Managed Care Quality Strategy Evaluation 2021-2024

WEST VIRGINIA DEPARTMENT OF
HUMAN SERVICES
Bureau for Medical Services

Contents

Introduction

The West Virginia Department of Human Services' (DoHS) Bureau for Medical Services (BMS) Office of Managed Care (OMC), West Virginia Children's Health Insurance Program (WVCHIP), Office of Quality Management (OQM) as well as the managed care organizations (MCO) developed and implemented a written Managed Care Quality Strategy. The Strategy's goals were to assess and improve the quality of health care and services provided by the managed care organizations (MCOs) to Medicaid and WVCHIP membership under the Mountain Health Trust (MHT) and Mountain Health Promise (MHP) programs as required by 42 CFR 438.340 and 42 CFR 457.1240(e). WVCHIP is under the BMS, and their members receive services through the MHT program. The Managed Care Quality Strategy is further guided by the BMS mission, which is committed to administering the West Virginia Medicaid Program, while maintaining accountability for the use of resources in a way that assures access to appropriate, medically necessary and quality healthcare services for all members, in a user-friendly manner, to providers and members alike, while focusing on the future by providing preventive care programs.

The program's goal is to improve access to high-quality health care to managed care members by emphasizing the effective organization, financing, and delivery of primary health care services. The intention of the Managed Care Quality Strategy is to provide an overarching framework to drive quality and performance improvement among its three contracted MCOs, with the goal of improving health outcomes for its members.

The OMC is committed to a strong quality and performance improvement approach that ensures that the MHT and MHP programs will continue to deliver quality, accessible care to members while simultaneously driving improvement in key areas. The BMS and OQM will continue to refine the Managed Care Quality Strategy based on the results of its monitoring, assessment, and improvement activities to ensure it effectively drives improvement in the areas most integral to the MHT and MHP programs.

Additionally, as its quality infrastructure becomes more sophisticated, the goal to utilize process measures to achieve outcomes measure success. The Managed Care Quality Strategy partners will also remain adaptable to the continually changing health care quality landscape, so the approach remains aligned with other national, statewide, and local initiatives.

Managed Care Plans

Plan	Type	Services	Population
Unicare	MCO	Behavioral and Physical Services	Statewide
Aetna Better Health of West Virginia	MCO	Behavioral and Physical Services	Statewide
The Health Plan of West Virginia	MCO	Behavioral and Physical Services	Statewide

Quality Strategy

Methodology

The Managed Care Quality Strategy employs a three-pronged approach to improving the quality of health care delivered to members in the MHT and MHP programs. This approach allows the OMC to drive improvement in key health areas while maintaining the overall quality of the services that are currently delivered by the MHT and MHP Programs. The OMC quality approach evaluates the quality of care delivered to members in the managed care program. The OMC and the OQM use several methods to assess the quality of care being delivered by the MCOs, including the following:

- Evaluation of the Quality and Appropriateness of Care: The BMS have procedures in place to ensure that high-quality, appropriate care is delivered to all MCO members, including those with special health care needs, regardless of their race, ethnicity, and primary language spoken.
- Performance Measurement: The OMC's MHT and MHP contracts require MCOs to collect and report measures from the National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (NCQA HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.
- External Quality Review (EQR): The BMS contract with an external quality review organization (EQRO) to conduct independent evaluations of MCO performance, in accordance with Federal Regulations.
- MCO Reporting: MCOs are required to submit reports to the OMC, which allows strong monitoring of the MCO quality activities and operations.

The 2021-2024 Managed Care Quality Strategy associates the goals, objectives, and interventions with specific BMS, WVCHIP, and MCO activities. The identification of these priorities supported the BMS, WVCHIP, and MCO quality improvement efforts. The OMC and the OQM play a central role in monitoring and overseeing quality improvement under MHT and MHP. The OMC leads the evaluation and updates to the Managed Care Quality Strategy is completed as needed, but no less than once every three years, as required by managed care regulations at 42CFR §438.340(c) and §457.124. A significant change to the Medicaid Quality Strategy is defined by the BMS as follows:

- Changes in the MCO operations that impact adequate capacity and services including, but not limited to benefits, geographic service areas, or payments.
- Enrollment of a new population group in the managed care program.

Goals and Objectives

The intent of the 2021-2024 Managed Care Quality Strategy was to identify goals and objectives that focused on process as well as achieved outcomes. By aligning priorities, measures, activities and setting achievable goals, the Managed Care Quality Strategy helped leadership make decisions surrounding quality improvement in the MHT and MHP programs.

The Managed Care Quality Strategy outlines five priorities for the MHT programs. The priorities represent broad areas that support overarching goal of the programs which are to provide access to high-quality health care for all members. The BMS selected priorities that were flexible enough to accommodate changing conditions in the program, such as the expansion in the benefits covered by MCOs, but provide a clear path to drive quality improvement.

The goals and supporting objectives were to be measurable and take into consideration the health status of all populations served by the West Virginia Medicaid Managed Care program.

