Size: Rate:	☐ 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.	N/A	Sample Size: Rate:	Implementation Phase	Sample Size: Rate:	☐ 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.	N/A	Sample Size: Rate:	Implementation Phase	Sample Size: Rate:	☐ 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 part 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:

ACDE did not provide sufficient data for the baseline and measurement periods. The modification from the submitted PIP and their updated PIP after onsite visits have no information provided for these reporting periods. ACDE failed to provide data for the numerator and denominator for the measures.

ACDE should develop clear processes and a formal mechanism to ensure data collected for baseline and measurement periods are provided, accurate, and compliant.

Muscle Relaxers and Opioids Concomitant Use

1. General PIP Information

MCP Name: AmeriHealth Caritas Delaware

PIP Title: Muscle relaxers and opioids concomitant 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 emergency department (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 different age threshold for children, specify 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 2021, Lead Measures 1, 2, 3, and 4 were based on members identified via pharmacy claims data Quarter 3 2021; and Lag Measures 1 and 2 were based on members identified via pharmacy claims data Quarter 3 2020.

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 2021:
  - Distributed a member education letter and brochure on concurrent use of opioids and muscle relaxers to members on December 2, 2021. Members who received the educational mailing in 2020 were excluded from the 2021 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 2021:
  - Distributed provider education letter on concurrent use of opioids and muscle relaxers on December 2, 2021. The provider cohort was based on member pharmacy claims and divided into three categories:
    - Unique providers who prescribed opioid(s) ***and*** muscle relaxer(s) to the member cohort.
    - Unique providers who prescribed opioids to the member cohort.
    - Unique providers who prescribed muscle relaxers to the member cohort.

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:
  - Analyzed claims data diagnosis codes for member cohort, including Quarter 3 2020 ED claims data for BH/PH integration. Results indicated that 68% of the member cohort had a BH co-morbidity.
  - Reviewed feedback from the survey section of the provider mailing.
  - Refined data collection processes and validation for Lag Measures 1 and 2.
  - Lag Measure 2: Analyzed ED claims data for member cohort to identify inclusions/exclusions to data collection. Based on claims data reviewed, there are no exclusions to ED claims data collection.

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

- Quarter 2 2021:
  - Evaluated impact of urgent care facilities on ED utilization and claims. Determined that utilization of urgent care facilities does not influence ED claims for this PIP.
- Quarter 3 2021:
  - Continued analysis ED claims data detail due to consistent numerator Quarter 1 2021 through Quarter 3 2021 for diagnoses and recurrence.
  - Reviewed member enrollment data in light of decreased denominator Quarter 2 2021 and Quarter 3 2021.
- Quarter 4 2021:
  - Reviewed Quarter 3 2021 pharmacy claims compared to 2020 baseline pharmacy data. Identified 290 new unique members and 154 new unique providers for the 2021 mailing.
  - Continued analysis ED claims data detail due to consistent numerator Quarter 1 2021 through Quarter 3 2021 for diagnoses and recurrence.

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 providers who prescribed opioid(s) and muscle relaxers to the member cohort and who were educated on the risks of muscle relaxers and opioid(s) use together.	2020	Sample Size: 83 Rate: 91.6%	2021	Sample Size: 71 Rate: 94.4%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.5012
Lead 2: Percentage of providers who prescribed opioid(s) to the member cohort and who were educated on the risks of muscle relaxers and opioid(s) use together.	2020	Sample Size: 48 Rate: 91.7%	2021	Sample Size: 36 Rate: 88.9%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.6678

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 3: Percentage of providers who prescribed muscle relaxers to the member cohort and who were educated on the risks of muscle relaxers and opioid(s) use together.	2020	Sample Size: 79 Rate: 92.4%	2021	Sample Size: 47 Rate: 91.5%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.8541
Lead 4: Percentage of members in member cohort that had prescriptions filled for muscle relaxers and opioid(s) that have been educated on the risks of concomitant use.	2020	Sample Size: 438 Rate: 97.3%	2021	Sample Size: 290 Rate: 100.00%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
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%	2021	Sample Size: 396 Rate: 40.9%	☒ 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%	2021	Sample Size: 396 Rate: 13.17%	☒ 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 part 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:

Four of the six quantifiable measures demonstrated improvement, three of those four measures of improvement were statistically significant. The PIP has accomplished the goals established by educating providers and members on the risks of concomitant use of muscle relaxers and opioids, decreasing the number of members receiving muscle relaxers and opioids and decreasing ED visits for overdose.

ADHD Clinical Practice Guidelines, Medication, and Therapy

1. General PIP Information

MCP Name: AmeriHealth Caritas Delaware

PIP Title: Increase in compliance to the American Academy of Pediatrics' (AAP's) clinical practice guidelines for ADHD

PIP Aim Statement: Will Pediatric Primary Care Providers (PCPs), Nurse Practitioners, Psychologists, Psychiatrists, Licensed Professional Counselors and Licensed Clinical Social Workers, and Neurologists educated on the AAP's clinical practice guidelines for ADHD increase member compliance to both stimulant medication and outpatient (OP) BH therapy at least once every four weeks in the 6 to 12 years old population of ACDE 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.)

