West Virginia Managed Care Quality Strategy

Mountain Health Trust and Mountain Health Promise

April 1, 2021

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Section 1: Introduction and Overview

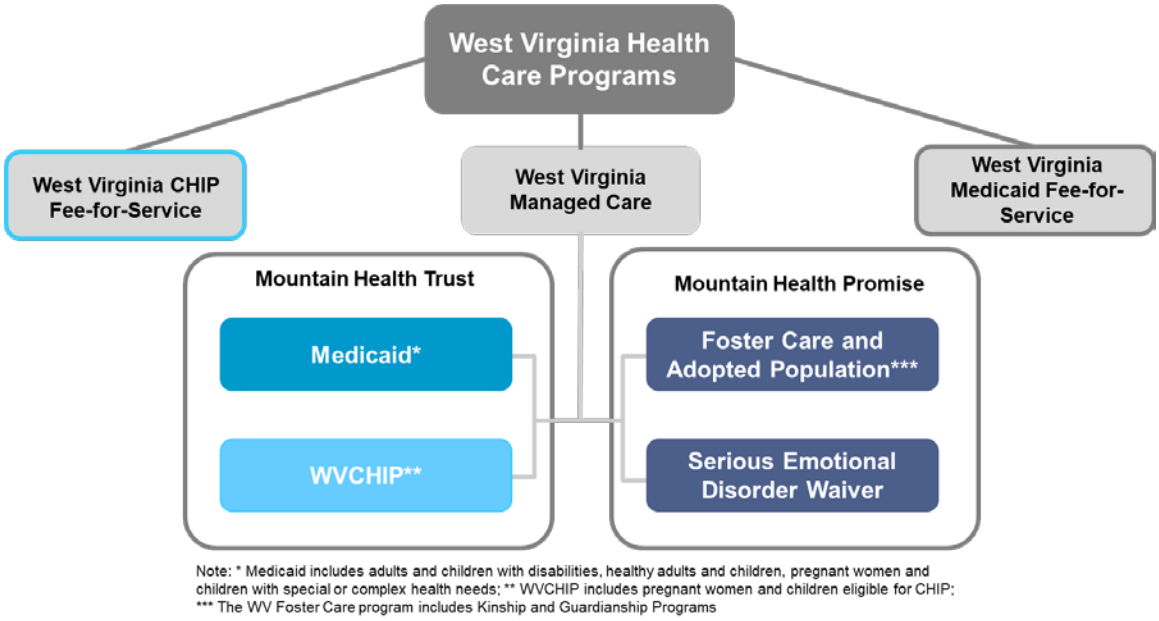
West Virginia has operated at least one Medicaid managed care program in the State since 1996. Over time, West Virginia managed care has evolved to include the Mountain Health Trust (MHT) and Mountain Health Promise (MHP) programs. MHT-Medicaid is the MHT program operated by Bureau for Medical Services (BMS) for the Medicaid population. In addition to administering the MHT-Medicaid program, BMS also administers the MHP program. MHT-WVCHIP is administered by West Virginia Children's Health Insurance Program (WVCHIP) for the Children's Health Insurance (CHIP) population.

The programs aim to improve access to high-quality health care for Medicaid and CHIP members by emphasizing the effective organization, financing, and delivery of primary health care services.

The intention of this Quality Strategy is to provide an overarching framework for BMS and WVCHIP to drive quality and performance improvement among its contracted managed care organizations (MCOs), with the ultimate goal of improving health outcomes for its members.

The structure of the MHT and MHP programs is below in Figure 1.

Figure 1. West Virginia Managed Care Program Structure



In order to demonstrate compliance with the Centers for Medicare & Medicaid Services (CMS) quality strategy requirements set forth in 42 CFR §438.340 and 42 CFR §457.1240, BMS and WVCHIP prepared an analysis that identifies each required element of the Quality Strategy and where it has been addressed (Appendix C).

Section 2: Program History and Structure

Background

History of West Virginia's Managed Care Programs

West Virginia has operated at least one Medicaid managed care program in the State since 1996. West Virginia managed care has evolved to include the MHT and MHP programs. MHT-Medicaid and MHP are administered by the Bureau for Medical Services (BMS). MHT-WVCHIP, implemented in 2021, is administered by West Virginia Children's Health Insurance Program (WVCHIP). The programs aim to improve access to high-quality health care for Medicaid and CHIP members by emphasizing the effective organization, financing, and delivery of primary health care services.

Under the MHT and MHP programs, BMS and WVCHIP contract with MCOs for the provision of covered medically necessary services, including medical, behavioral, dental and vision services. Specifically:

- BMS currently contracts with MCOs to operate the two Medicaid managed care programs, MHT-Medicaid and MHP.
- Under separate contracts with the MCOs, WVCHIP operates MHT-WVCHIP, the State's CHIP managed care program that is also under the Mountain Health Trust umbrella, under separate contracts with the MCOs. MHT-WVCHIP transitioned to a managed care model on January 1, 2021.

While most individuals receive health care services through one of West Virginia's managed care programs, the State continues to offer services through its Medicaid and CHIP fee-for-service (FFS) models. BMS and WVCHIP remain committed to delivering high-quality health care services for all Medicaid and CHIP members. However, this Quality Strategy focuses on measurement and interventions within the West Virginia managed care programs.

Mountain Health Trust (MHT)

MHT-Medicaid

The Mountain Health Trust (MHT) program is open to eligible Medicaid members living across the State of West Virginia receive their benefits through one of three participating MCOs. Members select a primary care provider (PCP) who acts as their medical home. The medical home promotes better quality and more patient-centered care by providing a continuous source of care that is coordinated and accessible to the member. The medical home concept is central to the MHT program.

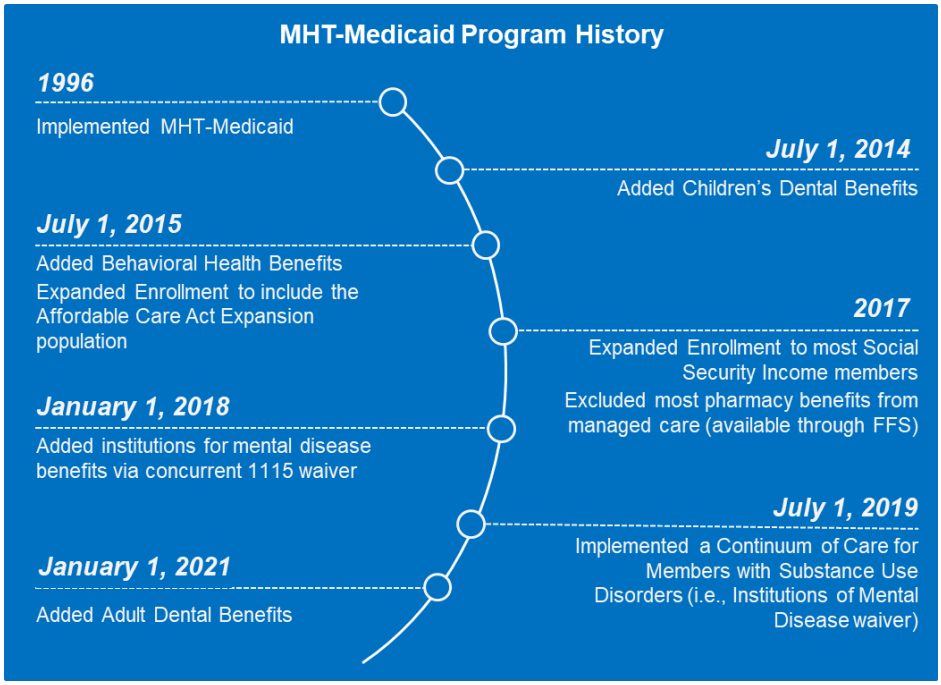
BMS Mission Statement

"The Bureau for Medical Services is committed to administering the Medicaid Program, while maintaining accountability for the use of resources, in a way that assures access to appropriate, medically necessary, and quality health care services for all members; provide these services in a user friendly manner to providers and members alike; and focus on the future by providing preventive care programs."

MCOs provide members with acute and preventive physical health care services as well as valuable services to help members manage their health care (e.g., care coordination and

transportation). Additionally, they provide a wide range of supplementary services, including health service coordination, coordination with social services such as housing and nutrition, case management, and health education. The populations and services included under the MHT-Medicaid's program's history have evolved.

Figure 2. Evolution of MHT-Medicaid Populations and Services



MHT-WVCHIP

WVCHIP's primary purpose is to provide health insurance coverage to uninsured children in families whose income disqualifies them from coverage available through the Medicaid Program, but is less than or equal to 300% of the current Federal Poverty Level (FPL).

WVCHIP Mission Statement

"To provide quality health insurance to eligible children in a way that improves child population health and promotes healthy kids and healthy communities."

The West Virginia Legislature passed House Bill 4299 on April 19, 1998 to create WVCHIP. West Virginia Children's Health Insurance Program is currently housed within DHHR and governed by the West Virginia Children's Health Insurance Program Board of Directors. On January 1, 2021, WVCHIP transitioned members to MHT-WVCHIP managed care to enhance the health care access and services available to members. The WVCHIP managed care model has the ability to provide some services that cannot be offered in a FFS program, such as enhanced disease management and innovations in care coordination. MCOs can improve access to care for members, leading to better health outcomes.

Mountain Health Promise (MHP)

The MHP program is a specialized managed care plan for children and youth in foster care or the adoption assistance program, which includes kinship care and legal guardianship.

Implemented in March 2020, the MHP program aims to improve care coordination for medical services (e.g., physical, behavioral, dental services) and provide socially necessary services to eligible children and youth. In the MHP program, eligible children and youth living across the State of West Virginia receive their benefits through a specialized MCO to coordinate services or, if a member of the foster care and adopted children population, may disenroll to FFS. Since March 2020, the MHP program mandatorily enrolls and coordinates services for members enrolled in the West Virginia Children with Serious Emotional Disorders 1915(c) Waiver (SED Waiver). MCOs are responsible for coordinating SED Waiver services such as in-home family support, respite care, and specialized therapy.

As in the MHT-Medicaid program, each MHP member has a PCP who acts as his or her medical home and provides continuous coordination and access to services. The medical home concept is central to the MHP program, as the needs of these special populations can be unique, continue indefinitely, and require diligent monitoring.