2021-2024 Goals and Objectives

Goal(s)	Objectives

• Promote a health care delivery system that consistently offers:
  ○ Timely access to health care
  ○ High clinical quality, including use of evidence-based models of treatment
  ○ Care at the appropriate time to deter avoidable use of emergency and acute care
  ○ Children and adolescents' access to primary care according to the periodicity schedule
  ○ Tools and supports that empower individuals to self-manage their health, whole-person and whole-household wellness, and use of health care services.
• Promote effective communication and team-based care to better coordinate care across the full continuum of health care.
	• Offer a wide range of physical, behavioral health, and social services to address whole-person health.
	• Improve child wellness and primary care provider (PCP) visit rates.
	• Improve the rate of medically necessary Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) utilization.
	• Expand the use of healthcare services that offer preventive value (e.g., vaccinations, well-child visits, annual examinations).
	• Implement sound person-centered planning that addresses the whole person and advances individual and family goals.
	• Improve screening and referral for social determinants of health including the use of Z-Codes for need and impact measurement.
	• Use care transition supports to empower patient education, timely and effective post-discharge follow-up while assessing strategies to avoid re-hospitalization and risk reduction

Goal(s) (Cont.)	Objectives (Cont.)

• Reduce the incidence of targeted conditions that negatively impact health and quality of life, including:
  ○ Cardiovascular disease and its contributors (cholesterol and hypertension)
  ○ Chronic respiratory disease (chronic obstructive pulmonary disease (COPD), asthma, and other conditions related to smoking)
  ○ Depression
  ○ Diabetes
  ○ Opioid misuse
  ○ Obesity
• Strengthen State oversight of programs to maximize partnership with contracted MCOs as committed partners to drive health impacts and act as good stewards of resources.
	• Improve acute care hospitalization follow-up rates.
	• Improve care for mothers and infants (e.g., immunization rates, postpartum visits, etc.).
	• Implement team-based care coordination models using evidence-based practices to move to holistic, multidisciplinary care coordination.
	• Improve hospital-acquired infection metrics.
	• Improve chronic condition metrics (e.g., diabetes, smoking, etc.).
	• Implement population health management tailored to conditions using a combination of evidence-based practices and community-based customization.
	• Advance tools and supports that empower improved individual health behaviors related to priorities such as (a) nutrition, (b) exercise, (c) reduce/eliminate the use of tobacco, alcohol, and other substances, (d) sexual health and family planning, and (e) mental wellness.
	• Monitor member satisfaction scores.
	• Ensure timely MCO reporting per contract standards.
	• Implement updated continuous quality improvement practices to enhance partnership.

Evaluation

Evaluation of the success of the Managed Care Quality Strategy originally relied upon data obtained from the Data Warehouse/Decision Support System. The main Data Warehouse/Decision Support System tool utilized for measure reporting came with limitations. The Data Warehouse/Decision Support System was retired in the Spring of 2023. It was replaced with the State's Medicaid Enterprise Data Solution (EDS). To properly evaluate the span of this strategy, legacy systems are needed. Without the access, replication of multiple queries and specific logic were lost. While the vendor did provide pre-built components for quality measure reporting in both systems, it is impossible for State data analyst to replicate previous Data Warehouse/Decision Support System queries in the EDS with a 1:1 match.

Despite the challenges, the MCOs continue to demonstrate their commitment to continuous quality improvement. Per the following excerpt from the EQRO Annual Technical Review 2023, "They are largely compliant with federal and state managed care requirements. When deficiencies are identified, the MCOs respond quickly with appropriate actions. The MCOs demonstrated some improvement in the quality and effectiveness of their performance improvement projects interventions. The MCOs performed better, on average, when compared to national average benchmarks in HEDIS® and CAHPS® survey measures, as reported in Appendix A1 and A2.2 of the 2023 Annual Technical Report located on the BMS OMC's website. The three MCOs' performance continued to trend in a positive direction and provided evidence of improved quality, accessibility, and timeliness of health care."

Contract Compliance

The OMC's first approach to promoting quality is assessment of MCO compliance with Federal and State quality standards, including those outlined in 42 CFR Subpart D and 42 CFR Subpart L. Monitoring and compliance with these standards are key to providing high-quality, accessible care because the standards establish an infrastructure to drive quality improvement.

The MCOs are required to submit annual, monthly, quarterly, and periodic reports to the OMC as described in the program's respective MCO contracts. These reports provided information that allowed the OMC to monitor the MCO's operation and performance on an ongoing basis. Additionally, the OMC used prospective, concurrent, and retrospective methods to assure compliance with the managed care quality standards.

The OMC intended to achieve the quality strategy goals and objectives through MHT and MHP contracts for the provision of covered services to eligible Medicaid and WCHIP members. Through quality assurance and quality improvement oversight activities, the OMC monitored the MCOs to ensure they operate in accordance with the contract. Any violation of MCO contract requirements or performance, the OMC had the option to initiate a Corrective Action Plan, imposed sanctions for non-performance or violations of contract requirements. During

this evaluation period, Corrective Action Plans were not issued regarding the activities in this strategy.

Performance Measures

The OMC requires the MCOs to report annually on member-outcome performance measures, including the HEDIS® quality metrics, Centers for Medicare and Medicaid Services (CMS) Adult and Child Core Set measures, Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators, CAHPS ® measures, and state-specified quality measures, if applicable.

Performance measurement is key to monitoring and improving quality. It allows the BMS and WVCHIP to understand the quality of care currently being delivered to members and evaluate MCO performance over time. The MHT and MHP contracts require the MCOs to calculate and report a variety of performance measures to track and monitor their members' health outcomes.

Specifically, the 2021-2024 Managed Care Quality Strategy required measure reporting in the following areas:

- Screening and preventive care (e.g. childhood immunizations)
- Chronic Care (e.g. asthma and diabetes management)
- Access, availability and timeliness of care (e.g. access to primary care)
- Utilization (e.g. emergency department utilization)
- Member Satisfaction measures (e.g. satisfaction with physician and health plan)

Of all measures that the MCOs are required to report, the BMS and WVCHIP selected a subset of key metrics to measure the programs' progress towards specific quality goals.