Target age group (check one):

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

***If PIP uses different age threshold for children, specify age range here**: Children 6–12 years of age

1. General PIP Information

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 2021.

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 2021:
  - Provider education included a synopsis of the AAP guidelines for the assessment and treatment of ADHD in the form of a mailing to 460 providers (PH and BH therapy providers) was distributed to targeted providers on March 31, 2021.
- Quarter 2 2021:
  - A New Lead Measure Quarter 2 2021 to educate prescribers of ADHD guidelines for member assessment after receiving a new prescription for a stimulant. An educational mailing on the AAP's clinical practice guidelines for ADHD, specifically follow-up after distributing a new prescription for a stimulant and including CMS recommended timeframes for scheduling follow-up was distributed to 243 prescribing providers (PH and BH therapy providers) June 28, 2021.
- Quarter 3 2021:
  - None.
- Quarter 4 2021:
  - Provider education presented at provider forums for three counties October 2021 about the AAP's clinical practice guideline for ADHD of behavioral therapy and medications by BH Chief Medical Officer (CMO).

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:
  - Reviewed and updated targeted providers for mailing distribution based on 12 month review of facets claims for members ages 6 to 12 with a diagnosis of ADHD. Updated and expanded provider specialties to include additional provider types for increased penetration and outreach to provider network.

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

- Technical specifications for prescriber mailing were refined and reviewed in alignment with providers who received the ADHD general education mailing.
- Refined data specifications for Lag Measures 1–6 to align with updated provider types.

- Quarter 2 2021:
  - Refined technical specifications for Lag Measures 5 and 6 to narrow the number of focal diagnoses to get a more actionable population. Data reported for Quarter 1 2020 (baseline) through Quarter 1 2021 was updated to align with the revised data specifications.
  - Refined technical specifications and obtained baseline data for Lag Measures 7 and 8.
- Quarter 3 2021:
  - None.
- Quarter 4 2021:
  - None.

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 ACDE contracted PCPs (Pediatric, Family Practice, General Practice), Nurse Practitioners (Certified Registered Nurse Practitioners, Psychiatric Nurse Practitioners, Pediatric Nurse Practitioners), Psychiatrists, Neuropsychiatrists, Psychologists, Neuropsychologists, Licensed Professional Counselors, Social Workers (Masters of Social Work, Licensed Independent Social Work, and Licensed Clinical Social Work),	2019	Sample Size: 291 Rate: 93.8%	2021	Sample Size: 460 Rate: 95.2%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.404

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**
and Neurologists within the provider cohort educated about the AAP's clinical practice guidelines for ADHD, specifically prescribing stimulant medications and OP BH therapy at least once every four weeks. The provider cohort is identified as those contracted providers within the specialties listed above who are identified via claims as treating a member age 6–12 years for management of ADHD.						
Lead 2: Percentage of ACDE contracted PCPs (Pediatric, Family Practice, General Practice), Nurse Practitioners (Certified Registered Nurse Practitioners, Psychiatric Nurse Practitioners, Pediatric Nurse Practitioners), Psychiatrists, Neuropsychiatrists, and Neurologists within the provider cohort educated about the AAP's clinical practice guidelines for ADHD, specifically follow-up after distributing a new prescription for a stimulant, including CMS timeframes for scheduling. The provider cohort is identified as those contracted prescribing providers within the specialties listed above who are identified via claims as	2021	Sample Size: 242 Rate: 97.0%	N/A	Sample Size: N/A Rate: N/A	☐ 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 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**
treating a member age 6–12 years for management of ADHD.						
Lag 1: Percentage of members diagnosed with ADHD ages 6 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%	2021	Sample Size: 1,145 Rate: 26.5%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.5273
Lag 2: Percentage of members diagnosed with ADHD ages 6 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	2018	Sample Size: 756 Rate: 16.7%	2021	Sample Size: 1,145 Rate: 28.3%	☒ 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 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**
the AAP's clinical practice guidelines for ADHD.						
Lag 3: Percentage of members diagnosed with ADHD aged 6 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%	2021	Sample Size: 1,145 Rate: 19.0%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 4: Percentage of members diagnosed with ADHD aged 6 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	2018	Sample Size: 756 Rate: 9.1%	2021	Sample Size: 1,145 Rate: 26.2%	☒ 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 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**
about the importance of the AAP's clinical practice guidelines for ADHD**.**						
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 in 30 days from initial diagnosis of ADHD.	2020	Sample Size: 141 Rate: 14.2%	2021	Sample Size: 74 Rate: 27.0%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
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%	2021	Sample Size: 74 Rate: 13.5%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.5886
Lag 7: Percentage of members who had a PCP, Nurse Practitioner, Psychiatrist, Neuropsychiatrist, or Neurologist **prescribing provider** follow-up visit (**at least one**) in 30 days from filling a new prescription for a stimulant. A new	Quarter 1 2021	Sample Size: 13 Rate: 38.5%	Quarter 4 2021	Sample Size: 24 Rate: 25.0%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.3924