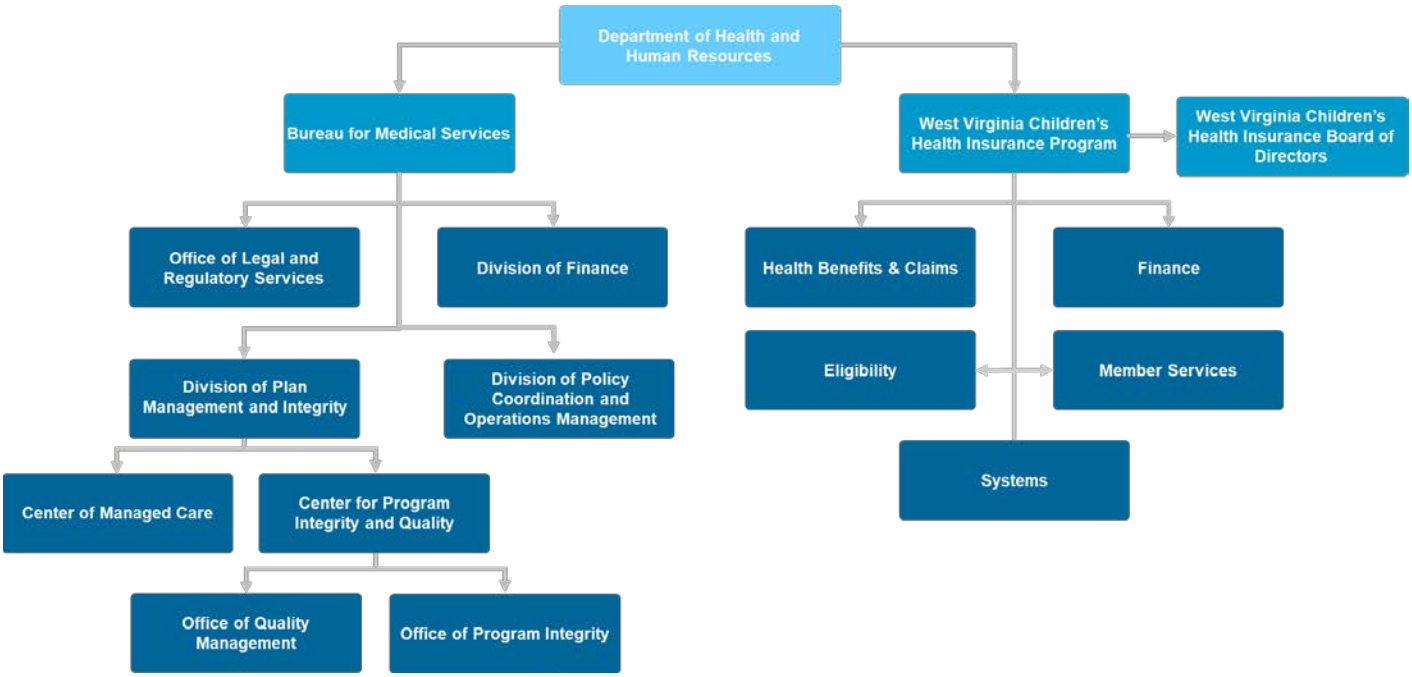
The State also provides support to the MHP population through coordination with the West Virginia Bureau for Children and Families (BCF) and the State Ombudsman office to advocate for the rights of eligible children and youth across programs and State agencies.

State of West Virginia Quality Improvement Structure

BMS's Center for Managed Care and WVCHIP both play a central role in monitoring and overseeing quality improvement under MHT and MHP. Specifically:

- ***MHT-Medicaid and MHP:*** BMS' Center for Managed Care administers the MHP and MHT-Medicaid programs. The Chief of this office oversees all aspects of the MHT-Medicaid and MHP programs, including quality activities. The BMS Office of Quality Management administers the EQRO contract.
- ***MHT-WVCHIP:*** The MHT-WVCHIP program is governed by the Children's Health Insurance Board of Directors. The Executive Director of WVCHIP is charged with overseeing the MHT-WVCHIP program and quality activities. The organizational and oversight structure of the MHT and MHP programs is shown in Figure 3.

Figure 3. West Virginia Managed Care and Quality Organizational Structure



BMS and WVCHIP receive input from several formal and informal groups to support their quality work:

Stakeholder Group	Description
External Quality Review Organization (EQRO)	BMS contracts with an EQRO to conduct annual, external independent reviews of the quality outcomes associated with the timeliness of and access to services covered under each MCO contract of the MHT and MHP programs.
Medical Services Fund Advisory Council (the Council)	BMS also works with the Council to obtain input on the direction of MHT-Medicaid and MHP-related quality activities. The Council advises BMS on a range of issues, including the development and revision of the Quality Strategy. The Council includes providers, members, legislators, and agency staff.
Drug Utilization Review Board (DUR Board)	The DUR Board and BMS work together to improve the quality of health care for Medicaid members and to assist in containing health care costs by reviewing prescription claims prospectively and retrospectively.
Pharmaceutical and Therapeutics Committee (P&T Committee)	The P&T Committee acts in an advisory capacity to assist BMS in selecting drugs for the Preferred Drug List that are effective and cost-efficient, while ensuring maximum safety, aligning with sound clinical evidence, and providing medically appropriate drug therapies.
WVCHIP Board of Directors	WVCHIP's Board of Directors supports the program by developing plans to provide health services that are specific to the needs of children and the Board of Directors promotes fiscal stability through the development of an annual financial plan designed to support necessary services for the members. WVCHIP's Executive Director is responsible for engaging the Board of Directors in activities critical to the administration of WVCHIP, including implementing policies and procedures as well as monitoring quality and care delivery metrics.

In addition, BMS and WVCHIP partner with numerous stakeholders, including advocates, legislators, providers, other State agencies, the MCOs, the MHT enrollment broker, WVCHIP Board of Directors, and the EQRO. These groups provide feedback on quality activities and programs on an ongoing basis both formally and informally.

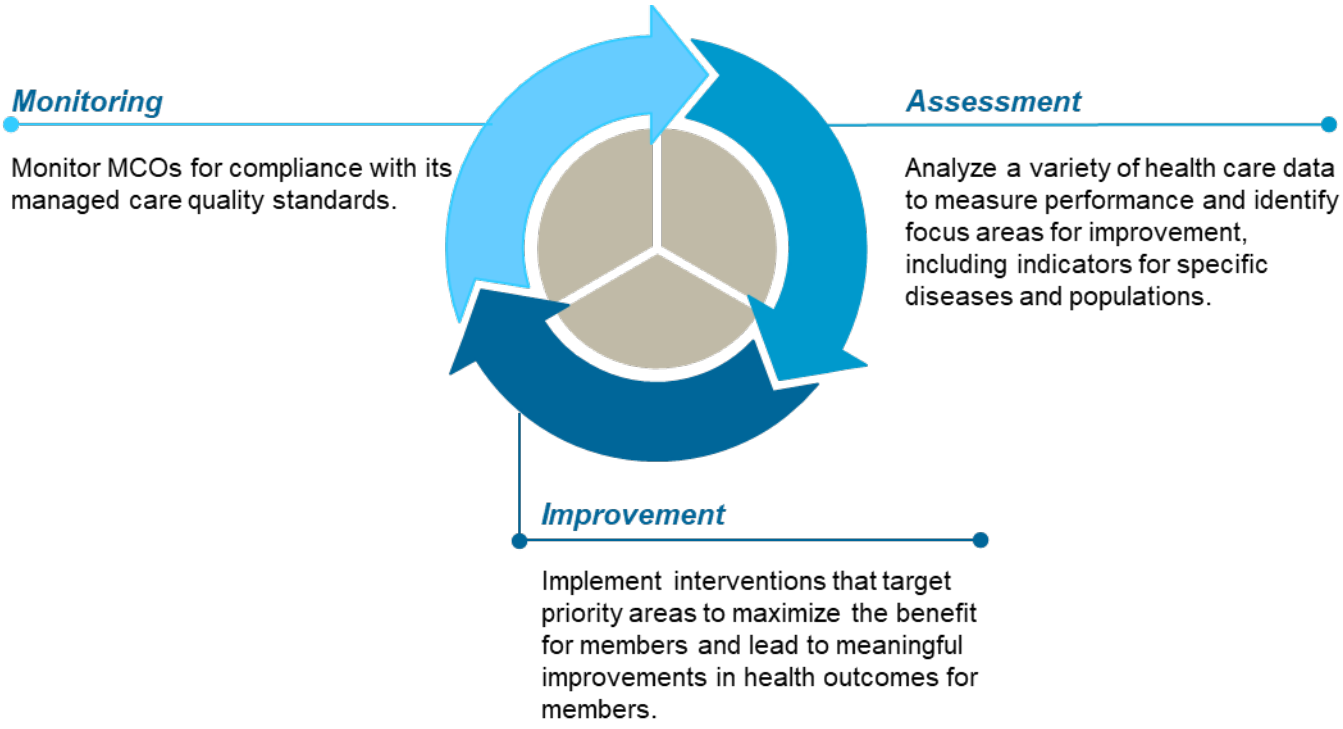
Section 3: Quality Strategy Approach, Goals and Objectives

A robust approach to quality is integral to achieving the aims of the MHT and MHP programs. It ensures that the MCOs provide access to high quality care that meets the programs' standards for members. Furthermore, the MHT and MHP approach coordinates the quality improvement work of BMS, WVCHIP, and the MCOs so that all involved entities will focus on shared priorities and, as a result, make greater quality gains.

Approach

The Quality Strategy employs a three-pronged approach to improving the quality of health care delivered to members in the MHT and MHP programs:

Figure 4. MHT & MHP Quality Strategy Approach



This approach allows BMS and WVCHIP 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.

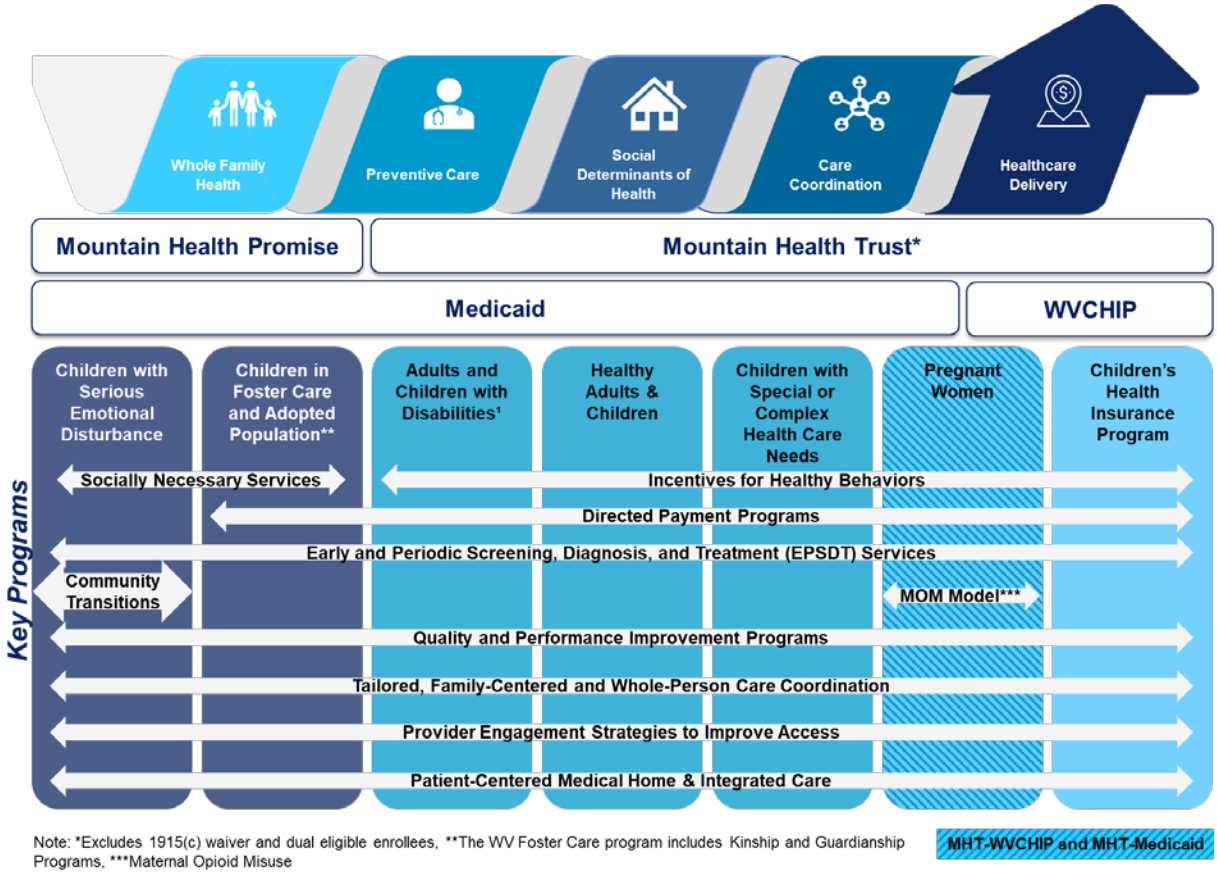
Quality Framework

The Quality Strategy associates goals, objectives, and interventions with specific BMS, WVCHIP, and MCO activities. The identification of these priorities will support BMS, WVCHIP, and MCO quality improvement efforts. The activities are described in greater detail throughout the Quality Strategy.