Appendix A: The MHT Performance Measure provides results for performance measures that are directly aligned with the Managed Care Quality Strategy 2021-2024 goals and objectives. Measures designated by a * in the appendix means that the rate includes the fee-for-service population in the calculation.

Appendix B: The WVCHIP Performance Measure provides results for performance measures that are directly aligned with the Managed Care Quality Strategy 2021-2024 goals and objectives.

The MHP specifications are included in the MHT program, therefore, their results are not listed separately.

It is important to note that according to the 2023 EQRO Annual Technical Report (Measurement Year (MY)22), all MCOs received overall Performance Measure Validation ratings of 100%, providing high confidence in MCO measure calculations and reporting.

- An analysis of MHT averages compared to NCQA® Quality Compass as a comparison benchmark showed the following measure rate(s) was/were equal to or exceeds the NCQA Quality Compass 90th percentile:
    - No measures fall into this category per analysis.
- An analysis of MHT program averages compared to NCQA® Quality Compass as a comparison benchmark showed the following measure rate(s) exceeds the NCQA Quality Compass 75th percentile but not the 90th percentile:
    - Well-Child Visits in the First 30 Months of Life (15 months to 30 months)
    - Childhood Immunization Status – Combination 3
    - Follow-Up After Emergency Department Visit for Alcohol, Other Drug Abuse or Dependence: 30-Day
- An analysis of MHT averages compared to NCQA® Quality Compass as a comparison benchmark showed the following measures rate exceed the NCQA Quality Compass 50th percentile but not the 75th percentile:
    - Annual Dental Visits (2-3 Years)
    - Follow-Up After Hospitalization for Mental Illness: 30-Day
    - Prenatal and Postpartum Care: Postpartum Care
- An analysis of MHT averages compared to NCQA® Quality Compass as a comparison benchmark showed the following measures rate are at or below the NCQA Quality Compass 50th percentile:
    - Well-Child Visits in the First 30 Months of Life (0-15 Months)
    - Eye Exam for Patients with Diabetes
    - Follow- Up After Emergency Department Visit for Mental Illness: 30-Day
    - Medical Assistance with Smoking and Tobacco Cessation: Advising Smokers to Quit
    - Cervical Cancer Screenings
    - Use of Imaging Studies for Low Back Pain

Consumer Assessment of Healthcare Providers and Systems

The CAHPS survey tool was used to collect information about consumer-reported experiences with health care. The survey provides a demographic and health profile of adult and child members as well as insights to understanding their experiences and satisfaction with different facets of their health care, such as communication with their personal physician, specialist care, customer service, and care coordination. The survey measures how well the health plan is meeting members' expectations and issues to identify areas of opportunity for improvement to ultimately improve the quality of care and service provided to members. The CAHPS survey also allows the OQM to benchmark its results with other plans and thereby set realistic goals for improvement.

An analysis of HEDIS and CAHPS survey measures demonstrated MCO averages met or exceeded the national average benchmarks in many measures relating to the effectiveness of care, access and availability of services, preventive care utilization, and member experience. However, one measure that continued to present as an opportunity for improvement each year was Advising Smokers and Tobacco users to Quit which continues to perform below the 50th percentile.

For additional information, please refer to the BMS OMC website.

External Quality Review Activities

The BMS contract with an EQRO to conduct annual, external, independent reviews of the timeliness of access to, and quality outcomes related to the services covered under each MCO contract in compliance with 42 CFR §438.340, 42 CFR §438.350, and 42 CFR §457.1250. Further, the OMC works with the EQRO, which has experience with quality measurement and the MCOs, to determine reasonable and achievable improvement goals for the selected measures.

The MHT and MHP programs demonstrated they had information systems capable of capturing and processing data required for reporting.

Performance Evaluations and Improvements

The OMC ensures through their contracts, that each MCO has an ongoing quality assessment and performance improvement program for the services it furnishes to its members.

Performance Improvement Project (PIP)Validation

The PIP's goal to achieve significant, sustained improvement in clinical or nonclinical care areas that are important to MHT and MHP members. PIPs are crucial pieces of MCO quality programs and allow specific areas of concern to be targeted for improvement.

The OMC requires MCOs to initiate and maintain three PIPs. wo state-mandated PIPs. As a result, the PIPs present the opportunity to create system-wide changes and even greater improvements in the quality of care delivered to members.

For the third PIP, each MCO selects their own project, which allows them to focus on the needs of their specific enrolled population. These PIPs may focus, for example, on increasing compliance with adolescent well-care visits, improving childhood obesity care, and increasing compliance with childhood immunizations.

The MCO must use one of the more quality indicators to assess its performance. The quality indicators must be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research. Indicators should measure changes in health status, functional status, member satisfaction, or valid proxies of these outcomes.

The MCOs conducted three PIPs each and reported MY 2022 results, as applicable. The MCOs reported their fifth and final remeasurement rates for the state-mandated Annual Dental Visits PIP. All MCOs achieved improvement; validation scores ranged from 95-100%. All three MCOs initiated a new state-mandated PIP, Follow-Up After Emergency Department Visit for Mental Health, and reported baseline performance. All MCOs received a validation score of 100%. The MCO's third PIP topic was self-selected and the MCOs are at various stages of development with their projects. All MCOs improved performance in at least one PIP measure in their self-selected PIPs. Validation scores ranged from 90-100%.

