West Virginia Mountain Health Trust Program
State Strategy for Assessing and Improving Managed Care Quality
Updated October 1, 2019

Section I: Introduction

Background and Purpose of Mountain Health Trust Program

Mountain Health Trust (MHT) is West Virginia's Medicaid managed care program that has operated in the State since 1996. The program, which is administered by the Bureau for Medical Services (BMS or the Bureau), aims to improve access to high-quality health care for Medicaid beneficiaries by emphasizing the effective organization, financing, and delivery of primary health care services.

In the MHT program, eligible Medicaid beneficiaries living across the State of West Virginia may choose to receive their benefits through a participating managed care organization (MCO), which is a health plan that coordinates services for members. Beneficiaries will select a primary care provider (PCP) who will act as their medical home. The medical home promotes better quality, 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.

MCOs provide enrollees with most acute and preventive physical health care services. Additionally, they provide a wide range of supplementary services, such as health service coordination, case management, and health education. In an effort to expand managed care BMS contracted with MCOs to begin administering the children's dental benefit on January 1, 2014 and behavioral health benefit on July 1, 2015.

While MHT initially served children with special health care needs and low-income children and families, the program currently serves approximately 80% of Medicaid members. BMS expanded the program to enroll the Affordable Care Act (ACA) expansion population on July 1, 2015 and most SSI beneficiaries as of January 1, 2017.

Mountain Health Trust Program Management Structure

The Office of Managed Care, which is housed within BMS, administers the MHT program. The Director of this office oversees all aspects of the MHT program, including its quality activities. The Bureau receives input from several formal and informal groups to support its quality work.

BMS contracts with an external quality review organization (EQRO) to conduct annual, external independent reviews of the quality outcomes associated with, timeliness of, and access to services covered under each MCO Contract.

BMS also works with the following group that provides input on the direction of MHT-related quality activities.

- Medicaid Services Fund Advisory Council (Council): The Council, which is coordinated within BMS, advises the Bureau on a range of issues, including the development and revision of the Quality Strategy. The Council includes providers, beneficiaries, legislators, and agency staff.

In addition, BMS is in frequent contact with numerous stakeholders, including advocates, legislators, providers, other state agencies, the MCOs, the enrollment broker, and the EQRO. These groups provide feedback on quality activities and programs on an ongoing basis both formally and informally. For

instance, BMS regularly engages advocates to provide feedback on a variety of issues, including the Quality Strategy.

Section II: Quality Strategy Approach, Priorities, and Goals

A robust approach to quality is integral to achieving the aims of the MHT program. It ensures that the MCOs provide access to high quality care that meets the program's standards for enrollees. Furthermore, it will coordinate the quality improvement work of BMS and the MCOs so that all involved entities will focus on shared priorities, and as a result, make greater quality gains. The Quality Strategy describes BMS' approach to delivering high-quality, accessible care to all MHT enrollees.[1]

BMS released the original Quality Strategy in 2008 and the document has been updated several times since. BMS put strategies in place to transition the program from a monitoring and oversight approach to one focused on improvement and outcomes.

Approach

The Quality Strategy employs a three-pronged approach to improving the quality of health care delivered to beneficiaries in the MHT program:

1. Monitoring: BMS monitors MCOs for compliance with its managed care quality standards.
2. Assessment: BMS analyzes a variety of health care data to measure performance and identify focus areas for improvement, including indicators for specific diseases and populations.
3. Improvement: BMS and its vendors, including the MCOs and the enrollment broker, implement interventions that target priority areas to maximize the benefit for MHT enrollees.

This approach allows BMS to drive improvement in key health areas while maintaining the overall quality of the services that are currently being delivered by the MHT program.

Priorities and Goals

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

1. Make care safer by promoting the delivery of evidence-based care
2. Engage individuals and families as partners in their care by strengthening the relationship between patients and their primary care provider
3. Promote effective communication and coordination of care
4. Promote effective prevention and treatment of diseases that burden MHT enrollees
5. Enhance oversight of MCO administration

The priorities align with those identified by the National Quality Strategy, which was 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 increases the likelihood that its quality activities will coordinate with other national, state, or local health care improvement efforts.

[1] Because an increasing percentage of MHT beneficiaries are enrolled in MCOs – a trend that is expected to continue – the Quality Strategy primarily focuses on care delivered by MCOs.

Where appropriate, BMS has selected performance measures and improvement goals to correspond with the priorities. These performance measures indicate areas within each priority that BMS and the MCOs will focus on improving. BMS chose measures intended to provide the greatest benefit to MHT enrollees. The improvement goals will be set based on CY 2017 performance.

Finally, priorities, measures, and goals are associated with specific BMS and MCO activities. This will help ensure that BMS and MCO work is supporting quality improvement. 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 program.

Table 1 outlines the structure of the Quality Strategy as described above. The five priorities are listed in the top row of the table. The corresponding measures, goals, and activities and interventions are listed in the column below each priority.

