

**DELAWARE MEDICAID AND CHIP
MANAGED CARE
QUALITY STRATEGY**

**DIVISION OF MEDICAID & MEDICAL ASSISTANCE
2010**

Contents

- 1. Quality Strategy Overview**
 - a. Quality Strategy Development**
 - b. Quality Strategy Implementation**
 - c. History of Managed Care**
 - d. Goals and Objectives**
- 2. Assessment – Quality and Appropriateness of Care**
 - a. National Performance Measures**
 - b. State Standards**
 - i. Access to Care**
 - ii. Structure and Operations**
 - iii. Quality Assessment and Performance Improvement**
 - c. Monitoring Mechanisms – State Monitoring and Evaluation**
 - d. Health Information Technology**
- 3. Improvement and Interventions**
 - a. Progress Toward Goal Achievement**
- 4. Strategy Review and Effectiveness**
 - a. How the Quality Strategy is Reviewed**
 - b. MCO Reporting Requirements**
 - c. CMS Reporting Requirements**
- 5. Achievements and Opportunities**
- 6. Appendix A – Definition of Medical Necessity**
- 7. Appendix B – Acronyms**

Quality Strategy Overview

The Delaware Quality Management Strategy (QMS) is a comprehensive plan incorporating quality assurance monitoring and ongoing quality improvement processes to coordinate, assess, and continually improve the delivery of quality care and services to participants in managed care, waivers, and Medicaid and CHIP funded programs. The QMS provides a framework to communicate the State’s vision, objectives, and monitoring strategies addressing issues of health care cost, quality, and timely access. It encompasses an interdisciplinary collaborative approach through partnerships with enrollees, stakeholders, governmental departments and divisions, contractors, managed care organizations (MCOs), community groups, and legislators.

The QMS supports the Missions of the Delaware, Department of Health and Social Services (DHSS) and the Division of Medicaid & Medical Assistance (DMMA), to:

“Improve the quality of life for Delaware’s citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations”

–DHSS

“To improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost effective manner”

–DMMA

To accomplish these missions, the QMS seeks to:

- assure Medicaid and CHIP enrollees receive the care and services identified in Waivers and Medicaid and CHIP funded programs by providing ongoing tracking and monitoring of quality plans, improvement activities and assurances; and
- provide ongoing tracking and monitoring of Medicaid and CHIP funded program quality plans to achieve the Centers for Medicare and Medicaid Services (CMS) requirements of “achieving ongoing compliance with the waiver assurances” and other federal requirements.

The Medicaid Managed Care Program, which is known as the Diamond State Health Plan (DSHP), and Title XXI, known as the Delaware Healthy Children Program or Children’s Health and Insurance Program (CHIP) are focused on providing quality care to the Medicaid population and the CHIP population in the State through increased access and appropriate and timely utilization of health care services. We believe this will be achieved through a systematic and integrated QMS that is consistent with current scientific evidence based principles and coordinated with quality initiatives across all Medicaid and CHIP funded programs.

Goals, Values and Guiding Principles

The Medicaid Managed care program, which is known as the DSHP, and Title XXI, known as the Delaware Healthy Children Program, are focused on providing quality care to the majority of the Medicaid and CHIP population and children in the State through increased access and appropriate and timely utilization of health care services. Goals and

objectives provide a persistent reminder of program direction and scope. As identified in the 1115 waiver, the goals that play a significant role in the development of the quality strategy are:

Goal 1: *To improve access to care and services for adults and children with an emphasis on primary care and preventive care.*

Goal 2: *To improve quality of care and services provided to Delaware Medicaid and CHIP participants.*

Goal 3: *To control the growth of health care expenditures.*

Guiding Values or Principles

- DMMA seeks to achieve excellence through ongoing quality improvement activities.
- The QMS employs a multi-disciplinary, collaborative approach to identify, assess, measure and evaluate the access, timeliness, and quality of care and services being provided to Medicaid and CHIP clients.
- Medicaid and CHIP populations will receive care and services congruent with the six aims for health care systems identified by the Institute of Medicine. Care provided to Delaware Medicaid and CHIP participants will be:

“safe; effective; patient-centered; timely; efficient and equitable.”¹

- Participants are supported in taking responsibility for their own health and health care through use of preventive care and education.
- Providers of care and services are accountable for delivering quality services and programs in compliance with Federal and State regulations, as well as State QMS requirements.
- Opportunities to identify and initiate collaborative quality improvement activities across MCOs and Medicaid and CHIP funded programs create benefits for participants.
- Access to care and services should be equitable.
- Cultural sensitivity to variation in the health care needs of a diverse population is an essential element in providing quality services and decreasing disparities.
- Linkages between the community, The Medical Society of Delaware, individual providers, advocacy groups, and DMMA programs are valuable to enhance quality improvement activities.
- Forums for communication, which enhance an open exchange of ideas while maintaining privacy guidelines, are valued for identification of issues and to conduct quality improvement activities.

¹ Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. 2001.

QMS Strategy Development

DMMA's Medical Management and Delegated Services (MMDS) Leadership team, through an iterative process that includes participation by the multidisciplinary state-wide Quality Improvement Initiative (QII) Task Force, initiates development of the QMS. Input is incorporated from governmental agencies, providers, consumers and advocates assisting in identifying quality activities and metrics of importance to the Medicaid and CHIP population. Results of the annual review of the effectiveness of the prior year's quality plan and the external quality review (EQR) technical report provide additional data to further focus strategy development.

External Quality Review Report

The EQR technical report provides detailed information regarding the regulatory compliance of the Medicaid and CHIP MCOs as well as results of Performance Improvement Projects (PIPs) and Performance Measures (PMs). Report results include information regarding the effectiveness of the MCO's program, strengths and weaknesses identified and potential problems or opportunities for improvement. This information is utilized for input into the QMS and for initiating and developing quality improvement projects.

Participant Input

Input from Medicaid and CHIP participants into the development of the QMS is accessed through a variety of methods. One method is the use of member satisfaction surveys that may include Consumer Assessment of Healthcare Providers and Systems (CAHPS) and surveys administered through the Health Benefits Manager (HBM) and other Medicaid and CHIP funded programs. Additional sources of participant input include member grievances and complaints as well as public forums, such as the QII and the Medical Clinical Advisory Committee (MCAC), that include advocacy and public participants. The MCAC is a group appointed by the Secretary of the Delaware DHSS composed of representatives from the medical community, consumers, consumer or advocate groups and other fields concerned with health as the Secretary may deem appropriate to advise DMMA about health and medical care services.

Public Input

Quality improvement goals and activities are drafted and integrated into the quality strategy and forwarded to the MCAC and QII for feedback by key stakeholders. The QMS is submitted for public comment every 3 years or if significant changes are made to the document. A notification of public interest is released in the *Delaware Register of Regulations*, a monthly publication, allowing a 30-day period for public input. Once public input has been received and incorporated into the document, the process proceeds as described above, and the final strategy document is prepared and approved by DMMA.

Quality Management Strategy Implementation

DMMA has delegated its quality oversight responsibilities for Medicaid and CHIP funded programs, including waivers and managed care programs, to the MMDS. Responsibilities include oversight and monitoring of quality plans and improvement activities. Through the efforts of the MMDS leadership team, the QMS has developed a structure and processes that support and encourage achievement of sustainable improvements in the quality of care and services provided to all Medicaid and CHIP participants. The quality strategy promotes integration and collaboration both horizontally and vertically across state agencies and externally with key stakeholders including advocacy groups, providers, participants, MCOs and CMS.

The MMDS leadership team uses the QII Task Force as one of the various mechanisms to accomplish oversight responsibilities and solicit input for improvements. Participants of the QII Task Force includes representatives from all Medicaid and CHIP funded programs and waivers, MCOs, Health Benefits Manager, the Pharmacy Benefits Manager (PBM), the External Quality Review Organization (EQRO), State agencies receiving Medicaid and CHIP funding, and the MMDS leadership team. These stakeholders appoint representatives from their organization to serve on the Task Force. Appointees are provided with an outline of the expected roles and responsibilities of membership on the QII. The chair person of the QII Task Force is appointed by DMMA from their leadership team.

Each organization or governmental agency represented on the QII Task Force has their own quality committee that is accountable for all phases of the quality management (QM) process. QII Task Force representatives link these quality committees to a unifying point. The QII Task Force is the central forum for communication and collaboration for quality strategies, plans, and activities and provides the opportunity to develop systematic and integrated approaches to quality activities. The QMS employs a deliberate process of ongoing continuous quality improvement (QI) with feedback mechanisms that affect change and improve quality of care to participants. The MMDS and the QII Task Force use data and information at each stage of the QI process to analyze and identify trends as well as sentinel and adverse events. Task Force members discuss findings to identify issues and recommend opportunities for strategically developing an overall QI work plan to ensure appropriate integration of QI activities such as Performance Improvement Projects and Performance Measures. Within this process opportunities are sought to develop collaborative quality activities that span across the Medicaid and CHIP programs.

Members of the QII Task Force participate in a scheduled rotation of reporting quality activities that are formal processes focusing on critical, high impact issues to determine compliance in meeting their established goals. A consistent format is used to assure that key components of the quality process are included within all phases of quality activities and reporting. QII reporting may include statistical analysis, root cause analysis, analysis of barriers, and resulting or recommended improvement interventions. These presentations allow an opportunity for dialogue, exchange of information and identification of best practices.

Report results are documented in QII Task Force meeting minutes and communicated to the larger stakeholder group and the MCAC. The MCAC and stakeholder group reviews QMS activities and provides feedback and support for quality-related issues. These ongoing communications create a continuous feedback loop that impacts quality of care improvements for Medicaid and CHIP participants. Quality results are also reported through the state sponsored *Quality Courier* and various newsletters and forums.

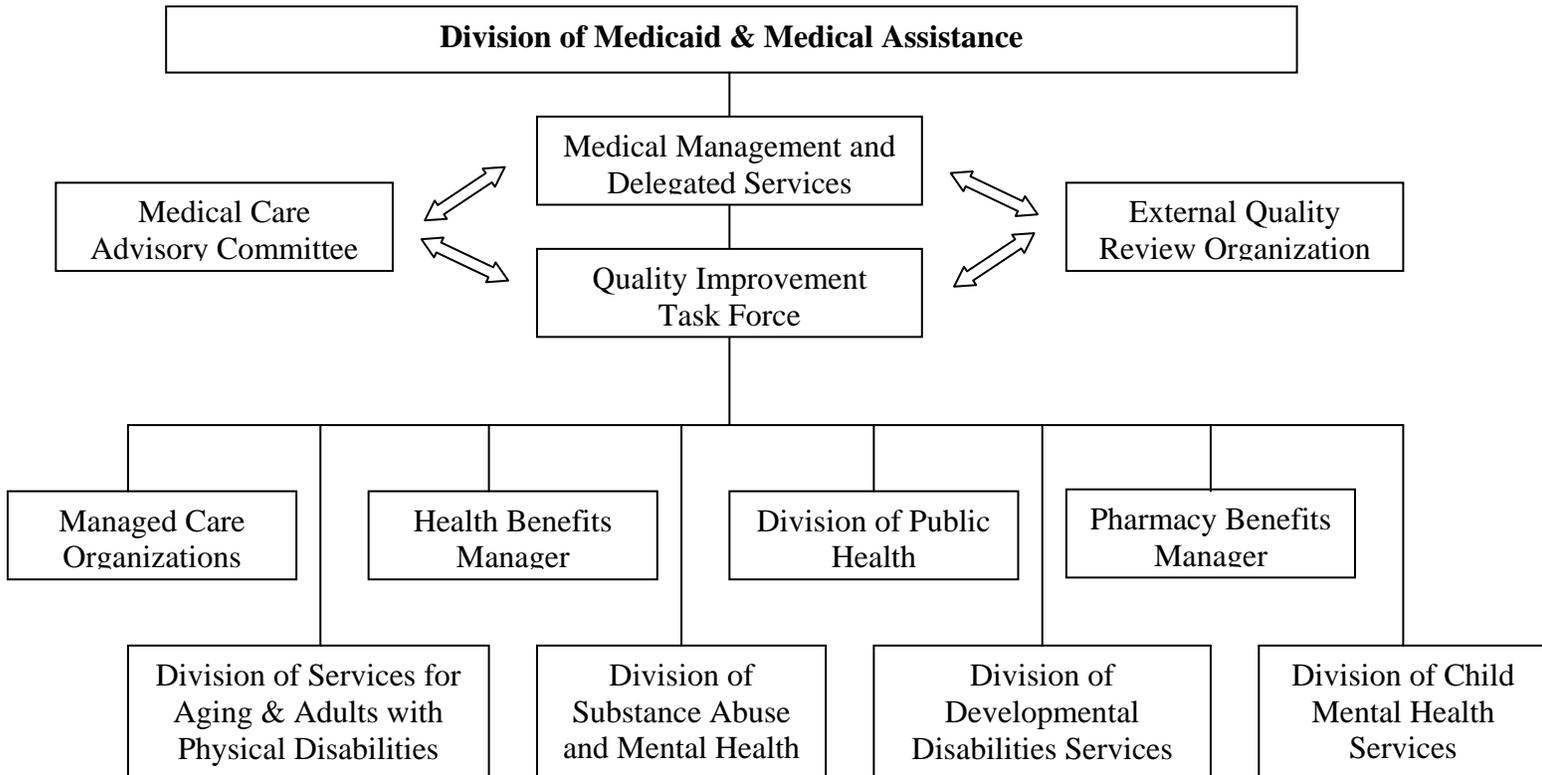
The following table illustrates the Delaware Quality Management Integrated Model.

Table 1 Quality Management Integrated Model: Roles and Responsibilities

| Entities | Membership | Roles and Responsibilities |
|----------------------|---|--|
| MCAC | <ul style="list-style-type: none"> • CMS • Providers • Advocacy • Enrollees/Clients • Medicaid and CHIP Leadership | <ul style="list-style-type: none"> • Forum for input from key stakeholders into quality efforts and key health care management concerns. • Forum for input on State policy for health care delivery to Medicaid and CHIP enrollees. |
| MMDS Leadership Team | <ul style="list-style-type: none"> • DMMA Medicaid and CHIP Leadership | <ul style="list-style-type: none"> • Oversight of QII Task Force. • Approval and oversight of QMS development, implementation and evaluation. • Reporting QII and QMS efforts and outcomes to MCAC to solicit feedback. • Communication and support of stakeholder Advisory groups. |
| QII Task Force | <ul style="list-style-type: none"> • MMDS leadership team • Representatives from all Medicaid and CHIP Programs • MCOs • Representatives from Agencies. Responsible for Waiver Programs • HBM • PBM | <ul style="list-style-type: none"> • Supports development and implementation of the Medicaid and CHIP QMS. • Supports integration of the Medicaid and CHIP QMS with managed care and waiver quality strategies. • Provides forum for best practice sharing. • Provides support and feedback to waiver programs for the: <ul style="list-style-type: none"> – establishment of priorities, – identification, design, and implementation of quality reporting and monitoring, – review of findings from discovery processes, and – development of remediation strategies. • Identification and implementation of quality improvement strategies. • Provides feedback on quality measurement and improvement strategies to participating agencies and program staff. • Reporting to MMDS. |

Quality Management Structure

The following diagram visually represents participants of the Quality Management Structure demonstrating levels of oversight accountabilities and communication flows of quality activities. The structure is developed to maximize integration, seek opportunities for collaboration, and assure a rigorous QMS is in place.



History of Managed Care in Delaware

Medicaid

In 1994, the Delaware Health Care Commission recommended conversion of numerous aspects of the Medicaid program to a managed care model. The reasoning was that

savings would be achieved from the use of a managed care model and those savings, along with some additional State funding, would be used to expand health coverage to all uninsured Delawareans at or below 100 percent of the Federal Poverty Limit (FPL). After applying to the Health Care Financing Administration (now CMS), DHSS received approval for waivers under 1115 of the Social Security Act, including:

1. 1902 (a) (10) (B) Amount Duration and Scope;
2. 1902 (a) (1) Statewideness;
3. 1902 (a) (10) and 1902 (a) (13) (E) Payment of Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC);
4. 1902 (a) (23) Freedom of Choice;
5. 1902 (a) (34) Retroactive eligibility; and
6. 1902 (a) (30) (A) as implemented by 42 CFR 447.361 and 447.362 Upper Payment Limits for Capitation Contract Requirements.

The waiver covers Medicaid services as defined by the Medicaid program and communicated in the contract. The DSHP waiver includes three groups of potential eligibles:

- Individuals categorically eligible for Medicaid in Delaware under Title XIX of the Social Security Act.
- Uninsured non-categorically eligible adult citizens with incomes below 100 percent of the FPL.
- Women of childbearing years who lose Medicaid eligibility for non-fraudulent reasons for limited family planning services for 24 additional months.

Population exclusions include: Individuals dually eligible for Medicare and Medicaid as well as individuals in long-term nursing facilities, or covered under one of the State's Home and Community-Based Services Waivers, are not enrolled in the DSHP.

Within the waiver process, the State identified three goals to achieve in implementing a managed care model to provide care and services to the Medicaid population:

- to improve access to care and services for adults and children,
- to improve quality of care and services provided to Delaware Medicaid participants, and
- to control the growth of health care expenditures for the Medicaid population.

The Delaware Medicaid managed care program, DSHP, was implemented in 1996 upon receiving waiver approval. DSHP began with four MCOs participating in the Medicaid managed care program. Of the four MCOs, two provided services statewide, one MCO provided services in New Castle County only and the remaining MCO provided services only in Kent and Sussex Counties. In 1997, one contracted MCO withdrew from participation in the DSHP, and by 1998, the MCO serving two of three counties only, became a statewide provider. In July 2000, one MCO withdrew from participation in the DSHP, leaving two remaining choices for eligible enrollees, both of which provided statewide services. In 2002, DHSS selected one contractor to provide Medicaid managed care services and the DHSS then elected to create a State operated program of managed medical care, using internal case management with quality measures as an alternative choice for DSHP enrollees. Diamond State Partners (DSP) was approved by CMS as an Enhanced Fee-for-Service (FFS) program. DSP and the commercial plan currently provide the network of care and services for the Delaware Medicaid managed care population. In 2004, the MCO contract was re-bid and in July was awarded to the current contractor, Delaware Physicians Care Inc. (DCPI), a subsidiary of Schaller Anderson. In 2006, DMMA released a request for proposals (RFP) for a new managed care contract. In 2007 DPCI was purchased by Aetna. On July 1, 2007 Diamond State Health Plan expanded the program by offering a second commercial managed care option. In addition to Delaware Physicians Care Inc. (DPCI) and Diamond State Partners, the Medicaid only, managed fee for service program, enrollees may also choose Unison Health Plan of Delaware. The contracts between the state and these two managed care plans are for a two year period from July 1, 2007 through June 30, 2009 (SFY 2008 and 2009) with three additional option years until June 30, 2012.

