DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

Diamond State Health Plan
Quality Strategy

as of December 31, 2022

DRAFT — FOR PUBLIC REVIEW

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Introduction

Executive Summary

The State of Delaware (Delaware or State) Department of Health and Social Services (DHSS), Division of Medicaid and Medical Assistance (DMMA) developed this Medicaid Comprehensive Quality Strategy (QS) in accordance with the Code of Federal Regulations (CFR), at 42 CFR §438.340. In Delaware, the vast majority of all Medicaid recipients receive services through the State's Medicaid managed care delivery system known as the Diamond State Health Plan (DSHP) and the Diamond State Health Plan Plus (DSHP Plus). DMMA's QS serves as the framework to accomplish its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Delaware Medicaid health ecosystem. The QS promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, quality of care, member satisfaction, and timeliness of services for Delaware's DSHP and DSHP Plus recipients. In short, the QS was purposefully developed with the aim to continually improve the delivery of quality health care and services through its managed care delivery system.

The QS was purposefully developed to outline DMMA's approach to continually improve the delivery of quality health care and services through its managed care delivery system.

DMMA Responsibilities

Detailed throughout this document are the QS's purpose, scope, goals and objectives, standards and guidelines, and monitoring and improvement strategies. This includes progressive actions that can be taken to hold the contracted managed care organizations (MCOs) accountable.

As the single State agency responsible for the Medicaid program, DMMA maintains ultimate authority and responsibility for the maintenance and annual evaluation of the QS. DMMA updates the QS at least every three years and/or as needed based on results of the annual QS evaluation, MCO performance, stakeholder input and feedback, achievement of goals, changes resulting from legislative, State, federal, or other regulatory authority, and/or significant changes to the programmatic structure of the Delaware Medicaid program.

To demonstrate compliance with the Centers for Medicare & Medicaid Services (CMS) QS requirements in 42 CFR §438.340 published in May 2016, DMMA created a crosswalk (Appendix C) that lists each of the required elements of State QSs, and the corresponding section of the DMMA QS and, where applicable, MCO contracts that address the required elements.

Scope of the Quality Strategy

The following are included in the scope of the QS:

- All Medicaid and Children's Health Insurance Program (CHIP) managed care recipients in all demographic groups across all three Delaware counties for which the MCOs are approved to provide Medicaid and CHIP managed care services.
- All aspects of care — including accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by DMMA's DSHP and DSHP Plus program.
- All aspects of the MCOs' performance related to access to care, quality of care, and quality of service, including networking, contracting, credentialing, and medical record-keeping practices.
- All services covered — including preventive care services, primary care, specialty care, ancillary care, emergency services, chronic disease and special needs care, dental services, mental health services, diagnostic services, pharmaceutical services, skilled nursing care, home health care, prescription drugs, and long-term services and supports (LTSS).
- All professional and institutional care in all settings, including inpatient, outpatient, and home settings.
- All MCO contracted network providers and any other delegated or subcontracted provider types.
- All aspects of the MCOs' internal administrative processes related to service and quality of care — including but not limited to customer services, enrollment services, provider relations, confidentiality and privacy of medical records and information, care coordination and case management services, utilization review activities, preventive health services, health education, information services, and quality improvement.

Overview

History of the Program

Delaware's DSHP 1115 Demonstration Waiver was initially approved in 1995 and implemented on January 1, 1996. The original goal of the Demonstration was to improve the health status of low-income Delawareans by expanding access to health care to more individuals throughout the State; creating and maintaining a managed care delivery system with an emphasis on primary care; and controlling the growth of health care expenditures for the Medicaid population. The DSHP 1115 Demonstration was designed to mandatorily enroll eligible Medicaid recipients into MCOs and create cost efficiencies in the Medicaid program that could be used to expand coverage. Delaware achieved its objective of implementation of mandatory managed care focused on primary care in 1996 and invested the resulting waiver savings in Delaware's Medicaid eligibility coverage expansion to

uninsured adults up to 100% of the federal poverty level (FPL). Long before Medicaid expansion under the Affordable Care Act (ACA), Delaware was a pioneer in coverage expansion for individuals who would otherwise not be eligible for Medicaid. Delaware built upon this success with the eventual expansion of coverage for family planning services, leading up to participating in Medicaid expansion under the ACA in 2014.

Through an amendment approved by CMS in 2012, Delaware was authorized to create the DSHP Plus, which is Delaware's managed long-term services and supports (MLTSS) program. DSHP Plus aimed to include additional State plan populations to receive services through MCOs, including (1) individuals receiving care at nursing facilities (NFs) other than intermediate care facilities for the mentally retarded (ICF/MR); (2) children in pediatric NFs; (3) individuals who receive benefits from both Medicaid and Medicare (dual eligibles); and (4) workers with disabilities who buy-in for coverage. This amendment also added eligibility for the following new demonstration populations: (1) individuals who would previously have been enrolled through the 1915(c) home- and community-based services (HCBS) waiver program for the elderly and disabled. This includes those receiving services under the Money Follows the Person demonstration; (2) individuals who would previously have been enrolled through the 1915(c) HCBS waiver for Individuals with Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS) Related Diseases; (3) individuals residing in NF who no longer meet the current medical necessity criteria for NF services; and (4) adults and children with incomes below 250% of the Supplemental Security Income Federal Benefit Rate who are at risk for institutionalization. Additionally, this amendment expanded HCBS to include: (1) cost-effective and medically necessary home modifications; (2) chore services; and (3) home delivered meals.

In 2013, the Demonstration was renewed and amended to provide authority to extend the low-income adult demonstration population to individuals with incomes up to 100% of the FPL until December 31, 2013. After that date, the Demonstration population was not necessary because it was included under the approved State plan as the new adult eligibility group authorized under the ACA. The new adult group, for individuals with incomes up to 133% of the FPL, receive medical assistance through enrollment in MCOs pursuant to this Demonstration. In addition, Delaware's authority for the family planning expansion program under this Demonstration expired December 31, 2013, when individuals became eligible for Medicaid expansion or Marketplace coverage options.

The Demonstration was amended in 2014 to authorize coverage for enhanced behavioral health services and supports for targeted Medicaid beneficiaries through a voluntary program called Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) starting in 2015. PROMISE enrollees include Medicaid beneficiaries who have a severe and persistent mental illness (SPMI) and/or a substance use disorder (SUD) and require HCBS to live and work in integrated settings.

Technical changes were incorporated into the Demonstration in October 2017 and an amendment was approved in December 2017 to add coverage for out-of-state former foster care youth.

In July 2019, the Demonstration was extended for an additional five years, and an amendment was approved to provide the State with authority to provide high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD).

Delaware also submitted an amendment to the Demonstration on August 11, 2020, to revise the budget neutrality expenditures to reflect the costs associated with the adult dental benefits that were recently added to the Medicaid State plan. Delaware requested this amendment because, although the dental services are authorized under State plan authority, they will be administered through the DSHP managed care delivery system, which is authorized by this Demonstration. The amendment was approved effective January 19, 2021.

Program Demographics

DHSS is designated as the single State agency responsible for the overall administration of Medicaid and the Delaware Healthy Children Program (DHCP). DMMA has administrative responsibility for these programs at the operational level and works in partnership with the Division of Social Services to carry out the eligibility and aid code determination functions for the Medicaid population. Delaware's Medicaid managed care program, comprised of DSHP and DSHP Plus, is operating under the authority of a Section 1115(a) Demonstration and provides integrated physical, behavioral health, and LTSS to eligible Medicaid members through contracted MCOs. Currently approximately 87% of the State's Medicaid and DHCP clients (approximately 280,000 individuals) are enrolled in DSHP and DSHP Plus.

Table 1.1 presents the gender and age bands of DSHP and DSHP Plus programs based on September 2022 eligibility information, extracted from the Delaware Medicaid Enterprise System (DMES) as of October 2022.

Table 1.1 — Delaware Medicaid Managed Care Demographics

Age Band	Male	Female	September 2022 Members
0–1	2,969	2,885	5,854
1–17	53,430	51,120	104,550
18–20	7,266	7,588	14,854
21–44	38,042	52,967	91,009
45–54	10,600	12,358	22,958
55–64	10,623	11,919	22,542
65–74	1,712	2,624	4,336
75+	978	2,748	3,726
Total Members	125,620	144,209	269,829

Table 1.2 presents enrollment information by the three Delaware counties and by Medicaid Health Plan for the DSHP and DSHP Plus programs based on September 2022 eligibility information, extracted from the DMES as of October 2022.

Table 1.2 — Medicaid Members by County and Health Plan

County	Member Counts			% of Total		
	Highmark	AmeriHealth	Total	Highmark	AmeriHealth	Total
Kent	30,272	22,904	53,176	18.6%	21.4%	19.7%
New Castle	95,181	60,781	155,962	58.5%	56.7%	57.8%
Sussex	37,243	23,461	60,704	22.9%	21.9%	22.5%
Total	162,696	107,146	269,842	100.0%	100.0%	100.0%

The Quality Enterprise

Vision and Mission

The QS supports the missions of the DHSS department and the following divisions to:

"*Improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations*." — DHSS

"*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

"*Improve or maintain the quality of life for Delawareans who are at least 18 years of age with physical disabilities or who are elderly. The Division is committed to the development and delivery of consumer-driven services which maximize independence through individual choice, enable individuals to continue living active and productive lives and protect those who may be vulnerable and at risk*." — Delaware Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)

"*Improve the quality of life for adults having mental illness, alcoholism, drug addiction, or gambling addiction by promoting their health and well-being, fostering their self-sufficiency and protecting those who are at risk*." — Division of Substance Abuse and Mental Health (DSAMH)

"*To develop and support a family-driven, youth-guided, trauma-informed prevention and behavioral health system of care."* — Division of Prevention and Behavioral Health Services (DPBHS) of Department of Services for Children, Youth and Families (DSCYF)

"*Protect residents in Delaware long-term care facilities through promotion of quality of care, quality of life, safety and security, and enforcement of compliance with State and federal laws and regulations.*" — Division of Health Care Quality (DHCQ)

"*Provide leadership for a service system that is responsive to the needs of the people we support by creating opportunities and promoting possibilities for meeting those needs*." — Division of Developmental Disabilities Services (DDDS)

"*To protect and enhance the health of the people of Delaware by: Working together with others; Addressing issues that affect the health of Delawareans; Keeping track of the State's health; Promoting positive lifestyles; Responding to critical health issues and disasters; and Promoting the availability of health services.*" — Division of Public Health (DPH)

To accomplish the DHSS vision and mission statements reflected above, the QS seeks to:

- Assure DSHP and DSHP Plus members receive the care and services required for Medicaid and CHIP-funded programs and all other waiver programs serving the DSHP population by identifying program goals and evaluation measures.

- Provide ongoing tracking and monitoring that meet CMS requirements of "achieving ongoing compliance with the waiver assurances" and other federal requirements for DSHP and DSHP Plus. This tracking allows reporting on progress with meeting program goals through monitoring quality plans, performance measures, and quality improvement plans.

- Assure that the State maintains administrative authority and implements DSHP Plus and PROMISE in compliance with waiver assurances and other program requirements currently part of the 1915(c) or 1915(i) waiver programs, either by the State or by the MCO through specific contract provisions, including requirements such as: level of care; person-centered planning and individual service plans; qualified providers; health and welfare of enrollees; and fair hearings.

Process for Quality Strategy Development, Review, and Revision

DMMA fosters a multidisciplinary approach to developing, reviewing, and revising the QS. The approach involves the contracted Medicaid MCOs, the State's External Quality Review Organization (EQRO), and public stakeholders including providers, recipients, recipient advocates, and outside partners who are directly concerned about — and impact on — access, quality of care, and quality of service. All stakeholders have the opportunity to comment on the development of quality goals and objectives highlighted in the QS.

Development of the QS

Using the results of the most recent QS evaluation and the annual External Quality Review (EQR), DMMA selected performance measures used to evaluate health plan performance in achieving the goals and objectives identified in the QS. Delaware gathers input from contracted Medicaid MCOs, program members, and stakeholders, and includes epidemiological, performance measurement results, and other available clinical data, to establish the basis for selecting and prioritizing performance measures to monitor improvement of the health and wellness of Delaware's DSHP and DSHP Plus populations.

DMMA acknowledges the importance of participant, family, and advocate input into the development of the QS. Through a variety of mechanisms listed below, participant feedback is collected and reviewed. Each MCO is required to operate a Member Advisory Committee that includes DSHP and DSHP Plus populations representing members residing in long-term care facilities and in home- and community-based settings. Member experience of care surveys include the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) conducted annually by the MCOs and the National Core Indicators-Aging and Disabilities (NCI-AD) survey conducted by DMMA every other year. The NCI-AD specifically addresses the experience of care for recipients enrolled in the DSHP Plus program who are receiving the enhanced benefit package.

The State's Medical Care Advisory Committee (MCAC) is another forum hosted by the State. The MCAC consists of State Medicaid agency leadership, managers, and Medicaid physicians and providers along with individuals, stakeholders, and other interested parties impacted by the State's use of managed care, regarding the effective implementation of these changes to seniors and person with disabilities. The Secretary of DHSS may appoint representatives to participate on the MCAC, as appropriate. DMMA is committed to continuous quality improvement and as such will be establishing the topic of quality as a standing item on the MCAC agenda. The DMMA Quality unit will utilize this time to report on quality updates and/or issues as well as discuss any feedback during public comment periods.

Tribal consultation is not necessary at this time, as Delaware does not currently have any federally recognized tribes. However, should that change, DMMA acknowledges its responsibility to seek tribal consultation in the development of the QS.

Federal requirements state that the QS is updated at a minimum every three years or more frequently when there is a significant change to the State Medicaid Plan. A notification of public interest is released in the Delaware Register of Regulations, a monthly publication, allowing a 30-day public comment period. Once public input has been received and incorporated into the document, the document is then submitted as draft to CMS for comment and feedback. Once CMS' comments and feedback are received and incorporated into the QS, the document is then finalized and shared publicly on the DMMA website at: https://dhss.delaware.gov/dhss/dmma/files. In addition to updates to the current QS, DMMA evaluates the effectiveness of the QS from the three years prior. This evaluation document is also submitted to CMS for review and shared publicly on the DMMA website at: https://dhss.delaware.gov/dhss/dmma/files.

Review of the QS

DMMA uses a multi-modal approach to review the QS, which includes DMMA's monitoring and oversight activities, the EQRO's assessment and validation findings, and input from CMS and other regulatory bodies. The EQRO, under direction from DMMA, tracks the MCOs' performance for each of the required performance measures and reports the information annually in an EQR technical report. Additionally, the MCOs are required to track their own performance and report achievements and

opportunities for improvement via the MCO's Quality Management Program Evaluation, which is submitted annually to DMMA by each MCO.