Table 1: Quality Strategy Priorities, Measures, Goals, and Activities

Priorities				
Make care safer by promoting the delivery of evidence-based care	**Engage individuals and families as partners in their care by strengthening the relationship between patients and their primary care provider**	**Promote effective communication and coordination of care**	**Promote effective prevention and treatment of diseases that burden MHT enrollees**	**Enhance oversight of MCO administration**
Measures				
	1. Children and Adolescents' Access to PCP (12-24 months, 25 months-6 years, 7-11 years, and 12-19 years) 2. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	1. Percentage of enrollees receiving care through a PCMH	1. Childhood Immunizations – Combination 3 2. Prenatal and Postpartum Care-Postpartum Care 3. Annual Monitoring for Patients on Persistent Medications –Total 4. Medical Assistance with Smoking and Tobacco Use Cessation – Survey 5. Comprehensive Diabetes Testing – 6. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents –Counseling for Nutrition 7. Initiation & Engagement of Alcohol and Other Drug Dependence Treatment – Initiation 8. Follow-Up After Hospitalization for Mental Illness (Follow-Up Visit Within 7 Days of Discharge)	SPR Compliance Rate
Goals				
	Measure 1: Achieve and/or maintain rates equal to or above the HEDIS (2018) CY 2017 75th percentile by CY 2019. **Measure 2:** Achieve rates equal to or above the HEDIS (2018) CY 2017 National Medicaid Average by CY 2019.	**Measure 1:** Increase percentage by 5% annually	**Measures 1,-3, 5-8:** Achieve rates equal to or above the HEDIS (2018) CY 2017 National Medicaid Average by CY 2019. **Measure 2 and 4:** Increase rates by 5% from baseline performance by CY 2019.	Achieve a 100% SPR compliance rate on major standards: enrollee rights and protections, grievance systems, quality assessment and performance improvement, and fraud and abuse
Activities and Interventions				
Require use of clinical practice guidelines Change payment policies for never events and hospital acquired infections Utilize prospective drug review	Enrollment outreach Ensure access to a primary care provider Promote enrollee engagement in treatment plans Review enrollee grievances and appeals Administer CAHPS survey	MCO-based patient centered medical homes initiatives Focus on case management Coordinate with health homes Promote use of treatment plans Promote use of electronic health records through the West Virginia Health Information Network and the WV Immunization Registry	Implement performance incentive program Implement performance improvement projects Analyze HEDIS measures	Annual external quality review Provider credentialing and recredentialing processes Utilization management processes MCO reporting requirements MCO contract requirements Fraud, abuse, and waste monitoring

Section III: Development and Review of the Quality Strategy

BMS' process for developing and reviewing the Quality Strategy ensures that it drives meaningful improvement in clinical and preventive health areas that affect MHT enrollees. The process also provides a wide range of stakeholders, including beneficiaries, with the opportunity to review and provide feedback on draft versions of the document.

Initial Development

BMS reviewed the MHT program goals, the National Quality Strategy, and the Governor of West Virginia's goals to develop broad quality priorities that would be flexible to changing conditions within and outside of the MHT program.

To select the measures associated with the priorities, BMS reviewed MCO performance data, including HEDIS measures. The Bureau chose measures using the following criteria:

- Relevance to the core populations served by the MCOs, including children, children with special health care needs, and pregnant women
- Number of MHT members for which the measure is applicable
- Alignment with priority chronic diseases, including asthma, diabetes, and obesity
- Alignment with existing BMS and MCO quality improvement activities, including the performance withhold program
- Alignment with the Governor of West Virginia's statewide goals
- Inclusion in the core set of quality measures for children and adults in Medicaid and CHIP, 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 MHT program for a short period of time, so it can be difficult for MCOs to substantially affect the health statuses of members.)

BMS worked with its EQRO, which has experience with quality measurement and the MCOs, to determine reasonable, achievable improvement goals for the selected measures. The goals will be set based on CY 2017 performance.

Stakeholder Input

BMS solicited feedback on the Quality Strategy, including the priorities and selected measures, from many stakeholders, including beneficiaries, the MCOs, providers, advocates, and other State agencies. The Bureau requested feedback in both informal and formal settings, as described below.

- Advocates: BMS solicited feedback from advocates and other interested stakeholders by inviting them to a public meeting to discuss the updates to the Quality Strategy.
- Managed Care Organizations: BMS asked the MCOs to provide feedback on the Quality Strategy at the annual MCO Orientation Meeting. BMS also requested informal feedback from the MCOs throughout the drafting process.
- The Medical Services Fund Advisory Council: The Bureau will obtain the input of beneficiaries and other stakeholders by sharing the strategy with the Medicaid Services Fund Advisory Council at its meeting. The Council will also review and adopt the final version of the Quality Strategy, as is required when significant changes are made to the document.

- The Mountain Health Trust Task Force: BMS obtains feedback from the Task Force at their quarterly meetings.

The stakeholder input process will be used to refine the Quality Strategy and obtain buy-in from relevant groups. BMS will continually revise the document as they receive feedback from stakeholders.

Review

BMS will conduct a full review of the Quality Strategy in conjunction with the biannual managed care waiver renewal process. A formal review will also be triggered by a significant change to the MHT program, which is defined as any major program expansion such as coverage of a new population or service. During a formal review, the Bureau 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 enrollees.

The Bureau will submit a copy of the strategy to CMS whenever substantial changes are made and will submit reports on the implementation and effectiveness of the strategy as required.

Section IV: State Standards

The Bureau'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. Monitoring compliance with these standards is key to providing high-quality, accessible care because the standards establish an infrastructure to drive quality improvement.

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

Table 2: Methods for Determining Compliance with Quality Standards

Prospective Methods	• BMS MCO certification • MCO contracts with the State of West Virginia • BMS 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 HEDIS and CAHPS results • Review of encounter data and annual reports • Review of complaint, grievance, and appeals filings

The quality monitoring strategies described above are used to determine whether MCOs are meeting the minimum required standards of the Mountain Health Trust program, commensurate with federal and state laws and regulations. The minimum standards are described in the MCO Contract and are compliant with the final Medicaid managed care regulations issued by the Centers for Medicare and Medicaid Services on May 6, 2016. The quality of care standards are summarized below. References to specific sections of the waiver and relevant contracts are noted where appropriate.

Access Standards

Availability of Services (§438.206)

The Bureau ensures that all applicable services covered under the State Plan are available and accessible to MCO enrollees. The MCOs provide to enrollees, directly or through arrangements with others, all of the covered services described in Exhibit A of the MCO Contract. Presently non-emergency transportation services are excluded from MCOs' capitation rates, but remain covered Medicaid services for persons who are enrolled in the MCO (the Bureau will continue to pay the transportation broker on a PMPM basis). MCOs must ensure that enrollees are aware of how to access carved-out services.

The Bureau ensures, through its contracts, that each MCO meets the requirements shown in the table below. MCOs are required to submit quarterly assurance of adequacy through a PCP panel and specialist availability report. On an annual basis, the Bureau requires MCOs to submit their full provider networks for re-evaluation. The Bureau measures and compares the networks against established FFS benchmarks. The full MCO Statement of Work (MCO Contract Article III) is included.