By aligning priorities, measures, and activities and setting achievable goals, the Quality Strategy will drive quality improvement in the MHT and MHP programs.

Figure 5 summarizes the structure of the Quality Strategy as described above and includes examples of quality interventions leveraged in the MHT and MHP programs.

Figure 5. Quality Framework Summary for Mountain Health Trust and Mountain Health Promise



Goals and Objectives

The Quality Strategy outlines five (5) priorities for the MHT and MHP programs. The priorities represent broad areas that will support the overarching aim of the programs – to provide access to high-quality health care for all members. BMS and WVCHIP selected priorities that are flexible enough to accommodate changing conditions in the program, such as an expansion in the benefits covered by MCOs but provide a clear path to drive quality improvements.

Table 1. Mountain Health Trust and Mountain Health Promise Goals and Objectives

Goal	Objectives	Example Activities	Example Measures
1. 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	1. Offer a wide range of physical, behavioral health, and social services to address whole-person health. 2. Improve child wellness and PCP visit rates. 3. Improve the rate of medically necessary EPSDT utilization. 4. Expand use of health care services that offer preventive value (e.g., vaccinations, well-child visits, annual examinations).	• Require use of evidence-based clinical practice guidelines • Ensure access to a primary care provider • Analyze the Healthcare Effectiveness Data and Information Set (NCQA HEDIS®) measures	• Children and adolescents' access to PCP (12-24 months, 25 months-6 years, 7-11 years, and 12-19 years) • Well-Child visits in the third, fourth, fifth, and sixth years of life • Prenatal and postpartum care • Adult access to preventive / ambulatory health services (NCQA HEDIS®) • Annual dental visits (NCQA HEDIS®) • Network adequacy monitoring • Directed Payment Program (DPP) breast cancer screenings (preventive)

Goal	Objectives	Example Activities	Example Measures
2. Offer tools and supports that empower individuals to self-manage their health, whole-person and whole-household wellness and use of health care services.	1. Implement sound person-centered planning that addresses the whole person and advances individual and family goals. 2. Improve screening and referral for social determinants of health (SDoH) including use of Z-Codes for need and impact measurement. 3. 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.	• Outreach to members • Promote member engagement in treatment plans • Utilize prospective drug review • Engage managed care partners in the delivery and uptake of member education for appropriate utilization of the health care system	• Annual monitoring for patients on persistent medications – total rate • Monitor use of Z-Codes • Member incentive programs • Depression and/or drug screenings of members/guardians • Community health and social determinants of health services • Family wellness measures
3. Promote effective communication and team-based care to better coordinate care across the full continuum of health care.	1. Improve acute care hospitalization follow-up rates. 2. Improve care for mothers and infants (e.g., immunization rates, postpartum visits, etc.). 3. Implement team-based care coordination models using evidence-based practices to move to holistic, multidisciplinary care coordination.	• Monitor MCO-based patient centered medical homes initiatives and case management • Coordinate with health homes • Promote use of treatment plans • Promote use of electronic health records through statewide information sharing platforms and the WV Immunization Registry • Utilize prospective drug review	• Follow-up after ED visit for mental illness • Follow-up after hospitalization for mental illness • Follow-up after ED visit for alcohol and other drug abuse or dependence • Follow-up care for children prescribed ADHD medication • Medication reconciliation post discharge (NCQA HEDIS®) • Transitions of care (NCQA HEDIS®) • Rate of PCMH / care coordinator assignment

Goal	Objectives	Example Activities	Example Measures
4. 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	1. Improve hospital acquired infection metrics. 2. Improve chronic condition metrics (e.g., diabetes, smoking, etc.). 3. Implement population health management tailored to conditions using a combination of evidence-based practices and community-based customization. 4. Advance tools and supports that empower improved individual health behaviors related to priorities such as (a) nutrition, (b) exercise, (c) reduce/eliminate use of tobacco, alcohol and other substances, (d) sexual health and family planning, and (e) mental wellness.	• Analyze NCQA HEDIS® measures • Review MCO care coordination approaches and strategies • Monitor MCO care coordination activities and efforts • Assess SDoH needs of members and make appropriate referrals	• Childhood immunizations – Combination 3 • Weight assessment and counseling for nutrition and physical activity for children/adolescents • Controlling high blood pressure (NCQA HEDIS®) • Comprehensive diabetes care (NCQA HEDIS®) • Use of opioids at high dosage (NCQA HEDIS®) • Use of opioids from multiple providers (NCQA HEDIS®) • Depression remission or response for adolescents and adults (NCQA HEDIS®)
5. Strengthen State oversight of programs to maximize partnership with contracted MCOs as committed partners to driving health impacts and acting as good stewards of resources.	1. Monitor member satisfaction scores. 2. Ensure timely MCO reporting per contract standards. 3. Implement updated continuous quality improvement practices to enhance partnership.	• Continue and refine Performance Improvement Projects (PIPs) • Conduct external quality review • Monitor provider credentialing and recredentialing processes • Confirm MCO contract compliance • Assess member satisfaction through Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey • Review member grievances and appeals	• Member satisfaction (CAHPS®) • Disenrollment survey • Grievance and appeals monitoring • PIP reports

These goals align with those identified by the National Quality Strategy, created under the Affordable Care Act and developed by the US Department of Health and Human Services. By coordinating its Quality Strategy with the National Quality Strategy, BMS and WVCHIP will increase the likelihood that the quality activities will coordinate with other national, state, or local health care improvement efforts.

Where appropriate, BMS and WVCHIP selected performance measures and improvement goals to correspond with the priorities. These performance measures indicate areas within each priority that BMS, WVCHIP, and the MCOs will focus on improving.

Section 4. Quality Strategy Development and Review

BMS and WVCHIP's process for developing the Quality Strategy promotes meaningful improvement in clinical and preventive health areas that affect MHT and MHP members. The process also provides a wide range of stakeholders with the opportunity to review and provide feedback.

Initial Development

Originally drafted in 2008, the Managed Care Quality Strategy addressed the MHT-Medicaid program only. The MHP program had a separate Quality Strategy from 2020 to 2021. This iteration (2021) of the Quality Strategy is the first time MHT–Medicaid, MHT–WVCHIP, and MHP programs are addressed together in a collective Managed Care Quality Strategy. This Quality Strategy also recognizes the unique characteristics of each managed care program within the State and addresses them individually when appropriate.

Since the original inception of the Quality Strategy, BMS and WVCHIP annually select the measures associated with program priorities and review MCO performance data, including NCQA HEDIS® measures. BMS and WVCHIP select measures using the following criteria on an annual basis:

- Relevance to the core populations served by the MCOs, including children, children with special health care needs, persons who have disabilities, and pregnant women
- Number of program members for which the measure is applicable
- Alignment with priority chronic diseases, such as asthma, diabetes, and obesity
- Alignment with existing BMS, WVCHIP and MCO quality improvement activities
- Inclusion in the core set of quality measures for children and adults in MHT and MHP a set of priority measures selected by the US Department of Health and Human Services and developed by leading quality organizations, including the National Committee for Quality Assurance (NCQA)
- Historical MCO performance on the measure compared with national benchmarks
- Whether the measure examines care processes rather than health outcomes (members are often enrolled in the programs for a short period of time, so it can be difficult for MCOs to substantially affect the health statuses of members)

BMS and WVCHIP work with the EQRO, which has experience with quality measurement and the MCOs, to determine reasonable, achievable improvement goals for the selected measures. BMS and WVCHIP are currently in the process of setting future improvement goals.

Stakeholder Input

BMS and WVCHIP solicited feedback on the Quality Strategy from all interested stakeholders in March 2021. BMS and WVCHIP posted the Quality Strategy to the BMS website as part of the State's standard public notice process providing an opportunity for any interested stakeholder to offer comments and questions. Additionally, BMS and WVCHIP requested feedback specifically from key stakeholders including the Medical Services Fund Advisory Council, WVCHIP Board of Directors, West Virginia Hospital Association, and West Virginia State Medical Association.

BMS and WVCHIP received limited stakeholder questions focused on the inclusion of WVCHIP in the Quality Strategy, current PIPs, report cards, and NCQA accreditation. Based on the limited stakeholder input received, BMS and WVCHIP made minor revisions to the Quality Strategy prior to submission to CMS. BMS and WVCHIP also responded to stakeholder questions received through the public input process.

Review

BMS and WVCHIP conduct a full review of the Quality Strategy in conjunction with the biennial 1915(b) managed care waivers renewal process. This review considers the quality metrics included in the waiver monitoring results and continuous monitoring of the MHT and MHP programs. The most recent monitoring results can be found in the 2021 1915(b) waiver renewal and the 2019 and 2020 Annual Technical Reports provided by West Virginia's EQRO vendor. [1]

A formal review will also be triggered by a significant change to the MHT or MHP programs, which is defined as any major program expansion such as coverage of a new population or service. During a formal review, BMS and WVCHIP will follow the same process outlined above.

While formal review will occur every two years, the Quality Strategy will be updated and evaluated, as needed, on an ongoing basis so that it better promotes quality improvement and serves the needs of members.

BMS and WVCHIP will submit a copy of the Quality Strategy to CMS whenever substantial changes are made and will submit reports on the implementation and effectiveness of the strategy as required.

Section 5. Assessment

The BMS and WVCHIP quality approach evaluates the quality of care delivered to members in the managed care program. BMS and WVCHIP use several methods to assess the quality of care being delivered by MCOs, including the following:

- Evaluation of the quality and appropriateness of care: BMS and WVCHIP 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.

[1] The 2019 and 2020 Annual Technical Reports are available at: https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Pages/default.aspx.

- Performance measurement: BMS and WVCHIP require MCOs to collect and report measures from the Healthcare Effectiveness Data and Information Set (NCQA HEDIS®) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys.
- External quality review: BMS and WVCHIP contract with an EQRO to conduct independent evaluations of MCO performance, in accordance with Federal regulations.
- MCO reporting: MCOs are required to submit reports to BMS and WVCHIP, which allows BMS and WVCHIP to monitor MCO quality and operations.

Quality and Appropriateness of Care

BMS and WVCHIP established a written Quality Strategy for assessing and improving the quality of health care and services furnished to MHT and MHP members under the MCO contracts as required by 42 CFR §438.340 and 42 CFR §457.1240(e).

BMS and WVCHIP have additional procedures in place to ensure that individuals with special health care needs receive quality and appropriate care. BMS defines individuals with special health care needs as members who receive services funded by Title V (Maternal and Child Health Block Grant). WVCHIP also defines individuals with special health care needs within the WVCHIP contract.

BMS and WVCHIP further describe strategies to deliver quality and appropriate care and reduce health disparities in the Social Determinants of Health section of this Quality Strategy.