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**
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, prescribing provider is defined as the prescriber or another provider from the same practice.						
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, prescribing provider is defined as the prescriber **or** another provider from the **same** practice.	Quarter 1 2021	Sample Size: 5 Rate: 0.0%	Quarter 4 2021	Sample Size: 6 Rate: 16.7%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.3384

4. PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part 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): Among the 10 measures, there are differing phases for measurement periods. The ranges are: one Measure in baseline year, two Measures are in second re-measurement year, one measure is in third re-measurement year, two measures are in seventh re-measurement year, and four measures are in eleventh re-measurement year. **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: Seven of the 10 quantifiable measures demonstrated improvement, five of those seven measures of improvement were statistically significant. The PIP has accomplished the goals established by educating providers on the AAP's clinical practice guidelines for ADHD to increase member compliance to both stimulant medication and OP BH therapy at least once every four weeks in the 6 to 12 years old population.

HHO Performance Improvement Project Overall Assessment

Of the five required PIPs, the State required the EQRO to validate three PIPs during the 2022 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. Highmark Health Options' (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 home- and community-based services (HCBS) members. The PIPs and the specifications to be applied included:

- HRA standards — State-developed specifications
- PH and BH care coordination (CC) — MCO-developed specifications
- LTSS utilization — MCO-developed specifications

Overall Results

As noted earlier in this report, the HHO Quality department has faced challenges in leadership and staffing over the past several years, including the review period of 2021 as evidenced by quantifiable measure results and the confidence in reported results. HHO now has the resources and team to focus efforts particularly as it relates to PIPs. Specifically, the Manager of Quality Improvement (QI), Regulatory, and Accreditation exhibited a strong base knowledge to identify PIP topics, develop an appropriate question, select quantifiable Lead and Lag Measures, and implement and assess interventions all of which are supported by enhanced analytics. Although there is a strong PIP team in place, the submitted documentation was contradictory which made validation of the three PIPs impossible. The reporting periods, numerators, and denominators identified for baseline and measurement periods are not clearly stated for validation against supporting PIP documentation. The Request for Information (RFI) and Quality Improvement Activity (QIA) form submission failed to provide clear specifications when attributing to the reporting periods, numerator, and denominator. As follow-up to the onsite discussion, HHO submitted an Excel spreadsheet containing additional information to be used for validation. The data for the reporting periods, numerator, and denominator in the follow-up Excel spreadsheet did not align with the MCO's RFI submission so validation was unable to occur.

PIP	Confidence in Reported Results
PIP 1: HRA standards	Low Confidence
PIP 2: BH and PH CC	Low Confidence
PIP 3: LTSS reducing ED utilization	Low Confidence

HRA Standards

1. General PIP Information
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.)

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 different age threshold for children, specify 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)

- Quarter 2 2021:
  - $10 gift certificate for completion of an HRA listed in Member Handbook 2021, Member Newsletter Fall 2021, and Member Newsletter Spring 2021.

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:
  - Provider forum.

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:
  - Implemented use of experienced HRA vendor interventions to complement existing HHO outreach team interventions.
- Quarter 2 2021:
  - Business proposal submitted for four part-time staff to be employed for HRA efforts beginning May 3, 2021 — onboarded with detailed training which includes actively engaging member during calls. The number of questions counted toward the HRA completion was changed from 11 out of 19 questions counts as completion.
- Quarter 3 2021:
  - HHO onboarded four part-time staff with staggered schedules (Monday through Friday, 8:00 am–8:00 pm and Saturday, 8:00 am–4:00 pm with no overlap) to increase timeliness of outreach and 100% HRA completion. Member Experience director provided new talking points to the vendor to aid in engaging the HHO member longer when vendor performs outreach.

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

- Quarter 4 2021:
  - New reporting logic was identified for Lead 2 (HHO team HRA outreach) denominator.

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 HHO members who received outreach by the vendor within 60 days of enrollment.	2021	Sample Size: 4,572 Rate: 33.57%	Quarter 4 2021	Sample Size: 1,149 Rate: 44.38%	☐ Yes ☒ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lead 2: 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 2021	Sample Size: 1,149 Rate: 8.96%	☐ Yes ☒ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 1: Percentage of HHO members who received outreach by the vendor and completed an HRA within 60 days of enrollment.	2021	Sample Size: 1,535 Rate: 48.99%	Quarter 4 2021	Sample Size: 510 Rate: 75.00%	☐ Yes ☒ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 2: 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: 3.60%	Quarter 4 2021	Sample Size: 103 Rate: 63.10%	☐ 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 part 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: The reporting periods, numerators, and denominators identified for baseline and measurement periods are not clearly stated for validation against supporting PIP documentation. The RFI and QIA form submission failed to provide clear specifications when attributing to the reporting periods, numerator, and denominator. As follow-up to the onsite discussion, HHO submitted an Excel spreadsheet containing additional information to be used for validation. The data for the reporting periods, numerator, and denominator in the follow-up Excel spreadsheet did not align with the MCO's RFI submission so validation was unable to occur. Consider the following recommendations: • Develop standard means, have clear processes, and a formal mechanism to ensure data collected for baseline and measurement periods are accurate and compliant. • Develop a standardized mean for documenting the numerator and denominator per measure specifications to ensure correct rate calculation.