Requirement	Regulatory Citation	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 enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.	§438.206(b)(1)	Article III, Section 2.1.1
b. Provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.	§438.206(b)(2)	Article III, Section 2.1.3
c. Provide for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	§438.206(b)(3)	Article III, Section 5.1
d. If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO must adequately and timely cover these services out of network for the enrollee, for as long as the MCO is unable to provide them.	§438.206(b)(4)	Article III, Section 5.2
e. Require out-of-network providers to coordinate with the MCO with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.	§438.206(b)(5)	Article III, Section 5.2
f. Demonstrate that its providers are credentialed.	§438.206(b)(6)	Article III, Section 2.1.5
g. Demonstrate that the network includes sufficient family planning providers to ensure timely access to covered services.	§438.206(b)(7)	Article III, Section 1.2.4
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)	Article III, Section 2.1.2
i. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.	§438.206(c)(1)(ii)	Article III, Section 2.1.2
j. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.	§438.206(c)(iii)	Article III, Section 2.1.2

Requirement	Regulatory Citation	MCO Contract Reference
k. Establish mechanisms to ensure compliance by providers.	§438.206(c)(iv)	Article III, Section 2.1.2
l. Monitor providers regularly to determine compliance.	§438.206(c)(v)	Article III, Section 2.1.2
m. Take corrective action if there is a failure to comply.	§438.206(c)(vi)	Article III, Section 2.1.2
n. Participate in the Bureau's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.	§438.206(c)(2)	Article III, Section 2.1.2
o. Ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	§438.206(c)(3)	Article III, Section 2.1.2

Assurances of Adequate Capacity and Services (§438.207)

The Bureau ensures through its contracts that each MCO gives assurances and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the Bureau's standards for access to care. The Bureau ensures that each MCO meets the requirements shown in the table below.

After the Bureau reviews the documentation submitted by the MCO, the Bureau will certify to CMS that the MCO has complied with the Bureau's 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. The Bureau will make available to CMS, upon request, all documentation collected by the Bureau from the MCO.

Requirement	Regulatory Citation	MCO Contract Reference
a. Submit documentation to the Bureau, in a format specified by the Bureau 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 enrollees for the service area. • Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.	§438.207(b)	Article III, Section 2.1
b. Submit the documentation described in paragraph (b) of this section as specified by the Bureau, but no less frequently than the following: • At the time it enters into a contract with the Bureau. • At any time there has been a significant change (as defined by the Bureau) 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)	Article III, Section 2.1

Coordination and Continuity of Care (§438.208)

The Bureau ensures through its 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 enrollees and assess Medicaid enrollees identified as having special health care needs. The Bureau ensures that each MCO meets the requirements shown in the table below.

The Bureau has 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 Contract Statement of Work, 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 enrollees determined to need a course of treatment or regular care monitoring. The treatment plan must be developed by the enrollee's primary care provider with participation from the enrollee and in consultation with any specialists caring for the enrollee and shall meet applicable quality assurance and utilization standards. The MCOs approve the treatment plan as expeditiously as the enrollee'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 enrollees that do not adhere to their treatment plans.

Requirement	**Regulatory Citation**	**MCO Contract Reference**
a. Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee. The enrollee must be provided information on how to contact their designated person or entity.	§438.208(b)(1)	Article III, Section 5.3

Requirement	Regulatory Citation	MCO Contract Reference
b. Coordinate the services the MCO furnishes to the enrollee: • Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; • With the services the enrollee receives from any other MCO; • With the services the enrollee receives in FFS Medicaid; and • With the services the enrollee receives from community and social support providers.	§438.208(b)(2)	Article III, Section 5.3
c. Provide that the MCO makes a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful.	§438.208b(3)	Article III, Section 5.9
d. Share with other MCOs serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.	§438.208(b)(4)	Article III, Section 5.3 Article III, Section 5.6.3
e. Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards	§438.208(b)(5)	Article III, Section 5.9
f. Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	§438.208(b)(6)	Article III, Section 5.10
g. Implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.	§438.208(c)(2)	Article III, Section 5.6.3
h. For enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan produced by the MCO must be: • Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly or at the request of the enrollee; • 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)	Article III, Section 5.6.3
i. Have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs (for enrollees with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring).	§438.208(c)(4)	Article III, Section 5.6.3

Coverage and Authorization of Services (§438.210)

The Bureau ensures through its contracts that each MCO complies with the requirements regarding coverage and authorization of services. Exhibit A of the MCO Contract identifies, defines, and specifies the amount, duration, and scope of each service that the MCO is required to offer.

The Bureau ensures that each MCO meets the requirements shown in the table below.

Requirement	**Regulatory Citation**	**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)	Article III, Section 5.4
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)	Article III, Section 5.4
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 enrollee's ongoing need for such services and supports; and o Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used.	§438.210(a)(4)	Article III, Section 5.4 Article III, Section 1.2.4
d. Specify what constitutes ``medically necessary services'' in a manner that: • Is no more restrictive than that used in the Bureau Medicaid program as indicated in State statutes and regulations, the Bureau 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)	Article II, Section 1 Article III, Section 1.1
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)	Article III, Section 5.4
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)	Article III, Section 5.4

Requirement	Regulatory Citation	MCO Contract Reference
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 enrollee's condition or disease.	§438.210(b)(3)	Article III, Section 5.4
h. Notify the requesting provider, and give the enrollee written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 438.404.	§438.210(c)	Article III, Section 3.8 Article III, Section 5.4
i. Provide notice for standard authorization decisions as expeditiously as the enrollee'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 enrollee, or the provider, requests extension; or • The MCO justifies (to the Bureau upon request) a need for additional information and how the extension is in the enrollee's interest.	§438.210(d)(1)	Article III, Section 3.8
j. For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service. The MCO may extend the 3 working day's time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO justifies (to the Bureau upon request) a need for additional information and how the extension is in the enrollee's interest.	§438.210(d)(2)	Article III, Section 5.4
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 enrollee.	§438.210(e)	Article III, Section 5.4

Structure and Operation Standards

Provider Selection (§438.214)

The Bureau ensures through its 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. The Bureau has established a uniform credentialing and recredentialing policy that each MCO must follow and ensures that each MCO meets the requirements shown in the table below. Detailed MCO credentialing requirements are contained in Article III of the MCO Contract.