Performance Measurement

Performance measurement is key to monitoring and improving quality. It allows BMS and WVCHIP to understand the quality of care currently being delivered to members and evaluate MCO performance over time. BMS and WVCHIP require the MCOs to calculate and report a variety of performance measures as specified in the MCO contract.

BMS and WVCHIP require the MCOs to report NCQA HEDIS® and CAHPS® measures, which indicate the quality of care delivered by MCOs and member satisfaction with the managed care programs. More specifically, the MCOs must collect and report measures 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 the measures that the MCOs are required to report, BMS and WVCHIP selected a subset of key metrics to measure the programs' progress towards specific quality goals and are in the process of determining improvement goals for 2021 and beyond. By limiting the number of metrics, BMS and WVCHIP can focus on improving the most impactful metrics related to the goals set forth in this Strategy. The subset of measures is a central part of the Quality Strategy because they focus BMS, WVCHIP, and their vendors' quality improvement activities. The measures are outlined in Appendix A.

National Performance Measures

BMS and WVCHIP understand the importance of aligning performance measure requirements with those of other national, state, and local entities. As a result, BMS and WVCHIP require the MCOs to report relevant measures included in NCQA HEDIS®, the CMS Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, and the CMS Core Set of Health Care Quality Measures for Medicaid-Eligible Adults.

BMS and WVCHIP also incorporate any national performance measures and levels that may be identified and developed by CMS in consultation with states and other relevant stakeholders into the Quality Strategy and into the MCO contracts during the next MCO contract revision. BMS and WVCHIP requirements for MCO performance measures and levels are contained in the MCO contracts and Appendix A of this Quality Strategy for reference.

Monitoring and Compliance

BMS and WVCHIP require MCOs to submit annual, monthly, quarterly, and periodic reports to BMS or WVCHIP as described in the program's respective MCO contracts. These reports provide information that allows BMS and WVCHIP to monitor the MCOs' operations and performance on an ongoing basis.

Monthly Reports

MCOs are required to submit monthly reports that summarize information from the previous month. This allows for monitoring of quality and fraud and abuse activities to identify issues quickly. Currently, MCOs are required to submit reports on the following:

- Suspension and Adverse Enrollment Action Report
- Third Party Liability Cases Not Pursued
- Substance Use Disorder (SUD) Utilization/Finance Report
- Recovery of All Overpayments Report, included in the Fraud Waste and Abuse (FWA) Report
- Institution for Mental Disease (IMD) Report (MHT-Medicaid and MHP only)
- Children's Residential and Psychiatric Residential Treatment Facilities (PRTF) Services and Demographics Report (MHT-Medicaid and MHP only)
- Fraud, Waste, and Abuse (FWA) Reporting
- Claims Aging Report

Quarterly Reports

MCOs are required to submit certified quarterly reports that summarize information from the previous quarter and must be submitted to BMS and WVCHIP no later than 45 calendar days after the close of the quarter to which they apply. This allows BMS and WVCHIP to identify and respond to any potential problems (such as a high number of grievances or a drop in the size of the network) in a timely fashion. Currently, MCOs must submit reports on the following:

- Enrollment and membership
- Children with special health care needs
- Provider access and availability (PCP and specialist)
- Grievances and appeals

- Utilization of health care services
- Member and provider services functions
- Financial performance
- EPSDT services

Periodic Reports

MCOs must provide BMS and WVCHIP with uniform data on a regular basis, as described in the MCO contract. These include but not limited to the following reports:

- Enrollment composition
- Member satisfaction
- NCQA HEDIS® performance
- Financial performance
- Required reportable diseases

Annual Reports

MCOs must also annually measure and report their performance to BMS and WVCHIP on standard measures and report the status and results of each performance improvement project to BMS and WVCHIP as requested. Specific requirements are included in the MCO contracts.

External Quality Review (EQR)

BMS and WVCHIP 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. The EQRO performs four mandatory external quality review (EQR) activities.

The EQR activities provide BMS and WVCHIP with important information about MCO performance, including whether the MCOs are meeting the access, structure and operations, and measurement and improvement standards required by the MCO contracts. The EQRO also conducts MCO quality measurement and improvement activities in accordance with industry standards and confirms that each MCO provides care that is comparable to the care provided by other MCOs participating in the MHT and MHP programs and commercial health plans.

Table 2: External Quality Review Activities

EQR Review Activity	Description
An operational system review of each MCO	This activity assesses MCO compliance with Federal and State managed care regulations regarding: • Member rights • Quality assessment and performance improvement activities • Member and provider grievance systems • Fraud and abuse detection A successful audit demonstrates that the MCOs have policies, procedures, and documentation in place that meet the requirements and ensure quality, accessible, and timely care for members.
Validation of performance measures produced by each MCO	Performance measure validation ensures that MCOs are producing accurate, reliable data. This ensures that BMS and WVCHIP can use the data to compare, benchmark, and monitor MCOs.
Validation of the performance improvement projects (PIPs) conducted by the MCOs	MCOs are required to have at least three PIPs, which are meant to achieve significant, sustained improvement in clinical or nonclinical care areas, at all times. PIP validation ensures that the MCOs follow PIP best practices, including selecting measures, conducting barrier analysis, and developing and implementing appropriate interventions for the target population. The MCO submits quarterly reports to BMS, WVCHIP, and the EQRO on each PIP's progress. The EQRO validates all PIPs on an annual basis.
Validation of MCO network adequacy	MCOs are required to meet network standards designed to prevent the members from traveling too far for services. In establishing and maintaining a network, MCOs must consider the anticipated MHT and MHP enrollment, expected utilization of services, numbers and types of providers required, number of providers who are not accepting new patients, and geographic location of providers and members.

EQR Review Process

The EQRO conducts an operational systems compliance review through on-site evaluation and reviews MCO documentation on the MCO's processes for quality assurance, member information, utilization management, credentialing, member rights, health education, and fraud and abuse. The EQRO conducts validation activities for the performance improvement projects and the performance measures in accordance with CMS-approved protocols and the NCQA HEDIS® audit methodology.

Upon completion of the external review, the EQRO develops and submits a detailed report of findings and recommendations for quality improvement to BMS, WVCHIP, and the MCOs. Quality improvement plans are developed by the MCO for each component of the external review that does not meet the minimum required standards set forth in the MCO contracts or that resulted in any quality concerns. The quality improvement plans must address timelines and corrective action steps for remediation of the quality concern. BMS and WVCHIP monitors

corrective action plans on a quarterly basis to ensure that the MCO is addressing all areas identified as needing improvement.

The EQRO creates a systems performance review, performance measure validation, and performance improvement project report for each MCO on an annual basis. They also compile an Annual Technical Report in compliance with 42 CFR §438.364 and 42 CFR §457.1250, which includes comprehensive information on quality, access, and timeliness of care in the MHT and MHP programs. It also highlights the program's strengths and challenges and identifies opportunities to improve MCO performance. These reports provide BMS and WVCHIP with the results of all EQR activities for use in planning. For instance, BMS and WVCHIP use the reports to select measures for the Quality Strategy and the Performance Incentive Program and to monitor the progress of the MHT and MHP programs at both the MCO and program level.

Duplication of Standards

As allowed by the CMS "non-duplication" regulation (42 CFR §438.360 and 42 CFR §457.1250), the EQRO contractor will review the Medicare, Medicaid, and CHIP standards for instances where structural and operational standards overlap. Such areas for overlap may include credentialing and recredentialing procedures, using practice guidelines, reporting processes to the MCO Board of Directors, and approval of the Quality Improvement Committee. In these cases, the EQRO will base its reporting on the Medicare findings to avoid duplication. For example, because the credentialing and recredentialing procedures used for Medicare and Medicaid are the same and the process used by Medicare for review of provider credentialing is substantially the same as that used by the EQRO for Medicaid, the EQRO would use the Medicare review for the requirements that are the same.

The MCO will continue to be subject to EQRO review of those activities that are unique to the Medicaid and WVCHIP programs, such as review of grievance and appeals processes, timelines, notifications regarding state fair hearing processes, and EPSDT outreach and notices. BMS, WVCHIP, and the EQRO will monitor, on an ongoing basis, the Medicare standards and processes for review to determine where it is appropriate to use the Medicare review to avoid duplication.

NCQA Accreditation

The CMS "non-duplication" regulation also gives states the authority to use information obtained from a private accreditation review to demonstrate compliance with the operational review standards. States can deem private accreditation organization standards as equivalent to state standards, and MCOs who have been accredited can be exempt from demonstrating compliance with deemed standards during the EQRO's operational systems review. This mechanism was designed to prevent duplication of mandatory compliance review for certain standards that are also required by national accrediting organizations, such as NCQA.

Since January 2014, all MCOs that participate in the MHT and MHP programs have been required to achieve NCQA accreditation. The MCOs' NCQA accreditation status can be found in the Annual Technical Report compiled by the EQRO.

This provides an opportunity to reduce the burden associated with compliance reviews on MCOs. In cases where the State or Federal standard is less stringent than the NCQA requirement, BMS and WVCHIP can use NCQA's assessment in place of the EQR compliance

review. Therefore, the EQRO compares Federal and State standards with those required by NCQA and provides recommendations on which standards can be deemed using NCQA accreditation. In addition to comparing the NCQA and Federal/State standards, the EQRO considers MHT and MHP program priorities, past MCO performance, and the MCOs' NCQA accreditation rating level when recommending which standards to be deemed.

Section 6. State Standards

BMS and WVCHIP'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 compliance with these standards is key to providing high-quality, accessible care because the standards establish an infrastructure to drive quality improvement.

BMS and WVCHIP use prospective, concurrent, and retrospective methods to assure compliance with the managed care quality standards.

Table 3: Methods for Determining Compliance with Quality Standards

Method Type	Quality Monitoring Strategies
Prospective Methods	• MCO certification • MCO contracts with the State of West Virginia • Review of MCO provider network • West Virginia State Insurance Commission MCO licensing
Concurrent Methods	• Review of quarterly reports and encounter data • Monitoring of enrollment broker activities, including disenrollment
Retrospective Methods	• Annual external quality review, including validation of performance improvement projects, validation of performance measures, and compliance review • Review of NCQA HEDIS® and CAHPS® results • Review of encounter data and annual reports • Review of complaint, grievance, and appeals filings

BMS and WVCHIP use the quality monitoring strategies above to determine whether MCOs meet the minimum required standards of the MHT or MHP programs, commensurate with Federal and State laws and regulations. The MCO contract for each program describes minimum standards and are compliant with all Medicaid and CHIP managed care regulations currently in effect. References to specific sections of the regulations and relevant contracts are available in Appendix B.

Access Standards

Availability of Services (§438.206 and §457.1230)

BMS and WVCHIP ensure that all applicable services covered under the State Plan are available and accessible to MCO members. The MCOs provide to members, directly or through arrangements with others, all of the covered services described in the respective MCO contract. Presently, non-emergency medical transportation (NEMT) services are not covered under the MHT or MHP programs, however, MCOs may cover NEMT as a value-added service. NEMT is

also available under the Medicaid FFS program. MCOs must ensure that members are aware of how to access carved-out services.

BMS and WVCHIP ensure, through their contracts, that each MCO meets the requirements shown in the table in Appendix B. MCOs are required to submit quarterly assurance of adequacy through a PCP panel and specialist availability report. On an annual basis, BMS and WVCHIP require MCOs to submit their full provider networks for re-evaluation. BMS and WVCHIP measure and compare the networks against established network adequacy standards.

Network Adequacy Standards (§438.68 and §457.1218)

It is BMS and WVCHIP'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, BMS and WVCHIP require 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. Appendix B identifies the MCO contract sections that outlines the 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. Standards vary based on population and provider type to ensure medical services are accessible throughout the State.