Behavioral Health and Physical Health Care Coordination

1. General PIP Information
MCP Name: Highmark Health Options
PIP Title: BH and PH CC
PIP Aim Statement: Does coordination of care for adult members 18–64 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.)

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 different age threshold for children, specify 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 2021:
  - Care coordinators encouraged BH members with diabetes to take LDL and A1C test at home and mail into vendor.
- Quarter 2 2021:
  - Vendor mailed home testing kits to the 2020 Healthcare Effectiveness Data and Information Set (HEDIS®) Diabetes and Schizophrenia (SMD) measure population.
- Quarter 3 2021:
  - Community Health Workers (CHWs) began outreach to members not in CC.

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 3 2021:
  - CHW began outreach to those member's providers when unable to reach members.
  - Providers were educated about the BH/PH PIP during the provider forums.

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:
  - Lead 1 outreach rate was based on baseline methodology that did not include data collection of outreach efforts but instead reflects members that were elected and engaged with a care coordinator; but were not necessarily outreached and educated based on the PIP study. Lead 1 does show a decrease in the members elected and engaged. This has led to a revision in the baseline methodology.

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

- Quarter 2 2021:
  - In Quarter 1, methodology for data collection and validation was revised along with components of the study question to remove the concept of "elected and engaged". In Quarter 2, this has allowed for data collection on members that have been outreached and educated on the importance of getting their diabetic LDL and HbA1c screenings completed for the measurement year. With the inclusion of LTSS case managers in the PIP to outreach their members in the Lead 1 denominator along with CC outreach, and CHW outreach to all eligible members not engaged in care management there has been a successful outreach of 85% of the quarterly population.
- Quarter 3 2021:
  - During this quarter, PIP logic, methodology, and definition enhancements were implemented allowing for removal of two-month runout data reporting and a re-run of each measure's rates which reflect enhancements and includes one-month lag due to HEDIS measure SMD. Since the methodology enhancements, the rates of all measures have improved which aligns with the outreach efforts performed by case managers, CHW, and care coordinators in Lead 1, which showed an increase of 69 percentage points above the target goal of 25%. The actions of members getting an annual LDL and/or HbA1c screening which is evident through Lags 1, 2, and 3 are above the target goals of 70%, 75%, and 60% respectively.
- Quarter 4 2021:
  - In this quarter, we saw an increase in Lead 1 by 4.69 percentage points, Lag 1 increased by 6.79 percentage points, Lag 2 increased by 1.76 percentage points, and Lag 3 increased by 10.49 percentage points. This can be attributed to the methodology enhancements implemented in Quarter 3 by the workgroup. Credit can also be attributed to the implementation of the new care management platform GuidingCare implemented in Quarter 4 2021.

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 importance of LDL-c and A1c.	2020	Sample Size: 243 Rate: 16.05%	Quarter 4 2021	Sample Size: 153 Rate: 98.00%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.49

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 adult members 18–64 years of age with a schizophrenia diagnosis who completed their LDL-C test.	2020	Sample Size: 39 Rate: 64.10%	Quarter 4 2021	Sample Size: 151 Rate: 80.79%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.49
Lag 2: Percentage of adult members 18–64 years of age with a schizophrenia diagnosis who completed their HbA1c test.	2020	Sample Size: 39 Rate: 69.23%	Quarter 4 2021	Sample Size: 151 Rate: 84.76%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.49
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.	2020	Sample Size: 39 Rate: 58.97%	Quarter 4 2021	Sample Size: 151 Rate: 75.49%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.49

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part 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.

4. PIP Validation Information
EQRO recommendations for improvement of PIP: The reporting periods, numerators, and denominators identified for baseline and measurement periods are not clearly stated for validation against supporting PIP documentation. The RFI and QIA form submission failed to provide clear specifications when attributing to the reporting periods, numerator, and denominator. As follow-up to the onsite discussion, HHO submitted an Excel spreadsheet containing additional information to be used for validation. The data for the reporting periods, numerator, and denominator in the follow-up Excel spreadsheet did not align with the MCO's RFI submission so validation was unable to occur. Consider the following recommendations: • Develop standard means, have clear processes, and a formal mechanism to ensure data collected for baseline and measurement periods are accurate and compliant. • Develop a standardized mean for documenting the numerator and denominator per measure specifications to ensure correct rate calculation.