Requirement	Regulatory Citation	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)	Article III, Section 2.1.4 – Section 2.1.5
b. Must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	§438.214(c)	Article III, Section 2.1.4
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)	Article III, Section 2.1.4
d. Must comply with any additional requirements established by the Bureau.	§438.214(e)	Article III, Section 2.1.5

Enrollee Information (§438.218)

Enrollee information requirements are part of the Bureau's overall quality strategy. The MCO Contract Statement of Work, Article III, contains requirements for enrollee information as specified in 42 CFR 438.10. The full MCO Contract is included.

Confidentiality (§438.224)

The Bureau ensures through its 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 Contract Statement of Work (Article III, Sections 3.6 and 5.10), contains requirements that are consistent with 42 CFR Part 431 Subpart F.

Enrollment and Disenrollment (§438.226)

The Bureau ensures through its contracts that each MCO complies with the enrollment and disenrollment requirements and limitations. The MCO Contract Statement of Work (Article III, Section 3.2) contains requirements that are consistent with 42 CFR 438.56.

Grievance Systems (§438.228 and §438.416)

The Bureau ensures through its contracts that each MCO has in effect a grievance system that meets the requirements of 42 CFR Part 438 Subpart F. Detailed MCO grievance requirements are contained in the MCO Contract Scope of Work (Article III, Section 3.8). 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 Contract. The State reviews the grievances and appeals report each quarter and, in conjunction with the EQRO, conducts annual audits of the grievances and appeals reports and MCO processes to ensure compliance with regulations and timeframes.

The Bureau delegates to the MCO responsibility for notice of action under Subpart E of Part 431 of this chapter. The Bureau or its contractor reviews or audits each delegated MCO and its providers and subcontractors to ensure that they are notifying enrollees and providers in a timely manner.

Subcontractual Relationships and Delegation (§438.230)

The Bureau ensures through its contracts that each MCO complies with requirements regarding subcontractual relationships and delegation. Detailed MCO delegation requirements are contained in the MCO Contract Scope of Work (Article III, Section 11).

Requirement	Regulatory Citation	MCO Contract Reference
a. Oversee and be accountable for any functions and responsibilities that it delegates to any subcontractor.	§438.230(a)(1)	Article III, Section 11
b. Evaluate the prospective subcontractor's ability to perform the activities to be delegated before any delegation.	§438.230(b)(1)	Article III, Section 11
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)	Article III, Section 11
d. Monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the Bureau, consistent with industry standards or State MCO laws and regulations.	§438.230(b)(3)	Article III, Section 11
e. Take corrective action if the MCO identifies deficiencies or areas for improvement.	§438.230(b)(4)	Article III, Section 11

Measurement and Improvement Standards

Practice Guidelines (§438.236)

The Bureau ensures through its contracts that each MCO complies with requirements regarding practice guidelines. Detailed MCO practice guidelines requirements are contained in the MCO Contract Scope of Work (Article III, Section 5.8).

Requirement	Regulatory Citation	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 enrollees. • Are adopted in consultation with contracting health care professionals. • Are reviewed and updated periodically as appropriate.	§438.236(b)	Article III, Section 5.8
b. Disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	§438.236(c)	Article III, Section 5.8
c. Ensure that decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	§438.236(d)	Article III, Section 5.8

Quality Assessment and Performance Improvement Program (§438.330)

The Bureau ensures through its contracts that each MCO has an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees. Detailed MCO quality assessment and performance improvement requirements are contained in the MCO Contract Scope of Work (Article III, Section 6).

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, the Bureau will incorporate these performance measures and topics into the QAPI program requirements.

The Bureau 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. The Bureau requires 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.

The Bureau ensures that each MCO meets the requirements shown in the table below.

Requirement	**Regulatory Citation**	**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 enrollee satisfaction.	§438.330(b)(1)	Article III, Section 6.2
b. Collect and submit performance measurement data.	§438.330(b)(2)	Article III, Section 6
c. Have in effect mechanisms to detect both underutilization and overutilization of services.	§438.330(b)(3)	Article III, Section 6
d. Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	§438.330(b)(4)	Article III, Section 6
e. Perform a combination of the following activities: • Measure and report annually to the Bureau its performance, using standard measures required by the Bureau • Submit to the Bureau data, specified by the Bureau, which enables the Bureau to calculate the MCO's performance using the standard measures identified by the Bureau	§438.330(c)(2)	Article III, Section 6.2 - 6.3
f. Have an ongoing program of performance improvement projects that are designed to achieve significant improvement in health outcomes and enrollee 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)	Article III, Section 6.2

Requirement	Regulatory Citation	MCO Contract Reference
g. Report the status and results of each project to the Bureau 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)	Article III, Section 6.2.2

Health Information Systems (§438.242)

The Bureau ensures, through its 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 disenrollments for other than loss of Medicaid eligibility. The Bureau will review and validate that the encounter data collected, maintained, and submitted by the MCO meets the requirements below. The Bureau must have procedures and quality assurance protocols to ensure that enrollee encounter data submitted is a complete and accurate representation of the services provided to the enrollees under the contract between the Bureau and the MCO. The requirements for MCO health information systems are contained in the MCO Contract Scope of Work (Article III, Section 6.4).

The Bureau ensures that each MCO meets the requirements shown in the table below.