The DSHP has used the services of a Health Benefits Manager throughout the history of the waiver to:

- manage MCO enrollment;
- provide managed care education;
- ensure bilingual client outreach at State Service Centers; and
- perform Health Risk Assessments for DPCI and DSP

Since the last renewal in 2004, the DHSS has reorganized to create a new Division of Medicaid and Medical Assistance (DMMA) which has primary responsibility for DSHP. The DMMA continues to work in tandem with the Division of Social Services (DSS) in managing eligibility.

An effective and comprehensive approach to quality was understood to be an essential component in achieving the goals and objectives established within the 1115 Waiver. Since the beginning of the demonstration project, a quality assurance (QA) system has been in place to direct, develop and manage quality processes, and to monitor Medicaid program compliance. In 2003, the State became compliant with the Balanced Budget Act of 1997 (BBA) regulations, the Quality Management Unit (QMU), re-designed the Quality Strategy updating standards, and incorporating BBA revised regulations. Expectations of compliance with BBA regulations were communicated through updated contracts. The 2004 EQRO evaluated the MCO in accordance with BBA regulations. Thereafter, the EQRO conducted annual compliance reviews of the MCO processes as

per CMS requirements and protocols. Throughout the history of the waiver, Delaware has demonstrated that the DSHP can provide quality physical and behavioral health care services through a private and public sector cooperation to a greater number of uninsured or underinsured individual.

CHIP

Section 4901 of the Balanced Budget Act of 1997 (P.L. 105-33) amended the Social Security Act by adding a new Title XXI, the State Children's Health Insurance Program (SCHIP). SCHIP regulations are found in the Code of Federal Regulations (CFR) at 42 CFR Part 457. The Delaware SCHIP is known as the *Delaware Healthy Children Program* (DHCP) and was approved by the Centers for Medicare & Medicaid Services on October 1, 1998, with a program implementation date of January 1, 1999.

Under Title XXI, states are provided federal matching funds to offer one of three program options: 1) a separate child health program; 2) a Medicaid expansion; or 3) a combination of both. Delaware has implemented a combination program, with infants (under age 1) under 200% covered through a Medicaid expansion program and uninsured children aged 1 to 19 covered through a separate child health program – DHCP. Under the federal financial participation formula (FFP) for SCHIP, Delaware is funded 65% with federal funds and 35% with State funds. With minor variations, Medicaid, in contrast, is funded at 50% federal and 50% State funds. Unlike Medicaid, which is an open-ended entitlement, SCHIP federal funds are capped and are allocated to states based on a formula specified in the enabling legislation.

Title XXI provides funds to states for the purpose of covering uninsured, low-income children who are not eligible for Medicaid. SCHIP children are not eligible for Medicaid because their family income exceeds that allowed under Medicaid (Title XIX).

The Delaware Healthy Children Program is targeted to uninsured children under age 19 with income at or below 200% of the Federal Poverty Level (FPL). Countable income, excluding certain deductions for earnings, child care costs, and child support, is compared to 200% FPL (based on family size) to determine eligibility. With some exceptions, children must have been uninsured for at least 6 months prior to their application for DHCP. Children who are eligible for Medicaid may not choose the DHCP as an alternative to Medicaid. Children applying for DHCP must be screened for Medicaid eligibility before they can be evaluated for DHCP. Children of parents who work for public agencies and who have access to State Employee's medical insurance, are not eligible for DHCP even if they do not opt to purchase that coverage.

The child must be a current Delaware resident with intent to remain, and the child must be a citizen of the United States or must have legally resided in the U.S. for at least 5 years if his/her date of entrance into the U.S. is 8/22/96, or must meet the Personal Responsibility and Work Opportunity Reconciliation Act of 1997 (PRWORA) definition of "qualified alien", and must be ineligible for enrollment in any public group health plan (as stated above). Proof of citizenship and identity are not federally mandated under SCHIP although both are federal requirements in the Medicaid program. Still, the State does require that all applicants for SCHIP and Medicaid provide proof of citizenship and

identity since all applications cascade through the same DCIS eligibility modules and since children must be made eligible for Medicaid if they qualify.

Children covered under a separate SCHIP program are not “entitled” to coverage even if they meet eligibility requirements, and are not “entitled” to a defined set of benefits.

Under DHCP, services are provided by MCOs. DMMA contracts with the same MCOs to provide services for both the Medicaid and SCHIP populations. All DHCP beneficiaries must enroll with an MCO in order to obtain services. Children will be assigned an MCO if the families fail to make a selection. Families must also select a primary care physician (PCP) who will serve as the children’s “medical home”. If a PCP is not selected, one will be assigned to the children.

The Delaware Healthy Children Program was implemented on January 1, 1999. Because of slow uptake in enrollment, premiums were waived during the second half of the year to encourage enrollment, and reinstated in 2000. By the end of the first year, 2,448 children were enrolled. By October 2008, there were 5,652 children were enrolled in DHCP. Over the course of a typical calendar year, approximately 11,000 individual children are enrolled in DHCP. Enrollees drop on and off the program during the course of a year. Some reasons include: income reductions that make children eligible for Medicaid, income increases that make children ineligible for DHCP, gaining of parent’s employer-related health coverage, moving out-of-state, and because families may enroll children when they are sick and disenroll children when they are well to avoid paying monthly premiums.

There are various outreach activities occurring in the State to find and enroll these children – activities such as the “Covering Kids & Families” program, and Astra Zeneca’s “Healthy Delawareans Today and Tomorrow”. During the 2008 legislative session, Delaware House Bill 286 was passed and requires DHSS to collaborate with the School Districts to share free and reduced lunch data for the purpose of identifying potentially eligible SCHIP children.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA or Public Law 111-3) reauthorized the Children's Health Insurance Program (CHIP). CHIPRA finances CHIP through federal Fiscal Year 2013. The intent of this legislation was to preserve coverage for the millions of children who rely on CHIP and provide the resources for States to reach millions of additional uninsured children.

In 2010, in accordance with CHIPRA, Delaware’s EQRO began incorporating the CHIP population into the annual MCO compliance reviews including PIP and PM validations.

Rationale for Managed Care

Fundamental to implementation of a managed care model is the belief that the use of a managed care system will improve the quality of care delivered in the Medicaid and CHIP programs by consistent application of managed care principles, a strong quality assurance program, partnerships with providers, and review and evaluation by an EQRO. Applying these techniques will serve to maintain or improve health outcomes for participants by improving consistent access to care, improving the quality of health care services by achieving a medical home and achieving cost-effective service delivery. By expanding partnerships with physicians, practitioners, suppliers, providers, communities, and consumers, Delaware will emphasize primary prevention strategies and the needs of Children with Special Health Care Needs (CSHCN).

Goals and Objectives

The Medicaid Managed care program, which is known as the DSHP, and Title XXI, known as the Delaware Healthy Children Program, are focused on providing quality care to the majority of the Medicaid and CHIP population and children in the State through increased access and appropriate and timely utilization of health care services. Goals and objectives provide a persistent reminder of program direction and scope. DMMA endeavors to utilize nationally recognized and accepted performance measures and benchmarks. To align with this strategy in 2008 DMMA changed from HEDIS “like” to full HEDIS technical specifications for annual MCO performance measure reporting. As identified in the 1115 waiver, the goals that play a significant role in the development of the quality strategy are:

Goal 1: To improve access to care and services for adults and children with an emphasis on primary care and preventive care.

Objectives:

- HEDIS measures reviewed as part of Goal 1:
 - Children and Adolescents’ Access to Primary Care Practitioners
 - Adults’ Access to Preventive/Ambulatory Health Services
 - Timeliness of Prenatal and Postpartum Care
- DMMA will use the benchmark of the HEDIS national Medicaid HMO 75th percentile
- For those measures that have not reached the national 75th percentile, the goal is to improve the HEDIS rate by 5% per year until the benchmark is attained
- For those measures that have attained and/or maintained the national 75th percentile, the goal is to strive towards an incremental annual increase to reach the national Medicaid HMO 90th percentile

Goal 2: To improve quality of care and services provided to Delaware Medicaid and CHIP participants.

Objectives – Access and Prevention:

- HEDIS measures reviewed as part of Goal 2 Access and Prevention:
 - Lead Screening in children
 - Breast Cancer Screening
 - Cervical Cancer Screening
- DMMA will use the benchmark of the HEDIS national Medicaid HMO 75th percentile
- For those measures that have not reached the national 75th percentile, the goal is to improve the HEDIS rate by 5% per year until the benchmark is attained
- For those measures that have attained and/or maintained the national 75th percentile, the goal is to strive towards an incremental annual increase to reach the national Medicaid HMO 90th percentile
- Non-HEDIS measures reviewed as part of Goal 2 Access and Prevention:
 - DMMA monitors monthly reports totaling the number of members referred to either the State funded prenatal/postpartum case management program Smart Start and/or those members referred to the MCO specific case management maternity programs

Objectives – Chronic Care/Health Management:

- HEDIS measures reviewed as part of Goal 2 Chronic Care/Health Management:
 - Comprehensive Diabetes Care – Lipid Screening, HbA1c screening, and Retinal eye exams
 - Cholesterol Management of Patients with Cardiovascular Conditions – LDL-C Screening
 - Appropriate Treatment for Children with Upper Respiratory Infection
 - Antidepressant Medication Management
- DMMA will use the benchmark of the HEDIS national Medicaid HMO 75th percentile
- For those measures that have not reached the national 75th percentile, the goal is to improve the HEDIS rate by 5% per year until the benchmark is attained
- For those measures that have attained and/or maintained the national 75th percentile, the goal is to strive towards an incremental annual increase to reach the national Medicaid HMO 90th percentile

Goal 3: To control the growth of health care expenditures.

Objectives:

- HEDIS measures reviewed as part of Goal 3:
 - Ambulatory Care Emergency Department Visits/1,000
 - Inpatient Utilization broken down by Medicine, Maternity, Surgery, Non-Acute as well as Total Inpatient for Days/1,000, Discharges/1,000, and average length of stay

- DMMA will use the benchmark of the HEDIS national Medicaid HMO 25th percentile, due to the inverse nature of how HEDIS reports the data.
- For those measures that have not reached the national 25th percentile, the goal is to decrease utilization so that HEDIS rates decline by 5% per year until the benchmark is attained
- For those measures that have attained and/or maintained the national 25th percentile, the goal is to strive towards an incremental annual decrease in utilization until towards the national Medicaid HMO 10th percentile

Assessment: Quality and Appropriateness of Care

Procedures for Race, Ethnicity, Primary Language, and Data Collection. The RFP which is a part of the MCO contract includes language requirements compliant with Federal regulations.

- ***Data collection:*** Delaware updated its procedures for collecting racial and ethnic data consistent with the Office of Management and Budget (OMB) revised standards via Administrative Notice (A-14-2003) on September 11, 2003. Delaware follows the guidance presented in the Notice for obtaining information when individuals fail to self-identify themselves. The two ethnic categories are: Hispanic or Latino and Non Hispanic or Latino. The five racial categories are: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White.

During the application process, the applicant identifies race, ethnicity, and primary spoken language. The data collected for race and language is passed daily to the Medical Management Information System (MMIS). Ethnicity, race and language are currently communicated to the MCO in monthly enrollment files.

- ***Communication with MCO:*** The MCO is notified of client enrollment/disenrollment information via a monthly enrollment report in the form of a data file. The file is electronically transmitted on or before the first day of each enrollment month. It includes clients who are newly enrolled, clients who were enrolled last month and continue to be enrolled, clients who transferred into the plan, and clients who are no longer enrolled with the plan. Starting in 2007 a daily file update of the client enrollment/disenrollment was created and transmitted to the MCOs. The MCO is responsible for payment of the Benefit Package for each enrolled client. To facilitate care delivery appropriate to client needs, the enrollment file also includes race/ethnicity, primary language spoken, and selective health information. The MCO will use information on race/ethnicity and language to provide interpretive services, develop educational materials for employee training, and facilitate enrollee needs in the context of their cultural and language requirements. The race/ethnicity information captured for Medicaid and CHIP eligibility purposes is categorized in accordance with the Bureau of the Census, and then forwarded from the eligibility file. Primary language spoken and predetermined health indicators are forwarded from the managed care system. Although neither method collects 100 percent of the required data, there are data for a significant portion of the population served. Until the Medicaid and CHIP eligibility process implements mandatory disclosure of race/ethnicity and primary language, the State relies on demographic updates to the Enrollment file.

Mechanisms the State Uses to Identify Persons with Special Health Care Needs to MCOs

The special health care needs (SHCNs) population is defined as:

- children who have or are suspected of having a serious or chronic physical developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally;
- children with vision or hearing impairments;
- foster or adoptive children; and
- persons at risk of, or having, chronic diseases and disabilities.

To identify persons with SHCN's, the HBM, initiates outreach calls to all new enrollees within 30 days of enrollment for purposes of conducting a health risk assessment (HRA). The completed HRAs are provided to the MCO on a regular basis.

As of July 2007, UHPDE conducts its own health risk assessments for UHPDE enrollees.

The HRA provides the MCO and the State with important information about the health risks of new enrollees. By providing opportunities for early identification of enrollees who are pregnant, have SHCNs, or chronic conditions such as diabetes or asthma, referrals to special programs designed to coordinate care and contain unnecessary health costs can be made.

Within five days of receiving an HRA, the MCO will review and prioritize each HRA based upon the enrollee's needs and conditions. The HRA is then distributed to case or disease managers to complete a more thorough clinical evaluation. The MCO has developed condition specific detailed assessment forms. Based upon assessment results and in partnership with the member, a more detailed care plan may be developed or the appropriate frequency of follow-up outreach identified. Follow-up care may include, specialist referrals, accessing durable medical equipment, medical supplies, and home health services. Where appropriate, case managers will provide coordination and continuity of services to clients. The MCO is required to complete a treatment plan for all beneficiaries meeting the requirements of persons with special health care needs as defined above. All treatment plans must comply with the regulations found in federal regulations at 42 CFR 438.208, including requirements for direct access to specialists.

MCOs are required to have in place mechanisms to assess the quality and appropriateness of care furnished to all enrollees with particular emphasis on children with special health care needs. These mechanisms may include but are not limited to performance measures and performance improvement projects.

Clinical Guidelines

The use of evidence based clinical practice guidelines is expected as their application has been demonstrated to decrease variation in treatment resulting in improved quality. Guidelines must be based upon valid and reliable clinical evidence given the needs of the MCOs enrollees. The guidelines can be adapted or adopted from National professional organizations or developed in a collaborative manner with community provider input. All

practice guidelines must be adopted in consultation with contracting health care professionals and reviewed and updated in a clinically appropriate manner. Clinical guidelines are expected to represent the range of health care needs serviced by the MCO. Compliance with 42 CFR 438.236 is reviewed during the EQR process.

The MCO will utilize Clinical Practice guidelines including, but are not limited to those addressing:

- Adult preventive care;
- Pediatric preventive care with a focus on EPSDT services;
- Diabetes;
- Asthma;
- Adult and child behavioral health services; and
- Obstetrical care including a requirement that patients be referred to obstetricians or certified nurse midwives at first visit at which pregnancy is determined
- Developmental Screening
- Childhood Overweight

External Quality Review

The Federal and State regulatory requirements and performance standards as they apply to MCOs will be evaluated annually for the State in accordance with 42 CFR 438.310I and 42 CFR 438.310(b) by an independent EQRO, including a review of the services covered under each MCO contract for: a) timeliness, b) outcomes, and c) accessibility, using definitions contained in 42 CFR 438.320 and CHIPRA: Public Law 111-3.

The federally mandated scope of the annual EQR includes: a) criteria used to select entities to perform the reviews, b) specification of activities to be performed by the EQRO, c) the circumstances in which the EQR may use other accreditation review results, and d) standards for availability of review results.

The EQRO competence and independence requirements are used as criteria in selecting an entity to perform the review as mentioned in 42 CFR 438.354 and 42 CFR 438.356(b) and (d) using the rates as described in 42 CFR 433.15(b)10 and 42 CFR 438.370. To ensure competence, the EQRO must have staff with demonstrated experience and knowledge of: a) the Medicaid program, b) MCO delivery systems, c) QM methods, and d) research design and statistical analysis. The EQRO must have sufficient resources to conduct needed activities, and other skills necessary to carry out activities or supervise any subcontractors. To ensure independence, the EQRO must not be: a) an entity that has Medicaid and CHIP purchasing or managed care licensing authority, b) governed by a body in which the majority of its members are government employees, c) reviewing an MCO in which the EQRO has a control position or financial relationship by stock ownership, stock options, voting trusts, common management, or contractual relationships, d) delivering any services to Medicaid and CHIP recipients, and e) conducting other activities related to the oversight of the quality of MCO services except for those specified in 438.358. EQROs are permitted to use subcontractors, however, the EQRO is accountable for, and must oversee, all subcontractor functions as mentioned in 42 CFR 438.356(c).

The specification of activities to be performed by the EQRO broadly includes: a) measurement of quality and appropriateness of care and services, b) synthesis of results compared to the standards, and c) recommendations based on the findings. The EQRO will meet these obligations by utilizing the EQR protocols developed by CMS to perform the mandatory activities required of EQROs as mentioned in 42 CFR 438.352 and 438.358, including: a) data to be gathered, b) data sources, c) activities to ensure accuracy, validity and reliability of data, d) proposed data analysis and interpretation methods, and e) documents and/or tools necessary to implement the protocol. The State will ensure that the EQRO has sufficient information for the review from the mandatory and optional EQR-related activities described in the regulation as mentioned in 42 CFR 438.350. This information will be obtained through methods consistent with established protocols, include the elements described in the EQR results Section, and results will be made available as specified in the regulation.