The MHP Aetna Better Health of West Virginia submitted its first remeasurement results for both state-mandated projects, Annual Dental Visits and Care for Adolescents: The MHP achieved statistically significant improvement and a validation score of 100% for its Annual Dental Visits PIP. Performance declined in the MCO's Care for Adolescents PIP; the MCO achieved a score of 86%. For MHP, Aetna Better Health of West Virginia submitted second remeasurement results for the self-selected topic, Reducing Out-of-State Placement for Children in Foster Care. Performance declined in this PIP, and the MCO received a validation score of 81%.

Network Adequacy and Availability Validation

It is the OMC's goal to improve network adequacy and address gaps in care, particularly in remote areas, by leveraging telemedicine and other promising practices. To monitor network adequacy, the OMC requires the MCOs to establish and maintain provider networks in geographically accessible locations and in sufficient numbers to provide all covered services available to the populations in a timely manner. The MCO contract further identifies the MCO minimum standards for the MCO's provider network.

Network standards for West Virginia's Managed Care programs include provider-to-member ratios and travel time and distance. The provider-to member ratios ensure that MCO provider networks have adequate capacity, while the travel time and distance standards establish choice and geographic accessibility of providers.

The CMS requires the BMS to ensure MCOs maintain provider networks sufficient to provide timely and accessible care to Medicaid beneficiaries across the continuum of services. As set forth in the Code of Federal Regulations (42 CFR §438.68), states are required to establish quantitative network adequacy standards for specified provider types and all geographic areas covered by MCO contracts. Network adequacy standards must account for regional factors and the needs of West Virginia's Medicaid population. To ensure services provided by West Virginia Medicaid's MCOs meet acceptable standards for quality, access, and timeliness of care, BMS contracts with an EQRO. As part of the external quality review, the EQRO validates MCO data to determine whether state-defined provider network adequacy standards were met.

The Code of Federal Regulations (42 CFR 438.206 – Availability of Services): requires each MCO make services included in its contract available 24 hours a day, seven days a week, when medically necessary. Providers should have a process in place to direct MHT and MHP members to care after regular business hours. The EQRO validates each MHT MCO's network access on a quarterly basis and provides an assessment of the MCO compliance with the requirement.

NOTE: The calendar year (CY) 2024 findings are not yet finalized by MCOs; therefore, the following are based on the end of year 2023 ATR findings

2023 ATR Evaluation Findings: Aetna Better Health of West Virginia: Mountain Health Promise

Result	ABH	MHT MCO Average
Compliant survey calls	44	47
Noncompliant survey calls	16	14
Compliance score	73.3%	77.5%
Confidence in MCO compliance	Low Confidence	Moderate Confidence

- Aetna Better Health of West Virginia MHP achieved a compliance score of 73.3% and a rating of low confidence for quarters 1-3. Performance:
  - Fell short of the established compliance threshold (90.0%) by 16.7 percentage points.
  - Fell short of the average (77.5%) by 4.2 percentage points.
- 44 of 60 providers were compliant during quarters 1-3.
- 16 of 60 providers were noncompliant during Quarters 1-3 and resurveyed during Quarter 4.
  - 13 of 16 barriers to access were successfully remedied (81%):
    - Seven providers were removed from the MCO provider directory.
    - Six providers were successfully contacted and compliant.
  - Three of 16 barriers to access were not successfully remedied (19%):
    - One recorded or automated message did not direct member to care.
    - One phone number was incorrect and did not reach the intended provider.
    - One phone number was not in service.
- Aetna Better Health of West Virginia achieved a compliance score of 95.0% and a rating of high confidence after Quarter 4 remediation. Year-end performance:
  - Improved 21.7 percentage points from quarters 1-3 to quarter 4.
  - Exceeded the BMS compliance threshold (90.0%) by 5.0 percentage points.
  - Fell short of the MHT MCO average (95.8%) by 0.8 percentage points.

2023 ATR Evaluation Findings: Aetna Better Health of West Virginia: Mountain Health Trust

Result	ABH	MHT MCO Average
Compliant survey calls	49	47
Noncompliant survey calls	11	14
Compliance score	81.7%	77.5%
Confidence in MCO compliance	Moderate Confidence	Moderate Confidence

Level of confidence scale for MCO compliance: High Confidence - 90.0% to 100%; Moderate Confidence - 75.0% to 89.9%; Low Confidence - 60.0% to 74.9%, No Confidence - <60.0%.

- Aetna Better Health of West Virginia MHT achieved a compliance score of 81.7% and rating of moderate confidence for quarters 1-3. Performance:
    - Fell short of the established compliance threshold (90.0%) by 8.3 percentage points.
    - Exceeded the MHT MCO average (77.5%) by 4.2 percentage points.
- 11 of 60 providers were noncompliant during quarters 1-3 and resurveyed during quarter 4.
    - Nine of 11 barriers to access were successfully remedied (82%):
        - Five providers were removed from the MCO provider directory.
        - Four providers were successfully contacted and compliant.
    - Two of 11 barriers to access were not successfully remedied (18%):
        - One phone number was incorrect and did not reach the intended provider.
        - One provider was retired or not practicing at the location.
- Aetna Better Health of West Virginia achieved a compliance score of 96.7% and a rating of high confidence after quarter 4 remediation. Year-end performance:
    - Improved 15.0 percentage points from quarters 1-3 to quarter 4.
    - Exceeded the established compliance threshold (90.0%) by 6.7 percentage points.
    - Exceeded the MHT MCO average (95.8%) by 0.8 percentage points.

2023 ATR Evaluation Findings: The Health Plan of West Virginia: Mountain Health Trust

Result	THP	MHT MCO Average
Compliant survey calls	48	47
Noncompliant survey calls	12	14
Compliance score	80.0%	77.5%
Confidence in MCO compliance	Moderate Confidence	Moderate Confidence

Level of confidence scale for MCO compliance: High Confidence - 90.0% to 100%; Moderate Confidence - 75.0% to 89.9%; Low Confidence - 60.0% to 74.9%, No Confidence - <60.0%.