Requirement	Regulatory Citation	MCO Contract Reference
a. Collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the Bureau to meet the requirements of section 1903(r)(1)(F) of the Act.	§438.242(b)(1)	Article III, Section 6.4
b. Collect data on enrollee and provider characteristics as specified by the Bureau, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the Bureau.	§438.242(b)(2)	Article III, Section 6.4
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)	Article III, Section 6.4
d. Make all collected data available to the Bureau and upon request to CMS, as required.	§438.242(b)(4)	Article III, Section 6.4
e. Collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.	§438.242(c)(1)	Article III, Section 5.11.4
f. Submit enrollee encounter data to the Bureau at a frequency and level of detail to be specified by CMS and the Bureau, based on program administration, oversight, and program integrity needs.	§438.242(c)(2)	Article III, Section 5.11.4.1

Requirement	Regulatory Citation	MCO Contract Reference
g. Submit all enrollee encounter data that the Bureau is required to report to CMS under § 438.818	§438.242(c)(3)	Article III, Section 5.11.4.1
h. Submit encounter data to the Bureau in standardized ASC X12N 837 and NCPCP formats, and the ASC X12N 835 format as appropriate.	§438.242(c)(4)	Article III, Section 5.11.4

Section V: Assessment

The Bureau's second quality approach involves evaluating the quality of care that is currently being delivered to MHT enrollees. This allows BMS to determine the areas where MCOs are performing poorly so that they can efficiently invest resources to promote improvement in struggling areas. Additionally, assessment plays a role in monitoring MCO compliance with quality standards.

BMS uses several methods to assess the quality of care being delivered by MCOs, including the following:

- Evaluation of the quality and appropriateness of care: BMS has procedures in place to ensure that high quality, appropriate care is delivered to all MHT enrollees, including those with special health care needs, regardless of their race, ethnicity, and primary language spoken.
- Performance measurement: The Bureau requires MCOs to collect and report measures from the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.
- External quality review: BMS contracts with an external quality review organization (EQRO) to conduct independent evaluations of MCO performance, in accordance with federal regulations.
- MCO reports: MCOs are required to submit several reports to BMS, which allows the Bureau to monitor MCO quality.

Quality and Appropriateness of Care

The Bureau has established a written quality strategy for assessing and improving the quality of health care and services furnished to all Medicaid enrollees under the MCO contracts as required by 42 CFR §438.340. Many of these procedures are performed by the EQRO. Other procedures are described elsewhere in this strategy, particularly in Section IV.

In accordance with 42 CFR §438.340(b)(6), the Bureau 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 Medicaid enrollee is identified, the Bureau will provide it to the MCO at the time of enrollment. The Department of Health and Human Resources (DHHR) collects information on the race, ethnicity, and primary language spoken of each Medicaid enrollee at the time of initial determination of Medicaid eligibility and enters the data into the State's eligibility system, RAPIDS. This information is then sent to the MCOs through a HIPAA compliant transmission. The enrollment broker reviews the information to assess the demographics of the MHT population and recommends appropriate changes to the enrollee materials and cultural competence programs.

BMS has additional procedures in place to ensure that individuals with special health care needs, which the Bureau defines as enrollees who are funded by Title V, receive quality, appropriate care. These procedures are also described in the Section IV of this document.

Performance Measurement

Performance measurement is key to monitoring and improving quality. It allows BMS to understand the quality of care currently being delivered to MHT enrollees and evaluate MCO performance overtime. Therefore, the Bureau requires the MCOs to calculate and report a variety of performance measures as specified in the MCO contract (Article III, Section 6).

Most importantly, BMS requires the MCOs to report HEDIS and CAHPS measures, which indicate the quality of care delivered by and enrollee satisfaction with the MHT program. 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)
- Enrollee satisfaction measures (e.g., satisfaction with physician and health plan)

Of the measures that the MHT MCOs are required to report, BMS selected a small set and outlined associated improvement goals as described in Section II. The limited set of measures is a central part of the Quality Strategy because they focus BMS and its vendors' quality improvement activities. The measures goals, and current benchmarks are outlined in Table 3.

Table 3: Quality Strategy Selected Measures and Goals

Measure	Goal	WV MHT MCO WA MY 2017	Goal	MY 2017 WV MHT Performance Compared to NMA
Adolescent Well-Care Visits	Achieve rates equal to or above the HEDIS 2018 (CY 2017) and the National Medicaid Average (NMA) by MY 2018.	56.70%	HEDIS 75th Percentile	↑
Adult BMI Assessment	Achieve rates equal to or above the HEDIS 2018 (CY 2017) and the NMA by MY 2018.	88.53%	HEDIS 75th Percentile	↑
Annual Dental Visit (Total)	Achieve rates equal to or above the HEDIS 2018 (CY 2017) and the NMA by MY 2018.	61.35%	HEDIS 75th Percentile	↑
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Achieve rates equal to or above the HEDIS 2018 (CY 2017) and the NMA by MY 2018.	27.08%	HEDIS 50th Percentile	↓
Childhood Immunizations – Combination 3	Achieve rates equal to or above the HEDIS 2018 (CY 2017) and the NMA by MY 2018.	67.07%	HEDIS 50th Percentile	↓
Comprehensive Diabetes Care – HbA1c Testing	Achieve rates equal to or above the HEDIS 2018 (CY 2017) and the NMA by MY 2018.	87.59%	HEDIS 75th Percentile	↑
Controlling High Blood Pressure	Achieve rates equal to or above the HEDIS 2018 (CY 2017) and the NMA by MY 2018.	58.38%	HEDIS 75th Percentile	↑

Table 3: Quality Strategy Selected Measures and Goals

Measure	Goal	WV MHT MCO WA MY 2017	Goal	MY 2017 WV MHT Performance Compared to NMA
Immunizations for Adolescents – Combination 1	Achieve rates equal to or above the HEDIS 2018 (CY 2017) and the NMA by MY 2018.	83.41%	HEDIS 70th Percentile	↑
Immunizations for Adolescents – HPV	Achieve rates equal to or above the HEDIS 2018 (CY 2017) and the NMA by MY 2018.	25.17%	HEDIS 25th Percentile	↓
Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	Achieve rates equal to or above the HEDIS 2018 (CY 2017) and the NMA by MY 2018.	67.31%	HEDIS 50th Percentile	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition (Total)	Achieve rates equal to or above the HEDIS 2018 (CY 2017) and the NMA by MY 2018.	71.65%	HEDIS 75th Percentile	↑
Well-Child Visits in the first 15 Months of Life (6 or more visits)	Achieve rates equal to or above the HEDIS 2018 (CY 2017) and the NMA by MY 2018.	67.83%	HEDIS 75th Percentile	↑
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Achieve rates equal to or above the HEDIS 2018 (CY 2017) and the NMA by MY 2018.	75.12%	HEDIS 75th Percentile	↑

↑WV MHT MCO rate above NMA
↓WV MHT MCO rate below NMA

National Performance Measures

BMS understands the importance of aligning its performance measure requirements with those of other national, state, and local entities. As a result, the Bureau has required the MCOs to report relevant measures included in the Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (i.e., measures related to services delivered by the MHT program). Table 4 outlines the Core Measures that BMS currently uses.