Mandatory EQRO activities conducted by the Delaware EQRO as mentioned in 42 CFR 438.358 include:

- Validation of performance improvement projects;
- Validation of MCO performance measures reported by the MCO, or performance measures calculated by the State; and
- Review within the previous 3-year period to determine the MCOs compliance with standards for access to care, structure and operations, and quality measurement and improvement.

Methods to conduct activities outlined in the CMS' EQR protocol include:

- Medical chart reviews;
- MCO case management file reviews;
- Clinic and provider surveys;
- National Committee for Quality Assurance (NCQA) results;
- Data analysis;
- Administrative oversight and quality assessment and improvement review; and
- Focused studies of certain aspects of care.

Optional activities that DMMA may elect to have the EQRO perform include:

- Validation of encounter data reported by an MCO;
- Administration or validation of consumer or provider surveys of quality of care;
- Calculation of performance measures in addition to those reported by and validated by the EQRO;
- Conduct performance improvement projects in addition to those conducted by an MCO and validated by the EQRO;
- Conduct studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time; and
- Technical assistance. The EQRO may, at the State's direction, provide technical guidance to groups of MCOs to assist them in conducting activities related to the mandatory and optional activities that provide information for the EQR.

The EQRO produces at a minimum, the following information as required in 42 CFR 438.364(a), without disclosing the identity of any patient as mentioned in 42 CFR 438.364(c):

- A detailed technical report describing data aggregation and analysis and the conclusions (including an assessment of strengths and weaknesses) that were drawn as to the quality, timeliness, and access to care furnished by the MCO. For each activity conducted, the report does include:
 - a) objectives,
 - b) technical methods of data collection and analysis,
 - c) description of data obtained, and
 - d) conclusions drawn from the data;
- Recommendations for improving the quality of health care services furnished by the MCO; and
- An assessment of the degree to which the MCO effectively addresses previous EQRO review recommendations.

The EQRO provides this information by:

- Holding a review exit conference with the State and MCO administrative and clinical management staff to address findings and recommendations; and
- Providing a written summary of reports, including findings and recommendations to the State and MCO.

The State provides copies of the information, upon request, to interested parties, through print or electronic media, or alternative formats for persons with sensory impairments as mentioned in 42 CFR 438.364(b).

EQR results and technical reports are submitted to MMDS for review and feedback. Report results, including data and recommendations, are then analyzed and used to identify opportunities for process and system improvements, Performance Measures or Performance Improvement Projects. Report results are also used to determine levels of MCO compliance with federal and state requirements and assist in identifying next steps.

If an MCO is deemed non-compliant during any aspect of the EQR process, development of a Corrective Action Plan is required to address areas of noncompliance including a time line for achieving compliance. MMDS may request the EQR to provide technical assistance regarding compliance review report findings and effectiveness of corrective action plans. Corrective Action Plans are submitted to MMDS for review and approval prior to implementation by the MCO. MMDS monitors progress of these corrective actions through several mechanisms which may include internal meetings with the MCO, review of monthly, quarterly and annual required PMs and EQRO reports. As per federal requirements, the EQRO reviews MCO Corrective Action Plans for effectiveness as part of the annual compliance review.

Performance Measures and Performance Improvement Projects

CMS, in consultation with States and other stakeholders, may specify performance measures (PMs) and topics for performance improvement projects (PIPs) to be required by States in their contracts with MCOs. As CMS has not yet identified a mandatory set of PMs or PIPs, the MMDS leadership team, in conjunction with input from the QII Task Force, MCAC and other stakeholders, has identified a set of performance measures and focused topics for required performance improvement projects. These state mandated measures and projects address a range of priority issues for the Medicaid and CHIP populations. These measures have been identified through a process of data analysis and evaluation of trends within these populations.

Final selection and approval of PIPs and PMs is the responsibility of the MMDS Leadership team. State specific PMs are reported by the MCO and results are reviewed quarterly by MMDS, with final HEDIS results reviewed annually. Validation results of the PIPs are reviewed by MMDS on an annual basis in conjunction with the EQRO compliance report results.

State-Specific Mandatory Performance Reporting

A goal of the State is to have accurate data that clearly reflects the performance of the MCOs in managing the delivery of healthcare to their Medicaid and CHIP enrollees. Currently the State requires a number of performance metric results to be reported on an annual, biannual, quarterly and monthly basis. The measures are submitted by the MCO in a State-mandated format using State specific definitions and have required timeframes to calculate and report by. Any deviances are to be noted as variances by the MCO and actions taken for improvement are to be described. The metrics that are mandated for each MCO to self-report are submitted electronically via an approved template, titled “Quality and Care Management” (QCM). These measures include:

Annual

- State-specified Lead Screening
- CAHPS® survey
- Provider Satisfaction Survey
- HEDIS®
 - Well-Child Visits in the First 15 months of Life (W15)
 - Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
 - Children and Adolescents’ Access to Primary Care Practitioners (CAP)
 - Adults’ Access to Preventive/Ambulatory Health Services (AAP)
 - Timeliness of Prenatal and postpartum care (PPC)
 - Childhood Immunization Status (CIS)
 - Lead Screening in Children (LSC)
 - Breast Cancer Screening (BCS)
 - Cervical Cancer Screening (CCS)
 - Use of Appropriate Medications for People with Asthma (ASM)
 - Comprehensive Diabetes Care (CDC)
 - Cholesterol Management for Patients with Cardiovascular Conditions (CMC)
 - Controlling High Blood Pressure (CBP)
 - Appropriate Treatment for Children with Upper Respiratory Infection (URI)

- Antidepressant Medication Management (AMM)
- Ambulatory Care (AMB)
- Inpatient Utilization – General Hospital/Acute care (IPU)
- Mental Health Utilization (MPT)

Bi-Annual

- GeoAccess

Quarterly

- Grievances
- Appeals
- EPSDT Outreach Efforts

Monthly

- Health Risk Assessments
- Case Management
 - Including Smart Start referral
- Disease Management
- Access to Care
- Timely Appointments
- Network Availability
- Customer Service
- Utilization Management
- Education and Outreach

The QCM reporting process has been in place since calendar year 2008. Throughout 2008 and 2009 the State and the EQRO provided technical assistance to each MCO to refine and correct any areas in the QCM reports that were not in compliance with the mandatory standardization. In 2009, the EQRO completed an Information Systems Capabilities Assessment (ISCA) of each MCO to assess the extent to which the MCO's internal processes and information systems were capable of producing and reporting valid encounter data, performance measures and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its enrollees. Additionally, as part of the annual Compliance Review of each MCO, the EQRO validates select performance measures.

Delaware Performance Improvement Projects

PIPs are required by CMS as an essential component of an MCO's Quality Program and are used to identify, assess and monitor improvement in processes or outcomes of care. DMMA has mandated each MCO conduct three PIPs. The State selected all three PIPs for independent validation by the EQRO during the compliance review cycle. Two of the PIPs, Prenatal/Postpartum Care and Inappropriate Emergency Department Utilization are State required topics. The third required PIP, allows for a topic selected by the individual MCO, that is relevant to its population, and approved by DMMA as pertinent to the needs of Delaware's Medicaid and CHIP populations. To meet new federal requirements specified under CHIPRA legislation DMMA selected the Inappropriate Emergency Department Utilization project for EQRO validation of the appropriateness and effectiveness of interventions specific to CHIP population.

Whenever possible, DMMA encourages MCO's to utilize HEDIS specifications when appropriate. The PIPs and the specifications to be applied included:

- Prenatal/Postpartum – HEDIS specifications and MCO specific measures
- Inappropriate Emergency Department Utilization – HEDIS specification and MCO specific measures

Intermediate Sanctions

The premise behind the QMS process is one of continuous quality improvement. Delaware strongly believes in working with its MCO in a proactive manner to improve the quality of care received by Delaware Medicaid and CHIP beneficiaries. However, should the need arise, part of the Delaware quality management process is the existence of sanctions and conditions for contract termination that may be imposed should the continuous quality improvement process not be effective. These sanctions meet the Federal requirements of 43 CFR Subpart I as well as Delaware state requirements for sanctions and terminations.

The performance standards for MCOs shall be defined as absolute and total compliance with the participation requirements specified in Chapter II of the RFP. The MCO shall meet these performance standards in full or be subject to sanctions by the State, including but not limited to monetary or enrollment related penalties.

Whenever the State determines that the MCO is failing to meet performance standards, it may suspend the MCOs right to enroll new members. The State, when exercising this option, shall notify the MCO in writing of its intent to suspend new enrollment. The suspension period may be for any length of time specified by the State, or may be indefinite. The State also may notify enrollees of MCO non-performance and permit these members to transfer to another MCO.

The State may impose sanctions against an MCO, if the MCO:

- (a) Fails substantially to provide medically necessary items and services that are required (under law or under the contracting entities contract with the State) to be provided to a member covered under the contract;
- (b) Imposes premiums or charges on members in excess of the premiums or charges permitted under the contract, if any;
- (c) Acts to discriminate among members on the basis of their health status or requirements for health care services, including any practice that would reasonably be expected to have the effect of denying or discouraging enrollment in the MCO by eligible members whose medical condition or history indicates a need for substantial future medical services;
- (d) Misrepresents or falsifies information that it furnishes to CMS or the State;
- (e) Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider;
- (f) Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210;
- (g) If the State determines that the MCO distributed, directly or through any agent or independent MCO, marketing materials in violation of the contract and that have not been approved by the State or that contain false or materially misleading information (applies to MCO & PCCM; voluntary for PIHP & PAHP); *or*
- (h) Has violated any of the other applicable requirements of Sections 1903(m) or 1932 of the Act and any implementing regulation.

Where these violations are documented, the State will require a corrective action plan be developed, approved by the State, and implemented within 10 days from notification of the violation. The State will monitor improvement via reports and/or onsite reviews, the content of which will be specific to the violation and defined by the State. Performance free of violation must occur for 60 days or until the State and CMS agree the violation has been corrected and is not likely to recur.

If the corrective action plan is not successful, intermediate sanctions will be applied. Payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR 438.730.

The State may also choose to:

- Suspend payments for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;
- Appoint temporary management for the MCO as provided in 42 CFR 438.706;
- Apply additional sanctions allowed under State statute or regulation that address areas of noncompliance; and
- Limit enrollment or terminate the contract with the MCO.

The State may not terminate a contract with an MCO, unless the MCO is provided with a hearing prior to the termination. However, if the State determines that it is necessary to appoint emergency temporary management for optional or required sanctions upon the MCO, the temporary management of the MCO may be assumed by the Delaware Department of Insurance.

Temporary management will be imposed if the MCO has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Act. In this circumstance, enrollees will have the right to terminate enrollment without cause will be notified by the State.

The circumstances under which the sanction of temporary management may be imposed include:

- In the event of a failure to meet the performance requirements;
- Continued egregious behavior by the MCO, including, but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of Sections 1903(m) and 1932 of the Act; or
- There is substantial risk to enrollees' health; or
- The sanction is necessary to ensure the health of the MCO's enrollees while improvements are made to remedy violations under 438.700 or until there is an orderly termination or reorganization of the MCO.

The State may not delay imposition of temporary management to provide a hearing before imposing this sanction. In addition, the State may not terminate temporary management until it determines that the MCO can ensure that the sanctioned behavior will not recur.

The MCO shall also pay to the State the actual damages according to the following subsections. Written notice of said failure to perform shall be provided to the MCO. The State may, at its discretion, refund to the MCO all or part of the damages assessed and collected following corrective actions on the part of the MCO. The use of discretion by the State does not waive the MCO's non-compliance in the event of termination of the contract.

The MCO shall ensure that performance standards as described are met in full. The size of the damages associated with failure to meet performance standards will vary depending on the nature of the deficiency. Therefore, in the event of any breach of the terms of the contract with respect to performance standards, unless otherwise specified, sanctions shall be assessed against the MCO in an amount equal to the costs incurred by the State to ensure adequate service delivery to the affected members. If the degree of non-compliance results in transfer of members to another MCO, the sanctions shall include the difference in the capitated rates paid to the non-compliant MCO and the rates paid to the replacement MCO.

The MCO shall carry out the monthly member reconciliation tasks.

The MCO shall comply with the operational and financial data reporting requirements described in Chapter II of the RFP. The MCO shall be liable for up to one thousand dollars (\$1,000) for each business day that any report is delivered after the date when it is due, or includes less than the required information, or is not in the approved media or format. The State may also suspend capitation payments or enrollment for the period of time the MCO is not in compliance.

The objective of this standard is to provide the State with an administrative procedure to address general contract compliance issues which are not specifically defined as performance requirements or for which damages due to non compliance cannot be quantified in the manner described in Chapter IV.

Any MCO selected under this contract will be required to provide all member benefits, enrollment, grievance, and provider network information in a timely manner determined by the State, and in the required format, determined by the State.

The State may identify contract compliance issues resulting from the MCO's performance of its responsibilities through routine contract monitoring activities. If this occurs, the Project Manager or designee will notify the MCO in writing of the nature of the performance issue. The State will also designate a period of time, not to be less than ten (10) business days, in which the MCO must provide a written response to the notification and implement that plan within 30 days from the initial notification.

If the non-compliance is not corrected by the specified date, the State may assess sanctions up to the amount of one thousand dollars (\$1,000) per business day after the due date until the non-compliance is corrected.

Amounts due the State as sanctions may be deducted by the State from any money payable to the MCO pursuant to the contract. The Project Manager shall notify the MCO in writing of any claim for sanctions at least fifteen (15) days prior to the date the State deducts such sums from money payable to the MCO.

The State may, at its sole discretion, return a portion or all of any sanctions collected as an incentive payment to the MCO for prompt and lasting correction of performance deficiencies.

The Project Manager, with the agreement of the Division Director, may exercise the following remedial actions should the Project Manager find the MCO substantially failed to satisfy the scope of work found in the contract. Substantial failure to satisfy the scope of work shall be defined to mean incorrect or improper activities or inaction by the MCO. Incorrect payments to the MCO due to omission, error, and/or fraud shall be recovered from the MCO by deduction from subsequent payments under this contract. The State may:

- (a) Withhold payment to the MCO until the necessary services or corrections in performance are satisfactorily completed; or
- (b) Suspend enrollment in the MCO until the corrections are satisfactorily completed.

State Standards

In an effort to provide adequate access to care for Delaware's Medicaid and CHIP populations, all standards for access to care, structure and operations, and quality measurement and improvement, listed in the chart below and throughout the QMS document are incorporated in the MCO contract/RFP which is in accordance with Federal Regulations.

The following table summarizes State defined access standards:

| Appointment Standard | | | | | |
|--|---|--|--|---|---|
| General | Specialty | Maternity | Behavioral Health | EPSDT | SHCNs Foster Care |
| Emergency Services – Available twenty-four (24) hours a day, seven (7) days a week | Emergency Services – Immediate | Emergency Services – Immediate | Emergency Services – Within twenty-four (24) hours of request. Immediate treatment for a potentially suicidal individual | Early and Periodic Screening Diagnosis and Treatment (EPSDT) Screening – Available no more than two (2) weeks after the initial request | DFS Suspects Physical and/or Sexual Abuse – Within twenty-four (24) hours |
| Emergency Primary Care Provider (PCP) – Available same day | Urgent Care PCP – Available within forty-eight (48) hours of referral | Initial Prenatal Care – First Trimester – Within three (3) weeks of first request | Routine Care – Within seven (7) calendar days of request | Initial Visit for Newborns – Newborn physical exam | DFS – All Other Cases – Within five (5) days of notification that the child was removed from home |
| Urgent Care PCP – Available within two (2) calendar days | Routine Care – Available within three (3) weeks of member request | Initial Prenatal Care – Second Trimester – Within seven (7) calendar days of first request | | Preventive Pediatric Visit – According to the American Academy of Pediatrics periodicity schedule up to age twenty-one (21) | DFS – Child Access to Screening Tool – Within thirty (30) days of notification the child was removed from home; whenever possible should be completed within five (5) days time frame |
| Routine Care – Available within three (3) weeks of member request | | Initial Prenatal Care – Third Trimester – Within three (3) calendar days of first request | | | |
| | | Initial Prenatal Care– High Risk – Pregnancies Within three (3) calendar days of identification of high risk | | | |

Access Standards

The following performance standards apply to Medicaid and CHIP populations:

| Performance Standards |
|---|
| Delivery Network |
| Contracted network of appropriate Providers (42 CFR 438.206(b)(1)) |
| Each MCO must meet the following requirements. |
| <ul style="list-style-type: none">• Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each MCO must consider the anticipated Medicaid enrollment, the expected utilization of services, and take into consideration the characteristics and health care needs of specific Medicaid populations enrolled with the Contractor. The MCO must also consider the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services, the numbers of network providers who are not accepting new Medicaid patients, and the geographic location of providers and Medicaid enrollees. Distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, will be considered and whether the location provides physical access for Medicaid enrollees with disabilities.• The networks must be comprised of hospitals, physicians, behavioral health providers, and other specialists in sufficient numbers to make available all covered services in a timely manner.• Contractors must ensure that their networks include providers who specialize in the care of HIV members.• Contractors will coordinate services with the State Public Health Laboratory supported by documented evidence of agreement.• The primary care network must have at least 1 full time equivalent PCP for every two thousand patients. The State must approve all capacity changes that exceed two thousand five hundred patients. |

Performance Standards

Direct Access to Women's Health Specialist (42 CFR 438.206(b)(2))

- Provides female enrollees with 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 a women's health specialist.
- Contractors must ensure that the network procedures for accessing family planning services are convenient and easily comprehensible to members.
 - Pap smear is included as a family planning service if performed according to the United State Preventative Services Task Force Guidelines which specifies cervical cancer screening every one (1) to three (3) years based on the presence of risk factors (early onset of sexual intercourse, multiple sexual partners); however, Pap smear annual frequency may be reduced if three (3) or more annual smears are normal.
- A women's health specialist may serve as a primary care provider.
- The Smart Start Program must be offered to all pregnant women who have at least one risk factor. And providers of obstetrical care must show evidence of screening for Smart Start in patient charts.