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 different age threshold for children, specify 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 2 2021: — A Care Decisions Magnet was mailed out to all members to educate them on proper ED usage and triage of where to go for care. — Eliza Emergency Room (ER) Avoidance campaign implemented to all members to educate on proper ED use.
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 3 2021: — Enriched provider collaboration with member initiatives. The workgroup planned to develop a provider survey for feedback on enhanced collaboration. Implementation planned for Quarter 1 2022. — Education on ED utilization reduction was sent out via the Provider Newsletter.
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: — Business case was completed to hire one new RRT staff. • Quarter 2 2021: — There was consistent use of Electronic Health System (EHS) task Intervention> Member-Focused> Verbalize strategies for avoiding unplanned utilizations for data collection, increased opportunities for safely conducting onsite outreaches; staff returned to community; and one new case manager was hired onto the RRT to give a total of three for outreach efforts. • Quarter 3 2021: — Introduced/educated on appropriate data capture documentation for new care management system to ensure PIP data collection, the new RRT staff was onboarded, and training on new care management system (GuidingCare) to ensure appropriate data collection.

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 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: 24.40%	Quarter 4 2021	Sample Size: 103 Rate: 47.57%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 1: 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: 84.00%	Quarter 4 2021	Sample Size: 43 Rate: 81.63%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Lag 2: Percentage of the number of ED visits for LTSS HCBS members with three or more visits/quarter.	2021	Sample Size: 1,006 Rate: 36.40%	Quarter 4 2021	Sample Size: 1,067 Rate: 35.89%	☒ 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 part 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

4. PIP Validation Information
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: The reporting periods, numerators, and denominators identified for baseline and measurement periods are not clearly stated for validation against supporting PIP documentation. The RFI and QIA form submission failed to provide clear specifications when attributing to the reporting periods, numerator, and denominator. As follow-up to the onsite discussion, HHO submitted an Excel spreadsheet containing additional information to be used for validation. The data for the reporting periods, numerator, and denominator in the follow-up Excel spreadsheet did not align with the MCO's RFI submission so validation was unable to occur. Consider the following recommendations: • Develop standard means, have clear processes, and a formal mechanism to ensure data collected for baseline and measurement periods are accurate and compliant. • Develop a standardized mean for documenting the numerator and denominator per measure specifications to ensure correct rate calculation.

Section 6

Information Systems Capabilities Assessment

At the request of the Division of Medicaid and Medical Assistance (DMMA), Mercer Government Human Services Consulting (Mercer) conducted the External Quality Review (EQR) Information Systems Capabilities Assessment (ISCA) corrective action plan (CAP) review of AmeriHealth Caritas Delaware (ACDE) and Highmark Health Options (HHO) for the time period of January 2021 through December 2021. 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 Centers for Medicare & Medicaid Services (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 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 7, 2022 through April 8, 2022 for ACDE and April 4, 2022 through April 5, 2022 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 AmeriHealth Caritas Family of Companies (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 made a seamless transition to two geographically dispersed state-of-art secure data centers in 2021. The organization accomplished this task by utilizing a series of exercises to establish a Data Center Strategy, Reference Architecture, and a Data Center Transition Model for its business solutions. ACDE leveraged a multi-work stream framework including a fit-out of the facility, buildout of Security and Infrastructure solutions, deployment of business applications/services, testing, and a controlled phased cutover plan.

ACDE has made progress in developing the foundation for data governance by publishing Integrated Best in Class Data and Analytics (BICDA) Strategy and Roadmap and finalizing the Enterprise Data Office (EDO) team functions including roles and responsibilities. There is still work to be done with regards to finalizing the selection of tools and technologies for the data platform and developing data governance policies. The insights gained from ACDE's ISCA desk review and discussions confirmed ACDE's efforts to improve the claims operations and underlying infrastructure to ensure accurate claims processing and timely encounter submissions.

As implied through their well organized and thoughtful request for information (RFI) response, ACDE continued to exhibit strong process orientation and mature systems capabilities, along with a deep understanding of DMMA requirements.

ACDE Strengths

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

- ACDE's strong processes, testing, and knowledgeable teams contributed to the successful and seamless data center migration.
- ACDE robust practices lead to impressive performance outcomes with the Delaware member and provider call centers, claims processing and payments, and utilization management (UM) service level agreements.
- ACDE demonstrated noteworthy knowledge in claims processing and related functional areas (e.g., provider network management [PNM]) to collaborate effectively and ensure accurate and timely claims processing and payments.

ACDE Opportunities

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

- ACDE has made progress with the development and implementation of its enterprise data analytics and the data governance plan but the time it has taken to formalize the data governance practices seems extensive. Baseline data governance policies should be implemented and adapted as needed to guide all enterprise data analytic activities.
- ACDE conducts an audit of subcontractor claims by selecting a small sample of claims (N=30) and if issues are identified, ACDE reports the issues to the subcontractor without conducting a root-cause analysis or performing an analysis to assess the magnitude of the issue. ACDE should increase their subcontractor audit size sample as well as perform an assessment of the root cause as well as the magnitude when issues are identified.
- ACDE's contractual timeframe limitations for claims review by the payment integrity vendor does not allow for the review of all high-cost claims. Claims review showed that ACDE missed the opportunity to ensure accurate pricing of high dollar claims. ACDE should identify opportunities to streamline the payment integrity review processes.
- ACDE subcontractor's ad-hoc data submissions, upon DMMA's request, should have additional oversight to ensure high quality products are delivered as the ACDE executive leadership and corresponding business owners are accountable for DMMA reporting accuracy and timely submissions.