- The Health Plan achieved a compliance score of 80.0% and a rating of moderate confidence for quarters 1-3. Performance:
    - Fell short of the established compliance threshold (90.0%) by 10.0 percentage points.
    - Exceeded the MHT MCO average (77.5%) by 2.5 percentage points.
- 48 of 60 providers were compliant during quarters 1-3.
- 12 of 60 providers were noncompliant during quarters 1-3 and resurveyed during Quarter 4.
    - 12 of 12 barriers to access were successfully remedied (100%):
        - Seven providers were removed from the MCO provider directory.
        - Five providers were successfully contacted and compliant.
- The Health Plan achieved a compliance score of 100.0% and a rating of high confidence after Quarter 4 remediation. Year-end performance:
    - Improved 20.0 percentage points from quarters 1-3 to Quarter 4.
    - Exceeded the established compliance threshold (90.0%) by 10.0 percentage points.
    - Exceeded the MHT MCO average (95.8%) by 4.2 percentage points.

2023 ATR Evaluation Findings: Unicare Health Plan of West Virginia: Mountain Health Trust

Result	UHP	MHT MCP Average
Compliant survey calls	48	47
Noncompliant survey calls	12	14
Compliance score	80.0%	77.5%
Confidence in MCP compliance	Moderate Confidence	Moderate Confidence

Level of confidence scale for MCP compliance: High Confidence - 90.0% to 100%; Moderate Confidence - 75.0% to 89.9%; Low Confidence - 60.0% to 74.9%, No Confidence - <60.0%.

- Unicare Health Plan achieved a compliance score of 80.0% and a rating of moderate confidence for quarters 1-3. Performance:
    - Fell short of the established compliance threshold (90.0%) by 10.0 percentage points.
    - Exceeded the MHT MCO average (77.5%) by 2.5 percentage points.
- 48 of 60 providers were compliant during quarters 1-3.
- 12 of 60 providers were noncompliant during quarters 1-3 and resurveyed during Quarter 4.
    - Eight of 12 barriers to access were successfully remedied (67%):
        - Three providers were removed from the MCO provider directory.
        - Five providers were successfully contacted and compliant.
    - Four of 12 barriers to access were not successfully remedied (33%):
        - Two phone numbers reached a generic voicemail message that did not identify the provider/practice.
        - One phone number was not answered and did not have an automated message.
        - One phone number was not in service.
- Unicare Health Plan achieved a compliance score of 93.3% and a rating of high confidence after quarter 4 remediation. Year-end performance:
    - Improved 13.3 percentage points from quarters 1-3 to quarter 4.
    - Exceeded the established compliance threshold (90.0%) by 3.3 percentage points.
    - Fell short of the MHT MCO average (95.8%) by 2.5 percentage points.

Use of Sanctions

The State contract establishes intermediate sanctions under certain circumstances as required by 42 CFR §438.700 and 42 CFR §457.1270. The state contract awards the MCO due process protections including a notice of sanction (42 CFR §438.710). The State contract informs the MCOs that the State must notify CMS of any sanctions imposed (42 CFR §438.724). In addition, the state retains authority to impose additional sanctions at its discretion under State statutes

or State regulations (42 CFR §438.702(b)). The State exercises this authority by monitoring the following key dimensions to determine areas of the potential non-performance:

- Member enrollment and disenrollment
- Provision of coverage and benefits
- Operational requirements
- Quality assurance, data, and reporting
- Payment provisions
- Subcontractor oversight
- Other business terms

The following remedies are currently available through the MCO contracts:

- Corrective action plans
- Financial penalties, including liquidated damages
- Suspension of new enrollment or disenrollment
- Termination or non-renewal of contract

EQRO 2023 ATR Evaluation Findings: No sanctions were levied during the timeframe of the evaluation period.

Conclusion

The OQM reviewed the Managed Care Quality Strategy 2021-2024 to assess compliance with federal and State-specific requirements and to evaluate the overall progress on behalf of the OMC under the BMS. Goals one, three, and four did have direct measures linked (see Appendix A and B) demonstrating improvement in certain areas. Goals two and five did not have direct measures linked to them in the Managed Care Quality Strategy resulting in the inability of the State to observe improvement(s) or lack thereof. It is recommended that goal setting be collaborative, and that the goal targets are achievable and reasonable to achieve in the next iteration of the Managed Care Quality Strategy.

Review and validation activities also occurred over the course of the evaluation period by the State's EQRO vendor.

The EQRO vendor evaluated each MCO and found:

- MCOs conducted PIPs in a methodical manner. After experiencing a decline in performance due to the COVID-19 public health emergency, the MHT Medicaid average demonstrated improvement in both state-mandated measure for the Annual Dental Visits PIP. Improvement was also demonstrated over this last year in the MHT MCO WVCHIP average for both PIP measures.