In order to meet access requirements, the MCOs must meet the defined provider-to-member ratios and time and distance standards in every county. In calculating provider-to-member ratios, the MCOs may only count unique providers located within the county. For the time and travel standard, the MCOs may count all provider locations within the county or within the appropriate travel time from the county border.

Assurances of Adequate Capacity and Services (§438.207 and §457.1230)

BMS and WVCHIP ensure through their contracts that each MCO gives assurances and provides supporting documentation that demonstrates its capacity to serve the expected enrollment in its service area in accordance with BMS and WVCHIP standards for access to care. BMS and WVCHIP ensure that each MCO meets the requirements in Appendix B.

After BMS and WVCHIP review the documentation submitted by the MCOs, BMS, and WVCHIP will certify to CMS that the MCOs have complied with the requirements for availability of services. The submission to CMS will include documentation of an analysis that supports the assurance of the adequacy of the network for each MCO. BMS and WVCHIP will make available to CMS, upon request, all documentation collected by BMS and WVCHIP from the MCO.

Coordination and Continuity of Care (§438.208 and §457.1216)

BMS and WVCHIP ensure through their contracts that each MCO complies with the requirements regarding coordination and continuity of care, including procedures to deliver primary care to and coordinate health care service for all MCO members and to assess members identified as having special health care needs. BMS and WVCHIP ensure that each MCO meets the requirements shown in the table in Appendix B.

BMS and WVCHIP have mechanisms to identify persons with special health care needs, defined as individuals with complex or serious medical conditions and who also require health and related services of a type or among beyond that required generally. Identification is a multi-step process. Persons with special health care needs (adults and children) are identified by the enrollment broker during the health assessments conducted as part of the enrollment process. Enrollment counselors review all health assessment forms and record any information on medical conditions, physician preferences, or potential health problems in a comment field on the enrollment screen. Counselors conducting enrollment over the telephone also record any health assessment information in this field. This information, along with copies of the health assessment forms, is forwarded to MCOs with the enrollment rosters. The MCOs also identify children who have special needs regardless of their enrollment in the State's Children with Special Health Care Needs Program, which is a separate State-run program that provides medical services and care coordination to individuals under the age of twenty-one who meet specified financial and medical eligibility criteria.

As stated in the MCO contracts with BMS and WVCHIP, the MCOs must have procedures in place for identifying persons with special health needs. The MCO shall use appropriate health care professionals in assessing those conditions, identifying medical procedures to address and/or monitor these conditions, and developing treatment plans appropriate for those members determined to need a course of treatment or regular care monitoring. The treatment plan must be developed by the member's primary care provider with participation from the member and in consultation with any specialists caring for the member and shall meet applicable quality assurance and utilization standards. The MCOs approve the treatment plan as expeditiously as the member's health condition requires. These treatment plans must be time-specific and updated periodically by the primary care provider. Furthermore, the MCOs must have mechanisms in place to follow-up with members that do not adhere to their treatment plans.

Transition of Care Policy (§438.62 and §457.1216)

BMS and WVCHIP ensure that each MCO has a transition of care policy that minimizes gaps in services and streamlines the transition for members. Per the MCO contracts, the MCO must have a transition of care policy to ensure continued access to services during a transition to or from FFS to a MCO, a transition from one MCO to another, or between settings of care when members, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

Each MCO's transition of care policy must, at a minimum, meet BMS and WVCHIP's defined transition of care policy and comply with Federal requirements as specified in 42 CFR § 438.62(b) and 42 CFR §457.1216. Each MCO's transition of care policy must ensure compliance with 42 CFR §438.62(b)(1)(vi) regarding the process for the electronic exchange of, at a minimum, the data classes and elements included in the content standard adopted at 45 CFR §170.213. The MCOs are required to identify and facilitate transitions for members that are moving from one MCO to another or from the MCO to FFS or to private insurance and require additional or distinctive assistance during a period of transition. When relinquishing members, the MCOs must cooperate with the receiving MCO, FFS program or private insurance plan regarding the course of on-going care with a specialist or other provider. Priority will be given (in no specific order) to members who have medical conditions or circumstances such as members who:

- Are currently hospitalized or in an inpatient setting;
- Are pregnant with high risk pregnancies in their third trimester, or are within thirty (30) calendar days of their anticipated delivery date;
- Are in the process of receiving a major organ or tissue transplantation service or which has been authorized;
- Have a chronic illness, including mental illness, which has placed the member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other, facilities;
- Are in treatment such as SUD, chemotherapy, radiation therapy, or dialysis;
- Have ongoing special health care needs such as specialized DME, including ventilators and other respiratory assistance equipment; and
- Are currently receiving home health services.

The member must have access to services consistent with the access they previously had under the member's previous MCO or FFS program, and is permitted to retain their current provider for a period of thirty (30) calendar days, even if that provider is not in the MCO's network, while a transition of care plan is developed.

In the case of transition of members between MCOs or from FFS to managed care, members that are in the middle of ongoing outpatient treatment covered by Medicaid FFS, WVCHIP FFS, or another MCO prior to their new MCO effective date, will be covered by the new MCO until the end of the current authorization period as granted by either another MCO or FFS, or until the MCO has evaluated and assessed the enrollee and issued or denied a new service authorization.

Each MCO will monitor providers to ensure transition of care from one entity to another to include discharge planning as appropriate. Consistent with Federal and State laws, Medicaid, WVCHIP FFS, or the MCO that was previously serving the member will fully and timely comply with requests for historical utilization data from the new MCO or with requests for copies of member medical records from the member's new provider(s), as appropriate.

MCOs must have in place procedures to share, with the State or other MCOs serving the member, the results of any identification and assessment of that member's needs to prevent duplication of those activities.

Coverage and Authorization of Services (§438.210 and §457.1230)

BMS and WVCHIP ensure through their contracts that each MCO complies with the requirements regarding coverage and authorization of services. The MCO contracts identify, define, and specify the amount, duration, and scope of each service that the MCO is required to offer. BMS and WVCHIP ensure that each MCO meets the requirements in Appendix B.

Structure and Operation Standards

Provider Selection (§438.214 and §457.1233)

BMS and WVCHIP ensure through their contracts that each MCO implements written policies and procedures for selection and retention of providers and that those policies and procedures include, at a minimum, the requirements of the regulation. BMS and WVCHIP established a uniform credentialing and recredentialing policy that each MCO must follow and ensures that

each MCO meets the requirements in Appendix B. The MCO contracts contain detailed MCO credentialing requirements.

Member Information (§438.10 and §457.1207)

BMS and WVCHIP ensure through their MCO contracts that members are informed of the services, operations, and rights under the MHT and MHP programs. The MCO contracts contain requirements for member information as specified in 42 CFR §438.10, 42 CFR §457.1207, and in Appendix B.

Confidentiality (§438.224 and §457.1110)

BMS and WVCHIP ensure through their contracts that each MCO uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR Parts 160 and 164, Subparts A and E, to the extent that these requirements are applicable. The MCO contracts contain requirements that are consistent with 42 CFR Part 431 Subpart F.

Enrollment and Disenrollment (§438.54, §457.56, §457.1210, and §457.1212)

BMS and WVCHIP ensure through their contracts that each MCO complies with the enrollment and disenrollment requirements and limitations.

Grievance Systems (§438.228, §438 Subpart F, and §457.1260)

BMS and WVCHIP ensure through their contracts that each MCO has in effect a grievance system that meets the requirements of 42 CFR §438.228, 42 CFR §438 Subpart F and 42 CFR §457.1260. Detailed MCO grievance requirements are contained in the MCO contracts. The State requires MCOs to maintain records of grievances and appeals and reviews this information through the MCO quarterly reporting process, as required in the MCO contracts. The State and EQRO that collect quarterly grievances, denials and appeals information from the MCOs review the grievances and appeals report each quarter and conduct annual audits of the grievances and appeals reports and MCO processes to ensure compliance with regulations and timeframes.

BMS and WVCHIP delegate to the MCO responsibility for notice of action under 42 CFR §431 Subpart E of this chapter. BMS, WVCHIP, or their contractor reviews or audits each delegated MCO and its providers and subcontractors to ensure that they are notifying members and providers in a timely manner.

Subcontractual Relationships and Delegation (§438.230 and §457.1233)

BMS and WVCHIP ensures through their contracts that each MCO complies with requirements regarding subcontractual relationships and delegation. Detailed MCO delegation requirements are contained in the MCO contracts.

Measurement and Improvement Standards

Practice Guidelines (§438.236 and §457.1233(c))

BMS and WVCHIP ensure through their contracts that each MCO complies with requirements regarding practice guidelines. BMS and WVCHIP require MCOs to adopt and disseminate practice guidelines that are based on valid and reliable medical evidence, or a consensus of health care professionals in the particular field, consider the needs of the enrolled population,

are developed in consultation with contracting health care professionals, and are reviewed and updated periodically.

Quality Assessment and Performance Improvement Program (§438.330 §457.1240)

BMS and WVCHIP ensure through their contracts that each MCO has an ongoing quality assessment and performance improvement program for the services it furnishes to its members. Detailed MCO quality assessment and performance improvement requirements are contained in the MCO contract.

If CMS, in consultation with states and other stakeholders, specifies performance measures and topics for performance improvement projects to be required by states in their contracts with MCOs, BMS and WVCHIP will incorporate these performance measures and topics into the QAPI program requirements.

BMS and WVCHIP will review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The review will include the MCO's performance on the standard measures on which it is required to report and the results of each MCO's performance improvement projects. BMS and WCHIP require that an MCO have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. BMS and WVCHIP ensure that each MCO meets the requirements in Appendix B.

Health Information Systems (§438.242 and §457.1233(d))

BMS and WVCHIP ensure through their contracts that each MCO maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollment for reasons other than loss of eligibility. BMS and WVCHIP will review and validate that the encounter data collected, maintained, and submitted by the MCO meets the requirements below. BMS and WVCHIP must have procedures and quality assurance protocols to ensure that member encounter data submitted is a complete and accurate representation of the services provided to the members under the contract between BMS, WVCHIP, and the MCO. The requirements for MCO health information systems are contained in the MCO contract. BMS and WVCHIP ensure that each MCO meets the requirements in Appendix B.

Section 7. Improvement and Interventions

Social Determinants of Health (SDoH)

SDoH include factors such as housing, education, income, transportation, food security, employment/workforce development, education, childhood experiences, behavior, access to care, and environment. Addressing SDoH is especially important for Medicaid and CHIP populations to improve long-term health outcomes and reduce disparities.

As a component of its population health strategy, BMS and WVCHIP are committed to addressing SDoH to eliminate health disparities within West Virginia. To advance SDoH priorities, BMS and WVCHIP require all MCOs under their managed care programs to “collect

and meaningfully use member-identified race, ethnicity, language, and social determinants of health data to identify and reduce disparities in health care access, services, and outcomes."

In addition, under the MHT program, the enrollment broker conducts assessments of members during the enrollment process to determine if any SDoH impact a member's health care and quality of life. The enrollment broker also informs members of community supports and shares assessment SDoH data recommends appropriate changes to the member materials and cultural competence programs with MCOs. MHT MCOs also take a number of steps through their care coordination programs to address SDoH, such as initial and ongoing evaluation of SDoH needs, member outreach, referrals to community-based organizations, provider trainings, and data collection.