HHO Overall Assessment

Based upon the ISCA CAP review, 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. Since 2019, HHO has been on a journey to improve the systems and processes to better align with DMMA's expectations and the needs of DMMA's managed Medicaid populations and providers. In 2021, HHO's goal was to enhance Medicaid operations functions under the motto: Right People, Right Jobs. Additionally, during the same timeframe, HHO implemented the *GuidingCare* system and Provider Directory changes.

HHO has made substantial progress in claims remediation and audit activities, as well as developed dashboards to support daily operations. HHO enhanced the process of subcontractor oversight using scorecards and regular meetings to ensure compliance with the contract requirements and resolve any concerns in a timely manner, although there is still work to be done in that area. The insights gained from HHO's ISCA desk review and onsite 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, along with a deep understanding of DMMA requirements.

HHO Strengths

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

- HHO's implementation of the new systems *GuidingCare* and Provider Directory was very smooth without members or providers experiencing disruption. HHO took the appropriate measures to ensure comprehensive testing was completed before the system changes were executed. HHO intends to implement a new claims system in the near future. Mercer encourages HHO to ensure that testing and data conversion is equally as smooth.
- HHO's use of the enterprise-wide data analytics platform allowed the organization to develop encounter Service Level Agreement (SLA) dashboards including progress bars and drill down capabilities to monitor performance and act quickly if any deviations were identified.
- 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.

HHO Opportunities

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

- Although HHO developed subcontractor oversight activities such as meetings and scorecards, more work needs to be done to ensure subcontractor compliance with the DMMA contract and expectations such as applicable audit percentages, precise encounters submission, accurate reporting, etc.
- HHO developed multiple processes to ensure accurate claims payments; however, HHO should review its processes related to the retroactive termination eligibility and claims processing to ensure timely claims reprocessing if member eligibility changes.
- HHO's commitment to excellence was evident but resolution process when concerns are identified needs to be improved, as it takes extensive time to resolve identified issues.

Section 7

NCI-AD Adult Consumer Survey

The Division of Medicaid and Medical Assistance (DMMA), in partnership with ADvancing States and Human Services Research Institute (HSRI), implemented the 2021–2022 National Core Indicators Aging and Disabilities (NCI-AD) Adult Consumer Survey in the State of Delaware (Delaware or State). DMMA recognizes the need for an independent assessment of home- and community-based services (HCBS) as well as all services provided under managed long-term services and supports (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 75 core indicators. Indicators are the standard measures used across states to assess the outcomes of services provided to individuals, including respect and rights, service coordination, care coordination (CC), employment, health, safety, person-centered planning, etc. An example of an indicator in the Service Coordination domain is: “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 Diamond State Health Plan (DSHP) Plus members in 2021–2022 and included for analysis was 784 (Total N=784).

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 more effectively address individual needs, 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., nursing facilities [NF]) and

HCBS. All service recipients were enrolled in one of two managed care organizations (MCOs): AmeriHealth Caritas Delaware (ACDE) and Highmark Health Options (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 two-day in-person training with these interviewers on January 28–29, 2020. 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 February 11, 2021 and Vital Research sent final data from the interviews to HSRI on June 25, 2022.

Survey Findings

At the time of this report, HSRI has not released findings from the 2021–2022 survey cycle.

Section 8

Delaware First Health Implementation/Readiness Review

Delaware First Health (DFH) is a newly contracted Medicaid Managed Care Organization (MCO) contractor for the Division of Medicaid and Medical Assistance (DMMA), providing managed care services to Delaware's Title XIX and Title XXI enrollees and the Diamond State Health Plan (DSHP) Plus Medicaid managed long-term care program under Section 1115 Demonstration waiver authority. Mercer Government Human Services Consulting (Mercer) was asked to prepare for and conduct a readiness review of DFH which began providing managed acute and managed long-term services and supports (LTSS) effective January 1, 2023.

The Readiness Review process began on October 5, 2022, when Mercer delivered the request for information (RFI) to DFH. Mercer used a Health Insurance Portability & 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 October 26, 2022. The Readiness Review team performed a desk review of DFH's documentation as well as facilitated an onsite review, which was held at the Sheraton Suites Wilmington Downtown located in Wilmington, Delaware on November 15, 2022 through November 17, 2022. The areas assessed were:

- Administration and Organization
- Network
- Grievances and Appeals (G&As)
- Service Coordination (SC)
- Utilization Management (UM)
- Care Coordination (CC)
- Case Management (CM)
- Pharmacy

- Dental
- Quality Management (QM) and Quality Improvement (QI)
- Information Technology and Claims Readiness
- Claims and Encounters and Information Systems

Request for Information

Mercer used the MCO RFI based on the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) protocols for assessing a MCO and conducting an information systems capabilities assessment, which was modified by Mercer to meet the needs of DMMA to acquire information specific for all areas of the Readiness Review. Examples of information requested included staffing plans, policies and procedures (P&Ps), claims payment, monitoring and operations descriptions, quality, CM, utilization and care management program descriptions, network development strategies, health and safety provisions (including critical incident monitoring and reporting), proposed work plans, planned program evaluations, and enrollee and provider communications (e.g., member and provider handbooks, website information, welcome packets, etc.).