BMS will 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 Contract during the next MCO Contract revision. Bureau requirements for MCO performance measures and levels are contained in the MCO Statement of Work (MCO Contract Article III, Section 6).

Table 4: Performance Measures Used by BMS

MCO Performance Measures
Adolescent Well-Care Visits
Annual Dental Visits for 2-3 Year Olds
Behavioral Health Risk Assessment for Pregnant Women
Childhood Immunization Status: Combination 3
Comprehensive Diabetes Care: HbA1c Testing
Dental Sealants for 6-9 Year Old Children at Elevated Risk
Follow-Up after Hospitalization for Mental Illness: 7 Days Follow-Up
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation Total
Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers to Quit
Mental Health Utilization: Any Service Total
Percentage of Eligible (Children) that Received Preventive Dental Services
PQI 01: Diabetes Short-Term Complications Admission Rate
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
PQI 08: Congestive Heart Failure (CHF) Admission Rate
PQI 15: Asthma in Younger Adults Admission Rate
Prenatal and Postpartum Care: Postpartum Care
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Nutrition
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
Adherence to Antipsychotic Medications for Individuals with Schizophrenia
Adult BMI Assessment
Annual Monitoring for Patients on Persistent Medications
Antidepressant Medication Management
Appropriate Testing for Children with Pharyngitis
Appropriate Treatment for Children with Upper Respiratory Infection
Asthma Medication Ratio
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
Breast Cancer Screening
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
Cervical Cancer Screening
Childhood Immunization Status
Chlamydia Screening in Women
Comprehensive Diabetes Care
Controlling High Blood Pressure
Diabetes Monitoring for People with Diabetes and Schizophrenia
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
Follow-Up After Hospitalization For Mental Illness
Follow-Up Care for Children Prescribed ADHD Medication
Immunizations for Adolescents
Lead Screening in Children
Medication Management for People With Asthma
Metabolic Monitoring for Children and Adolescents on Antipsychotics
Non-Recommended Cervical Cancer Screening in Adolescent Females
Persistence of Beta-Blocker Treatment after a Heart Attack

Pharmacotherapy Management of COPD Exacerbation
Statin Therapy for Patients With Cardiovascular Disease
Statin Therapy for Patients With Diabetes
Use of Imaging Studies for Low Back Pain
Use of Multiple Concurrent Antipsychotics in Children and Adolescents
Use of Opioids at High Dosage
Use of Opioids From Multiple Providers
Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Adults' Access to Preventive/Ambulatory Health Services
Annual Dental Visit
Children and Adolescents' Access to PCP
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment
Prenatal and Postpartum Care
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
Adolescent Well-Care Visits
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

External Quality Review (EQR)

BMS contracts with an External Quality Review Organization (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.[2] The EQRO performs four mandatory external quality review (EQR) activities, as specified by the Balanced Budget Act and described in table 5.

The EQR activities provide the Bureau 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 and outlined in Section IV of this document. They also ensure MCO quality measurement and improvement activities are being conducted in accordance with industry standards and that each MCO provides care that is comparable to the care provided by other MCOs participating in the MHT program and commercial health plans.

Table 5: External Quality Review Activities

An operational system review of each MCO	This activity assesses MCO compliance with Federal and State Medicaid managed care regulations regarding: • Enrollee rights • Quality assessment and performance improvement activities • Enrollee 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 enrollees.
Validation of performance measures produced by each MCO	Performance measure validation ensures that MCOs are producing accurate, reliable data. This ensures that BMS can use the data to compare, benchmark, and monitor MCOs.

[2] BMS currently contracts with the Qlarant (formerly Delmarva) to perform EQRO functions.

Validation of the performance improvement projects conducted by the MCOs	MCOs are required to have at least three performance improvement projects (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 and the EQRO on each PIP's progress and the EQRO validates all PIPs on an annual basis.
Validation of MCO network adequacy[3]	MCOs are required to meet network standards designed to prevent the enrollees from traveling to far for services. In establishing and maintaining a network, MCOs must consider the anticipated Medicaid enrollment, expected utilization of services, numbers and types of providers required, number of providers who are not accepting new Medicaid patients and geographic location of providers and Medicaid enrollees.

EQR Review Process

The operational systems compliance review is conducted by a team of EQRO analysts and clinicians who conduct an on-site evaluation and review MCO documentation on the MCO's processes for quality assurance, enrollee information, utilization management, credentialing, enrollee rights, health education, and fraud and abuse. The validation activities for the performance improvement projects and the performance measures are conducted according to the 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 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 Contract 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 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, performance improvement project report, for each MCO on an annual basis. They also compile an Annual Technical Report, which includes comprehensive information on quality, access, and timeliness of care in the MHT program. It also highlights the program's strengths and challenges and identifies opportunities to improve MCO performance. These reports provide BMS with the results of all EQR activities for use in planning. For instance, BMS uses the reports to select measures for the Quality Strategy and the Performance Incentive Program and to monitor the progress of the MHT program at both the MCO and program level.

Duplication of Standards

As allowed by the CMS "non-duplication" regulation (42 CFR §438.360), the EQRO contractor will review the Medicare and Medicaid standards for instances where structural and operational standards overlap between the Medicare review and the EQR Medicaid review (such as credentialing and recredentialing procedures, using practice guidelines, reporting processes to the MCO Board of Directors, approval of the Quality Improvement Committee). In these cases, the EQRO will base its reporting on the Medicare

[3] This EQRO activity is pending for SFY 2019.