Finally, in accordance with 42 CFR §438.340(b)(6), BMS and WVCHIP will identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. Once this demographic information for each MHT and MHP member is identified, BMS and WVCHIP will provide it to the MCO at the time of enrollment. BMS and WVCHIP collect information on the race, ethnicity, and primary language spoken of each MHT and MHP member at the time of initial determination of Medicaid and WVCHIP eligibility and enter the data into the State's eligibility system, WVPATH (https://www.wvpath.org/).

Behavioral Health Services

The MHT MCOs began delivering the behavioral health benefit on July 1, 2015 and institutions for mental disease (IMD) services on January 1, 2018. With the transition of the WVCHIP membership into a managed care model in January 2021, all behavioral health services are included in the program. Inclusion of the benefit allows for increased coordination of behavioral health and medical services, which will improve overall quality of care for members.

BMS and WVCHIP use the following NCQA HEDIS® measures, as appropriate for the populations' age and conditions, to monitor the quality of the behavioral health services being delivered to members:

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Antidepressant Medication Management
- Diabetes Monitoring for People with Diabetes and Schizophrenia
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Follow-Up After Hospitalization for Mental Illness
- Follow-Up Care for Children Prescribed ADHD Medication
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

BMS and WVCHIP will evaluate performance on the measures listed above, as appropriate, to determine whether any should be included as a priority measure in the strategy in the future.

Performance Improvement Projects (PIPs)

PIPs aim 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.

BMS and WVCHIP require MCOs to initiate and maintain three PIPs. As part of this requirement, BMS also requires the MCOs to participate in two PIP collaboratives – one focused on increasing annual dental visits for members 2-3 years old and one focused on improving follow-up after emergency department visits for alcohol and other drug dependence. For these collaboratives, the MCOs will work together to implement coordinated interventions and use the same performance measures to track progress. As a result, they 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 on increasing compliance with adolescent well-care visits, improving childhood obesity care, and increasing compliance with childhood immunizations.

BMS, WVCHIP, and the MCOs identify topics through continuous data collection and analysis. These topics should be systematically selected and prioritized to achieve the greatest practical benefit for members and should reflect the prevalence of a condition among, or need for a specific service by, the MCO's members based on member demographic characteristics, health risks, and any other special needs.

The MCO must use one or 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 MCO will assess its performance on its selected indicators by collecting and analyzing reliable data on an on-going basis.

Some recent examples of PIPs are listed in Table 4.

Table 4. MHT-Medicaid Performance Improvement Projects

Topic	Care for Adolescents	Promoting Health and Wellness in Children and Adolescents	Follow-Up After Hospitalization for Mental Illness
Aim	Will multipronged interventions improve annual rates of adolescent care including immunizations and well visits for members 9-21 years of age?	Will system-level interventions focused on children and adolescent well-being increase rates for the Adolescent Well Care Visits and BMI Percentile Documentation and Counseling for Nutrition measures by 10 percentage points over the course of the PIP?	Will member, provider, and MCO-targeted interventions improve follow-up compliance for members hospitalized with select mental illness diagnoses? The MCO aims to demonstrate statistically significant improvement by the 2nd remeasurement year and to exceed the NCQA Quality Compass National Medicaid Average plus 5 percentage points for each measure.

Disease Management Programs

All MHT and MHP MCOs operate disease management programs to help members with diabetes, asthma, and other chronic conditions live healthier lives. The programs address disease management issues commonly encountered by the populations served. They incorporate self-management education, member outreach, case management, and clinical support services. The programs engage patients in their care and promote effective care coordination.

Coordination with Health Homes

West Virginia implemented a health home model for individuals who are suffering from bipolar disorder and are at risk for Hepatitis B and/or C within the MHT-Medicaid program. The health home will deliver services that augment clinical care, including comprehensive care management and coordination and identification of appropriate community resources. The state may also implement additional health home models in the future.

NCQA Accreditation

Beginning in 2014, all MCOs were required to be accredited by NCQA. NCQA has a rigorous accreditation process and its standards support continuous quality improvement. This accreditation requirement will enhance oversight of the MCOs by adding an additional layer of review. It will also reduce some of the burden associated with EQR compliance reviews. The MCOs NCQA accreditation status can be found in the Annual Technical Report compiled by the EQRO and posted on the BMS website.[2]

Intermediate 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 draft SFY22 MCO contracts:

[2] West Virginia's MCOs NCQA accreditation is available online at http://dhhr.wv.gov/bms/Members/Managed%20Care/MCOcontracts/Documents/Managed%20Care%20Health%20Plan%20Accreditation%20Status%20for%20West%20Virginia_12.16.20_v2.pdf.

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

Health Information Technology

A strong health information technology system drives quality improvement by supporting quality monitoring, assessment, and improvement activities. BMS and WVCHIP have an information system that aids initial and ongoing operation and review of the Quality Strategy. The information system includes the Medicaid and WVCHIP eligibility and claims/expenditures systems, the managed care enrollment system, and the encounter data system. Each system component is described in more detail below:

- **Medicaid and WVCHIP eligibility and claims/expenditure systems**. The Medicaid and WVCHIP eligibility systems provide data that is used to determine which members are eligible for enrollment in the MHT-Medicaid, MHT-WVCHIP, or MHP programs. The eligibility and claims systems are used to ensure that fees for carved-out services for members are paid appropriately. These systems provide information that is used in the rate-setting process. Data from the eligibility and claims systems are also used to provide comparison information on the Medicaid and WVCHIP FFS system, which is used by the State to evaluate the performance of the MHT and MHP programs as part of ongoing quality monitoring efforts.
- **Managed care enrollment system.** The managed care enrollment system is maintained by the contracted enrollment broker and linked to the State's Medicaid Management Information System (MMIS). The enrollment information system includes information on past and current MHT-enrolled members, including current and past MCO assignments, whether individual enrollment in the current MCO was voluntary or assigned, and current primary care provider assignments. The enrollment system tracks reasons for disenrollment and plan switches. This system also includes information on provider networks, so that the enrollment broker can assist members in selecting a primary care provider. As noted above, the State collects and shares with the MCOs information on the race, ethnicity, and primary language spoken for each member.
- **Encounter data system.** The encounter data system exchanges information between the eligibility and claims systems. MCOs participating in the managed care programs are required to submit monthly encounter data for all defined benefit package services, no later than 90 calendar days after the end of the quarter in which the encounters occurred. All encounters are submitted in electronic or magnetic format, consistent with the formats and coding conventions of the CMS 1500 and UB04. BMS and WVCHIP review all encounter data for timeliness and usability and perform longitudinal analysis to make sure that the data are complete and accurate. The analysis uses NCQA HEDIS® measure definitions corresponding to the year of data, where possible, to ensure consistency and comparability to other encounter data studies.

Specifically, each of the components in the information system provides the State with an "early warning system" to monitor general quality throughout the managed care program. The eligibility system identifies the race, ethnicity, and primary language of each member, which the State

provides to the MCO. For MHT and MHP, the enrollment broker, or State depending on the program, maintains the enrollment fields and tracks reasons for provider changes and MCO disenrollment, which can be signs of member dissatisfaction.

Section 8. Delivery System Reforms

The MHT and MHP programs consistently deliver high-quality services to their members. BMS decided to expand the MHT-Medicaid program to include dental services and behavioral health services. MHT-WVCHIP transitioned to managed care in January 2021 to provide multiple services under a capitated rate agreement with MCOs, potentially offering additional services.

In addition to the quality monitoring and improvement activities that are performed for all benefits, BMS, WVCHIP, and the MCOs have taken additional steps to ensure the high quality of these new services.

WVCHIP Managed Care Transition

On January 1, 2021, WVCHIP transitioned its benefit delivery system from a FFS model to a managed care model. This transition benefited members, providers, and the program. Members have their choice of three MCOs to enroll in and receive benefits under MHT. Members benefit from enhanced health care access and services available under managed care. Members who move between Medicaid and WVCHIP coverage should not experience major gaps of care. Providers will benefit from a reduced administrative burden by an alignment of prior authorization and billing processes with larger health care payers. WVCHIP will benefit from managed care efficiencies related to provider enrollment, utilization management, and more predictive program costs.

To help assure a successful transition, WVCHIP began addressing enrollment processes in the fall of 2019. These changes involved removing a step in the transfer of enrollment date from the eligibility determination system to the claims processing system and developing a reconciliation of enrollment data between the two systems. To remove this additional step in the process, the eligibility system had to directly interface with the claims processing system. The eligibility system also had to determine what enrollment group the member should be enrolled in and transmit this additional data. Additional changes planned prior to the start of managed care include WVCHIP changing its member ID numbers to Medicaid ID number format. The member ID should not change as members move between Medicaid and WVCHIP.

Special Populations

Through the MHP program, BMS provides comprehensive health services, children's residential care services, and Socially Necessary Services (SNS) to select West Virginia Medicaid managed care members who are in foster care, are receiving adoption assistance, or those children eligible under the Serious Emotional Disorder (SED) Waiver program.

Children in Foster Care

Children who are in foster care receive a comprehensive EPSDT exam within 30 days of placement in foster care and a follow-up visit within 90 days of placement in foster care, as needed. The MCO also participates in a multi-disciplinary team (MDT) process that works

together with the child in foster care and the child's family to develop a case service plan and coordinate services. It is the central point for decision making during the life of a case and the MCO participates at the request of the CPS worker, judge, or the MDT itself.

Eligible under the Serious Emotional Disorder (SED) Waiver

The MHP MCO supports children eligible under the SED waiver by helping to keep them with their families, in the home and with a support network while receiving the services they need to improve their outcomes. The MCO also ensures that a child eligible and enrolled in the MCO through the SED waiver will have a Person-Centered Service Plan Team (PCSPT) to develop measurable outcomes that guide the child or youth toward less intensive services and transition or graduation from the waiver. They receive services such as:

- Case management
- In-home family support
- Independent living / skill building
- Job development
- Respite care
- Supported employment
- Assistive equipment
- Community transition
- In-home family therapy
- Mobile response
- Non-medical transportation
- Peer parent support
- Specialize therapy

Directed Payment Program (DPP)

Under the MHT-Medicaid and MHP programs, BMS operates two DPPs – one aimed at all facilities and another aimed at specialty providers. The DPPs provide qualifying providers with additional dollars as an access fee for Medicaid members utilizing their services (inpatient admissions, outpatient claims, or physician visits) and focuses more dollars to higher need settings. Each MCO shall fully participate in and faithfully execute all directed payment programs established by BMS.

BMS established criteria for each DPP, including but not limited to the time frame for the directed payment; providers who will participate in the directed payment; and the mechanism for the calculation and delivery of the amount(s) to be paid to the selected providers. MCOs collect and provide to BMS such information as is required to support all directed payment programs.

Payments to providers are based upon member utilization of services at each provider during the quarter.

DPPs are established in accordance with CMS requirements, including:

- In accordance with 42 CFR §438.6(c)(2)(i)(C), BMS expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 CFR §438.340;

- In accordance with 42 CFR §438.6(c)(2)(i)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to Intergovernmental Transfer Agreements;
- In accordance with 42 CFR §438.6(c)(2)(i)(F), the payment arrangement is not renewed automatically;
- In accordance with 42 CFR §438.6(c)(2)(i), BMS must assure that all expenditures for this payment arrangement are developed in accordance with 42 CFR §438.4, the standards specified in 42 CFR §438.5, and generally accepted actuarial principles and practices.

Section 9. Opportunities

Opportunity for improvement in delivering high quality care is a continual dynamic process. BMS and WVCHIP's managed care programs continue to face many challenges, including the relatively low health status of West Virginians in general and disparities in care quality and access between rural and urban settings.