Adequate and Timely Second Opinion (42 CFR 438.206(b)(3))

- Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.

Adequate and Timely Out-of-Network Providers (42 CFR 438.206(b)(4) & (b)(5))

- If the network is unable to provide necessary services, covered under the contract, to DHSSHP, the MCO must adequately and timely cover these services out of network for the enrollee, for as long as the MCO is unable to provide them.
- Requires out-of-network providers to coordinate with the MCO with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.
- The MCO is responsible for making timely payment to out-of-network providers for medically necessary, covered services, up to their fee maximum for contracting providers.
- All MCOs must reimburse out-of-network providers for family planning services rendered to enrollees.

Provider Credentialing as required in regulation (42 CFR 438.206(b)(6))

- Demonstrates that its providers are credentialed and compliant with 438.214.

Performance Standards

Timely Access (42 CFR 438.206(c)(1)(i-vi))

- Each MCO must meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. Standards for access and timeliness are identified in the chart at the beginning of the standards section.
- Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
- Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.
- Establish mechanisms to ensure compliance by providers, monitor providers regularly to determine compliance, and have take corrective action if there is a failure to comply.
- The MCO must agree to make available to every member a PCP whose office is located within thirty 30 minutes driving time or thirty (30) miles from the member's place of residence.

Performance Standards

Cultural Considerations (42 CFR 438.206(c)(2))

- Each MCO will participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds by:
 - The MCO is required to have available interpretive services and to provide Spanish interpretive services at all times and for all other languages upon request.
 - The MCO will encourage and foster cultural competency in its employees.

Assurances of Adequate Capacity 438.207

Documentation and Assurances of Adequate Capacity and Services (42 CFR 438.207 (b), (c))

- Each MCO must give assurances to the State and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care.
- *Nature of supporting documentation.* Each MCO must submit documentation to the State, in a format specified by the State to demonstrate that it complies with the requirements below.
 - Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area.
 - Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.
- *Timing of documentation.* Each MCO must submit the required documentation, no less frequently than:
 - at the time it enters into a contract with the State or at any time there has been a significant change (as defined by the State) in the MCOs operations that would affect adequate capacity and services, including changes in Contractor services, benefits, geographic service area, payments or enrollment of a new population with the MCO.

Performance Standards

Coordination and Continuity of Care 438.208

Primary Care and Coordination of Health Care Services for all MCOs. (42 CFR 438.208 (a)(b)(1)-(b)(4))

- The MCO will comply with all State standards identified in the QMS.
- Each MCO must implement procedures to deliver primary care to and coordinate health care service for all MCO enrollees ensuring that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.
- The MCO must have written policies and procedures for assigning each of its members to a primary care provider.
- The MCO must contact the member within five (5) business days of his or her enrollment and provide information on options for selecting a primary care provider or confirmation that the member has been assigned to the PCP of choice.
- If a member does not select a primary care provider within thirty business days of enrollment, the MCO must make an automatic assignment, taking into consideration such know factors as current provider relationships, language needs and area of residence
- The primary care provider serves as the member's initial and most important contact and maintains the continuity of a member's health care.
- Coordinate the services the MCO furnishes to the enrollee with the services the enrollee receives from any other MCO or behavioral health provider.
- Share with other MCOs serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.
- Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.
- The MCO must have written policies and procedures for maintaining the confidentiality of data, including medical records/member information and adolescent/STD appointment records.
- For members in case management the MCO will assure case managers initiate and maintain a member care/treatment plan that includes;
 - a thorough initial assessment including all domains of care with periodic updates, including member strengths and barriers to care;
 - short and long term goals that are developed in collaboration with the member;
 - periodic assessment of goal achievement and development of new goals; and
 - identification and documentation of coordination of care opportunities with all providers involved in the members care.

Performance Standards

Additional Services For Enrollees With Special Health Care Needs

The MCO must demonstrate that they have in place all of the following to meet the needs of CSHCNs.

- Satisfactory methods for ensuring their providers are in compliance with Title II of the Americans with Disabilities Act.
- Members with disabling conditions or chronic illnesses may request that their primary care physicians be specialists.
- Satisfactory care coordination and case management systems for coordinating service delivery with out-of-network providers, including behavioral health providers and ongoing service providers.
- Policies and procedures to allow for the continuation of existing relationships with out-of-network providers, when considered to be in the best interest of the member.
- Demonstrate satisfactory methods for care coordination with the Department of Education, school districts, the Division of Family Services, early intervention programs and other agencies for the purpose of coordinating and assuring appropriate service delivery.
- Care Coordination with the Delaware school-based Wellness Centers.
- Contractors must coordinate and link with Division of Public Health Immunization Registry in order to track immunizations provided to their covered population. Contractors must assure all childhood immunizations are obtained and should report immunization levels as required under the DMAMC data and reporting requirements.
- Include an adequate network of pediatric providers and sub-specialists, and contractual relationships with tertiary institutions, to meet enrollees' medical needs.
- Satisfactory methods for assuring that children with serious, chronic, and rare disorders receive appropriate diagnostic workups on a timely basis
- A satisfactory approach for assuring access to allied health professionals (Physical Therapists, Occupational Therapists, Speech Therapists) experienced in dealing with children and their families.

Identification and Assessment (42 CFR 438.208(c)(1)(2))

- Each MCO must implement mechanisms to assess each Medicaid enrollee identified by the State, or its Health Benefits Manager, and identified to the MCO and by the State as having special health care needs. This is done to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

Performance Standards

Mechanisms for Enrollees with Special Health Care Needs: Development of Treatment Plans (42 CFR 438.208(c)(3))

- MCOs will produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be:
 - Developed by the enrollee’s primary care provider with enrollee participation and in consultation with any specialists caring for the enrollee in a timely manner, if this approval is required by the MCO;
 - In accordance with any applicable State quality assurance and utilization review standards.

Mechanisms for Enrollees with Special Health Care Needs: Direct Access to Specialists (42 CFR 438.208(c)(4))

- For enrollees with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, each MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee’s condition and identified needs.
- The MCOs will have documented policies and procedures for enrollees with special health care needs to achieve direct access to Specialist services as appropriate for the enrollee’s condition and identified needs.

Coverage and Authorization of Services 438.210

Amount, Scope and Duration of Service Coverage (42 CFR 438.210(a)(1-4))

- MCOs are required to provide for all medically necessary and appropriate Medicaid covered services, consistent with FFS Medicaid, in sufficient amount, scope, and duration to achieve the purpose of the service(s) and, may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.
- The MCO may place appropriate limits on a service based criteria applied under the State plan, such as medical necessity or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. And specify what constitutes “medically necessary services” in a manner that:
 - is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and
 - addresses the extent to which the MCO is responsible for covering services related to the following:
 - the prevention, diagnosis, and treatment of health impairments,
 - the ability to achieve age-appropriate growth and development, and
 - the ability to attain, maintain, or regain functional capacity.
- The MCO UR/UM staff must be fully aware of the Medicaid medical necessity definition and covered benefits.

Performance Standards

Policies and Procedures for Authorization of Services (42 CFR 438.210(b)(1), (2), and (3))

- For processing of initial and continuing authorization of services, the MCO and its subcontractors must have in place, and follow, written policies and procedures addressing denial of services, prior approval, and hospital discharge planning.
- The MCO must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and procedures to consult with the requesting provider when appropriate.
- That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

Notice of Adverse Action (42 CFR 438.210(c))

The MCO must have and follow policies and procedures defining requirements for notifying the requesting provider, and providing the enrollee written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The MCO's notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing.

Timeframe for decisions (42 CFR 438.210(d))(1), (2)&(e)

The MCO must provide the following decisions and notices meeting the following requirements:

- *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—
 - The enrollee, or the provider, requests extension; or
 - The MCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.
- *Expedited authorization decisions.* For cases in which a provider indicates, or the MCO, determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.
- The MCO may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, prepaid inpatient health plans (PIHP), or prepaid ambulatory health plans (PAHP) justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.
- Compensation for utilization management activities: Compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

Performance Standards

Compensation for UM activities (42 CFR 438.210(e))

The MCOs compensation structure shall not have incentives based on approvals, limitations, or denials of medically necessary services for enrollees.

Emergency and Post–Stabilization Care Service (42 CFR 438.114)

The MCO will comply with the following definitions:

- Emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
 - 1) Placing the health of the individual or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
 - 2) Serious impairment to bodily functions; or
 - 3) Serious dysfunction of any bodily organ or part.
- Emergency service means covered inpatient or outpatient services that are:
 - 1) Furnished by a provider who is qualified to furnish these services under this title; or
 - 2) Needed to evaluate or stabilize an emergency medical condition.
- Post-stabilization care services are defined as covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.
- The MCO must cover Post Stabilization services without requiring authorization, and regardless of whether the member obtains the services within or outside the Contractor's provider network if any of the following circumstances exist:
 1. The Post stabilization Services were pre-approved by the Contractor;
 2. The Post Stabilization Services were not pre-approved by the Contractor because the Contractor did not respond to the Provider's request for these Post stabilization services within one (1) hour of the request;
 3. The Post stabilization services were not pre-approved by the Contractor because the Contractor could not be reached by the provider to request pre-approval for these post stabilization services; or
 4. The Contractors representative and the treating physician cannot reach an agreement concerning the member's care and a Contracting physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician and treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR 422.113 (C) (3) is met.

Performance Standards

- The MCOs may not deny payment for treatment if enrollee had an emergency medical condition, or if representative of the MCO instructs the enrollee to seek emergency services.
- The MCOs may not limit what constitutes an emergency medical condition on the basis of lists of diagnosis or symptoms.
- The MCO may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider's MCO or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.
- The MCO must assure that an enrollee who has an emergency not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
- The MCO must assure that the attending emergency physician or the treating provider is responsible for binding determination of enrollee stabilization for transfer or discharge based upon the general rule for coverage and payment.

Structure and Operations

The following Structure and Operations Performance Standards apply to both Medicaid and CHIP populations:

| Structure and Operations Performance Standards |
|--|
| Provider Selection |
| Selection and Retention (42 CFR 438.214(a), (b)(2)) <ul style="list-style-type: none">• The MCO must have written credentialing and recredentialing policies and procedures for determining and assuring that all providers under contract to the plan are licensed by the State and qualified to perform their services according to the DMMA Quality Assurance Strategy.• A documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO and how the MCO will follow those processes.• Verification of provider qualifications will include but is not limited to:<ul style="list-style-type: none">– Current valid license to practice,– Clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility,– Valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate,– Education and training including evidence of graduation from the appropriate professional school and completion of a residency or specialty training,– Board certification of the practitioner states s/he is board certified on the application,– Current, adequate malpractice insurance meeting the MCOs requirements,– History of professional liability claims that resulted in settlements or judgments by or on behalf of the practitioner (May be obtained by the National Practitioner Data Bank)– Information about sanctions or limitations on licensure from the applicable state licensing agency or board,– Information about sanctions or limitations by Medicare or Medicaid, and– Consultation with State staff. |
| Nondiscrimination (42 CFR 438.214(c)) (42 CFR 438.12(a)) <ul style="list-style-type: none">• Policies and procedures and documented practice within the MCO must be free of any indication of discrimination related to the population served or the cost of covered treatment. If the MCO declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.• Contractors must also have a written appeals process providers will use to challenge any denial of credentialing resulting from this process. |
| (42 CFR 438.12 (b)(1)) <p>The MCOs will not be required to contract with providers beyond the number necessary to meet the needs of the enrollees.</p> |

Structure and Operations Performance Standards

(42 CFR 438.12(b)(2))

- The MCOs may use different reimbursement amounts for different specialties or for different practitioners in the same specialty.

(42 CFR 438.12(b)(3))

- The MCO is not precluded from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

Excluded Providers (42 CFR 438.214(d))

- The MCO must be consistent with policy, procedure, and regulatory requirements and may not employ or contract with providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Act.

State Requirements (42 CFR 438.214(e))

- The MCO will have written policies and procedures for monitoring its providers and for disciplining providers who are found to be out-of-compliance with the Contractors medical management standards.
- The MCO will monitor appeals and grievance logs on a monthly basis to assess for network or provider related problems.

Confidentiality 438.224

Structure and Operations Performance Standards

Confidentiality requirements consistent with (42 CFR 438.224), (45 CFR parts 160 and 164)

- The MCO, including all providers, physicians' practitioners, suppliers, etc., shall have in place policies and procedures to maintain the confidentiality of all-medical records and assure that all records and their use meet all HIPPA requirements.
- The State is not required to obtain written approval from a member before requesting the member's record from the primary care provider or any other provider. And shall be afforded access within thirty 30 calendar days to all members' medical records whether electronic or paper.
- The Contractor shall upon the written request of the member, guardian or legally authorized representative of a member, furnish a copy of the medical records of the member's health history and treatment rendered. Such record shall be furnished within a reasonable time of the receipt of the written request.
- When a member changes primary care providers, his or her medical records or copies of medical records must be forwarded to the new primary care provider within ten (10) business days from receipt of request.
- The MCO must have written policies and procedures for maintaining the confidentiality of data, including medical records/member information and adolescent/STD appointment records.
- Access to all individually identifiable information relating to Medicaid members that is obtained by the MCO shall be limited by the MCO to persons or agencies that require the information in order to perform their duties in accordance with this contract, and to such others as may be authorized by the State in accordance with applicable law.
- The MCO must provide safeguards that restrict the use or disclosure of information concerning members to purposes directly connected with the administration of the contract.

Enrollment and Disenrollment 438.226

Enrollment and Disenrollment (42 CFR 438.226)

The State does not allow for disenrollment and prefers to apply the term transfer to the following MCO expectations.

The MCOs must ensure compliance with the enrollment and transfer requirements and limitations set forth in 438.56.

Structure and Operations Performance Standards

Transfer: Requirements and Limitations (42 CFR 438.56)

- The MCOs must have written policies that specify the reasons for which the MCO may request a transfer of an enrollee and reasons a transfer may not be requested. The MCO may not initiate transfers because of a medical diagnosis or health status of a member, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (unless enrollee's continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this enrollee or other enrollees), or non-compliance related to diagnosis, a member's attempt to exercise his or her rights under the grievance system, or based on the demands of a member to seek referrals to specialists or for information regarding their medical condition system.
- The MCO will identify methods to assure the State that it does not request transfer for reasons not covered by contract.

Transfer requested by the enrollee

- The MCO must provide that a recipient may request to transfer for cause at any time and without cause, at the following times:
 - During the 90 days following enrollee's initial enrollment date or State notice of enrollment date, whichever is later,
 - At least once every 12 months thereafter;
 - Upon automatic reenrollment per paragraph (g) of this Section, or
 - Upon State imposed sanctions per 438.702(a) (3).

Procedures for Transfer

- The MCO may initiate transfers for valid reasons including:
 - Persistent and documented refusals of the patient to follow prescribed treatments or comply with contractor requirements that are consistent with State and Federal laws and regulations.
 - Misuse of the system, abuse or threatening conduct by the member.
 - Deliberate falsification of application or enrollment materials by the member.
 - The MCO must have attempted through education and case management to resolve any difficulty leading to a request for transfer at least three (3) times over a period of ninety 90 consecutive, calendar days before requesting transfers, unless the member has demonstrated abusive or threatening behavior.
 - Contact attempts must occur at least at thirty days intervals of the 90-day period.
 - Prior to transfer, the case will be referred to the HBM, who must make at least one (1) attempt to resolve the matter.
-
- In cases involving abusive or threatening behavior, only one (1) attempt is required.
 - The Contractor must cite at least one (1) example of an appropriate reason to require transfer and give written notice of the request of transfer to both the member and the State.
 - All notifications regarding requests for transfer must inform the member of appeal rights and be documented.

Grievance Systems 438.228

Structure and Operations Performance Standards

Grievance Systems (42 CFR 438.228(a))

- a) The MCOs must have a grievance system in place that meets the requirements of subpart F of this Section.

Statutory Basis and Definitions 438.400

- The MCO is required to establish and maintain internal grievance system procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.
- An ‘action’ shall be defined as:
 - Denial or limited authorization of a requested service, including the type or level of service;
 - Reduction, suspension, or termination of a previously authorized service;
 - Denial, in whole or in part, of payment for a service;
 - Failure to provide services in a timely manner, as defined by the State or act within the timeframes of 438.208;
 - For a resident of a rural area with only one Contractor, the denial of a Medicaid enrollee’s request to exercise his or her right to obtain services out of network
- *Appeal* means a request for review of an action as defined in this section.
- *Grievance* means an expression of dissatisfaction about any matter other than an action, as “action” is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO level and access to the State fair hearing process.

General Requirements 438.402

The Grievance System (42 CFR 438.402 (a))

- Each MCO must have a system in place for enrollees that include a grievance process, an appeal process, and access to the State’s fair hearing system.

Authority to File (42 CFR 438.402(b))

- An enrollee may file a grievance or a MCO level appeal and may request a State Fair Hearing. A provider or the client's legal representative acting on behalf of the enrollee and with the enrollee’s written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of an enrollee.

Structure and Operations Performance Standards

Timing (42 CFR 438.402(b)(2))

- An enrollee may file a grievance either orally or in writing. A provider may file a grievance as the State permits the provider to act as the enrollee's authorized representative.
- The enrollee or the provider may file an appeal; and request a Fair Hearing within a timeframe that may not exceed 90 days from the date on the Contractors notice of action.

Procedure (42 CFR 438.402(b)(3))

- The enrollee may file a grievance orally or in writing and, either with the State or with the MCO. And unless he or she requests expedited resolution must follow an oral filing with a written, signed, appeal.

Notice Of Action 438.404, 438.200, 438.228, 438.206

42 CFR 438.228, 431.206(b) and 431.210:

The MCO has delegated responsibility for State Fair Hearing notices.