- All MHT MCOs reported baseline performance for the Follow-Up After Emergency Department Visit for Mental Illness PIP.
- For the MCO-selected PIPs, all MHT MCOs demonstrated improvement in at least one measure. The improvement was statistically significant for two of the three MCOs –
    - Aetna Better Health of West Virginia: Adolescents Well-Care Visits 12-17 Year Olds (Medicaid and CHIP) and Adolescents Well-Care Visits 18-21 Year Olds (Medicaid)
    - The Health Plan of West Virginia: Adolescents Well-Care Visits Total (Medicaid) and Weight Assessment and Counseling for Nutrition – Body Mass Index (BMI) Percentile Documentation (Medicaid and CHIP)
- MHP demonstrated improvement in both Annual Dental Visits PIP measures. The improvement was statistically significant in the Percentage of Eligibles that Received Preventive Dental Services measure.
- MHP failed to report improvement in its Care for Adolescents PIP and Reducing Out-of-State Placement for Foster Care PIP.
- There is an opportunity to improve successful contact with providers after regular business hours for the Network Adequacy Validation 24 hours a day, seven days a week access study. The MHT MCO average was 82.2% and the MHP average was 71.7%. The most frequent reason for unsuccessful contact was due to the phone number not reaching the intended provider. In instances where successful provider contact was achieved, Qlarant determined provider offices appropriately directed members to care—all MCOs achieved 97.7% compliance, or greater, with the provider 24 hours a day, seven days a week access requirement. A Quarter 4 resurvey of providers not accessible during quarters 1-3, resulted in mixed remediation results (MHT Aetna Better Health of West Virginia: 53.3%, The Health Plan of West Virginia: 100%, and Unicare Health Plan : 30.0%; MHP: 61.1%).
- An evaluation of claims data yielded an overall high level of encounter data accuracy, as evidenced by supporting medical record documentation in the Encounter Data Validation activity. The MHT MCO average match rate was 95.3%. MHP was the exception and achieved a match rate of 60.5%; this poor performance was largely attributed to one high-volume provider who did not consistently provide evidence of diagnosis-related documentation in the medical records reviewed.
- Overall, the MHT MCOs performed well in resolving and/or providing timely notice to members for grievances, denials, and appeals, having scored averages of 100%, 99.4%, and 99.2%, respectively. MHP's performance for the same review elements included 100%.

West Virginia's managed care programs continue to make strides and improve the quality of and access to health care services for its Medicaid and WVCHIP members. These beneficial gains are expected to improve health outcomes in the populations served. All MCOs demonstrated their

commitment to quality and quickly responded to recommendations or requests for corrective actions. The BMS and WVCHIP should continue to monitor and assess priority areas for improvement and will consider the EQRO vendor recommendations, which target the Managed Care Quality Strategy goals and objectives to better support improvement in the quality, timeliness, and accessibility of health care services furnished to West Virginia's managed care members.

APPENDIX A: MHT Performance Measure Results

GOAL	OBJECTIVE	MEASURE ABBREVIATION	MEASURE NAME	SUBCOMPONENT	MY19	MY20	MY21	MY22	MY23
1.	2.	ADV-CH	Annual Dental Visits	2-3 Years Old	-	54.08%	55.84%	58.59%	Retired
4.	4.	CCP-AD*	Contraceptive Care – Postpartum Women: Ages 21-44	Most or moderately effective contraceptive within 3 days postpartum	16.14%	15.72%	16.19%	16.02%	15.47%
4.	4.	CCP-AD*	Contraceptive Care – Postpartum Women: Ages 21-44	Most or moderately effective contraceptive within 90 days postpartum	45.49%	43.77%	43.00%	48.44%	45.33%
4.	4.	CCP-AD*	Contraceptive Care – Postpartum Women: Ages 21-44	Long-acting reversible contraception (LARC) within 3 days postpartum	1.65%	2.40%	2.29%	2.52%	2.09%
4.	4.	CCP-AD*	Contraceptive Care – Postpartum Women: Ages 21-44	LARC Within 90 days postpartum	9.29%	8.47%	8.50%	10.57%	11.02%
4.	4.	CCP-CH*	Contraceptive Care – Postpartum Women: Ages 21-44	Most or moderately effective contraceptive within 3 days postpartum	4.19%	5.57%	5.35%	4.2%	5.1%

GOAL	OBJECTIVE	MEASURE ABBREVIATION	MEASURE NAME	SUBCOMPONENT	MY19	MY20	MY21	MY22	MY23
4.	4.	CCP-CH*	Contraceptive Care – Postpartum Women: Ages 15-20	Most or moderately effective contraceptive within 90 days postpartum	45.51%	47.80%	41.63%	47.2%	42.3%
4.	4.	CCP-CH*	Contraceptive Care – Postpartum Women: Ages 15-20	LARC within 3 days postpartum	1.63%	2.74%	2.91%	2.2%	2.1%
4.	4.	CCP-CH*	Contraceptive Care – Postpartum Women: Ages 15-20	LARC within 90 days postpartum	10.86%	10.65%	12.33%	14.0%	13.2%
4.	2.	CCS-AD	Cervical Cancer Screening(s)	Ages 21-64	56.70%	49.72%	51.50%	50.75%	48.19%
4.	4.	CCW-AD*	Contraceptive Care – All Women: Ages 21-44	Most or moderately effective contraception	23.84%	22.98%	21.74%	20.04%	15.99%
4.	4.	CCW-AD*	Contraceptive Care – All Women: Ages 21-44	LARC	3.61%	3.20%	2.94%	2.74%	2.20%
4.	4.	CCW-CH*	Contraceptive Care – All Women: Ages 15-20	Most or moderately effective contraception	41.22%	39.20%	36.63%	34.68%	15.98%
4.	4.	CCW-CH*	Contraceptive Care – All Women: Ages 15-20	LARC	4.62%	3.69%	3.29%	3.20%	2.20%
1.	4.	CDC	Comprehensive Diabetes Care: Eye Exam(s)			35.38%	39.58%	Replaced	Replaced
1.	4.	CIS- CH	Childhood Immunization Status: Combo 3	Combo 3	71.3%	71.76%	66.83%	68.99%	70.27%