For areas that require a specialized focus and targeted performance improvement interventions, DMMA conducts focused studies and requires its MCOs to conduct ongoing performance improvement projects (PIPs). The purpose of PIPs is to achieve significant, sustained improvement in both clinical and nonclinical areas through ongoing measurements and intervention. PIPs provide a structured method of assessing and improving processes and outcomes of care for the population that a MCO serves. The EQRO validates a subset of the MCOs' PIPs annually and submits to DMMA validation of findings, conclusions, and recommendations to improve PIP interventions and outcomes for the following year's PIP review cycle. Throughout the year, the MCOs are required to conduct and report on interim measurements to determine if PIP interventions are successful. The MCOs report on their intervention evaluation efforts during monthly and/or quarterly meetings with DMMA and the EQRO. The ongoing evaluation and exchange of information regarding quality improvement activities and barriers enable the MCOs to target performance improvement efforts in specified areas. DMMA uses the results of the PIP validation findings to assess each MCO's achievement of goals and to make modifications to the QS based on the MCOs' performance, if necessary. Per 42 CFR 438.340(c)(2), the QS is to be reviewed and updated every three years. This review must include an evaluation of the effectiveness of the QS conducted within the previous three years.

The comprehensive EQRO process outlined below is the primary mechanism DMMA uses to monitor each MCO's compliance with its contract, and with the goals and objectives identified in the QS.

Figure 1.1 — External Quality Review Process

DMMA's EQRO conducts comprehensive MCO reviews at least once every three years. The purpose of the review is to determine, from a review of documents, observations, and interviews with key health plan staff, an MCO's understanding and application of the Balanced Budget Act of 1997 (BBA) and contractually required standards. These comprehensive reviews assess each MCO's quality improvement structure. This structure is necessary to facilitate quality improvement and ongoing assessment of performance measures and PIPs. This enables DMMA and the EQRO to assess each MCO's performance in achieving quality goals and objectives identified in the QS. At the conclusion of the comprehensive review process, a detailed report and corrective action plan (CAP) for any metric that was not fully met is issued to the MCO. These reports and any CAPs enable the MCO to

implement remediation plans to correct any areas of deficiency found during the review process. The report also helps DMMA determine each MCO's compliance with the contract and identify areas of the contract that need to be modified or strengthened to ensure that an MCO complies with the standards. The EQRO, at DMMA's request, can provide technical assistance to the MCOs to help identify solutions to close identified gaps.

Annually, DMMA assesses each MCO's Quality Management Program Evaluation to ensure that the MCO continually monitors and evaluates its own achievement of goals and objectives to improve the accessibility, timeliness, and quality of services provided to DSHP and DSHP Plus recipients. DMMA provides feedback to the MCOs regarding programmatic strengths identified from the review as well as opportunities to improve the structure and direction of the MCO's quality program.

Revision of the QS

DMMA and its EQRO evaluate the effectiveness of the QS and report on the evaluations in the annual EQR technical report. The EQR technical report includes a review of member's access to care and the quality of services received. In accordance with 42 CFR 438.364, the report includes the following information for each mandatory activity conducted:

- Activity objectives
- Technical methods of data collection and analysis
- Description of data obtained
- Conclusions based on the data analysis

The report also includes an assessment of MCO strengths and weaknesses as well as recommendations for improvement. DMMA utilizes the information obtained from each of the EQR mandatory activities, as well as the information presented in the EQR technical report, to make programmatic changes and modifications regarding quality improvement in the QS.

DMMA updates the QS, as needed, based on each MCO's performance, stakeholder input and feedback, achievement of goals, changes resulting from legislative, State, federal, or other regulatory authority, and/or significant changes to the programmatic structure of the Delaware Medicaid program. DMMA utilizes the MCAC to solicit feedback from Delaware Medicaid stakeholders and the public during the revision phase of the QS. Additionally, DMMA invites public comment and feedback on the QS and has identified a Quality Director responsible for fielding questions or comments. The final CMS approved DMMA QS can be found on the DMMA website at: https://dhss.delaware.gov/dhss/dmma/files.

Definition of Significant Change

DMMA revises the QS to reflect changes in scope and identified needs. DMMA defines significant changes to the QS that require input from recipients and stakeholders as:

- Any change to the QS resulting from legislative, State, federal, or other regulatory authority.
- Any change in membership demographics of 50% or greater within one year.
- Any change in the provider network of 50% or greater within one year.

Oversight and Governance of the Quality Strategy

Under the direction of the Delaware DHSS, DMMA maintains ultimate authority and accountability for the maintenance and annual evaluation of the QS. DMMA meets monthly with each MCO to discuss its performance measure results, PIP activities, and other topics pertinent to the QS goals and objectives. On the first month of each quarter, the monthly meeting takes the form of the Quality Improvement Initiatives (QII) Task Force. The QII membership is chaired by DMMA's Director of Quality and comprised of the Chief Medical Officer along with other representatives from DMMA's various business units (as appropriate), contracted Medicaid MCOs, the EQRO, and other State entities and/or business units. Intentionally designed, the QII provides a forum to identify and disseminate best practices, coordinate quality activities, and connect various stakeholders across the Medicaid managed care ecosystem in efforts to improve the quality, timeliness, and access to health care and services.

Figure 1.2 — DMMA Quality Improvement Organizational Structure

As figure 1.2 demonstrates, DMMA is responsible for establishing the quality goals and desired outcomes for the Medicaid managed care program. The QS reflects DMMA's approach to achieving its program goals, as defined in its DSHP 1115 waiver. The QII acts as the forum that connects the various stakeholders across the Medicaid ecosystem. The contracted Medicaid MCOs are responsible for ensuring that the goals and objectives defined in the QS are attained. The outcomes attained by the program are then evaluated and DMMA adjusts the QS as needed to continue to drive improved

quality, access, and timeliness of service and care outcomes, for enrolled DSHP and DSHP Plus members.

Purpose of the Quality Strategy

Consistent with its mission, the purpose of DMMA's QS is to:

- Establish a comprehensive quality improvement system that is consistent with the Triple Aim to achieve better care for patients, better health for communities, and lower costs through improvement in the health care system.
- Provide a framework to implement a coordinated and comprehensive system to proactively drive quality improvement throughout the DSHP and DSHP Plus program. The QS promotes the identification and dissemination of creative initiatives to continuously monitor, assess, and improve access to care, clinical quality of care, and health outcomes of the population served.
- Identify opportunities for improvement in the health outcomes of the enrolled population and improve health and wellness through preventive care services, addressing social determinants of health, chronic disease and special needs management, and health promotion.
- Identify opportunities to improve quality of care and services and implement improvement strategies to ensure DSHP and DSHP Plus recipients have access to high quality, timely, effective, and culturally appropriate care.
- Identify creative and efficient models of care delivery that are steeped in best practice and make health care more affordable for individuals, families, and the State government.
- Improve recipient satisfaction with care and services.

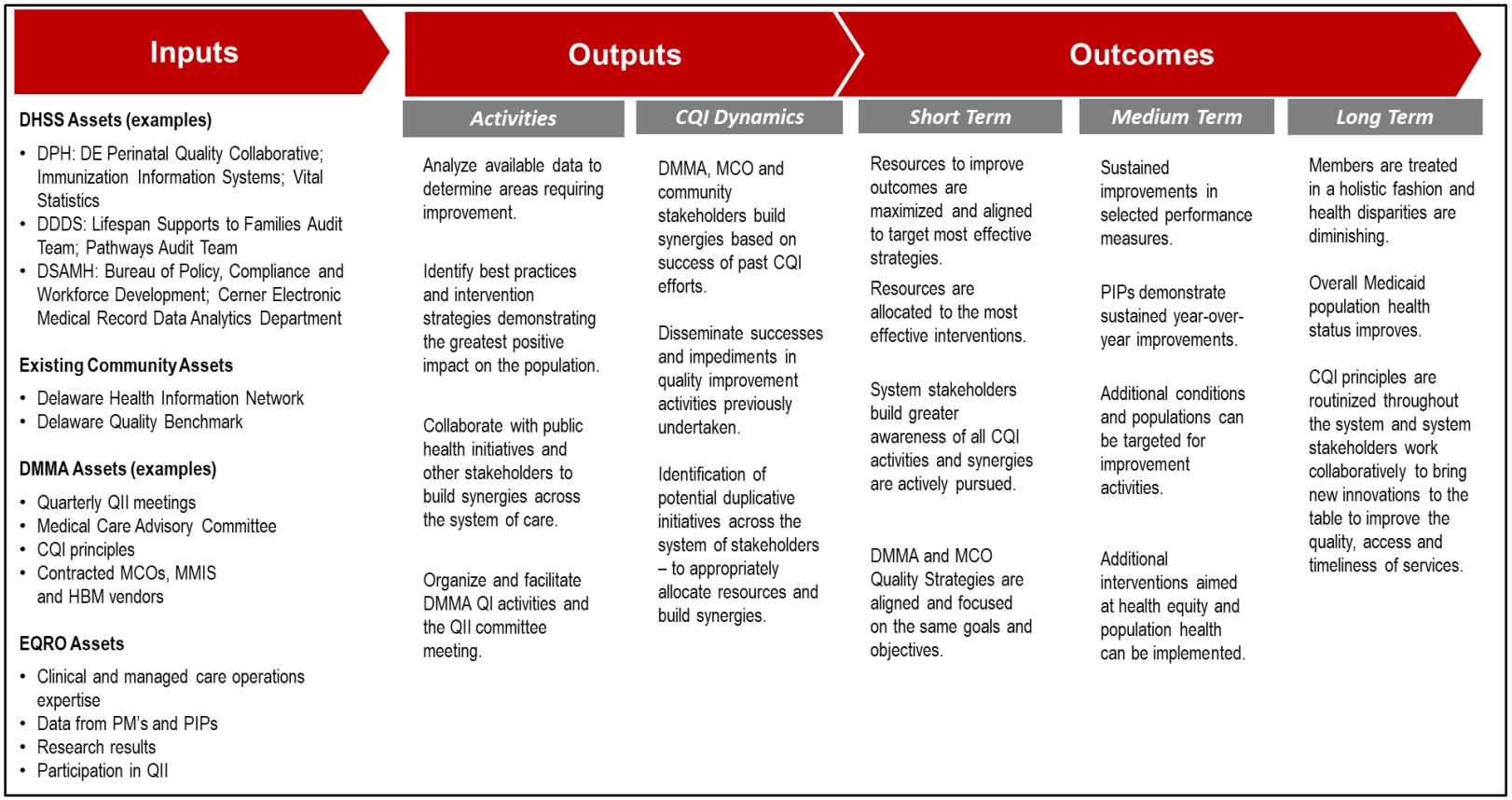
Quality Strategy Guiding Principles

- Cultivating collaborative partnerships and enhancing communication pathways among State agencies and external partners to improve health education and health outcomes, to manage vulnerable and at-risk members, and to improve access to and availability of services for all DSHP and DSHP Plus recipients.
- Utilizing rapid-cycle process improvement methods to identify, analyze, and resolve operational inefficiency; using additional performance measures, PIPs, contract compliance monitoring, and emerging practice activities to drive improvement in member outcomes.
- Advancing person-centered models of care and strengthening evidence-based prevention, wellness, and health management initiatives to improve members' health status and achievement of personal health goals.

- Developing a transparent and collaborative environment focused on achieving incremental, year-over-year sustained measurable results and promoting a culture focused on continuous quality improvement.
- Enhancing the member and provider experience.
- Amplifying the use of data analytics to provide actionable information and developing the discipline to ensure that information retrieval and reporting are timely, accurate, and complete.
- Working collaboratively and transparently with other Department of Health divisions, MCOs, and community resources to promote health equity by aligning incentives to reduce waste, promote quality, and ensure sustainability.

The logic model on the following page depicts the DMMA's strategy for improving health outcomes and establishes outcomes over the short, medium, and long term.

Figure 1.3 — DMMA Logic Model for Improving Health Outcomes



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Establishing Standards, Guidelines, and Definitions

Network Adequacy Standards Development: Access and Availability

DMMA developed standards to ensure that all covered DSHP and DSHP Plus services delivered through contracted Medicaid MCOs are available and accessible to enrollees by having an adequate provider network. The standards address providing access to covered services through providers who are within reasonable travel time; providing the full scope of Medicaid and CHIP services; having timely access to services; and providing services in a culturally competent manner.

To set clear standards related to access to care and provider networks, DMMA identifies and quantifies the needs of major Medicaid subgroup enrollees (e.g., adults, children), health and LTSS needs, needs of current Medicaid managed care members, and the number and types of providers each participating MCO's network must have to meet those needs. Below is a table of additional considerations and assurances that DMMA takes into account to ensure network adequacy.

Table 2.1 — Network Adequacy Considerations and Assurances

Network Adequacy Considerations and Assurances:
Anticipated Medicaid enrollment.
Expected utilization of services.
Characteristics and health care needs of specific Medicaid populations and anticipated membership.
Number and types of network providers required to provide contracted services.
Numbers of network providers who are not accepting new patients.
Geographic location of network providers to Medicaid enrollees, considering travel time, and distance.
Availability of triage lines or screening systems, telemedicine, e-visits, and/or other evolving and innovative technology solutions.
Consideration of member or provider grievances related to access and availability.
Member experience of care results in accessing necessary services, choice of providers, and ability to collaborate in care.
The ability of network providers to ensure physical access, reasonable accommodation, culturally competent communications, and accessible equipment for Medicaid enrollees with physical and mental disabilities.
Consideration of population distribution by race, ethnicity, and preferred language and impacts on the delivery of culturally competent care.

DMMA uses demand for specific services based on utilization patterns derived from Medicaid and CHIP encounter data available for previous periods in DMMA's Medicaid Management Information System (MMIS), referred to as DMES. DMMA used MCO encounter data to establish high volume adult and pediatric specialists to be included in the State's defined time and distance standards. DMMA defined high volume specialists as those that 1% or more of the population access for services.

To obtain this information, DMMA uses the following types of data:

- Delaware Medicaid eligibility files, including race, ethnicity, and language data.
- Health plan encounter data for the population in managed care.
- Geo-spatial analysis by county by provider type.
- MCO Provider Network Development and Management Plans (PNDMPs).