Desk Review

Mercer received information electronically and reviewed all documents submitted over a series of weeks. The information was organized on the SharePoint site into folders and subfolders, coordinating with the data request format. During the onsite review phase, additional information was collected; a small number of outstanding data needs remained. At the close of the onsite review process, the outstanding information needs were summarized and submitted to Mercer for further review and consideration following the onsite visit.

An EQR compliance review tool adapted from CMS protocols was utilized for the review. The tool was designed to include State standards reflecting key issues and priorities of DMMA. The tool assisted the reviewers in coordinating the review process in a logical manner. Mercer's desk review results helped to focus observations and interviews to gather additional information during the onsite review.

Onsite Review

The condensed onsite review took place at the Sheraton Suites Wilmington Downtown located in Wilmington, Delaware, utilizing web-based video and telephonic technology to link onsite and remote External Quality Review Organization (EQRO), DMMA, and

DFH participants. The onsite review began with an introductory session, with Mercer, DMMA representatives, and appropriate DFH staff present in person or in attendance via teleconference.

Brief Background of Delaware First Health

DFH is a newly established, wholly-owned subsidiary of Centene Corporation. DFH was selected to serve the State's Medicaid managed care programs, DSHP, and DSHP Plus populations. Throughout the remainder of the report, the entity responsible for delivery of a certain aspect of the program will be referenced by the entity name. The reader should understand while reading the report that ultimate responsibility for administration of the DMMA Medicaid managed care program lies with DFH. Responsibilities are assigned in the following manner:

Entity	Responsibilities
Centene Management Company	Information Systems Claims Processing Special Investigations Unit (SIU) Fraud, Waste, & Abuse Support Provider Data Management Human Resources Support UM Finance Pharmacy Administrative Services Nurse Advice Line Third-Party Services & Support through a Management Agreement
Delaware First Health	Member & Provider Services Claims Management Program Integrity & Compliance Vendor Management Provider Participation Agreements Provider Manual Provider Directory Network Development/Management Provider Satisfaction QM/QI CC

Entity	Responsibilities
	LTSS SC CM Disease Management UM Pharmacy Services Covered Services Member Rights Member Services Vision Care Services Enrollments, Transfers, and Disenrollment Provider Payment Training
Centene Management Company Support	Training Claims Audit Member & Provider Support Claims & Encounters Support Accreditation Healthcare Effectiveness Data and Information Set (HEDIS®) Operations Healthcare Analytics Appointment Availability Audits Provider Data Management/Credentialing Compliance SIU Fraud, Waste, & Abuse Finance/Actuarial Information Systems Human Resources & Training
Evolve Vision	Vision Benefit Management Credentialing Network Management Provider Services Provider Relations

Entity	Responsibilities
	UM Vision Call Center
CaremarkPCS Health, Inc. (CVS)	Pharmacy Benefit Management Claims Processing Network Administration Pharmacy Call Center Rebate Administration
Evolve Dental	Dental Benefit Management Dental Call Center (Member & Provider) Credentialing Network Management Provider Services Provider Relations UM
ModivCare	Non-Emergency Medical Transportation
Cenpatico Behavioral Health, LLC	Behavioral Health (BH) UM BH Authorization Appeals BH Authorization Denials BH Clinical Training (Staff & Provider)
National Imaging Associates	Management of: Advanced Diagnostic Imaging Services Cardiac Services Therapy Services (Physical/Occupational/Speech) Network Development UM Claims Reviews
Subcontractors	Cotiviti (Payment Integrity Solution) Centene Pharmacy Solutions Language Services Associates Hughes Leahy Karlovic (Marketing & Advertising) The Rawlings Company (Subrogation Services Payment Integrity & Recovery)

Entity	Responsibilities
	Skygen USA (SaaS Vendor Providing Core Administrative Software) Optum Insight Performant (Payment Integrity Services) GB Collects (Third-Party Collections) Voiance (Live Conduit Over-The-Phone Interpretation)