GOAL	OBJECTIVE	MEASURE ABBREVIATION	MEASURE NAME	SUBCOMPONENT	MY19	MY20	MY21	MY22	MY23
1.	3.	DEV-CH*	Developmental Screening in the First Three Years of Life	Screened by 12 Months	57.12%	56.02%	56.42%	57.88%	56.65%
1.	3.	DEV-CH*	Developmental Screening in the First Three Years of Life	Screened by 24 months	52.98%	59.02%	51.75%	53.36%	54.97%
1.	3.	DEV-CH*	Developmental Screening in the First Three Years of Life	Screened by 36 months	48.22%	49.35%	46.51%	47.17%	48.75%
1.	3.	DEV-CH*	Developmental Screening in the First Three Years of Life	Developmental screening in first three years of life	53.01%	54.77%	51.63%	52.56%	53.42%
1.	4.	EED	Eye Exams for Patients with Diabetes (New MY22)	Ages 18-75	-	-	-	38.15%	42.50%
3.	3.	FUA	Follow-Up After Emergency Department Visit for Alcohol, Other Drug Abuse or Dependence: 30-Day	Ages 13+	-	48.69%	52.32%	58.38%	48.85%
3.	3.	FUH	Follow-Up After Hospitalization for Mental Illness: 30-Day	Ages 6+	-	63.03%	63.50%	63.22%	63.56%
3.	3.	FUM	Follow-Up After Emergency Department Visit for Mental Illness: 30-Day	Ages 6+	-	50.35%	50.01%	54.25%	54.95%
4.	2.	LBP	Use of Imaging Studies for Low Back Pain (inverted rate)	Ages 18-75	-	67.39%	67.13%	67.61%	63.93%
4.	2.	MSC-AD	Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers to Quit	Adults	75.5%	71.41%	71.40%	71.70%	NR
1.	4.	P-DENT – CH	Percentage of Eligible (Children) that Received Preventive Dental Services	Form CMS-416	-	-	Retired	NR	NR

GOAL	OBJECTIVE	MEASURE ABBREVIATION	MEASURE NAME	SUBCOMPONENT	MY19	MY20	MY21	MY22	MY23
3.	2.	PPC	Prenatal & Postpartum Care: Postpartum Care	Ages 21+	72.14%	74.98%	75.26%	78.84%	82.37%
4.	2.	PQI01-AD*	Diabetes Short-Term Complications Admission Rate (per 100,000 Beneficiary Months)	Ages 18-64	138.36	22.76	12.84	9.15	10.60
4.	2.	PQI01-AD*	Diabetes Short-Term Complications Admission Rate (per 100,000 Beneficiary Months)	Ages 65+	13.69	10.27	5.21	6.83	5.81
4.	2.	PQI05 – AD*	COPD or Asthma in Older Adults Admission Rate (per 100,000 Beneficiary Months)	Ages 40-64	63.22	54.44	29.82	24.48	36.57
4.	2.	PQI05 -AD*	COPD or Asthma in Older Adults Admission Rate (per 100,000 Beneficiary Months)	Ages 65+	173.76	132.79	76.09	123.87	56.79
4.	2.	PQI08 – AD*	Congestive Heart Failure Admission Rate (per 100,000 Beneficiary Months)	Ages 18-64	23.13	37.09	1933.48	14.51	4.80
4.	2.	PQI08 – AD*	Congestive Heart Failure Admission Rate (per 100,000 Beneficiary Months)	Ages 65+	187.45	213.28	146.14	111.85	13.17
4.	2.	PQI15 – AD*	Asthma in Younger Adults Admission Rate (per 100,000 Beneficiary Months)	Ages 18-39	1.73	1.65	1.17	1.18	1.61
1.	4.	SEAL – CH*	Dental Sealants for 6–9-Year-Old Children at Elevated Risk	Ages 6-9	21.86%	RETIRED	SEE SFM	SEE SFM	SEE SFM
1.	4.	SFM – CH*	Sealant Receipt on Permanent First Molar(s)	1+ Sealant	NR	6.90%	7.62%	NR	49.89%

GOAL	OBJECTIVE	MEASURE ABBREVIATION	MEASURE NAME	SUBCOMPONENT	MY19	MY20	MY21	MY22	MY23
1.	4.	SFM – CH*	Sealant Receipt on Permanent First Molar(s)	All Molars Sealed	NR	3.46%	3.45%	NR	32.87%
1.	2.	W30 – CH	Well-Child Visit(s) in the First 30 Months of Life	6+ WC Visits in the First 0-15 Months of Age	-	50.61%	52.78%	51.33%	54.23%
1.	2	W30 – CH	Well-Child Visit(s) in the First 30 Months of Life	2+ WC Visits from 15 to 30 Months of Age	-	73.27%	70.99%	71.33%	73.75%