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 program, such as review of grievance and appeals processes, timelines, notifications regarding state fair hearing processes, and EPSDT outreach and notices. The State 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.

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 the National Committee for Quality Assurance (NCQA).

Since January 2014, all MCOs that participate in the MHT program have been required to achieve NCQA accreditation. 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 can use NCQA's assessment in place of the EQR compliance review. Therefore, the Bureau requested that the EQRO compare federal and state standards with those required by NCQA and provide BMS with recommendations on which standards can be deemed using NCQA accreditation. In addition to comparing the NCQA and federal/state standards, BMS asked the EQRO to consider MHT program priorities, past MCO performance, and the MCOs' NCQA accreditation rating level when recommending which standards to be deemed. Based on these criteria, the EQRO recommended not deeming any of the compliance standards for the first year. However, BMS and the EQRO revisited deeming in 2016. The Balanced Budget Act of 1997, which became effective in 2002, and the Medicaid managed care regulations for external quality review (42 CFR §438.360) provided the authority for CMS to develop an optional process for states to use. In recognition of the comparability between government requirements and private accreditation standards, the CMS "non-duplication" regulation (42 CFR §438.360) gives states the authority to use information obtained from a private accreditation review to demonstrate compliance with the operational review standards.

This mechanism was designed to prevent duplication of mandatory compliance review for certain standards that were surveyed by a national accrediting organization, such as the National Committee for Quality Assurance (NCQA) and determined to meet requirements. If an MCO has undergone a survey and meets national accreditation guidelines, certain standards have been found to be comparable or equivalent to the BBA standards. This accreditation can demonstrate compliance with federal requirements to allow states to *deem* private accreditation organization standards as equivalent to state standards. The *deemed* standards would be *exempt from duplication of review* through the EQRO compliance review process.

All MCOs that participate in the MHT program were required to achieve NCQA accreditation by January 2014. This provided 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 can use NCQA's assessment in place of the EQR compliance review. Therefore, the Bureau requested that the

EQRO compare federal and state standards with those required by NCQA and provide BMS with recommendations on which standards can be deemed using NCQA accreditation. In addition to comparing the NCQA and federal/state standards, BMS asked the EQRO to consider MHT program priorities, past MCO performance, and the MCOs' NCQA accreditation rating level when recommending which standards to be deemed. Based on these criteria, the EQRO recommended not deeming any of the compliance standards for the first year of accreditation. In 2015, with the implementation of behavioral health benefits and the expansion population, BMS and the EQRO determined that deeming should be on hold in order to ensure that these two vulnerable populations are integrated into and monitored by the MCOs for access and quality issues. The EQRO will assess opportunities for deeming in 2016 when the NCQA Medicaid Managed Care Toolkit and Crosswalk are updated and published for fiscal year 2017. This timeframe will allow the MCOs time to ensure that the behavioral health benefit and the expansion population have been integrated into the daily operations of the MCOs.

MCO Reports

MCOs are required to submit annual, monthly, quarterly, and periodic reports to BMS as described in the MCO Statement of Work. These reports provide information that allows the Bureau to monitor the MCOs.

Monthly Reports

MCOs are required to submit monthly reports that summarize information from the previous month and must be submitted to BMS by the 15th of the following month to which they apply. This allows BMS to monitor quality and fraud and abuse activities to identify issues quickly. Currently, MCOs are required to submit reports on the following:

- Health care professionals, institutions, or suppliers denied credentialing, suspended, or terminated due to concerns about provider fraud, integrity, or quality deficiencies
- Suspected fraud and abuse cases
- Third party liability information

Quarterly Reports

MCOs are required to submit certified quarterly reports that summarize information from the previous quarter and must be submitted to BMS no later than 45 calendar days after the close of the quarter to which they apply. This allows BMS 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 are required to submit summary reports on the following:

- Medicaid 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 with uniform data on a regular basis, as described in the MCO Statement of Work (MCO Contract Article III, Section 5.11). These include the following reports:

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

Annual Reports

MCOs must also annually measure and report its performance to the Bureau, using standard measures required by the Bureau, and report the status and results of each performance improvement project to the Bureau as requested. Specific requirements are included in the MCO Contract.

Section VI: Improvement and Interventions

BMS' third quality approach is implementing interventions to improve the quality of care in targeted areas. Interventions include the following:

- Improvement programs and activities that improve the quality of care in focus areas identified by the Quality Strategy priorities and selected measures
- Sanctions that address areas in which MCO performance is deficient

In general, BMS gives the MCOs the freedom to choose, design, and implement interventions so that they best suit the needs of their enrollees. However, in some instances the Bureau provides more specific guidance to the MCOs. This may change as BMS continues to refine its quality approach.

Quality Improvement Programs

Based on the results of the assessment activities, BMS and the MCOs have implemented a range of quality improvement programs. Each program is linked with at least one of the Quality Strategy priorities described in Section II so that they will drive improvement in priority areas and improve MCO performance on the selected measures.

The improvement programs are specifically designed to target the MHT population and are formally and informally evaluated on a continual basis to ensure that they are improving quality. BMS will alter their quality improvement programs in response to changes in the MHT program and new information about care quality.

Due to budget constraints, the performance-related withhold was discontinued in SFY 2018.

Performance Improvement Projects

Performance improvement projects (PIPs) are designed to achieve significant, sustained improvement in clinical or nonclinical care areas that are important to MHT enrollees. They are crucial pieces of MCO quality programs and allow specific areas of concern to be targeted for improvement.

In SFY 2014, BMS increased the number of PIPs that MCOs are required to have in place from two to three. As part of this requirement, the state also required the MCOs to participate in two PIP collaboratives – one focused on improving diabetes care and one focused on reducing inappropriate usage of the emergency department. 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 enrollees.

Each MCO also runs their own PIP project, which allows them to focus on the needs of their specific enrolled population. These PIPs focus on increasing compliance with adolescent well-care visits, improving childhood obesity care, and increasing compliance with childhood immunizations.