MCO Notification of State Procedures (42 CFR 438.200(b))

- The MCO is required to provide information on State Fair Hearing procedures including, but not limited to the enrollee's right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing. Additionally, the State fair hearing description must be included in enrollee and provider information.
- The MCO must give the enrollee written notice of any action to include but not limited to, service authorizations, within the timeframes for each type of action.
- MCOs are responsible to ensure timely notification of enrollees of his/her right to use the State administrative grievance process.

Language and Format (42 CFR 438.404(a), 42 CFR 438.10(c) and (d))

Language:

- The MCO is required to make written information available in the prevalent non-English languages in its particular service areas. In Delaware, Spanish is currently the prevalent non-English language.
- Inform the member about rights as a member of MCO services; this will include informing the member both orally and in a clearly written format in the member's own language about both the MCO and State grievance and appeal procedures; if the member has an auditory and/or visual impairment, reasonable accommodations must be made to assure that the member is informed and understands his/her rights

Format:

- The MCO must produce written materials including notice of actions and must meet the language and format requirements to ensure ease of understanding. Information must be available in alternative formats, must be available and in an appropriate manner.
- The MCO is required to notify all enrollees and potential enrollees that information is available in alternative formats and how to access those formats.

Structure and Operations Performance Standards

Notice of Adverse Action Content (42 CFR 438.404(b)) (42 CFR 431.206(b) and 431.210)

- The notice must explain the action the MCO or its sub-contractor has taken or intends to take. The reason for the action and the enrollee's or the provider's right to file an appeal with the MCO or to request a State fair hearing. Procedures for exercising the enrollee's right to appeal or grieve. Circumstances under which an expedited resolution is available and how to request it; and the enrollee's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the cost of these services.
- The MCO will also inform enrollees that:
 - 1) the enrollee may represent himself or use legal counsel, a relative, a friend, or other spokesman;
 - 2) the specific regulations that support, or the change in Federal or State law that requires, the action; and
 - 3) an explanation of the individual's right to request an evidentiary hearing if one is available or a state agency hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted.)

Timeframes for Notice of Action: (42 CFR 438.404(c)(1))

Termination, Suspension, or Reduction of Services The MCO is required to give at least 10 days notice before the date of action when the action is termination, suspension, or reduction of previously authorized Medicaid-covered services, except:

- If probable recipient fraud has been verified, then 5 days
- By the date of the action for:
 - The death of a recipient;
 - A signed written recipient statement requesting service termination or giving information requiring termination or reduction of services;
 - The recipient's admission to an institution where he is not longer eligible for services;
 - The recipient's address is unknown and the mail directed to him has no forwarding address;
 - The recipient has accepted Medicaid services by another local jurisdiction;
 - The recipient's physician prescribes the change in level of medical care;
 - An adverse determination made with regard to the preadmission screening requirements for Nursing Facility admissions on or after January 1, 1989; or
 - The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the NF for 30 days.

Structure and Operations Performance Standards

Timeframes of Notice of Action (42 CFR 438.404(c)(2), (3), (4), (5)&(6))

Untimely Service Authorization Decisions

- The MCO is required to give notice on the date that timeframes expire if service authorization decisions are not reached for either standard or expedited service requests. Untimely service authorizations constitute a denial and are considered adverse actions. For denial of payment, the MCO is required to give notice at the time of any action affecting the claim.
- For standard service authorization decisions, (42 CFR 438.210 (d) (1)), that deny or limit services, notification occurs within the timeframe specified in Coverage and Authorization of Services.
- If the MCO is granted an extension, the enrollee must be given written notice of the extension, and be offered the opportunity to file a grievance if they disagree with the decision. The MCO must carry out the decision as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
- For service authorization decisions not reached within the timeframes (which constitutes a denial and is thus an adverse action), notification occurs on the date that the timeframes expire.
- For expedited service authorization decisions, notification occurs within the timeframe specified in Coverage and Authorization of Services.

Handling of Grievances and Appeals 438.406

General Requirements (42 CFR 438.406(a))

- The MCOs grievance and appeals process must be approved by the State. The appeals process shall consist of an informal internal review by the MCO (Stage 1 appeal) and a formal internal review by the MCO (Stage 2 appeal). The member always has the right to appeal to the DMMA, whether or not they have filed an appeal with the MCO.
- The MCO will provide enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- The MCO will acknowledge the receipt of each grievance and appeal within 5 days of receipt.
- Ensure that individuals who make decisions on Grievances and Appeals are individuals who were not involved in any previous level of review or decision-making. And who if deciding an appeal of a denial that is based upon lack of medical necessity or grievance resolution regarding denial of expedited resolution of an appeal or a grievance or appeal that involves clinical issues are health care professionals who have the appropriate clinical expertise as determined by the State, in treating the enrollees condition or disease.

Special Procedures – The Process for Appeals (42 CFR 438.406(b))

- The enrollee or provider may file an appeal either orally or in writing and must follow the oral filing with a written, signed appeal.

The MCO must:

Structure and Operations Performance Standards

- Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the enrollee or provider requests expedited resolution;
- Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing and inform the enrollee of the limited time for this in the case of an expedited resolution;
- Allow the enrollee and representative the opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records; and
- Consider the enrollee, representative, or estate representative of a deceased enrollee as parties to the appeal.

Resolution and Notification: Appeals. 438.408

Resolution and Notification (42 CFR 438.408(a), (b), (c))

- The MCO must resolve each appeal and provide notice as expeditiously as the enrollee's health condition requires but within the State established timeframes not to exceed 90 calendar days from the day the MCO receives the appeal.
- For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day the MCO receives the appeal and for expedited resolution of an appeal and notice to affected parties, the timeframe is no longer than 3 working days after the MCO receives the appeal.
- The MCO may extend the timeframes by up to 14 days if the enrollee requests an extension; or the MCO shows there is need for additional information and that the delay is in the enrollee's interest. For an extension not at the enrollee's request, the MCO must give the enrollee written notice of the reason for the delay. If the MCO extends the timeframes, it must—for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.

Format and Content of Resolution Notice (42 CFR 438.408(d)(e))

- The MCO must follow State defined requirements for notification of an enrollee of the disposition of an appeal.
- The MCO will provide written notice of disposition of grievances and appeals and for expedited resolution; the MCO must also make reasonable efforts to provide oral notice.
- The MCO must provide written notice of disposition, which must include the results and date of the appeal resolution. And for decisions not wholly in the enrollee's favor:
 - The right to request a State fair hearing,
 - How to request a State fair hearing,
 - The right to continue to receive benefits pending a hearing,
 - How to request the continuation of benefits, and
 - If the MCO action is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits.

Requirements for State Fair Hearings (42 CFR 438.408(f))

- Ensure that the MCOs appeal system cannot be prerequisite to, nor a replacement for, the

Structure and Operations Performance Standards

member's right to appeal to the DMMA and request a fair hearing in accordance with 42 CFR 431, Subpart E. The member always has the right to appeal to the Division of Social Services, whether or not they have filed for an appeal with the MCO

- The entire Appeal/Fair Hearing process must be accomplished within the specified 90-day period from notice of "action". The parties to the State fair hearing include the MCO as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.
- The parties to the State fair hearing include the MCO as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

Expedited Appeals Process: 438.410

General (42 CFR 438.410(a))

- The MCO must establish and maintain an expedited appeal process. The expedited review process is necessary when the MCO determines, or the provider indicates, that the time required for a standards resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

Punitive Action (42 CFR 438.410(b))

- The MCO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

Action following a denial of a Request for Expedited Resolution (42 CFR 438.410(c))

If an MCO denies a request for an expedited resolution of an appeal, it must:

- Transfer the appeal to the standard timeframe of no longer than 45 calendar days from the day the MCO received the appeal, with a possible 14-day extension.
- Give the enrollee prompt oral notice of the denial then written notice within two calendar days. This decision does not constitute an action therefore can be grieved but not appealed.

Structure and Operations Performance Standards

Information about the grievance system to providers and subcontractors. 438.414

Information (42 CFR 438.414) (438.10 (g))

- The MCO must provide procedures and timeframes related to grievance, appeal, and fair hearings to all providers and subcontractors at the time they enter into a contract.
- Information must include the right to a State fair hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing.
- The right to file grievances and appeals with requirements and timeframes for filing a grievance or appeal.
- The availability of assistance in the filing process including the toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.
- The fact that, when requested by the enrollee, benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing. The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.
- Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.

Record keeping and Reporting Requirements. 438.416

- The MCO is required to maintain records of grievances and appeals. Those records will include, at a minimum a log of all grievances/appeals whether verbal or written. The log should include Member identifying information, a statement of the appeal and resolution, if affected. Log data should be analyzed monthly to identify trends and/or patterns for administrative use and review
- Logs must always be available for State and CMS review.

Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending. 438.420

Terminology, Timely Filing and Continuation of Benefits (42 CFR 438.420(a), (b))

- Timely filing means that the appeal is filed on or before the later of the following:
 - Within 10 days of the MCO mailing the notice of action, or
 - The intended effective date of the MCO proposed action;
- The MCO must continue the enrollee's benefits if the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- An authorized provider ordered the services and the authorization period has not expired.
- The enrollee requests extension of benefits.

Structure and Operations Performance Standards

Duration of Continued or Reinstated Benefits (42 CFR 438.420(c))

- If the MCO continues or reinstates benefits, they will be continued until the enrollee withdraws the appeal or does not request a fair hearing within 10 days from when the MCO mails an adverse MCO decision. Benefits will also continue until a State fair hearing decision adverse to the enrollee is made or the authorization expires or authorization service limits are met.
- Information regarding continuance of benefits must be included in the “Notice of Action” letters to the client or the client’s representative.

Enrollee Responsibility for Services Furnished (42 CFR 438.420(d))

The MCO may recover the cost of the continuation of services furnished to the enrollee while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with (431.230 (b)), if the final resolution of the appeal upholds the MCOs action.

Effectuation of Reversed Appeal Resolutions. 438.424

Effectuation when Services were not Furnished (42 CFR 438.424(a))

- The MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee’s health condition requires if the MCO or State fair hearing officer reverses the decision to deny, limit, or delay services.

Effectuation when Services were Furnished (42 CFR 438.424(b))

- The MCO or the State must pay for disputed services in accordance with State policy and regulation if the MCO or State fair hearing officer reverses the decision to deny authorized services and the enrollee received the disputed services while the appeal was pending.

Structure and Operations Performance Standards

Sub contractual Relationships and Delegation 438.230

Written Agreement (42 CFR 438.230 (a), (b))

- The MCO is accountable for any functions and responsibilities that it delegates to any subcontractor as well as any payments to a subcontractor for services related to the contract.
- The MCO shall give the State immediate notice in writing, by certified mail, of any action or suit filed and of any claim made against the MCO or subcontractor(s) that, in the opinion of the MCO, may result in litigation related in any way to the contract with the State.
- MCOs are responsible to maintain a written agreement between the entity and subcontractor that specifies the delegated scope of work, and report responsibilities including revocation of agreement.
- Before any delegation, each Contractor must evaluate the prospective subcontractor's ability to perform the activities to be delegated.

Periodic Performance Review (42 CFR 438.230(b))

- MCOs are responsible for periodic evaluation of subcontractor performance consistent with established state schedule, industry standards or state MCO laws and regulations.

Corrective Action Plan (42 CFR 438.230(b))

- MCOs must ensure that identified deficiencies or areas for improvement are subject to corrective action.

Quality Assessment and Performance Improvement

Measurement and Improvement Performance Standards

Practice Guidelines

Dissemination (42 CFR 438.236(c))

- MCOs will disseminate the guidelines and new technologies to all affected providers, and upon request to enrollees, potential enrollees, consumer advocates.

Application (42 CFR 438.236(d))

- MCOs will assure that decisions regarding utilization management, enrollee education, coverage of services and other areas to which the guidelines apply are consistent with the guidelines.

Quality Assessment and Performance Improvement Program

Requirements (42 CFR 438.240(b))

- MCOs are required to have an ongoing quality assessment and performance improvement program consistent with contractual obligations, State and Federal requirements and accreditation guidelines.
- Contractors must survey their members on at least an annual basis to determine satisfaction with Contractor's services.
- The MCO must also have a quality management plan for the upcoming year that is consistent with the State Quality Plan. This plan must describe the program's scope; objectives and all planned projects, activities, and focused studies for the upcoming year. The plan must also describe monitoring of previously identified issues including tracking of issues over time. A timetable must be included, which clearly identifies target dates for implementation and completion of all phases of activities. This plan must be approved by DMMA prior to implementation.
- The Program at a minimum must outline the administrative and organizational structures and design of the quality management program.
- Describe methodologies and mechanisms for objective and systematic monitoring of access to care and services provided to members.
- Describe mechanisms to ensure that findings, conclusions, recommendations, actions taken, and results of actions taken are documented and reported to individuals within the organization for use in conjunction with other related activities.
- Describe methodologies and mechanisms for tracking issues over time with an emphasis on improving health outcomes; such mechanisms should be developed in accordance with the guidelines of the *Guide to Clinical Preventive Services (Report of the U.S. Preventive Services Task Force)*, the EPSDT guidelines, or other criteria based on scientifically or clinically validated analysis.

Measurement and Improvement Performance Standards

Performance Measures &/or Performance Improvement Projects (42 CFR 438.240) (b))

- The State and CMS may specify performance measures and topics for required MCO performance improvement projects which must be achieved through ongoing measurements and intervention, significant improvement, sustained over time, clinically and non clinically, with favorable effect on health outcomes and enrollee satisfaction.

Under-utilization and Over-utilization (42 CFR 438.240(b)(3))

- MCOs are required to implement mechanisms to detect over- and under-utilization of services.
- The MCO will develop a Utilization Management Plan and annual work plan. Describe methodologies and mechanisms for monitoring and auditing provider performance, identifying deficiencies, addressing deficiencies with corrective action, monitoring of corrective actions for intended results, and communicating of all findings to providers.

Quality and Appropriateness of Care (42 CFR 438.240(b)(4))

- MCOs are required to have in place mechanisms to assess the quality and appropriateness of care furnished to all enrollees with particular emphasis on children with special health care needs.

Performance Measurement Requirements (42 CFR 438.240(b)(2) and 42 CFR 438.240(c))

The MCOs are responsible to provide:

- A full description of how they will address the clinical program initiatives as specified by the State for the Medicaid population.
- Ongoing reports quarterly, semi-annually, and annually as specified in the reporting section. Additional reports as determined necessary by the State for quality assurance and improvement activities.

Requirements (42 CFR 438.240(b)(1) and 42 CFR 438.240(d)(1))

- The MCOs are responsible to conduct performance improvement projects, approved by the State that will achieve demonstrable and sustained improvement over time incorporating performance improvement standards of measurement, including objective quality indicators, implementation, and evaluation and planning.

Performance Measurement (42 CFR 438.204(c))

- The MCOs must measure and report to the State its performance using standard measures required by the State including those developed in consultation with States and other relevant stakeholders. (42 CFR 438.3204c and 438.240(a)(2)). The MCO must submit data specified by the State to enable the State to measure the MCOs performance.

Reporting and Outcome (42 CFR 438.240(d)(2))

- MCOs are required to report the status and results of each project to the State upon request and annually as requested for the EQR process and must produce new information on quality of care every year.

Measurement and Improvement Performance Standards

State Review (42 CFR 438.240(e)(2))

MCOs will be subject to annual review of the impact and effectiveness of their quality assessment and performance improvement program, including:

- Performance on the required standard measures.
- Results of Performance Improvement Projects.

Information Requirements

Enrollee Information as required by 42 CFR 438.10 (42 CFR 438.218)

The State assumes the following responsibilities:

- 438.10(a) The State defines the following terms compliant with 438.10(a), ‘enrollee’ means a Medicaid recipient who is currently enrolled in an MCO in a given managed care program. A ‘potential enrollee’ mean a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO.
- 438.10(b)(1)(d)(1)(i) The State, assures the MCO, that the HBM will provide all enrollment-related notices, informational materials, and instructional materials to enrollees/potential enrollees in a manner and format that may be easily understood.
- Choice Counseling - Mechanism. The state has delegated to the HBM the responsibility to help enrollees and potential enrollees understand the State’s managed care program.
- 42 CFR 438.10(c)(3)&(4)&(5) The State assures that the HBM makes its written information available in the prevalent non-English languages in its particular service area, as specified by the State in the contract. The State assures that the HBM makes oral interpretation services available free of charge to each potential enrollee and enrollee. The HBM must notify its enrollees:
 - that oral interpretation is available for any language,
 - that written information is available in prevalent languages, and
 - how to access the interpretation services and written information.
- 42 CFR 438.10(d)(1)(ii)&(d)(2) Information - Alternative formats. The State is responsible to assure written material is available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.
- 42 CFR 438.10 (e)(f) Information - Potential Enrollees and Enrollees non-covered services. The State assures through its contract with the HBM that each managed care enrollee is informed of any services available under the State plan and not covered by the capitated or FFS contractor. That the HBM shall make available to potential enrollees and new enrollees, information in a written and prominent manner of any benefits to which the enrollee may be entitled but which are not made available to the enrollee by the entity. Such information shall include information on where and how such enrollee may access benefits not made available to the enrollee through the MCO.
- 42 CFR 438.10(e)(1) & (e)(2) 42 CFR 438.102(c) Information - Potential Enrollees. The

Measurement and Improvement Performance Standards

State delegates through the contract to the HBM who must provide the information of this Section to each potential enrollee as follows:

- At the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program.
- Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs, PIHP, PAHPs, or PCCMs.

The information for potential enrollees must include the following:

- General information about:
 - the basic features of managed care;
 - which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program; and
 - MCO, PIHP, PAHP, and PCCM responsibilities for coordination of enrollee care.
- Information specific to each MCO, PIHP, PAHP, or PCCM program operating in potential enrollee's service area. A summary of the following information is sufficient, but the State must provide more detailed information upon request:
 - benefits covered;
 - cost sharing, if any;
 - service area; and
 - names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs, this includes at minimum information on primary care physicians, specialists, and hospitals.
- The State will provide through the HBM information to enrollees indicating benefits that are available under the State plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. This includes counseling or referral services that the MCO does not cover because of moral or religious objections.
- 42 CFR 438.10(f)(3) Information - Enrollees. The State assures the enrollment broker, provides information to each enrollee as follows:
- Notify all enrollees of their disenrollment rights, at a minimum, annually. For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 days before the start of each enrollment period.
- Notify all enrollees, at the time of enrollment, of the enrollee's rights to change providers or disenroll enrollment for cause.
- Notify all enrollees of their right to request and obtain information at least once a year.