DMMA requires that each MCO develop a PNDMP that outlines the MCO's process to develop, maintain, and monitor an adequate provider network that is supported by written agreements and is sufficient to provide access to all services under its contract. The PNDMP is submitted annually. Its purpose is to ensure sufficient provision of services to members by outlining network activity and performance in the preceding year, as well as proposing a comprehensive plan for the provision of services in the coming year. The elements of the PNDMP must include, but are not limited to, the following:

- A formal attestation of the MCO's network adequacy.
- An evaluation of the previous contract year's network plan.
- How services are provided promptly and reasonably accessible in terms of location and hours of operation.
- How the MCO ties network implications from its Cultural Competency Plans to ensure cultural and linguistic needs are met.
- The MCO's process for identifying and publicizing providers that offer reasonable accommodations for members such as physical access, accessible equipment, and culturally and linguistically competent communications.

In addressing standards for network adequacy and availability requirements, DMMA takes into consideration elements that support the enrollee's choice of provider and strategies that support community integration of the enrollee. Additional elements that benefit the best interest of enrollees who need LTSS are also taken into consideration. To ensure that these standards are achieved and maintained, DMMA monitors and holds the MCOs to meeting these standards.

Publication of Network Adequacy Standards

DMMA publishes the provider-specific time and distance standards, appointment availability standards, and other network adequacy standards such as provider to member ratios and PCP panel size limits in the Master Service Agreements (MSAs), available at https://dhss.delaware.gov/dhss/dmma/files. Upon request, network adequacy standards are also made available at no cost to enrollees in alternate formats or through the provision of auxiliary aids and services by contacting the DMMA Quality Representative noted on the front cover of this document.

Exceptions Process

DMMA expects contracted MCOs to meet the defined access and availability standards but permits its MCOs to request exceptions on a case-by-case basis. As part of the request to DMMA, the MCO must submit a CAP outlining how the MCO will monitor and address the network gap, including the use of single case agreements as necessary. If DMMA grants an exception request, enrollee access to that provider type will be monitored on an ongoing basis and the findings will be included in the MCO's PNDMP. DMMA is required by federal law to report network exceptions and monitoring results as part of its managed care program assessment report required under 42 CFR §438.66. Information used to monitor the exception includes member grievance data, trends in single case agreement requests for out-of-network services, and member experience survey results related to primary and specialty care access. The State also requires approval of any PCP caseload greater than 2,500 patients in aggregate.

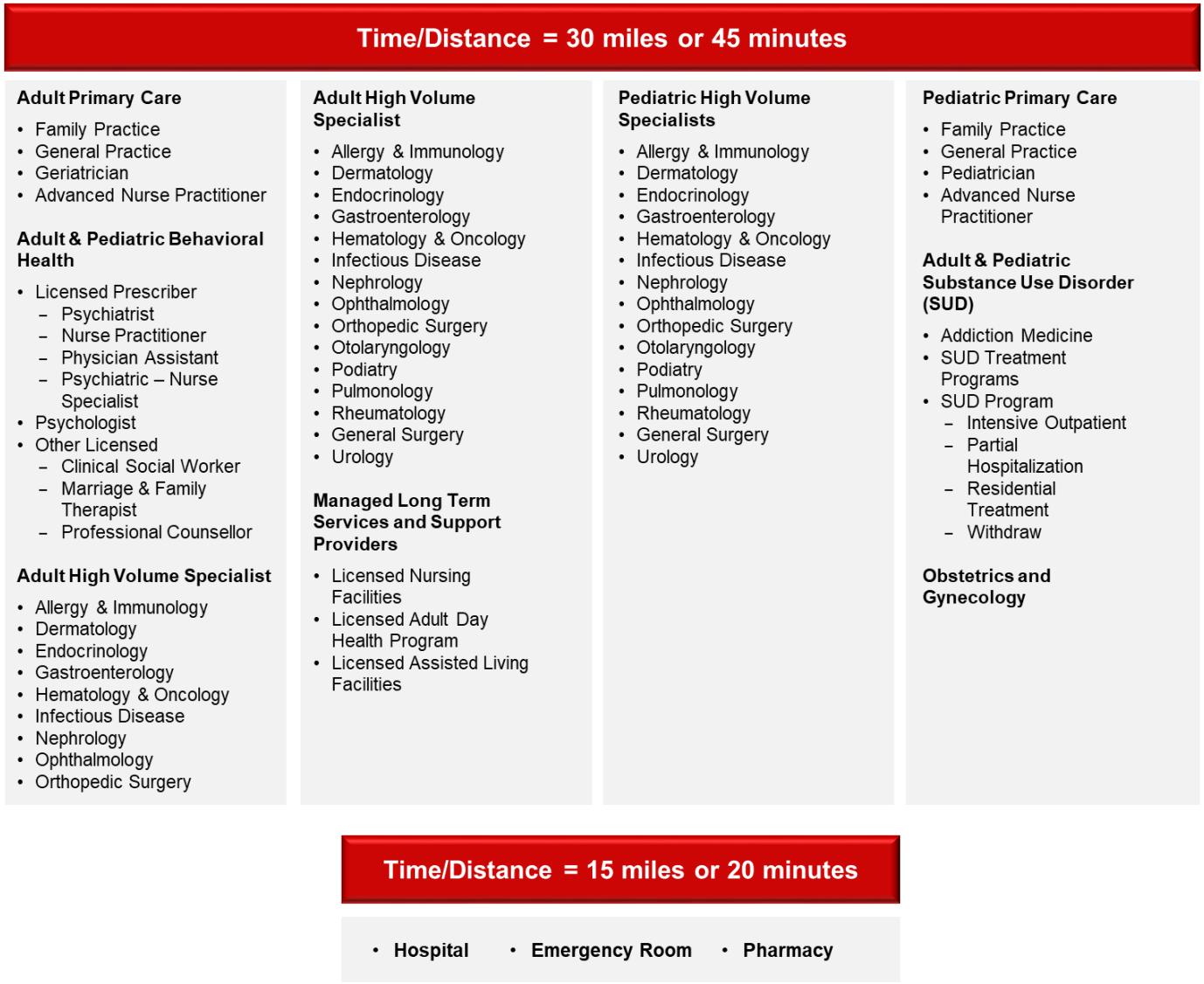
State Access Standards

Time and Distance Standards

According to federal law, a state that contracts with a MCO to deliver Medicaid services must develop and enforce network adequacy standards that include time and distance standards for provider types that include adult and pediatric primary care, obstetrics and gynecology, behavioral health (mental health and substance use disorder), adult and pediatric specialist (as identified by the State), hospital, emergency department, and pharmacy.

In accordance with the regulation, DMMA establishes time and distance standards based on provider type and the characteristics and special needs of Delaware's DSHP/DSHP Plus program populations. To that effect, DMMA has included contractual specifications for time and distance standards in the MSA, the State's contract with its Medicaid MCO. The State has established two standards one for hospitals, emergency departments, and pharmacies and another for all other federally required provider types.

Figure 2.2 — DMMA Time and Distance Standards



Other than Time/Distance Standards

Additionally, federal law requires states to implement network access standards other than time and distance to address provider types that may travel to the member's home to provide services, such as certain HCBS provided under the DSHP Plus program, or to provide assurances to high volume services (i.e., primary care).

Figure 2.3 — DMMA Standards Other than Time and Distance

Time/Distance = 30 miles or 45 minutes	
Adult and Pediatric Primary Care Requirements: • 1 PCP per every 2,500 DSHP/DSHP Plus members • Choice of at least two (2) PCPs, within the defined time/distance standards • Requirement to monitor PCP panel size to ensure aggregate member panel does not exceed 2,500 • Exception request for any PCP exceeding the 2,500 patient threshold	**Long Term Services & Supports Requirements:** • Choice of two (2) Personal Care Attendant Care Service providers

Other Network Access Standards

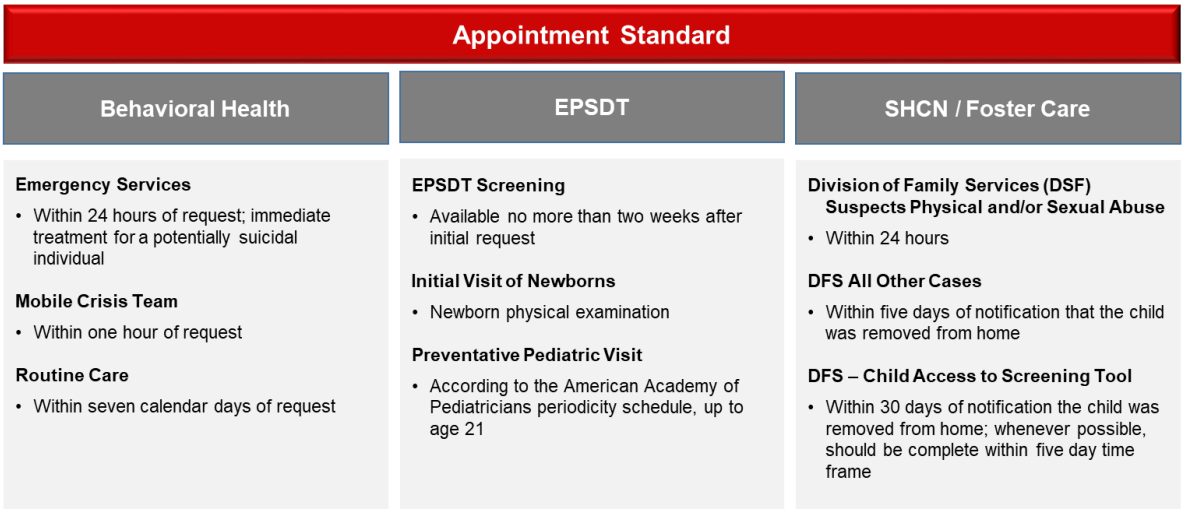
In accordance with other requirements found in §438.206, DMMA requires:

- All female members have direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services.
- A robust selection of family planning providers but does not limit access to only those providers that are in-network.
- Assistance in scheduling a second opinion from either in- or out-of-network providers, without cost to the member.

State Availability Standards

Figure 2.4 — DMMA Appointment Wait Time Standards

Appointment Standard		
General	**Specialty**	**Maternity**
Emergency Services • Available 24 hours a day, seven days a week **Emergency PCP** • Available same day **Emergency Care PCP** • Available within two calendar days **Emergency Services** • Available 24 hours a day, seven days a week	**Emergency Services** • Immediate **Urgent Care PCP** • Available within 48 hours of referral **Routine Care** • Available within three weeks of member request	**Emergency Services** • Immediate **Initial Prenatal Care** • First trimester: within three weeks of first request **Initial Prenatal Care** • Second trimester: within seven calendar days of first request **Initial Prenatal Care** • Third trimester: within three calendar days of first request • High-risk pregnancies: within three calendar days of identification of high risk



Alternative Service Wait Times

DMMA has also developed alternative service wait times for the DSHP Plus program to address the unique service array available to this population. These services are made available for the express purpose of maintaining a member safely in the home and as such the timely and full provision of these services are necessary to reduce the risk of hospitalization and support member safety. Timely provision of these services should consider the frequency, amount, duration, and scope of services to be delivered.

Figure 2.5 — DMMA Alternative Service Wait Time Standards

Adopting and Disseminating Clinical Practice Guidelines

State Standards for Clinical Guidelines

States are required to ensure that each MCO has the structure and clinical resources for adopting evidence-based clinical guidelines that meet the health care needs of enrollees. The use of clinical practice guidelines is expected as these standards have been demonstrated to decrease variation in treatment.

To meet the CFR requirements and satisfy DMMA's contract expectations, MCOs are obligated to:

- Provide local medical management through a Delaware licensed registered nurse with oversight of the MCO's Health Services program and a staff of registered nurses and licensed social workers and appropriately trained and experienced support staff with appropriate professional clinical expertise to perform care coordination and case management activities.
- Have full-time, Delaware-based Chief Medical Officers who are Delaware-licensed physicians or in the case of behavioral health, licensed Psychiatric Nurse Practitioner or Psychiatric Clinical Nurse Specialist with an Advanced Practice nursing license in Delaware.
- Have medical management staffing at a level that is sufficient to perform all necessary medical assessments and to meet all enrollees' case management needs at all times.
- Ensure that network practitioners are using relevant clinical practice guidelines.
- Establish the clinical basis for the guidelines.
- Update the guidelines at least every two years and initiate the review of a guideline before two years if new scientific evidence or national guidelines warrant the need for a review.
- Distribute the guidelines to the appropriate network practitioners.

In addition to the clinical guidelines adopted by the MCO that address the requirements noted above, DMMA has required the adoption of specific clinical guidelines, as outlined below. It is the expectation that all clinical practice guidelines, including those noted below, be adopted and disseminated to network practitioners as appropriate and upon request. These guidelines should be made available electronically to providers via the MCO's provider portal.

- Center for Disease Control (CDC) guidelines for Medical Eligibility for Contraception, a summary of which can be found at: https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html
- Current CDC Guidelines for Sexually Transmitted Infections Testing and Treatment, a copy of which can be found at: https://www.cdc.gov/std/treatment/default.htm
- Current Infectious Diseases Society of America Guidance for Persons with HIV, as summary of which can be found at: https://www.idsociety.org/practice-guideline/primary-care-management-of-people-with-hiv/ and https://www.samhsa.gov/resource/ebp/clinical-guidance-treating-pregnant-parenting-women-opioid-use-disorder-their-infants
- American Academy of Pediatrics, Bright Future Guidelines, additional resources can be found at: https://brightfutures.aap.org/clinical-practice/Pages/default.aspx

Other State Standards for Clinical Guidelines

DMMA is committed to developing systems that promote greater cultural competency and actively work to eliminate racial and ethnic disparities in care. To that end, DMMA includes the following cultural and linguistically appropriate services (CLAS) standards implementation guide with the expectation that contracted MCOs, and subcontractors, partner with respective network providers to driver stronger linkages to the delivery of culturally competent care. CMS' A Practical Guide to Implementing the National CLAS Standards may be accessed at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf. Research has demonstrated building competency in cultural differences can serve to break down barriers to care and build stronger therapeutic relationships.

Access to Continued Services and the Transition of Care

DMMA documents its transition of care requirements in its standalone policy available at https://www.dhss.delaware.gov/dhss/dmma/files/statewidetransitionplan.pdf. Consideration of enrollees moving from fee-for-service (FFS) into managed care, those moving between managed care contractors, those who may be transitioning between HCBS providers, and those who may be transitioning out of managed care into the FFS system are included under the transition of care policy.

Additional consideration is given to certain populations co-managed by the MCO and other State agencies, those who may be actively engaged in treatment, including ongoing treatment with pharmaceuticals and allowing for a continuity period. During this continuity period, the receiving MCO is responsible for honoring active service authorizations as well as rendering providers, regardless of whether they are in the receiving MCOs network, for a predefined time.