- <u>All three MCOs are required to participate in three performance improvement projects</u>
- Childhood Immunization Status (CIS) Combination*. An indicator for Well-Care Visits*.
    - The EQRO has recommended that this PIP be closed and that the MCO continues with the interventions it has deemed successful.
    - This measure will be replaced with the Maternity Care- Behavioral Health Risk Assessment
        - Percentage of women, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: depression screening, alcohol use screening, tobacco use screening, drug use screening (illicit and prescription, over the counter), and intimate partner violence screening.

- Emergency Department (ED) Collaborative Project
  The mandatory indicator is *Annual Percentage of Asthma Patients with one or More Asthma-Related Emergency Department Visits (ages 2-20)*.

- *Diabetes Collaborative Project*
  The mandatory indicator is *Hemoglobin A1c (HbA1c) Control (<8%)* with the goal to meet or exceed the HEDIS 2015 (MY 2014) National Medicaid Average by HEDIS 2016 (MY 2015

<u>Disease Management Programs</u>

All MHT MCOs have developed disease management programs to help enrollees with diabetes, asthma, and other chronic conditions live healthier lives. The programs are specifically designed to address disease management issues commonly encountered by the Medicaid population. 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.

<u>Coordination with Health Homes</u>

West Virginia has implemented a health home model for individuals who are suffering from bipolar disorder and are at risk for Hepatitis B and/or C. 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.

<u>NCQA Accreditation</u>

Beginning in 2014, all MCOs were required to be accredited by the National Committee for Quality Assurance (NCQA). NCQA has a rigorous accreditation process and its standards support continuous quality improvement. This accreditation requirement will enhance BMS oversight of MCO administration by adding an additional layer of review. It will also reduce some of the burden associated with EQR compliance reviews.

Intermediate Sanctions

The State contract establishes intermediate sanctions under certain circumstances as required by 42 CFR 438.700. 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 incorporated into the SFY16 MCO contract:

- Corrective action plans
- Financial penalties, including liquidated damages
- Suspension of new enrollment or disenrollment
- Withholding from capitation payments
- Receivership by state Medicaid agency
- Termination or non-renewal of contract

Section VII: Health Information Technology

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

- Medicaid eligibility and claims/expenditure systems. The Medicaid eligibility system provides data that is used to determine which Medicaid beneficiaries are eligible for enrollment in the Mountain Health Trust program. The eligibility and claims systems are used to ensure that fees for carved-out services for Mountain Health Trust enrollees are paid appropriately. These systems provide information that is used in the Mountain Health Trust rate-setting process. Data from the eligibility and claims systems are also used to provide comparison information on the Medicaid fee-for-service system which is used by the State to evaluate the performance of the Mountain Health Trust program as part of ongoing quality monitoring efforts.

- Medicaid 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 beneficiaries, 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 disenrollments and plan switches. This system also includes information on provider networks, so that the enrollment broker can assist beneficiaries 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 Medicaid enrollee.
- Encounter data system. The encounter data system exchanges information between the eligibility and claims systems. MCOs participating in the Mountain Health Trust program are required to submit encounter data for all defined benefit package services rendered monthly, 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. The Bureau reviews all encounter data for timeliness and usability and performs longitudinal analysis to make sure that the data are complete and accurate. The analysis uses Healthcare Effectiveness Data and Information Set (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 Medicaid managed care program. Medicaid eligibility is determined and maintained by the State DHHR. The eligibility system identifies the race, ethnicity, and primary language of each enrollee, which the State provides to the MCO. The managed care enrollment fields are updated and maintained by the enrollment broker. The enrollment broker tracks reasons for provider changes and plan disenrollment, which can be signals of enrollee dissatisfaction.

Section VIII: Delivery System Reforms

The MHT program has consistently delivered high quality services to its enrollees. As a result, BMS decided to expand the MHT program to include pharmacy services and children's dental.[4] Participating MCOs began delivering the pharmacy benefit on April 1, 2013, the children's dental benefit on January 1, 2014 and behavioral health services on July 1, 2015. In April 2017, The State decided to move the pharmacy benefit back to fee for service based on increasing pharmacy costs with the benefit in managed care. The change will be effective July 1, 2017.

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

Behavioral Health Services

The MCOs began delivering the behavioral health benefit on July 1, 2015. Inclusion of the benefit allows for increased coordination of behavioral health and medical services, which will improve overall quality of care for enrollees.

[4] The pharmacy expansion became effective on April 1, 2013.

During the transition period, BMS increased monitoring, particularly of the provider network, to ensure enrollee access to quality behavioral health services. The state required biweekly behavioral health network reporting, as well as reports on service utilization, grievances and appeals, and member services, until the provider networks and services were deemed adequate and stable. After 6 months a behavioral progress report was requested as a means continued program progress and stability.

BMS will use the following HEDIS measures to monitor the quality of the behavioral health services being delivered to members:

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Antidepressant Medication Management
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
- 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
- Identification of Alcohol and Other Drug Services
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Mental Health Utilization

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

Section IX: Conclusion

The MHT program has consistently used the medical home model to provide enrollees with access to quality health care services. MCOs perform near or above the national Medicaid average on HEDIS measures that look at access to primary and preventive care, and adults and children enrolled in the program report high levels of satisfaction with the care they receive. However, the MHT program continues 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.

As a result, BMS has developed a quality approach that ensures that the MHT program will continue to deliver quality, accessible care to enrollees while simultaneously driving improvement in key areas. The Quality Strategy outlines how the Bureau will monitor MCO compliance with Federal and State standards, assess the quality of the MHT program, and implement interventions to improve the care being delivered to enrollees. Specifically, it will promote the following key quality priorities:

1. Make care safer by promoting the delivery of evidence-based care
2. Engage individuals and families as partners in their care by strengthening the relationship between patients and their primary care provider
3. Promote effective communication and coordination of care
4. Promote effective prevention and treatment of diseases that burden MHT enrollees
5. Enhance oversight of MCO administration

The Bureau 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 program. Additionally, as its quality infrastructure becomes more sophisticated, BMS aims to transition from a focus on process measures to outcome measures. The Bureau will also

remain adaptable to the continually changing health care quality landscape so that its approach remains aligned with other national, statewide, and local initiatives.