BMS and WVCHIP are 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. BMS and WVCHIP will continue to refine the 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, BMS and WVCHIP aim to transition from a focus on process measures to outcome measures. BMS and WVCHIP will also remain adaptable to the continually changing health care quality landscape so that their approach remains aligned with other national, statewide, and local initiatives.

Appendix A: Quality Measures

Table 1. MHT and MHP Quality Measures [3]

Measure	Frequency	MHT-Medicaid	MHT-WVCHIP	MHP
Contraceptive Care – Postpartum Women Ages 15-20 (CCP-CH) (New)	Annual	X	X	X
Percentage of Eligible (Children) that Received Preventive Dental Services (PDENT-CH)	Annual	X	X	X
Contraceptive Care – All Women Ages 15-20 (CCW-CH) (New)	Annual	X	X	
Developmental Screening in the First Three Years of Life (DEV-CH) (New)	Annual	X	X	
Child and Adolescent Well-Care Visits (WCV-CH) (New)	Annual	X	X	
Childhood Immunization Status: Combination 3 (CIS-CH)	Annual	X	X	
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	Annual		X	X
Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)	Annual		X	X
Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)^	Annual		X	X
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)	Annual		X	X
Comprehensive Diabetes Care: Eye Exams	Annual	X		
Annual Dental Visits for 2-3 Year-Olds	Annual	X		
Contraceptive Care – Postpartum Women Ages 21–44 (New)	Annual	X		
Contraceptive Care – All Women Ages 21–44 (New)	Annual	X		
Dental Sealants for 6-9 Year-Old Children at Elevated Risk	Annual	X		
Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence: 30 Days Follow-Up	Annual	X		
Follow-Up After Emergency Department Visit for Mental Illness: 30 Days Follow-Up	Annual	X		
Follow-Up After Hospitalization for Mental Illness: 30 Days Follow-Up	Annual	X		

[3] Performance targets related to the MHT and MHP quality metrics can be found in the Annual Technical Report available on the BMS website.

Measure	Frequency	MHT-Medicaid	MHT-WVCHIP	MHP
Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers to Quit	Annual	X		
Cervical Cancer Screening	Annual	X		
PQI 01: Diabetes Short-Term Complications Admission Rate	Annual	X		
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	Annual	X		
PQI 08: Congestive Heart Failure (CHF) Admission Rate	Annual	X		
PQI 15: Asthma in Younger Adults Admission Rate	Annual	X		
Prenatal and Postpartum Care: Postpartum Care	Annual	X		
Use of Imaging Studies for Low Back Pain	Annual	X		
Well-Child Visits in the First 30 Months of Life (New)	Annual	X		
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)^	Annual		X	
Well-Child Visits in the First 30 Months of Life (W30-CH)**	Annual		X	
Immunizations for Adolescents (IMA-CH)	Annual		X	
Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)	Annual		X	
Live Births Weighing Less Than 2,500 Grams (LBW-CH)	Annual		X	
Low-Risk Cesarean Delivery (LRCD-CH)	Annual		X	
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	Annual		X	
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	Annual		X	
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Annual		X	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Annual		X	
Sealant Receipt on Permanent First Molars (SFM-CH)	Annual		X	
Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)	Annual			X

Appendix B: Regulation and Contracts Matrices

Table 1. Availability of Services Regulation and Contracts Matrix

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
a. Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract, considering the following: • The anticipated Medicaid enrollment. • The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO. • The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services. • The numbers of network providers who are not accepting new Medicaid patients. The geographic location of providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities.	§438.206(b)(1) §457.1230	Article III, Section 2.1.1	Article III, Section 2.1.1	Article III, Section 3.1.1
b. Provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.	§438.206(b)(2) §457.1230	Article III, Section 2.1.3	Article III, Section 2.1.3	Article III, Section 3.1.3
c. Provide for a second opinion from a qualified health care professional within the network or arranges for the member to obtain one outside the network, at no cost to the member.	§438.206(b)(3) §457.1230	Article III, Section 5.1	Article III, Section 5.1	Article III, Section 6.1

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
d. If the network is unable to provide necessary services, covered under the contract, to a particular member, the MCO must adequately and timely cover these services out of network for the member, for as long as the MCO is unable to provide them.	§438.206(b)(4) §457.1230	Article III, Section 5.2	Article III, Section 5.2	Article III, Section 6.2
e. Require out-of-network providers to coordinate with the MCO with respect to payment and ensures that cost to the member is no greater than it would be if the services were furnished within the network.	§438.206(b)(5) §457.1230	Article III, Section 5.2	Article III, Section 5.2	Article III, Section 6.2
f. Demonstrate that its providers are credentialed.	§438.206(b)(6) §457.1230	Article III, Section 2.1.4 and Article III, Section 2.1.5	Article III, Section 2.1.1	Article III, Section 3.1.4 and Article III, Section 3.1.5
g. Demonstrate that the network includes sufficient family planning providers to ensure timely access to covered services.	§438.206(b)(7) §457.1230	Article III, Section 1.2.4	Article III, Section 1.2.4	Article III, Section 2.2.6
h. Meet and require its providers to meet state standards for timely access to care and services, taking into account the urgency of the need for services.	§438.206(c)(1)(i) §457.1230	Article III, Section 2.1.2.4	Article III, Section 2.1.2.4	Article III, Section 3.1.2.4
i. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members.	§438.206(c)(1)(ii) §457.1230	Article III, Section 2.1.2.2	Article III, Section 2.1.2.2	Article III, Section 3.1.2.2
j. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.	§438.206(c)(iii) §457.1230	Article III, Section 2.1.2.2	Article III, Section 2.1.2.2	Article III, Section 3.1.2.2
k. Establish mechanisms to ensure compliance by providers.	§438.206(c)(iv) §457.1230	Article III, Section 2.1.2.2	Article III, Section 2.1.2	Article III, Section 3.1.2.2
l. Monitor providers regularly to determine compliance.	§438.206(c)(v) §457.1230	Article III, Section 2.1.2.4	Article III, Section 2.1.2.4	Article III, Section 3.1.2.4
m. Take corrective action if there is a failure to comply.	§438.206(c)(vi) §457.1230	Article III, Section 2.1.2.4	Article III, Section 2.1.2.4	Article III, Section 3.1.2.4

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
n. Participate in DHHR's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.	§438.206(c)(2) §457.1230	Article III, Section 2.1.2.3	Article III, Section 2.1.2.3	Article III, Section 3.1.2.3
o. Ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.	§438.206(c)(3) §457.1230	Article III, Section 2.1.2.3	Article III, Section 2.1.2.3	Article III, Section 3.1.2.3
p. Provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.	§438.206(b)(2) §457.1230	Article III, Section 2.1.3	Article III, Section 2.1.3	Article III, Section 3.1.3

Table 2. Network Adequacy Standards Regulation and Contracts Matrix

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
Develop a quantitative network adequacy standard for the following provider types, if covered under the contract: (i) Primary care, adult and pediatric. (ii) OB/GYN. (iii) Behavioral health (mental health and substance use disorder), adult and pediatric. (iv) Specialist (as designated by the State), adult, and pediatric. (v) Hospital. (vi) Pharmacy. (vii) Pediatric dental.	§438.68(b)(1) §457.1218	Appendix I	Appendix J	Article III, Section 3.1.3 and Appendix K

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
If applicable, develop a quantitative network adequacy standard for LTSS provider types. (i) Time and distance standards for LTSS provider types in which an member must travel to the provider to receive services; and (ii) Network adequacy standards other than time and distance standards for LTSS provider types that travel to the member to deliver services.	§438.68(b)(2) §457.1218	Appendix I	Appendix J	Appendix K
include all geographic areas covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for the same provider type based on geographic areas.	§438.68(b)(3) §457.1218	Appendix I	Appendix J	Appendix K

Note: §438.68(c)(1), (d), and (e) are state requirements and not explicitly included in the MCO contracts. These requirements are demonstrated in State policies and procedures and postings to the BMS and WVCHIP websites.

Table 3. Capacity and Services Regulation and Contracts Matrix

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
a. Submit documentation to DHHR, in a format specified by DHHR to demonstrate that it complies with the following requirements: • Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of members for the service area. • Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.	§438.207(b) §457.1230	Article III, Section 2.1.1	Article III, Section 2.1.1	Article III, Section 3.1.1

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
b. Submit the documentation described above as specified by DHHR, but no less frequently than the following: • At the time it enters into a contract with DHHR. • At any time there has been a significant change (as defined by DHHR) in the MCO's operations that would affect adequate capacity and services, including-- o Changes in MCO services, benefits, geographic service area or payments; or o Enrollment of a new population in the MCO.	§438.207(c) §457.1230	Article III, Section 2.1.1	Article III, Section 2.1.1	Article III, Section 3.1.1

Table 4. Coordination and Continuity of Care Regulation and Contracts Matrix

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
a. Ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member. The member must be provided information on how to contact their designated person or entity.	§438.208(b)(1) §457.1216	Article III, Section 5.3	Article III, Section 5.3	Article III, Section 6.3
b. Coordinate the services the MCO furnishes to the member: • Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; • With the services the member receives from any other MCO; • With the services the member receives in FFS Medicaid; and • With the services the member receives from community and social support providers.	§438.208(b)(2) §457.1216	Article III, Section 5.3.6 and Article III, Section 5.3.3.5	Article III, Section 5.3.2	Article III, Section 6.3

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
c. Provide that the MCO makes a best effort to conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful.	§438.208b(3) §457.1216	Article III, Section 5.3.1	Article III, Section 5.3.1	Article III, Section 2.2.2
d. Share with other MCOs serving the member with special health care needs the results of its identification and assessment of that member's needs to prevent duplication of those activities.	§438.208(b)(4) §457.1216	Article III, Section 5.3 Article III, Section 5.8	Article III, Section 5.3.2 Article III, Section 5.3.4	Article III, Section 6.3.1
e. Ensure that each provider furnishing services to members maintains and shares, as appropriate, an member health record in accordance with professional standards	§438.208(b)(5) §457.1216	Article III, Section 5.8	Article III, Section 5.8	Article III, Section 6.8
f. Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	§438.208(b)(6) §457.1216	Article III, Section 5.3.1 and Article III, Section 5.9	Article III, Section 5.3.4	Article III, Section 6.3.3
g. Implement mechanisms to assess each Medicaid member identified as having special health care needs in order to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.	§438.208(c)(2) §457.1216	Article III, Section 5.3.2	Article III, Section 5.3.4	Article III, Section 6.3.3

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
h. For members with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan produced by the MCO must be: • Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or needs change significantly or at the request of the member; • Approved by the MCO in a timely manner, if this approval is required by the MCO; and • In accord with any applicable State quality assurance and utilization review standards.	§438.208(c)(3) §457.1216	Article III, Section 5.3.4	Article III, Section 5.3.4	Article III, Section 6.3.3
i. Have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs (for members with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring).	§438.208(c)(4) §457.1216	Article III, Section 5.3.4	Article III, Section 5.3.4	Article III, Section 6.3.3

Table 5. Coverage and Authorization of Services Regulation and Contracts Matrix

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
a. Ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.	§438.210(a)(3)(i) §457.1230	Article III, Section 5.4	Article III, Section 5.4	Article III, Section 6.4
b. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.	§438.210(a)(3)(ii) §457.1230	Article III, Section 5.4	Article III, Section 5.4	Article III, Section 6.4