The majority of member transitions occur within the managed care system as members may move from one MCO to the other. When this occurs, DMMA has developed a standardized process using the Member Transfer Coordination of Care form by which the receiving MCO requests data and information from the sending MCO. The sending MCO is required to share and timely transfer data and information pertinent to the member's ongoing treatment plan/plan of care and providers using the specified form.

Special Population Considerations

For members who are enrolled in either the PROMISE program or DDDS Lifespan waiver, DMMA requires that the receiving MCO outreach to the respective agency to alert them to the transition, to provide a new point of contact, and to initiate the transfer of requisite information to the MCO case manager/care coordinator. For PROMISE enrolled members the MCO must outreach to DSAMH and for those enrolled in the Lifespan waiver outreach to DDDS.

Continuity of Care Period

In general, the continuity period considers the ongoing treatment plan/plan of care as well as the member's providers. The maximum defined continuity period is 90-days but can be as little as 30-days. The following table outlines basic continuity periods and considerations.

Figure 2.6 — DMMA Continuity Period by Population

Continuity Period by Population		
Population	**Continuity Period**	**Continuity Period Exceptions**
Non-pregnant/First trimester Non-DSHP Plus	• Lesser of 90-days or provider releases member	• If provider resides within time/distance standards • If not, a member can be redirected to a participating provider within the 30-days, no reduction to services
Pregnant second and third trimester	• Prenatal period through 60-days postpartum	• If provider resides within time/distance standards • If not, a member can be redirected to a participating provider within the 30 days, no reduction in services
DSHP Plus - LTSS	• Greater of 30-days or MCO completes face-to-face assessment, regardless of provider's participation status	• Until a face-to-face assessment is completed services cannot be reduced, terminated, or otherwise changed
Members with prior authorized prescriptions in the FFS system	• Expiration of the State prior authorization	• Only applies to members moving from FFS
Members receiving non-behavioral health non-prior authorized prescriptions	• 60 days	• Only applies to members moving from FFS
Members receiving behavioral health, non-prior authorized prescriptions	• 90 days	• Only applies to members moving from FFS

DSHP Plus and HCBS Provider Continuity

The State's continuity and transition policies consider members who have met eligibility to receive HCBS whether under DSHP Plus, PROMISE, or the DDDS Lifespan waiver. From time-to-time there may be need to facilitate a change in HCBS providers, even if the member is not transitioning to another MCO or system of care. The established standards for HCBS provider transitions require: no lapse in service provision, seamless handoffs of treatment plan/plan of care information between provider agencies, maintenance of confidentiality, and allow for and grant member requests to obtain a new provider.

Identifying Persons Needing Long-Term Services and Supports and those with Special Health Care Needs

Members who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type and amount beyond that generally required by members, including children with Special Health Care Needs (SHCN) and those who would benefit from the provision of LTSS are encompassed under the State's definition of members with SHCN.

The SHCN population is defined as:

- Members who have or are suspected of having a serious or chronic physical, developmental, behavioral, or emotional condition.
- Children with vision or hearing impairments, or who require an Individualized Education Plan (IEP).
- Foster or adoptive children.
- Persons at risk of or having chronic diseases and disabilities.
- Members diagnosed with HIV/AIDS.
- Members who are elderly and/or physically disabled.
- Members who are developmentally disabled.
- Members who use English as a second language.

Additionally, by contract MCOs are required to assess individuals who may benefit from the enhanced LTSS benefit array available under the DSHP Plus program. Assessment for enrollment into this program is completed using the State's Pre-Admission Evaluation (PAE) to determine level of care and to support needs assessment. DSHP Plus is Delaware's Medicaid MLTSS program its population is defined as:

- Members who receive care at NFs other than intermediate care facilities for individuals with intellectual disabilities (ICF/IID).
- Members in pediatric NFs.
- Members who receive benefits from both Medicaid and Medicare (dual eligibles).
- Members with disabilities who buy-in for coverage.

- Members who would previously have been enrolled through the 1915(c) HCBS waiver program for the elderly and disabled (including those receiving services under the Money Follows the Person demonstration).

- Members who would previously have been enrolled through the 1915(c) HCBS waiver for Individuals with HIV/AIDS related diseases.

- Members residing in NFs who no longer meet the current medical necessity criteria for NF services.

- Adults and children with incomes below 250% of the Supplemental Security Income Federal Benefit Rate who are at risk for institutionalization. DSHP Plus is administered by DMMA through Medicaid MCOs.

Information pertaining to eligibility category, disability status as well as race, ethnicity, and language data are transmitted on the eligibility file shared with the MCOs. MCOs are required to use the information from the eligibility file to identify individuals with SHCN and individuals who may benefit from the enhanced LTSS benefit.

Non-Duplication of External Quality Review Activities

CMS defines an EQR as the analysis and evaluation by an EQRO of aggregated information on quality, timeliness, and access to the health care services that a MCO, or its subcontractors, furnish to Medicaid enrollees. The annual EQR results in the generation of an annual EQR technical report. Section 1932(c)(2) of the Social Security Act and 42 CFR §438.350-370 requires that each state that contracts with an MCO must ensure that a qualified EQRO performs an annual EQR for each contracted MCO. The 2016 Medicaid and CHIP Managed Care Final Rule applies all EQR and EQRO requirements to CHIP plans in 42 CFR §457 Subpart L.

To decrease state administrative burden and cost in the procurement of EQRO services, CMS allows states flexibility to utilize results from Medicare or private accreditation surveys to supplement information obtained during the mandatory activities under EQR, effectively reducing the scope of the required EQR. While such flexibility is appreciated, DMMA views the EQR process as an integral component of its quality program.

To that end, DMMA and its EQRO partner together annually to complete mandatory EQR activities (additional information about EQR can be found in Section 3). DMMA has adopted the philosophy that the EQR provides a unique opportunity to not only address federal requirements for quality, access, and timeliness but to also assess compliance with State contract standards and address the unique nature of DMMA's DSHP and DSHP Plus programs. The EQR is approached as a collaborative assessment between the State, its EQRO, and its contracted MCOs focused on uncovering operational, procedural, and resource issues that may inhibit MCOs from fully achieving DMMA's stated goals and objectives. DMMA has declined to invoke the non-duplication clause at this time.

State Quality Performance Measure Program and Value-Based Payment Activities

The purpose of this initiative is to accelerate the implementation of reforms/innovation within Delaware's health care delivery system to migrate the system away from traditional FFS, volume-based care to a system that focuses on rewarding and incentivizing improved outcomes, value, quality improvement, and reduced expenditures. Delaware seeks to align the incentives of the Contractor, providers, and members through innovative value-based payment strategies.

DMMA has adopted a two-part strategy to address MCO performance as well as the performance of the MCO's contracted provider network. The following bullet points offer an overview of each part of the strategic approach.

1. **Quality Performance Measures (QPM):** DMMA will select measures that relate to any of the following domains: quality, access, utilization, LTSS, provider participation, spending, and/or member/provider satisfaction. For each measure selected, DMMA will establish a baseline of performance and the threshold for improvement. When improvement thresholds are not met, DMMA reserves the right to assess a financial penalty for each measure. For purposes of this initiative, it is expected that the Division will select measures that align with other quality initiatives, such as the Delaware Health Care Quality Benchmarks and CMS Adult and Child Core Set, but reserves the right to select other QPM that reflect the Division's goals and objectives and applicability to the Medicaid/CHIP population.

2. **Value-Based Purchasing Strategies (VBPS):** By contract each MCO is required to develop and implement provider payment/contracting strategies that promote value over volume and reach minimum payment threshold levels in each year of operation. The Division will impose a financial penalty for any year in which the minimum threshold level for VBPS, as defined in the contract, is not achieved for that year.

State Directed Payment Activities

DMMA has a number of State-directed payment arrangements that support the advancement of its goals and objectives to ensure access, improve population health outcomes, and ensure appropriate fiduciary responsibility of taxpayer resources. The State is requiring their MCOs to adopt a minimum fee schedule for Calendar Year (CY) 2021 through CY 2023 with the facilities listed below:

- NFs
- Hospice
- School-based Wellness Centers
- Behavioral Health Crisis Center Services
- Home Health
- Direct Service Professionals (DSP) Recruitment and Retention Payments for Agency Providers

3

Improvement Strategies and Monitoring Activities

DMMA has a well-established quality framework that leverages existing sets of standards and requirements from CMS, DMMA, and the National Committee for Quality Assurance (NCQA). These three fundamental sets of requirements and standards offer an opportunity to examine the various and unique facets of the DSHP/DSHP Plus managed care program and provide a roadmap for continuously improving the quality of its managed care delivery system.

The contracts between DMMA and each MCO provide for the following legal order of precedence:

- Federal Regulations
- Delaware State Plan
- DSHP 1115 Waiver and associated Special Terms and Conditions
- Delaware Administrative Code for Health and Human Services, specifically Medicaid and CHIP
- DMMA MSA with MCOs, which requires MCOs be NCQA accredited and incorporates the QS into the MSA by reference.

The State leverages its EQRO to address the federally mandated quality, access, and timeliness regulations as well as the more Delaware specific contract requirements. More information on EQRO activities can be found below.

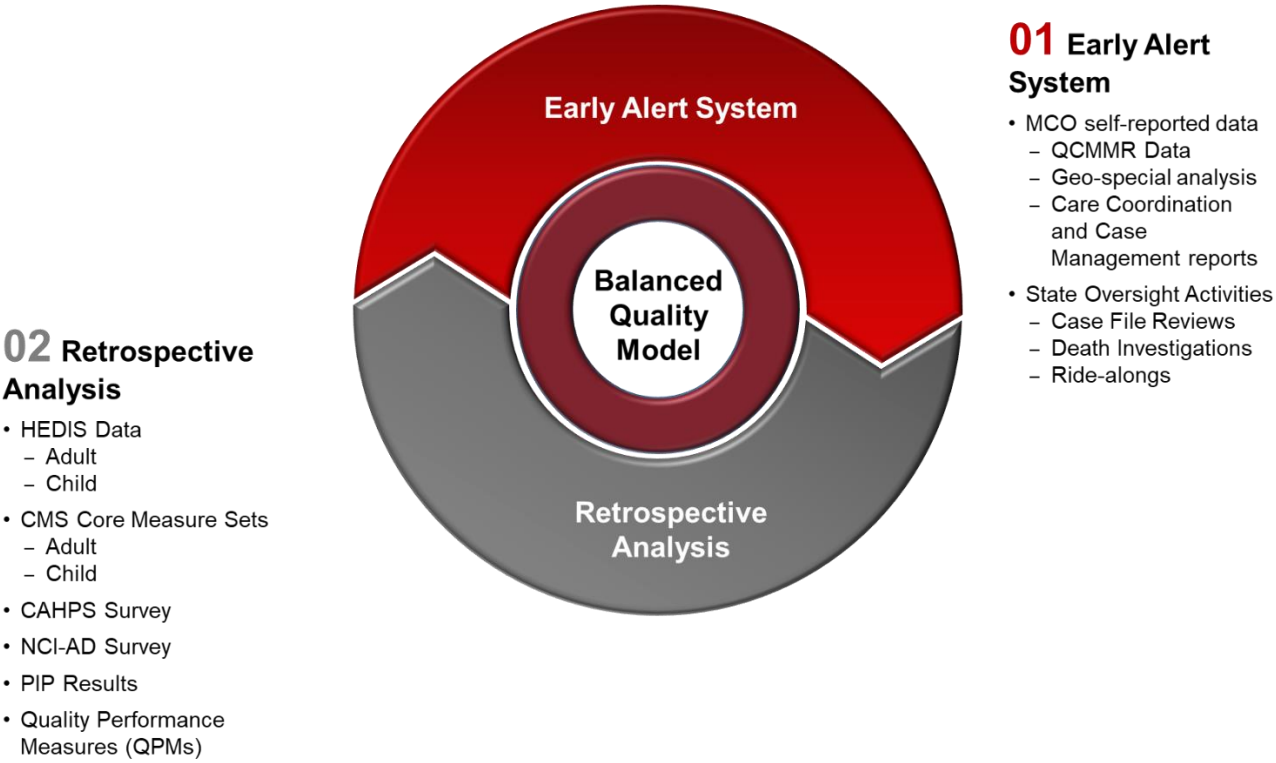
When considering DMMA's strategy for ongoing monitoring and continuous quality improvement it is important to understand that Delaware employs a Balanced Quality Model that consists of two components: 1) an Early Alert system and 2) a Retrospective Analysis.

- The Early Alert system consists of reviewing MCO self-reported data as well as real-time data collected as part of active monitoring and oversight activities such as conducting case file reviews or embedding DMMA's nurses and social workers with MCO case managers in joint visits to conduct face-to-face visits with members. The goal of all monitoring and oversight is to be able to quickly identify variances from expectations and take rapid action to investigate before issues become more significant.
- Retrospective Analysis of audit results and performance measurement looks backward to evaluate if appropriate care and services were received, assess compliance with federal and State

regulations and contract standards, and examines whether specific interventions have succeeded in meeting established goals and performance thresholds.

The following Diagram provides an overview of the Balanced Quality Model.

Figure 3.1 — Balanced Quality Model



The Balanced Quality Model allows DMMA to successfully monitor and oversee program operation while evaluating progress towards goals. This iterative model highlights how continuous quality improvement principles are engaged to drive improvement efforts.

Developing the Goals and Objectives

DMMA has identified clinical quality, access, and utilization measures for the DSHP and DSHP Plus programs using nationally recognized measure sets (e.g., Healthcare Effectiveness Data and Information Set [HEDIS®], CMS Adult and Child Core Set). DMMA includes a subset of HEDIS and CMS Core Sets (adult and child) to track and trend MCO performance and to establish benchmarks for improving the health of Medicaid and CHIP populations served through the managed care delivery system. The measures shared publicly on the DMMA Quality website at: https://dhss.delaware.gov/dhss/dmma/files are prioritized for continuous improvement and selected based on the needs of the populations served and the favorable health outcomes that result when

relevant clinical guidelines are adhered to by each MCO's provider network. Additionally, when selecting measures for the specific needs of the populations (e.g., DSHP and DSHP Plus), DMMA takes into consideration the availability and reliability of the data that are used to calculate the measures. The goals and objectives are described in Appendix B.

Quality Strategy Goals and Objectives

DMMA reviewed epidemiological data, evaluated MCO HEDIS results, and considered other Delaware specific health information such as progress towards Delaware's Healthy People 2020 goals in updating the QS goals and objectives.