Measurement and Improvement Performance Standards

MCO Requirements

Information Requirements (42 CFR 438.10 (a), (b))

- 438.10(a) The MCO will be compliant with how the State defines the following terms compliant with 438.10(a), ‘enrollee’ means a Medicaid recipient who is currently enrolled in an MCO in a given managed care program. A ‘Potential enrollee’ mean a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO.

The MCO is required to meet the following State standards regarding information:

- (b) The MCO must provide all informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.
- (3) The MCO will have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.
- (c) (1) *Language*. The MCO must comply with the States definition of prevalent non-English languages spoken by enrollees and potential enrollees throughout the State.
- (c) (3) The MCO will make available written information in each prevalent non-English language in its service area.
- (c), (4) The MCO will make oral interpretation services available and free of charge to each potential enrollee and enrollee in its service area for Spanish at all times and for all languages not just those identified by the State as prevalent upon request.
- (c)(5) (i)&(ii) The MCO will notify its enrollees that:
 - that oral interpretation is available for any language and written information is available in prevalent languages; and
 - how to access those services.
- (d) *Format*. (1),(i)&(ii) The State expects the MCO will assure that written material uses:
 - (i) easily understood language and format at a sixth grade level; and
 - (ii) written materials are available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
 - (2) The MCO will inform all enrollees and potential enrollees that information is available in alternative formats and how to access those formats.
- (f)(4)The MCO will provide enrollees with written notice of any change (that the State defines as “significant”) in the information specified in paragraphs (f) (6) of this Section and, if applicable, paragraphs (g) and (h) of this Section, at least 14 days before the intended effective date of the change.
- (f)(5) The MCO, PIHP, and, when appropriate, the PAHP or PCCM, must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from the provider.

Measurement and Improvement Performance Standards

- 438.10(f)(6)(i) The MCO will provide the following information to enrollees;
 - Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, include identification of providers that are not accepting new patients. For MCOs, this includes, at a minimum, information on primary care physicians, specialists, and hospitals.
- 438.10(f)(6)(ii) restrictions on the enrollee's freedom of choice among network providers.
- 438.10(f)(6)(iii) enrollee rights consistent with 438.100.
- 438.10(f)(6)(iv) information on grievance and fair hearing procedures, and for MCO and PIHP enrollees, the information specified in §438.10(g)(1), and for PAHP enrollees, the information specified in §438.10(h)(1).
- 438.10(f)(6)(v) describing the amount, duration, and scope of benefits, and in sufficient detail to assure the enrollee understand entitled benefits.
- 438.10(f)(6)(vi) the procedures for obtaining benefits and authorizations for services.
- 438.10(f)(6)(vii) the extent and how enrollees may obtain benefits, including family planning services from out of network providers, and
- 438.10(f)(6)(viii) the extent of and how after hour emergency services are provided including:
 - 438.10(f)(6)(viii), (a) what constitutes and emergency providing definitions consistent with 438.114;
 - 438.10(viii)(b) a prior authorization is not required for Emergency Services;
 - 438.10(viii)(c) the process and procedures for obtaining emergency services, including use of the 911- telephone system;
 - 438.10(viii)(d) locations of emergency setting and locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract, and
 - 438.10(viii)(e) informing enrollees that they have a right to access the nearest emergency facility without regard to contracting status;
- 438.10(6) (ix) The MCO will provide information to enrollees congruent with 422.113;
- 438.10 (6)(x) policy on referral for specialty care and other benefits not furnished by the enrollees primary care provider, and
- 438.10(6)(xi) cost sharing if any.

Measurement and Improvement Performance Standards

Information to Enrollees 42 CFR 438.10 G

The MCO will provide enrollees with information about State fair hearing, the right to a hearing and the method for obtaining a hearing:

- Information to enrollees will also include the rules that govern representation at the hearing.
- The right to file grievances and appeals, requirements and timeframes for filing a grievance or appeal and the availability of assistance in the filing process.
- The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.
- The fact that, when requested by the enrollee, benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and the enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.
- Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.
- Advance directives, as set forth in §438.6(i) (2).

Additional information that is available upon request, including the following:

- Information on the structure and operation of the MCO or PIHP.
- Physician incentive plans as set forth in §438.6(h) of this chapter.

Monitoring Mechanisms – State Monitoring and Evaluation:

The MMDS leadership team monitors compliance with reporting requirements and reviews selected measures and metrics to ensure that MCO's are operating in the most efficient and effective manner consistent with Federal and State requirements. The scope of this review includes seeking out evidence of ongoing improvement efforts and resulting outcomes. The MMDS leadership team will provide feedback to the MCO should results reflect general non-compliance or sub-standard performance. The MMDS evaluates and provides feedback regarding identified opportunities for improvement, including analysis of trends and barriers, brainstorming interventions for improvement, barrier removal or additional measurement. If interventions are suggested, re-measurement occurs in the appropriate period following implementation.

Mechanisms

As required by CFR 438.204(b)(3), Delaware regularly monitors and evaluates the MCOs compliance with the standards. DMMA engages in a variety of methods to assure that the MCO develops and implements a quality plan that meets the expectations communicated through the QMS, the managed care contract, and compliance requirements specified within BBA regulations and CHIPRA. In addition to internal meetings, methods include:

Member and Provider Satisfaction Surveys:

- In order to assess the quality and appropriateness of care to all Medicaid and CHIP enrollees, Delaware administers a client survey designed to measure client experience and satisfaction with the MCO using as a base the CAHPS survey. This survey is administered by the HBM. The survey is administered annually to a statistically valid random sample of clients who are enrolled in health plans at the time of the survey. The State agency approves the final survey tool and methodology. The survey contains questions designed to measure at least the following dimensions of client satisfaction with MCO providers, services, delivery, and quality:
 - overall satisfaction with MCO services, delivery, and quality,
 - client knowledge of managed care from a patient's perspective,
 - client knowledge of rights and responsibilities, including knowledge of grievance procedures and transfer process,
 - client perception of accessibility to services, including access to providers, and
 - other factors that may be requested by the State.
- The MCO is also expected to administer an annual CAHPS, the results of which is reviewed during the EQR process.
- A Provider Satisfaction Survey is completed annually by each MCO and the results are reviewed by the State in addition to the EQRO during the compliance review.
- Frequency: Annual/Biannual.
- Monitors: Availability of services, timely access to care, primary care and coordination/continuity of services, and coverage and authorization of services.
- Monitored by the MMDS Leadership Team.

- External Quality Review: Refer to previous EQR Section.
- Frequency: Annual.

- Monitors: Availability of services, delivery of network adequacy, timely access to care, cultural consideration, primary care and coordination/continuity of services, special health care needs, coverage and authorization of services, emergency and post stabilization services, provider selection/credentialing, enrollment and disenrollment, grievance systems, practice guidelines, quality assessment and performance improvement program, health information systems, performance improvement projects, and performance measurement.
- Monitored by: MMDS Leadership Team

Grievance/Appeal Logs:

- State review of grievance and appeal data and information is also used to assess quality and utilization of care and services. Results from ongoing analysis are applied to evaluation of compliance with quality expectations.
- Frequency: Quarterly.
- Monitors: Availability of services, delivery of network adequacy, timely access to care, cultural consideration, primary care and coordination/continuity of services, special health care needs, coverage and authorization of services, emergency and post stabilization services, enrollment and disenrollment, grievance systems, and health information systems and any quality of care and/or service issues that have been defined by DMMA as being egregious.
- Monitored by: MMDS Leadership Team.

MCO Reporting:

As previously described in the MCO reporting section the State conducts monthly, quarterly, bi-annual and annual review of numerical data and narrative reports describing clinical and quality related information on health services and outcomes.

- Frequency: Reference MCO Reporting Requirements Section
- Monitors: Availability of services, delivery of network adequacy, timely access to care, primary care and coordination/continuity of services, provider selection/credentialing, grievance systems, quality assessment and performance improvement program, performance improvement projects, and performance measurement.
- Monitored by: MMDS Leadership Team.

MCO Performance Measures:

- Results are reported and validated via several channels. Validation of PMs selected by the State is performed by the EQRO during the compliance review. Additionally, state specific PM's are monitored by the MMDS Leadership Team as previously described.
- Frequency: Quarterly monitoring of State Mandated Measures and annual validation by the EQRO of specific measures.
- Monitors: Availability of services, quality assessment and performance improvement program, and performance measurement.
- Monitored by: MMDS Leadership Team

MCO Performance Improvement Projects:

- Results of the EQRO PIP validation process will be analyzed, compared to expected outcomes and determinations to continue or adjust will be based upon results.
- Frequency: Annually, following EQRO validation of results.
- Monitors: Quality assessment and performance improvement program, and performance improvement projects.
- Monitored by: MMDS Leadership Team.

Health Information Technology

In accordance with 42 CFR 438.242, the MCO must operate a Management Information System (MIS) capable of maintaining, providing, and documenting information. The MIS will be capable of collecting, analyzing, integrating, and reporting data sufficient to document the MCO's compliance with contract requirements.

MCOs must collect and ensure accurate and complete data on enrollees, providers and services through a data system as specified by the State. To ensure data accuracy, MCOs will cooperate with the State in carrying-out data validation steps. DMMA has developed an operational data collection plan to monitor actual program performance with respect to service access and health status/outcomes. The components of the plan include: encounter reporting, summary utilization reports, quality information including focused quality of care studies, member satisfaction surveys, financial reports and grievance and appeals reports, access to care, medical outcomes, and health status.

The State requires the MCO to make all collected data available to the State and upon request to CMS. All encounters must be submitted in electronic or magnetic format that meets all the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Standards.

The State expects the MCOs to submit encounter reports that include all capitated data, for all services rendered that fall within the Basic Benefit Package, including behavioral health data even when the MCO has a subcontracting behavioral health program. Encounter reports must be submitted monthly, within 240 days of the date of service and no later than seventy-five (75) calendar days after the end of the period in which the

encounters were processed. All encounters must be submitted in electronic or magnetic format that meets all HIPAA Standards.

DMMA gathers and monitors encounter data from the MCO to assess over- and under-utilization using formats consistent with the formats and coding conventions of the HCFA 1500, UB92, or other formats required under the HIPAA Act of 1996. DMMA will assure compliance with reporting requirements and withholding capitation payments until encounter data requirements are met may enforce compliance. Should the State determine that Encounter data errors are not decreasing as expected the State may require that the MCO bear the cost of processing all encounters that consistently exceed the error tolerance. The State may also choose to auto-assign only to those Contracting entities that are providing complete, accurate encounter data.

As required by CFR 438.204(f), Delaware Medicaid Management Information System is used to monitor the encounter data submitted by MCOs. The MMIS system stores and utilizes Client Eligibility records, Managed Care Enrollment records, Premium Collection records, and Provider Eligibility records for:

- claims processing;
- encounter record processing;
- enrollment processing;
- premium collection;
- per capita payments; and
- related tracking and reporting.

The Surveillance and Utilization Review (SUR) System within the MMIS produces reports based either on claims data or encounter data or both. Information identified in the SUR unit is forwarded to the MMDS for investigation.

The ATLANTES Case Management System allows for online utilization reviews and prior authorizations that interface with the MMIS. The HRA performed by the Health Benefits Manager is entered directly into ATLANTES providing the medical management team with real time results. The system is capable of automated referrals to care management and for the generation of condition-specific care plans. In 2008, the Atlantes system was upgraded to a web-based application for DSP and involved the addition of enhanced functionality and staff training.

Improvement and Interventions

Interventions for improvement of quality activities is determined based upon review and analysis of results of each activity and ongoing assessment of participants health care needs.

Performance Measures

Performance measures provide information regarding directions and trends in the aspects of care being measured. This information is used to focus and identify future quality activities and direct interventions for existing quality activities. For measures progressing toward or meeting goals, ongoing measurement with barrier analysis may continue. Measures meeting goals for at least two consecutive cycles may continue to be measured to assure improvement is maintained or may be retired or placed on an alternating year remeasurement cycle. For measures demonstrating consistent lack of progress or goal achievement Corrective Action Plans may be required to assist the MCO in meeting measurement expected results. The corrective action must demonstrate appropriate actions to positively impact measurement results.

The MMDS Leadership Team determines the PMs to be validated during the EQR process and when to alter the required reporting schedule as described above. MCO's are required to develop a corrective plan for areas of non-compliance. Sanctions may be implemented should other efforts of cooperation fail.

Performance Improvement Projects

As previously described a PIP is intended to improve the care, services, or member outcomes in a focused area of study. Currently, a minimum of three PIPs are required: one topic is at the discretion of the MCOs and two are stipulated by the State. The State may opt to mandate additional PIPs, based on results of sub-optimal performance measures or identified needs in the population. Discretionary PIP topics must be presented to the MMDS leadership team for review and approval. Additionally, the MCO shall present this information to the QII Task Force along with a request for input and suggestions. Quality reporting on the status of the PIPs will also be conducted at QII meetings in addition to reporting to MMDS. The content of the improvement process and status reporting has been developed within the QII Task Force and must include, but is not limited to the following elements: problem analysis, interventions, results, barrier identification, outcomes, next steps, and time lines.

The State quality strategy general expectations for PIPs include:

- year one: PIP development process and baseline results, analysis identifies interventions for remeasurement year;
- year two: interventions implemented and results reported (reported results may not include full impact of interventions based upon timing issues);
- year three: remeasurement and ongoing improvement with adjustment in interventions as appropriate;

- year four: remeasurement demonstrating ongoing improvement or sustainability of results, and
- future years to be determined based upon results, sustainability and enrollee needs.

PIPs will be validated during the EQR process and results are expected to demonstrate achievement or progress toward achievement of the State identified goal. For areas of noncompliance, Corrective Action Plans are required which will be monitored for improvement by MMDS. Sanctions may be implemented should all other methods of cooperation fail to occur.

Input for Cross Organizational Opportunities:

During presentation and discussion of Performance Metrics and Performance Improvement Projects at the QII Task Force, opportunities are sought to implement cross organizational or agency quality activities, interventions or changes and improvement in information system identification or processing of data and identification of topics for focused quality study.

Progress towards Goal Achievement

The table below represents state selected, mandatory, HEDIS specific reporting metrics for MCOs. Data contained within demonstrates each MCO's year-over-year performance in the specific domains related to use of services, access and availability of care, and effectiveness of care. As of 2008, enrollment for DSP was insufficient to make application of HEDIS measures statistically significant. Therefore, the table below reflects both MCOs which manage the healthcare needs of over 90 percent of Delaware's Medicaid population. The associated national 75th percentiles provide benchmarks from which DMMA establishes ongoing performance targets. DMMA will utilize the HEDIS National Medicaid HMO 25th percentile for all utilization measures. The change in percentiles is due to the inverse nature of how HEDIS reports the data.

| HEDIS Access and Effectiveness of Care Performance Measures 2010 calendar year 2009 | | | | | |
|--|--------------|--------------|------------------|----------------|---|
| Measure | DPCI 2008 | DPCI 2009 | Unison 2008 | Unison 2009 | 2008 75th Percentile Medicaid HMO |
| Use of Services | | | | | |
| Well- Child Visits in the First 15 months of Life (W15) | | | | | |
| 0 visits | 0.25 | 0.73 | 1.57 | 0.49 | 3.15 |
| 1 visit | 0.5 | 0.73 | 1.57 | 0.24 | 3.29 |
| 2 visits | 2 | 1.95 | 2.76 | 1.22 | 4.85 |
| 3 visits | 4.24 | 1.95 | 11.81 | 5.35 | 7.11 |
| 4 visits | 13.72 | 9.25 | 20.87 | 11.19 | 12.44 |
| 5 visits | 17.46 | 16.30 | 25.98 | 19.95 | 19.45 |
| 6 or more visits | 61.85 | 69.10 | 35.43 | 61.56 | 67.39 |
| Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) | 79.27 | 76.70 | 67.92 | 73.22 | 75.86 |
| Access/ Availability of Care | | | | | |
| Children and Adolescents' Access to Primary Care Practitioners (CAP) | | | | | |
| 12 - 14 months | 98.11 | 97.48 | 96.84 | 96.57 | 97.85 |
| 25 months - 6 years | 91.33 | 91.45 | 89.16 | 90.47 | 91.04 |
| 7 - 11 years | 92.96 | 94.10 | N/A ² | 92.53 | 92.46 |
| 12 - 19 years | 87.35 | 88.88 | N/A ² | 84.15 | 90.22 |
| Adults' Access to Preventive/Ambulatory Health Services (AAP) | | | | | |
| 20 - 44 years | 88.14 | 89.05 | 83.88 | 85.14 | 85.58 |
| 45 -64 years | 92.15 | 92.82 | 85.13 | 88.28 | 89.62 |

² The 2008 Unison Measures were not populated due to the required HEDIS 2 year look back period. The plan started operations in July of 2007.

| HEDIS Access and Effectiveness of Care Performance Measures 2010 calendar year 2009 | | | | | |
|--|--------------|--------------|------------------|----------------|---|
| Measure | DPCI 2008 | DPCI 2009 | Unison 2008 | Unison 2009 | 2008 75th Percentile Medicaid HMO |
| 65 plus years | 84.19 | 87.77 | 83.08 | 82.35 | 89.37 |
| Timeliness of Prenatal and Postpartum Care | | | | | |
| At least 1 prenatal visit | 88.2 | 88.2 | 80.33 | 84.66 | 89.29 |
| 1 postpartum visit between 21 and 56 days after delivery | 70.6 | 67.2 | 53.25 | 57.23 | 68.23 |
| Effectiveness of Care - Quality | | | | | |
| Childhood Immunization Status (CIS) | | | | | |
| Combination 2 (DTaP, IPV, MMR HiB, hepatitis B, VZV) | 81.71 | 80.05 | N/A ² | 73.97 | 82.06 |
| Lead Screening in Children (LSC) | 61.46 | 64.48 | 55.15 | 64.23 | 79.32 |
| Breast Cancer Screening (BCS) Total ³ | 53.22 | 55.30 | N/A ² | 52.63 | 57.36 |
| Cervical Cancer Screening | 72.13 | 70.07 | 49.25 | 64.32 | 72.99 |
| Use of Appropriate Medications for People with Asthma (ASM) | | | | | |
| 5 - 9 years of age ⁴ | 92.69 | 94.98 | N/A ² | 92.50 | 94.58 |
| 10 - 17 years of age | | | | | 92.00 |
| 18 - 56 years of age | 92.12 | 87.49 | N/A ² | 85.63 | 89.05 |
| Combined Rate | 91.08 | 90.63 | N/A ² | 88.57 | 91.12 |
| Comprehensive Diabetes Care (CDC) | | | | | |
| Lipid Screening | 72.45 | 75.91 | 66.67 | 66.67 | 79.52 |
| HbA1C Screening | 78.47 | 78.10 | 73.66 | 70.88 | 86.24 |
| Retinal Eye Exam Screening | 61.68 | 61.86 | 40.95 | 56.20 | 62.30 |
| Cholesterol Management of Patients with Cardiovascular Conditions (CMC) | | | | | |
| LDL-C Screening | 77.20 | 83.21 | N/A ² | 82.76 | 85.17 |
| LDL -C Control (<100 mg/dl) | 43.13 | 50.36 | N/A ² | 39.08 | 48.61 |
| Controlling High Blood Pressure (CBP) | 57.18 | 60.83 | 55.23 | 47.17 | 62.26 |
| Appropriate Treatment for Children with Upper Respiratory Infection (URI) | 85.47 | 85.52 | 86.40 | 88.21 | 91.23 |
| Antidepressant Medication Management (AMM) | | | | | |
| Effective acute phase treatment | 46.92 | 45.58 | 41.84 | 47.64 | 52.63 |
| Effective continuation phase treatment ⁵ | 31.51 | 28.05 | 27.55 | 27.95 | 35.64 |

³ HEDIS measure changed to only reporting total BCS rate versus being separated into the age brackets.