Overall Readiness Review Strengths

- DFH is well supported by Centene Corporate. An experienced corporate staff person is aligned with each DFH leadership role to ensure DFH staff are well supported as they onboard. Corporate staff will remain in place for the first 90 days to ensure a smooth transition to DFH staff only. This will provide a strong foundation for DFH and connection to corporate.
- DFH has a comprehensive training program that includes various training methods, Delaware-specific training, and proactive follow-up for staff who may require additional coaching.
- Key network providers have been engaged and contracts are in place or under development. There is also a robust corporate Value-Based Payment (VBP) department available to support VBP in Delaware.
- DFH offers value-added services to address health related social needs (HRSNs) and improve the well-being of Delaware's Medicaid membership. General Education Development (GED) and tutoring programs are offered to enhance education. Various home-based interventions for asthma are offered, including mold remediation, pest control, air purifiers, carpet cleaning, hypoallergenic bedding, and low Volatile Organic Compound (VOC) cleaning supplies. Post discharge meal delivery is available for food support following discharge. SafeLink and Connections Plus offer mobile devices. In addition, transportation, housing transition, and social isolation supports are available such as senior center vouchers, Pyx application, and member toolkits.
- DFH's UM program description is thorough and well written including Delaware-specific covered benefits, benefits which require prior authorization, and the specific medical necessity criteria used. The TruCare system, used by UM, CC, and CM, allows shared access to member information and the ability for UM to send alerts/notifications to the care coordinators/case managers. In addition, Customer Service representatives can view the TruCare system.
- DFH, through the larger Centene pharmacy services team, has a strong basic pharmacy infrastructure that appears to be experienced in Medicaid implementation.

- Envolve Dental is a sister, organization affiliated with Centene. Therefore, the MCO is in a unique position to easily obtain and use quality related data for the adult dental program. “Quality is everyone’s business”, was stated more than once during the onsite review. This thought was evident in the robust program description that was submitted, and by the team’s understanding of the importance of member G&As as a valuable data source for continuous improvement.
- DFH has the integrated infrastructure in place to ensure accurate and timely processing of eligibility, enrollment, claims, providers, CC, and encounter data. The DFH system has the capability for integration of data between systems and with external partners. Centene has strong security standards and is compliant with National Institute of Standards and Technology (NIST), Minimum Acceptable Risk Standards for Exchanges (MARS-E), and System and Organization Controls 2 (SOC2) requirements.
- The change management process includes well-defined descriptions of the types of change (user stories), peer review, testing and management review, and approval. This indicates that system changes are appropriately managed for ensuring systems stability and reliability.
- DFH’s claims editing processes includes three different prepayment editing vendors that perform correct code editing sourced to CMS, American Medical Association (AMA), Current Procedural Terminology (CPT), International Classification of Diseases edition 10 (ICD-10), and State specific guidelines. Additionally, DFH utilizes a ‘robo-claims’ processing tool to automate the processing of a common set of claims that require manual intervention without requiring individual decision making to determine the outcome of the claim.
- ImpactPro, a user-friendly business intelligence platform in place at DFH, seamlessly facilitates CC activities by incorporating claims history, etc.; having the capability of integrating the transitioning member’s claims history will help ensure continuity of care.
- Key personnel that have been hired have DMMA encounter submission expertise, which will help ensure complete, accurate, and timely encounter data, particularly in the initial months of implementation.

Overall Readiness Opportunities

- Complete hiring of key personnel, ensure adequate staffing, and follow through on the strong training program to orient staff to the Delaware Medicaid managed care program. The contract requires transition plans for unfilled openings in the key positions within 90 days of implementation.
- Update draft P&Ps across the Readiness Review track teams to include DMMA-specific requirements and brand as DFH.

- Develop a collaboration protocol with Delaware State agencies; having this process in place prior to go-live will ensure continuity of care for members. Define the roles and responsibilities for SC. Activities that are included as provisions of SC within the contract should be coupled with a process accessible to staff that outlines the requirements of the Service or Program Coordinator's role in activity completion.
- Finalize the process to evaluate appropriateness of denial determination and readability of denial letters for delegation oversight.
- Update the 2023 Delaware First Health Provider Manual to reflect the contractual requirements for CC. Within the Provider Manual, a description of care management includes three tiers, CC, Care Management, and Complex Care Management. While DFH may offer services beyond the Master Service Agreement (MSA) contractual requirements, the CC description, and CM description, must align with the MSA.
- Update the risk stratification criteria to include low- and high-risk stratification criteria for maternity members required in the MSA.
- Update the DFH member website to include adult dental benefit information.
- Update P&Ps, benefit accumulators, and claims system to reflect benefit limits including prior authorization requirements for requesting the $1,500 adult dental emergency benefit. Ensure that programmers and systems configuration specialists are well versed in the DMMA requirements and that DMMA’s requests get timely responses regarding systems changes during the contractual period and especially during the initial implementation phase.
- Review and update the claims denial messages sent to providers, including dental and vision, to ensure messages are clear, accurate, and informative, and facilitate prompt action from the provider.
- Finalize the DFH Business Continuity and Disaster Recovery (BC-DR) plan to ensure members can receive uninterrupted services on January 1, 2023, in the event of a state of emergency.
- Remedy the following items on the DFH website and/or member portal: Full 508 accessibility assessment to ensure the website is accessible to all members; allowance for members to complete a health risk assessment (HRA) in the member portal; updating the message a member receives when submitting an inquiry via the member portal (the MCO will respond to questions or comments received within one business day from receipt).
- Finalize and implement the process of capturing the data for the provider preventable conditions based on the CMS rule to ensure accurate claims processing and encounter submission.
- Develop desk level procedures and training to ensure dental claims processors correctly process adult dental claims, including the adult dental emergency benefit.

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