Maternal and Infant Health

Delaware is ranked twelfth in the nation for rate of low-birth weight infants and eighteenth in the nation for preterm births. Preterm-related causes account for nearly 40% of infant deaths in the State.[1] Stark disparities continue to persist for both prematurity rate and infant mortality rates across the State. Black infants are 2–3 times more likely to die in the first year of life than white infants.[2]

Over the past five years, mental health has been the contributing factor for nearly 50% of maternal deaths in Delaware. Postpartum depression affects about one in nine postpartum individuals, with rates much higher among low-income mothers. People of color and those living in poverty are more likely to experience maternal mental health conditions but less likely to get help. Addressing these disparate outcomes is a key mission of the Delaware Healthy Mother Infant Consortium (DHMIC). DMMA collaborates closely with the DHMIC and shares the mission to improve the outcomes of maternal and infant health.

Goal 1: Improve Maternal and Infant Health	
Objective	
1.1:	Increase the timeliness of prenatal care
1.2:	Increase the rate of postpartum depression screening and follow-up
1.2a:	Increase postpartum depression screening
1.2b:	Increase the rate of follow-up after a positive postpartum depression screen
1.3:	Increase well-child visits in the first 30 months of life
1.4:	Decrease the rate of babies born with low-birth weight

[1] March of Dimes Peristats. *Prematurity Profile: A Profile of Prematurity in Delaware*. Available at: https://www.marchofdimes.org/peristats/reports/delaware/prematurity-profile (accessed December 12, 2022).
[2] Delaware.gov. *Delaware Vital Statistics, Executive Summary Report 2019*. Available at: https://dhss.delaware.gov/dhss/dph/hp/files/summary2019.pdf (accessed December 12, 2022).

Chronic Condition Management

There has been a significant increase in diabetes and heart disease in the past five years in Delaware residents. In 2020, more than one in 10 Delaware adults have reported being diagnosed with diabetes.[3] Between 2016 and 2020, Delaware has performed below the national median rate in the Adult Core Set Measure "Percentage of adults ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled". Individuals having these chronic conditions are at increased risk of having a heart attack or stroke or developing other diabetes-related diseases, such as kidney disease and retinopathy. Managing these chronic conditions can increase the life expectancy of these individuals. DMMA believes this is an area where managed care can help and has identified performance measures to help improve member's outcomes in this area.

Goal 2: Improve Chronic Condition Management
Objective
2.1: Improve diabetes care
2.1a: Increase hemoglobin A1c control for patients with diabetes
2.1b: Increase the use of and adherence to statin therapy
2.1b.1: Increase the use of statin therapy
2.1b.2: Increase statin adherence to 80%
2.2: Improve heart disease care
2.2a: Increase control of high blood pressure
2.2b: Improve the use of and adherence to statin therapy
2.2b.1: Increase the use of statin therapy
2.2b.2: Increase statin adherence to 80%

Reduction of Communicable Diseases

COVID-19 has changed our sense of the dangers of infectious diseases for generations to come. However, even as the world's attention was directed at one communicable disease, we lost ground on others. Although reported cases of sexually transmitted infections (STIs) dropped during the beginning months of the pandemic, they have since surged, with no signs of slowing. That example shows that reducing communicable diseases should be a persistent goal that requires steady attention. Prevention through immunization, appropriate treatment and antibiotic stewardship, and active infectious disease monitoring are key elements of a high quality health care system.

In 2020, Delaware ranked nineteenth in reported cases of Chlamydia, thirty-fifth in reported cases of Gonorrhea, twenty-fourth in reported cases of Primary and Secondary Syphilis, and thirtieth in

[3] Delaware.gov. *More than 1 in 10 Delaware Adults Report Having Diabetes in 2020*. Available at: https://www.dhss.delaware.gov/dhss/dph/dpc/diabetes02.html#:~:text=More%20than%201%20in%2010,Risk%20Factor%20Survey%20(BRFS) (accessed December 12, 2022).

reported cases of Congenital Syphilis. These rates illustrate a need to focus on reducing the spread of sexually transmitted diseases (STDs) in the State.

Goal 3: Reduce Communicable Diseases	
Objective	
3.1:	Increase Chlamydia screening
3.2:	Increase rate of adult influenza immunization
3.3:	Increase childhood immunizations
3.4:	Increase the frequency of appropriate treatment of upper respiratory infections
3.5:	Increase avoidance of antibiotic treatment for acute bronchitis/bronchiolitis
3.6:	Reduce HIV disease progression

Behavioral Health Condition Identification and Management

Depression is the leading cause of ill health and disability worldwide. According to the latest estimates from World Health Organization (WHO), more than 300 million people are now living with depression, an increase of more than 18% between 2005 and 2015. Lack of support for people with mental disorders, coupled with a fear of stigma, prevent many from accessing the treatment they need to live healthy, productive lives.[4] Data collected in the 2018–2019 National Survey on Drug Use and Health (NSDUH) showed the percentage of Delawareans ages 12–18 reporting a major depressive episode in the past year was 15.5% and 8.5% for adults ages 19 and older. This same report showed that 5.2% of adults in Delaware had serious thoughts of suicide in the past year.[5] Because of statistics like these, DMMA is making depression screening a key focus.

In 2020, Delaware reported 436 drug overdose deaths for an age-adjusted rate of 46.9 per 100,000 people. This represents a 157% increase from 2011.[6] As of November 1, 2022, Delaware Medicaid claims data lists buprenorphine-naloxone the ninth most prescribed medication among adults aged 19 and older. In 2020, 56.7% of Delawareans (age 18 and older) receiving Medicaid benefits reported initiating or engaging in alcohol and other drug (AOD) treatment.[7] As a result of these statistics, DMMA is pushing for increased effort in the areas of medication management, follow-up after emergency department visit, and/or hospitalization for mental illness as well as other areas in behavioral health identification and management.

[4] World Health Organization. (2017) GENEVA, *Depression: let's talk" says WHO, as depression tops list of causes of ill health*. Available at: https://www.who.int/news/item/30-03-2017--depression-let-s-talk-says-who-as-depression-tops-list-of-causes-of-ill-health (accessed December 12, 2022).
[5] Kaiser Family Foundation. *Mental Health in Delaware*. Available at: https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/delaware (accessed December 12, 2022).
[6] Delware.gov, My Healthy Community. *Drug Overdose Deaths*. Available at: https://myhealthycommunity.dhss.delaware.gov/locations/state/topics/drug-overdose-deaths (accessed December 12, 2022).
[7] Medicaid.gov. *Medicaid & CHIP in Delaware*. Available at: https://www.medicaid.gov/state-overviews/stateprofile.html?state=delaware (accessed December 12, 2022).

Goal 4: Improve Behavioral Health Condition Identification and Management	
Objective	
4.1:	Increase follow-up care for children prescribed ADHD medication
4.1a:	Increase follow-up care for children initially prescribed ADHD medication
4.1b:	Increase follow-up care for children prescribed ADHD medication on an ongoing basis
4.2:	Increase rate of depression screening and follow-up for adolescents and adults
4.2a:	Increase rate of depression screening for adolescents and adults
4.2b:	Increase rate of follow-up for adolescents and adults after a positive depression screen
4.3:	Increase rate of initiation and engagement of AOD abuse or dependence treatment
4.4:	Increase rate of follow-up after hospitalization for mental illness
4.5:	Increase rate of follow-up after emergency department visit for mental illness

Member Care Experience

Member perspective provides important information about how a Medicaid program is working to improve member health, access to services, and the quality of care delivered by providers. DMMA requires its MCOs to conduct a member satisfaction survey at least annually. CAHPS, a nationally recognized and standardized instrument is used to collect member satisfaction data. Delaware continues to perform above the National Median rates on both adult and pediatric CAHPS measures.

DMMA recognizes the need for an independent assessment of HCBS as well as all services provided under MLTSS. DMMA, in partnership with ADvancing States and Human Services Research Institute, implemented the NCI-AD Adult Consumer Survey in Delaware. Delaware uses data from the survey to strengthen MLTSS policy, inform quality assurance activities, evaluate managed care performance and compliance, and improve the quality of life of MLTSS participants. Delaware will continue to ensure that its members receive the highest level of care while ensuring care is member-centered.

Goal 5: Improve Member Experience of Care	
Objective	
5.1:	Improve CAHPS composite measures
5.1a:	Increase member ability of getting needed care
5.1a.1:	Increase adult members' ability of getting needed care
5.1a.2:	Increase pediatric members' ability of getting needed care
5.1b:	Increase member ability of getting needed care
5.1b.1:	Increase adult members' ability of getting care quickly
5.1b.2:	Increase pediatric members' ability of getting care quickly
5.1c:	Increase members' rating on health plan customer services
5.1c.1:	Increase adult members' rating on health plan customer services
5.1c.2:	Increase pediatric members' rating on health plan customer services
5.1d:	Increase members' rating of health plan
5.1d.1:	Increase adult members' rating of health plan
5.1d.2:	Increase pediatric members' rating of health plan

Establishing Performance Thresholds and Expectations

DMMA has established the HEDIS 75th (25th for inverse measures) percentile as the expected performance threshold. All rates that do not currently meet the expected performance requirement are expected to increase by 10% relative improvement each year. These expectations for performance do not carry specified potential financial penalties as those described in the State Quality Performance Measure Program and Value-Based Payment Activities section above. The thresholds for the QPMs have been set specifically for each of those measures. If a measure has achieved the 75th percentile, DMMA has established a stretch goal of the 90th (10th for inverse measures) percentile towards which the MCOs should continue to drive improvement.

As noted above, member experience data is collected via the CAHPS survey. DMMA has established the Medicaid 75th percentile for adult and children surveys as the minimum threshold for performance.

DSHP Plus Program

Performance measures in the QS specific to DSHP Plus program, were initially established based on certain Section 1915(c) waiver assurances and sub-assurances, including administrative authority, level of care, qualified providers, service plan, and participant safeguards. The tables below reflect these core domains and performance measures and how DMMA monitors each under the 1115 waiver authority to ensure prompt remediation of individual findings and promote system improvements in the managed LTSS delivery system. Performance measures pertaining to the DSHP Plus program will be established based on results from the baseline assessment and are established with the stretch goal of 90%. Results that fall below the 75% threshold will require a CAP.

Goal 1: DSHP Plus members have a level of care determination indicating the need for services placement, prior to enrollment in DSHP Plus LTSS and receipt of Medicaid-reimbursed services.		
Domain	**Performance Measure**	**Measurement Method**
Level of Care	Number and percent of members who had an approved PAE prior to enrollment in the DSHP Plus LTSS program and receipt of Medicaid-reimbursed HCBS.	**Data Source**: Eligibility Unit report **Sampling Approach**: Not Applicable **Frequency**: Annually **Responsibility**: DMMA Eligibility Unit is responsible for production of the report. **Remediation**: DMMA Eligibility Unit is responsible for remediation of individual findings.

Goal 2: DSHP Plus HCBS providers meet minimum qualifications established by the State prior to enrollment in DSHP Plus and delivery of HCBS.		
Domain	**Performance Measure**	**Measurement Method**
Qualified Providers	Number and percent of DSHP Plus HCBS providers (licensed and unlicensed) reviewed, for whom the MCO provides documentation that the provider meets minimum qualifications established by the State and were credentialed by the MCO prior to enrollment into the DSHP Plus program and delivery of HCBS.	**Data Source**: Provider credentialing file record review **Sampling Approach**: NCQA 8/30 methodology, with an initial pull of 10 files rather than only eight files. **Frequency**: Annually **Responsibility**: The EQRO, on behalf of DMMA is responsible for provider file reviews. **Remediation:** MCOs are responsible for remediation of individual findings with review/validation by DMMA**.**

Goal 3: DSHP Plus LTSS members are offered a choice between institutional (NF) services and HCBS.		
Domain	**Performance Measure**	**Measurement Method**
Service Plan	Number and percent of DSHP Plus LTSS files reviewed with documentation of information provided that specifies choice were offered between institutional settings and HCBS.	**Data Source:** Choice form documentation which is part of the application process and included in the eligibility documentation. **Sampling Approach**: Not Applicable **Frequency:** Annually **Responsibility:** DMMA Eligibility Unit is responsible for production of the report. **Remediation:** DMMA Eligibility Unit is responsible for remediation of individual findings.

Goal 4: DSHP Plus LTSS members who select HCBS are offered a choice between HCBS service providers.		
Domain	**Performance Measure**	**Measurement Method**
Service Plan	Number and percent of DSHP Plus LTSS member files reviewed indicating choice was offered between HCBS providers.	**Data Source:** Member record review **Sampling Approach**: NCQA 8/30 methodology, with an initial pull of 10 files rather than only eight files. **Frequency:** Annually **Responsibility**: The EQRO, on behalf of DMMA is responsible for provider file reviews. **Remediation:** MCOs are responsible for remediation of individual findings with review/validation by DMMA**.**

Goal 5: Plans of care are reviewed and updated at least annually.		
Domain	**Performance Measure**	**Measurement Method**
Service Plan	Number and percent of DSHP Plus LTSS member files reviewed in which the plan of care was reviewed and updated prior to the member's annual review date.	**Data Source:** Member record review **Sampling Approach**: NCQA 8/30 methodology, with an initial pull of 10 files rather than only eight files. **Frequency:** Annually **Responsibility**: The EQRO, on behalf of DMMA is responsible for provider file reviews. **Remediation:** MCOs are responsible for remediation of individual findings with review/validation by DMMA.

Goal 6: Plans of care reflect member goals, needs, and preferences.		
Domain	**Performance Measure**	**Measurement Method**
Service Plan	Number and percent of DSHP Plus LTSS member files reviewed in which the plan of care clearly identified the member's goals, needs, and preferences and include services and supports that are consistent with the member's goals, needs, and preferences.	**Data Source:** Member record review **Sampling Approach**: NCQA 8/30 methodology, with an initial pull of 10 files rather than only eight files. **Frequency:** Annually **Responsibility**: The EQRO, on behalf of DMMA is responsible for provider file reviews. **Remediation:** MCOs are responsible for remediation of individual findings with review/validation by DMMA.

Goal 7: Services are delivered in accordance with the plan of care including type, scope, amount, duration, and frequency specified in the plan of care.		
Domain	**Performance Measure**	**Measurement Method**
Service Plan	Number and percent of DSHP Plus LTSS member files reviewed in which the services have been delivered in accordance with the plan of care.	**Data Source:** Member record review **Sampling Approach**: NCQA 8/30 methodology, with an initial pull of 10 files rather than only eight files. **Frequency:** Annually **Responsibility**: The EQRO, on behalf of DMMA is responsible for provider file reviews. **Remediation:** MCOs are responsible for remediation of individual findings with review/validation by DMMA.