⁴ New age band for the 2010 HEDIS specifications indicate that measures should be ages 5-11, 12-50, and combined rate

| HEDIS Use of Services Performance Measures 2010 calendar year 2009 | | | | | |
|--|-----------|-----------|-------------|-------------|--|
| Measure | DPCI 2008 | DPCI 2009 | Unison 2008 | Unison 2009 | 2008 25th Percentile Medicaid HMO ⁶ |
| Ambulatory Care (AMB) | | | | | |
| Emergency Department Visits/1000 | 66.00 | 69.98 | 70.21 | 76.81 | 48.46 |
| Observation room stays/1000 | 0.95 | 0.75 | 1.13 | 1.78 | 0.95 |
| Outpatient Visits/1000 | 443.72 | 463.81 | 399.10 | 428.76 | 301.16 |
| Surgery Procedures/1000 | 11.21 | 11.72 | 8.44 | 10.54 | 6.42 |
| Inpatient Utilization | | | | | |
| Maternity Days/1000 | 13.61 | 12.22 | 19.10 | 17.66 | 11.05 |
| Maternity Discharges/1000 | 4.60 | 4.09 | 6.84 | 5.89 | 4.03 |
| Maternity ALOS | 2.96 | 2.99 | 2.79 | 3 | 2.47 |
| Medicine Days/1000 | 14.53 | 12.95 | 14.00 | 14.31 | 8.74 |
| Medicine Discharges/1000 | 2.95 | 3.29 | 2.84 | 3.31 | 2.53 |
| Medicine ALOS | 4.93 | 3.94 | 4.93 | 4.35 | 3.14 |
| Surgery Days/1000 | 16.52 | 16.47 | 11.50 | 13.86 | 4.44 |
| Surgery Discharges/1000 | 2.57 | 2.04 | 1.48 | 1.8 | 0.83 |
| Surgery ALOS | 6.43 | 8.06 | 7.75 | 7.70 | 4.82 |
| Non-acute care Days/1000 | 2.90 | 2.67 | 6.51 | 4.57 | 0.53 |
| Non-acute care Discharges/1000 | 0.22 | 0.21 | 0.32 | 0.20 | 0.04 |
| Non-acute care ALOS | 13.23 | 12.96 | 20.43 | 23.32 | 11.33 |
| Total IP Days/1000 | 39.95 | 37.28 | 38.06 | 39.78 | 23.52 |
| Total IP Discharges/1000 | 8.52 | 7.96 | 8.82 | 8.98 | 6.56 |
| Total IP ALOS | 4.69 | 4.68 | 4.32 | 4.43 | 3.12 |
| Mental Health Utilization⁷ | | | | | |
| Inpatient Services | 2.65 | 2.83 | 1.42 | 1.39 | 0.54 |
| Intensive OP and Partial Hospitalization | 0.99 | 1.29 | 0.44 | 0.48 | 0.02 |
| Outpatient and ED | 13.20 | 13.82 | 8.99 | 10.76 | 4.21 |
| Any services | 13.55 | 14.17 | 9.71 | 11.36 | 4.63 |
| * 2 Year Continuous Eligibility Criteria Not Met | | | | | |

⁵ Optimal Practitioner Contacts for medication management was discontinued

⁶ Due to the inverse relationship of the HEDIS use of services measures, DMMA selected the 25th percentile as a benchmark

⁷ Inpatient Total ALOS and Inpatient Total Discharges/1000 are no longer Mental Health Utilization specific

Goal 1: To improve access to care and services for adults and children with an emphasis on primary care and preventive care.

- An ongoing focus has been adequate access to prenatal and postpartum care. While both MCOs remain below the 75th Percentile for this benchmark in 2008 and 2009, progress has been either stable or trending in the right direction. Unison's baseline for prenatal visits was 80.33 percent in 2008 and increased to 84.66 percent in 2009. DPCI remained stable during this period at 88.2 percent. For postpartum visits, Unison showed a 4 percentage point improvement from 2008 to 2009. Both MCOs will focus on improving screening results for this important measure. .
- The percentage of children and adolescents with access to a PCP improved for both MCOs for the age groups 25 months to 6 years and 7 to 11 years. For both of these age groups, DPCI and Unison exceeded the 75th percentile for 2008 and 2009. .
- The percentage of adults with access to a PCP was close to meeting or exceeding the identified benchmark for both MCOs. DPCI exceeded the 75th percentile for adults aged 20 to 44 years and 45 to 64 years. Unison improved from 2008 to 2009 in both age groups but slightly under the benchmark. .Both MCOs will focus on improving access to PCPs in all age bands.

Future Opportunities revolve around ensuring MCOs meet the 75th percentile in areas of prenatal and postpartum care. The State mandates a performance improvement project in this area and results will continue to be monitored for sustained improvement.

Goal 2: To improve quality of care and services provided to Delaware Medicaid and CHIP participants.

- Based on the objectives of the last QMS, DMMA has added three new measures to this area: Lead Screening for children, Appropriate treatment of children with upper respiratory infection and anti-depressant medication management. The following bullets outline the progress towards goal from these new measures.
 - While under the benchmark for Lead Screening in children for 2008 and 2009, both MCOs showed incremental improvement with Unison improving from 55.15 percent in 2008 to 64.23 percent in 2009. This significant jump is a result of the inclusion of Delaware Lead Registry data as well as the change to HEDIS hybrid data collection methodology. DMMA will hold both MCOs accountable to bring this measure up to compliance.
 - Both MCOs made incremental progress toward the benchmark for Appropriate Treatment for Children with Upper respiratory infection in 2008 and 2009. As a key measure for Delaware, DMM will have both MCOs focus on continued improvement with this benchmark.
 - The benchmark for Antidepressant medication management has not been met for either MCO. DPCI showed a decrease in compliance with effective acute phase treatment from 2008 (46.92 percent) to 2009 (45.58). Unison, on the other hand, made some progress toward the benchmark with an increase from 2008 (41.84) to

47.64 percent in 2009. Effective continuation phase treatment showed a slight decline for DPCI from 2008 (31.51 percent) to 28.05 percent in 2009 while Unison stayed steady at 27.55 percent in 2008 and 27.95 percent in 2009.

- Another high priority for the State was breast and cervical cancer screenings with the intent to focus on prevention by increasing screening rates for these measures. These programs are coordinated with the DPH and supported in part by tobacco funding. Breast cancer screening rates for DPCI increased from 53.22 percent (2008) to 55.30 percent in 2009 while Unison's baseline achievement was 52.63 percent for 2009. DPCI continues to show incremental improvement year over year in this measure although both MCOs remain below the stated benchmark. Cervical cancer screening rates remain slightly below the benchmark in 2008 and 2009 for both MCOs. Unison improved from 49.25 percent in 2008 to 64.32 percent for cervical cancer screening in 2009. This significant increase may be due to the change in methodology moving from administrative to hybrid data collection. DMMA will continue to work with plans to ensure year over year improvements in these measures.
- Delaware has a high volume of Medicaid and CHIP participants with a diagnosis of diabetes, many of which are children. Interest throughout the State continues to focus on improving the quality of diabetic care. Three measures related to diabetic care: HbA1c, retinal exams, and lipid screenings, continue to show improvement toward the 75th percentile benchmark. . DPCI results for HbA1c screenings are steady year over year while Unison demonstrated a decline from 73.66 percent in 2008 to 70.88 percent in 2009. Retinal exam screening rates are holding steady for DPCI and have shown statistically significant improvement at Unison. This again is most likely due to the switch to hybrid data collection methodology. DMMA will continue to work with the MCOs to ensure year over year improvements to reach the benchmark are a priority.
- A large portion of the DSHP population is found to have a diagnosis of hyperlipidemia and therefore, it is important to measure rates of lipid screening within the population diagnosed with this condition. Current rates for lipid screening for participants diagnosed with hyperlipidemia are identified in the above chart. While under the 75th percentile, both MCOs have either remained stable or shown incremental improvement from year to year. DPCI has been moving toward improving the rate for lipid screening from 72.45 percent in 2008 to 75.91 percent in 2009. Unison has been stable at 66.67 percent for both 2008 and 2009. While under the 75th percentile, both MCOs will be accountable for improving compliance with this benchmark which has been identified at 79.52. .

Future Opportunities: While each MCO maintains their own HEDIS workgroups in efforts to improve HEDIS performance measures, DMMA will provide feedback to each MCO on areas of interest and possible areas for interventions and improvement based on the results of annual performance measurements.

Goal 3: To control the growth of health care expenditures.

- Utilization measures have been calculated and performance is tracked and monitored. Now that benchmarks have been identified, DMMA will use these as opportunities to control the growth of health care expenditures. Both MCOs were above the maternity average length of stay (ALOS) for 2009 and demonstrate a steady, if not, increasing utilization trend year-over-year; these changes are not statistically significant. For the medicine and surgery ALOS, each MCO is above the benchmark utilization goal. However, the medicine ALOS is trending downward with a decrease from 4.93 days in 2008 to 3.94 days in 2009 for DPCI and from 4.93 days in 2008 to 4.35 days in 2009 for Unison. Surgery ALOS for DPCI shows an increasing trend by almost a full day and a half between 2008 and 2009, while Unison shows a steady ALOS. While overall inpatient ALOS has remained steady year over year, the driver of the overall ALOS appears to be in the surgical category. This is an area of focus that DMMA will address with each of the MCOs.
- Emergency room visits per thousand members have increased from 2008 to 2009 across both MCOs. Some variability in this measure may be due to effects of the H1N1 pandemic that was experienced over the recent measurement year. However emergency department utilization continues to be an ongoing topic of concern for all healthcare constituents. DMMA has mandated a performance improvement project around this particular measure and continues to monitor MCO interventions to decrease Emergency Department utilization. Additionally, discussions regarding levels of ER usage have occurred at the QII Task Force meetings throughout 2008 and 2009. In 2010, the QII Task Force formed a sub-committee to explore quality initiatives related to access to care issues, quality of care issues regarding follow up and medication adherence, lack of referrals to appropriate sources/programs (Case Management/Disease Management, Behavioral Health, etc), and lack of coordination of care with PCPs that could be affecting emergency department utilization rates.
- Outpatient visits per 1000 showed an increase between 2008 and 2009 for both MCOs. DPCI went from 443.72 to 463.81 while Unison went from 399.10 to 428.76. These results are significantly higher than the established benchmark of 301.16 visits and will be a focus going forward.

Future Opportunities: DMMA will continue to work with the MCO's to identify plan and/or population specific drivers that could be affecting surgical ALOS, emergency department utilization and outpatient visits.

Strategy Review and Effectiveness

How the Quality Strategy is Reviewed

The QMS is reviewed by MMDS through an ongoing process that incorporates input from a multitude of sources. The effectiveness of the quality strategy is reviewed on an annual basis and revised based upon analysis of the results. The QMS may be reviewed more frequently if significant changes occur that impact quality activities or threaten the potential effectiveness of the strategy. As a result of the annual analysis process a quality plan for the upcoming year is developed congruent with the overall quality strategy. The development process begins with an assessment of the accomplishments of the prior year's quality plans and reports including the MCOs annual Quality Management Plan and Evaluation, the EQR technical report, as well as incorporating input from committees and other established quality forums that include governmental agencies, providers, MCOs, consumers, and advocates. These sources help MMDS in determining areas of focus for quality activities such as quality improvement measures, improvement projects and performance indicators.

The strategy is reviewed annually by the MMDS leadership team. As part of this review, the effectiveness of the QMS will be evaluated to determine whether potential changes to the quality strategy may be needed. Should the MMDS leadership team determine that the change is significant enough to require additional stakeholder input, the MCAC, QII Task Force and/or additional sub-committees may be engaged to assist in this endeavour.

The QMS is presented to QII Task Force, and Medical Care Advisory Committee for comment before being finalized. Articles published in the Quality Courier may be used to solicit input as well. Once the strategy is approved in draft form by the MMDS, further public input may be sought through the release of a notification of Public interest in the Delaware Register of Regulations, a monthly publication indicating a 30-day period for public input. Once public input has been received, the final QMS document is prepared and upon approval by the MMDS is distribution to key stakeholders

Following approval by the DMMA, any amendments or major revisions to the quality strategy will be shared with CMS and quarterly reports will be submitted.

MCO Reporting Requirements

- The time frame for the mandatory reports due to the state are:
 - Monthly reports will be due to the State on the 18th day of the following month.
 - Quarterly reports will be provided to the State on the 18th day of the month following the end of each quarter.
 - Annual reports will be submitted to the State on the 30th day of the month following the end of the calendar year.
 - Exceptions to this schedule will be identified with the applicable report.
 - Report formats will be provided in a separate attachment.

Monthly Reports

- The MCO will submit a monthly report with the following content:
 - HRAs:
 - Number of new Medicaid enrollees
 - Number of HRAs received/completed for New Enrollees or returning enrollees ≥ 90 days
 - Rate of HRAs received/completed within 30 Days of Enrollment and total
 - Case Management and Disease management
 - Number of new Medicaid enrollees referred via HRA to the CM program
 - Total number of new Medicaid enrollees referred to the CM or DM program
 - Number of existing Medicaid enrollees referred to the CM or DM program
 - Total number of new and existing Medicaid enrollees referred to the CM or DM program
 - Total number of Medicaid enrollees active in the CM or DM program
 - Timely access to provider appointments
 - Rate: Medicaid Enrollees Received a Routine Appointment with Primary Care Practitioners (PCP) within 3 weeks
 - Rate: Medicaid Enrollees Received a Routine Care Appointments with Specialist within 3 weeks
 - Rate of maternity appointment received in the 1st Trimester within 3 weeks
 - Rate of maternity appointment received in the 2nd Trimester within 7 days
 - Rate of maternity appointment received in the 3rd Trimester within 3 days
 - Rate of maternity appointment received for a high risk pregnancy within 3 days
 - Rate Medicaid Enrollees Received appointment with a Behavioral Health Provider within 7 days
 - Rate Medicaid Enrollees Received Appointment for EPSDT Screening within 2 weeks

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- Network Availability
 - Number of In-Network Primary Care Practitioners
 - Number of PCP w/ Open Panels
 - Percent of In-Network PCPs w/ Open Panels
 - New Providers Added to the Network in the Reporting Period who are PCPs or specialists
 - Percent of New Practitioners Added to the Network in Reporting Period who are PCPs or Specialists
 - Providers Terminated from the Network in the Reporting Period who are PCPs or specialists
 - Percent of Practitioners Terminated from the Network in Reporting Period who are PCPs or Specialists
- Customer Service Statistics
 - Average speed to answer by a live person reported in seconds
 - Percent answered within 30 seconds
 - Call abandonment rate
 - Number of enrollees requesting to change PCPs
- Utilization management – Inpatient Services
 - Medical: Admits/1,000 enrollees, Average length of stay, Days/1,000 enrollees, enrollee average cost per day, per member per month, number of inpatients with length of stay greater than 10 days, number of inpatients readmitted within 10 days with the same diagnosis
 - Surgical: Admits/1,000 enrollees, Average length of stay, Days/1,000 enrollees, enrollee average cost per day, per member per month, number of inpatients with length of stay greater than 10 days, number of inpatients readmitted within 10 days with the same diagnosis, number of inpatients with unexpected transfer or return to operating room
 - Intensive Care Unit/Cardiac Care Unit: Admits/1,000 enrollees, Average length of stay, Days/1,000 enrollees, enrollee average cost per day, per member per month, number of patients with unexpected transfer or return to ICU/CCU
 - Maternity: Admits/1,000 enrollees, Average length of stay, Days/1,000 enrollees, enrollee average cost per day, per member per month, Number of Cases of Fetal Demise Intra-Uterine (FDIU)
 - Neonatal Intensive Care Unit: Admits/1,000 enrollees, Average length of stay, Days/1,000 enrollees, enrollee average cost per day, per member per month
 - Rehab/Skilled Nursing Facility: Admits/1,000 enrollees, Average length of stay, Days/1,000 enrollees, enrollee average cost per day, per member per month
 - Psych/Detox: Admits/1,000 enrollees, Average length of stay, Days/1,000 enrollees, enrollee average cost per day, per member per month, Number of Psych Patients Readmitted within 7 Days

- Mental Health/Residential Rehab: Admits/1,000 enrollees, Average length of stay, Days/1,000 enrollees, enrollee average cost per day, per member per month
- Utilization management – Outpatient Services and Physician Visits
 - Emergency Room Outpatient Services: Visits/1,000 enrollees, enrollee average cost per visit, per member per month, Percent of Hospital Admissions Resulting in Inpatient Admissions
 - Maternity Outpatient Services: Visits/1,000 enrollees, enrollee average cost per visit, per member per month
 - Behavioral Health Outpatient Services: Visits/1,000 enrollees, enrollee average cost per visit, per member per month
 - Adult Physical Exams/Well baby physician visits: Visits/1,000 enrollees, enrollee average cost per visit, per member per month
 - Maternity Physician Visits: Visits/1,000 enrollees, enrollee average cost per visit, per member per month
 - Behavioral Health Physician Visits: Visits/1,000 enrollees, enrollee average cost per visit, per member per month
- Description and number of educational and outreach activities conducted throughout the month including EPSDT outreach activities
- Encounter data as defined by the State TPL information.