APPENDIX B: WVCHIP Performance Measures Results

GOAL	OBJECTIVE	MEASURE ABBREVIATION	MEASURE NAME	SUBCOMPONENT	MY19	MY20	MY21	MY22	MY23
4.	4.	ADD – CH	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Initiation	-	51.24%	46.19%	41.44%	36.31%
4.	4.	ADD – CH	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Continuation	-	64.18%	62.96%	48.89%	34.92%
		AMB – CH	Ambulatory Care: Emergency Department (ED) Visit(s) (per 100,000 member months)	Ages <19	-	45.99	48.67	27.73	70.97
		AMR – CH	Asthma Medication Ratio	Ages 5-18	-	NR	NR	89.34%	85.99%
4.	4.	APM – CH	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Glucose Ages 1-17	-	44.83%	58.62%	52.86%	64.79%
4.	4.	APM – CH	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Cholesterol Ages 1-17	-	21.84%	28.74%	31.43%	34.51%
4.	4.	APM – CH	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Glucose & Cholesterol Ages 1-17	-	18.39%	28.74%	30.0%	33.10%
4.	4.	APP – CH	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics	Ages 1-17	-	38.5%	55.3%	56.3%	45.0%
1.	4	AUD – CH	Audiological Diagnosis No Later Than 3 Months of Age	Age <3 Months	-	NR	Retired	NR	NR
4.	4.	CCP – CH	Contraceptive Care – Postpartum Women	Moderately Effective Within 90 Days Ages 15-20	-	100.00%	0%	0%	33.3%

GOAL	OBJECTIVE	MEASURE ABBREVIATION	MEASURE NAME	SUBCOMPONENT	MY19	MY20	MY21	MY22	MY23
4.	4.	CCP – CH	Contraceptive Care – Postpartum Women	LARC Within 90 Days Ages 15-20	-	0.0%	16.7%	0.00%	22.2%
4.	4.	CCW – CH	Contraceptive Care – All Women	Moderately Effective Within 90 Days Ages 15-20	-	33.4%	36.9%	30.7%	25.9%
4.	4.	CCW – CH	Contraceptive Care – All Women	LARC Within 90 Days Ages 15-20	-	2.0%	2.4%	2.1%	3.5%
		CDF – CH	Screening for Depression and Follow- Up	Ages 2-17	-	NR	NR	NR	NR
1.	4.	CIS – CH	Childhood Immunization Status – Combo 3	Combo 3	-	27.87%	24.35%	73.00%	Included in MHT #s
-	-	CPC – CH	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.1H - Child Version including Medicaid and Children with Chronic Conditions Supplemental Items	CAHPS 5.1	-	Data submitted to AHRQ	Data submitted to AHRQ	Data submitted to AHRQ	Data submitted to AHRQ
1.	3.	DEV – CH	Developmental Screening in the First Three Years of Life	Age <12 Months	-	55.4%	59.3%	60.4%	62.4%
1.	3.	DEV – CH	Developmental Screening in the First Three Years of Life	Ages 12 Months to <24 Months	-	59.7%	53.6%	55.6%	59.0%
1.	3.	DEV – CH	Developmental Screening in the First Three Years of Life	Ages 24 Months to <36 Months	-	56.0%	54.3%	46.8%	54.3%
1.	3.	DEV – CH	Developmental Screening in the First Three Years of Life	Total (Ages 0-3)	-	57.6%	54.8%	53.1%	57.9%
3.	3.	FUH – CH	Follow-Up After Hospitalization for Mental Illness	Ages 6-17 Within 30 Days of Discharge	-	51.0%	38.8%	68.1%	75.7%

GOAL	OBJECTIVE	MEASURE ABBREVIATION	MEASURE NAME	SUBCOMPONENT	MY19	MY20	MY21	MY22	MY23
1.	4.	IMA – CH	Immunizations for Adolescents	Combo 1	-	69.6%	63.7%	87.1%	Included in MHT #s
1.	4.	IMA – CH	Immunizations for Adolescents	Combo 2	-	17.3%	15.8%	27.4%	Included in MHT #s
1.	4.	IMA – CH	Immunizations for Adolescents	Meningitis	-	72.2%	65.6%	87.9%	Included in MHT #s
1.	4.	IMA – CH	Immunizations for Adolescents	Tdap	-	74.7%	70.9%	88.8%	Included in MHT #s
1.	4.	IMA – CH	Immunizations for Adolescents	HPV	-	19.5%	16.9%	28.5%	Included in MHT #s
3.	2.	LBW – CH	Live Births Weighing Less Than 2,500 Grams	Weight at Birth	-	Wide-Ranging Online Data for Epidemiologic Research (WONDER) (CDC)	Wonder Data	Wonder Data	Wonder Data
3.	2.	LRCD – CH	Low -Risk Cesarean Delivery	37+ Weeks Gestation	-	Wonder Data	Wonder Data	Wonder Data	Wonder Data
1.	4.	P-DENT -CH	Percentage of Eligible (Children) That Received Preventive Dental Services	Form CMS-416	-	NR	Retired	NA	NA
3.	2.	PPC – CH	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Prenatal	-	NR	NR	63.64%	NR
1.	4.	SFM – CH	Sealant Receipt on Permanent First Molars	1+ Sealant	-	8.85%	8.11%	NR	53.90%
1.	4.	SFM – CH	Sealant Receipt on Permanent First Molars	All Molar Sealed	-	3.70%	4.06%	NR	18.77%

GOAL	OBJECTIVE	MEASURE ABBREVIATION	MEASURE NAME	SUBCOMPONENT	MY19	MY20	MY21	MY22	MY23
1.	2.	W30 – CH	Well Child Visits in the First 30 Months of Life	6+ Visits: 0-15 Months	-	47.06%	51.92%	8.91%	14.88%

GOAL	OBJECTIVE	MEASURE ABBREVIATION	MEASURE NAME	SUBCOMPONENT	MY19	MY20	MY21	MY22	MY23
1.	2.	W30 – CH	Well Child Visits in the First 30 Months of Life	2+ Visits: 15-30 Months	-	70.66%	65.03%	25.48%	25.71%
1.	2.	WCV – CH	Well Care Visits: Child and Adolescents	Ages 3-21	-	NR	48.94%	18.94%	19.04%