Goal 8: DSHP Plus LTSS members receive education/information at least annually about how to identify and report instances of abuse, neglect, and exploitation.		
Domain	**Performance Measure**	**Measurement Method**
Participant Safeguards	Number and percent of DSHP Plus LTSS member files reviewed which document that the member received education/information at least annually about how to identify and report instances of abuse, neglect, and exploitation.	**Data Source:** Member record review **Sampling Approach**: NCQA 8/30 methodology, with an initial pull of 10 files rather than only eight files. **Frequency:** Annually **Responsibility**: The EQRO, on behalf of DMMA is responsible for provider file reviews. **Remediation:** MCOs are responsible for remediation of individual findings with review/validation by DMMA**.**

Goal 9: Members with identified critical incidents have a plan to prevent similar incidents to the extent possible.		
Domain	**Performance Measure**	**Measurement Method**
Participant Safeguards	Number and percent of DSHP Plus LTSS files with a critical incident that demonstrate a prevention plan is in place.	**Data Source:** Critical Incident Database and member record review **Sampling Approach**: Not Applicable **Frequency:** Quarterly **Responsibility**: DMMA is responsible for the quarterly review and analysis of critical incident data, submitted from any source and associated trends. This includes a review of files associated with members with reported critical incidents to identify that a prevention plan is in place. **Remediation:** MCOs are responsible for remediation of individual findings with review/validation by DMMA

Goal 10: DSHP Plus LTSS members are free from use of unauthorized restrictive interventions.		
Domain	**Performance Measure**	**Measurement Method**
Participant Safeguards	Number of unauthorized restrictive interventions/number of DSHP Plus HCBS LTSS population.	**Data Source:** Critical Incident Database **Sampling Approach**: Not Applicable **Frequency:** Quarterly **Responsibility**: DMMA is responsible for the quarterly review and analysis of critical incident data and associated trends to identify incidents with unauthorized restrictive interventions. **Remediation:** MCOs are responsible for remediation of individual findings with review/validation by DMMA.

Goal 11: DSHP Plus LTSS members receiving HCBS services have a back-up plan in place.		
Domain	**Performance Measure**	**Measurement Method**
Participant Safeguards	Number and percent of DSHP Plus HCBS files reviewed for whom there was a back-up plan in place in the event providers do not show up.	**Data Source:** Member record review **Sampling Approach**: NCQA 8/30 methodology, with an initial pull of 10 files rather than only eight files. **Frequency:** Annually **Responsibility**: The EQRO, on behalf of DMMA is responsible for provider file reviews. **Remediation:** MCOs are responsible for remediation of individual findings with review/validation by DMMA.

PROMISE Program

Performance measures in the QS specific to the PROMISE program were initially established based on certain Section 1915(i) waiver assurances and sub-assurances, including administrative authority, level of care, qualified providers, service plan, and participant safeguards. The tables below reflect these core domains and performance measures and how DMMA monitors each under the 1115 waiver authority to ensure prompt remediation of individual findings and promote system improvements in the behavioral health delivery system. Performance measures pertaining to the PROMISE program will be established based on results from the baseline assessment and are established with the stretch goal of 90%. Results that fall below the 75% threshold will require a CAP.

Goal 1: All members receive an evaluation using needs-based criteria, for whom there is reasonable indication that services may be needed.		
Domain	**Performance Measure**	**Measurement Method**
Needs Based Criteria	Number and percent of individuals who were referred to PROMISE for evaluation that demonstrate needs-based criteria was used to determine appropriateness for enrollment.	**Data Source**: Brief screen criteria check list **Sampling Approach**: Random sampling of program criteria **Frequency**: Quarterly in the beginning and then move to annually, if reaching 100% compliance **Responsibility**: DSAMH is responsible for annual review, analysis of data, and reporting to DMMA. **Remediation:** DSAMH is responsible for the remediation of individual findings.

Goal 2: All PROMISE enrollees receive a full assessment annually.		
Domain	**Performance Measure**	**Measurement Method**
Needs Based Criteria	Number and percent of PROMISE enrollees who received an evaluation 60 days in advance of expiration date.	**Data Source**: Supervisor case review list **Sampling Approach**: Not applicable (case reviews completed on all PROMISE enrollees) **Frequency**: Annually **Responsibility**: DSAMH is responsible for annual review, analysis of data, and reporting to DMMA. **Remediation:** DSAMH is responsible for the remediation of individual findings.

Goal 3: Compliance with utilization of approved processes and instruments to determine initial PROMISE level of need.		
Domain	**Performance Measure**	**Measurement Method**
Needs Based Criteria	Number and percent of PROMISE care management files that evidence correct forms and processes were used to determine PROMISE level of need.	**Data Source**: Beneficiary file review **Sampling Approach**: Random sampling **Frequency**: Quarterly **Responsibility**: DSAMH is responsible for quarterly review, analysis of data, and reporting to DMMA. **Remediation:** DSAMH is responsible for the remediation of individual findings.

Goal 4: All PROMISE providers meet minimum qualifications established by the State prior to enrollment in the program and delivery of waiver service.		
Domain	**Performance Measure**	**Measurement Method**
Qualified Providers	Number and percent of PROMISE providers (licensed and unlicensed) reviewed for whom there is documentation that the provider meets minimum qualifications established by the State and met minimum participation criteria prior to delivering waiver services.	**Data Source**: Provider record review and beneficiary interviews **Sampling Approach**: Random sampling **Frequency**: Annually **Responsibility**: DSAMH is responsible for annual review, analysis of data, and reporting to DMMA. **Remediation:** DSAMH is responsible for remediation of individual findings with review/validation by DMMA.

Goal 5: All PROMISE members are offered a choice between service providers.		
Domain	**Performance Measure**	**Measurement Method**
Service Plan	Number and percent of PROMISE member files reviewed that indicate choice was offered for PROMISE service providers.	**Data Source**: Beneficiary record review; Consent form **Sampling Approach**: Random sampling. **Frequency**: Annually **Responsibility**: DSAMH is responsible for annual review, analysis of data, and reporting to DMMA. **Remediation:** DSAMH is responsible for remediation of individual findings with review/validation by DMMA.

Goal 6: Service plans are updated/revised at least annually or when warranted.		
Domain	**Performance Measure**	**Measurement Method**
Service Plan	Number and percent of PROMISE member files reviewed in which the service plan is updated annually or when changes based on needs are warranted.	**Data Source:** Beneficiary record review **Sampling Approach**: Random sampling **Frequency:** Annually **Responsibility**: DSAMH is responsible for annual review, analysis of data, and reporting to DMMA. **Remediation:** DSAMH is responsible for remediation of individual findings with review/validation by DMMA.

Goal 7: Plans of care reflect member goals, needs, and preferences.		
Domain	**Performance Measure**	**Measurement Method**
Service Plan	Number and percent of PROMISE beneficiary files reviewed in which the plan of care clearly identified the member's goals, needs, and preferences and include services and supports that are consistent with the member's goals, needs, and preferences.	**Data Source:** Beneficiary record review **Sampling Approach**: Random sampling **Frequency:** Annually **Responsibility**: DSAMH is responsible for annual review, analysis of data, and reporting to DMMA. **Remediation:** DSAMH is responsible for remediation of individual findings with review/validation by DMMA.

Goal 8: Services are delivered in accordance with the plan of care, including type, scope, amount, duration, and frequency specified in the plan of care.		
Domain	**Performance Measure**	**Measurement Method**
Service Plan	Number and percent of PROMISE member files reviewed in which the service plan clearly identifies the member's goals, needs, and preferences and files indicate services and supports are delivered consistent with the member's plan of care.	**Data Source:** Beneficiary record review **Sampling Approach**: Random sampling **Frequency:** Annually **Responsibility**: DSAMH is responsible for annual review, analysis of data, and reporting to DMMA. **Remediation:** DSAMH is responsible for remediation of individual findings with review/validation by DMMA.

Goal 9: PROMISE members receive education/information at least annually about how to identify and report instances of abuse, neglect, and exploitation.		
Domain	**Performance Measure**	**Measurement Method**
Participant Safeguards	Number and percent of PROMISE member files reviewed which document that the member received education/information at least annually about how to identify and report instances of abuse, neglect, and exploitation.	**Data Source:** Annual assessments completed with assessment item (completed reflecting education/information has been discussed) **Sampling Approach:** Random sampling **Frequency:** Annually **Responsibility**: DSAMH is responsible for annual review, analysis of data, and reporting to DMMA. **Remediation:** DSAMH is responsible for remediation of individual findings with review/validation by DMMA.

Goal 10: PROMISE members with identified critical incidents have a plan to prevent similar incidents to the extent possible.		
Domain	**Performance Measure**	**Measurement Method**
Participant Safeguards	Number and percent of PROMISE member files with a critical incident that demonstrates a prevention plan is in place.	**Data Source:** Risk Management Tracking Tool: Critical incident notifications received by the Risk Management team, with reviews of each incident internally and discussions with providers for the development of a prevention plan, **Sampling Approach**: Not Applicable, 100% review of critical incidents **Frequency:** Ongoing, reported quarterly **Responsibility**: DSAMH is responsible for quarterly review, analysis of data, and reporting to DMMA. **Remediation:** DSAMH is responsible for remediation of individual findings, including discussions with providers, and monitoring provider's development of prevention plan and CAP. DSAMH monitors with review/validation by DMMA.

Goal 11: PROMISE members are free from unauthorized use of restrictive interventions.		
Domain	**Performance Measure**	**Measurement Method**
Participant Safeguards	Number and percent of PROMISE member restrictive intervention occurrences with an unauthorized restrictive intervention.	**Data Source**: Risk Management Tracking Tool: Risk Management team receives critical incident notifications from: 1) Client; 2) Clinical providers; 3) PROMISE staff; and 4) Audit team reviews **Sampling Approach**: 100% review by DSAMH Policy and Compliance team and PROMISE staff **Frequency**: Per occurrence reviews and quarterly reporting **Responsibility**: DSAMH is responsible for quarterly review, analysis of data, and reporting to DMMA. **Remediation**: DSAMH is responsible for remediation of individual findings with review/validation by DMMA.

Goal 12: PROMISE members have a back-up plan in place.		
Domain	**Performance Measure**	**Measurement Method**
Participant Safeguards	Number of beneficiaries with a documented back-up plan.	**Data Source**: Beneficiary record review **Sampling Approach**: Random sample for file review **Frequency**: Quarterly. **Responsibility**: DSAMH is responsible for quarterly review, analysis of data, and reporting to DMMA. **Remediation:** DSAMH is responsible for remediation of individual findings with review/validation by DMMA.

MCO Reporting Requirements

DMMA has a robust set of reporting requirements for its contracted MCOs. An overview of the activities and processes used to support oversight and monitoring for the DSHP program include:

- Evaluation of results of EQR and State contract compliance audits, including the strengths, opportunities, and recommendations for improvement.
- Annual and interim review of HEDIS results.
- Results of each MCO's performance under the State's value-based performance strategies program.
- Review of the accuracy, timeliness, and completeness of contractually required reporting which includes but is not limited to:
  - Grievance and appeal logs.
  - Claims payment timeliness and encounter submission reports.
  - Utilization management timeliness of decision making and rates of service utilization reports.
  - Evaluation of each MCOs Quality Assessment and Performance Improvement program.
  - GeoAccess reports and network adequacy reports.
  - Timeliness of appointment reports.
  - SUD and behavioral health survey reports.
  - Provider Satisfaction survey report.
  - Trending reports for HCBS waiver assurance measures.

- Progress of PIPs.

In addition, DMMA requires its MCOs to report on the State developed Quality Care Management and Monitoring Report (QCMMR) reporting templates. DMMA has developed separate templates, one for the DSHP and CHIP combined populations and one for the DSHP Plus population. All applicable reports specify the DSHP Plus population (NF or HCBS) receiving LTSS services separately. These templates enable the MCOs to submit their clinical data monthly which is then used by DMMA to monitor quality, access, timeliness, and care management aspects of operations of the Medicaid contracted MCOs.

The periods for the mandatory reports due to the State are as follows unless otherwise agreed to by DMMA:

- Monthly reports: due to the State on the eighteenth day of the following month.
- Quarterly reports: due to the State on the eighteenth day of the month following the quarter close.
- Semi-Annual reports: due January 31 and July 31.
- Annual reports: due to the State on the thirtieth day of the month following the end of the calendar year.

Performance Improvement Projects

PIPs are used to assess and improve processes and as a result, improve efficiency, satisfaction, and health outcomes. They embody the continuous quality improvement dynamic. In accordance with 42 CFR §438.330(d) each MCO is required to have at a minimum, one clinical and one nonclinical PIP in progress at all times. As part of their overall quality program, each MCO is expected to consider using a PIP framework as they approach quality improvement across the organization. Therefore, each plan is likely to have multiple PIPs underway throughout each year.

All PIPs must be conducted in accordance with 42 CFR §438.330(d) and designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through monitoring, measurement, and intervention. PIPs must be intentionally designed and require objective quality indicators, rigorous analysis of barriers to success, implementation of meaningful interventions designed to address identified barriers, evaluation of effectiveness, and activities for increasing and, in the case of goal achievement, sustaining improvements.

The majority of PIPs conducted should reflect areas where the MCOs are not currently meeting stated performance goals (e.g., HEDIS measures not meeting the 75th percentile) or where the MCOs are not meeting operational or process related standards (e.g., 60% of health risk assessments completed within 60-days of new enrollment). DMMA, as well as CMS, reserves the right to mandate PIP topics.

Annually, as required by law, the EQRO validates selected PIPs at the direction of DMMA. The EQRO acts as an external body conducting an independent validation that the MCOs performance improvement results demonstrate validity and reliability. Validation activities will adhere to the CMS protocol.

DMMA Specific PIP Requirements

PIP Topic Selection

DMMA has selected the topic of opioid use disorder in pregnant and postpartum people as the focus of one of the MCOs' clinical improvement projects. DMMA has developed the focus of the project, provided rationale and background to support the selected PIP focus, and provided the PIP methodology.

The MCO will select the topic and focus of a nonclinical service-related PIP, in accordance with 42 CFR §438.330(d). The MCO will be responsible for developing the focus of the project, providing rationale and background to support the selected PIP focus, and constructing the PIP methodology.

The MCO must maintain a listing of all current PIPs. At a minimum, the PIP listing must include the PIP name, PIP objective, and PIP start date. The list must be submitted to DMMA, or its designee, upon request and PIP documentation made available for review. Annually the EQRO will work with DMMA to select the PIPs for validation. CMS and DMMA required PIP topic(s) will be validated annually.

PIP Documentation

All PIP documentation must be maintained in such a way that it can be provided to DMMA upon request within two business days. PIPs selected for validation must be submitted using NCQA's Quality Improvement Activity document template.