Quarterly Reports

- Reporting regarding the Complaints, Grievance, and Appeals System within the MCO which includes:
 - Total Number of Complaints and Grievances received from Enrollees
 - Complaints and Grievances per 1,000 enrollees
 - Total number of medical complaint and grievances in the following categories:
 - Quality of Care
 - Days to appointment
 - Transportation to medical doctor
 - Specialist referral
 - Request for interpreter
 - Denial of emergency room claim
 - Other
 - Total number of non-medical complaints and grievances in the following categories:
 - Doctor's office staff
 - MCO office staff
 - Office Waiting time
 - Other
 - Total rate of medical and non-medical complaints and grievances by enrollees
 - Total Number of families or caregivers of Enrolled Children with Special Health Care Needs Where a Written Complaint was Filed Regarding Access to Care Specified in the Childs Care Plan

- Total Number of Families or Caregivers of Enrolled Children with Special Health Care Needs Where they Filed a Written Complaint Regarding Quality of Services Specified in the Child's Care Plan.
- Total Number of Member Appeals
- Total Number of Appeals Denied
- Percent of total denied appeals that were upheld or overturned by the MCO
- Percent of appeals made where the MCO acknowledged receipt within 5 days
- Percent of appeals made where the MCO resolved and notified enrollee of resolution within 45 days
- Percent of appeals made where the MCO resolved and notified enrollee of resolution within 90 days
- Number of Requests for Expedited Review of Appeals
- Percent of Expedited Review Requests Denied
- Percent of Expedited Review Requests Resolved & Notified within 3 days
- Number of Requests for Extensions of Appeals
- Percent of Extension Request Denials
- The minutes of the MCO Quality Management Committee quarterly meeting are submitted to DMMA.
- Quarterly summary of monthly reports listed above.
- The MCO reports HEDIS performance measures with quarterly status reports for each metric.
 - Reporting PMs the MCO uses criteria of the most recent specifications communicated by the State.
- EPSDT access reporting:
 - Total Number of EPSDT Visits
 - Rate of EPSDT Visits vs. Eligible
 - Total Number of Outreach Calls for EPSDT Visits for visits missed within 30 days
 - Total Number of Outreach Calls for EPSDT Visits for visits missed within 60 days
 - Total number of mailers sent to Members for missed EPSDT visits

Bi-annual Reports

- GeoAccess updates are due every six months. Reports will be due August 15 and February 15. Reports will include overall access to Primary Care, Specialty Care, and subspecialties of Cardiology, Orthopedics, Psychiatrists, and OB/GYN providers.
- Specific GeoAccess reports include but are not limited to:
 - accessibility summary;
 - city and county detail information;
 - thermal maps demonstrating access issues;
 - provider location maps; and
 - city access standard detail reports.

Annual Reports

- The MCO submits their quality management plans annually. If DMMA recommends revisions to the plan, a revision will be submitted to the State within 30 days following notification.
- The MCO reports HEDIS PMs, applying State specifications and final results annually. Date to be determined by DMMA.
- The MCO will submit results of HEDIS measures annually as requested by the State. Specific measures may be identified. At a minimum measures will include Timely Access to Prenatal Care, Timely Postpartum Care and Frequency of Prenatal Care Visits. Date to be determined by DMMA.
- The MCO reports lead-screening rates. The specifications for reporting the lead screening rates are defined by Medicaid Lead Screening Guidelines Committee.

CMS Reporting Requirements

- MMDS will prepare and submit quarterly reports summarizing progress toward QMS results. Progress toward goal achievement will be included as available from data and results reporting. Discussion of barriers and trends will be addressed.
- Quarterly reports will be submitted 60 days after the close of the quarter.
- The annual report will provide a more detailed overall analysis and assessment of the effectiveness of the QMS strategy including but not limited to the following:
 - quantifiable achievements;
 - data and numeric analysis;
 - discussion of variations from expected results;
 - barriers and obstacles encountered;
 - interventions planned to overcome barriers;
 - how participant and system changes were improved as a result of QMS initiative results; and
 - best practices and lessons learned with resultant changes to the following years strategy.

Achievements and Opportunities:

Successes

The State of Delaware has endeavored to assure the provision of the highest quality medical services to our vulnerable populations by promoting health and well-being and fostering self-sufficiency in the most cost-effective manner. As of 2010, this population will also include the CHIP population. All of this has been made possible through the 1115 Managed Care Demonstration Waiver. Successes have been achieved along with opportunities identified as a result of an effective Quality Management Strategy (QMS) which outlines the framework upon which quality activities and quality initiatives are built.

The Quality Improvement Initiatives (QII) Task Force has served as the central forum for the implementation of the QMS. The Task Force has evolved over the past few years from defining its purpose and refining the goals to effectively focusing on quality activities and initiatives which are making a difference for our Medicaid population. Collaborative discussions continue to take place within the Task Force meetings or during the sub-committee meetings that originate from the QII Task Force. There continues to be an exchange of knowledge and concern for the health care needs of our vulnerable population we serve. These exchanges have served to enhance knowledge and appreciation of concern across programs, divisions and external organizations and were evidenced through resultant quality initiatives.

During the QII Task Force meetings, ongoing quality updates and quality reporting are presented and form the basis of the standing Agenda topics. Information is shared, discussed and disseminated to the MCAC oversight committee. The MCAC provides consistent feedback which has resulted in a demonstration of positive support for continued quality activities with a potential for improvement through the quality process.

Another major area of strength has been ongoing partnerships with community providers. Through information dissemination and reporting of quality initiatives to community providers via the Quality Courier and other committee forums we have received valuable input resulting in program and system improvements. DMMA has a history of partnering with external organizations such as the Medical Society and others on quality activities. The partnership with the Medical Society on the Sickle Cell project led to the development of Clinical guidelines which Delaware applied until their retirement in 2008. Since that time, DMMA references nationally approved clinical guidelines that have been researched and supported by nationally recognized clinical experts.

Discussions at the QII Task Force meetings have resulted in the formation of a subgroups with representation from DSP and the Managed Care Organizations. One benefit has been the development of a mandatory PIP on Emergency Department visits for DSP and both Managed Care Organizations. Subsequent discussions have led the Task Force to form a sub-committee to further explore opportunities to reduce the inappropriate use of the Emergency Department. Other collaborative efforts take place between Task Force members outside of the group meetings to resolve issues and improve services. Another

sub-committee was formed to participate in a collaborative effort to update the QMS and develop annual goals and direction for the QII Task Force.

Continued development of our QII Task Force has been evident through quality reporting and updates on quality strategies by the participants; updates to the Task Force from the State Medicaid Medical Director and the managed care health plan Medical Directors; ongoing reports to the committee on quality program progress and activities; and the provision of a forum for active discussion of collaborative opportunities by participants to improve care for our Medicaid and CHIP population.

2008-2009 Success Updates:

1. Quality Focused Study on Childhood Overweight:

. This focused study was launched in February 2008 during a meeting with community providers and key Stakeholder.

The Division of Medicaid & Medical Assistance (DMMA) asked Mercer Government Human Services Consulting (Mercer), as part of its External Quality Review (EQR) activities to conduct a Childhood Overweight Focus Study in 2008. The study was done to:

- Evaluate the current provider practice patterns for screening and intervention of overweight and obesity in Delaware Medicaid children and adolescents.
- Identify barriers to screening and treatment as recommended in national clinical practice guidelines.
- Compare results from an earlier study conducted in 2003 by a DMMA subcontractor whereby data was collected to evaluate screening and diagnosis activities for overweight and obesity completed by Medicaid providers.

Mercer and DMMA worked with representatives from key stakeholder groups in Delaware which included experts and professional currently providing services and working with children within the Medicaid population who were overweight. These representatives were sought to provide direction for the study.

The key findings from the study included:

- Despite the routine recording of height and weight during EPSDT visits, data showed an absence of identification of overweight children through the documentation of BMI.
- Study participants stated they were knowledgeable of the AAP recommendations and guidelines for screening and treatment of overweight and obesity, including calculating BMI.
- Documentation of BMI by providers increased significantly between the 2003 (0%) and the 2008 study (13%).

Stakeholder workgroups were formed and tasked with addressing five (5) critical areas identified by the study:

- Resource and Access
- Provider Education and Tools
- Member & Community Outreach and Tools

- Benefits & Reimbursement
- Evaluation, Reporting & Metrics

The Stakeholder workgroups conducted exhaustive review of the critical areas identified. A final meeting of the combined workgroups was held in August 2009 and resulted in thorough review of the accomplishments of the work groups. Additionally, the work groups submitted recommendations which are now being reviewed for approval by the new Chief within DMMA. These accomplishments and recommendations included:

- Compiled a manual of accumulated resources on childhood overweight and obesity. The recommendation is that this information be made available in one place, possibly a website location. This recommendation will be referred to the State-wide initiative on Childhood Overweight being led by the Division of Public Health.
- Research was conducted of codes for reimbursement including obesity and overweight as well as behavioral/mental health. This list has been submitted for further review to determine if there is benefit to opening the codes for providers treating clients for overweight and obesity.
- Workgroups recommended DMMA adopt HEDIS measures for overweight/obesity and assign to the MCOs. This recommendation has now been referred for implementation.

Transition all workgroups to a collaborative partnership with Division of Public Health Initiative – Healthy Eating and Living (DE-HEAL). Several members of the DMMA workgroups have transitioned onto the teams established under the DE-HEAL program. The benefit of this transition from DMMA to DPH is that the DE-HEAL initiative is State-wide and will be addressing all of the critical areas addressed by DMMA on a larger scale and with greater resources.

2. ABCD Grant update

Additionally, DMMA worked collaboratively with community providers and key Stakeholders to look at developmental screening through the ABCD (Assuring Better Child Health and Development) grant project. This ABCD grant project was a 15 month endeavor sponsored by the National Academy for State Health Policy (NASHP) to increase the use of developmental screening tools as part of the primary care provider services during well-child care. The goal was to identify developmental issues early rather than later during the child’s developmental years. Delaware partnered with 18 other selected states to identify and implement policies and practices that move the use of standardized developmental screening tools as part of well-child care from a “best practice” to a “standard practice. NASHP provided technical assistance and an opportunity to exchange experience and expertise as well as national recognition of our efforts. .

The final ABCD grant report was submitted to the grantor, National Academy for State Health Policy in July 2008. DMMA was a key member of the Core Team for this ABCD grant. The report highlighted a number of findings and activities related to the ABCD grant. These include: A successful Stakeholders forum was held which featured Dr

Frances Glascoe, author of the PEDS (Parents Evaluation of Developmental Status) tool, offered valuable information about the benefit of developmental screening using a validated tool. From the beginning of the project and following the Stakeholders Forum, all ten pediatric satellite offices committed to the use of developmental screening with the use of the PEDS tool. The ten pediatric offices are located throughout Delaware and serve over 300,000 children in mostly medically underserved communities. The use of the PEDS tool continues to spread statewide and has led Delaware in a positive direction, working with the pediatric community in implementing developmental screening with the use of a validated tool. Delaware was invited to and presented at the National Academy of State Health Policy's Annual Conference. The topic was on Coordinating Services for Young Children with a focus on Delaware's Part C early intervention program. The ABCD grant core team was instrumental in assisting the University of Delaware Center for Disabilities Study with writing the grant proposal to look at Changing the Way Family/General Practice Physicians Screen for Developmental Milestones and Utilize Early Intervention and Early Childhood Special Education Services. The work of the ABCD initiative was an integral part of the proposed plan for a statewide spread of the work begun by ABCD. Ultimately, the work of this grant will pave the way for DMMA and the State of Delaware to implement plans to ensure that all children begin kindergarten physically and emotionally healthy.

Through rigorous quality processes, Medicaid Managed Care has been successful in improving or maintaining quality results and improving care and services to Medicaid and CHIP participants during times of MCO transition. We now have the added benefit of increased access and choice with the addition of another Managed Care Organization as of July 2007.

Opportunities:

Refined reporting processes and structures for the MCOs has been accomplished. This will lead to timely reporting and assessment of quality findings for identifying and implementing improvement measures. Additionally, this will be reflected in greater compliance with established performance benchmarks. However, as the program continues to mature continuing attention will be paid administrative efficiencies to enhance the value of the data being presented

Ongoing opportunities exist to continue to expound upon the skills and abilities of the QII Task Force participants through QII Task Force meetings/discussions, ad hoc groups, and other activities as appropriate.

Better opportunities exist to reduce the inappropriate use of the Emergency Department, improve preventative screening rates, and further identify cost saving measures. DMMA will continue to seek innovative ways to assure the provision of quality services for Medicaid and CHIP populations served.

Appendix A – Definition of Medical Necessity

13.0 Appendix H – Medical Necessity Definition

Medical Necessity is defined as:

The essential need for medical care or services (all covered State Medicaid and CHIP Plan services, subject to age and eligibility restrictions and/or EPSDT requirements) which, when prescribed by the beneficiary's primary physician care manager and delivered by or through authorized and qualified providers, **will**:

- Be directly related to the diagnosed medical condition or the effects of the condition of the beneficiary (the physical or mental functional deficits that characterize the beneficiary's condition), and be provided to the beneficiary only.
- Be appropriate and effective to the comprehensive profile (e.g. needs, aptitudes, abilities, and environment) of the beneficiary and the beneficiary's family.
- Be primarily directed to treat the diagnosed medical condition or the effects of the condition of the beneficiary, in all settings for normal activities of daily living, but will not be solely for the convenience of the beneficiary, the beneficiary's family, or the beneficiary's provider.
- Be timely, considering the nature and current state of the beneficiary's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time.
- Be the least costly, appropriate, available health service alternative, and will represent an effective and appropriate use of program funds.
- Be the most appropriate care or service that can be safely and effectively provided to the beneficiary, and will not duplicate other services provided to the beneficiary.
- Be sufficient in amount, scope and duration to reasonably achieve its purpose.
- Be recognized as either the treatment of choice (i.e. prevailing community or statewide standard) or common medical practice by the practitioner's peer group, or the functional equivalent of General Policy Provider Policy Manual other care and services that are commonly provided.
- Be rendered in response to a life threatening condition or pain, or to treat an injury, illness, or other diagnosed condition, or to treat the effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation, including loss of physical or mental functionality or developmental delay.

and will be reasonably determined to:

- Diagnose, cure, correct or ameliorate defects and physical and mental illnesses and diagnosed conditions or the effects of such conditions; **or**
- Prevent the worsening of conditions or effects of conditions that endanger life or cause pain, or result in illness or infirmity, or have caused or threaten to cause a physical or mental dysfunction, impairment, disability, or developmental delay; **or**
- Effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an institutional setting or other Medicaid program; **or**
- Restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury or condition; **or**
- Provide assistance in gaining access to needed medical, social, educational and other services required to diagnose, treat, or support a diagnosed condition or the effects of the condition.

in order that:

- The beneficiary might attain or retain independence, self-care, dignity, self-determination, personal safety, and integration into all natural family, community, and facility environments and activities.

Appendix B – Acronyms

Adjusted Clinical Groups (ACGs)
Balanced Budget Act of 1997 (BBA)
Children’s Health Insurance Program (CHIP)
Children’s Health Insurance Program Reauthorization Act (CHIPRA)
Centers for Medicare and Medicaid Services (CMS)
Children with Special Health Care Needs (CSHCN)
Congestive Heart Failure (CHF)
Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Controlled Dangerous Substances (CDS)
Delaware Physicians Care Inc. (DCPI)
Department of Health and Social Services (DHSS)
Diamond State Health Plan (DSHP)
Diamond State Partners (DSP)
Division of Medicaid & Medical Assistance (DMMA)
Division of Social Services (DSS)
Drug Enforcement Agency (DEA)
Early and Periodic Screening Diagnosis and Treatment (EPSDT)
Emergency Room (ER)
External Quality Review (EQR)
External Quality Review Organization (EQRO)
Federal Poverty Limit (FPL)
Fee-for-Service (FFS)
First State Health Plan (FSHP)
Health Benefits Manager (HBM)
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Health Risk Assessment (HRA)
Managed Care Organizations (MCOs)
Management Information System (MIS)
Medical Care Advisory Committee (MCAC)
Medical Management and Delegated Services (MMDS)
Medical Management Information System (MMIS)
National Committee for Quality Assurance (NCQA)
Office of Management and Budget (OMB)
Performance Improvement Projects (PIPs)
Performance Measures (PMs)
Pharmacy Benefits Manager (PBM)
Prepaid Ambulatory Health Plans (PAHP)

Prepaid Inpatient Health Plans (PIHP)
Primary Care Physician (PCP)
Quality Assurance (QA)
Quality Improvement (QI)
Quality Improvement Initiative (QII)
Quality Management (QM)
Quality Management Strategy (QMS)
Quality Management Unit (QMU)
Rural Health Centers (RHC)
Special Health Care Needs (SHCNs)
State Fiscal Year (SFY)
Surveillance and Utilization Review (SUR)