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
c. May place appropriate limits on a service: • On the basis of criteria applied under the State plan, such as medical necessity; or • For the purpose of utilization control, provided that o The services furnished can reasonably be expected to achieve their purpose; o The services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services and supports; and o Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used.	§438.210(a)(4) §457.1230	Article II, Section 4.10 Article III, Section 1.2.4	Article III, Section 5.4	Article III, Section 6.4 Article III, Section 2.2.6
d. Specify what constitutes ``medically necessary services'' in a manner that: • Is no more restrictive than that used in Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and • Addresses the extent to which the MCO is responsible for covering services related to the following: o The prevention, diagnosis, and treatment of health impairments. o The ability to achieve age-appropriate growth and development. o The ability to attain, maintain, or regain functional capacity.	§438.210(a)(4) §457.1230	Article II, Section 1 Article III, Section 1.1	Article II, Section 1 Article III, Section 1.1	Article II, Section 1
e. Have in place, and follow, written policies and procedures for the processing of requests for initial and continuing authorizations of services.	§438.210(b)(1) §457.1230	Article III, Section 5.4	Article III, Section 5.4	Article III, Section 6.4

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
f. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and consult with the requesting provider when appropriate.	§438.210(b)(2) §457.1230	Article III, Section 5.4	Article III, Section 5.4	Article III, Section 6.4
g. That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	§438.210(b)(3) §457.1230	Article III, Section 5.4	Article III, Section 5.4	Article III, Section 6.4
h. Notify the requesting provider, and give the member written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of §438.404.	§438.210(c) §457.1230	Article III, Section 3.8 Article III, Section 5.4	Article III, Section 5.4	Article III, Section 6.4
i. Provide notice for standard authorization decisions as expeditiously as the member's health condition requires and within State-established timeframes of 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if: • The member, or the provider, requests extension; or • The MCO justifies a need for additional information and how the extension is in the member's interest.	§438.210(d)(1) §457.1230	Article III, Section 5.4	Article III, Section 3.8 Article III, Section 5.4	Article III, Section 6.4

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
j. For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 3 working days after receipt of the request for service. The MCO may extend the 3 working day's time period by up to 14 calendar days if the member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the member's interest.	§438.210(d)(2) §457.1230	Article III, Section 5.4	Article III, Section 3.8.1 Article III, Section 5.4	Article III, Section 6.4
k. Compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.	§438.210(e) §457.1230	Article III, Section 5.4	Article III, Section 5.4	Article III, Section 6.4

Table 6. Provider Selection Regulation and Contracts Matrix

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
a. Follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO.	§438.214(b)(2) §457.1233	Article III, Section 2.1.4 – Section 2.1.5	Article III, Section 2.1.4	Article III, Section 3.1.5
b. Must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	§438.214(c) §457.1233	Article III, Section 2.1.4	Article III, Section 2.1.4	Article III, Section 3.1.4
c. May not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.	§438.214(d) §457.1233	Article III, Section 8.7	Article III, Section 2.6.3	Article III, Section 3.1.4
d. Must comply with any additional requirements established by DHHR	§438.214(e) §457.1233	Article III, Section 1.2	Article III, Section 2.1.5	Article III, Section 3.1.6

Table 7. Subcontractual Relationships and Designation Regulation and Contracts Matrix

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
a. Oversee and be accountable for any functions and responsibilities that it delegates to any subcontractor.	§438.230(a)(1) §457.1233	Article III, Section 11	Article III, Section 11	Article III, Section 16
b. Evaluate the prospective subcontractor's ability to perform the activities to be delegated before any delegation.	§438.230(b)(1) §457.1233	Article III, Section 11	Article III, Section 11	Article III, Section 16
c. Have a written agreement for each delegated activity that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	§438.230(c) §457.1233	Article III, Section 11	Article III, Section 11	Article III, Section 8.5
d. Monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by DHHR, consistent with industry standards or State MCO laws and regulations.	§438.230(b)(3) §457.1233	Article III, Section 11	Article III, Section 11	Article III, Section 8.5
e. Take corrective action if the MCO identifies deficiencies or areas for improvement.	§438.230(b)(4) §457.1233	Article III, Section 11	Article III, Section 11	Article III, Section 16

Table 8. Practice Guidelines Regulation and Contracts Matrix

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
a. Adopt practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the MCO's members. • Are adopted in consultation with contracting health care professionals. Are reviewed and updated periodically as appropriate.	§438.236(b) §457.1233(c)	Article III, Section 5.7	Article III, Section 5.7	Article III, Section 6.7

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
Disseminate the guidelines to all affected providers and, upon request, to members and potential members.	§438.236(c) §457.1233(c)	Article III, Section 5.7	Article III, Section 5.7	Article III, Section 6.7
Ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	§438.236(d) §457.1233(c)	Article III, Section 5.7	Article III, Section 5.7	Article III, Section 6.7

Table 9. Quality Assessment and Performance Improvement Programs Regulation and Contracts Matrix

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
a. Conduct performance improvement projects. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction.	§438.330(b)(1) §457.1240	Article III, Section 6.2	Article III, Section 6.2	Article III, Section 7.2
b. Collect and submit performance measurement data.	§438.330(b)(2) §457.1240	Article III, Section 6	Article III, Section 6	Article III, Section 7
c. Have in effect mechanisms to detect both underutilization and overutilization of services.	§438.330(b)(3) §457.1240	Article III, Section 6	Article III, Section 6	Article III, Section 7
d. Have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.	§438.330(b)(4) §457.1240	Article III, Section 6	Article III, Section 6	Article III, Section 7
e. Perform a combination of the following activities: • Measure and report annually to DHHR its performance, using standard measures required by DHHR • Submit to DHHR data, specified by DHHR, which enables DHHR to calculate the MCO's performance using the standard measures identified by DHHR	§438.330(c)(2) §457.1240	Article III, Section 6.2 - 6.3	Article III, Section 6.2-6.2.2	Article III, Section 7.2.2

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
f. Have an ongoing program of performance improvement projects that are designed to achieve significant improvement in health outcomes and member satisfaction, and that involve the following: • Measurement of performance using objective quality indicators. • Implementation of system interventions to achieve improvement in access to and quality of care. • Evaluation of the effectiveness of the interventions. • Planning and initiation of activities for increasing or sustaining improvement.	§438.330(d)(2) §457.1240	Article III, Section 6.2	Article III, Section 6.2-6.2.2	Article III, Section 7.2
g. Report the status and results of each project to DHHR as requested, but not less than once per year. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.	§438.330(d)(3) §457.1240	Article III, Section 6.2	Article III, Section 6.2.2	Article III, Section 7.2

Table 10. Health Information Systems Regulation and Contracts Matrix

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
a. Collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by DHHR to meet the requirements of section 1903(r)(1)(F) of the Act.	§438.242(b)(1) §457.1233(d)	Article III, Section 6.4	Article III, Section 6.4	Article III, Section 7.4
b. Collect data on member and provider characteristics as specified by DHHR, and on services furnished to members through an encounter data system or other methods as may be specified by DHHR.	§438.242(b)(2) §457.1233(d)	Article III, Section 6.4	Article III, Section 6.4	Article III, Section 7.4

Requirement	Regulatory Citation	MHT (Medicaid) MCO Contract Reference	MHT (WVCHIP) MCO Contract Reference	MHP MCO Contract Reference
c. Ensure that data received from providers is accurate and complete by: • Verifying the accuracy and timeliness of reported data; • Screening the data for completeness, logic, and consistency; and • Collecting service information in standardized formats to the extent feasible and appropriate.	§438.242(b)(3) §457.1233(d)	Article III, Section 6.4	Article III, Section 6.4	Article III, Section 7.4
d. Make all collected data available to DHHR and upon request to CMS, as required.	§438.242(b)(4) §457.1233(d)	Article III, Section 6.4	Article III, Section 6.4	Article III, Section 7.4
e. Collect and maintain sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members.	§438.242(c)(1) §457.1233(d)	Article III, Section 5.8	Article III, Section 5.10.5.1	Article III, Section 6.8
f. Submit member encounter data to DHHR at a frequency and level of detail to be specified by CMS and DHHR, based on program administration, oversight, and program integrity needs.	§438.242(c)(2) §457.1233(d)	Article III, Section 5.8	Article III, Section 5.10.5.1	Article III, Section 6.10.5.1
g. Submit all member encounter data that DHHR is required to report to CMS under §438.818	§438.242(c)(3) §457.1233(d)	Article III, Section 5.8	Article III, Section 5.10.5.1	Article III, Section 6.10.5
h. Submit encounter data to DHHR in standardized ASC X12N 837 and NCPCP formats, and the ASC X12N 835 format as appropriate.	§438.242(c)(4) §457.1233(d)	Article III, Section 5.8	Article III, Section 5.10.5.1	Article III, Section 6.10.5

Appendix C: Quality Strategy Crosswalk

Table 1. Federal Quality Strategy Crosswalk

#	Federal Citation[4]	Description
SECTION 2: Program History and Structure		
1	N/A	Include a brief history of the State's Medicaid (and CHIP, if applicable) managed care programs.
2	N/A	Include an overview of the QM structure that is in place at the State level.
SECTION 3: Quality Strategy Approach, Goals and Objectives		
3	N/A	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.
4	§438.340(b)(2)	Developing goals and objectives for continuous QI, which must be measurable and take into consideration the health status of **all populations** served by MCOs.
SECTION 4: Quality Strategy Development and Review		
5	§438.340(c)(1)	Public Comment – Obtaining input from the Medical Care Advisory Committee and consulting with tribes.
6	§438.340(c)(1)(i)	Public Comment – process for broader stakeholder engagement and comment.
7	§438.340(c)(3)	Submitting the Quality Strategy to CMS.
8	§438.340(c)(2)	Review and update Quality Strategy no less than once every three years.
9	§438.340(d)	Posting the Final CMS-Approved Quality Strategy.
10	§438.340(c)(i)	Evaluation of Effectiveness of Previous Quality Strategy.
11	§438.340(b)(11)	The State's definition of a "significant" change for purposes of revising the Quality Strategy and submitting to CMS.
SECTION 5: Assessment		
12	§438.340(b)(4)	Arrangements for annual, external independent reviews, in accordance with §438.350, of the quality outcomes and timeliness or, and access to, the services covered under each MCO.
13	§438.340(b)(10)	The information required under §438.360(c) (relating to non-duplication of EQR activities),
SECTION 6: State Standards		
14	§438.340(b)(1)	State-defined network adequacy standards developed in accordance with §438.68 (e.g., time and distance and LTSS provider standards).

[4] The CHIP program regulations, 42 CFR §457.1240, redirects all quality strategy requirements to 42 CFR §438.340. All Federal Regulations references listed in Appendix C apply to MHT-Medicaid, MHT-WVCHIP and MHP programs.

#	Federal Citation[4]	Description
15	§438.340(b)(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).
16	§438.340(b)(1)	State's approach to adoption and dissemination of evidence-based clinical practice guidelines in accordance with §438.236.
17	§438.340(b)(5)	Description of the State's transition of care policy required under §438.62(b)(3).
18	§438.340(b)(9)	Mechanisms implemented by the State to comply with §438.208(c)(1) (relating to the identification of persons who need LTSS or persons with special health care needs).
SECTION 7: Improvements and Interventions		
19	§438.340(b)(3)(ii)	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.
20	§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.
21	§438.340(b)(7)	Appropriate use of intermediate sanctions that, at a minimum, meet the requirements of 42 CFR §438, Subpart I.
APPENDIX A: Quality Strategy Selected Measures		
22	§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 PMs 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 BMS and WVCHIP website.