Each PIP must have an associated PIP plan and data analytics plan. The PIP plan acts as a project charter outlining the PIPs goals and objectives, team composition, meeting cadence, and milestones. Documentation of barrier analysis results and associated interventions, as well as the MCOs strategy for selecting interventions must be documented. The required data analytic plan must outline the resources and approach to data analysis, identify metrics for baseline and remeasurement, incorporate rapid-cycle process methodology of lead and lag measures, track measurement periods, and describe data sources.

At the beginning of every PIP project mandated by CMS or the State the MCO must submit its PIP and Data Analytic plan to DMMA for review and approval. At DMMA's request, the EQRO may provide technical assistance to the MCO to ensure these two key PIP program documents reflect a sound methodological approach and establish a foundation likely to result in performance improvement.

Prioritization of Resources

DMMA recognizes that resources are not unlimited and therefore expects that its contracted MCOs responsibly allocate resources to the topic areas and performance measures reflective of DMMA's QS goals and objectives. Through alignment of DMMA's QS and each MCOs Quality Assessment Performance Improvement program resources can be more efficiently allocated and catalyze synergies to drive improvements. Prioritization should be given to the objective measures that underlie DMMA's QS goals and to DMMA designated QPMs. Should prioritized measures meet established benchmarks and demonstrate consistency, MCOs should refocus attention on measures that are falling below established thresholds.

All MCOs shall use a rapid-cycle process improvement approach and allocate resources to ensure timely action and reaction to lead and lag measure results such that performance improvement does not languish. Measurement and remeasurement are necessary to assess impacts of interventions and cannot wait a year to determine if selected interventions are successful. Additionally, barrier analysis must be robust to ensure targeted interventions have the highest potential to reach improvement targets.

True performance improvement will occur only when the root cause(s) of poor performance is identified, and interventions are placed to address the identified issues. Therefore, DMMA expects that the refocusing of MCO resources should include consideration of robust interventions designed to drive meaningful improvements. These interventions are expected to actively engage the PIP's population of interest and not reflect passive outreach such as mailers and postcards as the primary mechanism for driving improvement.

PIP Workgroups

DMMA expects MCOs to form workgroups to address the various PIP activities. With prior notice, DMMA or its designee may participate in MCO workgroup meetings to discuss barrier analysis and intervention selection. When appropriate, technical assistance will be provided to ensure that identified barriers and selected interventions have a high probability of resulting in performance improvement.

Notes of workgroup meetings must be maintained as part of PIP documentation. DMMA may at times ask for contracted MCOs to present PIP workgroup results to the QII and expects that the MCO internal Quality Improvement committee members are informed about PIP activities and results.

Member and Provider Experience

Voice of the customer data is a critical source of information that can provide deep insights into the DSHP and DSHP Plus programs including information about benefits, network adequacy, quality of provider communications, and ease of working with contracted MCOs. DMMA requires MCOs to conduct the CAHPS survey annually. CAHPS gathers information from both adult and child populations; CAHPS composite measures can be benchmarked to other Medicaid plans regionally and nationally.

DMMA also assesses member experience in the DSHP Plus enhanced benefit program by fielding the NCI-AD survey. Similar to the CAHPS survey the NCI-AD is benchmarked nationally and results are used to drive program improvements.

DMMA views the provider community as an integral partner and expects contracted MCOs to deploy strategies to recruit and retain a robust provider network sufficient to meet the unique demographic and clinical needs of its membership. DMMA does not require a standardized provider survey. MCOs are given latitude to assess provider experience. DMMA reserves the right to develop a set of core provider survey questions, on which MCOs can build. These core questions would allow DMMA to compare results across MCOs and identify opportunities that may impact network adequacy and capacity.

Conducting Annual External Quality Review

Collaboration with the EQRO and conducting EQR activities, mandatory and optional, is a core feature of Delaware's Medicaid managed care quality initiative. DMMA is required to provide for four mandated EQR activities for the managed care MCOs, as follows:

- Compliance Review and Information Systems Capabilities Assessment (ISCA).
- Validate a sample of each MCO's performance measures annually.
- Validate two or more PIPs for each MCO annually.
- Validate network adequacy, within a year of CMS publishing the EQR protocol.

These and other Medicaid managed care quality assessment activities are conducted for DMMA by the contracted EQRO. Consistent with CMS guidance, the EQRO conducts these mandated activities using CMS published protocols.

The EQRO provides analysis and evaluation of aggregated information on quality, timeliness, and access to health care services furnished by the MCO to Delaware's Medicaid members.

Delaware's EQR process currently includes mandatory activities and optional activities specified in 42 CFR 438.358. Delaware's EQR evaluation is used to produce the federally required annual technical report that aggregates and analyzes data to draw conclusions about the timeliness, accessibility, and quality of services furnished by the two contracted MCOs, which includes an assessment of the plans' performance with respect to the three aforementioned areas; comparative information about plans when appropriate; recommendations for improving the quality of health care furnished to the State Medicaid enrollees, and an assessment of the degree to which each plan has effectively addressed the prior years' EQR recommendations. Results from all EQR activities are used to monitor plans' compliance with State and federal regulations, to evaluate the effectiveness and impact of the QS and to enhance the administration of the Medicaid managed care program.

Identifying, Analyzing, and Reducing Health Disparities

Population Level

At the population level, DMMA is working to improve its ability to identify at-risk populations. Upon identification, DMMA collaborates with stakeholders across the broader State health ecosystem to identify initiatives to reduce health disparities in the Medicaid population including:

- Analyzing data to characterize inequities in health and health care, their geographic distribution (e.g., neighborhood, rural, inner city), and their association with social determinants of health; and identify high-priority target areas.
- Promoting equitable access to quality health care and providers.
- Empowering communities to promote health equity.
- Influencing health, health care, and public policy in order to promote health equity ("health equity in all policies").
- Enhancing the capacity of public health and our partners to promote health equity.

MCO Level

At the individual Medicaid or CHIP enrollee level, DMMA is working with its MCOs to develop methods to identify disparities in health care access, service provision, satisfaction, and outcomes including:

- Obtaining data on member demographics (e.g., member-identified race, ethnicity, disability, gender identity, sexual orientation, geography, and preferred language) to stratify by high-risk disparate populations.
- Engaging local organizations to develop or provide cultural competency training and collaboration on initiatives to increase and measure the effectiveness of culturally competent service delivery.
- Performing internal analysis of performance measure data, to identify whether any subset of the population is negatively or positively impacted.
- Developing a Cultural Competence and Health Equity Plan that addresses how the MCO intends to better meet the needs of their Medicaid members to advance health equity and reduce health care disparities.

As at the population level, DMMA collaborates with many system stakeholders but works directly with its contacted MCOs across the Medicaid ecosystem on its many initiatives to reduce health disparities, build partnerships, and create synergies to close gaps and improve the health and wellbeing of enrollees.

To comply with the regulatory requirement for State procedures for race, ethnicity, and primary language spoken (CFR 438.206–438.210), DMMA requires the MCOs to participate in Delaware's efforts to promote the delivery of service in a culturally competent manner to all recipients, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCOs are required to ensure that appropriate foreign language versions of all member materials are developed and available to members, and to provide interpreter services for members whose primary language is not English. DMMA reviews and approves all member materials as part of a readiness review for all new MCOs entering the Delaware Medicaid managed care program. Delaware's EQRO also conducts a comprehensive review of each MCO's cultural competency program to ensure that each MCO meets these requirements.

Using Performance Incentive Awards and Intermediate Sanctions to Drive Improvement

DMMA purposefully builds a collaborative environment with and between its MCOs. However, DMMA recognizes the importance of having a managed care delivery system that is firmly accountable to provide accessible, timely, and quality focused health care. The MSA, (a.k.a., the Contract) is designed to delineate the regulatory and State-specific performance expectations. Even further, it is DMMA's responsibility to monitor each MCO's compliance with the contract and to respond promptly and effectively if an MCO fails to meet certain standards.

DMMA Intermediate Sanctions Policy

DMMA requests CAPs from the MCOs in cases for which compliance monitoring and/or deliverable reviews do not demonstrate adequate performance. For instance, the EQR process requires a CAP for all noted EQR variances, or when reports are consistently submitted incomplete or incorrect.

As a matter of content, all CAPs clearly state the finding, objectives, the individual, and/or department responsible, and the periods allowed to remedy subpar performance. MCO CAPs may include actions such as the following:

- Education by oral or written contact or through required training.
- Recertification for procedures or services that require certification.
- Required submission of a CAP, with subsequent monitoring or re-auditing to confirm compliance with the CAP.
- A prospective or retrospective analysis of patterns or trends.
- In-service training or education.
- Modification, suspension, restriction, or termination.

- Intensified review.
- Changes to administrative policies and procedures.

Should the CAP process not produce desired results, or when performance or noncompliance with the provision of covered, medically necessary benefits and services become an impediment to meeting the health care needs of recipients and/or the ability of providers to adequately attend to those health care needs, DMMA's intermediate sanction policy may be triggered. Intermediate sanctions may be imposed if the MCO:

- Fails substantially to provide medically necessary services that the MCO is required to provide under law or under its contract with the State, to a member covered under the contract.
- Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
- Acts to discriminate among members on the basis of their health status or need for health care services, including termination of enrollment or refusal to re-enroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.
- Misrepresents or falsifies information that it furnishes to CMS or to the State, a member, potential member, or health care provider.
- Fails to comply with the requirements for physician incentive plans, as set forth under Section 1903(m)(2)(A)(x) of the Social Security Act.
- Violates any requirement of the MSA.

The State may simultaneously impose intermediate sanctions on the Contractor along with a request for the development and implementation of a CAP. In addition to intermediate sanctions, there are provisions in the Contract that address sanctions if an MCO repeatedly fails to meet certain standards and finally, provisions that give DMMA the authority to terminate the contract.

Where DMMA determines that the MCO has demonstrated a pattern of failure to submit required data or meet data quality benchmarks on any contractually required metric or measure, the Division will send a notice of noncompliance. DMMA reserves the right to apply penalties for noncompliance.

Additionally, bearing the weight of fiscal responsibility to be good stewards of State tax dollars, DMMA stands prepared to impose sanctions quickly, carefully, appropriately, and when necessary and in the best interest of eligible members, should any circumstances arise.

Intermediate sanctions include:

- Civil money penalties, including federally required limits.
- The appointment of temporary management.
- Permitting individuals enrolled with the MCO to terminate enrollment without cause, and notifying such individuals of such right to terminate enrollment.
- Suspension or default of all enrollment of individuals.
- Suspension of premium payment to the MCO.
- Actual damages incurred by the State and/or members resulting from the MCO's noncompliance.
- Damages in an amount equal to the costs of obtaining alternative benefits for a member in the event of the MCO's noncompliance in providing covered services.
- Additional sanctions permitted under federal or State law.

Appendix A

Acronym Definitions

Acronym	Definition
ACA	Affordable Care Act
ADHD	Attention Deficit Hyperactivity Disorder
AOD	Alcohol and Other Drug
BBA	Balanced Budget Act of 1997
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CDC	Center for Disease Control
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CLAS	Cultural and Linguistically Appropriate Services
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DDDS	Division of Developmental Disabilities Services
DHCP	Delaware Healthy Children Program
DHCQ	Division of Health Care Quality
DHMIC	Delaware Healthy Mother Infant Consortium
DHSS	State of Delaware Health and Social Services
DMES	Delaware Medicaid Enterprise System
DMMA	State of Delaware Division of Medicaid and Medical Assistance
DPBHS	Division of Prevention and Behavioral Health Services
DPH	Division of Public Health
DSAAPD	Delaware Division of Services for Aging and Adults with Physical Disabilities
DSAMH	Division of Substance Abuse and Mental Health
DSHP	Diamond State Health Plan
DSHP Plus	Diamond State Health Plan Plus
DSP	Direct Service Professionals
EQR	External Quality Review
EQRO	External Quality Review Organization
FFS	Fee-for-Service

Acronym	Definition
FPL	Federal Poverty Level
HBM	Health Benefit Manager
HCBS	Home- and Community-Based Services
HEDIS®	Healthcare Effectiveness Data and Information Set
HIV/AIDS	Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome
ICF/IID	Intermediate Care Facilities for Individuals with Intellectual Disabilities
ICF/MR	Intermediate Care Facilities for the Mentally Retarded
IEP	Individualized Education Plan
IMD	Institution for Mental Diseases
ISCA	Information Systems Capabilities Assessment
MCAC	Medical Care Advisory Committee
MCO	Managed Care Organization
MLTSS	Managed Long-Term Services and Supports
MMIS	Medicaid Management Information System
MSA	Master Services Agreement
NCI-AD	National Core Indicators–Aging and Disabilities
NCQA	National Committee for Quality Assurance
NF	Nursing Facility
NSDUH	National Survey on Drug Use and Health
PAE	Pre-Admission Evaluation
PCP	Primary Care Provider
PIP	Performance Improvement Project
PNDMP	Provider Network Development and Management Plan
PROMISE	Promoting Optimal Mental Health for Individuals through Supports and Empowerment
QCMMR	Quality Care Management and Monitoring Report
QII	Quality Improvement Initiatives
QMS	Quality Management Strategy
QPM	Quality Performance Measure
QS	Quality Strategy
SHCN	Special Health Care Needs
SPMI	Severe and Persistent Mental Illness
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SUD	Substance Use Disorder

Acronym	Definition
VBPS	Value-Based Purchasing Strategies
WHO	World Health Organization

Appendix B

Quality Strategy Goals and Objectives

Goal 1:	Improve maternal and infant health	
		Measure Steward
Objective 1.1:	Increase the timeliness of prenatal care • HEDIS: PPC — Timeliness of prenatal care	HEDIS PPC
Objective 1.2:	Increase the rate of postpartum depression screening and follow-up	
Objective 1.2a:	Increase postpartum depression screening • HEDIS: PDS-E — Postpartum depression screening and follow-up — Depression screening	HEDIS PDS-E
Objective 1.2b:	Increase the rate of follow-up after a positive postpartum depression screen • HEDIS: PDS-E — Postpartum depression screening and follow-up — Follow-up on positive screen	HEDIS PDS-E
Objective 1.3:	Increase well-child visits in the first 30 months of life • HEDIS: W30 — Well-child visits in the first 30 months of life	HEDIS W30
Objective 1.4:	Decrease the rate of babies born with low birth weight • CDC: LBW-CH — Live births weighing less than 2,500 grams	CDC LBW-CH

Goal 2:	Improve chronic condition management	
		Measure Steward
Objective 2.1:	Improve diabetes care	
Objective 2.1a:	Increase control of Hemoglobin A1c • NCQA: HBD-AD — Hemoglobin A1c control for patients with diabetes	NCQA HBD-AD
Objective 2.1b:	Increase the use of and adherence to statin therapy	
Objective 2.1b.1:	Increase the use of statin therapy • HEDIS: SPD — Statin therapy for patients with diabetes — Received statin therapy	HEDIS SPD
Objective 2.1b.2:	Increase statin adherence to 80% • HEDIS: SPD — Statin therapy for patients with diabetes — Statin adherence 80%	HEDIS SPD
Objective 2.2:	Improve heart disease care	
Objective 2.2a:	Increase control of high blood pressure • NCQA: CBP-AD — Controlling high blood pressure	NCQA CBP-AD
Objective 2.2b:	Improve the use of and adherence to statin therapy	
Objective 2.2b.1:	Increase the use of statin therapy • SPC — Statin therapy for patients with cardiovascular disease — Received statin therapy: Total	HEDIS SPC
Objective 2.2b.2:	Increase statin adherence to 80% • SPC — Statin therapy for patients with cardiovascular disease — Statin adherence 80%: Total	HEDIS SPC

Goal 3:	Reduce communicable diseases	
		Measure Steward
Objective 3.1:	Increase Chlamydia screening • NCQA: CHL-AD — Chlamydia screening in women ages 21 to 24	NCQA CHL-AD
Objective 3.2:	Increase the rate of adult influenza immunization • NCQA: FVA-AD — Flu vaccinations for adults ages 18–64	NCQA FVA-AD
Objective 3.3:	Increase the rate of childhood immunizations • NCQA: CIS-CH — Childhood immunization status	NCQA CIS-CH
Objective 3.4:	Increase the frequency of appropriate treatment of upper respiratory infections • HEDIS: URI — Appropriate treatment for upper respiratory infection	HEDIS URI
Objective 3.5:	Increase avoidance of antibiotic treatment for acute bronchitis/bronchiolitis • HEDIS: AAB — Avoidance of antibiotic treatment for acute bronchitis/bronchiolitis	HEDIS AAB
Objective 3.6:	Reduce HIV disease progression • HRSA HVL-AD — HIV viral load suppression	HRSA HVL-AD

Goal 4:	Improve behavioral health condition identification and management	
		Measure Steward
Objective 4.1:	Increase follow-up care for children prescribed ADHD medication	
Objective 4.1a:	Increase follow-up care for children initially prescribed ADHD medication • HEDIS: ADD — Follow-up care for children prescribed ADHD medication — Initiation phase	HEDIS ADD
Objective 4.1b:	Increase follow-up care for children prescribed ADHD medication on an ongoing basis • HEDIS: ADD — Follow-up care for children prescribed ADHD medication — Continuation and maintenance phase	HEDIS ADD
Objective 4.2:	Increase rate of depression screening and follow-up for adolescents and adults	
Objective 4.2a:	Increase rate of depression screening for adolescents and adults • HEDIS: DSF — Depression screening and follow-up for adolescents and adults — Depression screening (Total)	HEDIS DSF-E
Objective 4.2b:	Increase rate of follow-up for adolescents and adults after a positive depression screen • HEDIS: DSF — Depression screening and follow-up for adolescents and adults — Follow-up positive screen (Total)	HEDIS DSF-E
Objective 4.3:	Increase rate of initiation and engagement of AOD abuse or dependence treatment • NCQA: IET-AD — Initiation and engagement of AOD abuse or dependence treatment	NCQA IET-AD
Objective 4.4:	Increase rate of follow-up after hospitalization for mental illness • NCQA: FUH-AD — Follow-up after hospitalization for mental illness — Age 18 and older	NCQA FUH-AD
Objective 4.5:	Increase rate of follow-up after emergency department visit for mental illness • NCQA: FUM-AD — Follow-up after emergency department visit for mental illness — Age 18 and older	NCQA FUM-AD

Goal 5:	Improve member experience of care	
		Measure Steward
Objective 5.1:	Increase CAHPS composite measures	
Objective 5.1a:	Increase member ability of getting needed care	
Objective 5.1a.1:	Increase adult members' ability of getting needed care • HEDIS: CAHPS (Q #9, #20) — Getting needed care	HEDIS CAHPS
Objective 5.1a.2:	Increase pediatric members' ability of getting needed care • HEDIS: CAHPS (Q #9, #23) — Getting needed care	HEDIS CAHPS
Objective 5.1b:	Increase member ability of getting needed care	
Objective 5.1b.1:	Increase adult members' ability of getting care quickly • HEDIS: CAHPS (Q #4 & #6) — Getting care quickly	HEDIS CAHPS
Objective 5.1b.2:	Increase pediatric members' ability of getting care quickly • HEDIS: CAHPS (Q #4 & #6) — Getting care quickly	HEDIS CAHPS
Objective 5.1c:	Increase members' rating on health plan customer services	
Objective 5.1c.1:	Increase adult members' rating on health plan customer services • HEDIS: CAHPS (Q #24 & #25) — Health plan customer service	HEDIS CAHPS
Objective 5.1c.2:	Increase pediatric members' rating on health plan customer services • HEDIS: CAHPS (Q #27 & #28) — Health plan customer service	HEDIS CAHPS
Objective 5.1d:	Increase members' rating of health plan	
Objective 5.1d.1:	Increase adult members' rating of health plan • HEDIS: CAHPS (Q #28) — Enrollee's ratings	HEDIS CAHPS
Objective 5.1d.2:	Increase pediatric members' rating of health plan • HEDIS: CAHPS (Q #31) — Enrollee's ratings	HEDIS CAHPS

Appendix C

Quality Strategy Crosswalk

The following table lists the required and recommended elements for State QSs, per 42 CFR § 438.202(a) and corresponding sections in the Delaware QS and the DMMA/MCO contract which address each required and recommended elements.

SECTION I: Introduction — Managed Care Goals, Objectives, and Overview		
Regulatory Reference	**Description**	**Corresponding Document and Page Reference or Comment**
	Overview of the lead Medicaid agency and its partnerships and collaborations with the other State entities and should have high-level goals of 1115 waiver as applicable.	Pages 1–2
	Include a brief history of the State's Medicaid (and CHIP, if applicable) managed care programs.	Pages 2–4
	Include an overview of the quality management structure that is in place at the State level (i.e., committee structure).	Page 10
	Include a description of the goals and objectives of the State's managed care program. This description should include priorities, strategic partnerships, and quantifiable performance driven objectives. These objectives should reflect the State's priorities and areas of concern for the populations covered by the MCO contracts.	Pages 27–32

SECTION II: Establishing Standards, Guidelines, and Definitions		
Regulatory Reference	**Description**	**Corresponding Document and Page Reference or Comment**
DMMA MSA 3.9.7.2	The Contractor's credentialing and recredentialing process or participation criteria shall ensure that all participating providers, including, but not limited to, licensed independent practitioners, licensed organizational providers, and non-licensed independent and organizational providers such as certain HCBS providers and certain behavioral health providers, are qualified to perform their services in accordance with the QS.	Pages 33

SECTION II: Establishing Standards, Guidelines, and Definitions		
Regulatory Reference	**Description**	**Corresponding Document and Page Reference or Comment**
§438.340(b)(1)	State-defined provider-specific network adequacy standards developed in accordance with 438.68 (to include time and distance).	Pages 14–19
§438.340(b)(1) DMMA MSA 3.9.17.3.1	State-defined availability of services standards developed in accordance with 438.206(b)(1)-(7)(e.g., direct access to women's health specialist; timely access standards for routine urgent and emergent services; 24/7 service availability; access and cultural competency; accessibility considerations). The Contractor shall, at a minimum, meet the appointment standards in the State's QS.	Pages 14–19
§438.340(b)(1) DMMA MSA 3.13.6.4	State's approach to adoption and dissemination of evidence-based clinical practice guidelines in accordance with 438.236. The Contractor shall comply with the additional requirements regarding clinical practice guidelines included in the QS.	Pages 19–21
§438.340(b)(5)	Description of the State's transition of care policy required under 438.62(b)(3).	Pages 21–22
§438.340(b)(8)	Mechanisms implemented by the State to comply with 438.208(c)(1) (relating to the identification of persons who need LTSS or persons with SHCN).	Pages 23–24
§438.340(b)(9)	The information required under 438.360(c) (relating to non-duplication of EQR activities).	Page 24
§438.340(b)(10)	Definition of a "significant change" for the purposes of paragraph (c)(3)(ii) of this section.	Page 10
DMMA MSA 4.1.7.6	Any incentive arrangement shall be necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's QS.	Page 25

SECTION III: Driving Improvement and Monitoring Progress		
Regulatory Reference	**Description**	**Corresponding Document and Page Reference or Comment**
§438.340(b)(2) DMMA MSA 3.13.3.10.1.1	Developing goals and objectives for continuous quality improvement, which must be measurable and take into consideration the health status of all populations served by MCOs. Measure and report to the State its performance, using standard measures required by the State and as described in the QS including those that incorporate the requirements of the MSA; and submit to the State.	Pages 28–32
§438.340(b)(3)(i)	A description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO with which the State contracts, including but not limited to, the performance measures reported in accordance with 438.330(c). The State must identify which quality measures and performance outcomes the State will publish at least annually on the State website.	Pages 28–32
MCO Reporting DMMA MSA 3.21.9.1 3.21.12.1 3.21.12.2 3.21.12.3 3.21.12.4	The Contractor shall submit a semi-annual GeoAccess Report as specified in the QS. The report shall include but not be limited to (i) an accessibility summary; (ii) city and county detail information; (iii) thermal maps demonstrating access issues; (iv) provider location maps; and (v) city access standard detail reports. The report shall at a minimum include overall access to the care types set forth in Section 3.9.17.2. The Contractor shall submit an annual Quality Management/Quality Improvement Work Plan and Evaluation as specified in the Quality Management Strategy (QMS). The Contractor shall submit its annual performance measure data as specified in the QS. The Contractor shall also submit quarterly status reports on each performance measure, as specified in the QS. The Contractor shall submit the results of its annual CAHPS survey as specified in the QMS. The Contractor shall submit quarterly status reports on each PIP, as specified in the QS.	Pages 43–46
§438.340(b)(3)(ii) DMMA MSA 3.13.5.3	A description of the PIPs implemented in accordance with 438.330(d), including a description of any interventions the State proposes to improve access or timeliness of care for enrollees. The Contractor must report the status and results of each PIP conducted per 42 CFR 438.330(d)(1) to the State as requested but not less than once per year. The Contractor shall conduct PIPs related to medical care, behavioral health, and LTSS as described in the QMS.	Pages 45

SECTION III: Driving Improvement and Monitoring Progress		
Regulatory Reference	**Description**	**Corresponding Document and Page Reference or Comment**
DMMA MSA 3.13.10.1 3.13.11.1	The Contractor shall conduct member satisfaction surveys as required in the QMS. The Contractor shall comply with all federal and State confidentiality law in conducting member satisfaction survey(s). The Contractor shall comply with the requirements in the QMS regarding provider satisfaction survey(s).	Pages 46–47
§438.340(b)(4)	Arrangements for annual, external independent reviews, in accordance with 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each MCO.	Page 47
§438.340(b)(6)	The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status (as basis for Medicaid eligibility). States must identify this demographic information for each enrollee and provide it to the MCO at time of enrollment.	Pages 48–49
§438.340(b)(7)	Appropriate use of intermediate sanctions that, at a minimum, meet the requirements of 42 CFR part 438, subpart I.	Pages 49–51
Incentives/VBP DMMA MSA 4.1.7.6	Any incentive arrangement shall be necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's QMS.	Pages 49–51

SECTION IV: HCBS Assurances — HCBS Waiver Assurances and Monitoring Processes		
Regulatory Reference	**Description**	**Corresponding Document and Page Reference or Comment**
STC 11-W-00036/4 requirement 44 and 46	XII. HCBS Service Delivery and Reporting Requirements: 44. Integration of HCBS assurances within the State QS — DSHP Plus and PROMISE 46. Quality Improvement Strategy for 1915(c) or 1915(i) approvable HCBS services	Pages 32–43

SECTION V: PROMISE — PROMISE Waiver Assurances and Monitoring Processes		
Regulatory Reference	**Description**	**Corresponding Document and Page Reference or Comment**
STC 11-W-00036/4 requirement 44 and 46	XII. HCBS Service Delivery and Reporting Requirements: 44. Integration of HCBS assurances within the State QS — DSHP Plus and PROMISE 46. Quality Improvement Strategy for 1915(c) or 1915(i) approvable HCBS services	Pages 32–43

SECTION VI: Evaluating, Updating, and Disseminating the Quality Strategy		
Regulatory Reference	**Description**	**Corresponding Document and Page Reference or Comment**
§438.340(c)(1)	Make the strategy available for public comment before submitting to CMS for review.	Page 7
DMMA MSA 3.13.1.1.2	The QMS is reviewed annually and may be revised based on such review. If significant changes occur that impact quality activities or threaten the potential effectiveness of the QMS, as determined by the State, the QMS may be reviewed and revised more frequently. The Contractor will have an opportunity to review and comment on proposed changes to the QMS through the Contractor's regular participation in the QII Task Force. The Contractor shall comply with any revisions to the QMS.	Pages 7–10
§438.340(c)(1)(i) DMMA MSA 3.14.2.10.3.1	Obtain input from the MCAC, beneficiaries, and other stakeholders. The Contractor shall maintain a member advisory committee as required in the State's QMS. The member advisory committee shall maintain a reasonable representation of DSHP Plus LTSS members (including members residing in NFs and members residing in the community) or other individuals representing DSHP Plus LTSS members.	Page 7
§438.340(c)(1)(ii)	Consult with Tribes in accordance with State's Tribal consultation policy (if applicable).	Page 7
§438.340(c)(2)	Review and update QS no less than once every three years.	Page 1
§438.340(c)(2)(i)	Evaluation of effectiveness of previous QS.	Page 8
§438.340(c)(2)(ii)	Post results the evaluation of effectiveness of the previous QS on the State's website as required under 438.10(c)(3).	Page 8

SECTION VI: Evaluating, Updating, and Disseminating the Quality Strategy		
Regulatory Reference	**Description**	**Corresponding Document and Page Reference or Comment**
§438.340(c)(2)(iii)	Updates to the QS must take into consideration recommendations provided by the EQRO.	Page 9
§438.340(c)(3)(i)	Submit a copy of the initial QS for CMS comment and feedback prior to adopting it in final.	Page 7
§438.340(c)(3)(ii)	Submit a copy of the revised QS whenever significant changes are made to the document or whenever significant changes occur within the State's Medicaid program.	Pages 7–8
§438.340(d)	Post final (CMS approved) QS on State website.	Page 9